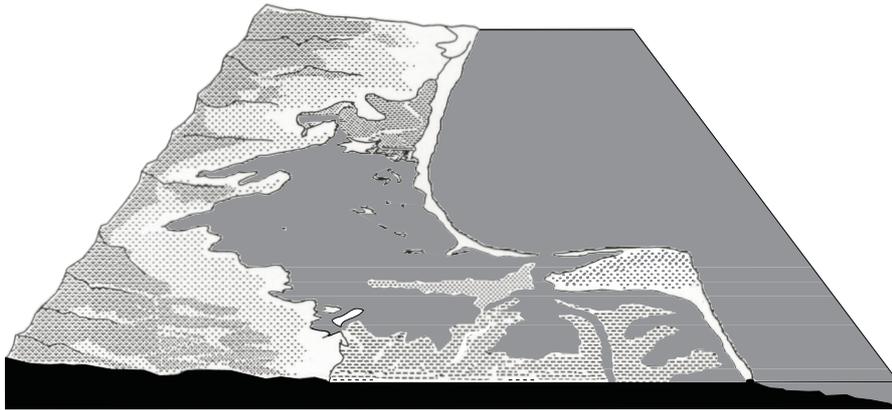


THE
NAPIER HOSPITAL
AND HEALTH SERVICES
REPORT



THE
NAPIER HOSPITAL
AND HEALTH SERVICES
REPORT

WAI 692

WAITANGI TRIBUNAL REPORT 2001



The cover design by Cliff Whiting invokes the signing of the Treaty of Waitangi and the consequent interwoven development of Maori and Pakeha history in New Zealand as it continuously unfolds in a pattern not yet completely known

A Waitangi Tribunal report

ISBN 1-86956-261-5

© Waitangi Tribunal 2001

www.waitangi-tribunal.govt.nz

Produced by the Waitangi Tribunal

Published by Legislation Direct, Wellington, New Zealand

Printed by SecuraCopy, Wellington, New Zealand

Set in Adobe Minion and Cronos multiple master typefaces

LIST OF CONTENTS

Letter of transmittal	xxi
Executive summary	xxiii
CHAPTER 1: INTRODUCTION	
1.1 The purpose of the report	1
1.2 The Treaty in the social policy sphere	1
1.3 Approach and method	4
1.4 The arrangement of the report	5
CHAPTER 2: THE NAPIER HOSPITAL CLAIM	
2.1 Chapter outline	7
2.2 The claimants	7
2.3 The development of the claim	8
2.3.1 Origins	8
2.3.2 The downgrading of Napier Hospital and the first claim (Wai 473)	8
2.3.3 The Wai 473 claim on hold	9
2.3.4 The closure of Napier Hospital and the second claim (Wai 692)	10
2.3.5 Consolidation into the regional inquiry and the broadening of the claim	11
2.3.6 The third amended statement of claim	12
2.3.7 The evolution of the claim	13
2.4 The claim in its final form	14
2.4.1 Treaty obligations	14
2.4.2 Historical grievances	15
2.4.3 Contemporary grievances	15
2.4.4 Findings and recommendations sought	17
2.5 The hearings and the evidence	18
2.6 Crown assistance with Tribunal research on contemporary issues	19
2.6.1 Disruption of commissioned research	19
2.6.2 Access to current official records	20
2.6.3 The relationship between Tribunal research interviews and Crown evidence	21
2.6.4 The Official Information and Commissions of Inquiry Acts	22
2.6.5 Assisting Tribunal research	24
2.6.6 Conclusions and findings	24
2.7 Limitations on findings presented in this report	26
2.7.1 Relationship with the main report on the Mohaka ki Ahuriri inquiry	26

CONTENTS

CHAPTER 2: THE NAPIER HOSPITAL CLAIM — *continued*

2.7.2	Sufficiency of evidence	27
2.7.3	The identity of the claimants	28
2.7.4	‘The Crown’ and public health service provision	31
2.7.4.1	Statutory provisions	31
2.7.4.2	The control test	33
2.7.4.3	The extent of Crown control in the health sector from 1885	34
2.7.4.4	Delegated agencies under the purchaser–provider regime (1991–2000)	34
2.7.4.5	Responsibility for Treaty obligations in respect of delegated authority	36
2.7.5	Specific and generic issues	36

CHAPTER 3: TREATY INTERPRETATION

3.1	Chapter outline	39
3.2	The role of the Tribunal	39
3.2.1	The identity of ‘the Crown’	39
3.2.2	Jurisdiction and substantiation	40
3.2.3	Discretion as to scope of recommendations	42
3.3	Status and application of the Treaty	44
3.3.1	Constitutional status	44
3.3.2	Interpreting the Treaty	45
3.3.3	Determining Treaty principles	46
3.3.4	Principles applicable to the claim	47
3.4	The principle of active protection	48
3.4.1	Protection of land	48
3.4.2	Protection of health as a taonga	49
3.4.3	Protection of Maori people and their health	49
3.4.4	The limits of active protection	54
3.4.5	Health resources under tribal authority	55
3.4.6	Tikanga Maori in mainstream health services	56
3.4.7	Balancing rangatiratanga and kawanatanga	57
3.5	The principle of partnership	58
3.5.1	The scope of partnership	58
3.5.2	The interface of partnership	59
3.5.3	Maori representation in decision-making processes	61
3.6	The principle of equity	61
3.7	The principle of options	65
3.8	The duty of good faith conduct	66
3.9	The duty of consultation	66
3.9.1	Consultation and Treaty principles	66
3.9.2	The extent of the Crown’s obligation to consult	67

CONTENTS

CHAPTER 3: TREATY INTERPRETATION — *continued*

3.9.3	Statutory requirements to consult	68
3.9.4	The process and standards of consultation	70
3.9.5	Tikanga Maori in the consultation process	71
3.9.6	Findings on consultation	73

CHAPTER 4: MAORI HEALTH AND THE AHURIRI TRANSACTION, 1840–51

4.1	Chapter outline	75
4.2	Analysis of the evidence	75
4.2.1	The challenge to Maori health	75
4.2.1.1	The customary Maori health system	75
4.2.1.2	The arrival of exotic diseases	77
4.2.1.3	A crisis of survival	79
4.2.1.4	Exotic diseases and ill health in central Hawke's Bay	80
4.2.2	Missionary medicine	81
4.2.2.1	The missionary influence	81
4.2.2.2	Colenso's medical campaign in Hawke's Bay	82
4.2.3	Crown health service provision for Maori	83
4.2.3.1	The formation of British policy on protecting Maori health	83
4.2.3.2	Governor Grey's hospital programme	85
4.2.3.3	Native medical officers	88
4.2.4	Crown land purchasing and public health expectations	88
4.2.4.1	Medical services as a land-selling incentive	88
4.2.4.2	Organised immigration and the Wairarapa land negotiations	91
4.2.5	The Ahuriri negotiations	93
4.2.5.1	A port town in Te Whanganui a Orotu	93
4.2.5.2	The promise of a hospital	97
4.2.6	The siting of the hospital	99
4.2.6.1	The alienation of Mataruahou and Te Taha	99
4.2.6.2	Mataruahou as a place of healing	102
4.3	The positions of the parties	106
4.3.1	The case for the claimants	106
4.3.2	The response of the Crown	107
4.3.3	The claimants' reply	108
4.4	Findings, Treaty breaches, and prejudice	108
4.4.1	The scope of our findings	108
4.4.2	Crown protection of Maori health in the 1840s	109
4.4.2.1	Did colonial policy and practice aim to protect Maori health?	109
4.4.2.2	Were adequate steps taken to protect Maori health in Hawke's Bay?	109
4.4.3	The Ahuriri transaction and the promise of a hospital	110

CONTENTS

CHAPTER 4: MAORI HEALTH AND THE AHURIRI TRANSACTION, 1840–51 — *continued*

4.4.3.1	Did collateral health service benefits feature in land purchase negotiations?	110
4.4.3.2	What health services were Ahuriri Maori seeking from the Crown?	111
4.4.3.3	Was a hospital promised to Ahuriri Maori in 1851?	111
4.4.3.4	What were the terms of the hospital promise?	112
4.4.4	Was there an undertaking on the siting of a hospital?	113
4.4.5	Did Mataruahou have cultural significance for Maori as a place of healing?	113
4.5	Overview of prejudicial effects	115

CHAPTER 5: THE STATE HEALTH SYSTEM AND AHURIRI MAORI, 1852–1980

5.1	Chapter outline	117
5.2	Analysis of the evidence	117
5.2.1	Maori expectations of the Ahuriri transaction	117
5.2.2	Two medical revolutions	119
5.2.3	The governance and financing of public hospitals	120
5.2.3.1	The provincial takeover of the State hospitals (1850s)	120
5.2.3.2	Hospital boards	121
5.2.4	Building the hospital on the hill	123
5.2.4.1	The first Napier Hospital (1855–60)	123
5.2.4.2	The second Napier Hospital (1875–84)	125
5.2.5	Napier Hospital and Maori patients	127
5.2.5.1	The hospital in operation	127
5.2.5.2	Maori use of the hospital	129
5.2.6	Barriers facing Maori access to hospital treatment	131
5.2.6.1	Distance	131
5.2.6.2	Doctor's referrals	135
5.2.6.3	Financial discrimination	135
5.2.6.4	Hospital fees and debt	136
5.2.6.5	Hospital facilities for Maori	139
5.2.6.6	Maori staff	139
5.2.6.7	Respect for tikanga Maori	140
5.2.7	Primary health services	142
5.2.7.1	New institutions and NMOs	142
5.2.7.2	An NMO at Napier (1856–67)	144
5.2.7.3	The NMO scheme in practice and Maori concerns	146
5.2.8	Public and community health	148
5.2.8.1	The beginnings of State primary healthcare services	148
5.2.8.2	Vaccination	148
5.2.8.3	Medical services through schools	149
5.2.8.4	Maori councils	150

CONTENTS

CHAPTER 5: THE STATE HEALTH SYSTEM AND AHURIRI MAORI, 1852–1980 — *continued*

5.2.8.5 District nurses for Maori	152
5.2.8.6 Relief for indigents	155
5.2.9 Maori ill health and the crisis of survival	156
5.2.9.1 Disease and depopulation	156
5.2.9.2 Poverty and ill health amongst Hawke's Bay Maori in the 1930s	158
5.2.10 Urbanisation and social reform	159
5.3 The positions of the parties	160
5.3.1 The case for the claimants	160
5.3.2 The response of the Crown	162
5.3.3 The claimants' reply	162
5.4 Findings, Treaty breaches, and prejudice	163
5.4.1 The scope of our findings	163
5.4.2 Consulting Ahuriri Maori and establishing their health needs	164
5.4.2.1 Were Ahuriri Maori consulted on the siting of Napier Hospital?	164
5.4.2.2 Were Ahuriri Maori consulted on their health needs?	165
5.4.2.3 Were sufficient steps taken to establish the health needs of Ahuriri Maori?	167
5.4.3 Representation, participation, and rangatiratanga	167
5.4.3.1 Were Ahuriri Maori represented in institutions determining their health services?	168
5.4.3.2 To what extent did Ahuriri Maori participate in health provider agencies?	169
5.4.3.3 To what extent were State health services delivered under Maori control?	170
5.4.4 The adequacy of State health services for Ahuriri Maori	171
5.4.4.1 How adequately did Napier Hospital meet the health needs of Ahuriri Maori?	171
5.4.4.2 How adequately did State primary health services meet the health needs of Ahuriri Maori?	173
5.4.4.3 Were State health services responsive to tikanga Maori?	174
5.4.4.4 Was the delivery of health services to Ahuriri Maori adequately monitored and supervised?	175
5.5 Overview of prejudicial effects	176

CHAPTER 6: CONSULTATION WITH MAORI ON THE CLOSURE OF NAPIER HOSPITAL

6.1 Chapter outline	179
6.2 Analysis of the evidence	180
6.2.1 Health reforms and institutional restructuring	180
6.2.1.1 Phase 1: area health boards (1989–91)	180
6.2.1.2 Phase 2: RHAS and CHES (1991–96)	180
6.2.1.3 The health reforms, phase 3 (1997–2000)	181
6.2.1.4 The health reforms, phase 4 (2001)	182
6.2.1.5 Restructuring in Hawke's Bay	182
6.2.2 The regional hospital concept revived and deferred (1980–89)	183
6.2.2.1 Prologue: hospital rivalry between Napier and Hastings	183
6.2.2.2 The hospital board's proposal for a new hospital	186

CONTENTS

CHAPTER 6: CONSULTATION WITH MAORI — *continued*

6.2.2.3 Consultation with Maori	188
6.2.3 The area health board and regionalisation revisited (1989–91)	189
6.2.3.1 Plans to regionalise hospital services	189
6.2.3.2 Consultation with Maori	192
6.2.3.3 The views of Ahuriri Maori	194
6.2.3.4 The beginnings of a convergence	194
6.2.4 The transitional regime and regionalisation revisited (1991–93)	195
6.2.4.1 Decisions made during the transitional regime	195
6.2.4.2 Consultation with local Maori	198
6.2.5 The decision to locate the regional hospital at Hastings (1993–95)	198
6.2.5.1 How Healthcare Hawke’s Bay made the decision	198
6.2.5.2 The Central RHA’s assurance on Napier Hospital	200
6.2.5.3 The hands of the purchaser and the shareholders	200
6.2.5.4 To consult or not to consult?	202
6.2.5.5 Purchaser, provider, and bridging the consultation split	203
6.2.5.6 Informing the public	207
6.2.5.7 The consultation process	208
6.2.5.8 Consultation with Maori through public and stakeholder meetings	211
6.2.5.9 Consultation with iwi – the Omahu hui	212
6.2.5.10 Consultation after the event – the kaumatua hui at Hastings Hospital	214
6.2.5.11 Consultation with Maori through written submissions	215
6.2.5.12 Consultation with Maori through oral submissions	215
6.2.5.13 An alternative Treaty-based consultation	216
6.2.5.14 Taking account of the views expressed	218
6.2.5.15 Public protest, parliamentary redress, and Maori opinion	219
6.2.6 The decision to remove Napier Hospital’s site ‘guarantee’ (1995–96)	220
6.2.6.1 An uneasy compromise	220
6.2.6.2 Official assurances on the status of Napier Hospital	220
6.2.6.3 The removal of Napier Hospital’s guarantee	222
6.2.6.4 Consultation by the Central RHA	225
6.2.7 The decision to vacate the Napier Hospital site for a downtown centre (1997)	227
6.2.7.1 The Napier services working party	227
6.2.7.2 From community hospital to downtown health centre	229
6.2.7.3 Consideration of Maori health needs	230
6.2.7.4 Consultation by the Napier services working party	231
6.2.7.5 Healthcare Hawke’s Bay’s public consultation	232
6.2.8 The establishment of the Napier Health Centre	234
6.2.8.1 The final rundown of Napier Hospital	234
6.2.8.2 The location of the downtown health centre	234

CONTENTS

CHAPTER 6: CONSULTATION WITH MAORI — *continued*

6.2.8.3 Consultation with local Maori	234
6.2.9 Maori cultural perceptions of the hospital and health centre sites	235
6.3 The positions of the parties	236
6.3.1 The case for the claimants	236
6.3.2 The response of the Crown	239
6.3.3 The claimants' reply	240
6.4 Findings, Treaty breaches, and prejudice	241
6.4.1 The scope of our findings	241
6.4.2 What was the extent of the Crown health agencies' obligation to consult?	241
6.4.3 Was there meaningful consultation on the regional hospital decisions?	242
6.4.3.1 The decision in principle to have a regional hospital	242
6.4.3.2 The decision to base the regional hospital in Hastings	243
6.4.4 Was there meaningful consultation on the decisions leading to the closure of Napier Hospital?	246
6.4.4.1 The decision to remove Napier Hospital's guarantee	246
6.4.4.2 The decision to close Napier Hospital	247
6.4.5 Was there meaningful consultation on the location and configuration of the Napier Health Centre?	248
6.4.6 Were Government undertakings regarding Napier Hospital fulfilled?	248
6.4.7 Is there a distinctive cultural association with the Napier Hospital site?	249
6.4.8 Were the descendants of the 1851 signatories adequately consulted?	250
6.5 Findings on prejudicial effects	250

CHAPTER 7: HEALTH SERVICES FOR AHURIRI MAORI IN THE ERA OF HEALTH SECTOR REFORM

7.1 Chapter outline	253
7.2 Analysis of the evidence	253
7.2.1 Four phases of health sector reform	253
7.2.2 The statutory framework	255
7.2.2.1 Hospital and area health boards	255
7.2.2.2 RHAS CHES	256
7.2.2.3 District health boards	257
7.2.2.4 Protection of surplus health agency land	259
7.2.3 Maori health services – what was promised	261
7.2.3.1 The Department of Health and the Hawke's Bay Area Health Board (1984–91)	261
7.2.3.2 Maori health services policy in the purchaser–provider era (1991–2000)	262
7.2.3.3 A house of contracts	264
7.2.3.4 Central government – statements of owners' expectations	265
7.2.3.5 Central government – the Crown's health objectives	266
7.2.3.6 Purchasing agencies – statements of intent and plans	269
7.2.3.7 The State provider – purchase contracts with Healthcare Hawke's Bay	271

CONTENTS

CHAPTER 7: HEALTH SERVICES FOR AHURIRI MAORI — *continued*

7.2.3.8	The State provider – Healthcare Hawke’s Bay’s Maori health policy	272
7.2.3.9	Consultation with Maori	274
7.2.4	Performance – what was delivered	276
7.2.4.1	The Hawke’s Bay hospital and area health boards – services for Maori	276
7.2.4.2	The Central RHA – needs assessment and consultation	277
7.2.4.3	The Central RHA – mainstream services	278
7.2.4.4	The Central RHA – Maori healthcare providers	280
7.2.4.5	Healthcare Hawke’s Bay – Hastings Memorial Hospital and services for Maori	282
7.2.4.6	Healthcare Hawke’s Bay – the Maori hospital experience	285
7.2.4.7	Healthcare Hawke’s Bay – Napier Hospital and the Napier Health Centre	287
7.2.4.8	Healthcare Hawke’s Bay – representation and advisory committees	289
7.2.5	Performance monitoring and accountability	292
7.2.5.1	Institutional relationships in the purchaser–provider health system	292
7.2.5.2	Political accountability – Ministers and Parliament	294
7.2.5.3	Services – the Ministry of Health	295
7.2.5.4	Ownership – CCMAU	297
7.2.5.5	Purchasing – the Central RHA and the HFA	298
7.2.5.6	Providing – Healthcare Hawke’s Bay	301
7.3	The positions of the parties	301
7.3.1	The case for the claimants	301
7.3.2	The response of the Crown	307
7.3.3	The claimants’ reply	308
7.4	Findings, Treaty breaches, and prejudice	309
7.4.1	The scope of our findings	309
7.4.2	What Treaty obligations did post-1993 Maori health policies and contracts place upon the Crown?	310
7.4.3	Were adequate Treaty protection mechanisms incorporated into health legislation?	313
7.4.4	Is the Napier Health Centre adequate and appropriate for Maori health needs?	314
7.4.5	Were Maori adequately represented at decision-making levels in Hawke’s Bay’s Crown health agencies?	315
7.4.6	Did the Hawke’s Bay health agencies sufficiently promote Maori workforce participation?	317
7.4.7	Did Crown health agencies give sufficient priority to the improvement of Maori health in their service planning and delivery?	319
7.4.8	Did the Hawke’s Bay health agencies adequately consult with Maori on their health service needs and delivery?	320
7.4.9	Were appropriate Maori structures developed for the delivery of mainstream services to Ahuriri Maori?	321
7.4.10	Did Crown agencies adequately assess the health needs of Ahuriri Maori?	324
7.4.11	Did monitoring systems adequately assure agency performance and provide for Maori input?	324
7.4.12	Was sufficient assistance provided to local Maori health service provider development?	326
7.4.13	Did the purchaser–provider system restrict health service benefits for Ahuriri Maori?	327
7.4.14	Was there a significant gap between policy and practice concerning Maori health improvement?	328
7.5	Findings on prejudicial effects	329

CONTENTS

CHAPTER 8: HEALTH STATUS AND OUTCOMES FOR AHURIRI MAORI

8.1	Chapter outline	331
8.2	Analysis of the evidence	331
8.2.1	Access to health services	331
8.2.1.1	The reconfiguration of State health services in Napier (1998–99)	331
8.2.1.2	Transport to the regional hospital	332
8.2.1.3	The impact of distance on Maori access to services in Hastings	337
8.2.1.4	Other cost and cultural barriers	339
8.2.2	Health status and outcomes	340
8.2.2.1	Socio-economic indicators of health status	340
8.2.2.2	Maori health status and trends	344
8.2.2.3	National indicators of Maori health outcomes	349
8.2.2.4	Recent trends in Maori health outcomes	351
8.3	The positions of the parties	353
8.3.1	The case for the claimants	353
8.3.2	The case for the Crown	354
8.3.3	The claimants' reply	354
8.4	Findings, Treaty breaches, and prejudice	354
8.4.1	The scope of our findings	354
8.4.2	Did Healthcare Hawke's Bay make adequate transitional arrangements for its Napier-based services?	355
8.4.3	Does the transport-based access standard take sufficient account of socio-economic status?	356
8.4.4	Has hospital and clinic access been adversely affected for Ahuriri Maori?	356
8.4.5	Has Maori health status worsened over the health reform period?	358
8.5	Findings on prejudicial effects	359

CHAPTER 9: FINDINGS ON TREATY BREACHES

9.1	Chapter outline	361
9.2	Treaty breaches	361
9.2.1	Chapter 5: The State health system and Ahuriri Maori, 1852–1980	361
9.2.2	Chapter 6: Consultation with Maori on the closure of Napier Hospital	364
9.2.3	Chapter 7: Health services for Ahuriri Maori in the era of health sector reform	366
9.2.4	Chapter 8: Health status and outcomes for Ahuriri Maori	369
9.3	Prejudice	370
9.3.1	Chapter 5: The State health system and Ahuriri Maori, 1852–1980	370
9.3.2	Chapter 6: Consultation with Maori on the closure of Napier Hospital	371
9.3.3	Chapter 7: Health services for Ahuriri Maori in the era of health sector reform	372
9.3.4	Chapter 8: Health status and outcomes for Ahuriri Maori	373
9.4	Overview of prejudicial effects	374

CONTENTS

CHAPTER 10: RECOMMENDATIONS

10.1 Chapter outline	377
10.2 A study of the health needs of Ahuriri Maori	377
10.3 Establishing a Maori health centre in Napier	379
10.4 Funding the health centre and holding the hospital site	381
10.5 Health policy and service partnership with Ahuriri Maori	384
10.6 Treaty principles incorporated into health legislation	385
10.7 Treaty monitoring programme in the health sector	386
10.8 Guarantee of consultation on future health service decisions	386
10.9 Costs of the claim	388

APPENDIX I: CHRONOLOGY

Timeline of developments in State healthcare for Maori in central Hawke's Bay	391
Timeline of developments in the State healthcare sector	394

APPENDIX II: STATEMENTS OF CLAIM

Wai 473 statement of claim	395
Wai 692 statement of claim	395
Wai 692 first amended statement of claim	396
Wai 692 second amended statement of claim	397
Wai 692 third amended statement of claim	401
Wai 400 amended statement of claim	405

APPENDIX III: THE TREATY OF WAITANGI

The text in English	407
The text in Maori	408
Translation of the Maori text	408

APPENDIX IV: RECORD OF INQUIRY

Record of hearings	411
Record of proceedings	412
Record of documents	414
Bibliography	423

LIST OF TABLES

Table 1: Growth in the population of Napier and Hastings, 1936–96	186
Table 2: Summary of institutional restructuring in the health sector, 1980–2001	254
Table 3: Quality standards in purchase contracts covering services to Maori	275
Table 4: Maori provider contracts in and for Napier, 1993–99	281
Table 5: Main accountabilities within the State health care sector, 1993–2000	299
Table 6: Services listed in 1999 to be provided at the Napier Health Centre	333
Table 7: Outpatient services available only at Hawke’s Bay Hospital	336
Table 8: Travelling time access standards, 1995	336
Table 9: Population of Maori ancestry and iwi affiliations, 1991	344
Table 10: Demographic and social indicators for Napier and Hastings, 1991	345
Table 11: Distribution of 1991 population by NZDep96 decile	346
Table 12: NZDep96 measures for Onekawa, Maraenui, and Marewa	346
Table 13: Distribution by decile of Maraenui–Marewa–Onekawa population, 1991	347
Table 14: Death and hospitalisation rates for Napier, 1988–94	347
Table 15: Significant causes of hospitalisation in Hawke’s Bay, 1989–94	348
Table 16: Hospitalisations relating to pregnancy and childbirth, 1989–94	348
Table 17: Diabetes hospitalisations, 1989–94	349
Table 18: Mortality rates, 1996–98	349
Table 19: Ethnic and deprivation gaps in life expectancy at birth, 1995–97	350
Table 20: Trends in life expectancy at birth for Maori and non-Maori, 1950–92	350

LIST OF CHARTS

Chart 1: Distribution of the Maori and non-Maori populations in the North Island, 1936	130
Chart 2: Maori share of urban and rural populations in the North Island, 1936	131
Chart 3: Timeline of health agencies in Hawke’s Bay, 1980–2001	185
Chart 4: Maori urban and rural population of central Hawke’s Bay, 1936–96	185
Chart 5: Customer satisfaction surveys, 1993–98	290
Chart 6: The ‘expectations gap’ in hospital services, early 1994	291
Chart 7: Napier Maori population by distance from Napier and Hastings Hospitals, 1991	337
Chart 8: Maori population of central Hawke’s Bay by distance from Hastings Hospital, 1991	337
Chart 9: Napier households without vehicles and Maori share of population, 1991	338
Chart 10: The life expectancy gap between Maori and non-Maori	351

LIST OF FIGURES

Figure 1: William Colenso, 1868	83
Figure 2: <i>Ahuriri Plains & Harbour, Hawke's Bay</i>	<i>facing page 93</i>
Figure 3: <i>Ahuriri Harbour & Roadstead, Hawke's Bay</i>	<i>facing page 93</i>
Figure 4: Donald McLean. Portrait photograph taken circa 1870	96
Figure 5: Tareha Te Moananui	96
Figure 6: Karaitiana Takamoana	96
Figure 7: <i>A Alexander, Ahuriri</i>	105
Figure 8: Napier and Mataruahou in 1862	124
Figure 9: Mataruahou at the top of Shakespeare Road in the 1860s	125
Figure 10: A twentieth-century view of the original Napier Hospital building in Sealy Road	126
Figure 11: <i>The Barracks, Napier</i>	127
Figure 12: The barracks on Hospital Hill looking north, 1868	128
Figure 13: The second Napier Hospital, 1880	129
Figure 14: Napier Hospital, circa 1928	134
Figure 15: Evacuating Napier Hospital after the 1931 earthquake	135
Figure 16: Akenehi Hei	141
Figure 17: Dr Thomas Hitchings	141
Figure 18: Ihaia Hutana of Ngati Kahungunu	141
Figure 19: Te Rangihiroa, Apirana Ngata, and Maui Pomare	151
Figure 20: The opening of the Hawke's Bay Fallen Soldiers' Memorial Hospital in Hastings	187
Figure 21: The main block at Hastings Hospital in 1971	188
Figure 22: Napier Hospital, circa 1990, looking southwest	189
Figure 23: Site layout of Napier Hospital in 1990	190
Figure 24: Healthcare Hawke's Bay's vision of hospital regionalisation	221
Figure 25: Healthcare Hawke's Bay's vision of hospital regionalisation	221
Figure 26: Crown perceptions of the structure of the State health sector after the 1993 health reform	293
Figure 27: Claimant perceptions of the structure of the State health sector after the 1993 health reform	293
Figure 28: Napier Health Centre	334
Figure 29: Site layout of Hawke's Bay Hospital in 1999	334

LIST OF MAPS

Map 1: Location map and Napier Hospital sites _____	xlii
Map 2: Ngati Kahungunu taiwhenua districts in Hawke's Bay _____	29
Map 3: The 1851 Ahuriri Crown purchase _____	94
Map 4: The entrance to Te Whanganui a Orotu in 1837 _____	101
Map 5: Te Whanganui a Orotu and Mataruahou in 1865 _____	<i>facing page 102</i>
Map 6: The first town plan of Napier, 1855 _____	114
Map 7A: Distribution of the Maori population in central Hawke's Bay, 1881 _____	132
Map 7B: Distribution of the Maori population in central Hawke's Bay, 1936 _____	133
Map 8: Districts under the Maori Councils Act 1900 _____	153
Map 9: Distribution of the Maori population in central Hawke's Bay, 1991 _____	161
Map 10: Service area of Crown health agencies in Hawke's Bay, 1989–2001 _____	183
Map 11: Distances to hospital – Napier and Hastings _____	209
Map 12: The Maori percentage of the population, 1991 – Napier and Maraenui _____	<i>facing page 326</i>
Map 13: Socio-economic deprivation in Napier, 1996 _____	<i>facing page 331</i>
Map 14: State housing in central Napier, mid-1990s _____	341

LIST OF ABBREVIATIONS

AHB	area health board
AJHR	<i>Appendix to the Journal of the House of Representatives</i>
app	appendix
BPP	<i>British Parliamentary Papers: Colonies New Zealand</i> (17 vols, Shannon: Irish University Press, 1968–69)
CA	Court of Appeal
CCMAU	Crown Company Monitoring Advisory Unit
ch	chapter
CHE	Crown health enterprise
CHEEU	Crown Health Enterprise Establishment Unit
CHEMU	Crown Health Enterprise Monitoring Unit
DHB	district health board
doc	document
EEO	equal employment opportunity
encl	enclosure
fn	footnote
GBPP	<i>Great Britain Parliamentary Papers</i>
HB	hospital board
HC	High Court
HCHB	Healthcare Hawke's Bay
HFA	Health Funding Authority
HHS	hospital and health service
J	justice (when used after a surname)
NIPB	National Interim Provider Board
NZLR	<i>New Zealand Law Reports</i>
p, pp	page, pages
P	president of the Court of Appeal (when used after a surname)
para	paragraph
PC	Privy Council
PHC	Public Health Commission
RHA	regional health authority
ROI	record of inquiry
THA	Transitional Health Authority
vol	volume

'Wai' is a prefix used for Waitangi Tribunal claims

PLACE NAMES

Hawke's Bay: Refers both to the former provincial district, which stretched from the Mahia Peninsula to Woodville and Cape Turnagain, and to the land abutting Hawke Bay. The hinterland of Napier and Hastings, approximately the area of the former Hawke's Bay County, we have designated 'central Hawke's Bay' for want of a standard geographical descriptor, and is to be distinguished from the district of Central Hawke's Bay centred on Waipukurau.

Heretaunga Plain: The coastal lowland south of Napier, reaching inland to Bridge Pa and Pakipaki.

Te Whanganui a Orotu: The former lagoon covering the area between central Napier and Mataruahou to the south and Bay View to the north.

Mataruahou: The Maori name for what is today known as Napier Hill, or a combination of Bluff Hill and Hospital Hill. The original Pakeha name was Scinde Island. Although the Wai 692 statement of claim uses the spelling 'Mataruahau', we have adopted the form prevailing at the time of the 1851 Ahuriri purchase.

Ahuriri: Commonly used today as the Maori name for Napier. In the mid-nineteenth century, Ahuriri denoted both the wider area surrounding Te Whanganui a Orotu and the entrance to the lagoon, which was also known to Pakeha as 'Port Ahuriri'.

ACKNOWLEDGEMENTS

The Mohaka ki Ahuriri Tribunal would like to thank a number of staff who assisted us at various stages of the hearing and report writing of this inquiry. They included Peter Barton and Turei Thompson (claims administration), Richard Moorsom (claims facilitation, map preparation, and report-writing assistance), Noel Harris (map production), and Dominic Hurley (editorial production).

The Honourable Parekura Horomia
Minister of Maori Affairs



The Waitangi Tribunal
110 Featherston Street
WELLINGTON

and

The Honourable Annette King
Minister of Health

cc

The Honourable Margaret Wilson
Minister in Charge of Treaty of Waitangi Negotiations

The Honourable Matt Robson
Minister for Courts

The Right Honourable Helen Clark
Prime Minister

Parliament Buildings
WELLINGTON

30 August 2001

Tena korua e nga Minita

Tena korua e nga rangatira e noho mai na i runga i ena taumata teitei, whakamana hoki e whakatutuki nei i nga kaupapa me nga moemoea a te iwi Maori. Ka nui te mihi atu ki a korua e noho mai na i roto i te whare i tomokina e Ta Te Rangihiroa, Ta Timi Kara, Ta Maui Pomare, te matua hoki i a Ta Apirana Ngata tae atu ki te hunga i whai ake i muri atu i a ratou.

He tangi ano hoki ki o tatou tini mate o tena wharuarua, o tena wharuarua puta noa i te motu. Kotahi anake te korero ki a ratou, haere mai koutou, haere hoatu. Haere ki te matatorutanga o te tangata, ki te au te rena, te urunga te taka, te moenga te whakaarahia.

Kati ka hoki mai ki a tatou e takatu nei i roto i te ao hurihuri-tena tatou katoa.

Ko tenei purongo i tipu ake i te tono a enei o nga uri o Ngati Kahungunu ara i a Hana Cotter, ratou ko Pirika Tom Hemopo ko Takuta Emery. He tono na ratou o Te Taiwhenua o Te Whanganui a Orotu o te iwi o Ngati Kahungunu otira na nga iwi e noho mai na i te takiwa o Ngati Kahungunu ki Ahuriri. Ko tona rohe mai i Ahuriri taone toro pera atu ki te awa o Mohaka i Heretaunga. Ko te tikanga o te tono nei mo nga herenga o te Karauna e pa ana ki te iwi Maori mo nga kaupapa awhina o te hauora.

* * * * *

We present to you our report on the claim made by Hana Cotter, Pirika Tom Hemopo, and Takuta Emery on behalf of themselves, of Te Taiwhenua o Te Whanganui a Orotu of Ngati Kahungunu Iwi, and of 'the peoples within the Ngati Kahungunu tribal rohe of Ahuriri', which extends from south of Napier northwards to the Mohaka River in Hawke's Bay.

The claim concerns the Crown's Treaty obligations to Maori in respect of health services. The claimants say that the Crown breached Treaty principles in both historical and contemporary times by failing both to provide for the health and wellbeing of Ahuriri Maori and to meet its enduring obligations arising from the 1851 Ahuriri Crown purchase to provide hospital and health services from Mataruahou, Napier. They allege that Napier Hospital was downgraded and closed during the 1990s without adequate consultation. They assert further that the Crown and its health agencies failed adequately to address health disparities, prejudicing health outcomes for Ahuriri Maori. The Crown conceded none of the grievances alleged, contesting some and declining to respond to others, notably to the broader allegations of historical failure to protect Maori health.

We have made findings on all the grievances alleged by the claimants. We conclude that, although several fail, the majority are well-founded and that the claimants suffered prejudice in both historical and contemporary periods. We summarise our principal findings and recommendations in the executive summary at the beginning of the report.

Our main recommendation is that the Crown endow a community health centre in trust for Ahuriri Maori, assigning part of the proceeds from the transfer of the Napier Hospital site out of the ownership of the Hawke's Bay District Health Board. We suggest that the centre be located not on the hospital site but in the inner suburb of Maraenui where the Ahuriri Maori population and the principal need for primary health services are most heavily concentrated. We believe that an early resolution of the claim is possible within the framework of current Government policy and health sector legislation, and we outline the procedure by which we think it can be achieved.

EXECUTIVE SUMMARY

THE CLAIM

This report concludes the inquiry of the Mohaka ki Ahuriri Tribunal into the Napier Hospital claim (Wai 692). Here, we summarise our principal conclusions, findings, and recommendations.

The claimants act for themselves individually and also on behalf of Te Taiwhenua o Te Whanganui a Orotu of Ngati Kahungunu Iwi and of ‘the peoples within the Ngati Kahungunu tribal rohe of Ahuriri’, which extends from Napier northwards to the Mohaka River in Hawke’s Bay.

The claim concerns the Crown’s Treaty obligations to Maori in respect of health services. The grievances it alleges range from a particular local controversy, the closure of Napier Hospital in the 1990s, to broad issues of health sector policy and practice affecting Ahuriri Maori. The claimants allege:

- ▶ that the Crown failed to honour a historical promise, given as part of the 1851 Ahuriri block purchase, to provide hospital services for Ahuriri Maori from Mataruahou, where Napier Hospital has stood since 1860;
- ▶ that Crown health agencies failed to consult Ahuriri Maori adequately or at all on each of the major decisions affecting the status of Napier Hospital and its move to a downtown health centre;
- ▶ that the Crown failed to address the health needs and inferior health outcomes of Ahuriri Maori and to provide culturally appropriate health services, in both historical and recent times;
- ▶ that the Crown failed to ensure adequate access to health services, both at Napier Hospital and at Hawke’s Bay Hospital in Hastings;
- ▶ that the Crown failed to ensure effective Maori participation and representation in the mainstream health institutions providing services for Ahuriri and Hawke’s Bay Maori;
- ▶ that monitoring systems were weak, did not perform, and excluded Maori input; and
- ▶ that the Crown failed to give effective support for Ahuriri Maori to provide for the health needs of their own communities.

The claim asserts a general Crown obligation deriving from the Treaty to ‘provide for the health and well-being of Maori’, as well as enduring obligations arising from the 1851 Ahuriri transaction. The claimants say that they have been prejudiced by preventable ill health and mortality and, in recent times, by continuing disparities in health outcomes compared to non-Maori and by poorer access to services as a result of the closure of Napier Hospital.

SCOPE OF THE REPORT

On 'Treaty' and 'community' grievances regarding Napier Hospital

The focus of this report is on the grievances advanced by the claimants. We do not revisit the general issues surrounding the closure of Napier Hospital. Nor do we consider the merits of restoring Napier Hospital to its former status, a remedy that the claimants are not seeking.

On the adoption of part of the Ahuriri lands (Wai 400) claim

We defer our consideration of the grievance that is shared with the Ahuriri lands claim (Wai 400) for our main report on the Mohaka ki Ahuriri inquiry, but we do consider the specific assertion that a hospital promise was made and not adequately fulfilled.

On who is 'the Crown' in the health sector

Regarding the extent of direct Crown responsibility in the health sector after the abolition of the provinces in 1876, we conclude:

- ▶ that, between July 1991 and December 2000, the Hawke's Bay Area Health Board commissioner, the Central RHA, the Transitional Health Authority, the HFA, and Healthcare Hawke's Bay were part of the Crown, and thus assumed the Crown's Treaty obligations;
- ▶ that the local hospital committee (1877–85), the Hawke's Bay Hospital Board (1885–May 1989), the Hawke's Bay Area Health Board (June 1989–July 1991) and the Hawke's Bay District Health Board (January 2001–present) had or have at least a majority of their governing boards locally elected or nominated, and were not or are not part of the Crown; and
- ▶ that, whether the Crown's health agencies are part of the Crown or exercise delegated authority, the Crown holds undiminished responsibility for ensuring that its Treaty obligations in respect of Maori health are fully discharged.

On generic and particular issues

Our inquiry into this claim is *not a generic national investigation* into the performance of the Crown's Treaty obligations in respect of Maori health. We do, however, consider the local grievances raised in their regional and national context. We are also mindful of the fact that this is the first Tribunal report to address Treaty issues in the mainstream health sector.

Access to official information

The researcher commissioned by the Tribunal to report on contemporary aspects of the claim was hampered in gaining direct access to documentary records and officials by the intervention of health sector agencies through the Crown Law Office. Notwithstanding the conscientious

EXECUTIVE SUMMARY

efforts of Crown counsel, our proceedings were thereby disrupted and our ability to pursue our inquiry into the claim put at risk of being compromised. We *find*:

- ▶ that the failure of several Crown agencies to offer all reasonable assistance to the Tribunal's commissioned researcher brought into question their commitment to *good faith conduct*.

Findings on Treaty interpretation

We identify four relevant Treaty principles:

- ▶ the principle of active protection;
- ▶ the principle of partnership;
- ▶ the principle of equity; and
- ▶ the principle of options;

and two duties arising from those principles:

- ▶ the duty of good faith conduct; and
- ▶ the duty of consultation.

The principle of active protection

The principle of active protection derives from the conditional cession by Maori of sovereignty to the Crown in exchange for the protection by the Crown of Maori rangatiratanga. Kawanatanga is thus qualified by tino rangatiratanga. Active protection extends not merely to taonga but to the Maori people possessing them.

On health as a taonga

- ▶ that, of itself, 'health' *cannot be regarded as a taonga* ; but
- ▶ that the various components of customary health knowledge and healing practice can be argued to constitute *intangible taonga, or cultural assets* ; and
- ▶ that such taonga include three general types of resource:
 - *associations of place*, such as wai tapu (protected sources of water);
 - *access to materials used for healing*, such as rongoa (medicinal flora); and
 - *specialist knowledge of healing*, as possessed by tohunga or traditional healers.

On privileged Maori entitlement to health services

- ▶ that the Treaty placed an enduring obligation upon the Crown to protect Maori against *the adverse transitional effects of settlement* – in particular, introduced diseases;
- ▶ that the Treaty *did not establish a permanent Maori entitlement* to additional health service resources as distinct from that of New Zealanders as a whole;

EXECUTIVE SUMMARY

- ▶ that the Crown endeavour to protect Maori against the ill effects of *any racially defined health condition* beyond the influence of environmental factors, such as an inheritable genetic trait; and
- ▶ that the Treaty's promise of 'royal protection' required the Crown to have due regard to the wellbeing of Maori as part of the community of citizens, which includes *removing adverse health disparities* by appropriate means, such as affirmative action for Maori as a population group.

On health services delivered under tribal authority

- ▶ that the active protection of rangatiratanga over possessions implies that the ability of Maori leaders *to promote the wellbeing of their people*, including their care and welfare, will also be protected.

On the recognition of tikanga Maori in mainstream services

- ▶ that, if Maori were guaranteed the right to their own culture, protecting that culture also calls for it to be *respected by medical professionals and within medical institutions* such as hospitals, subject to the limits of practicality, reasonable cost and clinical safety; and
- ▶ that, alongside the technological capability of healthcare, recognition of *the cultural dimensions of health* is essential for the delivery of effective health services to Maori.

The principle of partnership:

The principle of partnership arises from one of the Treaty's basic objectives, that of creating the framework for two peoples to live together in one country. The principle brings the spotlight to bear on the Crown's relationship with Maori in the provision of public healthcare services. That relationship spans the divide between State provision along uniformly monocultural lines for citizens as a whole and entirely separate provision by Maori for Maori.

On the interface of partnership

Partnership means, we believe:

- ▶ enabling *the Maori voice* to be heard;
- ▶ allowing *Maori perspectives* to influence the type of health services delivered to Maori people and the way in which they are delivered;
- ▶ empowering *Maori to design and provide health services* for Maori; and
- ▶ presenting *a coherent and accountable face* in order to sustain a high-quality relationship with its Treaty partner.

On participation and representation

We observe:

- ▶ that institutional participation is a matter not only of equality of opportunity in health agency employment but also of *avoiding entrenched monocultural approaches* to the exclusion of Maori health values; and
- ▶ that, to the extent that the governance of State healthcare is devolved to district agencies, consistency with the partnership principle demands a degree of assurance that *Maori are fairly represented*.

The principle of equity

We consider that it is the conferring of citizenship rights upon Maori that supplies the underlying principle of equity. These rights were, like all others, placed under Crown protection. The principle applies to Maori as citizens rather than as members of groups exercising rangatiratanga.

Applying the principle of equity to health standards and outcomes for Maori means, in our view:

- ▶ that Maori are assured of the right to *equal standards of healthcare* ;
- ▶ that beneficial health outcomes *cannot be assured for individual Maori* ;
- ▶ that *a general equality of health outcomes* for Maori as a whole is none the less one of the expected benefits of the citizenship granted by the Treaty; and
- ▶ that health services can deliver *only part of the package* leading to equal health outcomes.

The principle of options

The principle of options arises from the different paths the Treaty opened up for Maori: on the one hand, the self-management of tribal resources according to Maori tikanga; on the other, access to the new society, technology and culture of the settlers.

In our view, these paths are not mutually exclusive. The principle of options:

- ▶ requires *respect for tikanga Maori* within the practices of public hospitals and other State services, subject to clinical safety; and
- ▶ encourages Crown support of *indigenous medical knowledge and services* .

The duty of good faith conduct

The standards of conduct between the Crown and Maori, in particular that of utmost good faith, are relevant as much to the principle of protection as to the principle of partnership, and establish the general character of the relationship.

The duty of consultation

The courts have laid down clear guidelines on the limits of consultation. In particular:

- ▶ there is *no open-ended obligation to consult* on all occasions; and
- ▶ *consultation is not negotiation*.

We consider that consultation, when required, is a duty common to the observance of all four Treaty principles.

On when to consult

Key criteria for the Crown to consider when making executive decisions include:

- ▶ whether there are *Treaty implications*;
- ▶ if there are, whether the Crown has *sufficient information to act* consistently with Treaty principles; and
- ▶ if it does not, whether it needs to consult *affected Maori communities and organisations*.

A major change in the status of a service institution that was important to a sizeable Maori community, such as a hospital, would *normally require consultation*.

On how to consult

The general standard of consultation laid down by the courts may be summarised as:

- ▶ stating a proposal not yet finally decided upon;
- ▶ listening to what others have to say;
- ▶ considering their responses; and
- ▶ only then, deciding what will be done.

We consider further:

- ▶ that, when Treaty obligations are involved, it will commonly be appropriate to conduct *separate and specific consultation with Maori*; and
- ▶ that the mode of consultation should take appropriate account of Maori expectations and preferences, the essential guideline being *kanohi ki te kanohi* – face to face discussion.

FINDINGS ON HISTORICAL ISSUES (1851–1940)

Treaty breaches

The first Napier Hospital was opened in 1860 by the Hawke's Bay Provincial Council on the hilly bluff known to Ahuriri Maori as Mataruahou, which today fronts the Napier city centre. In 1880, it was replaced by a new hospital built on the present hospital site. The Government subsidised the cost of a part-time native medical officer (NMO) post in Napier from 1857, but abolished the post in 1867. Not until the early twentieth century did new primary medical services, such as the district nursing scheme, begin to reach Maori communities in central Hawke's Bay. The

devolution of community health improvement to Maori councils after 1900 was soon crippled by a lack of Government support and funding. The introduction of universal entitlement in the late 1930s removed most financial barriers for Maori, but Napier Hospital, like others, remained monocultural.

On the promise of a hospital to Ahuriri Maori in 1851

- ▶ that, in November 1851, Donald McLean made a *verbal promise of a Government hospital* to Ahuriri Maori on behalf of the Crown, this being stated as one of the benefits of a town within their rohe;
- ▶ that, although not written into the deed, the hospital promise formed part of the Ahuriri land transaction, and was thus *part of the consideration*; and
- ▶ that the promise was *enduring*, for the benefit of local Maori generally, and within the framework of the healthcare policy of the government of the day.

On the site of the hospital

- ▶ that the promised hospital was *not site-specific* but was to be located in the town that became Napier.

On the cultural significance of Mataruahou as a place of healing

- ▶ that, although sick Maori probably did go to Mataruahou for healing purposes, it probably held *no special significance as a place of healing* for local Maori at the time of its purchase by the Crown.

On consulting Maori regarding Napier Hospital

- ▶ that the Crown's failure to consult Ahuriri Maori over the siting of either hospital breached the principle of *partnership* and the duty of *consultation*, but that at the same time Maori were less concerned about the precise location than with establishing hospital services.

On consulting and establishing the health needs of Ahuriri Maori

- ▶ that the Government *had sufficient broad information* at the national level to comprehend the demographic and ill health plight of Maori as a whole;
- ▶ that, during the 1850s, Government consultation was *adequate*;
- ▶ that, by failing sufficiently to inform itself of the actual health status and needs of Ahuriri Maori communities from the 1860s until the 1920s and 1930s, the Crown breached the principles of *active protection* and *partnership* and the duty of *consultation*;

EXECUTIVE SUMMARY

- ▶ that the development of general health programmes without specific local consultation was *within the legitimate bounds of kawanatanga* ; and
- ▶ that the mode of marae-based consultation on village sanitary improvement pioneered by the Department of Health through Maori councils, including the Tamatea Maori Council, fully conformed to the principle of *partnership* and the duty of *consultation*.

On representation and participation in State health agencies

- ▶ that the failure to provide for the inclusion of Ahuriri Maori in national (1854–67), provincial (1854–76), or hospital (1876–1980s) governance, including any say in the management of Napier Hospital, breached the principles of *partnership* and *equity*; and
- ▶ that the long-run failure to improve the participation of Maori in the workforce at Napier Hospital and in State primary health programmes operating in Hawke's Bay breached the principles of *partnership* and *equity*.

On health services under Maori control

- ▶ that the absence of initiatives to give Maori a degree of control over Napier Hospital services or Department of Health programmes specifically for them may have resulted in significant opportunities to improve Maori uptake of medical treatment being missed but *did not necessarily breach Treaty principles* ;
- ▶ that the Maori councils scheme was an important and innovative initiative *in accord with Treaty principles*, but that, having launched the scheme and induced Maori, including Ahuriri Maori through the Tamatea Maori Council, to rely upon it for improving the health of their communities, the Crown breached the principle of *partnership* by failing to resource the councils adequately or, for some years after 1911, at all; and
- ▶ that the removal of the Maori councils' power to regulate Maori medical *tohunga* and the partial suppression of *tohunga* by legislation from 1907 was in breach of the principles of *partnership* and *active protection*.

On the adequacy of Napier Hospital

- ▶ that the hospital's open door to Maori conformed to the principle of *equity*, but that there is insufficient evidence to assess whether in practice or in all periods discrimination against Maori in their admission to and standard of treatment at Napier Hospital did not occur;
- ▶ that the national policy, applied at Napier Hospital from the 1880s, of subjecting Maori in-patients to means-testing was in breach of the principle of *active protection* ; and
- ▶ that the failure to rectify the Hawke's Bay Hospital Board's exclusion of Ahuriri Maori from outdoor relief by legislation or other means was a breach of the principles of *active protection* and *equity*.

On the adequacy of State primary health services

- ▶ that, in arbitrarily abolishing the NMO post in 1867 and in failing to extend other frontline primary health services to Ahuriri Maori communities in a timely manner and with sufficient resources, the Crown breached the principle of *active protection*.

On responsiveness to tikanga Maori

- ▶ that the failure to accommodate tikanga Maori in Napier Hospital by legislation or other means breached the principle of *options* and, at a time of severe ill health and steep demographic decline of Ahuriri Maori, also the principle of *active protection*.

FINDINGS ON PREJUDICE ARISING

General

Widespread and severe ill health, and especially the impact of introduced diseases, were a principal cause of the crisis of survival which saw a halving of the national Maori population during the half century after 1840. Ahuriri Maori did not escape, and in the 1930s their health status still lagged far behind that of Pakeha. This disaster was preventable only to a limited degree; nevertheless, Ahuriri Maori were left at the margins of what assistance public medical services could provide.

Particular

- ▶ that hospital and primary health services failed to address the urgency of Maori ill health or to enjoy the confidence of Maori, resulting in many ill Maori *failing to get the treatment they needed*;
- ▶ that the failure to restore the Napier NMO post left Ahuriri Maori communities for half a century *at the mercy of the diseases* sweeping their communities;
- ▶ that, until at least the 1920s, the Government lacked sufficient information to configure its primary health programmes so as to deliver effective services to Ahuriri Maori communities, leaving much Maori ill health *untouched by effective medical treatment*;
- ▶ that, despite the pioneering initiatives of the Maori health reformers in the early twentieth century, Maori were *denied equality of opportunity* in access to employment at Napier Hospital and in primary health programmes in Hawke's Bay;
- ▶ that the lack of funding for the work of the Tamatea Maori Council and the Maori health reformers *severely limited* both their effectiveness and *health improvements* amongst Maori communities in central Hawke's Bay;
- ▶ that the failure to accommodate tikanga Maori was a major factor in *turning Ahuriri Maori away* from Napier Hospital and in *reducing the effectiveness* of primary healthcare services;

EXECUTIVE SUMMARY

- ▶ that the suppression of indigenous practitioners made it *more difficult for Ahuriri Maori* to seek the alternative forms of medical assistance upon which most relied;
- ▶ that all but a handful of Ahuriri Maori who could have benefited from hospital treatment *did not receive treatment in Napier Hospital* during its first half-century (1860–1910), the period of their most urgent need;
- ▶ that the very low usage by Ahuriri Maori of Napier Hospital’s services was *neither measured nor addressed*; and
- ▶ that Ahuriri Maori were left *virtually without State medical assistance* between 1867 and the 1920s.

FINDINGS ON CONTEMPORARY ISSUES (1980–99)

Treaty breaches

During the 1980s and 1990s, Crown agencies promoted a series of proposals that eventually led to the transfer of acute hospital services to Hastings, the downgrading and closure of Napier Hospital, and the building of a new health centre on the edge of Napier’s city centre. Over the same period, successive waves of health sector reforms, restructurings, and policy changes affected the shape of the Crown’s obligations and the design and delivery of State health services to Maori, both nationally and locally in central Hawke’s Bay.

On consultation with Ahuriri Maori on decisions affecting the status of Napier Hospital

- ▶ that the Crown breached the principle of *partnership* and the duty of *consultation* in failing to ensure, either by invoking its powers of direction or by means of legislation, that appropriate consultation with Ahuriri Maori took place in respect of:
 - the Hawke’s Bay Hospital Board’s proposal in 1980 to regionalise hospital services; and
 - the Hawke’s Bay Area Health Board’s proposal in 1990 to regionalise hospital services in Hastings and to downgrade or close Napier Hospital;
- ▶ that the Crown, including its various central, regional and district health agencies, breached the principle of *partnership* and the duty of *consultation* in failing to consult adequately or at all with Ahuriri Maori in respect of:
 - the decision in principle in mid-1993 to regionalise hospital services in Hawke’s Bay;
 - the decisions in July–August 1994 and March–April 1995 to base the regional hospital in Hastings and to downgrade Napier Hospital;
 - the decision in December 1996 to remove the linkage of Napier-based services to Napier Hospital;
 - the decision in principle in December 1997 to vacate Napier Hospital for a downtown health centre; and

EXECUTIVE SUMMARY

- the selecting of the site of the Napier Health Centre in 1998 and the determining of its service configuration;
- ▶ that the Crown also breached the duty of *good faith conduct* by:
 - presenting the option of whether to have a regional hospital at all as being open when the decision had in fact already been made;
 - failing to consult adequately before lifting Napier Hospital's site guarantee (December 1996) and resolving to vacate the hospital site (December 1997), despite giving an assurance in 1994 of the hospital's continuation at its existing site;
- ▶ that the failure of Crown agencies to fulfil their obligation to consult even-handedly all the local representative organisations of the descendants of the 1851 Ahuriri signatories breached the principles of *partnership* and *active protection* and the duty of *good faith conduct*.

On statutory Treaty protection mechanisms

- ▶ that the health reform legislation *did not provide sufficient powers over land disposals* by Crown health enterprises to ensure that the Crown's Treaty obligations were met;
- ▶ that the Public Health and Disability Act 2000, by providing for ministerial oversight, established *direct Crown responsibility* for protecting the interests of Treaty claimants in health agency land, including the interest of the present claimants in any proposed disposal of the Napier Hospital site;
- ▶ that the controlling health sector legislation applicable during the 1980s and 1990s did not incorporate any explicit recognition of Treaty principles but it also *did not prescribe any actions inconsistent with Treaty principles* or prevent the Crown from meeting its Treaty obligations; and
- ▶ that the Public Health and Disability Act 2000 committed the Crown and its health agencies to a number of particular obligations consistent in particular with the principles of *partnership* and *equity*.

On the adequacy of the Napier Health Centre

- ▶ that in general the location and service configuration of the Napier Health Centre do not appear to have been in breach of Treaty principles, but *the evidence is insufficient* for us to arrive at particular conclusions.

On representation at decision-making levels

- ▶ that the failure of the Crown over a prolonged period to rectify the imbalance of Maori representation on the Hawke's Bay Hospital Board was inconsistent with the principles of *partnership* and *equity*;

EXECUTIVE SUMMARY

- ▶ that the CHE board appointments regime run by the Crown Company Monitoring Advisory Unit conformed to the principle of *equity* but breached the principle of *partnership*;
- ▶ that the failure of the statutory framework until 2000 to provide for formal channels of communication between purchaser and provider agencies on the one hand and representative Maori organisations on the other breached the principle of *partnership*;
- ▶ that, in failing to vest in their advisory committees sufficient authority and, in the case of the Central RHA, adequate representation, the Central RHA and Healthcare Hawke's Bay breached the principle of *partnership*; and
- ▶ that the explicit provisions in the Public Health and Disability Act 2000 for ensuring proportional Maori representation on district health boards and standing committees are fully consistent with the principle of *partnership*.

On Maori workforce participation

- ▶ that the Central RHA's failure to employ sufficient staff to sustain its Maori health unit's assigned objectives, especially in Maori provider development, verged upon being inconsistent with the principle of *partnership* and the duty of *good faith conduct*; and
- ▶ that the limited and tardy efforts of Healthcare Hawke's Bay to improve the participation and development of its Maori workforce and Maori health service breached the principles of *partnership* and *equity*.

On incorporating the Maori health gain priority

- ▶ that the five years or more that it took to develop a comprehensive planning methodology for addressing the Maori health gain priority was *not unreasonable* in light of the structural disruptions and pioneer role of the purchaser agencies; and
- ▶ that, although the information is insufficient to allow definite conclusions, the available evidence suggests a failure both nationally and in the Napier area to match expenditure and targeting to Maori health needs, and a breach by the Crown of the principles of *active protection* and *equity*.

On consultation regarding health service needs and delivery

- ▶ that, although its consultation programme was proactive, in failing to ensure regional balance, in particular by including Ahuriri Maori, the Central RHA breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that, by failing to meet its contractual and other obligations to consult local Maori, especially on issues of significance to them, Healthcare Hawke's Bay breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*.

On Maori structures for the delivery of mainstream services

- ▶ that the failure to ensure by statutory or other means before July 1993 that hospital and area health boards implemented culturally appropriate services for Maori breached the principles of *active protection* and *options*;
- ▶ that, while initial progress was slow, the eventual incorporation by the Central RHA and HFA of specific quality standards into their CHE purchase contracts *provided an adequate framework* for the development by CHES of culturally appropriate services;
- ▶ that the insufficient funding of Healthcare Hawke's Bay's Maori Health Service and implementing of tikanga Maori in mainstream practice breached the principles of *active protection* and *options*; and
- ▶ that the failure of Healthcare Hawke's Bay to make a serious effort to implement kaupapa Maori standards in mainstream services at either Napier or Hastings Hospital before 1999 breached the principles of *active protection* and *options*.

On assessing the health needs of Ahuriri Maori

- ▶ that, in failing to inform themselves adequately of the health situation of Ahuriri Maori, successive Crown health agencies have breached the principle of *active protection*; and
- ▶ that, in failing to publish sufficiently detailed and well-founded health status information on Maori communities in the Napier area, the responsible Crown health agencies have breached the principle of *partnership*.

On monitoring agency performance and providing for Maori input

- ▶ that the Central RHA's failure to monitor effectively Healthcare Hawke's Bay's performance of its Treaty and contractual obligations to provide culturally appropriate services breached the principles of *active protection* and *options*;
- ▶ that the Central RHA and HFA's reliance on informal persuasion and its reluctance to enforce strict contract compliance was understandable while it was developing and bedding in the new purchasing system, but that its failure to exert any leverage on Healthcare Hawke's Bay over a prolonged period amounted to a breach of the principles of *active protection* and *options*;
- ▶ that the failure to address adequately the known problems and limitations of ethnicity data and health outcome monitoring breached the principles of *active protection* and *equity*; and
- ▶ that the failure to involve representative local Maori organisations in designing or assisting the performance monitoring breached the principle of *partnership*.

On assisting local Maori health service provider development

- ▶ that, up to the end of the hospital board era in Hawke's Bay, an effective partnership with Maori as providers to their own communities barely existed, the result of a statutory and policy regime that in this respect breached the principle of *partnership* ;
- ▶ that, for all its flaws and limitations, the Maori provider programme as it developed during the 1990s did not breach Treaty principles – to the contrary, it affirmed the principles of *partnership* and *options* as well as the duty of *consultation* ; and
- ▶ that the retarded state of the scheme in Napier and the Crown's failure to establish a relationship with representative Maori organisations, in this case Te Taiwhenua o Te Whanganui a Orotu, breached the principle of *partnership*.

On the merits of the purchaser–provider health system

- ▶ that the structural flaws in the purchaser–provider model were *not in themselves inconsistent with Treaty principles* ; and
- ▶ that particular policies, acts or omissions arising from the health sector reform are, as indicated in previous sections, *open to scrutiny* in terms of their consistency with Treaty principles.

On transitional arrangements for Napier-based services

- ▶ that, in failing to make adequate provision for the transitional interval between reducing or closing non-acute services at Napier Hospital and opening those services at the Napier Health Centre (1998–99), thereby disadvantaging low-income Maori communities disproportionately, Healthcare Hawke's Bay breached the principles of *active protection* and *equity*.

On the transport-based service access standard and access for Ahuriri Maori to hospital and clinic services

- ▶ that the transport standard, assessing travelling distance by car as the most commonly available mode of transport, was on the whole *practicable and reasonable* ;
- ▶ that, in the absence of regular public transport, the provision of a free or low-cost bus service between Napier and the regional hospital was in accord with the principles of *active protection* and *equity* ; and
- ▶ that, beyond the transitional period, additional support for patients and whanau obliged to travel outside the bus schedule and facing hardship would be consistent with the principles of *active protection* and *equity*.

On the trend of Maori health status over the health reform period

- ▶ that, in failing since 1980, and more particularly from 1993 to 1998, to address with urgency the improvement of the health status of Ahuriri Maori, the Crown and its health agencies have breached the principles of *active protection* and *equity*; and
- ▶ that the greater urgency shown by the HFA and Ministry of Health since 1999 and the explicit statutory requirement for district health boards to tackle the disparity by improving Maori health outcomes *afford some hope of more effective long-term action*.

FINDINGS ON PREJUDICE ARISING

General

Whether the health status of Ahuriri Maori has improved or worsened over the last decade, the disparity in health status between Ahuriri Maori and non-Maori has shown little if any reduction and has remained markedly adverse. For many Ahuriri Maori, the health outcomes remain poor. A significant proportion of the ill health suffered by Ahuriri Maori was preventable but was not prevented.

Particular

- ▶ that *confidence* in the commitment of successive Crown health agencies in Hawke's Bay to working in partnership with Ahuriri Maori has been *seriously eroded*, damaging the cooperation needed to achieve faster improvements in the health status of Ahuriri Maori;
- ▶ that *confidence in the good faith of consultation* itself has been *damaged* by the belief that the agencies have little interest in taking Maori views seriously into account;
- ▶ that the *rangatiratanga of Ahuriri Maori*, and especially their capacity to sustain the demanding practical obligations of partnership, has been *placed under strain* by their experience of repeated marginalisation from decisions on health service issues they view as important;
- ▶ that Ahuriri Maori, whether directly or through a larger Maori grouping, were *inadequately represented* or not represented at all on the governing bodies of the district health agencies on which they relied for most State-provided health services;
- ▶ that *the views of Ahuriri Maori were marginalised* by being denied the opportunity to have them considered and to influence decisions affecting their health services, notwithstanding their greater need for such services;
- ▶ that the *exclusion of Ahuriri Maori from health sector governance* weakened their institutional ability to exercise rangatiratanga, and thus to participate effectively in other partnership processes such as consultation;
- ▶ that the *short staffing* of the Central RHA's Maori health programme contributed to the *insufficient consultation* with Ahuriri Maori, the *limited support* given to the development

EXECUTIVE SUMMARY

of Maori providers, including those in Napier, and the *inadequate monitoring* of Healthcare Hawke's Bay's services to Maori;

- ▶ that, under the hospital and area health board regime, *monocultural practices persisted* as a significant barrier to Ahuriri Maori gaining the full benefits of hospital treatment;
- ▶ that *the slow and incomplete introduction of culturally appropriate services* at Napier and Hastings Hospitals, to which the inadequate staffing and mandate of Healthcare Hawke's Bay's Maori health service contributed, perpetuated the barrier and caused distress to Ahuriri Maori patients and their whanau;
- ▶ that Healthcare Hawke's Bay *lacked proper advice from Ahuriri Maori* on Treaty perspectives and tikanga Maori in developing culturally appropriate hospital services for local Maori;
- ▶ that Ahuriri Maori have *lacked sufficient information* on their health status to participate fully as citizens and as partners of the Crown;
- ▶ that, at least until the late 1990s, it is likely that *insufficient health resources* were committed to addressing the health needs of Ahuriri Maori, and that what resources were committed were not adequately targeted;
- ▶ that, in the absence of adequate local information, Crown health agencies *have not sufficiently adapted their services*, especially in the field of primary healthcare, to the health needs of Ahuriri Maori;
- ▶ that the *failure to monitor and ensure compliance* with the prescribed kaupapa Maori quality standards resulted in *poorer hospital service* for Ahuriri Maori patients and whanau and decreased the effectiveness of those services;
- ▶ that, similarly, the failure to ensure that the required consultation obligations were fulfilled led to *a culture of non-consultation* becoming entrenched and Ahuriri Maori being excluded from input into decisions affecting services on which they relied;
- ▶ that the *monitoring of health outcomes for Maori* suffered from a *low priority and a lack of Maori input*, at least until 1999, retarding the ability of the health sector to improve its performance and responsiveness to Maori;
- ▶ that, with minor exceptions, *Ahuriri Maori have not been empowered* to provide primary healthcare services for their own communities;
- ▶ that Maori providers in Napier have *not received adequate assistance* for their service development;
- ▶ that, during 1998 and 1999, Ahuriri Maori, especially those in low-income households, experienced *additional hardship and emotional stress* as in-patients of Hastings Hospital, as supporting whanau, and as outpatients of clinics temporarily moved to Hastings; and
- ▶ that the *additional burden on school staff*, especially those in Maraenui, in providing support to pupils travelling to Hastings placed extra stress on their educational work.

RECOMMENDATIONS

On a study of the health needs of Ahuriri Maori

- ▶ that *neither a specialist body nor a comprehensive study* of health needs is required for the particular purpose proposed by the claimants, that being assessing the need for a Maori health facility on the Napier Hospital site;
- ▶ that the Hawke's Bay District Health Board discuss with the claimants and with other representative Maori groups in Hawke's Bay the need for *a study of Maori health status* with a view to fulfilling its statutory obligation to inform itself appropriately;
- ▶ that any such study be *delinked from decisions* on the proposed Maori health facility but be timed so as *to contribute to its planning* if it proceeds; and
- ▶ that the Hawke's Bay District Health Board give serious consideration to *participatory approaches to health status research*, enabling representative Maori groups and Maori providers to make effective contributions.

On establishing a Maori health centre in Napier

- ▶ that a 'facility for Maori health' be established as *a community health centre*;
- ▶ that the centre be *governed by trustees* on behalf of Ahuriri Maori and *bicultural in character*, serving in particular the special needs of Ahuriri Maori but open to all;
- ▶ that it function as *an integrated care organisation* providing a variety of primary, public, promotional, educational, and rongoa Maori services;
- ▶ that the Crown *endow the land and buildings* for the centre and a fund dedicated to *community-based research and information*; and
- ▶ that the centre be located within the inner suburban zone of *Maraenui–Marewa–Onekawa South*.

On retaining the Napier Hospital site

- ▶ that the Crown take early steps to conclude *an agreement in principle with the claimants* on the concept, general location and endowment of a community health centre, within the framework of current Government policy on reducing health inequalities and building the capacity of Maori health providers;
- ▶ that, once an agreement has been reached, the Napier Hospital site be *transferred to the Residual Health Management Unit* at full commercial value;
- ▶ that the agreed part of the proceeds be *vested in trust* for the purposes of endowing the community health centre;
- ▶ that the fulfilment of the agreement in its entirety be regarded as *a full and final settlement of this claim*;
- ▶ that, after the agreement is concluded, steps be taken to *extinguish the existing health trust* on part of the hospital land;

EXECUTIVE SUMMARY

- ▶ that, *if an agreement cannot be reached*, the health trust be kept in place and the hospital site retained in district health board ownership pending a final settlement of this claim; and
- ▶ that, if it is later proposed to alienate all or part of the hospital site from Crown ownership, *the interests of other Maori claimants* to the land be taken into account.

On health policy and service partnership with Ahuriri Maori

- ▶ that the Hawke's Bay District Health Board establish *a Treaty-based relationship* with Te Taiwhenua o Te Whanganui a Orotu as a representative Maori urban and district organisation;
- ▶ that the Ministry of Health and the Hawke's Bay District Health Board enter into *a framework agreement* with Te Taiwhenua o Te Whanganui a Orotu on the scope of health services to be provided at the proposed community health centre; and
- ▶ that the Ministry and board provide the centre with *appropriate start-up and development assistance* so that it can build up its capacity as an integrated primary healthcare provider.

On incorporating Treaty principles into health legislation

- ▶ that the Public Health and Disability Act 2000 *make sufficient provision* for the recognition and application of Treaty principles in the State health sector.

On a Treaty monitoring programme in the health sector

- ▶ that health service planning *incorporate Treaty compliance* into its methodologies;
- ▶ that *results for Maori be identified* in the monitoring of health programmes intended specifically or partly to benefit Maori;
- ▶ that representative Maori organisations *participate in the design* of monitoring procedures for programmes or programme components intended to benefit Maori;
- ▶ that *sufficient and accurate ethnicity data* be gathered to the extent needed to measure health service results for Maori;
- ▶ that monitoring results be *collated and published* at national and district levels in forms conveying clear and relevant information to Maori leaders and communities;
- ▶ that *data on health outcomes for Maori* at national and district levels be regularly published; and
- ▶ that *periodic independent evaluations* be undertaken, both of programme performance and of the effectiveness of monitoring systems.

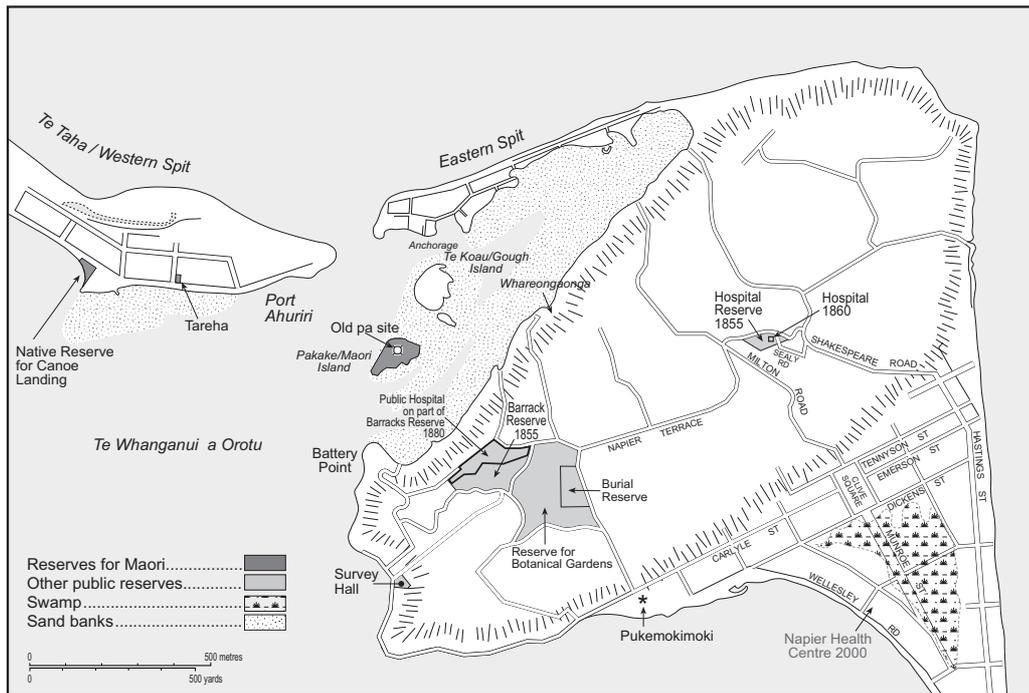
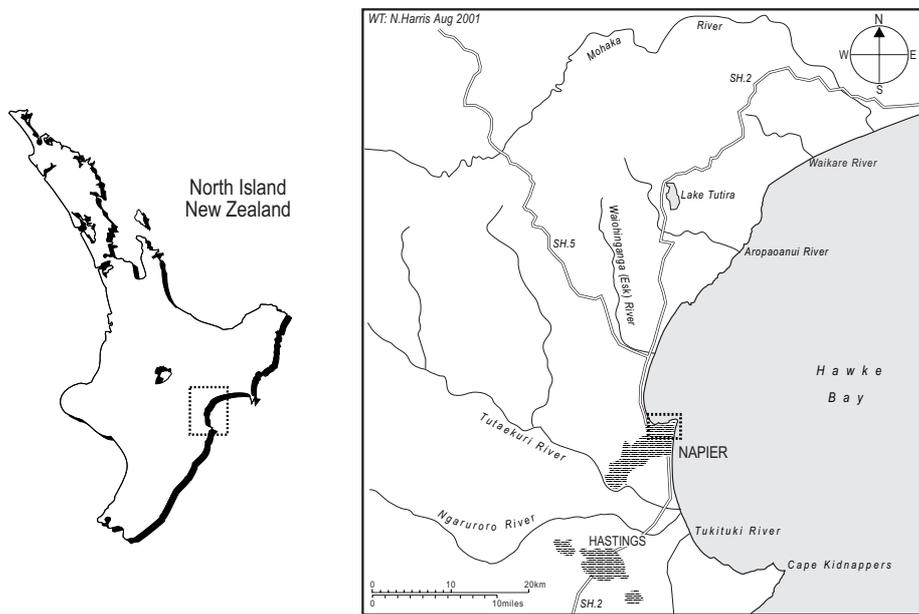
EXECUTIVE SUMMARY

On guaranteeing consultation on future health service decisions

- ▶ that the provisions in the Public Health and Disability Act 2000 *go a long way* towards providing the relief sought by the claimants;
- ▶ that the approach to consultation should be *even-handed and consistent*;
- ▶ that the consultative outreach should be *sufficiently comprehensive*;
- ▶ that *direct communication and meetings kanohi ki te kanohi* will commonly be the method preferred by Maori communities and leaderships;
- ▶ that *all communities affected* by a particular change, particularly on reconfiguring services or closing or opening a facility, should be included;
- ▶ that *consultation overload can be eased* by working to establish flexible partnership relationships with representative Maori organisations;
- ▶ that *multi-agency coordination* will also assist;
- ▶ that the Ministry of Health prepare and publish *an updated consultation guideline* for general use by Government agencies involved in the health sector;
- ▶ that each district health board prepare and publish *its own district guideline*;
- ▶ that in all cases the guidelines are drawn up *in cooperation with representative Maori organisations*;
- ▶ that the guidelines provide *clearly articulated standards and operational information* for practical use, covering such matters as type of issue, information to be provided, scope, frequency, meeting context, and process; and
- ▶ that the guidelines be *widely distributed and regularly updated*.

On reimbursing the costs of the claim

- ▶ that the claimants' reasonable costs in bringing both the Wai 473 and the Wai 692 claims be *reimbursed in full*.



Map 1: Location map and Napier Hospital sites. The roads and reserves are based on Domett's town plan of 1855 (map 6). Only public reserves in the vicinity of the two hospital sites are shown.

CHAPTER 1

INTRODUCTION

1.1 THE PURPOSE OF THE REPORT

This report of the Mohaka ki Ahuriri Tribunal is concerned with the Napier Hospital services claim, registered as Wai 692. The scope of the claim ranges from a particular local controversy – the closure of Napier Hospital – to broad issues of policy and practice in the health sector as they have been applied in Hawke’s Bay.

One matter must be clarified right at the outset. We cannot but be fully aware that what the people of Napier have seen as the loss of their hospital has been an intensely felt local issue, one that has been fiercely contested in successive campaigns over the past two decades. It resounds more loudly still in the passions of a wider and longstanding rivalry between the cities of Napier and Hastings.

We wish to make it clear what this report does and does not address. It does not re-examine the general issues surrounding the hospital’s closure. It does not review the pros and cons of the regional hospital project, except in so far as they are relevant to the grievances raised in terms of the Treaty of Waitangi. And it does not consider the merits of restoring Napier Hospital to its former status, a remedy which the claimants are not seeking.

Our task is to assess the claim before us in terms of the principles of the Treaty of Waitangi and to establish whether the claim is well-founded. The purpose of the report is to determine whether the claimants have been prejudiced by the Treaty breaches they allege, and, if they have, to make appropriate recommendations. In so doing, the report will range widely over the history of State health services in central Hawke’s Bay from the Ahuriri Crown purchase in 1851 up to the opening of the Napier Health Centre in 1999. Its central focus, however, is the relationship between Ahuriri Maori and the Crown in the field of healthcare.

1.2 THE TREATY IN THE SOCIAL POLICY SPHERE

The Napier Hospital services claim raises issues of public health policy and practice. It alleges breaches of the Treaty of Waitangi concerning the obligations of the Crown to protect and improve Maori health and the delivery of State health services to Maori. This is one of a growing number of claims that arise out of events occurring in recent times. Like Mokai School, on which

the Tribunal recently reported,² it was triggered by an attempt to close an institution that was important to the local Maori community and at the same time part of a mainstream social service.

Many question the relevance of the Treaty to social policy and service delivery, and thus the right of the Tribunal to enter this debate at all. Sir Douglas Graham, a former Minister of Justice, Attorney-General and Minister in Charge of Treaty of Waitangi Negotiations, has argued:

In health, education, welfare, housing and social services generally the question is whether [the Treaty] is relevant at all. Did the signatories really consider Maoris were to have any different rights in these areas than any other New Zealander? Did the Treaty really guarantee all Maoris would enjoy good health, with compensation if they did not?

. . . Entitlements to health, education, welfare, housing and other social benefits are not drawn from the Treaty at all but through citizenship . . .

There are rights that both parties have under the Treaty that must be respected. But there are many areas where the Treaty is simply irrelevant. The provision of health services is one of them.³

In similar vein, former Minister of Conservation Dr Nick Smith, commenting on the Tribunal's *Mokai School Report*, considered that 'the Waitangi Tribunal is outside its brief and it undermines its own credibility by accepting such claims as Treaty issues'.⁴

Such views are widely held. Where the Treaty is acknowledged to hold any continuing validity today for the purposes of redress, many would limit it to unfair alienations of Maori land and, like Sir Douglas, to protecting 'the customary ways of Maoris'.⁵

The criticism extends to Treaty-based remedial action that singles out Maori for special treatment. In the course of the public debate during the year 2000 on the inclusion of a so-called 'Treaty clause' in the Health and Disabilities Bill, Race Relations Conciliator Dr Rajen Prasad told a parliamentary select committee that it would be 'inappropriate to include a provision in this form in social policy legislation which could be seen as privileging one race over another'. He believed that it risked increasing racial tension, and might contravene both international human rights standards and the domestic New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.⁶ Opponents of the clause also cited the risk of exposure to legal action to enforce entitlement and the consequent expense that would involve.

Contrary views have been equally strongly expressed in favour of including a 'Treaty clause' in the governing health legislation, which was a remedy requested by the claimants. There has also been support for the relevance of the Treaty to the social policy sphere of government, perhaps most comprehensively from the Royal Commission on Social Policy.⁷ We do not intend to enter the debate at this point in our report, but draw attention in particular to our discussion of Treaty principles in chapter 3.

2. *The Mokai School Report*

3. Graham 2000

4. Smith 2000

5. Graham 2000

6. Race Relations Conciliator 2000

7. Royal Commission on Social Policy 1988

All Tribunal reports are founded on the formal and procedural obligations it is required to meet. Under the Treaty of Waitangi Act 1975, the Waitangi Tribunal is mandated to inquire into and report on all the claims it registers as falling within its jurisdiction. To qualify for registration, a claim must state that the claimant(s), being Maori, have been or are likely to be prejudicially affected by Crown agency (legislation, statutory instrument, policy, practice, act or omission) and that the Crown has acted in a manner ‘inconsistent with the principles of the Treaty’. The Act does not discriminate for or against any particular grounds of claim.

This is in accord with the fundamental tenets of natural justice that are reflected in general legislation governing citizens’ rights of redress, such as the Human Rights Act 1993: it is for the claimants to specify the ‘take’, or cause of action. Whether that cause enters the arena of social policy, or for that matter any other field of Government activity, is irrelevant to the test of validity for the registration of a claim. Thus, it is the claimants, not the Government or the Tribunal itself, who set the agenda on which the Tribunal reports. It is for the Tribunal then to assess the merits of the claimants’ case, although it has discretion not to inquire if it deems the subject trivial or the claim to be frivolous, vexatious, or not made in good faith.

Our principal reason for issuing a separate report on this claim is procedural. Because its grievances fall largely within the geographical area of the Mohaka ki Ahuriri regional inquiry, the claim was consolidated into that inquiry. Ordinarily, the Tribunal would integrate it into its general report on the regional inquiry. Issuing a report on one claim in advance runs the risk of preempting the Tribunal’s analysis and findings on the other claims before it. We have agreed to do so mainly in order to meet the Crown’s concerns about the continuing costs of holding the Napier Hospital site pending the Tribunal’s recommendations.

There is also a broader dimension. We are aware that because the alleged grievances relate to a mainstream social sector – hospital and other State health services – the claim takes the Tribunal into new territory. It also addresses contemporary issues that are directly relevant to current Crown policy and practice. Although it has a local focus, at the same time it raises questions that are likely to be of wider concern.

We do not believe that it would be appropriate to broaden our inquiry into a generic inquiry into the health sector nationally. However, in addressing for the first time grievances that derive from the mainstream health sector, we are conscious that our analysis of the evidence, findings and recommendations may be seen as relevant in other situations. We have taken this wider context into account in preparing our report.

Amongst the broader issues raised by the claim are the following:

- ▶ To what extent can a verbal commitment on future Government benefits, made at the signing of an early Crown purchase deed, be interpreted as a promise, and can such a promise be construed as part of such a binding agreement?
- ▶ Does the Treaty of Waitangi, as the claimants assert, place a general obligation upon the Crown to ‘provide for the health and well-being of Maori’, and, if so, does this entitle Maori to special or privileged access to Government resources?

- ▶ What kinds of statement of Government intentions and objectives in respect of health services to Maori are to be regarded as ‘policy’ that is susceptible to scrutiny in terms of the Treaty, and by which criteria and standards?
- ▶ Does the Treaty’s guarantee to Maori of equal rights as citizens apply to standards of health-care, to health outcomes, or to both, and what obligations are implied in terms of health and other State social services?
- ▶ To what extent are Government agencies required to consult Maori in making decisions on how health services are to be provided in a particular district, and what forms and standards of consultation should be adopted?
- ▶ How are Maori communities to be identified for the purposes of fulfilling the Crown’s Treaty obligations in respect of mainstream health services, including its duty of consultation, particularly where those communities are in urban areas?
- ▶ If the Crown is found to have breached Treaty principles in providing health services to Maori, how can the resulting prejudicial effects be identified, measured and analysed?

1.3 APPROACH AND METHOD

The subject-matter of this report is diverse. It ranges from particular actions or decisions to the broad sweep of national policy and its local implementation; from short sequences over weeks or months to a century or more; and from single locations such as the site of a hospital to district and national dimensions.

Such diversity raises difficulties of thematic scope, presentational balance and consistency of treatment. In this report, we have adopted a mix of narrative and analysis organised into chapters covering broad historical periods. Thus, the historical grievances are divided into two periods – up to and following the Ahuriri transaction in 1851 – while the contemporary grievances occupy three thematic chapters covering the 1980s and 1990s.

Whatever the complexities, the principal purpose of any Tribunal in reporting on a claim is at heart to make practical recommendations. The Tribunal sets out to assess all the information available to it so as to arrive at findings on the stated grievances and to make appropriate recommendations. As we will discuss further in chapter 3, in order to find a grievance well founded, the Tribunal must be satisfied:

- ▶ that the grievance is substantiated by the available evidence;
- ▶ that the Crown has violated one or more principles of the Treaty of Waitangi; and
- ▶ that the claimants have suffered or will suffer prejudice thereby.

We apply this three-step process of assessment to each grievance, or to the substantive issues raised in support of the grievance. In chapters 4 to 8, which review the evidence, our findings are presented at the end of each chapter. The findings of Treaty breaches and prejudice arising are then gathered together into the summary chapter 9.

In order to assure consistency of treatment and ease of reference, we have adopted a standard form of presentation in chapters 4 to 8 in reviewing the evidence and making findings thereon. Each chapter is accordingly set out as follows:

- (a) a brief outline of the chapter;
- (b) a review of the evidence, arranged by main topics and sub-themes;
- (c) the positions of the parties, outlining the cases of claimant and Crown counsel;⁸
- (d) our conclusions and findings; and
- (e) a summary of the findings.

1.4 THE ARRANGEMENT OF THE REPORT

The report is organised as follows. We begin in *chapter 2* by presenting the claim. After introducing the claimants, we outline the development of the claim and analyse the grievances it alleges against the Crown. We describe the hearings and the evidence presented. We review the question of research access to official information, which raised difficulties during the preparation of the claim for hearing. We then address a number of factors that bear on the scope of the report.

In *chapter 3*, we consider Treaty principles. We place this chapter early in the report for two main reasons. First, since we record our findings on the various grievances at the end of each chapter, it is essential to establish in advance the principles of the Treaty that we determine are applicable to this claim, as the Treaty of Waitangi Act 1975 requires us to do.⁹ Secondly, we consider it advisable in entering the new terrain of health policy and practice to summarise at the outset our view of the applicability of the Treaty to the issues that we have been asked to consider.

The main body of the report then proceeds more or less in chronological order. In *chapters 4 and 5*, we consider the grievances described by the claimants as historical and cover the century between the signing of the Treaty in 1840 and the implementation of the Social Security Act 1938, concluding with a brief summary of the post-war period up to 1980.

In *chapter 4*, we outline the general background to events in Hawke's Bay during the first decade of British colonisation, the period during which the Crown had the right of pre-emption on all land sales by Maori. In particular, we review the situation of Maori health and the formation of national policy on the provision of hospital and health services to Maori. We then examine more closely the context, negotiation, and completion of the Ahuriri transaction in 1851, focusing on the respective Maori and Government understandings of the agreement and on the alleged promise of a hospital on Mataruahou.

In *chapter 5*, we review the follow-up to the Ahuriri transaction and the State medical services provided to Ahuriri Maori from Napier. Against the backdrop of major shifts in national policy, we cover the founding of the first provincial hospital in 1860 and the short-lived extension of the native medical officer (NMO) service to the Napier area. We describe the establishment and

8. For the names of counsel, refer to appendix iv.

9. Section 5(2) of the Treaty of Waitangi Act 1975

growing significance of the second Napier Hospital after 1880, the brief excursion into community-based health improvement through the Maori councils, and the launching of the first primary healthcare programmes such as district nursing. In a brief concluding section, we traverse the rapid post-war growth of Napier and Hastings and the entrenchment of a two-hospital structure.

Chapters 6 to 8 cover the period described by the claimants as contemporary, that is, the period of the modern health reforms from the late 1980s onward. In *chapter 6*, we review the tangled history leading to the downgrading and closure of Napier Hospital. We examine in depth the process of consultation with local Maori prior to the making of each of the key decisions.

In *chapter 7*, we consider issues of policy, structural change, and accountability in the health sector, placing local issues in the wider context of the health reforms. There are three main sections:

- ▶ the statutory, policy, and contractual framework for meeting Treaty obligations to Maori and for improving Maori health;
- ▶ the outcomes in respect of health services to Ahuriri Maori; and
- ▶ monitoring procedures and their effectiveness in the case of Ahuriri Maori.

We conclude *chapter 7* by assessing the extent to which the State medical facilities in Napier and Hastings provided for specific Maori needs and tikanga, including the level of Maori participation and representation in the institutions themselves.

In *chapter 8*, we review the available evidence on the health and socio-economic status of Maori in the Napier area, looking in particular at indicators of health disparities and trends in health improvement. We also consider the extent to which the relocation of hospital services away from Napier Hospital has affected the objective of improving Maori health outcomes.

In *chapters 9 and 10*, we integrate the analysis, findings, and recommendations of the preceding chapters. *Chapter 9* brings together the findings on Treaty breaches and prejudice and *chapter 10* presents our recommendations.

The appendices contain a range of reference information, including a *chronology*, a *list of witnesses* and the matters on which they gave evidence, all the *statements of claim*, and the two texts of the *Treaty of Waitangi*. The *bibliography* contains the record of inquiry, which lists the relevant documents submitted in evidence, and other official, secondary, and unpublished sources cited in the report.

CHAPTER 2

THE NAPIER HOSPITAL CLAIM

2.1 CHAPTER OUTLINE

This chapter sets the context for our report on the Napier Hospital services claim. We begin by identifying the claimants and describe how the claim developed into its final form (sections 2.2 and 2.3). We outline the grievances and Treaty breaches alleged in the statement of claim and the remedies sought (section 2.4). We summarise our hearings of the testimony of claimant and Crown witnesses and the research and documentary evidence filed on the inquiry record (section 2.5). We comment on difficulties encountered in gaining research access to official information held by Crown agencies, and make recommendations aimed at avoiding recurrences in future Tribunal inquiries into contemporary claims (section 2.6).

We conclude the chapter by discussing four matters that have had a bearing on the scope of this report (section 2.7):

- ▶ the implications of the claimants' reliance on clauses in the Ahuriri lands claim (Wai 400), which we will consider in our main report together with the other claims before the regional inquiry;
- ▶ the relationship between the claimants and the origin and geographical extent of the grievances they have brought before the Tribunal;
- ▶ Which health sector entities should be regarded as part of 'the Crown' for the purposes of the Crown fulfilling its Treaty obligations; and
- ▶ the scope of the report itself, in particular distinguishing the wide-ranging issues raised within the local focus of the claim from generic issues that must be addressed on a national context.

2.2 THE CLAIMANTS

The claimants in the Napier Hospital services claim are Hana Loyla Cotter (Ngati Kahungunu), Pirika Tom Hemopo (Rongomaiwahine, Ngati Kahungunu, Waikato, Ngati Maniapoto) and Takuta Hohepa Mei Emery (Ngati Maniapoto, Ngati Kahungunu, Rangitane, Te Arawa). They state that they claim for themselves individually and also on behalf of Te Taiwhenua o Te Whanganui a Orotu of Ngati Kahungunu Iwi and of 'the peoples within the Ngati Kahungunu tribal rohe of Ahuriri'.

The identity of the groups which the claimants say they represent has been a point of contention in this claim. We consider this matter in section 2.7.3. At the outset, we note that the claimants identify their constituency both tribally, as a component of Ngati Kahungunu's representative iwi authority, and geographically, as all Maori people within a region that covers Napier and central-northern Hawke's Bay.

2.3 THE DEVELOPMENT OF THE CLAIM

2.3.1 Origins

In this section, we describe the development of the claim into its final form. Its origins can be traced back to 1994, when the claimants lodged an earlier claim on substantially the same issue. The claimants' application for an urgent hearing was declined in February 1998. Later that year, the claim was consolidated into the Mohaka ki Ahuriri regional inquiry. By the time that the Tribunal heard claimant and Crown evidence in mid-1999, the scope of the claim had broadened radically. The context of this rather complex history will assist in explaining how the issues raised by the claimants have emerged and taken shape.

2.3.2 The downgrading of Napier Hospital and the first claim (Wai 473)

In 1994, Healthcare Hawke's Bay decided to regionalise acute hospital services in Hastings and to scale down facilities and services at Napier Hospital. Before reaching its decision on 21 July 1994, the board of Healthcare Hawke's Bay conducted a public consultation. Tom Hemopo, who is one of the present claimants and was at that time responsible for legal affairs on behalf of Te Taiwhenua o Te Whanganui a Orotu, put in a written submission to the board in his individual capacity. He followed up with a verbal presentation to a session of the board's round of oral submissions.¹

Mr Hemopo's submission criticised the downgrading of Napier Hospital as breaching the Treaty of Waitangi. He alleged:

- ▶ that Healthcare Hawke's Bay had not adequately provided for Maori participation in its decision-making and service provision;
- ▶ that direct consultation with the tangata whenua had been insufficient;
- ▶ that the health of Napier Maori, as a taonga, could not be properly protected if hospital services were centralised in Hastings; and
- ▶ that even the reduced services assigned to Napier Hospital would eventually disappear.

The hospital downgrading was, Mr Hemopo stated, 'in direct breach of the Treaty of Waitangi and its guarantees'. If Healthcare Hawke's Bay persisted, he would be forced to take out a court injunction to halt the process.

1. Document w18(a)(83), pp 6114–6115; doc v17(a)

Healthcare Hawke's Bay did persist, and, shortly after its decision was announced, Mr Hemopo was authorised by Toro Waka, the chairperson of Te Taiwhenua o Te Whanganui a Orotu, to mount a legal challenge.² Together, they sought a legal opinion, which recommended a dual-track strategy of court action and a claim to the Waitangi Tribunal.³ The legal avenue was soon shut down by a legal challenge mounted by the Napier City Council, which went to the High Court in November 1994. However, their solicitor prepared a Treaty claim and, on 25 October 1994, lodged it with the Tribunal. The claim was made out on behalf of Mr Hemopo and the taiwhenua, with the support of Runanga Wahine ki Whanganui a Orotu.⁴

The statement of claim pointed to a failure of consultation in reaching the hospital decision, but it concentrated on legal argument rather than particulars of the alleged Treaty breaches and prejudice suffered. It had the character of a legal submission rather than a statement of the claimed grievances.

The solicitor deposed three draft briefs of evidence from the claimants.⁵ But despite the urgency of the situation, there was no request for an early hearing of the claim by the Tribunal. Nor, apparently, were applications made for research assistance or legal aid, and the claimants seemed unaware of these potential avenues of assistance.⁶

2.3.3 The Wai 473 claim on hold

The claim was eventually registered on 2 March 1995 and assigned the claim number Wai 473. By this time, the Napier City Council's challenge had succeeded in the High Court and Healthcare Hawke's Bay had completed its further consultation with the council as ordered by the court. Maori groups were not joined to this process.⁷ A month after the claim's registration, Healthcare Hawke's Bay announced that it had confirmed its original hospital decision.

The Tribunal's direction registering the claim noted that it was 'phrased in very general terms' and requested the claimants to supply, by 12 May 1995, further particulars in an amended statement of claim. Unless they did so, the Tribunal proposed to take 'no further action'.⁸ The claimants' solicitor interpreted the direction as a requirement to produce substantive evidence if the claim were not to lapse, and requested his clients to provide that evidence, together with funds and further instructions. A week after the deadline, he attempted to withdraw the claim.⁹ The Tribunal's registrar sought confirmation from the solicitor of the claimants' intention, but this was not forthcoming.¹⁰

2. Document 692(1)

3. Document 692(2)

4. Wai 473 ROI, claim 1.1

5. Documents 692(3), (4), (5)

6. Document 692(6)

7. Document v17(b)

8. Wai 473 ROI, paper 2.1

9. Documents 692(7), (8)

10. Documents 692(9), (10)

Shortly afterwards, Mr Hemopo was reported to be preparing for an early hearing of the claim, to the surprise of both the Tribunal and Healthcare Hawke's Bay, which had not been notified of its registration.¹¹ But the Tribunal had not scheduled a hearing. Finally, in January 1996, the Tribunal established directly from Mr Hemopo that he wished to proceed with the claim.¹² By this time, however, the regional hospital plan was progressing towards implementation.

No further action is evident over the next two years. During this period, Napier Hospital continued to function as a general hospital, while the regional hospital facilities were planned, constructed and organised at Memorial Hospital in Hastings.

2.3.4 The closure of Napier Hospital and the second claim (Wai 692)

Then, in late 1997, as the move of services from Napier to Hastings was getting under way, Healthcare Hawke's Bay announced its intention to close Napier Hospital altogether and build a downtown health centre in its place. In December 1997, it resolved to vacate the hospital's existing hill site.¹³

In early January 1998, Mr Hemopo joined with Takuta Emery and Hana Cotter to file a new statement of claim on behalf of Te Taiwhenua o Te Whanganui a Orotu. This claim was registered as Wai 692. The previous Wai 473 claim was not withdrawn but was in effect subsumed within the grounds of the new claim and not pursued further.

The claimants alleged that Healthcare Hawke's Bay was in breach of articles 1 and 3 of the Treaty of Waitangi and that 'its actions and activities to date are in direct violation of the spirit and intent underlying the partnership forged by our ancestors'. They sought relief in the form of a reversal of the closure decision, the reinstatement of all former services, a freeze on changes under way, and an independent audit of Healthcare Hawke's Bay's procedures for consultation with local Maori. They also requested the Tribunal to give the claim urgency in view of the anticipated adverse effects on Maori health.¹⁴

In late January 1998, expanding on the theme of partnership, the claimants amended their claim to allege an additional breach of article 2 of the Treaty in that Healthcare Hawke's Bay violated agreements entered into between their tipuna and the Crown to provide a hospital and associated services for the people of the region from Mataruahou'. If full hospital services were not restored, they sought as remedy:

'the return to those persons rightfully entitled, of all hospital services and facilities in the region comprising the Ahuriri Block and such further or other resources as may be required to enable Maori to hereafter provide full medical and hospital services to the people of that region'.¹⁵

This was the first mention of a site-specific agreement between the Crown and the sellers of the Ahuriri block. The amendment also made clear the claimants' wish to restore full hospital

11. Document 692(11); Wai 473 ROI, paper 2.2

12. Document 692(6)

13. Document w18(a)(74), p 6031

14. Claim 1.57

15. Claim 1.57(a)

services at Napier Hospital, whether provided by the Crown or by Maori with State funding or compensation. As interim relief, they requested that Healthcare Hawke's Bay halt any downgrading of facilities and services.

The request for urgency triggered a fast-track process. Within a month, the claim, dated 8 January 1998, had been registered and amended, and the application for urgency heard in Napier by Judge Patrick Savage. In his reserved decision, delivered on 3 February, Judge Savage noted that the claim was not in its final form, needed substantial further research, and was not ready to proceed. His ruling was that 'the application is declined at this stage but not dismissed. The applicants may consider their position and if they wish renew their application once they have put themselves in a better position.'¹⁶

2.3.5 Consolidation into the regional inquiry and the broadening of the claim

The claimants initiated research on their claim with Tribunal assistance but did not renew their application for urgency. At the judicial conference held on 30 January 1998 to consider that application, both parties had acknowledged a relationship with other claims then in hearing under the Mohaka ki Ahuriri inquiry.¹⁷ In November 1998, Judge Wilson Isaac, the presiding officer of the Mohaka ki Ahuriri Tribunal, invited the claimants to indicate whether they wished their claim to be heard within that inquiry. They responded that they did and the claim was accordingly consolidated.¹⁸

The claimants also advised that further research was needed. At this point they had not amended their statement of claim any further, but their preliminary research had raised additional issues. These were incorporated into two research projects, one covering the historical aspects of the claim and one the contemporary aspects.

The hearing took place in June 1999. A few days beforehand, the claimants replaced the two previous statements with a second amended statement of claim.¹⁹ This amendment divided the grievances into what the claimants described as historical and contemporary limbs. The *historical limb* focused on the 1851 Ahuriri transaction, alleging that:

The Crown induced Maori to alienate the Ahuriri lands with the explicit promise that a hospital and other health services would be established at Ahuriri for their use and benefit. These promises were an integral part of the bargain struck between Ahuriri Maori and the Crown in 1851.

Treaty breaches were said to have arisen in the Crown's failure to ensure equal standards of healthcare as between Maori and non-Maori and adequate access to health services for Ahuriri Maori. The claimants asked the Tribunal to find that health services sufficient to ensure a 'reasonable health status for Ahuriri Maori' were promised under the Ahuriri transaction; that they

16. Paper 2.261(h)

17. Paper 2.261(f), p 8; paper 2.261(g), p 12

18. Paper 2.303

19. Claim 1.57(b)

were to be provided from Mataruahou; and that any departure from that promise could not be made without the consent of Ahuriri Maori.

The claim alleged two additional breaches: a failure to ensure that the prescribed 15 to 25 per cent of the proceeds of Crown sales of Ahuriri land was applied for Maori purposes, 'including ongoing health needs'; and inadequate Maori participation and representation in health authorities in Hawke's Bay. The claim also called for a general finding that 'the Treaty of Waitangi embodies a guarantee to Maori of their continued health and well-being'.

Under the *contemporary limb* of the claim, the statement laid a number of general failures of health sector policy and practice at the door of the Crown. They included inadequate Maori participation and representation, inadequate Treaty protection in health legislation, and a failure to address the poor and unequal status of Maori health. The specific grievances cited were the Crown's disregard of its continuing obligations under the 1851 Ahuriri transaction, a lack of consultation over the downgrading and closure of Napier Hospital, and inadequate Maori representation in the Central RHA and Healthcare Hawke's Bay.

This amended statement formed the basis on which the claimants presented their case at the June 1999 hearing. It amounted to a major broadening of the scope of their claim. As well as the persisting obligations said to arise from the Ahuriri transaction, the claim now raised several general and specific historical grievances, as well as an issue of Treaty interpretation. In the modern period, it made a range of broad allegations about health policy and programmes as they affected access to health services and health outcomes for Maori, but gave little detail on how they related to specific breaches affecting the claimants.

The claimants also changed tack in the relief they requested. Instead of a full reinstatement of Napier Hospital, they now sought legislation and an endowment fund to establish on the hospital premises a 'Mataruahou Community Health and Research Centre'. The centre was to sustain 'hapu and community development initiatives', as well as provide health services 'for Ahuriri hapu and the general community'. Its governance was to embrace a partnership model and ensure 'that Ahuriri Maori are accorded full partnership status in the ownership, management, operation and decision making process'. The claimants also asked the Tribunal to recommend that health legislation be amended 'to incorporate appropriate Treaty protection mechanisms to ensure the ongoing active protection and representation of Maori within the health sector'.

2.3.6 The third amended statement of claim

The claim had still to reach its final form. Following the hearing of their evidence, the claimants submitted a third amendment to their statement of claim, which once again replaced its predecessor.²⁰ It was filed on 22 July 1999, less than a week before the start of the Tribunal's hearing of Crown evidence, and was registered over the objections of Crown counsel, who nevertheless did not take up the Tribunal's offer to adjourn the hearing.²¹

20. Claim 1.57(c)

21. Papers 2.355, 2.356, 2.357

The third amended statement of claim, which presented a comprehensive reformulation of the grievances and the remedies sought, is outlined in section 2.4. Here, we summarise its principal differences from the second amendment:

- ▶ it broadened the scope of the claim by laying a dual foundation for all the grievances concerning the Crown's general Treaty obligations as well as those concerning the general obligations held to derive from the 1851 Ahuriri transaction;
- ▶ it explicitly cross-linked the historical grievances to the Wai 400 amended statement of claim in respect of Ahuriri lands; and
- ▶ it greatly expanded the contemporary grievances into a wide-ranging set of alleged Treaty breaches in respect of health legislation, policy, process, and outcomes affecting Ahuriri and Hawke's Bay Maori and, in some respects, Maori as a whole.

Amongst the remedies sought, it called for 'a comprehensive inquiry . . . into Maori health needs in the Hawke's Bay and Ahuriri in particular', which would look at the suitability of locating a Maori health facility on the hospital site.

The circumstances in which the second and third amended statements of claim were presented were unusual. First, the claimants changed counsel after their hearing. Secondly, the preparation of the research report on the contemporary aspects of the claim, which the Tribunal had commissioned from Lisa Ferguson, was dislocated. All Ms Ferguson's research requests for documents and interviews with health sector agencies were brought under an Official Information Act procedure channelled exclusively through Crown counsel. As a result of the delay, the Crown was placed under an obligation to file additional documentation and witness briefs for the hearing of its evidence, which was scheduled to take place only six weeks later. The outcome was that the claim reached its final form only late in the period.

2.3.7 The evolution of the claim

We have traced the development of the claim to serve two main purposes. The first is to map out changes in the scope of the grievances and the remedies sought. The second is to assist in establishing the core issues raised and the remedies sought by the claimants. We remark in passing that, in our view, it was as a result of a combination of factors that the claim took so long to be fully articulated and brought to hearing.

It is apparent that the scope of the claim changed radically over the five-year period between the filings of the first claim (Wai 473) in October 1994 and the third amendment of the second claim (Wai 692) in July 1999. We perceive two broad phases of evolution.

In the *first phase*, from 1994 to January 1998, the claimants focused specifically on the reduction of services provided by Napier Hospital arising from the regional hospital project. The second claim drew on evidence and argument presented to the Mohaka ki Ahuriri inquiry in support of Nga Hapu o Ahuriri's land claim (Wai 400). It introduced the question of Crown obligations under the 1851 Ahuriri block transaction, but only in respect of a requirement persisting into modern times to continue providing hospital services from Mataruahou. The grievance

focus was contemporary and narrowly framed, while the principal remedy sought, the retention of Napier Hospital, was specific but radical in terms of health service planning.

In the *second phase*, from early 1998 to July 1999, the claimants raised historical grievances in their own right and defined them in broad terms. They also greatly extended the scope of their contemporary grievances to the structure and process of the health sector reforms and their impact in Hawke's Bay. However, they modified their original demand for the restoration of full services at Napier Hospital to a call for a study on whether a Maori health facility on the hospital site would be appropriate.

2.4 THE CLAIM IN ITS FINAL FORM

2.4.1 Treaty obligations

The amended statement of claim asserts a general Crown obligation deriving from the Treaty 'to provide for the health and well-being of Maori'. This extends to consulting Maori on substantive matters, giving Maori communities 'control of adequate and appropriate health resources', and ensuring equality of both healthcare standards and health outcomes as between Maori and non-Maori.²²

The statement adopts an interpretation of the 1851 Ahuriri transaction advanced by Nga Hapu o Ahuriri in the Wai 400 claim. It does so by incorporating two clauses of the Wai 400 amended statement of claim that assert an 'ongoing partnership' between the Crown and Ahuriri hapu and the latter's entitlement to the 'collateral advantages and expected benefits of settlement'.²³ On the basis of this general argument, the statement asserts that the Crown was and remains under a specific obligation to 'provide health and hospital services to the Maori of Ahuriri'.²⁴

The statement also attempts to define the scope of the Crown's Treaty obligations in the modern health sector. First, it identifies a number of statutory provisions, health policies and contractual commitments that it says were adopted pursuant to the Crown's general Treaty obligations. It then identifies a range of State institutions responsible for overseeing and delivering health services to Maori that were designated by statute as Crown departments and entities. The effect, it argues, was to impose on those agencies a number of obligations regarding monitoring, enforcement, consultation, health needs identification, service standards, health outcomes, and cultural sensitivity. Although not explicitly stated, it implies that Treaty obligations also arose in respect of health policies and programmes adopted in historical times.

22. Claim 1.57(c), para 4

23. Claim 1.23(d), paras 16–17

24. Claim 1.57(c), para 5

2.4.2 Historical grievances

The historical grievances are briefly but broadly phrased. The period is not indicated, but counsel's closing submission explained that it extends up to the 1930s. The grievances cover four main allegations against the Crown, namely that it failed:

- ▶ adequately to ascertain the health needs of Ahuriri Maori by consultation or other means;
- ▶ to provide for adequate Maori participation and representation in local health agencies;
- ▶ to give local Maori any control over health service delivery or administration; and
- ▶ to establish appropriate health services sufficient to ensure equal standards of healthcare.

The consequences for Ahuriri Maori, the claim alleged, were inferior or inappropriate health services that led to 'substantially worse health outcomes'.²⁵

The historical grievances are wide-ranging. In effect, they bring under examination not just Napier Hospital but all State health services, and the adequacy of the Crown's policy and practice over the best part of a century of far-reaching change in medical technology and public health provision.

The historical grievances are cast in general terms and make no mention of a specific promise in 1851 of a hospital to be sited on Mataruahou. The alleged promise nevertheless features prominently in claimant evidence, in counsel's closing submission, and in the first and second amended statements of claim. It is also implied in two of the contemporary grievances and one of the forms of relief requested.²⁶

2.4.3 Contemporary grievances

The contemporary grievances cover a much shorter period: the decade or so beginning in 1988. It was nevertheless a period that saw a series of upheavals in national policy and local health service delivery. The grievances, which extend to 21 particular clauses, relate to three core aspects of those changes:

- ▶ the Crown's departure from the alleged 1851 agreement to provide effective hospital and health services from Mataruahou;
- ▶ a failure to consult adequately on the major decisions concerning Napier Hospital and the range, delivery and location of State health services for Ahuriri Maori; and
- ▶ defects in national health legislation, policies, programmes and processes, and in the implementation thereof, that at the regional and local levels resulted in a failure to meet a number of Treaty obligations to Ahuriri Maori.

The *first aspect*, the 1851 commitment to provide effective health services from Mataruahou, appears in two of the grievances. These allege that the Crown failed generally to meet its continuing obligations under the 1851 transaction and that the downtown health centre intended to replace Napier Hospital would be 'inadequate and inappropriate' for meeting those obligations.²⁷

25. Ibid, para 7

26. Ibid, paras 12.7, 12.8, (d)

27. Ibid, paras 12.7, 12.8

The *second aspect*, consultation with Ahuriri Maori, is expressed in general and specific terms. The statement alleges that on none of its major decisions affecting the provision of State health services in Napier did the Crown or its health agencies consult adequately. These included the decisions in 1994 and 1995 to regionalise acute hospital services at Hastings and downgrade Napier Hospital, in 1997 to close Napier Hospital and build a health centre, and in 1998 to select a downtown site in Wellesley Road as the site of the new health centre. The claimants also accuse the Crown of a general failure to consult with Maori over ‘changes in health delivery and outcomes in Ahuriri and Hawke’s Bay’.²⁸

The *third aspect* is the impact upon Maori of changes in the public healthcare system during the health sector reforms of the last two decades. At its broadest, the statement asserts that the purchaser–provider model underlying the health reforms ‘has not worked to the benefit of Maori in Ahuriri or Hawke’s Bay’. It criticises the health reform legislation as lacking adequate Treaty protection mechanisms.

Arising from the system changes, the statement identifies a number of institutional failures in the reformed health system. Some are structural. They include the failure:

- ▶ to establish appropriate structures for delivering health services to Maori;
- ▶ to involve Maori in monitoring health services and outcomes;
- ▶ to provide sufficient State assistance to Ahuriri Maori to ‘develop their own capacity to provide healthcare’; and
- ▶ to ensure Maori participation and representation in health sector agencies, resulting in a lack of empowerment for Maori ‘to effectively join in the decision making processes affecting their health and health care’.²⁹

Other failings identified are questions of performance, including the failure:

- ▶ to prioritise Maori health improvement in health service planning and delivery;
- ▶ to analyse Maori health status;
- ▶ to define service access targets appropriately; and
- ▶ to deliver consistently on policy and public pronouncements.³⁰

The scope of the claim is thus at the same time narrow and local (decisions affecting Napier Hospital), regional (health services and status in Hawke’s Bay), and broad (national legislation, health policy, and institutional structures and performance). At this point we note that it is not always clear either from the statement of claim or from claimant counsel’s closing submissions precisely where the boundaries of the various grievances lie. Some appear to address national policy and the situation of Maori as a whole; others, the district-wide impact of those policies and the actions of health institutions; and yet others, the particular issues concerning Napier Hospital and Maori in and near Napier. We will take up this matter again in section 2.7.5.

The statement of claim indicates the main forms of prejudice said to have been suffered by the claimants. It alleges that, as a result of the historical Treaty breaches, Ahuriri Maori experienced

28. Claim 1.57(c), paras 12.2–12.5, 12.15

29. Ibid, paras 12.6, 12.10, 12.11, 12.14, 12.16

30. Ibid, paras 12.9, 12.12–13, 12.17–19

significantly inferior or inappropriate hospital and health services compared to non-Maori, and thereby ‘substantially worse health outcomes’.

This double consequence is also attributed to the contemporary Treaty breaches and is claimed to be continuing. In support, the statement asserts that, over the period of the modern health reforms, ‘Maori health measured by mortality and morbidity has become worse in absolute terms and relative to non Maori’.³¹

2.4.4 Findings and recommendations sought

The claimants request relief in the form of some 13 findings and recommendations from the Tribunal.³² Several are particular and local in scope, although still extensive. They ask the Tribunal to find:

- ▶ that the Crown’s provision of health services to Ahuriri Maori has breached the principles of the Treaty over the whole period since 1851 in respect of both historical and contemporary dimensions of the claim, although claimant counsel explained in his closing submissions that the half-century 1938 to 1988 was excluded;
- ▶ that the Crown has also breached the terms of the Ahuriri transaction;
- ▶ ‘that Mataruahou (Napier Hill Hospital Site) is of importance to Maori Health’; and
- ▶ that the failure to consult adequately with affected Maori through the 1990s on the series of decisions affecting the status and services provided by Napier Hospital amounted to a Treaty breach.

The claimants ask the Tribunal to make seven recommendations as to specific and general relief:

- ▶ at ‘an independent specialist body’ be convened to undertake a ‘comprehensive inquiry . . . into Maori health needs in the Hawke’s Bay and Ahuriri in particular’, with terms of reference drawn up by the Tribunal;
- ▶ at its main purpose should be to investigate ‘whether an appropriately funded facility for Maori health on the Napier Hospital site is appropriate’;
- ▶ at their own research and submissions to the inquiry be appropriately funded;
- ▶ at while not seeking to prejudge the outcome of the inquiry, the Crown make a commitment in advance that its findings be implemented;
- ▶ that the hospital site be retained and its facilities maintained in good condition pending the completion of the inquiry;
- ▶ that an effective health service partnership be entered into with the health agencies;
- ▶ that Crown health agencies consult with Maori and relevant Maori organisations, including iwi and hapu bodies, on any decisions affecting local health service provision to Maori;
- ▶ that a Treaty compliance monitoring programme be established;

31. Ibid, paras 7, 12, 12.1

32. Ibid, paras (a)–(m)

- ▶ that a clause be inserted into the Health and Disability Services Act 1993 to ‘give effect to the principles of the Treaty of Waitangi’; and
- ▶ that the Crown pay the costs of the claim.

2.5 THE HEARINGS AND THE EVIDENCE

The Tribunal heard evidence from the claimants over three days from Tuesday 8 June to Thursday 10 June in the hall of Te Taiwhenua o Te Whanganui a Orotu in Napier. (See appendix IV for full details of the witnesses and the main topics of their evidence.) Following the powhiri, the proceedings began with a site visit to Napier Hospital, where the Tribunal was able to familiarise itself with the main buildings and outlook. Heitia Hiha and Fred Reti described the claimants’ associations with the hospital site and surrounding area.

The claimants opened their case with professional evidence from Vincent O’Malley of the Crown Forestry Rental Trust, who summarised his historical report. Two of the claimants, supported by several members of the claimant group, gave traditional evidence on Maori health status and approaches to healthcare, on the associations of claimant hapu with Mataruahou and the surrounding area, on understandings of the 1851 Ahuriri transaction and its aftermath, and on local Maori perceptions in recent times of Napier Hospital and its closure.

Tom Hemopo and several other witnesses gave further evidence in support of the claim. They concentrated principally on the contemporary issues, in particular the lack of consultation on the decisions leading to the replacement of Napier Hospital by a downtown health centre, the impact of this change on Maori in the Napier area, and the prospect of establishing a Maori-controlled health facility.

Much of the second day was taken up with professional evidence from Lisa Ferguson, a historian specialising in the health sector. On the third day, claimant counsel led supporting evidence from a range of community and expert witnesses. The topics included:

- ▶ the history of the closure of Napier Hospital and the adequacy of community health services in Hawke’s Bay;
- ▶ the impact of the closure of Napier Hospital on the residents of a poor suburb of Napier with a high Maori population;
- ▶ the health status of Maori, Maori initiatives under the health reforms, and the current state of Maori health nationally;
- ▶ Maori health providers, the effects of socio-economic status on access to health services, Maori participation and representation in regional health institutions, and a possible transfer of Napier Hospital to Maori health providers; and
- ▶ partnership perspectives and concepts of health.

Six weeks later, the Crown presented an extensive range of expert opinion and documentation during the second part of the hearing of Crown evidence in the Mohaka ki Ahuriri inquiry. On 28 July 1999, the Tribunal was taken on a site visit to Hawke’s Bay Hospital in Hastings, which

included Mihiroa Whare and a surgical ward. The Crown evidence began the following day and concluded on 2 August after nearly three days of proceedings, much of which was taken up with cross-examination by claimant counsel.

Crown counsel led evidence from senior officials on their fields of responsibility and the role of their institutions in the health sector. Represented were the Crown Company Monitoring Advisory Unit (CCMAU), the Ministry of Health, the HFA–Central RHA, and the board and management of Healthcare Hawke’s Bay. Some of their evidence covered general themes of policy, programmes, performance, and institutional accountability. Other evidence addressed the history of the regional hospital project and the closure of Napier Hospital. The Crown also filed several voluminous collections of supporting documents.

By the conclusion of the hearings, the Tribunal had thus been presented with a large and diverse body of evidence, much of which had been clarified and extended in witnesses’ responses to questions from counsel and members of the Tribunal. We will review the sufficiency of evidence for the task with which the Tribunal is charged in section 2.7.2.

2.6 CROWN ASSISTANCE WITH TRIBUNAL RESEARCH ON CONTEMPORARY ISSUES

2.6.1 Disruption of commissioned research

We noted in section 2.3.6 that the research commissioned by the Tribunal on contemporary aspects of the claim had been interrupted by procedural difficulties arising from an intervention by Crown counsel acting on behalf of Government health sector agencies. As a result, the research report was delayed and incomplete. Although the Crown later filed a mass of documentation and led evidence from a number of witnesses, gaps remained in the information available to the Tribunal. Since the ability of the Tribunal to pursue its inquiry was, in our opinion, at risk of being compromised, we consider it appropriate to review the circumstances.

In December 1998, the Tribunal commissioned Lisa Ferguson to prepare a research report on the contemporary issues raised by the claim. Ms Ferguson’s assignment was initially scheduled for completion by 30 March 1999. In the normal course of her research she requested documents from various health sector agencies and interviews with their officials. In mid-February, with the research already well under way, the agencies began to refer all her requests to the Crown Law Office.

It became apparent that this was an orchestrated and unilateral move. On 22 March 1999, Crown counsel informed the Tribunal that in a number of cases agencies had withdrawn their consent to interviews, and that, at counsel’s request, most agencies were channelling her information requests to assistant Crown counsel to coordinate.³³ This step, counsel advised, had been taken mainly for their own administrative convenience, since the Crown Law Office was at the same time assisting the agencies to prepare the Crown’s evidence. He denied any attempt to restrict access to official information.³⁴

33. Paper 2,323, para 11

34. Ibid, paras 11–12

This 'sole channel' procedure covered not only requests for interviews but also requests for documents held by the agencies, and even assistance by officials in identifying relevant documents. With the exception of two interviews permitted despite the Crown Law Office's advice, Ms Ferguson was thenceforth denied the opportunity to communicate directly in any way with health agency officials.

The effect of this was to disrupt and delay Ms Ferguson's research. The first volume of her report was released only in early May 1999. Even then, she was obliged to note at no fewer than 18 places in the text an insufficiency of information arising from incomplete documentation supplied or interviews denied. The Tribunal was put in the position of having to consider invoking its powers under the Commissions of Inquiry Act 1908 to require the production of official documents and the appearance of witnesses, and on 3 May 1999 it notified the parties to this effect by direction.³⁵

As directed by the Tribunal, Ms Ferguson produced a set of questions addressing the gaps in official information, to which Crown counsel responded in part by supplying a further collection of documents, in part by undertaking to provide witness statements at the hearing of Crown evidence, and in part by questioning the relevance of several of the questions. The Crown later filed both witness statements and a very large body of supporting documents. This effort notwithstanding, several significant documents were produced only in the course of the Crown hearing and a substantial further set of documents was filed after the hearing.

We now turn to four issues that arise from the particular circumstances of the Tribunal's inquiry into this claim:

- ▶ the accessibility of current official records for research;
- ▶ the relationship between commissioned Tribunal research and Crown evidence;
- ▶ the statutory provisions covering Tribunal access to official information; and
- ▶ the role of Crown counsel in assisting Tribunal research.

2.6.2 Access to current official records

We noted above that the Tribunal's researcher encountered considerable difficulty in gaining full and timely access to official records through the centralised Official Information Act procedure orchestrated by Crown counsel. Regarding documentary information, Crown counsel insisted that his assistant counsel did in fact make strenuous efforts to assist Ms Ferguson.³⁶

This we do not doubt. The problem arises in the task itself. The Tribunal commissions researchers in order to benefit from their professional skills. Agency officials, for their part, have detailed knowledge of their records and filing systems. Crown Law Office staff may well be thought unlikely to possess either attribute. Interposing them between researcher and officials for the purpose of identifying relevant documentary information can only risk inefficiency and delay.

35. Paper 2.334

36. Paper 2.323, paras 9, 20, 23–24

To make an analogy, if historians commissioned by the Tribunal were denied all direct access to the records, finding aids and staff of National Archives, and instead had to conduct their research through Official Information Act requests transmitted through the Crown Law Office, we doubt whether any Tribunal inquiry into historical land claims could ever be satisfactorily completed.

The convenience of the Tribunal and its commissioned researcher does not seem to have entered into the considerations of Crown counsel. Both were inconvenienced, and ultimately Crown counsel as well, to the detriment of the efficiency and to a certain degree the effectiveness of the Tribunal's inquiry into the claim.

We would observe further that since Government agencies hold a great deal of recent and historical documentary information relevant to Tribunal inquiries, it is routine practice for commissioned researchers to make their own arrangements with those agencies to identify and access sources relevant to their assignment. It is preferable, and often essential, for researchers to communicate directly with officials who can advise them on the arrangement and filing systems of their agencies' records. In the case of Ms Ferguson, such communication was denied altogether, leaving her to fly blind in pursuing her assignment.

Whether or not the agencies in this instance were within their rights to appoint the Crown Law Office as sole channel, we do not consider this procedure helpful to the prosecution of Tribunal inquiries unless the circumstances are exceptional. Nor do we accept that where Tribunal and Crown research needs coincide, it is beyond the wit of the agencies involved to make practical arrangements so as to avoid unnecessary duplication of official effort.

2.6.3 The relationship between Tribunal research interviews and Crown evidence

The second issue concerns the relationship between commissioned Tribunal research and Crown evidence, and especially the interviewing of officials. We acknowledge the right of any person to refuse to be interviewed.³⁷ As a last resort, the Tribunal can invoke its powers to summon witnesses to appear. In this case, however, the issue is not the rights of individuals but the willingness of agencies to make their staff available for interview in their official capacities.

We accept Crown counsel's argument that the Crown has 'the right to prepare and present the Crown's response to the claim' and a duty to call witnesses having relevant information.³⁸ None the less, significant difficulties are bound to arise if the Crown seeks to deny access to a class of officials by asserting a pre-emptive right to their evidence. In particular:

- ▶ since Crown evidence is usually not heard until the claimant evidence has been concluded, the Crown would thereby gain sole discretion over which official witnesses it called, as well as which topics or events they addressed in evidence; and
- ▶ claimant counsel would be restricted in respect of whom they could cross-examine and on what matters.

37. Ibid, paras 13–15

38. Ibid, para 16

2.6.4

Crown counsel argued that in order to avoid the risk of officials being interviewed, having their testimony reported second-hand, and then being called to give evidence for the Crown, ‘the Crown would be unlikely to consent to interviews in such circumstances’.³⁹ In other words, until the Crown has made up its mind whom to call, all officials in the affected agencies are off limits to Tribunal researchers.

Such a position is untenable. Neither Crown counsel nor the agencies they represent have a monopoly of wisdom as to what information the Tribunal will require. This is one reason why the Tribunal commissions professional researchers to assist it in obtaining and evaluating relevant evidence. The question of partiality also arises since, in the words of Crown counsel, ‘in the case of a claim with contemporary elements such as this one, the Crown role will often involve presenting arguments in support of the impugned Crown policies’.⁴⁰

We discern a basic misapprehension concerning the conducting of research on the contemporary issues arising from a Treaty claim. A researcher directly commissioned by the Tribunal is answerable to the Tribunal itself rather than to any of the parties. We perceive no general difficulty in officials being both interviewed by a commissioned researcher and later called to give Crown evidence. The purpose of research interviews is not to depose witnesses but to gather for analysis information that, in respect of the recent past, will sometimes add significantly to the documentary record. Interviewees remain free to give evidence on behalf of themselves or their agencies.

The barring of interviews with officials increases the risk of prolonging an inquiry into one or more further rounds of research and hearings as the Tribunal and claimant counsel seek to cover gaps in the Crown’s evidence. This risk can be reduced if the Crown undertakes in advance to lead testimony from officials identified by the claimants and the Tribunal. We would, however, caution against overburdening the list of potential witnesses, which in complex contemporary cases may be lengthy.

2.6.4 The Official Information and Commissions of Inquiry Acts

We noted above that the intervention by Crown counsel was unilateral and done without notifying the Tribunal. Crown counsel argued that all Ms Ferguson’s requests for official information were subject to the Official Information Act regime, whether serviced by the agency concerned or by the Crown Law Office on its behalf.⁴¹ However, the Treaty of Waitangi Act 1975 vests the Tribunal with the powers conferred by the Commissions of Inquiry Act 1908.⁴² Both are therefore relevant to the terms of research access to official information.

The Official Information Act 1982:

- ▶ establishes the general principle that ‘the information shall be made available unless there is good reason for withholding it’;

39. Paper 2,323, para 17

40. Ibid, para 8

41. Ibid, para 12

42. Clause 8(1) of the second schedule to the Treaty of Waitangi Act 1975

- ▶ defines in considerable detail various categories of ‘good reason’;
- ▶ imposes on the agency concerned a duty of ‘reasonable assistance’ to the requester; and
- ▶ defines a further duty to ‘make the information available in the way preferred by the person requesting it’, unless doing so would, amongst other reasons, ‘impair efficient administration’.⁴³

We are satisfied that Crown counsel, having assumed the sole channel role, made every reasonable effort to meet Ms Ferguson’s requests. We are less convinced that the agencies concerned conformed to the spirit of the Act in denying Ms Ferguson the opportunity to approach them directly and to benefit from the assistance of their staff

The Official Information Act does not apply to ‘any provision which is contained in any other enactment and which authorises or requires official information to be made available’.⁴⁴ The Commissions of Inquiry Act 1908, on which the Treaty of Waitangi Act 1975 relies, does have such a provision, and in fact vests substantial powers of investigation in a commission and, by statutory extension, the Waitangi Tribunal:

- (1) For the purposes of the inquiry the Commission or any person authorised by it in writing to do so may—
 - (a) Inspect and examine any papers, documents, records, or things:
 - (b) Require any person to produce for examination any papers, documents, records, or things in that person’s possession or under that person’s control, and to allow copies of or extracts from any such papers, documents, or records to be made:
 - (c) Require any person to furnish, in a form approved by or acceptable to the Commission, any information or particulars that may be required by it, and any copies of or extracts from any such papers, documents, or records as aforesaid.⁴⁵

The Act also empowers a commission to order any document, extract, or other information to be supplied to a person appearing before it, and to set conditions for the supply and use made of the document. The supplier is accorded ‘the same privileges . . . as witnesses have in Courts of law’.⁴⁶

In carrying over these powers, the Treaty of Waitangi Act 1975 specifically empowers the chairperson, a presiding officer, or a mandated member to issue directions and ‘summonses requiring the attendance of witnesses before the Tribunal, or the production of documents’.⁴⁷

The Tribunal thus possesses ample authority under both its own Act and the Commissions of Inquiry Act to require Government agencies to provide official information without restriction and in a form and manner that it prescribes. Furthermore, it may authorise any person, including a commissioned researcher, to exercise these powers.

43. Sections 5–9, 12–13, 16(2), 17 of the Official Information Act 1982

44. Section 52(3)(a) of the Official Information Act 1982

45. Section 4C(1) of the Commissions of Inquiry Act 1908

46. Section 4C(3), (4) of the Commissions of Inquiry Act 1908

47. Clause 8 of the second schedule to the Treaty of Waitangi Act 1975

2.6.5 Assisting Tribunal research

In justifying the sole channel policy, Crown counsel stated:

The Crown's role in meeting a claim before the Tribunal is not to stand in the shoes of an orthodox defendant and oppose the claims. Its role is to assist the Tribunal, to test the evidence presented by the claimants where appropriate and to ensure that the Tribunal has all relevant material before it.⁴⁸

Crown counsel have advanced the same position on several previous occasions in the course of the Mohaka ki Ahuriri inquiry. We do not question the sincerity of the sentiments expressed. Our difficulty is that they do not resolve an obvious ambiguity of representation. On the one hand, Crown counsel wishes to assume a role akin to that of an *amicus curiae* (friend of the court). On the other, he is 'instructed' by no fewer than five Crown agencies, each with a record to defend. He speaks of 'presenting arguments in support of the impugned Crown policies' and of the 'preparation of the Crown's case'.⁴⁹

Our particular concern here is the propriety of Crown counsel intervening in the Tribunal's research process. Whilst representing Government agencies against which the claimants' grievances are directed, Crown counsel acted as sole channel and agent in obtaining official information for a commissioned research assignment. Counsel may succeed in juggling these uncomfortably juxtaposed responsibilities. The relationship between them is, all the same, not transparent, not least because the Crown's evidence is revealed only after the claimant evidence, along with the research commissioned by the Tribunal, has been presented.

Where official records are required from Government agencies in complex or urgent cases, we do not doubt that assistance from Crown counsel, including coordination, will often be helpful. Even so, coordination can take many forms. Unless exceptional circumstances can be demonstrated, we do not think it appropriate for Crown agencies to take refuge behind the Crown Law Office in responding to requests for official information from Tribunal-commissioned researchers.

2.6.6 Conclusions and findings

On research access to current official records, our conclusions are:

- ▶ that, unless exceptional circumstances apply, researchers directly commissioned by the Tribunal should be allowed to make their own arrangements with record-holding agencies and to rely on the assistance of their officials in identifying and accessing source material relevant to their assignment, including details of holdings and filing systems;
- ▶ that the Crown Law Office should advise the Tribunal at the time that the research is commissioned whether it considers exceptional circumstances require it to centralise agency responses to research requests; and

48. Paper 2.323, para 8

49. Ibid, paras 8–10

- ▶ that, in any case, commissioned researchers should be permitted to communicate directly with agency officials for the purpose of identifying documentary or other information held by their agencies, even if the information is then supplied, given the exceptional circumstances, through Crown counsel.

Our conclusions in respect of access to officials for research interviews are:

- ▶ that it is not appropriate for the Crown Law Office to advise Government agencies as a matter of policy to impose a blanket ban on interviews with officials by Tribunal-commissioned researchers, but that it should rather assess the merits of each case;⁵⁰
- ▶ that access should be denied only in exceptional circumstances and for specified reasons; and
- ▶ that, if interview requests are declined, or topics excluded from the scope of an interview, the agency should ensure that officials having the relevant information or expertise are available to testify at the hearing of the Crown's evidence.

In light of our difficulties in completing the commissioned research on the contemporary issues in the Napier Hospital services claim in a satisfactory and timely manner, we conclude:

- ▶ that, while mindful of the purposes of the Official Information Act 1982 and the grounds on which it allows the provision of information to be restricted, it is not generally appropriate to employ that Act as a means of restricting access to or limiting the supply of official information to the Tribunal as a commission of inquiry;
- ▶ that, where the Tribunal requires research likely to utilise current official records and the usual informal arrangements fail, it may be appropriate to rely more explicitly on the powers provided by section 4c(1) of the Commissions of Inquiry Act 1908 and clause 8 of the second schedule to the Treaty of Waitangi Act 1975; and
- ▶ that it is important for the integrity of the Tribunal's process for Crown counsel to minimise the risk of being seen as the 'gatekeeper' of official information.

Returning to the provision of official information to this Tribunal and the disruption of the Tribunal's commissioned research, our *findings* are:

- ▶ that the hearing of claimant evidence had to be delayed;
- ▶ that our conduct of the inquiry into this claim was placed under considerable strain;
- ▶ that an adversarial approach by the parties to the hearing of evidence was exacerbated;
- ▶ that much relevant information was excluded from the research scrutiny commissioned by the Tribunal, complicating our assessment of the evidence;
- ▶ that gaps in official documentation were not fully covered by the Crown's evidence, limiting, as we note further in chapter 7, our ability to reach findings on several particular aspects of the grievances before us; and
- ▶ that the failure of several Crown agencies, notably the HFA and Healthcare Hawke's Bay, to afford all reasonable assistance to the Tribunal's commissioned researcher in accessing relevant records and interviewing staff in their official capacities brought into question their commitment to *good faith conduct* (see section 3.8).

50. Ibid, para 19

2.7 LIMITATIONS ON FINDINGS PRESENTED IN THIS REPORT**2.7.1 Relationship with the main report on the Mohaka ki Ahuriri inquiry**

The Mohaka ki Ahuriri inquiry, with which the Napier Hospital services claim has been grouped, has heard all claims arising within its region and is reporting on them in an integrated manner. This separate report is an exception. It is therefore necessary to establish the extent to which, if at all, this claim overlaps with others to be reported on subsequently.

A number of other claims raise economic and social grievances, which extend to the state of health of the claimants and their tipuna. They do so, however, in terms of the impact of other grievances, such as the alienation of land. The Napier Hospital claim is directly concerned with the health services provided to local Maori by the State. It is thus complementary to the other claims.

The major exception, to which we drew attention in section 2.4.1, is the Ahuriri lands claim (Wai 400). The claimants say that the original promise of hospital and health services delivered from Mataruahou was made as part of the 1851 Ahuriri transaction. They proceed to adopt two clauses of the Wai 400 statement of claim, which take the position that at the time the Ahuriri hapu viewed the transaction as ‘a political compact involving reciprocity and exchange, incorporating the fundamental elements of customary transfer of land or tuku whenua’. The Wai 400 claimants argue further:

The ongoing obligations of the Crown were fundamental to the Maori understanding of the transaction. Unless they were delivered the consideration for the transfer was inadequate. If the Crown failed to fulfil those obligations, the agreement was breached and Ahuriri hapu had the right to renegotiate or repudiate the agreement.⁵¹

The Wai 692 claimants thus rely on a position that forms part of the Ahuriri lands claim. The Mohaka ki Ahuriri Tribunal will consider that claim in its main report. We wish to make it quite clear at this point that we will not be addressing any aspect of the Wai 400 claim in this report and that nothing we say here should be construed as expressing an opinion on the merits of that claim.⁵²

This exclusion raises the question of whether the Tribunal is able to deal comprehensively with the Napier Hospital services claim in this report. Our view is that we can. The essential question is whether, in relying on clauses in the Wai 400 statement of claim, the claimants establish a distinct grounds of claim or are simply asking us to report on part of the Wai 400 claim.

Two factors tell against a distinct grounds of claim. The first is that the Wai 692 claimants can properly invoke this part of the Wai 400 claim only if they consider themselves, as descendants of the signatories of the Ahuriri deed, part of the Wai 400 claimant group, Nga Hapu o Ahuriri. They do not therefore have a distinct identity. The second is that the Wai 692 statement of claim adds nothing of substance to the Wai 400 claim in respect of grievances stated or prejudice

51. Claim 1.23(d), paras 16.1, 17.1

52. This consideration also applies to terminology. Thus, our use of the term ‘Ahuriri transaction’ does not commit us to any particular view of what was agreed in 1851 between Ahuriri Maori and the Crown.

suffered. We conclude that, were we to address the clauses invoked from the Wai 400 claim in this report, we would be doing no more than to report on part of the Wai 400 claim.

At the same time, we wish to make it clear that this deferral does not restrict our ability to report on specific grievances arising from the Ahuriri transaction. We note further that the claimants assert a distinct grounds of claim that addresses much the same issue on which they rely in the Wai 400 claim. This is that the Crown had, and continues to have, a general obligation to 'provide for the health and well-being of Maori' that, the claimants say, derives directly from the Treaty of Waitangi.⁵³ This argument falls fully within the scope of our report.

For the reasons stated above, we see no difficulty in reporting separately on the Napier Hospital services claim whilst deferring those aspects it has in common with the Ahuriri lands claim to our main report on the Mohaka ki Ahuriri inquiry.

2.7.2 Sufficiency of evidence

Counsel for both parties have offered specific advice to the Tribunal on how we should consider the evidence presented to us. We comment briefly on two issues of limitation raised by counsel in their closing submissions, and on the approach we have adopted in this report towards the evidence as a whole.

Both Crown and claimant counsel agreed on the claimants' right to define their claim and the Tribunal's power to determine the scope of its inquiry.⁵⁴ Crown counsel, however, limited his submissions on historical aspects to the specific question of whether there was a promise to provide hospital services from Mataruahou under the 1851 Ahuriri transaction. The Tribunal has thus not benefited from Crown submissions on the other historical grievances alleged by the claimants or on the broader aspects of the hospital grievance. Crown counsel also took a selective approach in addressing the contemporary grievances raised by the claimants.

The Tribunal's task is none the less to take into account all the available information in reporting on the claim before it. We reiterate our intention to report on all grievances raised by the Wai 692 claimants except in so far as they overlap with parts of the Wai 400 claim relating to the status of the Ahuriri transaction.

Counsel took differing views of the status of the historical evidence presented to the Tribunal. Crown counsel stated, in regard to the promise of a hospital on Mataruahou, that 'its researcher could find no evidence which could assist the Tribunal on the issue'.⁵⁵ The unnamed researcher, however, was not called to give evidence. We agree with claimant counsel that it is difficult to place any reliance on research opinions that have been neither filed nor presented in evidence.⁵⁶ But we cannot accept claimant counsel's contention that 'if the Crown elects not to present evidence itself it is simply not in a position to challenge the historical basis of this claim'.⁵⁷ It is open

53. Claim 1.57(c), para 4

54. Document x48, para 1; doc y8, paras 1.3, 2.2

55. Document x48, para 19

56. Document y8, para 3.2

57. Document x31, para 2.4; doc y8, para 3.2

to all parties to argue their own constructions of any evidence presented to the Tribunal, from whichever quarter.

We endorse the sentiment of Crown counsel that, ‘as with any Commission of Inquiry, the Tribunal’s overriding quest must be to get to the truth of the matter’.⁵⁸ To that end, the Tribunal has scrutinised all the evidence and submissions presented in respect of the Wai 692 claim. We have also taken account of:

- ▶ the documents referenced in the research reports presented in evidence;
- ▶ any relevant evidence presented in other Tribunal proceedings, in particular, that presented to the Mohaka ki Ahuriri and Te Whanganui a Orotu inquiries); and
- ▶ various published documents, books, and scholarly research available in the public domain.⁵⁹

As in any inquiry that attempts to deal with complex and wide-ranging issues, the available evidence is inevitably more complete on some points than on others. In this case, two particular difficulties arose. One was the fact that this claim was the last to be heard in the Mohaka ki Ahuriri inquiry, which brought the preparation of both claimant and Crown evidence under severe time pressure. The other is the broad reach of some of the grievances, both in timescale and in thematic scope.

We commented in section 2.6 on the problems caused by the restrictions placed on research access to official information. Despite the procedural difficulties that arose, we do not believe that any of the parties attempted to withhold relevant information from the scrutiny of the Tribunal. We would like to thank all the parties – the claimants, the Crown and the health sector agencies – for their efforts to supply and present comprehensive information to the Tribunal.

We are satisfied that the available evidence is sufficient for us to report on all the matters raised in the claim. On a few questions, however, our findings are restricted by deficiencies in the information or in the scope of the coverage. In respect of several contemporary issues, we consider that the restrictions placed on the Tribunal’s commissioned researcher contributed to those deficiencies.

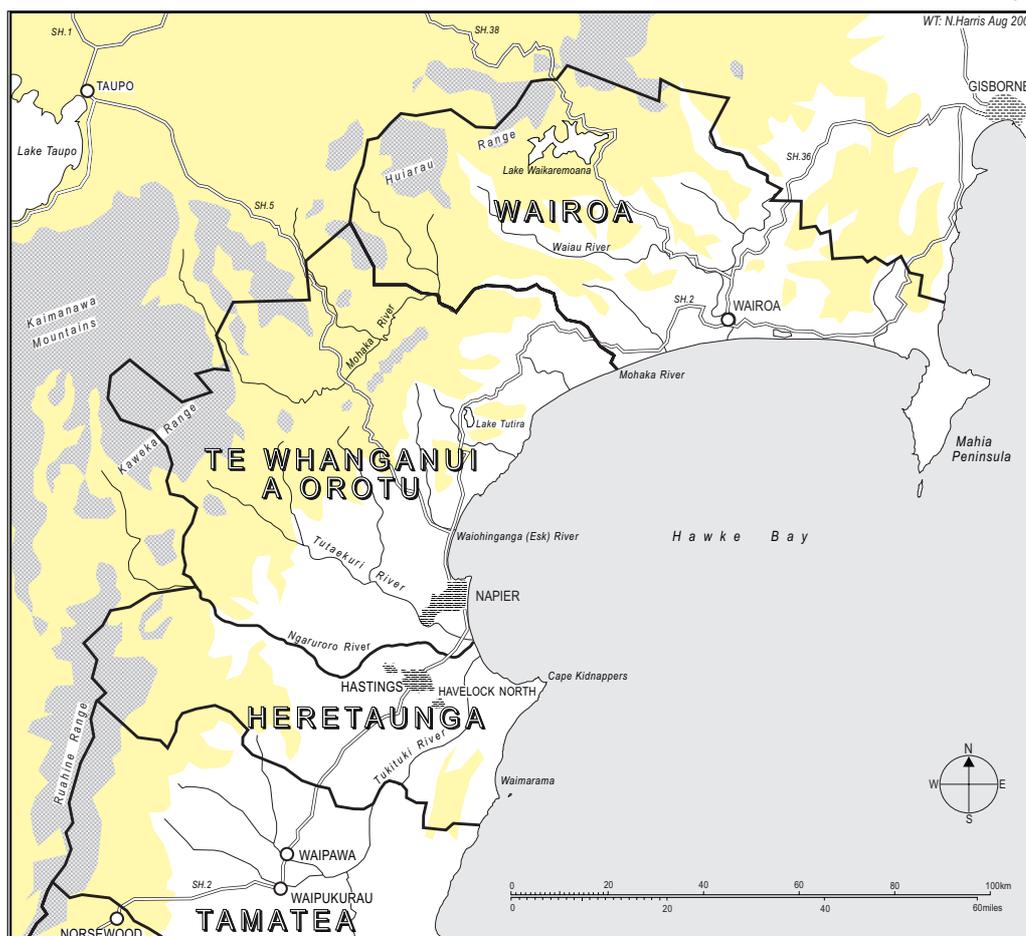
2.7.3 The identity of the claimants

In his closing submissions, Crown counsel expressed concern about what he interpreted as an ambiguity of claimant identity in respect of the grievances, prejudice and remedies presented. He discerned three sources of identity: Maori descended from tipuna represented by signatories to the Ahuriri deed; all Maori residing in the Napier urban area; and Maori living within Napier Hospital’s service catchment zone. He pointed out that the term ‘Ahuriri Maori’ appeared to take on different meanings according to context, and also that it was sometimes expanded to the wider region, as in the term ‘Maori in Ahuriri and Hawke’s Bay’.⁶⁰

58. Document x48, para 17

59. For example, docs 25, 26, 27

60. Document x48, paras 14–15



Map 2: Ngati Kahungunu taiwhenua districts in Hawke's Bay

We agree that, just as the Crown may seek clarity as to who is its Treaty partner in respect of the grievances raised and remedies demanded, the Tribunal needs to establish the standing of the claimants on whose allegations of Treaty breaches it is reporting. The statement of claim indicates that the three named claimants represent Te Taiwhenua o Te Whanganui a Orotu, one of the six district organisations of the Ngati Kahungunu iwi, and 'the peoples within the Ngati Kahungunu tribal rohe of Ahuriri'. There is no mention here of hospital catchment zones or urban areas. In other words, in bringing this claim the taiwhenua has assumed the role of representing the interests of all Maori within its district, which extends from the Mohaka and Ngaruroro Rivers inland to the administrative boundary of Hastings District Council in the Kaweka Range and includes the Tarawera and Tatarakina blocks (see map 2).⁶¹ Reinforcing this representative role, the Maori witnesses from the region who gave testimony or written evidence in support of the claim named a diversity of hapu from within and outside the district when stating their tribal affiliations.

61. Document 692(3)

It is nevertheless not clear precisely what is meant by the ‘tribal rohe of Ahuriri’. In the absence of any explanation, we assume that in the context of the statement of claim it refers to the taiwhenua district. The taiwhenua’s boundaries are, however, topographical and administrative rather than tribal in the sense of a zone of customary hapu rights. The meaning is complicated by the varying geographical uses made of the name ‘Ahuriri’ in historical and recent times:

- ▶ It describes the Ahuriri block that was subject to the 1851 transaction.
- ▶ It was also applied by early Pakeha map-makers and officials to the lowlands to the south subsequently better known as the Heretaunga Plain, where many of the hapu of the 1851 signatories settled.
- ▶ It names ‘Port Ahuriri’, formed at the heads of Te Whanganui a Orotu in the 1850s, and a suburb in the modern port area.
- ▶ ‘Ahuriri’ is also generally regarded today as the Maori name for the city of Napier.

The ambiguity becomes significant because the grievances relating to the Ahuriri transaction have distinct grounds of entitlement. If in 1851 a hospital was promised on Mataruahou as part of the consideration for the transaction, as the claimants say, who were the Maori parties to the agreement? A strict European contractual view would include the signatories alone. Modern equivalents would be the registered beneficiaries of land trusts, in which the rights pass by inheritance. Under this view, only the descendants of the signatories, wherever they might reside, would today retain a contractual right.

But the Maori understanding at the time would have extended the entitlement to all those living under the mana of the signatories, that is, members of their hapu and visitors from other hapu. More loosely, it would have extended to neighbouring hapu. If a promise was made, the local rangatira were in effect kaitiaki or guarantors of the non-exclusive availability of the resulting health services to all Maori who could take advantage of them. This was, as will be explored further in section 4.2.3, close to British colonial policy at the time of the Ahuriri transaction, which was to provide the services of public district hospitals to all Maori who could reach them. In pursuing this claim, the taiwhenua has thus adopted a leadership role roughly equivalent to that of the rangatira who concluded the Ahuriri transaction with Donald McLean in 1851.

The complicating factor, as Crown counsel points out, is that Te Taiwhenua o Te Whanganui a Orotu does not represent all the descendants of the Ahuriri signatories.⁶² One general hospital became two as urbanisation concentrated the district’s population into and near the two cities of Hastings and Napier. Ngati Kahungunu’s district organisation also reflects this division, Te Taiwhenua o Te Whanganui a Orotu being based in Napier and the Heretaunga Taiwhenua in Hastings. Nga Hapu o Ahuriri, whose members live in both districts, have thus been divided by the reversion to a single regional hospital now located in Hastings while the Heretaunga taiwhenua has supported the regional hospital project from its inception.

The situation is, however, by no means as polarised as the intensity of intercity rivalry between Napier and Hastings might suggest. The claimants have not objected to the regional hospital plan as such, but assert the promise of a hospital on Mataruahou, seek the retention of

62. Document x48, paras 14–15

appropriate services at Napier Hospital, and object to the inadequate consultation carried out on Napier Hospital's downgrading and closure. On these points, they were supported by the testimony of Ngahiwi Tomoana, the chairperson of Ngati Kahungunu and previously of Te Taiwhenua o Heretaunga.⁶³ They were also supported in their application for an urgent hearing in January 1998 by Albert Walker, the chairperson of the Wairoa taiwhenua.⁶⁴

We do not take the view that descendants of the 1851 signatories are disqualified from bringing a claim by virtue of representing only some rather than all of the descendants. Nor do we discount the standing of Te Taiwhenua o Te Whanganui a Orotu simply because it represents only a section of the population served by a regional health service provider such as Healthcare Hawke's Bay. In such cases, the evidence is nevertheless often subject to an additional test of relevance: indicators of the health status of Maori in Hawke's Bay, for example, must be shown to be applicable if used to portray the situation of Maori within the Taiwhenua district. Conversely, the position of Maori residing in other parts of Hawke's Bay comes within the scope of this report only to the extent that it is relevant to the Tribunal's assessment of the merits of the claim.

For the purposes of this report, we have adopted two slightly differing geographical interpretations of the term 'Ahuriri Maori':

- ▶ The first covers the period of the historical grievances (circa 1840–1940). It refers to the hapu of the signatories of the 1851 Ahuriri deed and all other Maori who came to reside within their rohe. In the mid-nineteenth century, they lived mainly in the coastal area from the Heretaunga Plain to the Mohaka River valley and inland to the Maungaharuru and Kaweka Ranges. Throughout this period until the late 1930s, when Hastings Memorial Hospital was upgraded to a general hospital, Napier Hospital stood alone in serving the region of central Hawke's Bay.
- ▶ The second interpretation covers the period of the contemporary grievances (circa 1980–2000). It refers to all Maori residing within the rohe of Te Taiwhenua o Te Whanganui a Orotu, including descendants of the signatory hapu. It excludes those living in the rohe of the neighbouring Taiwhenua o Heretaunga south of the Ngaruroro River but includes those in the hill country of Tarawera and Tatarakaia. During most of this period, the region was served by the two general hospitals in Hastings and Napier.

2.7.4 'The Crown' and public health service provision

2.7.4.1 *Statutory provisions*

Not only the identity of the claimants is in dispute in this inquiry. Crown counsel argued that the central and local State agencies in the health sector should be distinguished: the former were part of 'the Crown', but the latter, having delegated powers, were not. The question therefore arises as to whether the Tribunal has jurisdiction to inquire into the consistency with the Treaty of Waitangi of the acts and omissions of State health agencies operating in Hawke's Bay.⁶⁵

63. Document v18

64. Document 692(13)

65. Document x48, para 46

We consider first the position in statute law. Before the mid-twentieth century, statutes governing local health services do not appear to have attempted to define the boundaries of the Crown. In summary, we may distinguish four periods:

- ▶ 1840–54, during which the colonial government directly administered State health services;
- ▶ 1854–76, during which provincial councils controlled the public hospitals and the central government most other health services;
- ▶ 1877–85, a confused transitional period during which hospitals fell under local administration, in the case of Napier Hospital under a committee of management, which was dominated from 1879 by the participating local authorities;
- ▶ 1885–1957, during which the Government delegated the ownership and management of public hospitals to district boards, which were nominated by local authorities up till 1909, after which they were directly elected.

The Hospitals Act 1957 explicitly excluded hospital boards from the definition of ‘the Crown’:

Notwithstanding anything in this Act, in the exercise of its functions, duties, and powers a Board shall not be deemed for the purposes of any proceedings to be the agent or servant of the Crown or to be an instrument of the Executive Government of New Zealand, or to be entitled in any proceedings to claim any of the privileges of the Crown; and no officer or employee of the Board shall be deemed to be the agent or servant of the Crown.⁶⁶

Clauses defining regional and district health agencies as not part of the Crown have been included in every statute governing Crown health agencies since then, including:

- ▶ the Area Health Boards Act 1983, under which the Hawke’s Bay Area Health Board took over the assets and functions of the Hawke’s Bay Hospital Board in June 1989;⁶⁷
- ▶ the Public Finance Act 1989, which created a new class of ‘Crown agencies’, distinct from ‘the Crown’, that it defined in terms of being under Crown ownership, having a Crown power of appointment, or possessing ‘significant financial interdependence’ with central government;⁶⁸
- ▶ the Public Finance Amendment Act 1992, which applied the new category of ‘Crown entity’ to the area health board administrations in their final months and, from July 1993, to their successors, the RHAS and CHES;⁶⁹ and
- ▶ the Public Health and Disability Act 2000, which did not refer explicitly to the status of the new district health boards, but, by classing them as Crown entities, implied that they too were to be distinguished as outside the Crown.⁷⁰

66. Section 4(5) of the Hospitals Act 1957

67. Section 38(3) of the Area Health Boards Act 1983

68. Section 2 of the Public Finance Act 1989

69. First and fourth schedules to and sections 2, 3, 41 of the Public Finance Act 1989; section 27(1), (4) of the Health Reforms (Transitional Provisions) Act 1993

70. Section 42(1) of the Public Health and Disability Act 2000

We are in no doubt that from 1860 to 1876 the provincial Napier Hospital was operated as part of the Crown. Conversely, between 1877 and 1885 it fell under local management. Thereafter, the position was less categorical. In a supplementary memorandum requested by the Tribunal, Crown counsel concluded:

Bodies such as the former hospital boards and the former area health board which are more akin to a unit of local government do not generally fall within the definition of ‘the Crown’. They are subordinate bodies exercising delegating statutory power. They are not under the ‘direct control’ of the Executive Government.⁷¹

Crown counsel allowed that the exercise of ministerial powers of direction and delegation might constitute acts, omissions or policies by or on behalf of the Crown, but believed that the terms of the applicable legislation greatly limited such instances.⁷²

Claimant counsel, on the other hand, argued that the modern health agencies were, as Crown entities, part of the Crown. Counsel submitted that their predecessors had ‘similar responsibilities, similar controls (including finances) and were subject to frequent statutory refinement by the Crown’. They should therefore also be treated as part of the Crown.⁷³

2.7.4.2 *The control test*

In his memorandum, Crown counsel cited a recent Court of Appeal judgment which concluded that each instance had to be considered on its merits:

there is no one rule or principle which can be applied to determine whether an entity should be regarded as an agent for the Crown. Rather, the answer will depend in each case on a full assessment of the words of the legislation in the context in which the issue arises, and the nature of the power being exercised by the body or the rights or privileges being sought.⁷⁴

We agree that it is appropriate to evaluate each statutory regime on its merits and in its historical context. The statutory exclusion of an agency from the ambit of ‘the Crown’, while influential, is not in our view decisive. We must look beyond the specific statutory definition to assess the formal relationship between delegated health agencies and central government. For this purpose, we adopt the ‘control test’ endorsed in 1999 by the Court of Appeal, which identified three criteria:

1. the nature of the functions that the entity performs, and for whose benefit it performs these functions;
2. the nature and the extent of the powers entrusted to the entity;
3. above all, the nature and degree of control of the Crown or government over the entity . . .

71. Paper 2.409, para 9

72. *Ibid*, para 18

73. *Ibid*, paras 3–4

74. *Ibid*, para 6; *Tē Heu Heu v AG* [1999] 1 NZLR 98, 118, per Robertson J

2.7.4.3

The most important test to determine whether it should be treated as a part of the Crown or not is the so-called ‘control’ test: A Crown component will be treated as part of the Crown if it may be said to be ‘controlled’ by the Crown.⁷⁵

2.7.4.3 The extent of Crown control in the health sector from 1885

Applying this ‘control test’, we note that until the 1930s hospital boards were largely independent, having multiple income streams and being subject only to Government inspection. At the same time, we observe a pattern of strengthening central influence exerted by the Crown. The local boards were delivering a core Crown obligation – public hospital and health services. From the 1920s, and particularly the late 1930s, central government tightened its grip on hospital strategic planning, especially over capital expenditure and service development. After the introduction of the hospital benefit in 1939, Government funding dominated hospital budgets and, from 1957, boards were subject to ministerial direction.

The level of central government control was thus more a matter of degree than of sharp demarcation. The hospital and area health boards had a hybrid character that distinguished them both from autonomous rates-funded bodies such as county councils and road boards and from State enterprises run as independent trading businesses.

We find nevertheless that the most significant criterion of the boards’ independence from the Crown lies in their democratic accountability to local electorates. The Hawke’s Bay Hospital Board (1885–May 1989) and the Hawke’s Bay Area Health Board (June 1989–July 1991) had all or a majority of their governing boards locally elected or nominated. We conclude that these institutions, which had responsibility for Napier Hospital, were not part of the Crown. Nor, in our view, is the Hawke’s Bay District Health Board, which took over in January 2001.

2.7.4.4 Delegated agencies under the purchaser–provider regime (1991–2000)

Because many of the grievances in this claim arose in the 1990s, we will examine more closely the status of the agencies operating during that period. From August 1991, the elected boards were replaced by Government-appointed commissioners, thus bringing area health board operations under direct Crown control until their abolition in June 1993.⁷⁶

From July 1993 to December 2000, the State health service was divided between purchaser and provider agencies. Crown counsel considered both to be outside the Crown:

It is necessary to clarify the nature of the ‘Crown’ in this claim. The Ministry of Health and the Crown Company Monitoring Advisory Unit (CCMAU) are part of the ‘Crown’. They are Government Departments. They are subject to the Crown’s Treaty obligations. The HFA and HCHB [Healthcare Hawke’s Bay] are Crown entities but are not part of ‘the Crown’ for the purposes of the Crown’s Treaty obligations. In the context of this claim, the Crown accepts that to the extent that the actions of the HFA and HCHB impinge upon the Crown’s Treaty obligations they can

75. Paul Lordon QC, *Crown Law* (1991), p 44, quoted in *Te Heu Heu v AG*, p 119, per Robertson J

76. Section 4 of the Area Health Boards Amendment Act (No 2) 1991

properly be characterised as actions ‘for and on behalf of’ the Crown in terms of the Tribunal’s jurisdiction to inquire into such actions (section 6 Treaty of Waitangi Act 1975).⁷⁷

This distinction claimant counsel emphatically refuted, reiterating the position taken in the statement of claim that:

the Fourth Schedule of the Public Finance Act clearly defines each of the health entities as a Crown entity and each therefore retains the same obligations under the Treaty as the Crown itself. Treaty of Waitangi obligations include the terms and principles of the Treaty of Waitangi. While these are generally not legally enforceable through the Courts they are binding upon the honour of the Crown and are binding on each of the relevant entities in this claim.⁷⁸

Claimant counsel pointed out further that, as Crown entities, the Central RHA, the HFA and Healthcare Hawke’s Bay should be distinguished from State-owned enterprises, which were not so defined.⁷⁹

Claimant counsel’s position does not take account of the fact that the same Public Finance Act defined ‘Crown entities’ as not part of the Crown. But we agree that agencies in this category were ambiguously positioned between commercial State-owned enterprises outside the Crown and Government departments within the ambit of the Crown. We are not convinced that there is a significant difference between being part of the Crown and ‘acting for and on behalf of the Crown’ in respect of the Crown’s Treaty obligations.

We return to the control test discussed earlier. In our view, despite the introduction of competitive contracting, the State health system formed in the main a closed circuit of interlocking relationships. The purchaser agencies were no more than modestly autonomous arms of central government, which appointed their boards, provided all their funding, set their policy objectives, bound them to detailed annual agreements, and made them liable to ministerial direction.

In the provider domain, the status of CHES was obscured by their mandate – lifted after 1997 – to conduct their business, like State-owned enterprises, on a commercial basis.⁸⁰ In major respects, however, they were more tightly bound to the Government than their area health board predecessors. Central government owned them, appointed their boards, and provided all their funding apart from user charges, and could direct them to provide particular services. They were tied into annually negotiated purchase contracts, statements of intent, and business plans, and their strategic planning and financial performance were tightly regulated. Consolidating this web of control, local democratic governance was replaced, for both purchaser and provider, by direct accountability to Ministers.

We conclude that for the purposes of the Treaty of Waitangi Act 1975, both the Central RHA–HFA and Healthcare Hawke’s Bay were part of the Crown. They thus assumed the Crown’s Treaty obligations.

77. Document x48, para 46

78. Document x31, para 11.4; claim 1.57(c), para 9

79. Document y8, para 4.7

80. Sections 11, 37 of the Health and Disability Services Act 1993

2.7.4.5 Responsibility for Treaty obligations in respect of delegated authority

We concluded above that, from 1877 to 1991, the committees and boards that operated Napier Hospital were not part of the Crown. These institutions cannot therefore be held directly accountable for any breaches of the Treaty. Crown counsel agreed, however, that Crown responsibility was not thereby removed:

The Crown must and does ensure that in the exercise of delegated powers or functions, Crown entities act in a way that is consistent with the Crown's obligations under the Treaty. However, primary responsibility for discharge of these obligations remains with the Crown and not these entities.⁸¹

Claimant counsel likewise stressed the Crown's overall responsibility for meeting its Treaty obligations:

As the Treaty partner it is the Crown that has the responsibility to ensure that the delivery of health services proceeded in accordance with its Treaty obligations . . . A particular consequence of this obligation is that any purported delegation is also required to be consistent with the Treaty, not only at the time of delegation but throughout the period of the delegation.⁸²

The views of both counsel are similar to the findings of several previous Tribunal reports.⁸³ In this period, consequently, our scrutiny is directed to:

- ▶ the consistency of the governing health sector legislation with Treaty principles; and
- ▶ the adequacy of the Government's supervision of the health agencies to which it delegated responsibility for Napier Hospital.

2.7.5 Specific and generic issues

We observed in section 2.4.3 that several of the grievances concerning the modern period of the claim are expressed in terms of general policy, central institutions, national programmes, and health outcomes for Maori as a whole. This widening of the scope of the claim brings certain of its aspects to the verge of requiring a generic inquiry.

Crown counsel strenuously resisted a generalising approach:

The Crown has not approached this claim as if it were a general inquiry into the [health] reforms or of the Crown's delivery of health care to Maori from the time of the Treaty to the present. It is neither appropriate nor possible to do so on the evidence available.⁸⁴

Crown counsel none the less joined claimant counsel in inviting the Tribunal to pass judgement on the general success or failure of the health reforms in terms of the Treaty. He declared:

81. Document x48, para 46

82. Paper 2.408, para 5

83. For instance, *The Report of the Waitangi Tribunal on the Manukau Claim*, p 73; *The Whanganui River Report*, pp 331–332

84. Document x48, para 2

The Crown expressly rejects the proposition that there were failures in legislation or policy arising out of the health reforms of the early 1990's that failed to ensure that [the] poor health status of Maori would be addressed. There are such policies and programmes in place and the Crown maintains that they have produced positive benefits that should be endorsed.⁸⁵

Claimant counsel followed a similar path but in the opposite direction:

This claim is important because it is the only opportunity that these reforms and the effects they have had can be tested in an appropriate forum. The Waitangi Tribunal is perhaps the only forum where the effect of the health reforms on people can be assessed and commented on in detail.⁸⁶

We agree with Crown counsel that our inquiry into this claim does not have the character of a generic investigation into the performance of the Crown's Treaty obligations in respect of Maori health. On the one hand, the claimants represent a district Maori organisation and identify with a particular area within Hawke's Bay; a nationally representative Maori body is not involved. On the other, it would not be possible for the Tribunal to reach nationally valid findings on many of the grievances in the absence of detailed evidence both on other regions and on the national context.

Local grievances will often, however, raise wider issues. In so far as these are relevant to the claim in hand, the Tribunal would be failing in its duty if it declined to consider the local grievances before it in their regional and national context. In this regard, the Tribunal is well served by the efforts of both the claimants and the Crown in providing a large body of evidence on national policy and practice in the historical and modern periods.

85. Ibid, para 121

86. Document x31, para 8.5

CHAPTER 3

TREATY INTERPRETATION

3.1 CHAPTER OUTLINE

In this chapter, we develop the conceptual tools for the task of assessing whether the claim is well founded, outline the role of the Tribunal in reporting on the claim (section 3.2), and consider the status of the Treaty of Waitangi itself and the manner in which it is to be applied (section 3.3).

The main part of the chapter outlines the Treaty principles which we consider applicable to the claim. In doing so, we refer to relevant findings from previous Tribunal reports and the benchmark judgments of the Court of Appeal and Privy Council. Where appropriate – since this is the first Tribunal report to address a health sector claim – we discuss ‘the practical application of the principles of the Treaty’, as enjoined by the preamble to the Treaty of Waitangi Act 1975, to the general health issues raised by the claim.

We identify four relevant Treaty principles:

- ▶ the principle of active protection (section 3.4);
- ▶ the principle of partnership (section 3.5);
- ▶ the principle of equity (section 3.6); and
- ▶ the principle of options (section 3.7);

and two duties arising from those principles:

- ▶ the duty of good faith conduct (section 3.8); and
- ▶ the duty of consultation (section 3.9).

3.2 THE ROLE OF THE TRIBUNAL

3.2.1 The identity of ‘the Crown’

The Waitangi Tribunal was established by statute as a permanent commission of inquiry into Treaty claims submitted by Maori. To qualify, the claim must be directed against the Crown. We discussed in section 2.7.4 the institutional composition of the Crown in the health sector in historical and recent times. Here, we move beyond establishing the technical frontier of Crown agency to consider briefly the wider question of Crown identity and the right of redress.

Our purpose in doing so is not to enter into a discussion of constitutional forms but to clarify the applicability of the Treaty to grievances relating in part to a State-supplied social service. The principal focus of this claim is policy and practice in the mainstream healthcare sector. A widely

held view is that entertaining claims by one section of the population against ‘the Crown’ is inherently illogical, since the democratic state represents the people as a whole, inducing the entitled section to lay claims against itself. A further line of argument is that rationed State services, such as hospitals and health programmes, can be allocated only on the basis of equal rights of access and without creating a privileged right for ethnically defined groups.

We make several related observations. The fundamental status of ‘the Crown’ as a constitutional monarchy has remained unchanged from 1840 to the present day. It is undoubtedly the case that the symbolism of the British Queen as executive ruler had a powerful influence on Maori political perceptions. However, the constitutional effect of the Treaty was to join Maori to the community of British subjects, alongside immigrant settlers. The transition from British to New Zealand responsible government has not affected the status of the British monarch as formal head of State ‘in right of New Zealand’. For all practical purposes, ‘the Crown’ bears the same connotation as ‘the State’, an example being the routine designation of agents of the State, such as court prosecutors, as acting for ‘the Crown’.

The notion of particular groups of citizens being accorded the right to pursue claims for redress against the State in respect of State-supplied services is an accepted norm of modern democratic society. Examples in the field of health might be groups put at risk of harm by some State action or omission, such as military personnel exposed to radiation in nuclear tests, haemophiliacs supplied with infected blood, or women at risk of cervical cancer as a result of systemic failure in a screening programme. Whether or not the entitled group is ethnically defined does not affect the principle of entitlement.

The difference in respect of claims by Maori is that the entitlement derives from the Treaty, as recognised in statute law. The Treaty created enduring obligations on the part of the Crown towards Maori, in contrast to other British subjects. We consider in section 3.4.3 whether the principles of the Treaty did in fact impose any obligation upon the Crown to make special provision for Maori health needs.

3.2.2 Jurisdiction and substantiation

In section 6(1), the Treaty of Waitangi Act 1975 lays down a set of criteria, applicable from the signing of the Treaty, for the grounds of claim:

6. Jurisdiction of Tribunal to consider claims—(1) Where any Maori claims that he or she, or any group of Maoris of which he or she is a member, is or is likely to be prejudicially affected—

- (a) By any ordinance of the General Legislative Council of New Zealand, or any ordinance of the Provincial Legislative Council of New Munster, or any provincial ordinance, or any Act (whether or not still in force), passed at any time on or after the 6th day of February 1840; or

- (b) By any regulations, order, proclamation, notice, or other statutory instrument made, issued, or given at any time on or after the 6th day of February 1840 under any ordinance or Act referred to in paragraph (a) of this subsection; or
 - (c) By any policy or practice (whether or not still in force) adopted by or on behalf of the Crown, or by any policy or practice proposed to be adopted by or on behalf of the Crown; or
 - (d) By any act done or omitted at any time on or after the 6th day of February 1840, or proposed to be done or omitted, by or on behalf of the Crown,—
- and that the ordinance or Act, or the regulations, order, proclamation, notice, or other statutory instrument, or the policy or practice, or the act or omission, was or is inconsistent with the principles of the Treaty, he or she may submit that claim to the Tribunal under this section.

In broad terms, a claim must be directed against the Crown and relate to:

- ▶ legislation enacted at the national or provincial level, and derivative statutory instruments;
- ▶ Crown policies and practices; and
- ▶ acts or omissions by or on behalf of the Crown.

The Act sets up three tests that a claim, or the particular grievances therein specified, must meet in order for the Tribunal to adjudge it well-founded:

- ▶ it must be substantiated on the basis of the available evidence;
- ▶ the act or omission cited must be or have been inconsistent with the principles of the Treaty of Waitangi; and
- ▶ the claimants must have suffered or be likely to suffer prejudice thereby.

The Tribunal must be satisfied that all three tests are met. In respect of substantiation, we endorse the Turangi township Tribunal's rejection of the position that 'either the claimants or the Tribunal should be bound by court rules of civil procedure as to the burden of proof'. It continued:

The Tribunal's mandate is to ascertain the truth of what happened in any particular matter before it . . . When all the evidence is in, the Tribunal must then decide on the totality of the relevant evidence before it the extent to which, if at all, the claims before it are made out. It is then appropriate to do so on the balance of probability.¹

We consider that the advice of neither Crown nor claimant counsel as to the Tribunal's jurisdiction in this claim entirely meets the requirements laid down in the Act. In his closing submission, Crown counsel argued that there was little evidence of prejudice having arisen from the closure of Napier Hospital, and that this 'tells against . . . the jurisdiction of the Tribunal to find the claim well-founded'² In response, claimant counsel countered that 'it is not necessary for the claimants to show actual physical ill effects . . . It is just as prejudicial if the Crown has breached any of its obligations to Maori.'³

1. *The Turangi Township Report 1995*, p 293

2. Document x48, para 120

3. Document y8, para 2.7

3.2.3

By referring only to evidence of past prejudice, Crown counsel ignores the risk of future prejudice, which the claimants raise. On the other hand, a breach of obligation is not, as claimant counsel argues, in itself prejudicial, unless it can be shown that the claimants have been or are likely to be affected. The possibility of continuing or future prejudice is more significant in the case of grievances that arose in the very recent past. It may also be relevant in assessing health outcomes: some may become evident only slowly, perhaps over decades, and measuring them may take time, especially when distinguishing the effects of health interventions from other causes in what is often a complex multi-factorial situation.

A further question of relevance arises. Crown counsel submitted that the closure of Napier Hospital did not become a Treaty matter simply because it was a community issue that local Maori happened to share.⁴ Claimant counsel replied, in our view correctly, that ‘Treaty’ and ‘community’ issues were not necessarily mutually exclusive:

It cannot be correct that just because an issue is shared with the wider community it ceases to be a Treaty issue. Just because an act or omission of the Crown breaches the Treaty does not mean that it will not also have an adverse effect on the rest of the community. Likewise an action that prejudices the wider community can clearly also breach the Crown’s Treaty obligations to Maori. Put quite simply, Treaty issues and issues of concern to the community are not mutually exclusive concepts. The only difference is that if the prejudicial action or omission is in breach of the Treaty, Maori are entitled to utilise the forum of the Waitangi Tribunal to investigate the acts and/or omissions that have caused the prejudice.⁵

Finally, Crown counsel rejected, without giving reasons, the claimants’ position ‘as to the obligations on the Crown in respect of health care said to arise under the Treaty’. He indicated that the Crown would not be responding to ‘the very broad allegations about alleged historical failure in health policy generally’ and that it was ‘neither necessary or possible to undertake a meaningful inquiry into those issues’. Should the Tribunal decide to do so, however, ‘the Crown would need to consider the need for additional research and evidence and would wish to be heard more fully on the legal issues arising’.⁶

We have already indicated the scope and limitations of our inquiry into this claim in section 2.7. We would simply note here that the Crown has had full opportunity to present whatever legal submissions it wished to make.

3.2.3 Discretion as to scope of recommendations

The Treaty of Waitangi Act 1975 gives the Tribunal wide latitude in framing its recommendations, should it find any of the grievances to be well founded. The recommendations may be specific or general; may suggest that compensation be paid or that other action designed to

4. Document x48, para 6

5. Document y8, para 2.5

6. Document x48, paras 77–78

remove the prejudice be taken; may relate just to the claimants or to other persons who the Tribunal considers may be prejudiced in future; and may go outside the remedies requested by the claimants.⁷

We are aware that the earmarking of certain social service resources exclusively for Maori purposes has been a controversial issue in public debate. We therefore raise the matter briefly in general terms. Crown counsel appeared to have it in mind when advising the Tribunal to limit the scope of any recommendations that it might make:

It is submitted that the approach of the Tribunal when reviewing decisions or considering recommendations involving the allocation of resources should therefore be a cautious one, bearing in mind that its jurisdiction is confined to assessing particular breaches of the Treaty and not substituting for political decisions of the Executive and Parliament.⁸

Claimant counsel countered in reply that:

It is of particular concern to the claimants that the Crown has couched its comments in relation to remedies in terms of the Crown's exercise of the right to govern. It is submitted that once again this mistakes the nature of the claim and the type of relief sought. The claimants have identified specific relief for which recommendations from the Tribunal are sought and it is up to the Tribunal to decide whether such relief should be granted.⁹

In our view, both counsel err in seeking to restrict the discretion of the Tribunal. Claimant counsel is not correct when he seeks to limit the Tribunal's options to the 'specific relief' that the claimants have requested. Nor is it appropriate for Crown counsel to imply that, in making recommendations for relief, the Tribunal should steer clear of matters within the purview of the Government, such as 'the allocation of resources'.

Where compensation has been recommended as redress for well-founded claims, it has commonly taken the form of lump sums or capital assets. In the case of a social service such as healthcare, however, well-founded grievances may relate to the service provided as much as the physical infrastructure through which it is delivered. It may accordingly be appropriate for the Tribunal to recommend remedies in respect of those services. A recent precedent was the *Mokai School Report*, which recommended the reopening of the school and additional professional support.¹⁰

The fact that the consequential costs may be recurrent rather than one-off should not restrict the form of recommendation the Tribunal may make. We agree with Crown counsel, however, that a cautious approach is generally appropriate since the Government is obliged to exercise reasonable discretion in the provision of rationed services.

7. See *The Muriwhenua Land Report 1997*, p 391; *The Orakei Report 1987*, pp 261–262

8. Document x48, paras 120, 126

9. Document y8, para 5.1

10. *The Mokai School Report*, pp 132–133

3.3 STATUS AND APPLICATION OF THE TREATY

3.3.1 Constitutional status

The Treaty of Waitangi is the foundation document for modern constitutional government in New Zealand. It established the basis both for lawful British government and for future European settlement.¹¹ Moreover, it entrenched enduring obligations. As the *Ngai Tahu Report 1991* put it:

It was not intended merely to regulate relations at the time of its signing by the Crown and the Maori, but rather to operate in the indefinite future when, as the parties contemplated, the new nation would grow and develop.¹²

Any interpretation of the Treaty would therefore need to take account of changing conditions and values. In the opinion of Sir Robin Cooke, the then president of the Court of Appeal, ‘the Treaty has to be seen as an embryo rather than a fully developed and integrated set of ideas’. At the same time, ‘the Treaty is a living instrument and has to be applied in the light of developing national circumstances’.¹³

The Treaty itself, however, has no independent legal standing, except when it is incorporated into statute law. The powers of the Tribunal represent one such statutory creation. The *Ngai Tahu Sea Fisheries Report* summarised the position thus:

Certain legislative provisions, most notably the Treaty of Waitangi Act 1975 and its amendments, have resulted in the Treaty being given effect to and, as a consequence, residing in the ‘domestic constitutional field’. Other recent legislation requires or permits decision-makers to have regard to the Treaty. The High Court has ruled that the Treaty ‘is part of the fabric of New Zealand society’ and in certain circumstances regard may be had to its provisions in interpreting legislation. But in the absence of express legislative provision, Treaty rights cannot be enforced in the courts.¹⁴

We note in passing that the recent Public Health and Disability Act 2000 for the first time provides measures in health legislation ‘to recognise and respect the principles of the Treaty of Waitangi’.¹⁵

A series of judgments over the last 15 years, notably by the Court of Appeal and the Privy Council, have gone a long way towards clarifying the fundamental principles for interpreting the Treaty in modern circumstances. But as we saw in section 3.2.2, the Treaty of Waitangi Act 1975 requires the Tribunal to go well beyond the scope of the statutory provisions on the basis of which the case law has developed. It also states that the Tribunal, for the purposes of the Act,

11. Document X31, para 3.1

12. *The Ngai Tahu Report 1991*, pp 222–223

13. *Te Runanga o Muriwhenua Inc v Attorney-General* [1990] 2 NZLR 641, 655 (CA), per Cooke P; *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 663, per Cooke P

14. *The Ngai Tahu Sea Fisheries Report 1992*, p 268

15. Section 4 of the Public Health and Disability Act 2000

‘shall have exclusive authority to determine the meaning and effect of the Treaty as embodied in the 2 texts and to decide issues raised by the differences between them’.¹⁶

Nearly two decades ago, the Tribunal stated its belief that ‘the Treaty is capable of a measure of adaptation to meet new and changing circumstances provided there is a measure of consent and an adherence to its broad principles’.¹⁷ A few years later, the Royal Commission on Social Policy considered that:

the Treaty’s promise must also be seen as fundamental to those principles which will underline social wellbeing in years to come. Its careful application and active protection will enable New Zealanders to move forward together into the twenty-first century.¹⁸ Today, at the dawn of the twenty-first century, there is less of a ‘measure of agreement’ as to how the Treaty should be applied in the field of social policy and services.

In view of the evident lack of national consensus, we have taken some care in articulating the Treaty principles that we consider to be relevant to the claim under consideration. We refer where appropriate to the views of previous Tribunals on the issues raised. We should explain here that although the Waitangi Tribunal is constituted as a standing body of members, each individual Tribunal, comprising a group of members appointed by the chairperson, reports autonomously on the claim or claims into which it has inquired. It has regard to the findings made in the preceding body of Tribunal reports, but is not bound by them.

We also cite court judgments where these are helpful in defining Treaty principles, duties, and appropriate modes of application. We are mindful of the risk of circularity in this procedure – that is, the courts draw on articulations in Tribunal reports and later Tribunals rely in turn on the resulting case law. Where we draw on such case law in this report, we take full responsibility, as required by the Treaty of Waitangi Act, for the resulting interpretation.

3.3.2 Interpreting the Treaty

Not only is the Treaty of Waitangi not a constitutional blueprint, but it is also bilingual and the differences of meaning between the two texts are substantive. Some of those differences are ambiguities in wording, others are matters of content. In addition, Maori and British understandings of the meanings of key words differed, as did, to varying degrees, their expectations of what the Treaty would deliver. We endorse the position taken by previous Tribunals that, for the purposes of interpreting the meaning of the Treaty, it is essential that we take account of the surrounding circumstances in which it was formed.¹⁹

On the formal status of the Treaty, we endorse the conclusion of the *Ngai Tahu Sea Fisheries Report*:

16. Section 5(2) of the Treaty of Waitangi Act 1975; *The Ngai Tahu Report 1991*, p 222

17. *The Report on the Motunui–Waitara Claim*, p 52

18. Royal Commission on Social Policy 1988, p 80

19. *The Ngai Tahu Sea Fisheries Report 1992*, p 268; *The Radio Spectrum Mangement and Development Final Report*, p 37; *The Taranaki Report 1996*, p 18

We believe there is credible and persuasive support for the view that the Treaty of Waitangi was a valid treaty under international law. Certainly it was the intention of the British government to treat with the Maori people as a sovereign independent nation. Accordingly it is reasonable to apply the general principles of treaty interpretation to the Treaty of Waitangi.²⁰

One of those principles of particular relevance to our task of interpretation is the so-called *contra proferentum* rule, which is drawn principally from North American jurisprudence concerning treaties with native peoples. In the words of the *Ngai Tahu Report 1991*, the rule provides that ‘where an ambiguity exists, the provision should be construed against the party which drafted or proposed the provision, in this case the Crown’.²¹ Thus, in respect of an ambiguity or difference in meaning between the English and Maori texts, the understanding Maori had, or were likely to have had, at the time would be taken as authoritative.²²

The rule is neutral between the two language texts; neither is superior. Moreover, one may be interpreted by reference to the other. Some Tribunal reports have accorded greater weight to the Maori text by virtue of context, since that was the version heard and assented to by most Maori.²³ In Hawke’s Bay, however, only a handful of rangatira were given the opportunity to sign at all. We express no opinion as to which version Maori in that region would have regarded as the more authentic in the early years of British rule.

3.3.3 Determining Treaty principles

The Tribunal is required to establish whether the alleged grievances were or are ‘inconsistent with the principles of the Treaty of Waitangi’. The Act gives no guidelines on how principles are to be derived from the Treaty. Fortunately, as the recent *Radio Spectrum Management and Development Final Report* points out, there is now a large body of previous Tribunal findings and court judgments to draw on.²⁴

The obvious risk arises that the preoccupations of the present may be projected into the context in which the Treaty was signed more than a century and a half ago. We share the perspective expressed by Justice Somers in 1986:

The principles of the Treaty must I think be the same today as they were when it was signed in 1840. What has changed are the circumstances to which those principles are to apply. At its making all lay in the future.²⁵

At the same time, the Treaty would serve little practical purpose today if it were regarded merely as a fossil of the social, political and jurisprudential values of 1840. Societies evolve, and,

20. *The Ngai Tahu Sea Fisheries Report 1992*, pp 267–268

21. *The Ngai Tahu Report 1991*, p 223; also *The Mohaka River Report 1992*, p 34

22. *The Radio Spectrum Management and Development Final Report*, p 37

23. *The Ngai Tahu Report 1991*, p 223; *The Ngai Tahu Sea Fisheries Report 1992*, p 268; *The Muriwhenua Land Report 1997*, pp 386–388

24. *The Radio Spectrum Management and Development Final Report*, p 37

25. *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 692 per Somers J

with them, their values and systems of justice. Justice Richardson aptly expressed the dynamic of change:

Whatever legal route is followed the Treaty must be interpreted according to principles suitable to its particular character. Its history, its form and its place in our social order clearly require a broad interpretation and one which recognises that the Treaty must be capable of adaptation to new and changing circumstances as they arise.²⁶

How are we then to comprehend the principles of the Treaty today? In a 1994 judgment, the Privy Council addressed the issue succinctly:

The 'principles' are the underlying mutual obligations and responsibilities which the Treaty places on the parties. They reflect the intent of the Treaty as a whole and include, but are not confined to, the express terms of the Treaty . . . With the passage of time, the 'principles' which underlie the Treaty have become much more important than its precise terms.²⁷

Our immediate task is to determine Treaty principles that can be applied to the claim before us. The terms of the Treaty stated, in the English text, that the Maori chiefs ceded their sovereignty and the right of pre-emption over the sale of their lands to the British Crown in return for a guarantee of 'full exclusive and undisturbed possession' of their land and other properties, 'all the rights and privileges of British subjects', and royal protection.

There are significant differences between the two texts. In particular, in the Maori text the chiefs ceded 'kawanatanga katoa' (complete government) rather than 'sovereignty'. They were guaranteed 'tino rangatiratanga' (the unqualified exercise of their chieftainship) over their 'taonga katoa' (all their treasures, or valued possessions) rather than 'other possessions'. 'Taonga' has a broader meaning than physical assets and, according to Sir Hugh Kawharu, refers to 'all dimensions of a tribal group's estate, material and non-material'.²⁸ The Maori version of the Treaty thus conveyed more complex meanings, and a sense of mutuality.

One of the issues raised by the Napier Hospital services claim, the alleged promise of a hospital, relates to the terms of a Crown land purchase and is thus similar to many other claims concerning the alienation of Maori land. However, the majority of its grievances, and the main thrust of the claim, concern not property but the provision of health services to Maori. The claim takes the determination of applicable principles into new territory.

3.3.4 Principles applicable to the claim

Our starting point is *the principle of active protection*. It has been well defined in the *Turangi Township Report*:

26. *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 673 per Richardson J

27. *New Zealand Maori Council v AG* [1994] 1 NZLR 513, 517 (PC)

28. Sir Hugh Kawharu, 'Translation of the Maori Text of the Treaty', fn 6–8, at www.govt.nz/aboutnz/treaty.php3 and [1987] 1 NZLR 641, 662–663; see also Durie 1998, pp 82–83

the principle that the cession by Maori of sovereignty to the Crown was in exchange for the protection by the Crown of Maori rangatiratanga is fundamental to the compact or accord embodied in the Treaty and is of paramount importance. It should be seen as overarching and far-reaching because it is derived directly from articles 1 and 2 of the Treaty itself . . .

Implicit in this principle is the notion of reciprocity. Under article 1, Maori conceded to the Crown kawanatanga, the right to govern, in exchange for the Crown guaranteeing to Maori under article 2 tino rangatiratanga, full authority and control over their lands, forests, fisheries, and other valuable possessions (taonga), for so long as they wished to retain them.

It is clear, therefore, that the cession of sovereignty to the Crown by Maori was conditional . . . The confirmation and guarantee of rangatiratanga by the Queen in article 2 necessarily qualifies or limits the authority of the Crown to govern.²⁹

The best-known formulation of the duty to protect Maori rangatiratanga is that made by Sir Robin Cooke in the 1987 case *New Zealand Maori Council v AG* (the 'lands case'):

Counsel were also right, in my opinion, in saying that the duty of the Crown is not merely passive but extends to active protection of Maori people in the use of their lands and waters to the fullest extent practicable . . . I take it as implicit in the proposition that, as usual, practicable means reasonably practicable.³⁰

The ties of reciprocity point to a second widely recognised principle, *the principle of partnership*. It arises from one of the Treaty's basic objectives – to create the framework for two peoples to live together in one country.

A third principle, *the principle of equity*, emerges in particular from the granting to all Maori of the status of British subjects. This principle is relevant to the provision of State social services and to standards of healthcare for Maori.

A fourth principle, *the principle of options*, arises from the different paths the Treaty opened up for Maori. Under article 2, they were guaranteed self-management of tribal resources according to their own tikanga. Article 3, by contrast, gave Maori access to the society, technology and culture of the settlers. The right of choice implicit in these options establishes a principle that again has relevance to the provision of social services.

We now proceed to consider each principle in turn in the context of the issues raised by the claim.

3.4 THE PRINCIPLE OF ACTIVE PROTECTION

3.4.1 Protection of land

One of the grievances in this claim concerns the fulfilment of what is said to be a verbal promise made on behalf of the Crown as part of the consideration for the Crown purchase of the Ahuriri

29. *The Turangi Township Report 1995*, pp 284–286

30. *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 664, per Cooke P

block in 1851. As such, the terms of the Crown's guarantee under article 2 – in particular, that land would be alienated, but only 'at such prices as may be agreed upon' – would apply, as would the principle of active protection.

3.4.2 Protection of health as a taonga

In their second amended statement of claim, the claimants asserted that 'the health and well being of Maori is a taonga in terms of Article 11'.³¹ Since this assertion was not included in the third and final amended statement, we go no further here than to make a brief comment.

As we noted in section 3.3.4, both at the time the Treaty was signed and now, the fundamental concept of 'taonga' was and is held to extend to intangible as well as tangible possessions. One example is the Maori language, which the Tribunal and the Crown have both recognised as a taonga qualifying for protection under article 2.³² It is also undoubtedly the case that good health, and the healing of ill health, was and remains important to Maori. Our difficulty is that, although comprehended within a cultural frame of reference, health is a state of being rather than a thing or resource possessed, or something contributing to the sustenance of a possession or resource. We do not consider that the concept of property in any form applies to the human state of health or wellbeing.

On the other hand, we accept that the various components of customary health knowledge and healing practice can be argued to constitute intangible taonga, or cultural assets. They connect with fundamental values, in particular, the concepts of mauri (life essence) and wairua (spirituality).³³ The taonga include three general types of resource:

- ▶ associations of place, such as wai tapu (protected sources of water);
- ▶ access to materials used for healing, such as rongoa (medicinal flora); and
- ▶ specialist knowledge of healing, in particular the technical and spiritual knowledge possessed by tohunga or traditional healers.

Commonly, such taonga were and are known within particular hapu or groups of hapu. However, to the extent that Maori healing knowledge and practice have evolved into a more generalised specialism, their status is no less valid as a taonga. Whether of local or wider currency, such taonga are subject to a duty of protection by the Crown.

3.4.3 Protection of Maori people and their health

The claimants argue that the Crown had, and continues to have, a general obligation under the Treaty to protect Maori health. In their statement of claim, they assert that, 'pursuant to the terms and principles of the Treaty of Waitangi, from 1840 the Crown was and remains under an

31. Claim 1.57(b), para 6.1

32. *Report on Claims Concerning the Allocation of Radio Frequencies*, p 41

33. Durie 1998, pp 66–78

obligation to provide for the health and well-being of Maori'.³⁴ In his closing submission, claimant counsel argued:

The duty of active protection to Maori people is clearly substantial and ongoing. In the preamble to the Treaty, the Crown promised that Maori would be protected from the adverse effects of British settlement. Any adverse health effects of health disparity suffered by Maori as a result of settlement would clearly be such an effect. Thus it is submitted the Treaty places an extra burden on the Crown to address those disparities above any general duty it may owe to Maori as a disadvantaged minority.³⁵

The offer of 'protection' featured prominently in the Treaty itself. In the English text, the preamble stated that the British Queen was anxious to protect the 'just Rights and Property' of Maori chiefs and tribes, but implied that they should be placed in a position to enjoy such protection. The Maori text stated more categorically 'her concern to protect the chiefs and sub-tribes of New Zealand', and 'her desire to preserve their chieftainship' as well as their land ('i tana mahara atawai ki nga Rangatira me nga Hapu o Nu Tirani i tana hiahia hoki kia tohungia ki a ratou o ratou rangatiratanga').³⁶ Furthermore, according to the English version, her purpose in seeking to establish 'a settled form of Civil Government' was 'to avert the evil consequences which must result from the absence of the necessary Laws and Institutions alike to the native population and to Her subjects'.

Article 2 provided its guarantee of possession of land and other property comprehensively to 'the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof' ('ki nga Rangatira ki nga hapu – ki nga tangata katoa o Nu Tirani'). Finally, article 3 extended 'to the Natives of New Zealand' not only 'the Rights and Privileges of British Subjects' but also 'Her royal protection'. It was the assurance of royal protection in the preamble and article 3 that the *Radio Spectrum Management and Development Final Report* regarded as 'the source of the Crown's fiduciary duty to Maori'.³⁷

The sense of these references is clearly that the promised protection was to extend beyond rights in property, however conceived. Professor Mason Durie believes that 'protection of Maori well-being was obviously contemplated'. Maori were to be enabled to participate in the security of property, the peace and order, and the citizenship rights assured by the Treaty. Furthermore, Maori were to be protected from the 'evil consequences' of lawlessness, which the Treaty associated with unregulated European settlement. All Maori were to benefit, and the protection offered was general and not hedged with exclusions.³⁸

The sparse words of the Treaty do little to convey what British protection was supposed to cover, not least as regards Maori wellbeing. Since modern understandings of key concepts like

34. Claim 1.57(c), para 4

35. Document x31, paras 3.2–3.3

36. We adopt here the modern English translation of the Maori text by Professor Sir Hugh Kawharu in [1987] 1 NZLR 641, 662–663.

37. *The Radio Spectrum Management and Development Final Report*, p 36

38. Durie 1998, p 83

‘protection’ may differ significantly from those current at the time, it is important to set the Treaty in its historical context. The point is aptly expressed in the *Muriwhenua Land Report*:

The more specific intentions of the British are explained in the royal instructions through the Colonial Secretary, Lord Normanby, which flesh out and give meaning to the Treaty’s bland promise of protection. They so illuminate the Treaty’s goals that, in our view, the Treaty and the instructions should be read together.³⁹

At the time of the signing of the Treaty, as today, good health was considered an important aspect of social and personal wellbeing. Conversely, widespread ill health could risk the very survival of indigenous peoples. Strongly colouring British Government perceptions of New Zealand in the late 1830s was the humanitarian ‘fatal impact’ view, driven by the evangelical missions, that the unregulated intrusion of ‘civilised’ settlers into lands inhabited by ‘uncivilised’ or ‘savage’ peoples commonly spelt disaster for the latter.⁴⁰

Particularly influential was the 1837 report of the Select Committee on Aborigines, which pointed especially to wholesale depopulation in North America. Lamenting the fate of ‘uncivilised nations’, it declared:

Too often, their territory has been usurped; their property seized; their numbers diminished; their character debased; the spread of civilization impeded. European vices and diseases have been introduced amongst them, and they have been familiarized with the use of our most potent instruments for the subtle or the violent destruction of human life, viz brandy and gunpowder.⁴¹

Reviewing the situation in New Zealand, the committee painted an alarmist picture of tribal warfare, frontier lawlessness and immorality. It highlighted the reaction of Lord Goderich, the Colonial Secretary, who, on receiving similar information in 1832, thought that ‘the inevitable consequence is a rapid decline of population, preceded by every variety of suffering’, and that ‘the work of depopulation is already proceeding fast’. In his opinion, ‘there can be no more sacred duty than that of using every possible method to rescue the natives of those extensive islands from the further evils which impend over them’.⁴² Letters from missionaries and dispatches from James Busby, the British Resident at Waitangi, added further lurid colouring.

In this depressing prospect, diseases, usually seen as introduced by Europeans, were accorded a consequential, though destructive, role, both globally and in New Zealand. In his key report of June 1837, Busby predicted that, on top of other causes such as warfare, death from disease, even amongst Maori living at mission stations, threatened ‘at no very distant period to leave the country destitute of a single aboriginal inhabitant’.⁴³

39. *The Muriwhenua Land Report* 1997, p 117; also *The Ngai Tahu Report* 1991, pp 233–234

40. Adams 1974, chapters 3–5; Ward 1995, ch 3; Belich 1996, pp 182–187

41. *Report of the Select Committee on Aborigines*, House of Commons, Reports from Committees, vol 7, 1837 [425], p 5; Adams 1974, pp 92–93

42. Lord Goderich to Major-General Bourke, 31 January 1832 (quoted in *Report of the Select Committee on Aborigines*, House of Commons, Reports from Committees, vol 7, 1837 [425], p 17)

43. Busby to Colonial Secretary, New South Wales, 16 June 1837, BPP, vol 3, pp 27–28

The questionable accuracy of the information on which the British Government formulated its policy of intervention in New Zealand does not require further analysis here. Of relevance is the fact that the information was, on the whole, believed, and that it fitted the prevailing British perspective on global imperial expansion. In his instructions of August 1839 to Captain Hobson to seek from Maori the cession of sovereignty over New Zealand to the British Crown, Lord Normanby, the British Secretary of State for the Colonies, remarked gloomily that cession would be ‘but too certainly fraught with calamity to a numerous and inoffensive people’. He worried that the ‘extensive settlement of British subjects’ that was bound to follow the recent New Zealand Company expedition would:

unless protected and restrained by necessary laws and institutions, . . . repeat, unchecked, in that quarter of the globe, the same process of war and spoliation, under which uncivilized tribes have almost invariably disappeared as often as they have been brought into the immediate vicinity of emigrants from the nations of Christendom.⁴⁴

Normanby’s successor, Lord Russell, also expounded his anxiety about the potentially destructive impact of European settlement upon the Maori. Transmitting his instructions to Hobson for the establishment of Crown colony rule in December 1840, he observed that, notwithstanding the missionary efforts, it was:

impossible to cast the eye over the map of the globe, and to discover so much as a single spot where civilized men brought into contact with tribes differing from themselves widely in physical structure, and greatly inferior to themselves in military prowess and social arts, have abstained from oppressions and other evil practices. In many, the process of extermination has proceeded with appalling rapidity. Even in the absence of positive injustice, the mere contiguity and intercourse of the two races, would appear to induce many moral and physical evils, fatal to the health and life of the feebler party.⁴⁵

Averting such a fate for Maori was one of the principal justifications for British intervention in New Zealand. Professor Mason Durie concludes:

Taken together with Normanby’s ‘Instructions’ and Busby’s 1837 dispatch, it becomes apparent that the Treaty of Waitangi was concerned with much more than the protection of physical resources; human protection was also intended.⁴⁶

An overriding British aim was thus to preserve Maori wellbeing and, at worst, to assure Maori survival against what they feared might be the potentially fatal impact of British settlement. They saw the main dangers as arising out of frontier lawlessness and immorality, and the chief remedies as settled civil government and racial assimilation. But they also understood worsening ill health, especially imported diseases, to be a risk associated with European settlement and a contributing cause of Maori decline.

44. Normanby to Hobson, 14 August 1839, BPP, vol 3, p 85

45. Russell to Hobson, 9 December 1840, BPP, vol 3, p 149

46. Durie 1998, p 83

Combating ill health amongst Maori, whether by medical or other means, was therefore part of the agenda of active protection that the British rulers took on under the Treaty of Waitangi. In so far as Western medical technology was considered capable of contributing towards that goal and to the extent that was reasonably practicable, the Crown was duty bound to provide resources or programmes delivering appropriate health services to Maori.

We consider that three general obligations flow from the duty actively to protect Maori health. The first is protection against *the adverse effects of settlement*. Our view is that this obligation arises over and above considerations of equity. It calls for additional resources and effort to be deployed in favour of Maori whenever general programmes afford them insufficient protection. The scope of such active protection might include, on the one hand, medical responses to the effects of ill health and, on the other, remedial action against its causes, both direct (medical) and indirect (environmental, social, economic, cultural, institutional).

The obligation to protect was in our view enduring, even if both parties to the Treaty believed that the adverse effects of settlement would be temporary. At the time of the signing of the Treaty, the British authorities perceived an urgent risk that threatened Maori survival as a people. Ill health was part of that transitional risk.

There was indeed a crisis of survival for Maori, who were newly exposed to the global disease pool. This crisis resulted in a steep demographic decline that bottomed out only in the 1890s. Introduced diseases were the chief killers. Even if they partly misinterpreted the causes, the more dramatic consequences – epidemics and high mortality amongst Maori communities – were obvious enough to British officials and settler leaders from the outset. Not until the 1920s was the spectre of the ‘dying race’ finally banished from popular and governmental perceptions.

In the end, Maori adapted to the new diseases and achieved demographic survival. The transition was successful. Large-scale immigration continued, however. Some of the indirect health effects of ongoing settlement, arising from such impacts as land loss, impoverishment, and social dislocation, were adverse and persistent. In other words, situations in which the Crown’s obligation to devote additional resources to protecting Maori health were not necessarily confined to the early colonial period. But equally, in each instance the obligation ended once the transitional protective measures had achieved their purpose.

We conclude therefore that, while the Treaty did create an enduring right to transitional protection against particular adverse effects, it did not establish a permanent Maori entitlement to additional health service resources as distinct from that of New Zealanders as a whole. Put another way, once transition was complete, the principle of active protection did not privilege Maori as a group. This applies whether or not the level of health service provision to the general population, including Maori, is regarded at any point in time as sufficient.

The second general obligation concerns *abnormal vulnerability to disease*. Usually, this vulnerability arises from a constitutional predisposition to a particular racially defined condition beyond the influence of environmental factors, such as an inherited genetic trait. Should a specific vulnerability be demonstrated, an obligation arises to protect Maori as a group against its health effects.

3.4.4

The third general obligation, which aligns closely with considerations of equity, is *the promotion of Maori wellbeing*. The Treaty's promise of 'royal protection' required the Crown to have due regard to the wellbeing of Maori as part of the community of citizens. Where adverse disparities in health status between Maori and non-Maori are persistent and marked, the Crown is obliged to take appropriate measures on the basis of need so as to minimise them over the long run. Such measures may extend to the use of affirmative action for Maori as a population group in order to reduce structural or historical disadvantage. This aspect we consider further under the principle of equity in section 3.6.

3.4.4 The limits of active protection

We turn to the practical balance that always needs to be struck between active protection and other Treaty principles. A strict application of the principle of active protection may frustrate the operation of other principles. For example, a protective response to the much higher incidence of smoking amongst Maori, with its serious adverse implications for Maori health, might be to outlaw the sale of tobacco to Maori. The effectiveness of this restrictive intervention would none the less be achieved at the expense of limiting the ability of Maori leaders and communities to exercise their rangatiratanga (guaranteed under the principles of partnership and protection), and of discriminating against individual Maori as citizens (principle of equity).

Improving public health has been a core goal of Crown policy ever since the signing of the Treaty. Restrictive legislation passed in the public interest has long formed an accepted weapon in the State's armoury. A modern example is the criminalising of addictive drugs, not only for supply but also for individual possession and use. The question arising here is under what circumstances should the principle of active protection take precedence in the form of legislation restricting Maori rights. From the very outset, when the Treaty reserved the right of pre-emption over the alienation of Maori land to the Crown, such precedence has been invoked in favour of measures ostensibly aimed at preserving the Maori land base.

But discrimination for or against the Maori population, however well intentioned, inevitably cuts across fundamental values of equality before the law and between peoples. All too frequently in New Zealand history, the discrimination has not been benevolent and has been applied against Maori interests and for partisan ends. The use of pre-emption to promote Crown land purchasing from Maori is but one early instance. Furthermore, the appropriate boundaries of protection have constantly shifted in response to constitutional development and changing historical context. We hesitate therefore to lay down prescriptive general definitions of the limits of restrictive intervention in the name of active protection.

For the purpose of protecting Maori health, we believe that restrictive measures applying exclusively to Maori, rather than to citizens as a whole, can be justified only in exceptional circumstances so as to prevent imminent, demonstrable, significant and widespread danger to Maori wellbeing. In most such cases and across most historical periods, the protective intervention

would be expected to affirm the principle of partnership by proceeding only with the informed prior consent of Maori.

A balance must also be struck in any period between the Crown's obligation of active protection of Maori health and the responsibility of individual Maori to maintain their personal health. However powerful the medical technology and however lavish the means to afford it, individuals cannot be entirely cocooned from the health effects of their lifestyle choices and their exposure to their environment. In general, we do not consider it reasonable to expect that Crown action aimed at the active protection of Maori health, however assiduous, can guarantee particular health outcomes for individual Maori.

On the other hand, where Maori in general suffer significantly poorer health than non-Maori, individual Maori are entitled to rely on the Crown taking protective action to address the group disparity, as outlined in section 3.4.3. Such action has commonly taken two forms:

- ▶ the allocating of health resources for remedial purposes, whether specifically for Maori benefit or to assist an at-risk group of which Maori constitutes a high proportion; and
- ▶ the using of promotional means of information and advocacy, such as health education aimed at changing lifestyle habits.

Applying the above considerations to the example of smoking, the active protection of the health of Maori as a group would not require the Crown to impose restrictions on Maori access to tobacco in excess of those applying to all citizens. Nor would the Crown be expected under this principle, as opposed to any general legal liability, to guarantee individual Maori who smoked against the consequential effects, such as lung cancer. But Maori, as a high at-risk group, might reasonably expect screening and treatment programmes for those health effects to be adequately resourced and targeted for their benefit. They might also reasonably expect the Crown to target them with promotional efforts aimed at reducing their high incidence of smoking. And individual Maori could reasonably expect to rely on reasonable access to services of an appropriate standard of quality.

Both protective approaches – remedial and promotional – are, as we discuss further in section 3.6, consistent with the principle of equity. Their consistency with the principle of partnership will in most cases be strengthened by maximising Maori participation in decisions on programmes targeted at Maori communities and Maori agency in putting them into effect. This last aspect we discuss further in the following section.

3.4.5 Health resources under tribal authority

The claimants argue that the Crown was obliged to ensure that 'Maori would be given control of adequate and appropriate health resources within their communities as guaranteed in Article II'.⁴⁷ If, as we concluded in section 3.4.2, customary Maori healing resources and knowledge are taonga, it follows that the principle of active protection would apply to customary healing

47. Document x31, paras 3.6–3.7, 3.9.2

3.4.6

practices as well. This is not, however, what the claimants are concerned with. Their focus is rather on the delivery of Government health services under tribal authority.

The issue here is not the volume of State resources devoted to protecting Maori health but rather how they are delivered. It can be argued that the active protection of rangatiratanga over possessions implies that the ability of Maori leaders to promote the wellbeing of their people, including their care and welfare, will also be protected.⁴⁸ This would be close to the ‘active protection of Maori people in the use of their lands and waters to the fullest extent practicable’ advocated by Sir Robin Cooke. It also reflects the stronger emphasis in the Maori text of the Treaty on protecting the integrity of Maori communities.

Two aspects merit further comment. First, it is difficult to sustain the position that the obligation to protect rangatiratanga created a requirement to provide a specific service, that of health-care, under tribal authority. However, the obligation can be said to require that, in considering how to ensure the effective protection of a tribal group’s capacity to meet its welfare commitments, the Crown evaluates the option of delivering part of that service through tribal structures. The nature of services that may realistically be thus delivered, especially in the medical domain, has evolved radically since 1840.

Secondly, as in any society and system of government, the forms and functions of rangatiratanga have evolved over time. Such evolution was anticipated by both the British and Maori at the time the Treaty was signed, especially in response to missionary influence. It is reasonable to expect that the Crown’s protection of rangatiratanga would accommodate and assist that evolution, including the manner in which Maori leaderships fulfilled their welfare responsibilities. Such assistance might include building their technical capacity or devolving to them the delivery of particular services. The *Te Whanau o Waipareira Report* expressed the point thus:

In considering the shape of the protection to be given, regard must be had to the principle of rangatiratanga, and not only because a Maori rangatiratanga was recognised in the completion of the Treaty, but because that is the most appropriate way in which the Maori custom might be upheld, respect for custom being also orally promised to Maori when the Treaty was signed. Rangatiratanga requires in this instance that Maori should control their tikanga, including the way their social and political organisation develops, and to the extent reasonable and practicable Crown protection, in the form of support, should be so given as to enhance the capacity of the group to determine the programmes most needed and how they should be managed.⁴⁹

3.4.6 Tikanga Maori in mainstream health services

It is generally accepted that the protection afforded to rangatiratanga included tikanga Maori, with a few specific exceptions that the British viewed as repugnant. We concluded in section 3.4.2 that the protection of tikanga Maori included Maori customary health knowledge and

48. See Royal Commission on Social Policy 1988, pp 41–42

49. *Te Whanau o Waipareira Report*, p 31

practices. The further question arises as to whether the protection of tikanga Maori was to extend to Maori users of mainstream State health services.

We consider that, if Maori were guaranteed the right to their own culture, protecting it also placed an obligation on the Crown to ensure that it was respected by the publicly funded medical institutions and professionals that served them. The extent of such accommodation would, as usual, be subject to the limits of practicality, reasonable cost, and clinical safety. Recognition of the cultural as well as the technological dimensions of health is essential for the delivery of effective health services to Maori.

3.4.7 Balancing rangatiratanga and kawanatanga

Article 1 of the Treaty transferred to the Crown the power to legislate and the right to govern in accordance with its own policies, while Maori undertook a corresponding duty of reasonable co-operation. Establishing where the balance lies between governing in the interests of all New Zealanders and protecting the rangatiratanga of Maori is often controversial and anyway difficult to achieve by means of a generalised approach. The Tribunal must assess each claim on its merits.

This balancing act features prominently in cases where resource allocation is a major factor, as it is bound to be in the funding of a principal state social service such as healthcare. As Crown counsel put it:

Allocation of resources by the Crown is an inherently political matter. It involves constant assessment of current economic and social circumstances in light of competing claims.⁵⁰

The judgment of the Privy Council in the Maori language and broadcasting case set out some of the criteria for balance:

This relationship the Treaty envisages should be founded on reasonableness, mutual cooperation and trust. It is therefore accepted by both parties that the Crown in carrying out its obligations is not required in protecting taonga to go beyond taking such action as is reasonable in the prevailing circumstances. While the obligation of the Crown is constant, the protective steps which it is reasonable for the Crown to take change depending on the situation which exists at any particular time. For example in times of recession the Crown may be regarded as acting reasonably in not becoming involved in heavy expenditure in order to fulfil its obligations although this would not be acceptable at a time when the economy was buoyant. Again, if as is the case with the Maori language at the present time, a taonga is in a vulnerable state, this has to be taken into account by the Crown in deciding the action it should take to fulfil its obligations and may well require the Crown to take especially vigorous action for its protection. This may arise, for example, if the vulnerable state can be attributed to past breaches by the Crown of its obligations, and may extend to the situation where those breaches are due to legislative action.

50. Document x48, para 124

Indeed any previous default of the Crown could, far from reducing, increase the Crown's responsibility.⁵¹

In our view, this perspective is equally applicable to the protective obligations we have discussed in the preceding sections, especially the protecting of Maori against introduced diseases, the protecting of rangatiratanga in health services provision, and the protecting of tikanga Maori in mainstream health services.

3.5 THE PRINCIPLE OF PARTNERSHIP

3.5.1 The scope of partnership

Although today some question the notion that the Treaty created a partnership between the Crown and Maori, we agree with the view of Sir Robin Cooke in the 1987 *Lands* case that 'the Treaty signified a partnership between races'. He described the Crown as 'a partner acting towards the Maori partner with the utmost good faith which is the characteristic obligation of partnership'.⁵² Many have since adopted the term 'partnership' as appropriate shorthand to describe the relationship.

Whatever the ultimate political objectives of the parties, the relationship was to be enduring and was pegged to high ideals. The Treaty framework established three main dimensions:

- ▶ a fiduciary relationship of protection, in which the Crown tempered its exercise of sovereignty through the right to govern in the interests of all by protecting the rangatiratanga of Maori leaders and communities;
- ▶ a relationship 'akin to a partnership', in which the Crown cooperated with Maori in fields of common interest; and
- ▶ a relationship of citizenship, in which the Crown assured equal rights and standards to all Maori as individual British subjects.

In the second dimension, that of partnership, the balance within the relationship has varied over historical time, but in the long run moved towards the strengthening of the dominant position of the Crown. It is, as a result, sometimes difficult to distinguish fiduciary from partnership obligations.

In practice, the distinction is generally to be found in the approach taken. Protective action may require the Crown to intervene unilaterally to protect the Maori interest, or alternatively to strengthen Maori capacity to act for themselves. Partnership action, on the other hand, will commonly promote joint involvement. The distinction should not obscure the large areas of overlap. Self-managed Maori initiatives often utilise State resources, requiring a close and durable working relationship with Government agencies. Similarly, effective cooperation often includes State assistance to build the capacity of Maori partner organisations.

51. *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513, 517 (PC)

52. *New Zealand Maori Council v AG* [1987] 1 NZLR 1987 641, 664 per Cooke P

The partnership principle is significant to our consideration of the Napier Hospital services claim since it brings the spotlight to bear on the character of the Crown's relationship with Maori in the provision of mainstream social services, in this case healthcare. That relationship spans the divide between providing along uniformly monocultural lines for citizens as a whole and entirely separate provision by Maori for Maori. The *Waipareira Report* drew attention to the same underlying requirement of a relationship based on partnership:

In our view, it is glaringly apparent that, in a society based on a partnership of two peoples, the achievement of social goals requires the active support and participation of both. Inevitably, then, the tighter the control that one party exerts over social policy, the less the other is able to contribute, and the less likely the goals are to be reached. It appears to us that Crown agencies cannot exclude the values and aspirations of communities unless they are totally incompatible with Crown goals.⁵³

'Partnership' in this context means enabling the Maori voice to be heard and Maori perspectives to influence the type of health services delivered to Maori people and the way in which they are delivered. We endorse the view expressed in a recent Ministry of Health report that 'health cannot be imposed on a community but must develop in an acceptable manner from within in response to problems perceived at a local level'.⁵⁴

3.5.2 The interface of partnership

It is axiomatic that in any partnership the identity of each party should be well known to the other. Establishing the identity of the partners in the Crown–Maori relationship has commonly been taken for granted. In this claim, however, it has emerged as a significant issue. We discussed the legal, technical and geographical aspects relevant to the claim in section 2.7.3. However, it is appropriate also to clarify the general perspective and, in particular, how the respective Treaty partners are to be identified.

In the domain of the Crown, successive waves of health reform over the past two decades have created complex institutional structures and a fast-changing organisational landscape. Equally intricate has been the maze of contractual obligations and accountabilities erected under the purchaser/provider model of health service provision. This complexity may make it difficult for Maori seeking partnership to discern the face of the Crown.

To take a practical example, Crown and claimant counsel dispute whether Healthcare Hawke's Bay was obliged to consult Maori on its health service proposals. Here, not only the quality of consultation becomes an issue but also who should conduct it. The *Waipareira Report* identified a similar problem of interfacing:

53. *Te Whanau o Waipareira Report*, p 232

54. Ministry of Health 1994a, p 17

Waipareira has settled coordination problems but is prejudiced by a lack of coordination amongst the many Crown agencies. The Crown has many faces, but Waipareira cannot find a single Crown face to deal comprehensively with its concerns.⁵⁵

In the domain of Maori, the issue of identity is ostensibly straightforward, since the Crown's relationship is with Maori as a whole. The *Waipareira Report* commented:

Thus, partnership describes a relationship between the Crown and Maori generally rather than a relationship between the Crown and particular classes of Maori persons . . . The question whether any particular Maori group has Treaty rights is not to be answered by an inquiry as to whether that group is a Treaty partner, for the concept of partnership applies to all Maori and is primarily for the purpose of describing the way in which Maori and the Crown should relate to each other.⁵⁶

All the same, applying the partnership principle in practical situations will commonly bring Crown agencies into interaction with Maori organisations rather than with people as individuals. Mason Durie considers that 'partnership is strongest when it refers to an agreement between Iwi or hapu and the Crown, although it is sometimes used with limited justification to describe a working relationship between Maori and government agencies'.⁵⁷

Sometimes, tangata whenua tribal bodies will be to the fore. However, we endorse the findings of the *Waipareira Report* both that 'rangatiratanga may be possessed by diverse groups and is not confined to tribes' and that, in any case, the principle of partnership is not restricted to Maori groups possessing rangatiratanga.⁵⁸ These conclusions do not simplify the task of the Crown in meeting its partnership obligations.

In modern times, Crown agencies seem often to have found it difficult to establish who they should be engaging with on what subjects. They encounter the diversities integral to any civil society – those of organisational scale (iwi/region/marae), of institutional type (runanga/incorporation/service provider), and of overlapping legitimacy (tangata whenua/pan-tribal/interest group). In addition, many Maori, especially those in the larger towns, have no affiliation to or representation in local Maori organisations.

The inherent difficulties of interfacing are a feature of this claim, in which contemporary grievances arise from a mainly urban context. Developing the general discussion any further is well beyond the scope of this report, but we make the observation that the partnership principle must inevitably extend beyond what is done, or not done, into how the parties establish and sustain the relationship itself. We also believe that it is important for the Crown to present a coherent and accountable face if it is to sustain a high-quality relationship with its Treaty partner.

55. *Te Whanau o Waipareira Report*, p 227

56. *Ibid*, p 29

57. Durie 1998, p 85

58. *Te Whanau o Waipareira Report*, pp 19, 30

3.5.3 Maori representation in decision-making processes

The claimants have raised as grievances their alleged exclusion from decision-making processes governing the State health services of which they are users. Such exclusion, if established, can be assessed under the principle of active protection in terms of the appropriate balance between *kawanatanga* and *rangatiratanga*. But it also raises a question about the practical limits of partnership, which we concluded above embraces the general character of the relationship between Maori and the Crown.

Two issues arise concerning Maori ability to exert appropriate influence over health policy and service delivery. The first is institutional participation. Employment of Maori in the health sector workforce is a matter not only of equality of opportunity but also of avoiding entrenched monocultural approaches to the exclusion of Maori health values. Such participation, extending to all levels of medical and managerial expertise, creates space for Maori influence over service delivery to Maori patients. This, we conceive as one contributor to the bicultural expression of partnership.

The second issue is Maori representation in the governing bodies of district health agencies. Where boards are centrally appointed, appropriately balanced selection criteria may suffice. Where elected, the risk arises that Maori concerns and representation may become marginalised, a common experience of ethnic minorities in winner-takes-all electoral systems. A number of technical solutions are available, ranging from proportional franchises to a separate voters' roll, quotas, balancing appointments, tribal elections, and joint arrangements with representative Maori organisations. Our general conclusion is that, to the extent that the governance of State healthcare is devolved to district agencies, consistency with the partnership principle and 'the duty to act reasonably and in the utmost good faith'⁵⁹ demands a degree of assurance that Maori are fairly represented.

3.6 THE PRINCIPLE OF EQUITY

Article 3 of the Treaty has commonly been regarded as having the most direct relevance to the provision of social services to Maori. The obligations of the Crown, the claimants state, include 'ensuring that Maori are in receipt of the same standards of health care and health outcomes as other citizens of New Zealand (Article 3)'. In his closing submission, claimant counsel argued that 'the guarantees within this article to equality of treatment and the privileges of citizenship . . . clearly envisage, it is submitted, equality of access and outcome to health services'⁶⁰. We note that, in his closing submission, Crown counsel stated but did not argue his rejection of this position.⁶¹

Mason Durie has argued along similar lines to the claimants:

59. *New Zealand Maori Council v AG* [1987] 1 NZLR 1987 641, 664, per Cooke P

60. Claim 1.57(c), para 4.3; document x31, para 3.4

61. Document x48, para 77

Article Three of the Treaty of Waitangi, however, has more obvious and direct implications for health . . . By promising ‘all the Rights and Privileges of British subjects’, Maori individuals acquired new citizenship rights . . . But the undertaking also implied that there would be no serious gaps between Maori and other New Zealanders, and that, if necessary, the Crown would exercise ‘royal protection’ in order to meet its new obligations. Thus Article Three was as much about equity as citizenship. Its significance for health is particularly evident in light of continuing disparities in standards of health between Maori and non-Maori.⁶²

The principle of equity is important for our assessment of this claim. The promise of ‘royal protection’, which is also contained in article 3 and which we discuss in detail in section 3.4.3, does not in itself, contrary to Durie, bear the assurance of equality. This is implicit rather in the ‘rights and privileges of British subjects’ which the British Crown granted to Maori. We are sometimes reminded that British society exhibited many inequalities in 1840, including the denial to many of the right to vote. We might add that inequalities of various kinds have been evident in all periods of New Zealand history, including the present. Such arguments miss the essential point, which is that none of the basic rights and privileges of British subjects was at the signing of the Treaty limited by race.

We consider therefore that it is the conferring of citizenship rights upon Maori that supplies the underlying principle of equity. These rights were, like all others, placed under Crown protection. The principle applies to Maori as individual citizens rather than as members of groups exercising rangatiratanga.

Simple in the abstract, the principle is much more difficult to apply in practice in a social sector such as health. It plainly does apply to *equal standards of healthcare*, the first Treaty obligation asserted by the claimants. Thus, a pattern of inferior clinical treatment of Maori in a public hospital would be inconsistent with the principle of equity.

But equal standards of care might still leave Maori at a disadvantage if they found it more difficult than other citizens to gain access to the services provided, *equality of access* being the second Treaty obligation asserted by the claimants. There is a wide range of potential access barriers – physical, socio-economic, cultural – that might be found to tell against Maori. A systematic or prolonged failure on the part of the Crown to reduce such barriers would, in the absence of countervailing factors, commonly be inconsistent with the principle of equity. The timing and extent of remedial action would clearly depend on the technical and financial means available, and in particular on competing calls on Government resources for social programmes.

The complexities multiply when we turn to *equality of health outcomes*, the third Treaty obligation asserted by the claimants. Today, as in all periods since 1840, the incidence of ill health is generally greater amongst Maori than non-Maori. We have discussed the special obligation to protect Maori from the worst impact of introduced diseases in section 3.4.3. Clearly, it was not technically feasible even to aim at achieving equal health outcomes for Maori before the early twentieth century. But over at least the last half century, both medical and financial means have

62. Durie 1998, p 83

been potentially to hand for achieving in respect of health status what Prime Minister Helen Clark recently described as 'equality of citizenship'.⁶³

We turn therefore to the implications for State action of the obligation to minimise health disparities between Maori and non-Maori. An equity-based response might channel more health-care resources to meet the greater need. But since socio-economic and environmental factors play a large role, these might not do much to reduce the higher incidence of illness generating the extra demand for health services. The chief difficulty with the claimants' position is not the goal of equal health outcomes but the one-track focus on healthcare services as the means to achieve it. More ambulances under the cliff cannot remove the factors causing people to fall off

A broader equity-based response might envisage integrated approaches. One track might be programmes directed specifically to improve Maori economic, social, and cultural status. An alternative track might be aimed at tackling multiple deprivation in rural areas or city suburbs with high Maori populations. The strategic assumption would be that ultimately equal health outcomes are only likely to be assured when Maori disadvantage is also reduced in other essential dimensions of personal and community wellbeing.

Health programmes, even those with a strong preventive emphasis, cannot alone be expected to achieve that goal, although they make an important contribution. Making the case for an integrated approach, both the 1992 policy statement on Maori health and the 2000 *New Zealand Health Strategy* referred to the Maori conception of the 'four cornerstones of health'. The *Strategy* commented:

This intersectoral approach is consistent with Maori approaches to maintaining and improving wellbeing. The Whare tapa wha . . . Maori health model, which is also known as the four cornerstones of Maori health, describes four dimensions that contribute to wellbeing: te taha wairua (spiritual aspects), te taha hinengaro (mental and emotional aspects), te taha whanau (family and community aspects), and te taha tinana (physical aspects). It is considered that good health depends on the equilibrium of these dimensions.⁶⁴

There is a further consideration. Despite being disadvantaged as a group, Maori exhibit much the same range of socio-economic and health inequalities as non-Maori. In other words, a higher proportion of Maori than non-Maori suffer low incomes and poor health, but a substantial number of Maori do not. This diversity of personal and family circumstances does not invalidate programmes benefiting Maori as a whole, since universal or group-based strategies have often proven to be the most effective in reducing disadvantage, which is here the primary goal. But it does imply that selective programmes may also be consistent with the principle of equity. Such programmes might aim to:

- ▶ redress Maori disadvantage as part of at-risk groups, whether by health or socio-economic criteria;

63. Clark 2001

64. Document w18(b)(8002), p 15; Ministry of Health 2000a, p 5

- ▶ target services for those Maori actually suffering disadvantage in terms of poor health, or multiple deprivation likely to cause poor health; or
- ▶ focus on diseases or causes of ill health more prevalent amongst Maori than non-Maori.

In other words, there may be a number of affirmative approaches, whether separately or in combination, to minimising overall health disparities between Maori and non-Maori that are consistent with the principle of equity.

We note that the Public Health and Disability Act 2000 lays down the general aim ‘to reduce health disparities by improving the health outcomes of Maori and other population groups’, and sets the same objective for district health boards.⁶⁵ This aim is defined in terms of group outcomes and is qualified by the safeguard that ‘nothing in this Act entitles a person to preferential access to services on the basis of race’.⁶⁶ Stated in this manner, the Act fosters affirmative action on the basis of need so as to improve average Maori outcomes to the level of the general population. While not all Maori suffer disparity and health measures cannot alone deliver improved outcomes, the formulation in the Act is fully consistent with the Treaty principle of equity.

We draw the following conclusions about the application of the principle of equity to health standards and outcomes for Maori:

- ▶ The Treaty’s grant of citizenship rights is to Maori as individuals. It joins Maori to the community of citizens and provides no privileges for Maori above other citizens. It does, however, assure Maori of the right to equal standards of healthcare.
- ▶ Beneficial health outcomes cannot be assured for individual Maori or, for that matter, for any individual citizen.
- ▶ A general equality of health outcomes for Maori as a whole is one of the expected benefits of the citizenship granted by the Treaty. Its achievement is a long-term goal that depends on a broad range of State policies and services. Until realised, failure to set Maori health as a health gain priority would be inconsistent with the principle of equity.
- ▶ In general, health services make an important but partial contribution towards closing the health gap between Maori and non-Maori. Other factors, such as income inequality and housing standards, are commonly more influential. In other words, health services can deliver only part of the package leading to equal health outcomes.
- ▶ Devoting additional mainstream health resources to Maori as a whole is not the only way to advance the principle of equity. Depending on context, targeting resources for disadvantaged Maori, or for disadvantaged groups that include Maori, may also be effective.

We would like to emphasise at this point that our report on this claim is concerned with the provision of State healthcare and does not address the many other factors that affect health outcomes.

65. Sections 3(1)(b), 5(3)(c), 22(1)(e) of the Public Health and Disability Act 2000

66. Section 3(3)(a) of the Public Health and Disability Act 2000

3.7 THE PRINCIPLE OF OPTIONS

The principle of options complements the principles of active protection and equity. It assures Maori of the right to choose their social and cultural path. On the one hand, the Crown guaranteed to protect the rangatiratanga and established way of life of Maori. On the other, as British subjects Maori could enter the emerging settler society with full rights to participate. The *Report on the Muriwhenua Fishing Claim* summarised the choice thus:

Neither text prevents individual Maori from pursuing a direction of personal choice. The Treaty provided an effective option to Maori to develop along customary lines and from a traditional base, or to assimilate into a new way. Inferentially it offered a third alternative, to walk in two worlds ...⁶⁷

The *Ngai Tahu Sea Fisheries Report* elaborated on the implications:

In essence [this principle] is concerned with the choice open to Maori under the Treaty. Article 2 contemplates the protection of tribal authority and self-management of tribal resources according to Maori culture and customs. Article 3 in turn conferred on individual Maori the rights and privileges of British subjects. The Treaty envisages that Maori should be free to pursue either or indeed both options in appropriate circumstances. The Crown is obliged to offer reasonable protection to Maori in the exercise of the rights so guaranteed them.⁶⁸

This principle has some significance to our consideration of the Napier Hospital services claim. The claimants accuse Crown health agencies of 'failing to deliver health services to Maori in Ahuriri and Hawke's Bay in a manner consistent with tikanga Maori'.⁶⁹ The issue is whether the Crown has been or is under an obligation to respect tikanga Maori within its public health services.

There are two main aspects. One is making space for Maori indigenous medicine and its practitioners within the State system. The other is the accommodation of tikanga Maori, especially within public hospitals. 'Tikanga' refers here not just to particular healing practices but to the whole body of beliefs, tapu practices, and whanau support relevant to the care of Maori patients.

The issue turns on whether the Crown is entitled to offer an exclusively monocultural service, as it largely did until the last two decades. In our view, the principle of options requires, at minimum, respect for the most important facets of tikanga Maori within the practice of public hospitals and other State services, subject to clinical safety. The provision of indigenous medical services is a more discretionary matter but would, depending on alternative practitioners and demand, commonly enhance Maori choice, and thereby the principle of options.

67. *Report on the Muriwhenua Fishing Claim*, p195

68. *The Ngai Tahu Sea Fisheries Report 1992*, p 274

69. Claim 1.57(c), para 12

3.8 THE DUTY OF GOOD FAITH CONDUCT

The standards of conduct between Crown and Maori are commonly ascribed to the principle of partnership. In our view, they are equally relevant to the principle of protection and might best be applied to the general character of the relationship. In a 1993 case, Sir Robin Cooke summarised the Court of Appeal's decision in the 1987 *Lands* case:

It was held unanimously by a Court of five Judges, each delivering a separate judgment, that the Treaty created an enduring relationship of a fiduciary nature akin to a partnership, each party accepting a positive duty to act in good faith, fairly, reasonably and honourably towards the other.⁷⁰

We note that the Government's latest statement of negotiating principles to guide the settlement of Treaty claims includes a principle of good faith, according to which 'the negotiating process is to be conducted in good faith, based on mutual trust and cooperation towards a common goal'.⁷¹

3.9 THE DUTY OF CONSULTATION

Consultation with Maori has emerged as a major issue in this claim. In this section, we consider five questions:

- ▶ Which Treaty principles imply a duty to consult with Maori?
- ▶ Under what circumstances is the Crown obliged to consult?
- ▶ Are there statutory requirements for health sector agencies?
- ▶ By what processes and standards should consultation be carried out?
- ▶ How should tikanga Maori be incorporated into the consultation process?

3.9.1 Consultation and Treaty principles

Consultation has often been subsumed under particular principles, especially the principle of active protection as an attribute of the exercise of kawanatanga in terms of article 1. Claimant counsel argued along these lines:

That power also comes with duties attached. For the Crown to meet the health needs of Maori it must first understand what those needs are and how they have been affected by settlement. The only way this can be assessed is through consultation to ensure that problems are addressed and appropriate solutions are put in place.

In his view, one of the Crown's obligations was that 'Maori would be consulted on substantive matters affecting Maori health as provided for in Article 1 of the Treaty of Waitangi'.⁷²

70. *Te Runanga o Wharekauri Rekohu v AG* [1993] 2 NZLR 301, 304

71. Government press release, 3 August 2000

72. Document x31, paras 3.5, 3.9.1

We consider that consultation, when required, is a duty of government common to the observance of all four of the Treaty principles that we have defined. The active protection of Maori rangatiratanga, and of Maori people in general, requires the Crown to inform itself adequately in order to exercise its powers of sovereignty fairly and effectively. Partnership can scarcely proceed in ignorance of the views and wishes of the Maori partner. Ensuring equitable delivery of and outcomes from Government services requires information from the beneficiaries of those services, and often their direct involvement in generating that information. Finally, information and opinion from Maori is indispensable for the appropriate design of bicultural options.

3.9.2 The extent of the Crown's obligation to consult

We turn first to the extent of the Crown's general obligation to consult, on which there is now a substantial body of case law. In the 1987 *Lands* case, Sir Robin Cooke rejected the notion that the Crown was obliged to consult on each decision in a process of executive action:

A duty 'to consult' was also propounded [by the New Zealand Maori Council]. In any detailed or unqualified sense this is elusive and unworkable. Exactly who should be consulted before any legislative or administrative step which might affect some Maoris, it would be difficult or impossible to lay down.⁷³

Justice Richardson gave a similar view, concluding that 'in truth the notion of an absolute open-ended and formless duty to consult is incapable of practical fulfilment and cannot be regarded as implicit in the Treaty'.⁷⁴

Thus, considerations of practicality and definition ruled out any absolute obligation to consult in every instance. Justice Richardson turned instead to the purpose of consultation, which was to be able to make properly informed decisions. It was in his opinion for the decision-making party to demonstrate good faith:

I think the better view is that the responsibility of one treaty partner to act in good faith fairly and reasonably towards the other puts the onus on a partner, here the Crown, when acting within its sphere to make an informed decision, that is a decision where it is sufficiently informed as to the relevant facts and law to be able to say it has had proper regard to the impact of the principles of the Treaty. In that situation it will have discharged the obligation to act reasonably and in good faith.

He considered that consultation would often, but not always, be required:

In many cases where it seems there may be Treaty implications that responsibility to make informed decisions will require some consultation. In some extensive consultation and co-operation will be necessary. In others where there are Treaty implications the partner may have

73. *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 665, per Cooke P

74. *Ibid*, p 683, per Richardson J

sufficient information in its possession for it to act consistently with the principles of the Treaty without any specific consultation.⁷⁵

From this formulation emerge two key criteria for executive decisions: the Crown must establish whether there are Treaty implications and, if there are, it must satisfy itself that it has sufficient information to act consistently with Treaty principles. If it does not, consultation is strongly indicated.

A further criterion is the significance of the decision, not to the Crown, but to Maori who are or might be interested parties. In the 1989 *Forest* case, Sir Robin Cooke commented in respect of the principle of partnership: ‘We think it right to say that the good faith owed to each other by the parties to the Treaty must extend to consultation on truly major issues. That is really clear beyond argument.’⁷⁶ Thus, consultation may still be required even if the Crown believes that it already holds sufficient information.

Nevertheless, operational considerations may limit the Crown’s obligation. In the *Lands* case, Sir Robin was concerned that ‘wide-ranging consultations could hold up the processes of Government in a way contrary to the principles of the Treaty’.⁷⁷

What might then count as ‘truly major issues’? In our view, scale and context has a large bearing. The Court of Appeal cases addressed key questions of national policy. In the *Lands* case, Justice Richardson was concerned at the resulting delay if ‘the Crown must engage in extensive and protracted consultation with Maori interests in respect of each parcel of land it is contemplating transferring to a State-owned enterprise’.⁷⁸

However, a major change in the status of a service institution that is important to a sizeable community, such as a hospital, clearly rates fairly high on the index of significance. It would also feature more prominently on the agendas of regional and district entities than for central agencies. We believe that the downgrading or closure of a general hospital or equivalent health facility will rarely fail both to rank as ‘truly major’ for its catchment population and to raise Treaty implications, thereby requiring consultation with local Maori.

3.9.3 Statutory requirements to consult

In addition to the Treaty obligations discussed in the previous section, specific statutory requirements may arise. The legislation governing hospital boards was silent on consultation. Their successors, the area health boards, although also elected, were required to promote community involvement. A board was:

To plan future development of health services in its district, and, towards that end, . . .

- (ii) To support, encourage, and facilitate the organisation of community involvement in the planning of [health] services;

75. *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 683, per Richardson J

76. *New Zealand Maori Council v AG* [1989] 2 NZLR 142, 152, per Cooke P

77. *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 665, per Cooke P

78. *Ibid*, p 684, per Richardson J

It was also ‘to investigate and assess health needs in its district’.⁷⁹ These duties strongly imply an obligation to consult, and that Treaty principles would usually apply.

The above clauses were repealed by the 1991 amending legislation that inserted commissioners to run the area health boards. We note that, during the transitional period from August 1991 to June 1993, the commissioners were under no statutory obligation to consult. However, the community health committees that boards were empowered to appoint under the former Act were left in place. Their mandate was to ‘provide a forum for the various community groups working in the health field, and [to] provide a liaison between such groups and the board’, and thus afforded a potential vehicle of consultation.⁸⁰

The Health and Disability Services Act 1993, which set up the purchaser/provider split of responsibilities, stated that:

Every regional health authority shall consult in regard to its intentions relating to the purchase of services in accordance with section 34 of this Act.

Every regional health authority shall, in accordance with its statement of intent, on a regular basis consult in regard to its intentions relating to the purchase of services with such of the following as the authority considers appropriate:

- (a) Individuals and organisations from the communities served by it who receive or provide health services or disability services:
- (b) Other persons including voluntary agencies, private agencies, departments of State, and territorial authorities.⁸¹

Maori were not separately mentioned as individuals, communities or organisations, but the requirement to consult was explicit, placed on a general and continuing footing, and subject to Treaty obligations. No similar obligation was placed on CHES.

Although commencing in January 2001 and thus beyond the period considered by this report, the Public Health and Disability Act 2000, which ended the funder-provider system, contains quite extensive obligations to consult at both national and district levels. One of its general purposes is stated as being ‘to provide a community voice’, in part ‘by providing for consultation on strategic planning’.⁸²

In that Act, district health boards are given the objective of reducing:

with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.⁸³

79. Section 10(c), (b) of the Area Health Boards Act 1983

80. Section 8 of the Area Health Boards Amendment Act (No 2) 1991; section 31 of the Area Health Boards Act 1983

81. Section 18(4), 34 of the Health and Disability Services Act 1993

82. Section 3(1)(c) of the Public Health and Disability Act 2000

83. Section 22(1)(f) of the Public Health and Disability Act 2000

3.9.4

In light of the Act's recognition of the Treaty and its general aim of reducing health disparities for Maori, it is reasonable to assume that Maori form one of the intended 'population groups'. Thus, district health boards are formally required to consult Maori on remedial action for at least as long as Maori health outcomes remain worse than those of the general population.

District health boards are also required to consult their 'resident populations' before making 'significant' changes to their strategic or annual plans. The Act specifies the special consultative procedure set down in the Local Government Act 1974 as the minimum standard of consultation with which district health boards must comply. This standard requires them:

- ▶ to give public notice of the proposal;
- ▶ to allow between one and three months (unless they allow more time) for the public to make both written and oral submissions;
- ▶ to make written submissions publicly available; and
- ▶ to make the hearing of submissions and deliberations on the proposal, including the final decision, open to the public.⁸⁴

3.9.4 The process and standards of consultation

The courts have laid down clear guidelines on the limits of consultation. In particular, the Court of Appeal judgment in *Air New Zealand v Wellington Airport* distinguished consultation from negotiation:

We do not think 'consultation' can be equated with 'negotiation'. The word 'negotiation' implies a process which has as its object arriving at agreement.⁸⁵

In the High Court case being appealed, Justice McGechan had taken a similar view, while pointing out that consultation often led the parties down the path towards agreement:

To 'consult' is not merely to tell or present. Nor, at the other extreme, is it to agree. Consultation does not necessarily involve negotiation toward an agreement, although the latter not uncommonly can follow, as the tendency in consultation is to seek at least consensus.⁸⁶

Furthermore, the party consulted does not acquire a right of veto over the decision to be made, or the right to cause unreasonable delay. Crown counsel cited a Privy Council judgment:

It would not be reasonable to allow a situation to develop in which all initiative and all control of timing would pass from the Government. Nor would it be reasonable if their desire to reach the moment for decision could be frustrated.⁸⁷

84. Sections 38(3)(b), (4), 40 of the Public Health and Disability Act 2000; section s716A of the Local Government Act 1974

85. *Wellington Airport v Air New Zealand* [1993] 1 NZLR 671, 676, per McKay J

86. Quoted in *Wellington Airport v Air New Zealand*, p 675, per McKay J

87. *Port Louis Corporation v Attorney-General of Mauritius* [1965] AC at p 1133 (quoted in doc x48, pp 27–28)

He argued that the Treaty placed an obligation of reasonable cooperation on Maori: ‘The Courts have also recognised an onus on Maori to respond to consultation in a timely and appropriate manner. This is an aspect of the principle that Treaty obligations are reciprocal.’⁸⁸

Crown agencies embarking on consultation are none the less obliged to take serious account of the views put to them. In a radio interview in August 1994 on the decision to close Darfield Hospital, Prime Minister James Bolger commented:

I think the most important thing there . . . is that the obligation to consult by the Crown Health Enterprises and the Regional Health Authorities, whether its in Canterbury or Auckland or wherever, that they actually do genuinely consult, and are prepared to alter their original proposals once they’ve talked to the community. That’s what it’s all about.⁸⁹

It would not suffice, in other words, simply to call a hui and explain the proposals. The Court of Appeal commented thus on a national hui on the proposal to sell forestry assets:

A main complaint about the national hui in January 1989 is that the people there were confronted with a *fait accompli*. A Maori translation of the French words is *he kaupapa he kaupapa kua tau ke e kore taea te whakatika* – a proposal that has already been decided that you cannot correct. Assuredly that would not represent the spirit of the partnership which is at the heart of the principles of the Treaty of Waitangi . . .⁹⁰

Justice McGechan stressed the same obligation: ‘Consultation must be allowed sufficient time, and genuine effort must be made. It is to be a reality, not a charade.’ The party consulted should be ‘adequately informed so as to be able to make intelligent and useful responses’. The party consulting should keep an open mind and be ready to change.⁹¹ The Court of Appeal judgment summarised the process thus:

If the party having the power to make a decision after consultation holds meetings with the parties it is required to consult, provides those parties with relevant information and with such further information as they request, enters the meetings with an open mind, takes due notice of what is said, and waits until they have had their say before making a decision, then the decision is properly described as having been made after consultation.⁹²

3.9.5 Tikanga Maori in the consultation process

Where consultation is required that includes Maori, the question of approach demands serious consideration. If the issue at stake concerns Maori alone, specific consultation is indicated. More problematic is the case often arising in the social services field where Maori are part of the

88. Document x48, paras 48–55; *New Zealand Maori Council v AG* [1987] 1 NZLR 641, 664 per Cooke P

89. Bolger 1994

90. *New Zealand Maori Council v AG* [1989] 2 NZLR 142, 152 per Cooke P

91. Quoted in *Wellington Airport v Air New Zealand*, p 675, per McKay J

92. *Wellington Airport v Air New Zealand*, pp 683–684, per McKay J

general community of people affected. It can be argued that open public consultation automatically includes Maori as members of the community.

We do not think it possible to lay down a universal prescription, since due regard must be had to the particular context in each case. However, when Treaty obligations are involved we consider that it will commonly be appropriate to conduct separate and specific consultation with Maori. In its absence, Crown agencies may find it difficult to inform themselves adequately of Maori views, to respect the rangatiratanga of affected Maori groups, and thus to meet their protective and partnership obligations.

This perspective applies to the geographical scope of the decision-making context, and thus equally at the regional, district and local levels. The point was taken up in the *Waipareira Report* in regard to community development:

We are suggesting here that each Maori group in a district should be consulted about how delivery of and funding for social services might best promote the development of Maori communities in the district.⁹³

The mode of consultation should take appropriate account of Maori expectations and preferences. The *Waipareira Report* summarised the importance of avoiding a monocultural framework:

Consultation across cultural boundaries involves each party understanding the other's cultural imperatives and priorities – hence the importance of a bicultural approach . . . Consultation involves not just listening, but also responding; and in Treaty partnership mode, responding so as to accommodate the other's cultural values.⁹⁴

Active engagement is thus a key attribute. So too is adequate opportunity for collective discussion in a Maori cultural context. Often, this will be in a marae setting, at a time that assists the community to come together, and with due advance notice through networks accessible to Maori, the allowing of sufficient meeting time, and an opportunity for reporting back and following up. The *Waipareira Report* criticised the more passive approach of consultation by document:

a process of consulting Maori by seeking responses to discussion documents or draft policies from separate or scattered groups is not reliable. It does not provide proper opportunities for Maori themselves to gather together and weigh up a range of opinion, and to develop a consensus which represents the views, and enhances the rangatiratanga, of all Maori present.⁹⁵

At whatever level consultation is conducted, direct communication is critical. This, the *Maori Electoral Option Report* concluded, was one of the keys to greater effectiveness, much more than

93. *Te Whanau o Waipareira Report*, p 226

94. *Ibid*, p 224

95. *Ibid*, p 228

with indirect techniques such as mail handouts. The essential guideline is ‘kanohi ki te kanohi’ – face-to-face discussion.⁹⁶

As well as meetings with communities, active engagement will commonly involve interaction with the leaderships of representative Maori groups. Here, the accepted standards of meaningful consultation – all interested groups approached, sufficient information provided, adequate opportunity given to present views at meetings – will apply. All the same, they may not suffice to ensure a satisfactory consultation process. We make two additional suggestions as to procedure:

- ▶ Engage in initial consultation with representative Maori groups on the form and scheduling of the process. This would assist in ensuring that the consultation exercise meets Maori procedural expectations and thus achieves a fair outcome consistent with Treaty principles.
- ▶ Allow sufficient time for Maori leaders to seek mandates and for Maori groups to complete their internal discussions. Maori groups will often place a high value on consensual decision-making, which may take more than one meeting to achieve.

We conclude by emphasising that mutual cooperation and appropriate balance is essential to the effective balancing of the *kawanatanga* and *rangatiratanga* obligations between the Treaty partners. On the one hand, there is a high risk of consultation overload if conscientious agencies in the now-fragmented State sector beat paths to the doors of Maori tribal organisations on every significant issue. On the other, Maori groups may lack the technical and financial resources to respond in a timely and effective manner. The effectiveness of one-off consultations on specific decisions is likely to be greatly enhanced by the building of an ongoing consultative partnership between Crown agencies and Maori groups.⁹⁷

3.9.6 Findings on consultation

In 1988, Justice McGechan gave what he described as an ‘impromptu’ definition of consultation:

There is a difference between informing and consulting. Informing is telling people what will happen. Consulting involves the statement of a proposal not yet finally decided upon, listening to what others have to say, considering their responses and then deciding what will be done.⁹⁸

This broad three-stage approach was adopted in the *Mokai School Report* and we adopt it here, while adding a preliminary stage to assess the need for consultation. We summarise below the main criteria that we consider applicable to the process.

In determining whether to consult Maori, regard must be had to

- ▶ the importance to Maori of the issue to be decided, and in particular whether it is sufficiently important to require consultation regardless of discretionary considerations;
- ▶ whether statutory obligations require or strongly imply the need for consultation;
- ▶ whether and to what extent the issue has been the subject of previous consultation;

^{96.} *The Maori Electoral Option Report*, p 28

^{97.} See *Te Whanau o Waipareira Report*, p 229

^{98.} *West Coast United Council v Prebble* [1988] 12 NZTPA 399, 405, per McGechan J; also quoted in *Wellington Airport v Air New Zealand*, p 675

3.9.6

- ▶ what, if any, Treaty implications exist;
- ▶ the sufficiency of information already possessed or gathered by other means on Maori opinion and on the impact of the decision on affected Maori; and
- ▶ the existence of exceptional factors justifying proceeding without consultation in the interests of timely action and good government.

When stating a proposal not yet finally decided upon:

- ▶ communicate that part or all of the proposal is open to change and that the decision-makers remain genuinely prepared to consider alternative views;
- ▶ ensure that the proposal for decision is clearly stated, the Treaty implications are explained, any alternative options are spelt out, and the implications of not proceeding are indicated;
- ▶ disclose all relevant information, including technical details for professional evaluation; and
- ▶ present the information in a form that is readily understandable by the people being consulted, thus enabling them to make intelligent and useful responses.

When listening to what others have to say:

- ▶ make a clear decision at the outset, preferably with Maori participation, on the extent to which Maori will be consulted within the public process or separately;
- ▶ a programme reaching all sections of the affected Maori community, so far as is practicable through marae-based meetings and the guideline of *kanohi ki te kanohi* (face to face);
- ▶ communicate all relevant information through the Maori leadership and community networks, as well as through the public media;
- ▶ allow sufficient time for Maori leaders to establish their mandates and for internal consensual discussions within Maori groups and communities to be completed and reported back; and
- ▶ have a demonstrable commitment not just to inform but to listen and discuss.

When considering their responses and deciding what will be done, ensure that:

- ▶ all Maori responses are considered and integrated into the analysis of public submissions;
- ▶ any independent validation includes Maori responses;
- ▶ the proposals for decision are reviewed at each stage in terms of Treaty principles and obligations; and
- ▶ the final decision is fully communicated and explained.

CHAPTER 4

MAORI HEALTH AND THE AHURIRI TRANSACTION, 1840–51

4.1 CHAPTER OUTLINE

In this chapter, we cover the period of direct British rule in New Zealand from the signing of the Treaty to the threshold of representative government. The Ahuriri transaction, which paved the way for the extension of colonial government and Pakeha settlement to Hawke's Bay, took place towards the end of the period.

The chapter is presented at two levels. In the national context, we provide an overview of the traditional Maori health system and the impact on Maori health of new diseases introduced from abroad (section 4.2.2). We trace the formation of colonial government policy towards protecting Maori health and health programmes for Maori, notably the public hospitals and NMOS (section 4.2.3).

Turning to the regional context, we assess the impact of introduced diseases on the health status of Maori in Hawke's Bay in the 1840s, and Maori attitudes towards Western medicine and doctoring (sections 4.2.1.4 and 4.2.2.2). Then we consider the background to the Ahuriri transaction, and more specifically the way in which the prospect of organised Pakeha immigration and town development was communicated and perceived (section 4.2.4). We examine Maori expectations and the alleged promise of a hospital during the negotiation of the Ahuriri deed (section 4.2.5). We conclude by considering the evidence that Mataruahou was a traditional place of healing and whether the alleged promise of a hospital was site-specific (section 4.2.6).

4.2 ANALYSIS OF THE EVIDENCE

4.2.1 The challenge to Maori health

4.2.1.1 *The customary Maori health system*

We begin with a brief overview of the customary Maori health system that prevailed in most essentials at the time of the signing of the Treaty and persisted in Maori communities for many decades thereafter.

In his evidence, Ruruarau Heitia Hiha gave a view of traditional Maori medicine as experimental, innovative, expert and enjoying community support:

Our tipuna believed that they belonged to their environment through their whakapapa to Papatuanuku and Ranginui. They made use of the resources that were provided within that environment; they adapted to each new environment that they met; they developed the rongoa from that environment; they experimented and found new rongoa. They developed a 'health system'. This system was supported by whanau and the hapu. The tohunga became the kaitiaki of that system.¹

Durie argued that the philosophical basis of traditional Maori perceptions of health, illness, and medicine was the concept of tapu. This he defined as 'an all-pervasive force' that operated on both spiritual and secular planes, that could apply to 'people, places, animals, plants, events, and social relationships', and that could range from a permanent state to an interim measure intended to restore social equilibrium or afford protection. Within the daily life of local communities, 'the conferment of tapu was essentially a safety measure designed to invoke a sense of caution and to warn of threatened danger. For Maori it offered a series of practical rules to protect communities from known dangers.'²

Good health was less a state to be sought after than an indication of moral and spiritual wholeness. Conversely, illness, mental distress and unusual death were seen primarily as a moral problem and were commonly regarded as originating in breaches of tapu, leaving the violator spiritually blind.³ Without intervention, the sick person would not be expected to recover or even to live. Intervention was designed to address the whole matrix of social and spiritual factors:

Theories of causation related disease and illness to wider social, spiritual, and environmental events and did not confine them to explanations based only on the behaviour of the affected individual. The poor health of one person was taken as a comment on the group, either the immediate family or the more extended whanau and even hapu.⁴

Effective intervention against ill health was the responsibility of the tohunga, who played a key role in tribal society. As well as protecting the tribal memory and possessing knowledge and expertise in many fields, the tohunga was 'the guardian and expositor of tapu' and was credited with magical powers. The tohunga's diagnostic practice therefore concentrated on uncovering any breaches of tapu and on restoring balances between tapu and noa, and included detailed case histories.⁵ Maori emphasised spiritual, social and psychological rather than biological factors, and group interactions rather than individual pathology. But even if the fundamental causation was located at the spiritual level, healers also treated the symptomatic manifestations. In this respect, their curative approach differed little from their pre-scientific European counterparts.

1. Document v15, p 1
 2. Durie 1998, pp 7-8
 3. Lange 1999, pp 8-9
 4. Durie 1998, p 15
 5. Ibid, pp 15-17; Lange 1999, p 12

Therapies took three basic forms, often in combination: ritenga and karakia (rituals and incantations); simple surgical procedures; and rongoa (medicinal flora).⁶ Compared with the pre-scientific European medicine of the late eighteenth and early nineteenth centuries, Maori traditional healing placed less reliance on surgery, utilised herbal rather than chemically manufactured medicines, shared a similar ignorance of biological causation of disease, and adopted a communal and holistic rather than an individual and specific diagnostic approach.⁷ Neither Maori nor Western medicine was effective in healing acute conditions.

Nursing the sick did not feature prominently in therapeutic practice, since the focus was on identifying and rectifying the underlying social and spiritual causes. However, temporary shelters were built outside the village for two key stages in the life-cycle: a whare kohanga for women and attendants before and after childbirth; and a whare mate for seriously ill and dying people and their immediate families.⁸ In contrast to the nineteenth-century European hospital, in which many patients died, the place of death was highly tapu and could render a dwelling house uninhabitable.⁹

4.2.1.2 *The arrival of exotic diseases*

Before the arrival of the first European vessels, the indigenous population of New Zealand was spared many of the world's major diseases. There were two principal reasons for this. On the one hand, New Zealand was isolated from the global disease centres and from the carriers of pandemics. On the other, the population was too small and scattered to serve as a reservoir of killer infections and many endemic diseases.¹⁰

At this distance in time, it is impossible to establish anything like a full pre-contact disease profile. Various respiratory, intestinal and gastric diseases were probably widespread, as well as skin ailments, arthritis and rheumatism, and stomach and intestinal tumours may have been common. But viral diseases, lacking a sufficient population reservoir, were unknown, as were tuberculosis and leprosy (Hansen's disease).¹¹ Distilling his careful review of the research evidence, historical demographer Ian Pool concluded that, at the time of contact, 'birth rates might have been around 38–40 per 1000, death rates 30–35, and life expectation at birth of the order of 28–30 years', with gradual long-term population growth. Although very low by today's standards, this figure matches life expectancies in many European cities and countries at that time.¹²

Care must be taken not to overstate the healthiness of pre-contact Maori society. Nutrition was usually adequate but not always, especially in protein. The early dental attrition from gritty and fibrous staple foods may have worsened malnutrition and with it, exposure to disease.¹³ But

6. Durie 1998, pp 15–20; Lange 1999, pp 12–14

7. Durie 1998, pp 17–22

8. Ibid, pp 8–14; Lange 1999, pp 14–15; Oppenheim 1973, pp 38–39

9. Lange 1999, pp 14–15

10. Pool 1991, pp 35–36; Lange 1999, pp 2–3

11. Pool 1991, pp 35–36; Lange 1999, pp 2–5; Durie 1998, pp 22–23, 32

12. Pool 1991, pp 37–40, 57–58

13. Pool 1991, p 36; Lange 1999, pp 6–7

despite the high mortality, Lange describes the late eighteenth-century health situation in positive terms:

Able to eat well enough most of the time, following an active style of life, subject to a regime that in effect followed a number of sanitary principles, and prey to only a limited complement of diseases, the Maori were not troubled by levels of ill health sufficient to arouse them to particular concern or to attract the attention of European visitors.¹⁴

This stable situation was not to last. From the time of Captain Cook's expeditions, ships from Europe and North America connected New Zealand to the global disease pool. The first impact of introduced diseases was more or less immediate. As Pool puts it, 'each newly arrived ship brought its own cargo of viruses, bacteria and other pathogens flourishing in the squalid ports from which it had sailed'. By no means all of them survived the long sea voyages, the most virulent killing seafarers they infected and immunising the survivors. But those that did arrive found fertile territory, and the trans-Tasman quarantine became ineffective as the Australian disease pool was entrenched.¹⁵

Previously isolated, the Maori population had no immunity. Diseases that were endemic and survivable in Europe, such as measles and influenza, struck down Maori of all ages. Sexually transmitted diseases hit early and hard wherever contact between coastal Maori and foreign seafarers occurred. Acute intestinal infections such as dysentery and typhoid were also probably present before 1840.¹⁶

Pool suggests that the Maori population suffered a decline between 1769 and 1840, and that introduced disease was a larger factor than the oft-blamed musket wars. He points out, however, that on the worldwide evidence of dramatic mortality amongst suddenly exposed indigenous peoples, a far more severe decline might have been expected. That it didn't was in part a result of New Zealand being spared several of the world's worst infectious diseases, including yellow fever, typhus, plague, cholera, and, with a few minor post-1840 exceptions, smallpox.¹⁷

Three other limiting factors assisted. The first was the fairly low intensity of direct interaction between Maori and shipborne visitors outside a handful of coastal settlements. The second was the dispersion and low density of Maori settlement. The third was improving nutrition from imported food species, especially pigs and potatoes. This combination inhibited the rapid transmission of disease: outbreaks tended to be localised and epidemics regional rather than country-wide.¹⁸

The implications for Maori were none the less serious. As well as more pervasive ill health, higher mortality eventually tipped the population, albeit unevenly, into decline. In Lange's view, 'the population was not destroyed. But (for some of the tribes earlier than others), what had happened to their health was a disaster of unprecedented proportions.'¹⁹ Belich adopts Pool's most

14. Lange 1999, p 7

15. Pool 1991, pp 45-46; Belich 1996, pp 174, 176

16. Pool 1991, pp 44-46; Durie 1998, pp 32-33; Lange 1999, pp 3-5, 18-19

17. Pool 1991, pp 46-47; Dow 1999, pp 48-49; Lange 1999, p 18; Durie 1998, p 34

18. Pool 1991, p 46; Belich 1996, pp 175-176

19. Lange 1999, p 19

conservative scenario to suggest a reduction of the national Maori population from 86,000 in 1769 to 70,000 in 1840 – an average annual rate of –0.3 per cent. Pool himself puts the 1769 figure at around 100,000, reducing to between 70,000 and 90,000 by 1840. Both agree that introduced diseases were the most potent cause of a population decline that was beginning to accelerate by 1840.²⁰

4.2.1.3 *A crisis of survival*

During the 1820s and 1830s, the impact deepened. Ship visits multiplied. As well as causing many deaths in battle, the musket wars resulted in social disruption and migrations that weakened people's resistance and spread illness.²¹ It was, however, the proclamation of a British colony that unleashed the full force of introduced diseases by unlocking the door to systematic settlement, more extensive travelling, and, by the 1850s and 1860s, a national disease pool. With the settlers, and especially in their towns, many new infectious illnesses became entrenched. During the 1840s and 1850s, epidemics spread more frequently and widely amongst Maori communities with no or limited immunity. Measles struck in 1835 and, devastatingly, in 1854; what was probably whooping cough in 1847–48; and influenza repeatedly and particularly in the early 1840s and 1851–52. Most devastatingly, tuberculosis began to take hold.²²

The two decades following the signing of the Treaty marked a watershed. Within a few years, and before most of their North Island land had been alienated, Maori had lost social and political control over the major causes of their ill health. The new diseases hit not just individuals but whole communities, and returned again and again. Tohunga were powerless against the tokotoko rangi (epidemics), which they considered to be mate atua (illness beyond human control).²³ In some instances, Maori understood better than Pakeha that the diseases came with the ships.²⁴ But detecting their external origin was of little practical help.

In the aftermath of the signing of the Treaty, Maori faced what a growing number of their leaders recognised as a crisis of survival. Over the half-century following the signing of the Treaty, the national Maori population shrank by roughly half. Pool calculates that most of the decline was concentrated within the first 35 years of the period (ie, 1840–75) and most sharply in the 1840s and 1850s.²⁵

It would not be overstating the case to speak of a collapse in the Maori population in the aftermath of the signing of the Treaty. Notwithstanding the colonial military campaigns of the 1840s and 1860s, death in battle was an insignificant contributor to overall Maori mortality. Most of the collapse is attributable to full exposure to introduced diseases and to the social and economic conditions that intensified their impact. As Lange puts it, 'the conquest of the Maori population by new viruses and bacteria was undoubtedly an enormous calamity'.²⁶

20. Pool 1991, pp 53–58; Belich 1996, pp 173–174, 178

21. Pool 1991, pp 44, 58; Lange p 18; Belich 1996, pp 156–164; Adams 1974, pp 39–45

22. Lange 1999, pp 18–19; Pool 1991, pp 44–46; Durie 1998, p 32; Belich 1996, pp 177–178

23. Durie 1998, pp 31–32

24. Lange 1999, p 18

25. Pool, pp 60–62; Belich 1996, p 178

26. Lange 1999, p 19; Durie 1998, pp 30–31

4.2.1.4 Exotic diseases and ill health in central Hawke's Bay

Hawke's Bay, although remote from the early centres of immigration and trade, was not immune to the scourge of exotic diseases. Early carriers were whalers and traders, who visited the bay in growing numbers. Whaling settlements began to spring up along the coast during the 1830s, and in the 1840s the first Pakeha settlers established themselves on the margins of Te Whanganui a Orotu.²⁷

In Mr Hiha's view, a shift from hilltop to lowland village sites exacerbated the ill health of Ahuriri Maori communities. He considered that new farming methods were the principal factor:

The new work regime, lead [sic] to a change in the living habitat. There was a need to live nearer to your work, ie nearer to the crops and the animals. Our people did not cope well with the shift from the high ground to the damp low flats. Their health suffered.²⁸

This perception of ill health being associated with kainga situated on or near low-lying, damp or swampy ground was common in nineteenth-century New Zealand. It had its origins in the then prevailing miasmatic theory of disease, which attributed the cause of many afflictions to infectious vapours from the environment. It reinforced the view, propounded by Te Rangi Hiroa (Peter Buck) and others, that traditionally Maori had resided in healthy hilltop pa, moving down to less favourable lowland sites when warfare ended and new economic opportunities, such as the flax trade, opened up. The weight of archaeological and other evidence suggests, however, that some hilltop pa were permanently occupied, others were used in times of conflict, and many permanent kainga were situated close to waterways, gardens and natural resources.²⁹

In Ahuriri and Heretaunga, however, the invasions and warfare of the 1820s had led to wholesale depopulation as the tangata whenua took refuge in Nukutaurua. Only in the 1840s was the return of most Ngati Kahungunu hapu to their ancestral lands completed. Some established new settlements and avoided the sites of former battles as wahi tapu. The result was a movement into the lower Waiohinga (Esk) River valley, Wharerangi, and the margins of the rivers and swamps of the Heretaunga Plain south of Mataruahou, returning seasonally to fishing camps around Te Whanganui a Orotu.³⁰ The expanding farming and trading opportunities consolidated the lowland settlement pattern in the 1840s and 1850s.

Whether relocated on healthy sites or not, Maori settlements in Ahuriri and Heretaunga were by the 1840s exposed to introduced diseases that increasingly originated beyond their immediate contacts with visiting Pakeha. Following his arrival in 1844, the missionary William Colenso recorded in his journal his encounters with illness and death in the many Maori communities that he visited in Hawke's Bay and the Wairarapa. Interpreting these, Paul Goldsmith described a pattern of widespread illness and frequent epidemics:

27. Document J10, pp 8–12

28. Document v15, p 3

29. Lange 1999, p 21; Durie 1998, p 34; Belich 1996, pp79–80, 87–88

30. *Te Whanganui-a-Orotu Report 1995*, p 32

A period of significant sickness occurred in the year of 1847; influenza epidemics struck about the Ahuriri/Tangoio area in January 1848 and October 1850; whooping cough in July 1848; while the years 1849–51 were characterized by general sickness.³¹

Colenso's journal descriptions suggest considerable local variation from kainga to kainga, with many deaths in some contrasting with good survival rates in others. He calculated nevertheless that the overall mortality in the Wairarapa was more than 7 per cent during a single 10-month period in 1849–50.³² In 1850, Native Secretary Kemp, reviewing his 1850 survey of the southern North Island, including the Wairarapa, noted that Maori 'are by no means in that healthy state which one would be led to expect when compared with the advance they have made in other respects: In the former, it would appear that they are retrograding, and this decline is especially visible in and near the European towns'. He thought the population at best static, 'unless swept off by some unusual and fatal disease'.³³

In the late 1840s, Maori living in central Hawke's Bay had good reason to be anxious. The dangerous new illnesses struck indiscriminately across communities that had yet to build up natural resistance. Traditional medicine had few remedies for the alarming new symptoms, and its ineffectiveness against exotic diseases undermined confidence in the *tohunga*. As Mr Hiha put it: 'Our people lacked the immunity to ward them off. The *rongoa* was not available to cope with them. The "health system" was unable to cope. Their numbers were decimated.'³⁴

4.2.2 Missionary medicine

4.2.2.1 *The missionary influence*

With the new diseases came missionaries, who were often the first points of contact Maori had with the overseas world, outside of the port and whaling settlements. The missionaries proclaimed the power of their *atua*, a new religious morality of ill health, and the efficacy of the medicines some introduced into their evangelical work. As *tohunga* of a foreign *atua*, they might have been expected to have had some leverage over the unseen forces behind the terrible new foreign maladies.³⁵ So, too, might the medical *tohunga* promised by the government of the British Queen as a benefit of shared prosperity. In the context of increasing death rates, the interest of many Maori communities in European medicine and doctors quickened.

Missionaries and their sending societies were enthusiastic promoters of the medical methods then prevailing in Britain, both before and after the signing of the Treaty. According to Dow:

Few missionaries were fully trained in this discipline, but a number had a smattering of knowledge which enabled them to provide rudimentary care to family and colleagues in their

31. Goldsmith 1996, p 170

32. *Ibid*, p 170

33. H T Kemp, 'Final Report', 15 June 1850, NZGG (Province of New Munster), 21 August 1850, Wai 145 ROI, doc N3(c), p 603

34. Document v15, p 2

35. Durie 1998, p 32

4.2.2.2

isolated mission communities. This also allowed them to afford physical as well as spiritual succour to the Maori among whom they worked.³⁶

Missionaries had a wide field of influence. Many Maori within reach of their mission centres and walking circuits were willing to try out the new remedies where tohunga had failed, and saw them as a second line of defence against manifestations of exotic diseases. The missionaries were also the first agents of vaccination, and a number of mission stations became de facto hospitals, especially during local epidemics.

Missionaries remained the principal providers of primary healthcare to Maori during the 1840s and 1850s. Dow comments that, 'in a young colony with limited medical provision, the missionary presence had helped create an expectation among Maori that western medicine had a contribution to make to their welfare'.³⁷

4.2.2.2 *Colenso's medical campaign in Hawke's Bay*

Rangatira in Hawke's Bay were also looking for solutions. If rongoa could not cope, perhaps the new doctors and medicines promised by the colonial government might assist Hawke's Bay Maori against illnesses which their remedies were supposedly designed to combat. But Hawke's Bay had no place in Grey's hospital programme, and the Wellington hospital, which opened in September 1847, was too distant to reach. There was neither a resident magistrate nor an NMO. Meanwhile, Hawke's Bay rangatira and their families were not spared. Amongst their number was Tareha, who in 1850 lost his last three children then alive, while, according to Colenso, Tareha himself barely survived and his wife died the following year.³⁸

Colenso, who offered medical treatment to Maori despite his lack of any training, had a virtual monopoly on European medicines and was in popular demand as a healer.³⁹ But his methods were controversial. He was not afraid to mix medicine and religion in attacking Maori beliefs and cultural practices, in particular deploying death as an ideological weapon. His high-handed approach aroused the hostility of a number of chiefs, leading to a major confrontation in early 1850 after a period of high mortality.⁴⁰

Moreover, Colenso's array of chemical remedies was in practice often ineffectual against the new diseases that were devastating Maori communities. He compensated with dramatic effect:

Some of his medicine was of use; a lot may have had a placebo effect. But the powerful purgatives and emetics for which Colenso held a grim enthusiasm had a dramatic and immediate impact on his patients. The resultant purging, however, was occasionally so frightening that Colenso was accused of makutu.⁴¹

36. Dow 1999, p 18

37. Dow 1999, pp 18–23

38. Goldsmith 1996, p 173

39. Document U12, pp 89–99

40. Goldsmith 1996, pp 168–169, 173–174

41. Ibid, p 173



Figure 1: William Colenso, 1868. Photograph courtesy Alexander Turnbull Library (1/2-005028).

Colenso achieved a degree of success during 1848 and 1849 in the conversion of four prominent Hawke's Bay tohunga.⁴² However, widespread illness continued unabated, and the fact that it struck down Christian converts with equal force could not be disguised. In 1850, the first local Maori prophet–healers appeared, rivalling the exclusive religious hold of Pakeha missionaries.⁴³ This was a time of gathering medical and spiritual crisis.

4.2.3 Crown health service provision for Maori

4.2.3.1 *The formation of British policy on protecting Maori health*

We concluded in section 3.4.3 that protecting Maori from the adverse effects of unregulated settlement, and from worsening ill health as one of those effects, was a principal British concern at the time of the signing of the Treaty. But translating that concern into concrete policies and programmes was hampered by the expectation that the new colony would be financially self-reliant. Successive British secretaries of state for the colonies therefore tied Maori welfare provision to the land settlement strategy they adopted.

That strategy relied for most of the first quarter century of British rule on the right of Crown pre-emption in the acquisition of Maori land. It envisaged that a large contribution towards the funding of British colonisation would be derived from the profits made by reselling land to settlers at much higher prices than those paid to Maori.⁴⁴ In his instructions to Captain Hobson of

42. Ibid, p 177

43. Ibid, pp 174, 179–180

44. Document v12, p 31; Orange 1987, pp 29–31

August 1839, Lord Normanby insisted that only by the application of British capital and settler labour would most Maori land acquire and then increase its exchange value. He believed that ‘in the benefits of that increase the Natives themselves will gradually participate’.⁴⁵

Normanby recognised, however, that it would not suffice to await the eventual trickle-down of colonial prosperity to Maori, who were expected to take the first step by disposing of their land at highly concessionary rates. As well as providing for a protector of aborigines, his instructions to Hobson laid down the general aim of ‘promoting their civilization – understanding by that term whatever relates to the religious, intellectual, and social advancement of mankind’. This was a pretty broad mandate, which Normanby did not go very far towards elaborating, except to order Hobson to provide political and financial support to missionary efforts towards Maori, especially in religious instruction and schools. Neither the protection of Maori health nor State health services to Maori received explicit mention. Nor did he leave Hobson much financial leeway, requiring the expected surpluses from land sales to settlers to be applied to the costs of bringing out more settlers.⁴⁶

In December 1840, Normanby’s successor, Lord John Russell, sent Hobson, now Governor, instructions establishing New Zealand as a Crown colony. These were a little more precise. ‘Economy in public expenditure’ was to be the guiding principle, and priority was to go only to the ‘more immediately pressing’ objectives. Amongst these, however, ‘the public health and safety must, for example, precede every other care’.⁴⁷

Russell set down as one of his six policy aims for the protection of Maori ‘the avoidance of every practice towards them tending to the destruction of the health or the diminution of their numbers’. More specifically, he warned against the risks of aggressive cultural intrusion into Maori social norms:

I must also commend to your attention, and that of the protectors acting under you, a due regard to those rules which medical skill and experience may have established regarding the effect of sudden changes in dress, diet, and modes of living, on the health and longevity of men brought up from infancy in the habits of savage, or at least of uncivilized, existence. To the neglect of these rules, or to the hasty and inconsiderate formation of them, is, perhaps, to be attributed much of that rapid mortality which has attended all such tribes when taken under the care of European guides, even though animated by the most lively solicitude for their welfare.⁴⁸

Following up in January 1841 with additional instructions concerning the protection of Maori interests, Russell changed the allocation of land revenues. Henceforth, he required that between 15 and 20 per cent of the proceeds of Government land sales to settlers be allocated to the protector of aborigines. The money was to be allocated to a fund which would be used both to cover the protector’s operational costs and ‘for defraying all other charges which, on the

45. Normanby to Hobson, 14 August 1839, BPP, vol 3, pp 85, 87; doc U12, p31

46. Normanby to Hobson, 14 August 1839, BPP, vol 3, pp 87–89; Orange 1987, p 30

47. Russell to Hobson, 9 December 1840, BPP, vol 3, p 148

48. Russell to Hobson, 9 December 1840, BPP, vol 3, p 151

recommendation of the protector, the governor and executive council may have authorized for promoting the health, civilization, education and spiritual care of the natives'.⁴⁹

Spending proposals from the protector had to be authorised by the Governor and Executive Council. But the endowment fund's mandate excluded non-Maori purposes and its replenishment was compulsory – surpluses were to be invested, and in-payments were to be temporarily suspended only if it came 'to exceed every reasonable demand for this service'.⁵⁰

In mid-1842, the Colonial Secretary employed the same wording ('promoting the health, civilisation, education, and spiritual care of the aborigines') in defining the mandate of the trustees appointed to administer the endowment fund.⁵¹ In September 1842, the Imperial Government confirmed that 15 per cent of the land fund was to be assigned for Maori purposes.⁵²

Earl Grey's 1846 instructions to Governor Grey assigned the land fund to subsidising immigration and for 'defraying the costs of such other services therein as by us shall from time to time be prescribed by instructions'.⁵³ Neither here nor in subsequent instructions was a specific assignment for Maori purposes mentioned, although the Secretary of State did confirm his predecessor's instructions to Hobson of December 1840.⁵⁴ In 1851, Grey none the less believed that the Governor was still empowered to invoke Lord Russell's additional instructions of January 1841 to reserve a minimum of 15 per cent of the land fund for Maori purposes.⁵⁵

Thus, from the inception of British rule in New Zealand, protecting Maori health was on the official agenda of the civilising mission. During the Crown colony period (1840–52), the British administration operated under instructions from London that required land revenues to be applied to Maori welfare, including public health services.

4.2.3.2 Governor Grey's hospital programme

Implementing the policy was less straightforward. Welfare for Maori was supposed to be funded from the proceeds of land sales to settlers. In practice, however, little land was sold and the colonial Treasury was virtually bankrupt by 1845.⁵⁶ In any case, the administrative costs of the Protectorate Department took priority, consuming most of the available funds set aside from the proceeds of land sales to settlers. In 1842, the same year that trustees were appointed to implement the Maori welfare policy, the Government was declining hospital proposals on the ground that 'beyond a Dispensary [in Auckland] His Excellency fears no efficient means can be adopted for administering medical aid to the Natives until sufficient funds are procurable'.⁵⁷ Bishop Selwyn, one of the welfare fund's trustees, complained in late 1845 that nothing had as yet been done, even though, 'by this fund, we hoped that schools, hospitals, hostelries, would be built'.⁵⁸

49. Russell to Hobson, 28 January 1841, BPP, vol 3, pp 173–174; doc U12, pp 31–32

50. Russell to Hobson, 28 January 1841, BPP, vol 3, p 174

51. Shortland to Clarke, 26 July 1842 (quoted in doc U12, p 32)

52. Stanley to Hobson, 15 September 1842, GBPP, [323], pp 216, 218; doc W2, pp 10–14

53. Royal instructions, enclosed in Secretary of State to Governor Grey, 23 December 1846, BPP, vol 5, [763], pp 542–543

54. Secretary of State to Governor Grey, 23 December 1846, BPP, vol 5, [763], p 526

55. Governor Grey to Secretary of State, 30 August 1851, BPP, vol 8, 1852, [1475], pp 32–33

56. Bohan 1998, p 68; Gardner 1992, pp 58–61; doc J10, p 51–52

57. Colonial Secretary to Colonial Surgeon, Auckland, 10 June 1842 (quoted in doc U12, p 32)

58. Selwyn to FitzRoy, November 1845 (quoted in doc U12, p 32)

The bishop's hopes were soon to be fulfilled. November 1845 marked the arrival of a new Governor, George Grey, who was backed at last by British Government grants.⁵⁹ Alongside an active land purchase programme, Grey inaugurated a more active Maori welfare policy. In May 1846, justifying his decision to abolish the office of the protector of aborigines, Grey cited its record of inactivity, claiming that 'not a single hospital, school, or institution of any kind supported by the Government was in operation for the benefit of the natives'.⁶⁰

Grey claimed that he was assigning the savings from the closure of the Protectorate Department to spending on Maori welfare. His stated purpose was 'to expend such portion as the Colony can afford of the large sum that Establishment has hitherto cost annually, upon schools hospitals and other institutions for the natives'.⁶¹ This was part of a wide-ranging investment, through hospitality, gifts, economic aid and subsidised mission schools, in gaining the favour of chiefs whilst excluding them from governmental authority and raising the tempo of land purchasing.⁶²

The new Governor launched a public hospital building programme. In early 1847, he reported that hospitals were planned for Auckland, New Plymouth, Wanganui and Wellington and that three were then under construction. Later that year, the hospitals in Auckland and Wellington opened, with those in New Plymouth and Wanganui following in 1848 and 1851 respectively.⁶³

The initiative was in some respects in advance of prevailing policy in Britain itself. Public health services in the 1840s were rudimentary and supported as much by charity as by the State. While most large British towns had general hospitals, they were privately funded to provide for those who could not afford to pay for medical attendance in their homes. State hospital care was the last resort and was provided mainly to paupers, and in workhouses or poorhouses rather than hospitals.⁶⁴

Grey justified his State hospital scheme on the basis that Maori were to be its principal beneficiaries. In 1848, he highlighted to Earl Grey, the British Secretary of State, his attempts:

to introduce a tolerably efficient system of medical attendance into those portions of this colony which are most densely inhabited by natives, and to render the establishment of hospitals upon the European system one means of assisting in the civilization of the inhabitants of this country.⁶⁵

Winning Maori support for the colonisation project was one general objective that the public hospital service was to promote.⁶⁶ In 1849, Grey instanced the hospitals as one of the 'various measures' designed to 'bring the natives under the influence of the Government and to gain their

59. Gardner 1992, p 61; Bohan 1998, pp 67–68

60. Governor Grey to Secretary of State, 10 May 1846 (quoted in doc U12, p 33)

61. Colonial Secretary to Protector of Aborigines, 6 February 1846 (quoted in doc U12, p 33); also 5 February 1846 (quoted in Dow 1999, pp 15–16)

62. Ward 1995, pp 85–89

63. Governor Grey to Secretary of State, 4 February 1847, BPP, vol 5, 1847, pp 640–641; Dow 1999, p 27

64. Dow 1999, p 23

65. Governor Grey to Secretary of State, 5 April 1848, BPP, vol 6, 1849 [1120], p 20

66. Dow 1999, pp 26–27

confidence and attachment'.⁶⁷ His reports of positive Maori responses gained the endorsement of Earl Grey, who encouraged him to extend the scheme where practicable.⁶⁸

'Civilisation' of the indigenous people was Grey's second general objective. Benefits would result from 'the establishment of hospitals in which Europeans and natives were conjointly received'.⁶⁹ In 1852, towards the end of his term as Governor, Grey summarised the place of the hospitals in his grand strategy:

The maintenance of these hospitals is a matter of paramount importance to the native race; whilst, if the question is also viewed as a means for the diffusion of civilization, by showing the natives the value of and accustoming them to European houses, food, and comforts, and also as a means of gaining their attachment to the British Government and British race, I think it becomes still more evident that the proper and effectual maintenance of these hospitals is a matter of great importance.⁷⁰

Grey's vision of racial assimilation shaped his presentation of the hospital programme as benefiting Maori and Pakeha alike. Justifying his plans to Earl Grey in 1847, he declared 'I cannot but anticipate that the establishment of these mixed hospitals for Europeans and natives, under such careful superintendence, will produce very beneficial effects on the native race'.⁷¹ Two years later, he was emphasising equality of access and service: 'Hospitals have been established in the principal districts, to which both races have been equally admitted, and in which they have been tended with equal care.'⁷²

Providing a service to Maori was nevertheless a major purpose of the State hospital programme at its inception. Since paupers and the unhealthy were ostensibly screened out of the early immigrant flow to New Zealand, 'there was little incentive to erect hospitals in the colony' for settlers alone.⁷³ The hospitals were to admit 'indigent settlers' as well as Maori, but were not initially intended to serve the general settler population.

Despite Grey's assertion that the hospitals were well situated to serve large Maori populations, his four chosen locations were actually centres of Pakeha immigration rather than districts of denser Maori population. This may have suited Grey's promotion of racial amalgamation, although the policy of restricting settler access to indigents meant that Maori patients would have experienced contact only with the poorest section of the immigrant communities. His rhetoric on equality of access was, however, less convincing, since sick Maori often had to travel long distances to reach the hospitals.

Many were none the less willing to make the effort. Both Auckland and Wellington hospitals served wide catchment areas and patients with a diversity of hapu affiliations. Rangatira were

67. Governor Grey to Secretary of State, 9 July 1849 (quoted in doc U12, p 36)

68. Secretary of State to Governor Grey, 28 July 1848, BPP, vol 6, 1847–1848 [1002], p 180; doc U12, p 35

69. Governor Grey to Secretary of State, 5 April 1848, BPP, vol 6, 1849 [1120], p 20

70. Governor Grey to Secretary of State, 13 February 1852, BPP, vol 9 [1779], 1854, p 73

71. Governor Grey to Secretary of State, 4 February 1847, BPP, vol 5, 1847, pp 640–641

72. Governor Grey to Secretary of State, 9 July 1849 (quoted in doc U12, p 36)

73. Dow 1999, p 23

4.2.3.3

encouraged to use the hospitals as a confidence-building measure, and a good number did so.⁷⁴ In their first few years of operation, Maori made active use of the new public hospitals and, except in Auckland, comprised the majority of in-patients. At Wellington, nearly 90 per cent of in-patients treated in 1849 and 1850 were Maori, as were more than 90 per cent of outpatients at Wellington, New Plymouth, and Auckland during 1848 and 1849.⁷⁵

4.2.3.3 *Native medical officers*

Although the Government did provide limited medical supplies to missionaries, it was through directly appointed native medical officers (NMOs) that the colonial government delivered its frontline medical services to Maori. In the early 1840s, a native medical attendant or officer system began to take shape that was to persist unchanged in its core features for another century.⁷⁶

This system hinged upon the payment of direct subsidies from central funds to local officials or doctors in return for providing primary medical care to Maori. During the 1840s, the subsidies were drawn from the welfare fund. The Government appointed part-time NMOs, mainly from the ranks of the colonial surgeons located in the fledgeling settler towns, who visited nearby Maori villages to provide medical treatment.⁷⁷

In late 1846, Governor Grey began to establish a district administration run by a network of resident magistrates. The Government devolved administrative responsibility for expenditure on Maori health to the magistrates, who either called for tenders from local doctors or made their own local arrangements. It appears that in practice the Colonial Secretary continued to take many of the decisions. Military medics, colonial surgeons and even magistrates themselves served as NMOs as well as private doctors. Most officers had proper medical training, but not all.

In any case, the limited capacity of the fledgeling colonial State ensured that the geographical coverage was far from nationwide.⁷⁸ During the 1840s and early 1850s, Maori in Hawke's Bay – and, for that matter, the whole eastern North Island – remained beyond the reach of the NMO scheme.

4.2.4 Crown land purchasing and public health expectations

4.2.4.1 *Medical services as a land-selling incentive*

Governor Grey's hospitals and medical officers introduced a general programme of medical assistance to Maori. Despite the limited outreach of the State hospitals, they served as beacons of the future prosperity that would derive from Pakeha settlement. As Grey explained to the British Secretary of State in 1848, the prospect of future benefits, which included ploughing back into public works part of the Government's proceeds from land sales to settlers, provided an incentive to Maori to accept low prices for their land.⁷⁹

74. Dow 1999, pp 29–30

75. Dow 1999, pp 28–29

76. Originally known as Native Medical Attendants, see Dow 1999, p 227 fn 105

77. Dow 1999, pp 35–39; doc U12, pp 31–32

78. Dow 1999, pp 36–39

79. Document J10, pp 50–51; doc U12, pp 21–30

Grey pursued an aggressive policy of purchasing large areas of Maori land cheap and selling it dear in order to finance public infrastructure and immigration. Purchase agents were commonly instructed to talk up the vision of prosperity through settlement and did so when negotiating with Maori.⁸⁰

To varying degrees, hospitals and State health services formed part of the prospectus. In a few cases, specific health obligations were written directly into the early deeds of Crown land purchases before the three transactions in Hawke's Bay in late 1851. Most were endowments in New Zealand Company and Crown land purchases, such as the Wellington 'tenths' and the Wairarapa '5 per cents'. The endowments took the form either of reserves or of a share of the Crown's resale revenues.

The proceeds could in principle be applied to a whole range of beneficial purposes, including health services. In the case of nine large purchases in the Wairarapa during 1853 and 1854, however, the purposes of the 5 per cent returns from resales were written into the deeds; amongst others, they were 'for the construction of Hospitals and for Medical attendance for us'.⁸¹ The deed for lands sold in Auckland by Ngati Whatua in the 1850s contained a similar 10 per cent clause that included 'the construction of hospitals in which persons of our own race may be tended, for payment of medical attendance for us'.⁸² But most deeds were silent as to medical or any other social service as a consideration.

Indications of future State provision none the less featured in a number of land purchase negotiations, sometimes prominently. Walter Mantell, who completed the 20-million acre Kemp purchase in the South Island in 1848, later commented to a fellow land purchase officer on the negotiations with Ngai Tahu:

in making purchases from the natives I ever represented to them that though the money payment might be small, their chief recompense would lie in the kindness of the Govt towards them, the erection & maintenance of schools & hospitals for their benefit & so on – you know it all.⁸³

Raising the matter with the British Colonial Office in 1856, Mantell asserted that Ngai Tahu had been persuaded to accept a low price 'by promise of more valuable recompense in schools, in hospitals for their sick and general protection on the part of the Imperial Government'.⁸⁴

Mantell considered his undertakings to the Maori sellers, which included hospitals and medical attendance, to be properly authorised, specific and contractually binding upon the Crown:

Had I myself been justified in entertaining any fear that the Government would fail in fulfilling promises (verbally given on authority, only verbal for reasons which I considered valid), I should not have hesitated to insert them in the text of those Deeds of Cession which I drew.

80. Document U12, pp 21–23, 35; Ward 1995, pp 86–89; Ward 1999, p 116

81. Waitangi Tribunal 1997, vol 3, p 184

82. 'Maori translation' quoted in *The Report on the Orakei Claim*, p 29

83. Mantell to Symonds, 21 August 1855 (quoted in *The Ngai Tahu Report 1991*, p 951)

84. Mantell to Secretary of State, 5 July 1856 (quoted in Wai 27 ROI, doc T1, p 340)

His working assumption in the late 1840s was that Grey ‘seldom, to the best my recollection, refused any reasonable request on behalf of these Natives’.⁸⁵

Mantell had sought and obtained additional instructions in August 1848 in order to strengthen the inducements he could offer:

Lieutenant-Governor Eyre . . . impressed upon me the propriety of placing before the Natives the prospect of the great future advantages which the cession of their lands would bring them in schools, hospitals, and the paternal care of Her Majesty’s Government . . .⁸⁶

He explained that this instruction was deliberately left unwritten so as, amongst other reasons, not to compromise the goal of eventual assimilation by promising separate institutions for Maori.⁸⁷

Ironically, it was Mantell whom in mid-1849 Lieutenant-Governor Eyre originally intended to send to Hawke’s Bay to initiate the land purchase negotiations. At the last minute, he was diverted back to the South Island, and eventually Donald McLean was appointed instead.⁸⁸ McLean was later to adopt a narrower interpretation of the unwritten promises to Ngai Tahu. Commenting as Native Secretary on Mantell’s assertions, he denied any unfulfilled Government obligation towards Ngai Tahu.⁸⁹

But Grey’s successor, Governor Gore Browne, strongly endorsed Mantell’s interpretation of Crown policy:

I am satisfied from the date of the Treaty of Waitangi, promises of schools, hospitals, roads, constant solicitude for their welfare and general protection on the part of the Imperial government have been held out to the Natives to induce them to part with their land.⁹⁰

Mantell gave similar evidence in 1879 to the Smith–Nairn commission, which, in comparing the Murihiku with other South Island land purchases, concluded that ‘similar promises with respect to schools, hospitals, and other advantages were made to the sellers for the purpose of inducing them to part with their land’.⁹¹ Asked about Mantell’s account of his promises and authority, George Grey told the Commission:

I have no doubt, because those were the instructions I always gave. They were the instructions I gave in the old Hawke’s Bay purchase[s], and I explained that the payment made to them in money was really not the true payment at all.⁹²

Grey insisted that he had personally authorised Mantell to make these promises, and expected to fund them out of Government reserves earmarked for the purpose and out of the land fund.⁹³

85. Mantell to under-secretary, 31 July 1856 (quoted in *The Ngai Tahu Report 1991*, p 952)

86. Mantell to under-secretary, 31 July 1856 (quoted in *The Ngai Tahu Report 1991*, p 952)

87. Mantell to under-secretary, 31 July 1856 (quoted in *The Ngai Tahu Report 1991*, p 952); Wai 27 RO1, doc T1, p 341

88. Document J10, pp 93–94

89. McLean to Governor, 26 January 1857 (quoted in *The Ngai Tahu Report 1991*, p 953)

90. Governor Gore Brown to Secretary of State, 9 February 1857 (quoted in *The Ngai Tahu Report 1991*, p 953)

91. AJHR, 1881, G-6, pp 4, 6

92. Evidence of Sir George Grey, 6 December 1879, doc 02, app 2, pp 648–649

93. Evidence of Sir George Grey, 6 December 1879, doc 02, app 2, pp 649–650

Although testifying 30 years later, his account was consistent with the views he was expressing at the time of the purchases in the late 1840s and affirmed that the South Island inducements, including hospitals, flowed from a general policy that specifically included Hawke's Bay.

4.2.4.2 *Organised immigration and the Wairarapa land negotiations*

The initiatives that were to lead to the Ahuriri transaction in 1851 originated a decade earlier and came from both Maori and the Crown. In 1840, Major Thomas Bunbury visited Hawke's Bay aboard the *Herald* to secure the adherence of the Ngati Whatuiapiti chief Te Hapuku to the Treaty of Waitangi. Otherwise, the region received little attention in the nationwide gathering of signatures to the Treaty.⁹⁴ Few Ngati Kahungunu chiefs in Hawke's Bay were thus afforded a direct explanation of the Treaty or the opportunity to sign it.

Throughout the 1840s, there was no official presence in Hawke's Bay of any kind, and it appears unlikely that a single Crown representative visited the area before Donald McLean's arrival in December 1850. Local Maori were, however, well aware of developments in other parts of the country, including the organised immigration schemes launched in the early 1840s by the New Zealand Company at Wellington, Wanganui, New Plymouth and Nelson.⁹⁵ Te Hapuku, and probably other Hawke's Bay Maori, visited Wellington in the early 1840s.⁹⁶ By late 1844, rangatira in central Hawke's Bay, including Te Moananui and Tareha, were expressing interest in selling land in order to attract Pakeha settlement.⁹⁷

The large expanse east of the North Island's main divide had already attracted the interest of the promoters of systematic colonisation. In 1843, the New Zealand Company's directors discussed plans for a settlement associated with the Church of England, which the company's agent, William Wakefield, proposed to locate in the Wairarapa.⁹⁸ Interest soon extended northwards into Hawke's Bay.⁹⁹ During 1847–48, two rounds of purchase negotiations were undertaken with Maori in the Wairarapa. When in late 1848 the New Zealand Company's former acting secretary Francis Dillon Bell returned with Native Secretary H T Kemp, the company had set its sights on a much larger acquisition of a million acres for its proposed Canterbury settlement. Their purchase instructions defined a zone now 'extending Northward as far, as practicable as [sic] Hawke's Bay'.¹⁰⁰

Hawke's Bay rangatira were by now well aware that the rapidly developing Wairarapa leasehold system was both attracting Pakeha and yielding a good income.¹⁰¹ In November 1848, Kemp told two Hawke's Bay Maori bluntly that 'no more squatting would be allowed by the Government', and he suggested that, if they were anxious to have Europeans, 'proposals should be made in

94. Orange 1987, pp 81–82; Ward 1995, p 45; doc J10, pp 31–33; *Te Whanganui-a-Orotu Report 1995*, pp 31–32

95. Gardner 1992, p 60

96. Taylor 1966, p 230; Meurant diaries, 16 May 1843, doc w10, p 3149

97. Joseph Thomas and Henry Harrison, 'Journal of a Walk along the East Coast, from Wellington to Table Cape', entry for 28 October 1844, in *NZ Journal*, 20 December 1845, doc c3(a), p 11; Meurant diaries, 17 October 1844, doc w10, p 3150; doc c2, p 17

98. Document J10, pp 63–64

99. Document J10, p 65

100. Domett to Kemp, 12 October 1848 (transcript), doc A21(d), p 1055; doc J10, pp 73–77

101. Document J10, pp 67–68

writing by the principal chiefs of that district for the sale of the land'.¹⁰² At the same time, Lieutenant-Governor Eyre sought to enlist Colenso's advocacy of the advantages of the Canterbury settlement to the chiefs. Colenso refused, but he did convey the lieutenant-governor's message, together with his own qualified opposition, to a hui at Pakowhai on 22 December 1848.¹⁰³

The supposed benefits that Colenso conveyed to the hui, if true to the lieutenant-governor's letter, included 'ample reserves'; access to Anglican clergy; schools; settlers selected for their moral quality; a large community; and 'physical benefits and external advantages'.¹⁰⁴ Writing privately to Colenso on the same date, Eyre summarised his argument along now familiar lines:

The real payment however after all will be the advantages which civilization and the valuable institutions by which it is accompanied, will afford to them and to their Children, whilst the enhanced value of their Reserves by the occupation of the Country around them will at the same time give a greater money-value to their comparatively small possessions over what the whole territory now possesses.¹⁰⁵

There is no specific mention here of hospitals, doctors or medicines as benefits that would flow from selling land to the Crown. However, Grey's new hospitals, which had recently opened in Auckland and Wellington, were prominent examples of the 'valuable institutions' that were starting up in the settler towns. Furthermore, Colenso's vigorous amateur doctoring had by now firmly associated missionaries with European medicine in the eyes of Hawke's Bay Maori. Moreover, influenza and whooping cough epidemics had struck within the past year; and Colenso's assault on the credibility of *tohunga* was making some inroads, to the extent that Te Hapuku's own *tohunga*, Te Motu, had converted to Christianity two months earlier in October 1848.¹⁰⁶

In early 1849, what was to become the Canterbury settlement was diverted to the South Island.¹⁰⁷ But Hawke's Bay *rangatira* were already responding to the Government's insistence that they sell land in order to attract organised European settlement.¹⁰⁸ When, four months later, on 26 April 1849, Tareha and several leading Hawke's Bay chiefs invited Governor Grey to visit them to discuss a land deal, their letter, 'approved by all the people', was carefully couched in terms of the Crown's position as conveyed by Bell and Colenso. This focused on the Governor's insistence on purchasing, the selection of settlers of high character, and the location of the proposed Canterbury settlement:

according to what we have said or arranged the land at Ahuriri has become already the subject of negotiation with you for the purpose of sale. Friend hasten – and do not throw overboard this our Letter because this seems to be what pleases you viz the consenting on our part for the

102. Kemp journal, 24 November 1848, doc A22(b), s8; doc C2, p17

103. Colenso journal, 22 December 1848, doc A21(e), pp1123–1124; Colenso to Eyre, 23 December 1848, doc A21(e), pp1183–1184; doc C2, pp13–14; doc J10, pp77–81

104. Eyre to Colenso, 7 November 1848 (transcript), doc A21(d), pp1058–1059

105. Eyre to Colenso, 7 November 1848, doc A21(e), pp1173–1176

106. Goldsmith 1996, pp170, 177

107. Document J10, pp62–91

108. Bell to secretary, New Zealand Company, 21 December 1848, doc A21(d), p1092

selling of the land – Friend Gov Grey approve of this our request for White people for this our land and let them be Men of high principle or Gentlemen no people of the lower order – let them be good people – let them be the Colony of Missionaries who [we] have heard are coming out.¹⁰⁹

In June 1850, Te Hapuku and Hori Niania renewed the offer to sell land in Hawke's Bay for Pakeha settlement.¹¹⁰ By this time, the colonial government's strategic priority had shifted towards undermining the Wairarapa squatting system by providing alternative Crown land in Hawke's Bay for sheep-runs.¹¹¹ In December 1850, Crown land purchase agent Donald McLean arrived in Hawke's Bay.

4.2.5 The Ahuriri negotiations

4.2.5.1 A port town in Te Whanganui a Orotu

If land for sheep farmers was the top priority for Government officials, large settlements and towns, evoked by the earlier prospect of organised immigration, remained prominent in the perceptions of Maori leaders during McLean's year-long negotiations in Hawke's Bay, which resulted in the Crown purchase of the Waipukurau, Ahuriri, and Mohaka blocks in November and December 1851. Te Hapuku, while negotiating the sale of the Waipukurau block, told the Governor that he wanted 'respectable European gentlemen' to come 'direct from England' and form a 'large, large, large, very large town for me'.¹¹² During McLean's first stay at Te Hapuku's kainga, an old chief spoke of 'a town fully formed with streets . . . in the centre of the Heretaonga [sic] inland plains'.¹¹³

Tareha had a similar vision for Ahuriri. At the climax of the Ahuriri block negotiations on 2 May 1851, it was the prospect of 'future advantages' that McLean used to justify what Ahuriri rangatira considered to be a derisory offer price for the land.¹¹⁴ On the same day, Tareha, Te Moananui, and a number of other chiefs wrote to Governor Grey, urging him to deliver the non-monetary benefits they regarded as most important:

do not delay and hesitate to send some Pakeha for our properties as this was the basis of our agreement in accordance to our lands, and this is why we are writing to you. Give us a Pakeha for our village (settlement) so that the payments met will be great should it be given to a Pakeha in order that our unity as one may be dealt with. Our purpose is to have a town in our district in Ahuriri that you arrange this the Town and our village – be quick!¹¹⁵

109. Tareha and others to Governor, 26 April 1849 (transcript), doc A21(d), p 828

110. Document J10, pp 103–104

111. Document J10, pp 91–92, 102–103, 108, 168–169

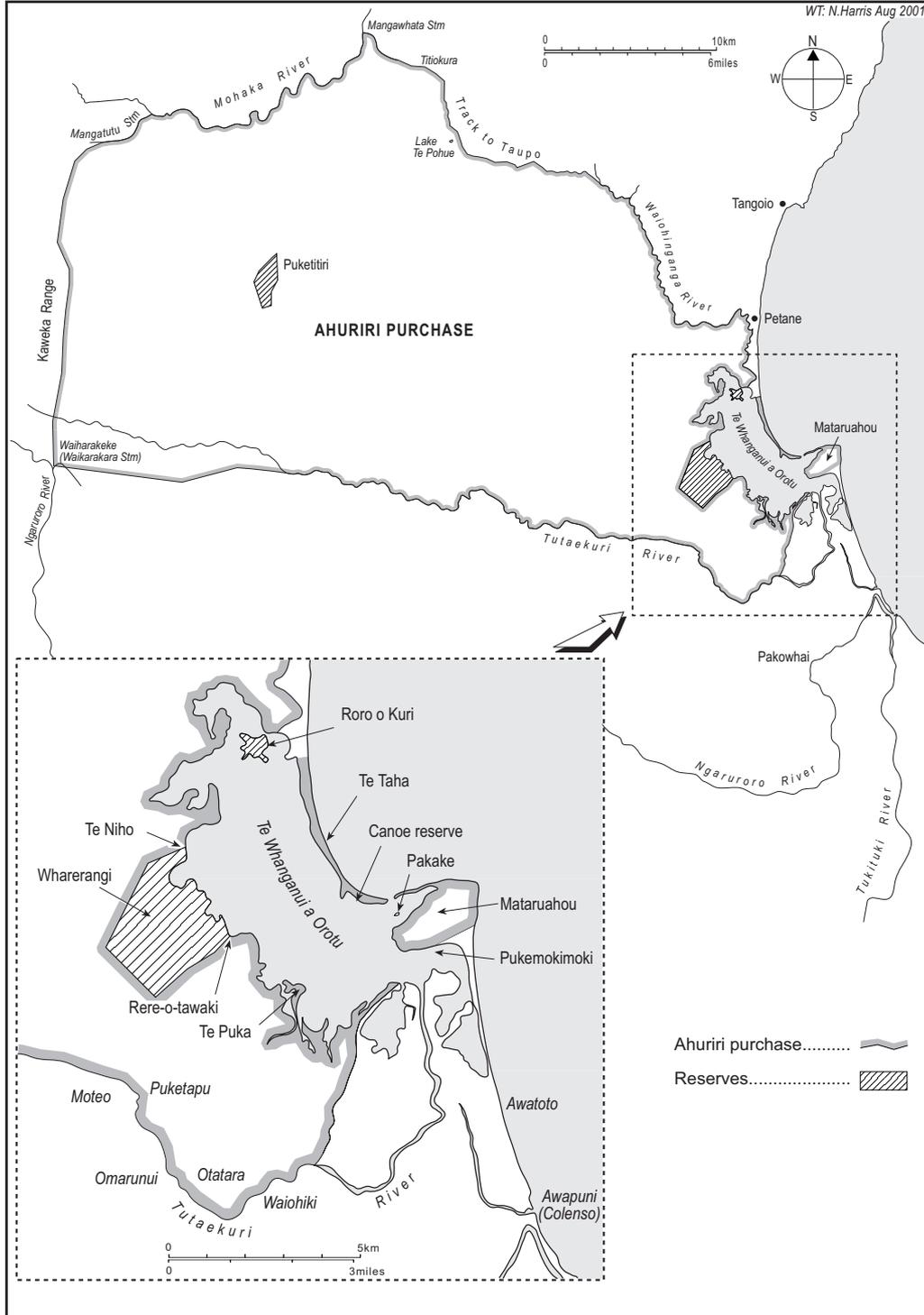
112. Te Hapuku to Governor Grey, 3 May 1851, AJHR, 1862, C-1, p 313. Te Hapuku was not himself one of the Ahuriri sellers.

113. McLean journal, 12 December 1850, ATL (quoted in doc J10, p 113)

114. McLean journal, 2 May 1851, doc A21(e), pp 1329–1330

115. Tareha and others to Governor, 2 May 1851 (translation), doc C3(a), p 109

4.2.5.1



Map 3: The 1851 Ahuriri Crown purchase

Alive to the need for a regional centre and a port, the Government officials were similarly alert to the potential for urban settlement. In December 1850, during his first visit, McLean thought that a town would be formed around the entrance to Te Whanganui a Orotu.¹¹⁶ By April 1851, he was aware of the intention of a newly arrived Pakeha, Joseph Thomas, to bring a party of British settlers to Ahuriri. Thomas claimed that he had Governor Grey's support, but the plan failed the following year.¹¹⁷

In June 1851, with the Ahuriri purchase agreed, surveyor Park reported that he could 'not imagine a finer site for a settlement than the district altogether would form', and he proposed laying out a town and suburban allotments near the harbour. Referring to the spit west of the harbour entrance, Park observed that 'on the North Spit there is room for a small town where the present European houses are'.¹¹⁸

McLean arranged for Park to be given the go-ahead in September 1851. His instructions for laying out the principal town were to include:

a recommendation as to which of the sections should be reserved for public purposes, and a particular specification in each case of the purposes themselves. These should be ample and should embrace every object of public utility and convenience.¹¹⁹

In November 1851, Park advised that the site for an inland town should await more thorough investigation:

In the meantime . . . , I propose laying off a Port town on the North spit of Ahuriri, which may extend to some 100 quarter acre lots, more or less and a few more on the south side of the harbour called Mataruahou or 'the Island' the whole of which should be reserved for a *future* town it would be premature at present to lay it all out for that purpose. [Emphasis in original.]¹²⁰

In mid-December, a month after the Ahuriri purchase, Park sent in a map of the proposed town. He noted that he had not numbered the sections, 'as there may be more reserves required than I have marked upon the plan'. The assignment of public reserves promised by McLean was, in other words, yet to be finalised. He also sent a map of Mataruahou 'shewing a design for a future town and the manner in which, at present, lots may be marked off and sold'.¹²¹

That McLean started the laying out of a port town before the deed was signed in November 1851 gave a sign of the Government's commitment to meet Maori expectations of a town within their rohe. A public hospital was one of the Government institutions that Maori could reasonably expect a town to bring.

116. Document U12, p 14

117. McLean journal, 7 April 1851, doc A21(e), p 1280; Mills 1999, pp 26–27

118. Park to McLean, 7 June 1851, AJHR, 1862, C-1, p 314; Park to McLean, 25 July 1851, doc A21(d), pp 1029–1031; doc J10, pp 141–144. The North Spit later became known as the Western Spit.

119. Colonial Secretary to Park, 22 September 1851, doc A21(d), p 1079 (transcript); doc U12, pp 16–17

120. Park to Colonial Secretary, 5 November 1851, doc A21(d), p 1036; doc J10, pp 141–145; doc U12, p 17

121. Park to Colonial Secretary, 15 December 1851, doc A21(d), pp 1042–1043; doc J10, p 145

4.2.5.1

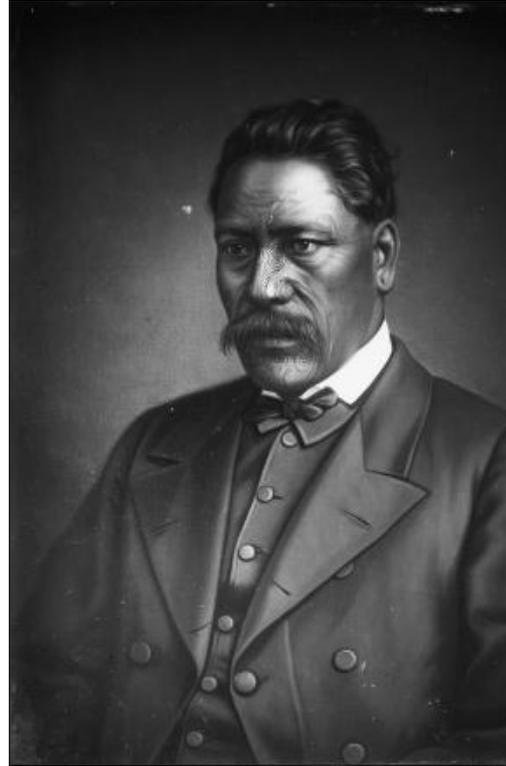


Figure 4 (above left): Donald McLean. Portrait photograph taken circa 1870. Photograph courtesy Alexander Turnbull Library (½-103970).

Figure 5 (above right): Tareha Te Moananui. Photograph of an oil painting by Gottfried Lindauer. Photograph courtesy Alexander Turnbull Library (½-019389).

Figure 6 (left): Karaitiana Takamoana. Portrait photograph taken in the 1870s. Photograph courtesy Alexander Turnbull Library (½-181854).

In September 1851, two months before the signing of the deed, that was in fact what the chief Karaitiana Takamoana, conveying what was clearly a collective plea, requested McLean to provide. Takamoana, an early convert trained as a teacher by Colenso and one of McLean's main negotiating partners, wrote with urgency:

Kia Ma, e ta, kia hohoro te kawe mai i nga moni ma matou kia wawe te nui mai nga Pakeha ki a Kawana, e ta, wakarite mai e koe i naianei he takuta mo matou. ka nui te mate o konei i roto i nga marama no reira matou ko nga pakeha i ki ai mehemea he ware turoro i konei e kore e mate etahi.

McLean, Sir, please send our money quickly. And more Pakeha to settle here soon. My friend, the Governor, please arrange that we get a doctor immediately. There has been a lot of sickness here in recent months. Therefore, we and the Pakeha believe that if we had a hospital there would be fewer deaths.¹²²

4.2.5.2 *The promise of a hospital*

McLean's firm view was that town planning was Pakeha business and had to be located on land in Crown title. In his official report, written six weeks after the signing of the Ahuriri deed, he conceded, that the Maori owners had a direct interest and reported that he had made a commitment to providing core social institutions in the new town:

I also informed the Chiefs that His Excellency had instructed public reservations to be made, which would most probably include a site for a church, hospital, market-ground, and landing place for their canoes, and that every facility would be afforded them of re-purchasing land from the Government.¹²³

Exactly when McLean made this statement is not clear. McLean's official report on the Ahuriri transaction comes across as a composite account of the final round of negotiations. These took place over the 10 days between McLean's arrival at Te Whanganui a Orotu on 7 November and the signing hui on 17 November. This final round involved meetings with particular chiefs, including one with Te Moananui and Tareha on 12 November; what appears to have been a lengthy public hui at the survey office on 14 November, at which he secured approval of the draft deed; and the signing hui on 17 November. The latter he described as a formal occasion at which he made 'a long opening speech to the natives', during which they 'crowded round and were silent and attentive all the time', before he read out the deed and starting the signing ceremony.¹²⁴

McLean recorded little in his diary of what he told Ahuriri Maori at the signing hui beyond noting that 'I do not recollect all I said'.¹²⁵ But whether or not he recited his hospital and other

122. Document U12, pp 17–18; Takamoana to McLean, 15 September 1851, doc M2, pp 33–34, doc C3(a), pp 64–65. An alternative translation (doc C3(a), p 117) differs little in substance. The phrase 'i naianei', omitted from the transcript of the original letter, has been translated as 'immediately'.

123. McLean to Colonial Secretary, 29 December 1851, AJHR, 1862, C-1, p 316

124. McLean journal, 17 November 1851, doc A21(e), pp 1359–1360; *Te Whanganui-a-Orotu Report 1995*, p 47

125. McLean journal, 17 November 1851, doc A21(e), pp 1359–1360

commitments in the course of his 'long speech', it is clear that they formed part of the final negotiation of the terms of the Ahuriri deed.

As well as acknowledging that the Maori owners had a legitimate stake in the planned port town, McLean undertook that a hospital would be provided. Although there is no reference to social institutions in the Ahuriri purchase deed, by invoking the Governor's formal authority ('His Excellency had instructed'), McLean was giving considerable weight to his assurances. By making specific reference to a hospital, he was acknowledging the plea for Government assistance and associating it with the benefits Maori could expect to flow from the Ahuriri transaction.

Making the case five years later in 1856 for the appointment of an NMO, this was how McLean himself appeared to interpret the Crown's obligation to Ahuriri Maori. He acknowledged that:

They have made frequent applications to the Government, and very justly urged as a reason for making the application that they had alienated large tracts of land to the Crown in the expectation of deriving various advantages which they have not yet realized. Amongst others they expected to have an hospital at Ahuriri, and it may be stated in favor of the application of these Natives for medical aid that they have alienated a million of acres to the Crown at a cost of less than three pence per acre, and that beyond the price paid for their lands, and the advantages they derive from the residence of Europeans among them, nothing to signify has as yet been done by the Government for their amelioration or improvement, if I may except a pension of Sixty pounds per annum promised to one of the principal chiefs.¹²⁶

Thus, Ahuriri Maori believed they had been promised a hospital as part of the land deal. We should not be too distracted here by semantic precision. McLean did not cite a contractual promise, but the 'expectation' of a hospital may reasonably be inferred to connect with his December 1851 commitment. The 'large tracts' and 'million of acres' may indicate that he was considering the wider Maori population of Hawke's Bay, but Ahuriri Maori were certainly amongst that population, and it was to them that he had given his 1851 commitment. And 'at Ahuriri' in all probability referred to the general vicinity of 'Port Ahuriri' at the entrance to Te Whanganui a Orotu lagoon.

McLean's case was that local Maori were beginning to derive economic benefits from Pakeha settlement but that the Government had not yet come to the party, and in particular had not yet delivered on its promise of a hospital. Moreover, Maori had actively followed up to get the promise realised.

McLean was less forthcoming in his evidence in 1875 to a Native Affairs Committee inquiry into Maori claims concerning Te Whanganui a Orotu. He told the committee that he had informed Ahuriri Maori that Park was to lay off a town on the North (ie Western) Spit, but of the hospital and church 'there was nothing else implied in the shape of a promise beyond this that these buildings were to be placed there'.

To a later question, he responded: 'The natives were merely told that such buildings were to be put up on this particular place, & that a Township was to be formed, but not for them'. This was,

¹²⁶ McLean to Governor's private secretary, 21 June 1856, doc U12(a), pp16-18

he said, in line with Maori wishes, since ‘they were anxious that a European Township should be formed’. He agreed with his questioner’s suggestion that ‘these “promises” were simply intimations to the Natives that, according to the usual custom of Europeans, there would be churches & hospitals built there’.¹²⁷

McLean seems to have been intent on assuring the committee that he had made no promises of a town or institutions exclusively for Ahuriri Maori except for the canoe reserve. In this, he was correct, since Grey’s hospitals were public and open to all races, even if initially Pakeha patients were often in the minority. His answers did, all the same, confirm an undertaking that a hospital (‘such buildings’) would be built as part of a new town to be located on the Western Spit. At the time of his undertaking in mid-November 1851, he did not specify a site, but placed it within the boundaries of the new town.

Evidence from the claimants, drawing on community memory transmitted down the succeeding generations, was that the hospital was part of their agreement with the Crown. Mr Hiha stated that the agreement was between the Crown and the Ahuriri hapu. Hine Pene explained that her tipuna ‘looked at it from the point of view that along with the purchase price they would benefit from the services promised’.¹²⁸ Both Hana Cotter and Merekingi Ratima emphasised that their tipuna intended the hospital to serve both Maori and Pakeha.¹²⁹

4.2.6 The siting of the hospital

4.2.6.1 *The alienation of Mataruahou and Te Taha*

In his official report on the signing of the Ahuriri deed, McLean did not indicate exactly where the promised hospital and other public reserves would be situated, since Park’s survey took a further month to complete. By the time that the Ahuriri deed was signed on 17 November 1851, the plan for a port settlement was well advanced. McLean had bargained hard to ensure that Mataruahou, which together with the harbour entrance he considered essential ‘to command the Harbour’,¹³⁰ was included in the land to be transferred to the Crown. For their part, the sellers had made it clear at the outset that they wished to retain Mataruahou and other water frontage ‘for the purposes of fishing and trading’.¹³¹

At the price-setting hui on 2 May 1851, McLean acknowledged that he had ‘repeatedly asked for two places at the entrance of the harbour which they did not now mention as included in the sale’, and implicitly linked their exclusion to his rejection of the price named by the Maori owners. Tareha responded, according to McLean, by conceding them to the Crown in order to achieve a better price:

127. Document A21(d), pp 908–909, 911–912

128. Patrick Parsons, summary of interview with Hine Pene, 27 July 1998 (in doc v8, p 16)

129. Patrick Parsons, summary of interview with Merekingi Ratima, 31 July 1998 (in doc v8, p 17); doc v15; transcript 4.26

130. McLean journal, 1 January 1851, doc A21(e), pp 1409–1410

131. McLean to Colonial Secretary, 23 January 1851, AJHR, 1862, c-1, p 309

Tariha then got up and said McLean I will stand here till you agree to give me what I ask for my land the places you ask for Moturuahou [Mataruahou] and te Taha I now agree to sell, as you request give us £4,000 – that is a small sum for our large land.¹³²

Whether inadvertently or not, McLean gave them to understand that he valued Mataruahou and Te Taha highly by the manner in which he stated his offer price for the Ahuriri block as a whole:

. . . I replied to Tariha by telling him that Mr Park had reported the block to me that they had gone round as very hilly broken & poor free of wood and available land which he would not value at more than £500 – that they had now certainly agreed to sell more favorable and valuable spots therefore to shorten our talk as I was anxious to be off in the morning I would name £1500 as a good and ample price for their land.¹³³

His Maori audience took him to mean that he was placing a value of £1000 on Tareha's offer of Mataruahou and Te Taha, as Park discovered in the months following:

The natives of the Ahuriri block have heard the terms upon which Hapuku is to have £4,800 and before that they had been speaking to me about the smallness of the sum for their land, having got into their head that the Island [Mataruahou] was valued at £1000 and the block at only £500 . . .¹³⁴

A purchase agreement signed by Tareha, Te Moananui, Puhara and some 20 others included Mataruahou ('to matou whenua i Mutu rua hou').¹³⁵ Tareha's concession notwithstanding, Mataruahou remained a bone of contention after the hui, for it was valued by the Maori sellers as well as the Crown officials.

A fortnight before the final signing on 17 November, a group of chiefs, including Tareha, sought advice from Colenso about retaining part of what they had been pressured to concede at the 2 May hui. On 7 November, Colenso informed McLean, who noted that the sellers 'seemed doubtful about selling the whole of Moturuahou [Mataruahou] Island that they wanted several reserves on the Island'.¹³⁶ Over 11 and 12 November, he discussed the block boundaries with Tareha and Te Moananui. His agenda included 'relinquishing their reserves or what they wish to be reserved for them on the Mataruahou Island'. He found them 'very reasonable' – in fact, 'much more so than during my former visit'.¹³⁷ He followed up the next day by going with Tareha and Park 'to fix the boundaries of Mataruahou'.¹³⁸

132. McLean journal, 2 May 1851, doc A21(e), pp 1327–1328

133. McLean journal, 2 May 1851, doc A21(e), pp 1328–1329; *Te Whanganui-a-Orotu Report 1995*, pp 42–43

134. Park to McLean, 25 July 1851, doc A21(d), p 1024. This was still Takamoana's view in 1875: evidence of Karaitiana Takamoana, 19 August 1875, Native Affairs Committee, doc A21(d), pp 895–897.

135. 'Agreement, Ahuriri', 1 May 1851, doc X57, pp 3354–3357. The agreement itself is not dated and, despite the cover note, was probably concluded on 2 May. McLean's signature does not appear, although Robert Park signed as witness.

136. Colenso journal, 3 November 1851, doc A21(e), p 1160; McLean journal, 7, 11 November 1851, doc A21(e), pp 1346, 1349–1350. Colenso recorded that he refused to advise them; McLean complained that he had in fact given them specific advice.

137. McLean journal, 12 November 1851, doc A21(e), p 1352

138. McLean journal, 13 November 1851, doc A21(e), p 1353; doc J10, pp 151–152



Map 4: The entrance to Te Whanganui a Orotu in 1837. A section from Captain T Wing's chart of 'Hau-Ridi' (Ahuriri) harbour. The island to the left of the lagoon entrance is labelled 'ko hau or myself', the pa to the right 'wati abite [Whatuiapiti] tribe', and Mataruahou 'great scarcity of wood and water about this harbour but plenty may be got some four miles up the Wai tute kuri'. Taken from Maling 1999, plate 44. Original: ms Alexander Turnbull Library.

In the end, nothing was reserved on Mataruahou itself, while only three small reserves were set aside in the deed close to Mataruahou: a small island, Pukemokimoki, to the south; 'a small piece of land' to the north, later taken to refer to Pakake Island, as a temporary urupa; and a town landing place for canoes, later demarcated as a half-acre site on the lagoon shore of the Western Spit (see maps 1 and 3).¹³⁹

McLean's report on the final negotiations reveals the extent to which he was able to override Maori objections to the inclusion of Mataruahou in the deed, which he ascribed mainly to the sellers' concern to retain access to their kaimoana in Te Whanganui a Orotu:

139. Document 110, pp 158-160; *Te Whanganui-a-Orotu Report* 1995, pp 46-49

4.2.6.2

Tareha and other chiefs at Ahuriri were anxious to have several portions of valuable land reserved for them on both sides of the Harbour, especially on the Mataruahau [sic] Island, which they had always considerable reluctance in transferring, from a fear that they might be eventually deprived of the right of fishing, collecting pipis, and other shell-fish which abound in the Bay . . .

With reference, however, to the reservations for fishing villages and other purposes, I objected to all of them excepting one pa, in the occupation of Tareha . . .¹⁴⁰

McLean's summary agrees substantially with the evidence given to the Native Affairs Committee in 1875 by the Te Ati Awa chief Wi Tako, who accompanied McLean to Hawke's Bay:

Te Moananui referred to the islands Te Koau, Pakake, and Poroporo and another island named I think Motuhara [Mataruahou]. He wanted this place reserved for him as a fishing reserve, and as a place where they could get pipis. I did not see anything written down about this request. I only heard the talk.¹⁴¹

McLean's resistance extended northwards to the Western Spit, or Te Taha, where he wanted a free hand to plan the port town. The only exclusion promised in the deed was the canoe landing place. But McLean reported to the Colonial Secretary that he had also given verbal undertakings that were not written into the deed. One was for a town section for Tareha, 'in lieu . . . of these reservations so much demanded by the Natives, and which would materially interfere with the laying off [of] a Town'.¹⁴² This was a personal concession to Tareha 'as the principal Chief' and did not extend to the other sellers.

4.2.6.2 *Mataruahou as a place of healing*

The claimants gave evidence that Mataruahou held significance for them as a place of healing. The tenor of the claimant evidence was that their tipuna took a broad and unifying view of the hospital. Both races, according to Merekingi Ratima (Ngati Kurumokihī), were to benefit:

My tipunas blessed that place. They gave it up for both races – pakeha and Maori for healing. That was the understanding . . . They talked it over and they reckoned it was good and they gifted it to them for a thing [hospital] for both races. That's how it was.¹⁴³

Hana Cotter saw the building of a hospital in an area traditionally associated with healing as symbolising a shared purpose:

Counsel: Furthermore, upon the arrival of the European and the subsequent establishment of the hospital there – it was in line with Maori thinking because it was already considered as being a hospital before . . .

140. McLean to Colonial Secretary, 29 December 1851, AJHR, 1862, C-1, p 316

141. Evidence of Wi Tako, 19 August 1875, Native Affairs Committee, doc A21(d), pp 899–906; *Te Whanganui-a-Orotu Report 1995*, pp 50–51

142. McLean to Colonial Secretary, 29 December 1851, AJHR, 1862, C-1, p 316

143. Patrick Parsons, summary of interview with Merekingi Ratima, 31 July 1998 (in doc 08, p 17)

Cotter: Yes.

Counsel: . . . the arrival of the European?

Cotter: Yes, that's correct. It was unifying, too. It unified them, the Maori and the European right to this time.¹⁴⁴

Little, if any, evidence survives in the written record of the values that Maori associated with Mataruahou at the time of the Ahuriri transaction. That it was important to local Maori is apparent from their strong and prolonged resistance to McLean's determination to include it in the Ahuriri purchase. Even in the final stage of the year-long negotiations, Tareha and other chiefs were agonising over Mataruahou and were still looking to retain reserves there. They sought the advice of Colenso and engaged McLean in further negotiation. Both McLean and Wi Tako testified to the 1875 inquiry that, at their meeting five days before the signing of the Ahuriri deed, Te Moananui and Tareha's chief reason for seeking reserves was to assure continued access to the kaimoana in Te Whanganui a Orotu. There is no record, at the time or later, of the views of Ahuriri Maori in their own words.

Several claimants indicated that community memory pointed to health associations with Mataruahou that remained significant for them. Interviewed by Patrick Parsons, Peggy Nelson described the origins of human settlement on Mataruahou in terms of the legend of Pania and the kaitiaki Moremore:

Karitoki, the husband of Pania, was the first to occupy Mataruahou . . . on a permanent basis. He used to live up at Hukarere. He didn't stay there all the time. He used to come up during the winter months for protection against invaders who came this way knowing how good a place it was. He lived where Hukarere school is with his people.¹⁴⁵

The central theme of the legend was the strengthening of the local people's right to harvest kaimoana. Ms Nelson summarised the outcome:

Pania left a decree that when the people went fishing they were to observe certain restrictions in and around the sea. Her authority went right out into the sea. They were allowed to catch fish but they were never allowed to eat them on the beach . . . They were to observe the tapu she had put on it. Her son Moremore acted as the kaitiaki of the waters around Ahuriri.¹⁴⁶

Woven into the legend are several key strands of community experience binding Mataruahou into the traditional history of the area: the importance of kaimoana in Te Whanganui a Orotu and coastal waters; the seasonal cycle of movement between coastal and inland food resources; and the vulnerability to outside attack.

Ms Nelson described Mataruahou as being divided into three zones: a sacred eastern part, a residential middle section, and a medicinal western end:

144. Transcript 4.26; also doc v15

145. Patrick Parsons, summary of interview with Peggy Nelson, 29 May 1998 (in doc v8, p 12)

146. Patrick Parsons, summary of interview with Peggy Nelson, 29 May 1998 (in doc v8, p 13)

Since ancient times the western portion of Mataruahou, where the Napier hospital is located, has been associated with healing. That hill was a special place. They all went there. They walked up there if they were not very well and stayed and made their own kautas out of raupo. They carried whatever they needed up there on their own backs. They had their own little huts made of raupo. They made their own flax mats to lie on. That's all they looked at, the sea.

The early Maori used to go up and stay on the hill at the west end of the island when they had sickness. To them it possessed healing qualities. They would come up there to get that breeze at certain times and they lived on the side where the hospital is.¹⁴⁷

According to Hine Pene, a granddaughter of Tareha, 'the part of the Napier hill where the hospital is located is associated with healing. That's the wairua part.'¹⁴⁸ Heitia Hiha also emphasised the importance of the outlook, the height, the sea and the wind:

Mataruahou and especially the northern aspect has its own mauri and wairua. This aspect overlooks the healing areas at the bottom at Ahuriri. What can be seen from the hill is also important for the healing process; the sea, the waves and nature are positive things that help to lift the spirit, the wairua of an ill person.¹⁴⁹

In his evidence, Mr Hiha described a seasonal and mobile pattern of resource use. People would occupy the lowland kainga around Te Whanganui a Orotu mainly during the summer to harvest the kaimoana. One such site was at the foot of the northern slope of Mataruahou and was overlooked by the present Napier Hospital. Just offshore was the former island pa Pakake, which was partly abandoned in the 1820s after a Waikato assault resulted in great loss of life, and which remained tapu to several local hapu as the burial site of many of the victims. The neighbouring small island Te Koau was used as a seasonal fishing kainga during the 1840s and 1850s (see maps 4 and 5 and figures 2 and 3).¹⁵⁰

Mr Reti testified that Mataruahou was a place of assembly for a number of local hapu. There may have been urupa on the hill, but knowledge of them had not survived. Both he and Mr Hiha considered that kainga, mahinga kai, and other human activity would have been concentrated on the lower slopes near the kaimoana harvesting grounds and the water highways. Mr Hiha thought that, while many paths crossed it, there were no pa sites on the hills of Mataruahou itself. In his opinion, it was the lower slopes on the northern side to which people resorted for healing and rongoa.¹⁵¹

Early Pakeha accounts of Mataruahou tend to confirm an absence of human occupation. In 1855, Domett described it as:

147. Patrick Parsons, summary of interview with Peggy Nelson, 29 May 1998 (in doc v8, pp 13–14)

148. Patrick Parsons, summary of interview with Hine Pene, 27 July 1998 (in doc v8, p 16)

149. Document v15

150. W B Rhodes in *New Zealand Gazette*, 24 April 1841, doc A21(c), p 600; NZGG (Province of Wellington), 20 November 1855, p 135; *Hawke's Bay Herald*, 10 April 1858, 16 October 1874; evidence of Meihana Takihi, 26 August 1889, and Taehoa Topera (sister of Tareha), 25 April 1892, Native Land Court, Napier minute book, vol 19, pp 126–127; vol 26, pp 193–194; Wilson 1939, p 167

151. Heitia Hiha and Fred Reti, oral testimony on behalf of the claimants, hearing, 8–9 June 1999



Figure 7: *A Alexander, Ahuriri*. Watercolour by Joseph Rhodes showing Onepoto at the western end of Mataruahou, with Hospital Hill in the foreground, in the early 1850s. Image courtesy Alexander Turnbull Library (A-159-031).

an oblong mass of hills; the whole mass being flattish topped, and of nearly uniform height, with precipitous or very steep sides . . . but rent or cracked, as it were, into several ravines, forked and branching as they recede from the sea or the lagoons which almost entirely surround the elevated mass.

He noted ‘the utter absence of fuel, except a few patches of brushwood in the ravines’ and ‘the possible difficulty of obtaining water’ (see figure 7).¹⁵²

Dr Hitchings, the first provincial surgeon, who lived on Mataruahou, found water less of a problem for the incoming settlers. In 1860, he remarked:

The ‘Island’ was a few years ago entirely covered with high fern, which is now giving place to European and native grasses. The soil is rich and fertile . . . The subsoil is a sandy clay resting on beds of sandstone, chalk and shell limestone. There are surface springs on different parts of the island but water may be procured anywhere by sinking to about the sea level.¹⁵³

A dispute between Tareha and a local trader, McKain, which was settled by McLean two days after the signing of the Ahuriri deed, reveals that sheep were already on Mataruahou.¹⁵⁴ During

152. NZGG (Province of Wellington), 20 November 1855, pp 133–134

153. Hitchings to Superintendent, 5 December 1860, doc U12(a), p 57

154. McLean diary, 19 November 1851, doc A21(e), p 1366

the following decade, Pakeha descriptions made no mention of Maori use or occupation, present or former, of the hill area of Mataruahou. It appears unlikely that Maori were living or cultivating there in 1851.

4.3 THE POSITIONS OF THE PARTIES

4.3.1 The case for the claimants

As a general ground for their historical grievances, the claimants say that the ‘terms and principles’ of the Treaty of Waitangi require the Crown to ‘provide for the health and well-being of Maori’. This includes consulting Maori on health matters, ensuring adequate and appropriate health resources under Maori control, and delivering equality of healthcare standards and health outcomes.¹⁵⁵

Claimant counsel, as we noted in chapter 2, asserted the general position that ‘better health for Maori was one of the outcomes the chiefs who signed the Treaty would reasonably have expected’. Conversely, he argued, the Crown’s duty of active protection required it to address any adverse health effects resulting from British settlement.¹⁵⁶

Counsel argued that, as an inducement to Maori to sell land and accept low prices, the colonial government had an established policy of talking up a range of consequential benefits that Maori could expect to result from Pakeha settlement and public investment. These benefits, described by counsel as ‘promises’, included hospitals and doctors.¹⁵⁷

Counsel contended further that, complementing its land purchase negotiating strategy, in 1841 the British Imperial Government instructed that a proportion of the proceeds be set aside as an endowment for the promotion of Maori welfare. From 1842, the colonial government included health promotion in its Maori welfare policy. In 1846 it established a hospital service directed mainly towards Maori. Ahuriri Maori therefore had good reason to take seriously any health-related promises associated with Crown purchasing of their land.¹⁵⁸

Counsel relied in his closing submission principally on the professional evidence presented to the Wai 692 hearing by historian Vincent O’Malley. In respect of the Ahuriri transaction, counsel argued three main contentions. First, during the 1840s, Maori in Hawke’s Bay, as elsewhere, suffered a pattern of severe ill health and depopulation caused mainly by exotic diseases. They were ‘receptive to western technology to alleviate the effects of the newly introduced diseases’.¹⁵⁹

Secondly, in line with current policy, colonial officials extolled to Hawke’s Bay Maori the ongoing benefits of selling land to the Crown, both in late 1848 in connection with the Wairarapa negotiations and in 1850–51 in the course of Donald McLean’s negotiation of the Ahuriri purchase. Furthermore, ‘a hospital in the town at Ahuriri was clearly among the collateral benefits

155. Claim 1.57(c), para 5

156. Document x31, paras 3.2–3.7

157. *Ibid*, paras 4.6–4.11

158. *Ibid*, paras 4.12–4.19

159. *Ibid*, paras 4.1–4.5

promised to Maori as a result of entering the Ahuriri transaction'. This promise was valid irrespective of any broader interpretation of the Ahuriri transaction as an agreement.¹⁶⁰

Thirdly, claimant counsel stated that 'Mataruahou is an ancient place of healing which was and remains an appropriate place for a hospital'. The location had specific spiritual significance for Ahuriri Maori and fitted the general cultural association of health with hilltop sites. The Tribunal was requested to find that Mataruahou 'is of importance to Maori Health'.¹⁶¹

4.3.2 The response of the Crown

The Crown presented no evidence of its own to the Tribunal on the historical grievances alleged by the claimants. In his closing submission, Crown counsel did not address the general issues of Maori health status, Maori attitudes towards Western medicine, or colonial policy and programmes for protecting Maori health.

Explaining the absence of Crown evidence on the Ahuriri transaction itself, Crown counsel stated that 'the Crown did not call any additional evidence of an historical nature not because it misunderstood the claim but because its researcher could find no evidence which would assist the Tribunal on the issue'. Counsel therefore based his presentation of the Crown's stance on the evidence presented by the claimants and on his interpretation of the claim.

That interpretation defines the scope of the claim as 'having a narrow ambit with specific issues'.¹⁶² Counsel stated that 'it was, and is the view of the Crown that the alleged promise to provide health services to Ahuriri Maori from the hill site is the foundation of the claim in Treaty terms'. Later, he said that 'the Crown could find no additional evidence relating to the alleged collateral promise of a hospital on the hill site at the time of the Ahuriri purchase'. And, referring to the evidence of claimant witnesses, he concluded that 'there is no support for the proposition that their ancestors had understood that part of the consideration for the Ahuriri transaction would be the provision of a hospital on the hill in perpetuity'.¹⁶³

The Crown's submission thus addressed only one of the main contentions made by claimant counsel and construed the point at issue in different terms. On that issue, counsel stated: 'The Crown does challenge the historical basis of the claim. It is not made out'.¹⁶⁴ In support, he directed attention to the submission of his co-counsel on the Wai 400 claim,¹⁶⁵ who made a number of criticisms of Mr O'Malley's use of the evidence for the promise of a hospital.

In that submission, Crown co-counsel advanced a general case on the meaning of collateral benefits as inducements to sell land to the Crown. Such benefits held out to Maori were non-binding predictions of future prosperity and not undertakings. He argued that 'it is rather a case of officials such as McLean painting the world which land sales could bring', a world of land

160. Ibid, paras 5.1–5.9

161. Ibid, paras 5.9–5.14; claim 1.57, para (d)

162. Document x48, para 2

163. Ibid, paras 7, 19.8, 21

164. Ibid, para 21

165. Ibid, paras 19, 19.2

alienation and Pakeha settlement with which Ngati Kahungunu chiefs were already familiar by 1851. He portrayed the Crown as a passive follower of private initiative:

The Crown could not command Europeans to go to any particular place, nor direct the investment of private capital. At most, it could go some way to create the environment for development to happen . . .¹⁶⁶

He argued that descriptions of future benefits were no more than indications, conditional upon the success of Pakeha settlement and the right of the Government to determine its spending priorities. In his view, McLean's indications during the negotiation of the Ahuriri purchase, including that of a future hospital, fitted this pattern well.¹⁶⁷

4.3.3 The claimants' reply

In reply, counsel for the claimants criticised what he saw as the Crown's failure to address either the Treaty interpretation questions raised by the claimants concerning the Crown's obligations in respect of Maori health or the breaches alleged in respect of the Treaty and the Ahuriri transaction. He asserted, not entirely accurately, that Crown co-counsel 'did not himself address the comprehensive evidence of Mr O'Malley on the types of promises made in respect of the Ahuriri transaction let alone the long history of promises for the provision of health services'.¹⁶⁸

On the one historical issue that Crown counsel did address, the promise of a hospital on Mata-ruahou, claimant counsel considered that none of the factors listed in the Crown's closing submission 'undermine the clear evidence of promise and expectation which was part of the wider Ahuriri transaction'.¹⁶⁹

4.4 FINDINGS, TREATY BREACHES, AND PREJUDICE

4.4.1 The scope of our findings

The evidence that we have reviewed in this chapter addresses two core strands in the claimants' case. One is the Crown's performance of its Treaty obligation to protect the health of Maori in Hawke's Bay. This we consider briefly here, and in greater depth in chapter 5.

The other is the alleged promise of a hospital as part of the Ahuriri transaction in 1851. Our consideration of this issue relates not to possible breaches of Treaty principles in the negotiation and terms of the Crown purchase of the Ahuriri block but to the status and implications of the hospital promise. They form an essential backdrop to chapter 5, in which we consider whether Treaty breaches and consequential prejudice arose.

166. Document x54, pp 49–50

167. Ibid, paras 111–123

168. Document v8, paras 3.2–3.5

169. Ibid, paras 3.1–3.6

4.4.2 Crown protection of Maori health in the 1840s

Extract from the statement of claim:

4. Pursuant to the terms and principles of the Treaty of Waitangi, from 1840 the Crown was and remains under an obligation to provide for the health and well-being of Maori . . .

4.4.2.1 *Did colonial policy and practice aim to protect Maori health?*

Claimant counsel argued that, from the outset, the colonial government developed a welfare policy for Maori that included within its scope the protection of Maori health. Our *findings* are:

- ▶ that, during the first decade of colonial rule, the British authorities, both in London and on the ground in New Zealand, acknowledged an obligation to protect Maori health, even if they were at times fatalistic about the chances of averting the ultimate disappearance of the Maori population;
- ▶ that they recognised that meeting this obligation in the pioneer phase required additional measures beyond equal provision for Maori alongside other British subjects;
- ▶ that their dominant model was systematic colonisation – communities of British settlers building economic prosperity and a European civilisation, and regional towns providing economic hubs and centres of public service delivery, including doctors and hospitals;
- ▶ that the policy set up by Governor Grey in 1846 aimed to provide targeted assistance for Maori at two levels: free access to Government hospitals and a free field doctor service through subsidised NMOS;
- ▶ that, disregarding any wider political purposes, these medical programmes were enlightened initiatives that served to address the Crown's Treaty obligation to protect Maori from the adverse effects of settlement; and
- ▶ that the positive initial response from Maori testifies to widespread interest in such assistance.

4.4.2.2 *Were adequate steps taken to protect Maori health in Hawke's Bay?*

The initial outreach of Governor Grey's hospital and doctor programmes was limited. Maori in Hawke's Bay received no practical benefits before 1851 except for the medicines occasionally supplied to William Colenso. Wellington Hospital was too distant to reach, and no NMO was stationed in Hawke's Bay.

Our *findings* are, however:

- ▶ that the early colonial state had little capacity to deliver medical services outside the centres of Pakeha settlement;
- ▶ that both the colonial government and Maori rangatira attempted to initiate the organised immigration into the Wairarapa and Hawke's Bay that both understood to be the foundation for service institutions such as hospitals; and
- ▶ that it was not unreasonable for such initiatives to take more than a decade to come to fruition.

4.4.3 The Ahuriri transaction and the promise of a hospital

Extract from the statement of claim:

5. the Crown was under a further obligation . . . in accordance with the terms of the Ahuriri Block transaction . . ., namely to provide health and hospital services to the Maori of Ahuriri.

4.4.3.1 Did collateral health service benefits feature in land purchase negotiations?

The claimants' assertion that a hospital was verbally promised to Ahuriri Maori in 1851 raises the question to what extent medical benefits were part of a policy or practice of offering inducements to Maori to sell land to the Crown. We are concerned here not with general expectations of developmental gain but with explicit commitments that might cover medical services.

The Ahuriri purchase deed was not amongst the few early purchase deeds to have contained such commitments. According to Mr O'Malley, however, in some instances when talking up the vision of prosperity through settlement, Crown land purchase agents held out the prospect of collateral benefits, including health services. Walter Mantell considered that his verbal undertakings to South Island Maori, which included hospitals, were specific enough to have been written into the purchase deeds. He was not alone in believing that they exemplified a general policy.

Although the available evidence is not comprehensive, we consider it sufficient to make the following *findings*:

- ▶ that the promotion of collateral benefits under Governor Grey's land purchase regime was a Crown policy;
- ▶ that hospitals and medical services commonly featured amongst the collateral benefits; and
- ▶ that, on occasion, and even when they were not written into the purchase deed, the verbal undertakings given by land purchase agents were sufficiently specific to be regarded as part of the consideration given by the Crown for the land.

We also note that the linkage between the reselling of Crown land purchased from Maori and State welfare provision for Maori was a formal component of official policy during the Crown colony period. We do not accept Crown co-counsel's portrayal of the colonial government as a passive follower of private settler initiative.¹⁷⁰ We reach four interlinked *findings*:

- ▶ that the expected benefits of Pakeha settlement promoted by land purchase officers clearly set up the State as the principal funder or provider of social benefits to Maori, in particular of hospitals;
- ▶ that promoting Maori health was part of a national Government welfare policy for Maori, in which Crown pre-emption ensured that the colonial State had the central role in recycling funds from the resale of Maori land into social services for Maori, as required by Lord Russell's 1841 instruction to plough back a minimum of 15 per cent for the benefit of all Maori;

170. Document x54, pp 49–50

- ▶ that the emerging model was for Government services, including public hospitals, to be delivered from regional towns in association with intensive Pakeha settlement; and
- ▶ that when Crown purchase agents advanced this model as an inducement to Maori to sell large blocks of land, the social institutions and services were commonly promoted as part of the promised package.

4.4.3.2 What health services were Ahuriri Maori seeking from the Crown?

Claimant counsel painted a picture of Ahuriri Maori actively seeking health services from the Crown as part of the wider benefits deriving from the Ahuriri transaction. The essential backdrop was the gathering crisis of survival confronting Maori throughout Hawke's Bay and the Wairarapa during the 1840s. Introduced diseases were no longer localised around coastal points of contact with visiting Pakeha but were sweeping through many Maori communities in increasingly frequent and deadly epidemics.

We have little concrete information on the welfare expectations of Ahuriri Maori at the time of the Ahuriri transaction. Our review leads us to the following *findings*:

- ▶ that many Ahuriri Maori were willing to try out Western medical and spiritual remedies, at least against the devastating power of 'mate Pakeha';
- ▶ that by December 1848, if not before, most Hawke's Bay chiefs knew the outlines of Governor Grey's programme of hospitals and doctors, launched over the previous two years;
- ▶ that the chiefs of Ahuriri and Heretaunga set their sights on the prospect of a Pakeha town within their rohe, with churches, schools, and hospitals amongst its key social institutions; and
- ▶ that Karaitiana Takamoana's letter of September 1851 urged the Government to do its part by providing a public hospital and a doctor, services that he and other chiefs were well aware the Government had in its power to deliver.

4.4.3.3 Was a hospital promised to Ahuriri Maori in 1851?

The evidence available to the Tribunal is less explicit than that pertaining to Walter Mantell's promises of hospitals and doctors to Ngai Tahu in the late 1840s. In particular:

- ▶ McLean's written instructions were less precise;¹⁷¹
- ▶ he did not apparently seek or receive specific authority to promise such collateral benefits; and
- ▶ his diary and correspondence lack any references to a discussion of Government health services with Ahuriri Maori during the three rounds of negotiation between December 1850 and November 1851.

On the other hand, too much significance should not be read into the lack of specific instructions. Governor Grey's 'flour and sugar' policy encouraged his officials to promote the benefits of assimilation and to reward land-selling chiefs.¹⁷² Grey himself later placed the Ahuriri

171. For instance, Colonial Secretary to McLean, 14 April 1851, AJHR, 1862, C-1, p 311; for background, see doc c2

172. Ward 1995, pp 86–87

4.4.3.4

purchase under this policy umbrella. McLean could thus proceed with reasonable confidence of the Governor's support for promises of specific benefits that eased the way to a ground-breaking land deal like the Ahuriri purchase. He did make at least one such verbal promise, that of a town section to Tareha, and it was subsequently honoured.

The Ahuriri purchase deed contains no reference to a hospital. The question as to whether a hospital was promised as part of the consideration for the land therefore turns on whether in concluding the Ahuriri transaction McLean made a verbal undertaking in a manner that could be construed as forming part of the transaction.

On balance, we consider that a reasonable interpretation of the available evidence leads to the following *findings*:

- ▶ that McLean did make a verbal promise to Ahuriri Maori of a Government hospital as one of the benefits of a town within their rohe;
- ▶ that the promise was not written into the deed;
- ▶ that the promise was nevertheless made at a critical point in the final negotiation of the Ahuriri purchase deed and functioned as one of the inducements held out to Ahuriri Maori to sell their land to the Crown;
- ▶ that the hospital promise formed part of the Ahuriri land transaction, and thus part of the consideration;
- ▶ that the promise was properly made in the name of the Governor;
- ▶ that the promise placed an obligation upon the Crown in terms of the Treaty of Waitangi; and
- ▶ that fulfilment of the promise was linked not to the progress of Pakeha settlement but to Ahuriri Maori expectations that Government services, including a hospital, would follow their sale of land to the Crown.

4.4.3.4 *What were the terms of the hospital promise?*

The claimants' perspective, drawing on community memory transmitted down the succeeding generations, tends to support a broad interpretation of the historical evidence. Our *findings* are:

- ▶ that the agreement of which the promise formed a part was between the Crown and the hapu of the Maori sellers of the Ahuriri land;
- ▶ that the promise of a hospital envisaged not a facility or ward exclusively for the benefit either of Ahuriri Maori or of Maori generally but rather a facility that would be open to all – that is, to other Maori and Pakeha as well;
- ▶ that the promise gave an assurance to Ahuriri Maori that they would be provided with a hospital service, which at that time took the form of Governor Grey's programme of free treatment for Maori in Government hospitals;
- ▶ that the hospital would be located in the new port town within their rohe and would be built at a reasonably early date; and
- ▶ that, within the framework of the healthcare policy of the Government of the day, the promise was enduring.

4.4.4 Was there an undertaking on the siting of a hospital?

Extract from the statement of claim:

5. the Crown was under a further obligation . . . in accordance with the terms of the Ahuriri Block transaction . . ., namely to provide health and hospital services to the Maori of Ahuriri.

12.7 The Crown by itself and through the Crown health entities has continued to fail to give effect to its obligations under the 1851 Ahuriri transaction including providing effective health services and facilities for Ahuriri Maori from the site at Mataruahou.

No information survives on precisely where the hospital was to be located. Park's plan of the proposed town of Ahuriri, which he started to survey at the time of the final negotiations and signing of the Ahuriri deed, has not been found. The only clue is Park's indication that he made, as instructed, 'reserves' amongst the sections he laid off on the Western Spit, which may have included the hospital reserve promised by McLean to Ahuriri Maori while his town survey was in progress.

For his part, McLean was adamant in 1875 that the public reserves were within the town plan laid off on the Western Spit.¹⁷³ Although there are references to Park's survey fieldbooks during the preparation of the first town plan of Napier in 1854, there is no information on which public reserves were carried over, if any. Any Maori opinion on the siting of a hospital reserve is also absent in the sparse written record of the Ahuriri negotiations.

None the less, it might still be argued that there was agreement that the hospital site, once selected, would remain fixed. There is, however, no supporting evidence for this, and the context was more flexible. What little information has survived suggests that the Maori interest was in gaining good access to medical services rather than the precise location of a hospital. Both parties are agreed that, in the words of claimant counsel, there was 'no record of a specific promise to build the hospital on Mataruahou'.¹⁷⁴

Accordingly our *findings* are:

- ▶ that the promise of a hospital was not site-specific; and
- ▶ that the promised hospital was to be located in the town that became Napier.

4.4.5 Did Mataruahou have cultural significance for Maori as a place of healing?

Extract from the statement of claim:

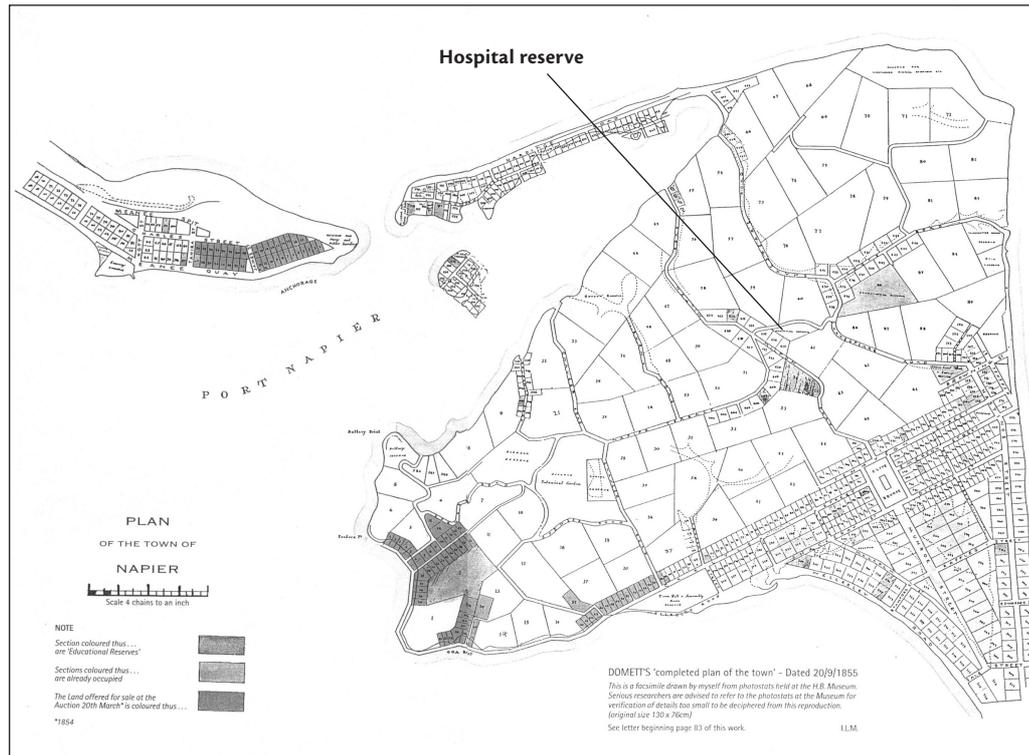
(d) Relief sought: A finding that Mataruahou (Napier Hill Hospital Site) is of importance to Maori health.

In gauging the cultural significance of Mataruahou for Ahuriri Maori, it is essential to consider people's perspectives in the context of their times. Much of the claimant evidence on this issue

173. Evidence of Sir Donald McLean, 6 September 1875, doc A21(d), p 911

174. Document x31, para 5.14

4.4.5



Map 6: The first town plan of Napier, 1855. Taken from Mills 1999, map at end. Hospital reserve label added.

reflected the views of the present or the living memory of the recent past, and is therefore not relevant to reconstructing the situation in 1851.

What cultural values Mataruahou had for Ahuriri Maori at the time of the Ahuriri transaction is difficult to determine. The historical evidence available to the Tribunal is silent on this aspect. That the chiefs fought hard to retain Mataruahou and, later, to keep parts of it as reserves highlights its importance to them. But the only purpose indicated was to assure access to kaimoana. There was no mention of occupation sites, wahi tapu, healing places or sources of rongoa. Nor has any later evidence down to recent times been presented of traditional cultural associations with the hills of Mataruahou.

The evidence presented by the claimants relies on cultural traditions preserved by Ahuriri hapu, and in particular the legend of the kaitiaki Moremore. However, the legend as presented makes no reference to healing properties.

Since the pre-1840 island pa Pakake lay about 250 metres offshore from the northern slope of what is now Hospital Hill, it is reasonable to suppose that its inhabitants came ashore for healing when ill. Sending the sick and dying and women in childbirth to temporary whare outside the kainga was a common community practice. This area is below the site of the present hospital but is some distance from the original hospital on Sealy Road, near Shakespeare Road (see map 1). There is no surviving evidence of recently occupied village sites on Mataruahou at the time of the Ahuriri transaction in 1851. Its hills and gullies possessed few resources for healing purposes, lacking trees and vegetation to provide rongoa and streams and pools for healing rituals.

Our *findings* are:

- ▶ that sick people may have gone to Mataruahou for healing purposes, particularly its western slopes; but
- ▶ that it is unlikely all the same that Mataruahou held special significance for local Maori as a place of healing at the time of its purchase by the Crown.

4.5 OVERVIEW OF PREJUDICIAL EFFECTS

Since we have made no findings of Treaty breaches in this chapter, there are no prejudicial effects to review.

CHAPTER 5

THE STATE HEALTH SYSTEM AND AHURIRI MAORI, 1852–1980

5.1 CHAPTER OUTLINE

In this chapter, we review the effectiveness of the State healthcare system in fulfilling the Crown's healthcare obligations to Maori in Napier and central Hawke's Bay. We focus on two broad levels of medical service: secondary care, delivered mainly through hospitals, and primary care, delivered through an increasingly diverse array of frontline health professionals and organisations.

We begin by outlining the expectations of Ahuriri Maori concerning the health services to be provided by the State (section 5.2.1). We review briefly the general evolution of medical technology and the public health system (section 5.2.2) and Maori representation in hospital governance (section 5.2.3). We discuss the establishment and operation of Napier Hospital under provincial and hospital board auspices (section 5.2.4), how adequately its services provided for local Maori (section 5.2.5), and to what extent access barriers limited Maori use of the hospital (section 5.2.6).

In the field of primary health services, we evaluate the service provided by the NMO based in Napier from 1856 until its abrupt removal in 1867 (section 5.2.7). We review the effectiveness of primary healthcare services – such as district nursing that were set up in the early twentieth century (section 5.2.8). We also assess the extent of State support to Maori community initiatives and providers, notably the system established under the Maori Councils Act 1900 (section 5.2.8.4).

Finally, we briefly assess health outcomes (section 5.2.9). We trace the demographic decline and recovery of Maori in central Hawke's Bay from the 1840s to the early twentieth century, and review the limited information available on their health status. We conclude with a brief outline of the rapid urbanisation and social reform in the decades during and after the Second World War (section 5.2.10).

5.2 ANALYSIS OF THE EVIDENCE

5.2.1 Maori expectations of the Ahuriri transaction

Karaitiana Takamoana's appeal to McLean in September 1851 for a doctor and a hospital speaks a deep unease about the impact of disease on Maori communities in Hawke's Bay. This unease persuaded a number of chiefs to lend support to a self-help initiative launched by Colenso.

Believing that chiefs were profiting from the land sales while ignoring poorer members of their tribes, Colenso wanted the chiefs to channel part of their sale proceeds into providing for the sick. During the lead-up to the land-sale payments, he promoted his proposal:

for *each* principal Chief to lay by out of his share of the Land proceeds a small sum wherewith to purchase Tea, Sugar, Rice, Biscuit, Wine etc, for the Sick of his tribe & village, the same to be secured in a little separate room, or hut, and to be considered ‘*tapu*’ (ie set apart, so as to be used only for that purpose) as their seed sweet-potatoes formerly were. [Emphasis in original.]¹

By the time of the Ahuriri disbursement, Colenso had taken sole charge of the sick fund for reasons he does not explain. He soon secured £1 donations to this fund from five chiefs, including Karaitiana Takamoana, Noa Huke and Paora Torotoro, which he topped up with a £2 contribution of his own. That Noa Huke should donate his single sovereign while still in debt shows a strong commitment.

Nevertheless, this modest project failed within a year, all the chiefs demanding a refund of their contributions. The failure is likely to have reflected a withdrawal of support from Colenso personally, Takamoana having been amongst the chiefs who had in January 1850 challenged his ministry and his medical methods.² That several prominent chiefs were prepared to back an unpopular missionary’s initiative indicates their serious interest in securing the benefits of European medical methods for their disease-ravaged communities. That interest intensified after the devastating measles epidemic in 1854. About two years thereafter, Takamoana, Tareha and other rangatira associated with Te Moananui united to seek Pakeha assistance in establishing a multi-hapu town with European housing on the Ngaruroro River south of Napier, health improvement being one of their main motivations.³

Takamoana’s references in September 1851 to both a doctor and a hospital fit what was by then a well-established Maori awareness of both arms of Governor Grey’s health programme for Maori – the State hospitals in the main centres and the NMOS in the rural areas. There is little documented evidence of Ahuriri Maori following up Takamoana’s 1851 request for doctors and a hospital. However, in 1856 McLean acknowledged that ‘they have made frequent applications to the Government’.⁴

An opportunity to do so would have arisen when Governor Grey visited the Wairarapa and Hawke’s Bay in September 1853.⁵ Recalling that occasion a quarter of a century later in a speech as the recently elected Premier to about 500 Maori gathered at Waiohiki, including Tareha, Takamoana and other chiefs who signed the Ahuriri deed, Grey reminded them of the benefits he had then told them would result from selling land to the Crown for Pakeha settlement, which extended to ‘doctors to nurse you when you were sick’.⁶

1. Colenso journal, 5 October, 7 November, 1 December 1851; doc U21(a), pp 458–461; doc A21(e), pp 1161, 1166–1167; doc U12, pp 98–99

2. Colenso journal, 1 December 1851, 30 October 1852, annual report, 1 December 1851, doc A21(e), pp 1166–1167, 1190–1191; Goldsmith 1996, pp 174, 178; Cowie 1996, p 34

3. Anonymous article reprinted from Chambers’ *Edinburgh Journal*, September 1857, *Hawke’s Bay Herald*, 10 April 1858

4. McLean to Governor’s private secretary, 21 June 1856, document U12(a), pp 16–18

5. Bohan 1998, pp 137–138

6. *Te Wananga*, 29 December 1877, doc O2, p 511, app 3

McLean's summary of the position of Ahuriri Maori in 1856 was set in the context of nearly five years of Government inactivity since the Ahuriri transaction. They had sold a large area of land in return, they believed, for benefits additional to the purchase money. These included Government public investment, in particular a hospital.⁷

5.2.2 Two medical revolutions

Medicine and hospitals in the mid-nineteenth century were far removed from their modern forms. The theory and practice of Western medicine had changed little in centuries. Medical professionals had but a hazy knowledge of the causes of disease, few effective drugs, and crude surgical techniques. However self-confident their promoters might be as bearers of 'civilisation', hospitals could offer little more than first aid, basic nursing and a refuge for sick indigents unable to afford a doctor's services.

This was the medical technology that British settlement brought to New Zealand. It was, however, on the threshold of the first of the two major scientific and cultural revolutions in Western medicine of modern times. During the late nineteenth and early twentieth centuries, the germ theory of disease and the new science of bacteriology transformed Western medical methods. They generated discoveries of how particular diseases were transmitted and the environmental conditions in which they flourished.

But doctors still had few effective remedies to hand for curing many common diseases. Medical professionals concentrated on preventive methods and systematic nursing. Their influence and rising public expectations led to Government-sponsored campaigns focusing on public sanitation, vaccination and personal hygiene. In the early twentieth century, the first community health programmes got under way, especially in maternity and child health.

The role of hospitals was correspondingly transformed. From being refuges of last resort for the indigent, with crude surgical methods and high mortality rates, hospitals gradually improved their effectiveness as medical institutions. From the 1860s, antiseptic techniques began to enter hospital practice. Surgical procedures became safer and more effective in addressing a wide range of conditions. Despite lacking pharmaceutical firepower, hospitals also offered improved chances of recovery from serious illness. Treatment, however, relied heavily on nursing, and hospital stays were often lengthy, extending to months and even years.

The second revolution in Western medicine gathered pace during and after the Second World War. The driving force was advances in chemical and biological science that vastly expanded the range of diseases and conditions that could be effectively treated by drugs, especially antibiotics. It developed vaccines against a number of major diseases. It also combined with advances in surgical methods to extend the scope of intervention to the extent that by 1980, the end of the period reviewed in this chapter, radical reconstructive surgery and transplants of major organs were routine procedures. These technological changes swung the therapeutic emphasis from

7. McLean to Governor's private secretary, 21 June 1856, doc v12(a), pp 16–18

prevention and alleviation to intervention and cure, with medical professionals and institutions enormously empowered as agents of community wellbeing.

During the second half of the twentieth century, public hospitals strengthened their position as core community institutions, and increasingly provided for Maori as well. Many of the scourges of previous generations, such as tuberculosis and polio, could now be treated with drugs and prevented by immunisation. This medical technology also greatly increased the effectiveness of primary healthcare delivered by doctors, district nurses and other community professionals. Hospitals, their curative powers expanding, concentrated on acute cases and shorter in-patient stays. At the same time, medical specialisation proliferated and the cost of ever more sophisticated equipment and drugs rose steeply. Both factors generated a dynamic of centralisation into large general hospitals, for which, by the 1970s, the infrastructure of small- and medium-sized town hospitals was increasingly ill-suited.

5.2.3 The governance and financing of public hospitals

5.2.3.1 *The provincial takeover of the State hospitals (1850s)*

By the time that the first Napier Hospital opened its doors in 1860, the public hospital regime had changed radically from Governor Grey's hospital scheme a decade earlier. As the campaign for responsible government gathered momentum in the early 1850s, settler opposition to spending on Maori purposes made the continued funding of free hospital treatment for Maori uncertain. In 1850, Grey failed to secure agreement on civil list payments for 'native purposes'. Renewing the attempt, in 1851 he proposed an annual appropriation of £7000, which, as well as being used for schools, magistrates, police, payments to chiefs and broadly defined 'other purposes', would be applied to 'the construction and maintenance of hospitals, to which Maories are admitted on equal terms with other subjects of Her Majesty'.⁸

The Constitution Act 1852 ended the Governor's power to assign 15 per cent of the land fund to Maori purposes while entrenching the annual sum of £7000 for the civil list under the control of the Governor. The sum was assigned to 'Native purposes' but was otherwise left undefined.⁹ Grey's optimism that a settler-controlled General Assembly 'would freely and cheerfully contribute such amounts as were required for the wants of the native population' was not borne out, the efforts of his successor, Gore Browne, during the later 1850s meeting strong resistance.¹⁰

The 1850s witnessed a radical shift in the social and political priorities that had shaped early Crown policy on health services for Maori. The inauguration of representative government in 1854 devolved significant functions, including health, to a second tier of provincial government. It also placed all State expenditure, except the £7000 reserved for Maori purposes, under the control of central and provincial legislatures answerable to electorates in which Maori were vastly outnumbered. Out of 299 names on the Hawke's Bay electoral roll of 1858, just five were Maori,

8. Governor Grey to Secretary of State, 4 August 1851, BPP, vol 8, 1852, [1475], p 32; Dow 1999, p 16

9. Schedule to and section 64 of the Constitution Act 1852

10. Governor Grey to Secretary of State, 4 August 1851, BPP, vol 8, 1852, [1475], p 32; doc U12, p 38, citing Wai 27 ro1, doc T1, p 405; Ward 1995, p 93

including Te Moananui, Tareha and Takamoana, their single votes weighted not by their mana as leaders of their hapu but by their ownership of Crown-derived sections.¹¹

The State hospitals were not easy to fit into the new dispensation. In September 1854, Parliament voted to transfer the hospitals to provincial management with dual funding, their costs to be divided ‘between the General and Provincial Governments in proportion to the European and Native patients treated’. Hospital treatment for Maori would continue to be largely centrally financed, and supplemented in Wellington from tenths revenues. But the small Civil List appropriation served many competing priorities and had little chance of being topped up by an unsympathetic Legislature. Effectively, a hospital programme targeted mainly at Maori that also provided a safety net for indigent settlers had been converted into a settler-controlled public hospital service with limited subsidies for the treatment of Maori patients.

Provincial control of the hospitals and a changing demographic balance contributed towards a shift in focus during the 1850s from Maori to Pakeha needs. By the late 1850s, the immigrant population was approaching parity with Maori, and far outnumbered them in the hospital towns and their immediate hinterlands. Initially excluded from the State hospitals and lacking privately funded alternatives, Pakeha sought and gained access to the hospitals in growing numbers. In 1850, Pakeha in-patients at Auckland Hospital already outnumbered Maori by two to one. The Colonial Secretary might advise New Plymouth’s district surgeon to allow ‘any Europeans who may apply for admission provided that by so doing you are not likely to prevent the Hospital being as useful as possible to the Native race’. But in practice, district surgeons could not turn away the growing tide of paying Pakeha patients, who by the mid-1850s were common.¹²

Financial imperatives were also driving the change. Because very few Maori owned freehold land and paid rates, the new provincial authorities declined to take responsibility for Maori health. Government funding of free treatment for Maori was in practice by annual block grant. Hospitals soon ceased reporting the number of their Maori patients. Moreover, the hospital subsidy, if not the number of Maori admissions, was shrinking. The annual vote declined from £2070 for 1854–55 to £1400 in the following year, and to less than £1200 for 1858–59.¹³ Conversely, even if some defaulted, a growing inflow of paying Pakeha patients meant an increased hospital income.

5.2.3.2 Hospital boards

Provincial management of the State hospitals did not long outlast the close of the New Zealand wars. The abolition of the provinces in 1876 ushered in a decade of transition in which responsibility was shared between a Central Board of Health and local boards.¹⁴ In 1885, the Hospitals and Charitable Institutions Act established a national system of district hospital boards that was to last for the next century. Many of the boards also administered relief for the poor, a

11. Hawke’s Bay Provincial Centennial Council 1958, pp 49–51; Reed 1972, p 103

12. Dow 1999, pp 33, 35; doc U12, p 34

13. Ibid, pp 32, 35

14. Dow 1995, p 34; Tennant 1989, ch 1

rudimentary and discretionary precursor of the national benefit system introduced in April 1939 by the Act of 1938.¹⁵

The 1885 Act placed control of the hospital and charitable aid boards in the hands of the local bodies whose districts they served.¹⁶ The local bodies elected their board representatives roughly in proportion to their share of the population served, until in 1909 direct election was introduced. The Hawke's Bay Hospital Board covered the two main towns of central Hawke's Bay, Napier and Hastings, and the small towns and rural areas within the boundaries of the Hawke's Bay and Wairoa County Councils. By 1913, Wairoa had been separated off and the board had five representatives from Hawke's Bay County, including southern Napier and Taradale, three from Napier Borough and two from Hastings.¹⁷

Hospitals' operating expenditure was financed from a mixture of central and local, public and private funding.¹⁸ In practice, public funding predominated to the extent of around 70 per cent of total hospital income between 1886 and 1910. At just under 40 per cent, central government subsidies provided the largest share, but the participating local bodies were not far behind at 30 per cent. By contrast, voluntary contributions were under 10 per cent and patient payments only 12 or 13 per cent, notwithstanding the operative policy that patients were expected to pay for their treatment unless they could not afford to. The hospital system was thus from the outset largely State-run and State-funded.

The system gave local bodies minority financial responsibility but full executive control. Where several such bodies were combined in one board, parochial rivalry was common over cost-sharing, board representation, and where to locate the health facilities, especially the principal hospitals. Divisions between town and country interests tended to predominate. Most local funding came from the rates and the ratepayers' interest dominated the boards.

There was no provision for Maori representation in hospital governance. Voters registered on the county (Hawke's Bay) and borough (Napier and Hastings) electoral rolls elected local body councillors, who appointed delegates to the boards. After 1909, the hospital boards were directly elected. But the county franchise was restricted to ratepayers; few Maori qualified by occupying freehold property, and even fewer paid rates, which for much of the period resulted in their being struck off the electoral roll.¹⁹ Until the 1930s, in central Hawke's Bay nearly all Maori lived on rural land within Hawke's Bay County. They were thus not only a minority of the county population but an even smaller proportion of registered electors. Hospital boards were under no statutory obligation to seek advisory input from Maori, even after the creation in 1900 of Maori councils with a specific mandate in the field of community sanitary health.

Maori representation in the national oversight of hospital policy and the powers delegated to hospital boards was more clearly established, although ineffective until the Maori health reformers took the lead in the early twentieth century. Between 1854 and 1867, no Maori was

15. Dow 1999, p 60; Tennant 1989, chs 3, 5; Bassett and King 2000, p 150

16. Section 7 of the Hospitals and Charitable Institutions Act 1885,

17. AJHR, 1913, H-31, table XIII, p 141

18. Dow 1999, p 61

19. Section 41 of the Counties Act 1876; sections 40-45 of the Counties Act 1908

elected to the House of Representatives. From 1868, the four Maori seats elected from the Maori electoral roll provided representation for Hawke's Bay Maori through the constituency for Eastern Maori. Indeed, Tareha was the first member of Parliament to be elected for that seat. But at times statutory discrimination still restricted the Maori franchise. The 1879 electoral reform, for instance, which opened the franchise to the great majority of Pakeha men, at the same time restricted Maori voters to male ratepayers and sole owners of freehold worth at least £25.²⁰ For many Maori, representation in the institutions that governed the State health service nominally open to them was a remote concept.

5.2.4 Building the hospital on the hill

5.2.4.1 *The first Napier Hospital (1855–60)*

For nearly a decade after the Ahuriri deed was signed, the prospect of a hospital remained an abstract concept. Meanwhile, the influx of settlers gathered pace as the pastoral frontier reached Hawke's Bay and Te Whanganui a Orotu became the regional centre of trade and communications. According to Colenso, some 50 settlers were residing there by 1852.²¹ In 1854, Alfred Domett was appointed the first commissioner of Crown lands and resident magistrate at Ahuriri. He replaced Park's inadequate original plan with a new survey of what became the town of Napier, now centred to the south of Mataruahou (see map 6).²²

Although Domett had Park's field-books sent up from Wellington, the town plan was not finalised until late 1855. His report accompanying the plan gave the first mention of a hospital reserve situated on Mataruahou itself:

A small suburban section on the hills has been marked for an hospital, as the site is healthy and cheerful. But as some time may elapse before the settlement is advanced enough to make it convenient to place an hospital there, one of the unappropriated reserves on the flat, could be taken for that object.²³

Domett's correspondence during 1854 and 1855, when as commissioner of Crown lands he was supervising the surveying of the town of Napier and the first sale of sections, gives no hint that he consulted or considered consulting local Maori on the siting of public institutions, including the hospital. Domett's selection of a hill section on Mataruahou for the hospital reserve followed the European medical orthodoxy of the time that damp, low-lying environments were potentially unhealthy, although he was relaxed about placing it alternatively 'on the flat' for convenience. His chosen site was near the saddle of the hill close to the main track (Shakespeare Road) connecting Port Ahuriri with the new town centre on the south side of Mataruahou. This was some distance (about 800 metres) from the western end of the island, which, according to

20. Section 2 of the Qualification of Electors Act 1879

21. William Colenso, 'A Few Brief Historical Notes and Remarks', doc A21(c), p 620

22. Document v8, pp 7–8; Hill 1990, pp 43, 46

23. Commissioner of Crown lands, Napier, to Superintendent, 28 September 1855, NZGG (Province of Wellington), 1855, p 135



Figure 8: Napier and Mataruahou in 1862, taken from Hastings Street close to the shore. The first Napier Hospital was located over the top of the hill. Photograph courtesy Alexander Turnbull Library (PA1-q-193-062).

claimant evidence, was traditionally associated with healing. In other words, Pakeha considerations of health and utility prevailed.

The hospital reserve was proclaimed in November 1855 but the building of the hospital was to take another five years.²⁴ In the end, the first hospital in Napier arrived in a rush. Two separate initiatives coincided. The first arose indirectly from the armed conflict during 1857 and 1858 between Te Hapuku and the central Hawke's Bay chiefs led by Te Moananui. In 1858, settler anxiety led to the dispatch of Imperial troops to Napier, where they were barracked at Onepoto on Mataruahou. Late in the same year, Hawke's Bay separated from Wellington to become a province in its own right.²⁵

The first superintendent of Hawke's Bay, T H Fitzgerald, lost little time in seeking central government funding for a provincial hospital in Napier. But the military could not wait. Tenders were called to rent a house near Onepoto as a military hospital. In May 1859, the Provincial Council stepped in and rented a building on Emerson Street in the centre of town as a temporary 12-bed hospital for male military and civilian patients. Meanwhile, the council voted £350 for the construction of a purpose-built hospital, and a new 10-bed hospital was opened on the hospital reserve in Sealy Road at the top of Mataruahou in May 1860.²⁶

In his first annual report, the provincial surgeon, Dr Thomas Hitchings, gave a general description:

24. NZGG (Province of Wellington), 20 November 1855

25. Document v12, pp 48–49

26. Conly 1992, pp 6–7; doc v12, p 50

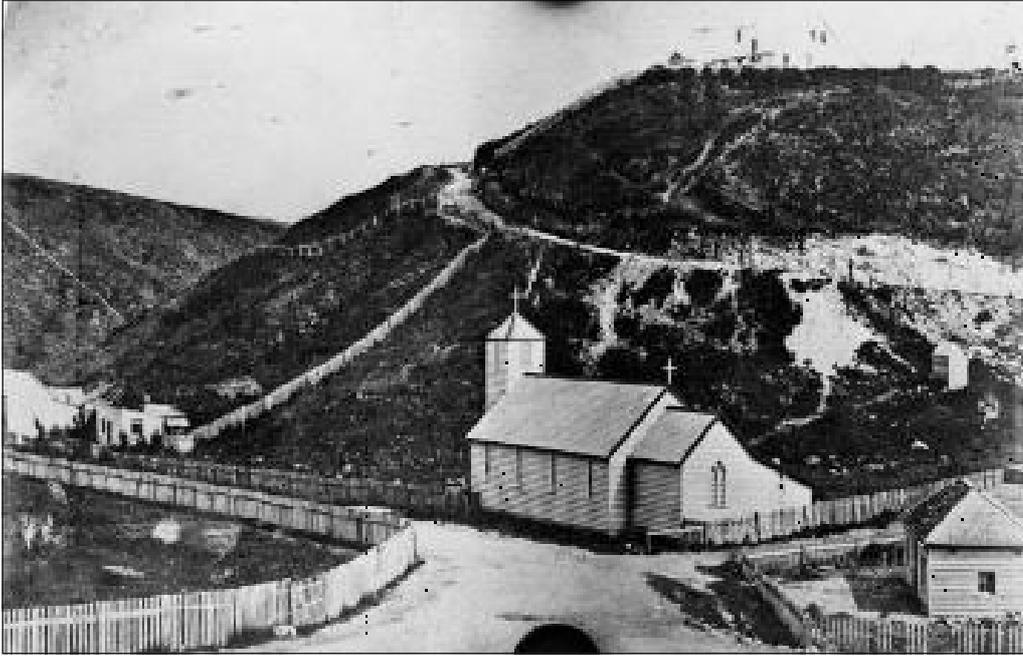


Figure 9: Mataruahou at the top of Shakespeare Road in the 1860s. The first Napier Hospital was situated to the right of the building in the bottom left corner. Photograph courtesy Alexander Turnbull Library (½-017074).

The hospital of Napier is situated on an elevated site in the Town about 200 feet above the sea level[;] it has a northerly aspect & commands extensive views both land & sea-ward. It consists of a plain building of one storey, weatherboarded 40 feet by 28 ft. There are two wards each 16 ft by 14 ft & 13 ft high with a trap door communicating with the roof which ensures free ventilation[;] one ward is allotted for male, the other for female patients, each contains five beds which gives nearly 600 cubic feet of air for each patient.²⁷

The planning and building of the hospital were a regional Pakeha affair. Although the superintendent cited provision for Maori patients when sounding out the prospects for central government funding, there is no sign that Maori were consulted on the siting of the hospital or were involved in any way in its planning and design. Nor do the health needs of Hawke's Bay Maori, recognised several years previously in Wellington as urgent, appear to have been taken into account.

5.2.4.2 The second Napier Hospital (1875–84)

Napier Hospital followed a development path typical of fast-expanding regional towns. The small hospital on the Sealy Road site survived for two decades. A shortage of patient accommodation, criticised by Hitchings in its year of opening, persisted as additions failed to keep pace with the expanding immigrant population. In 1875, a typhoid epidemic obliged the Provincial Council to use the now abandoned Imperial barracks to house overflow patients.

27. Hitchings to Superintendent, 5 December 1860, doc u12(a), p 61

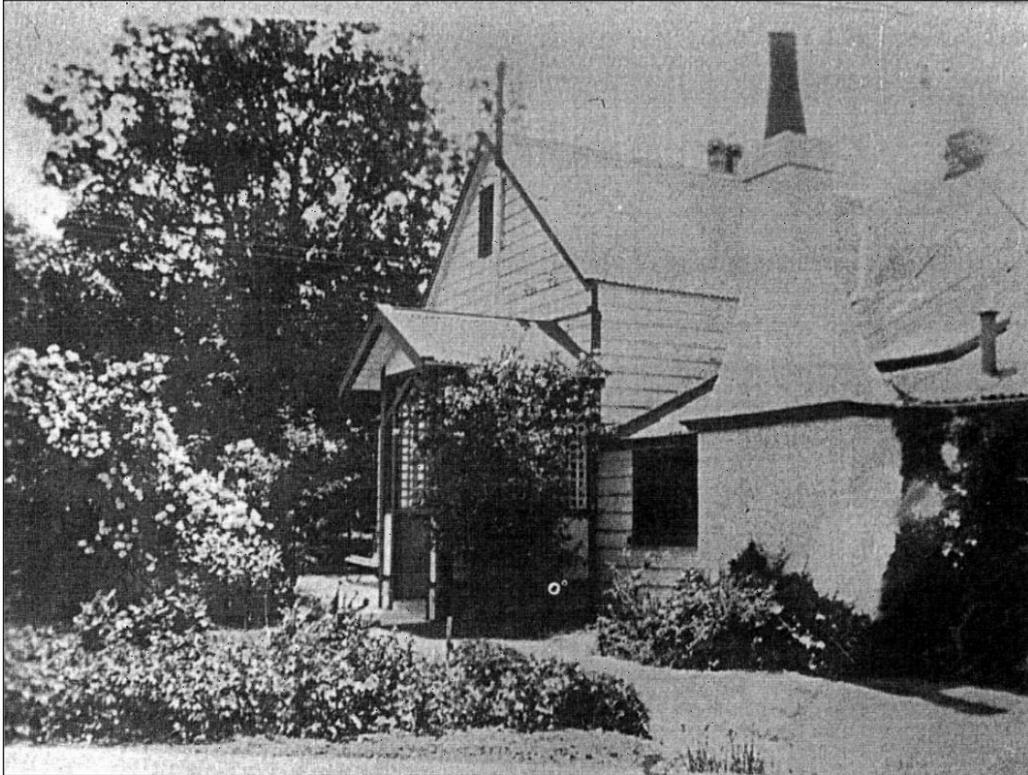


Figure 10: A twentieth-century view of the original Napier Hospital building in Sealy Road.
 Photograph, Hawke's Bay Hospital Board archive. Taken from Conly 1992, p 11.

Following the abolition of the provinces, in 1877 the Charitable Institutions Act opened the door to local initiatives by offering a 50 per cent subsidy for capital projects.²⁸ Early in 1877, a hospital committee, headed by the mayor of Napier, began a fund-raising campaign. It already had 3½ acres of land, made over by the Government from the barracks reserve. The new 35-bed hospital began taking patients in July 1880.²⁹ Like its predecessor, it soon proved too small to meet public needs. By 1883, the maximum number of beds had increased to 54.³⁰

The hospital committee's call in 1877 for public subscriptions included an explicit pitch for Maori support:

The Maoris of Hawke's Bay are particularly invited to join in this movement, which applies to all alike, and it is hoped that it may lead to increased friendly feeling between the two races. The Maoris are requested to give land instead of money, as it will perpetuate their names in the future, and show posterity how the aboriginal natives of the country and the European settlers progress together.³¹

28. Document U12, p 62

29. Ibid; AJHR, 1882, H-23, p 5

30. Document U12, p 63; AJHR, 1883 H-3A, pp 14-15; 1884, H-7A, pp 12-13; doc U12(a), p 480

31. *Hawke's Bay Herald*, 6 January 1877 (quoted in doc U12, p 63)



Figure 11: *The Barracks, Napier*. Watercolour by Charles D Barraud showing the barracks on Hospital Hill looking west, circa 1866. Image courtesy Alexander Turnbull Library (B-004-026).

No Maori contribution is recorded, whether of land or of cash. Nor do Maori seem to have responded to further appeals in the early 1880s, when the new hospital ran into funding deficits. One possible reason was that by this time Maori in central Hawke's Bay had little land left to give, following the sale of most of their remaining land during the 1860s and 1870s under the Native Land Court regime. North of Napier, the raupatu land returned to Maori under the 1870 Mohaka–Waikare agreement was locked up in title complications and long-term leases.

In any case, even if Maori cash or land was wanted, no Maori was invited to join the fundraising committee. As finally constituted in 1879, the committee of management comprised the mayor of Napier; nominees of the Napier Borough Council (two), the Hawke's Bay County Council (two), and the Wairoa County Council (one); and four members elected by subscribers of £1 or more.³² As had happened 20 years earlier, Maori were excluded from the design, planning and management of the new hospital.

5.2.5 Napier Hospital and Maori patients

5.2.5.1 *The hospital in operation*

Provincial surgeon Hitchings was critical from the outset at what he saw as the inadequacy of the new hospital. During the planning stage in 1859, he forced the council to add £100 to the initial £250 it voted for its construction. Despite getting his way, he considered the building too small, especially for coping with epidemics:

32. Conly 1992, pp 19–21



Figure 12: The barracks on Hospital Hill looking north, 1868. This was the site of the second Napier Hospital, opened in 1880. Photograph courtesy Alexander Turnbull Library (1/2-004735).

The accommodation in the present hospital is barely sufficient to supply the increasing wants of the Province, and in case of any infectious disease breaking out would be wholly insufficient for the reason that the male ward only contains five beds and the admission of one female patient would confine the benefits of the institution to that number.

He advocated an additional wing and a facility for ‘lunatics’, who were left to police control.³³ His reference point was the settler population, by now more than 2000 strong. For the larger Maori population of some 3700, and even for the 700-odd Maori living on the lowlands around Napier, the hospital could at best be of marginal use.³⁴

The accommodation remained inadequate. During 1865, 39 patients were admitted, and Hitchings complained of ‘the number of patients constantly in the gaol’.³⁵ A year later, the visiting justice warned the superintendent that ‘great alterations are required in the Napier Hospital’, pointing to overcrowded wards, poor food and ‘a general want of cleanliness’.³⁶

The overcrowded and sometimes squalid conditions of the provincial hospital on Sealy Road persisted until the opening of its replacement on the barracks site in 1880. From its origins as a provincial refuge of last resort for the destitute, Napier’s hospital now served much of the district’s working population and had broad support from the Pakeha community.³⁷ Piecemeal

33. Hitchings to Superintendent, 5 December 1860, doc U12(a), p 62

34. Document x57, p 3277; Fenton 1859, table

35. Hitchings, undated return of patients; Hitchings to Superintendent, 31 May 1865, doc U12(a), pp 70, 72

36. Smith to Superintendent, 31 March 1866, doc U12(a), p 71

37. *The Third Annual Report of the Committee of Management of the Napier Hospital* (in doc U12(a), p 482)

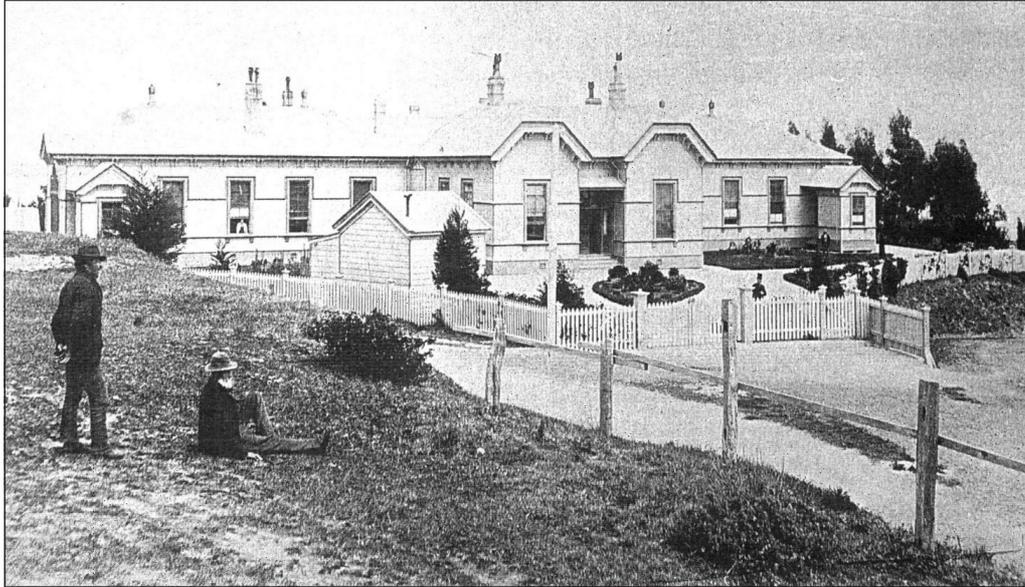


Figure 13: The second Napier Hospital, 1880. Photograph, Hawke's Bay Hospital Board archive.
Taken from Conly 1992, p 11.

expansion continued and by 1913 Napier Hospital's capacity had grown to 124 beds, including the children's and isolation wards.³⁸

5.2.5.2 Maori use of the hospital

In 1851, Ahuriri Maori were seeking a Government hospital to serve Maori needs. What they got in 1860 was a small provincial hospital catering mainly for the sick and terminally ill paupers of settler society. They appear to have shared the caution by now widespread amongst Maori in other hospital regions. Drawing on what he describes as his 'impressionistic and admittedly rather unscientific observations' on the basis of the names recorded between 1861 and 1880, Vincent O'Malley suggests a pattern of 'intermittent Maori use of the hospital throughout the 1860s and into the early 1870s, peaking during periods of major military activity on the East Coast'.³⁹ This pattern implies that in peacetime Maori patient numbers were low. Excluding military casualties, it is unlikely that the hospital would have treated more than a handful of Maori patients annually.

The opening of the new Napier Hospital in 1880 did not lead to a change in the pattern. During the 1880s and 1890s, it appears to have admitted very few Maori patients. Over a five-year period in the mid-1880s, the admissions register recorded, according to Mr O'Malley, 'just one obviously Maori name (that of a young girl admitted by her school)'.⁴⁰ Similarly, only one name out of 28 deaths in 1883 was Maori ('Manahi, Maori clergyman').⁴¹

38. AJHR, 1913 H-31, p 116

39. Document U12, pp 51–52

40. Ibid, pp 51–52, 61–63

41. *The Third Annual Report of the Committee of Management of the Napier Hospital* (in doc U12(a), p 481)

5.2.5.2

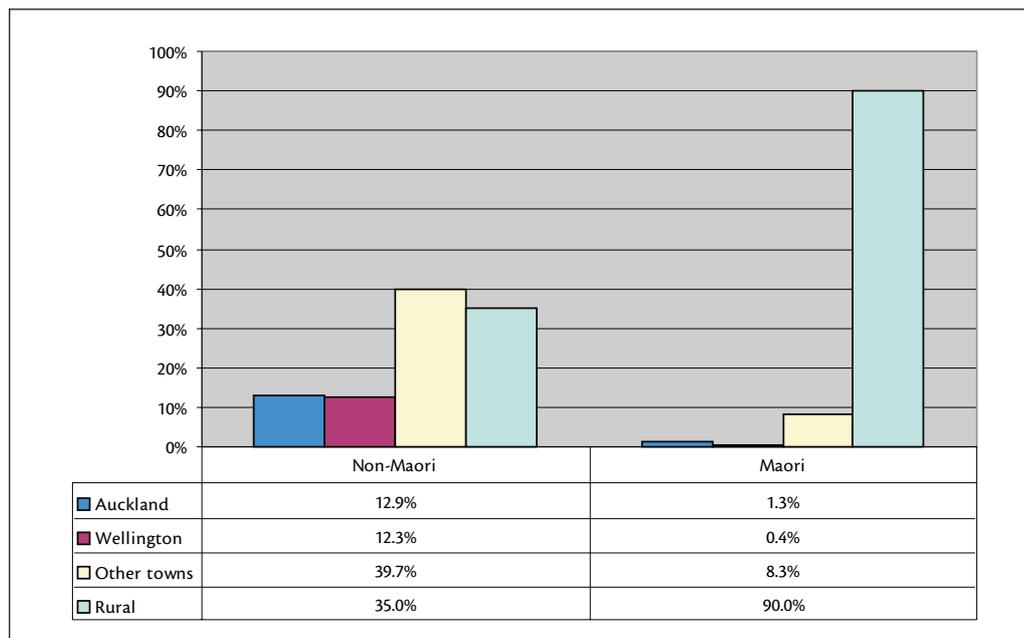


Chart 1: Distribution of the Maori and non-Maori populations in the North Island, 1936

Mr O’Malley concludes that ‘for reasons which are not immediately obvious, Napier Hospital had become of marginal significance to Ahuriri Maori’ by the 1880s. He found ‘insufficient evidence to get to the bottom of this issue’.⁴² Several aspects will be discussed further in section 5.2.6.

Information is lacking altogether on the first two decades of the twentieth century. However, Maori aversion to hospital in-patient treatment persisted. Commenting in 1932 on the social context of Maori ill health in Hawke’s Bay, the regional medical officer of health noted that ‘Maoris generally are averse to entering hospital’ and ‘make use of the hospitals only when compelled to do so’.⁴³ Four years later, a subsequent medical officer of health reported similar resistance amongst a number of Maori tuberculosis cases living in impoverished circumstances.⁴⁴

Strengthening Maori reluctance was the perception, by no means unrealistic at the time, that Western medicine and hospitals had little to offer against pervasive scourges of poor communities such as tuberculosis. Commenting on the case of a tuberculosis-afflicted boy who by then was hump-backed and nearly blind, the school medical officer for Hawke’s Bay noted that ‘the grandfather said the boy had been in hospital but they did him no good so he took him out’.⁴⁵ Although Maori use of hospital services had by the 1930s picked up considerably from the nearly complete disengagement of the late nineteenth century, financial and cultural barriers were still interposing significant barriers to effective access for many.

42. Document U12, p 63

43. Medical officer of health, Wellington, to Director-General of Health, 13 October 1932, doc U12(a), pp 300–301

44. Medical officer of health, Wellington, to Director-General of Health, 11 January 1937, doc U12(a), pp 291–292

45. School medical officer, Hawke’s Bay, monthly report, September 1932, doc U12(a), p 303

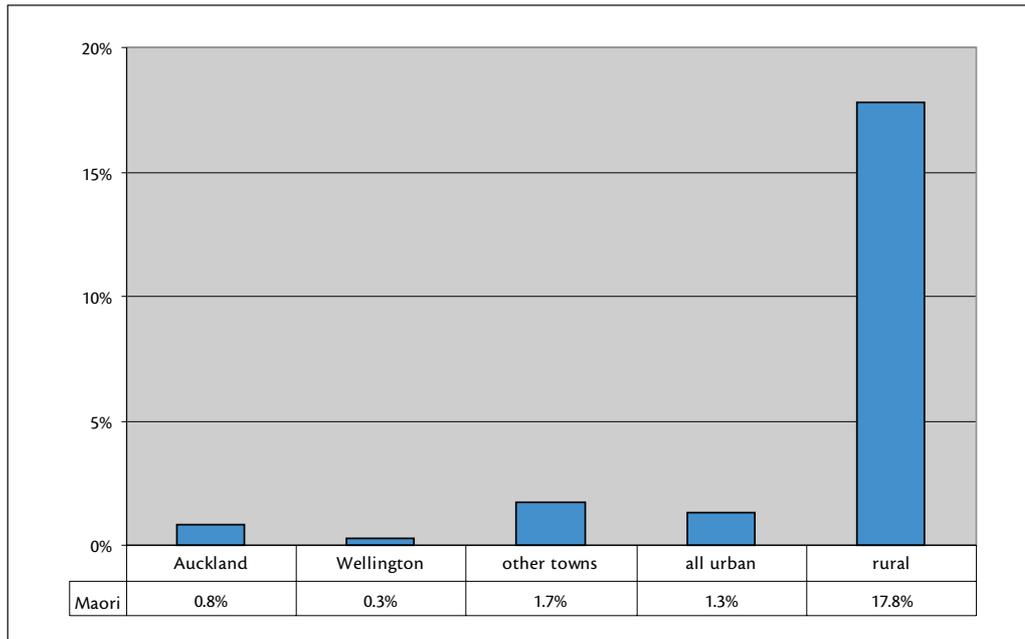


Chart 2: Maori share of urban and rural populations in the North Island, 1936

5.2.6 Barriers facing Maori access to hospital treatment

5.2.6.1 Distance

From the outset, hospitals were located in settler towns. As a result, it was the pattern of Pakeha settlement and urbanisation that determined the geography of hospital locations. A number of rural hospitals did serve nearby Maori communities. But the majority of rural Maori did not live close to the rural hospitals in Pakeha districts, and even further from the large town hospitals.

During the last three decades of the nineteenth century, hospitals expanded as they enhanced their reputation as places of healing rather than refuges for the indigent poor. Increasingly, they came to be regarded as core social institutions, and proliferated during successive waves of immigration.⁴⁶ Local hospitals providing basic facilities were built to serve many small town and rural communities.⁴⁷ They were commonly scaled to the needs of their supporting Pakeha communities.

As urbanisation accelerated after the turn of the twentieth century, cities and regional towns became the driving force. Most acquired hospitals, which expanded and diversified their range of services. As the catchment populations expanded and, during the 1920s and 1930s, motorised transport extended their geographical outreach, large urban hospitals became more prominent, and economies of scale more significant in hospital planning.

In this process, Maori were increasingly marginalised. Large-scale immigration and a declining Maori population saw the demographic balance swing overwhelmingly against Maori in the North Island. Where in the late 1850s Maori formed nearly two-thirds of the North Island population, by the end of that century their share was reduced to only 10 per cent and by 1945, despite

46. Dow 1999, p 70

47. Ibid, pp 60–71

5.2.6.1

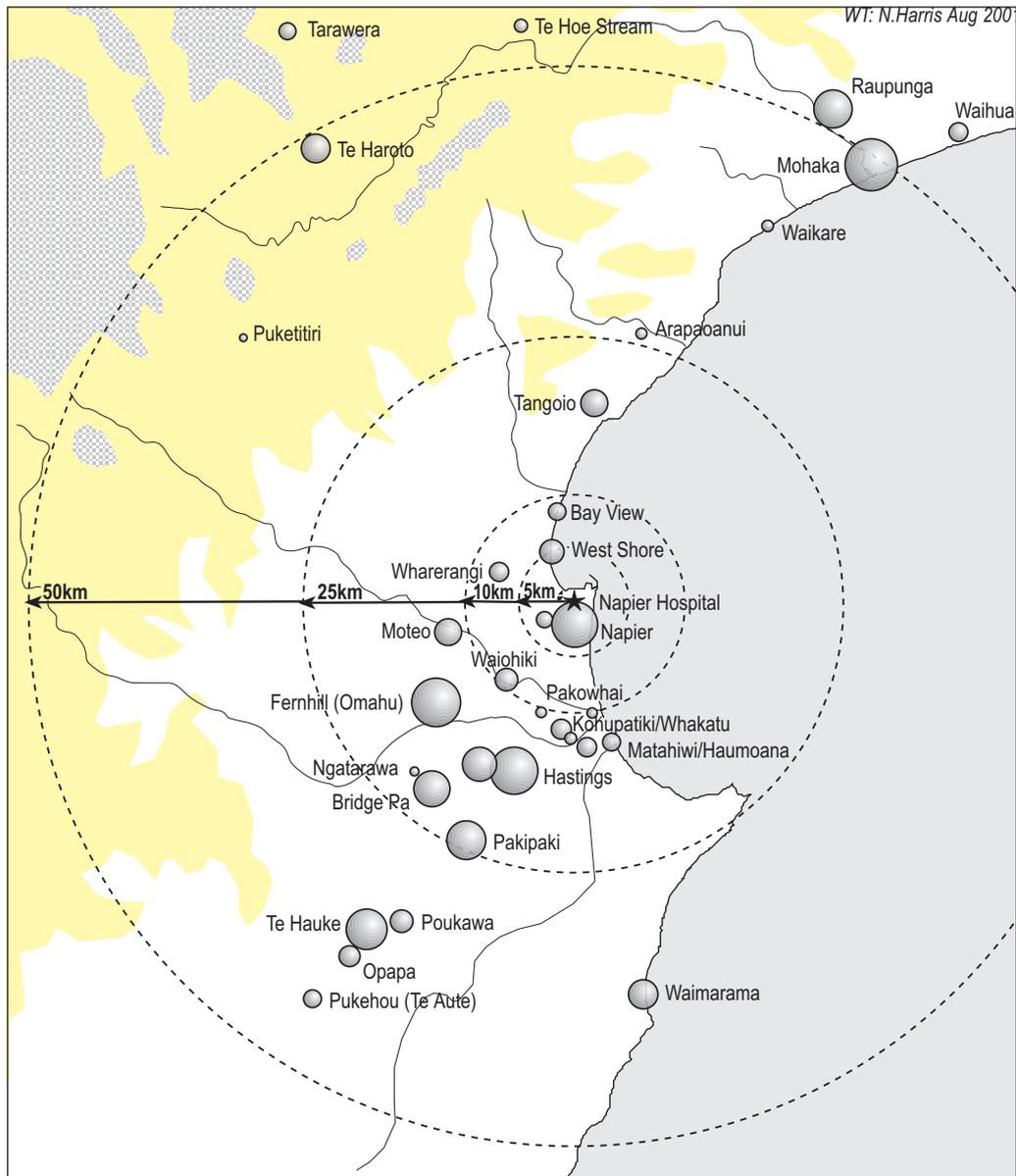


Map 7A: Distribution of the Maori population in central Hawke's Bay, 1881.

Based on data from the 1881 Maori census. The circles are scaled to the number of Maori residing in each locality.

a slow recovery in their numbers, to 8 per cent. Throughout this period, the great majority – still 90 per cent of North Island Maori as late as 1936 – continued to live in the rural areas, mainly on the shrinking remnants of their land base (see charts 1 and 2).

Cities and towns, the centres of hospital development, were overwhelmingly Pakeha. Looking at the North Island, fewer than 1400 Maori were living in Auckland and Wellington in 1936 out of the 6534 Maori residing in cities and towns, who in turn comprised just 10 percent of the total Maori population. Together, Maori in towns comprised less than 1.3 per cent of the total town



Map 7B: Distribution of the Maori population in central Hawke's Bay, 1936. Based on data from the 1936 population census. The circles are scaled to the number of Maori residing in each locality.

population of the North Island.⁴⁹ Many rural Maori lived far from a rural hospital, and even farther from the expanding hospitals in the regional centres.

Maori in central Hawke's Bay were better placed than most. Much of the mid-nineteenth century population lived in settlements on and adjoining the Heretaunga Plain south of Napier or near the river mouths to the north (see map 7A). Napier could be reached by foot, canoe and horse, and, as the road network expanded, also by vehicle. But the rigours of travelling to hospital from anywhere beyond the close environs of Napier would have been exacting for the seriously ill and injured. The rural Pakeha population was equally disadvantaged, except that,

49. Population census 1936; Pool 1991, tables 5.2, 6.10, 6.12, 7.15–7.17, A.1

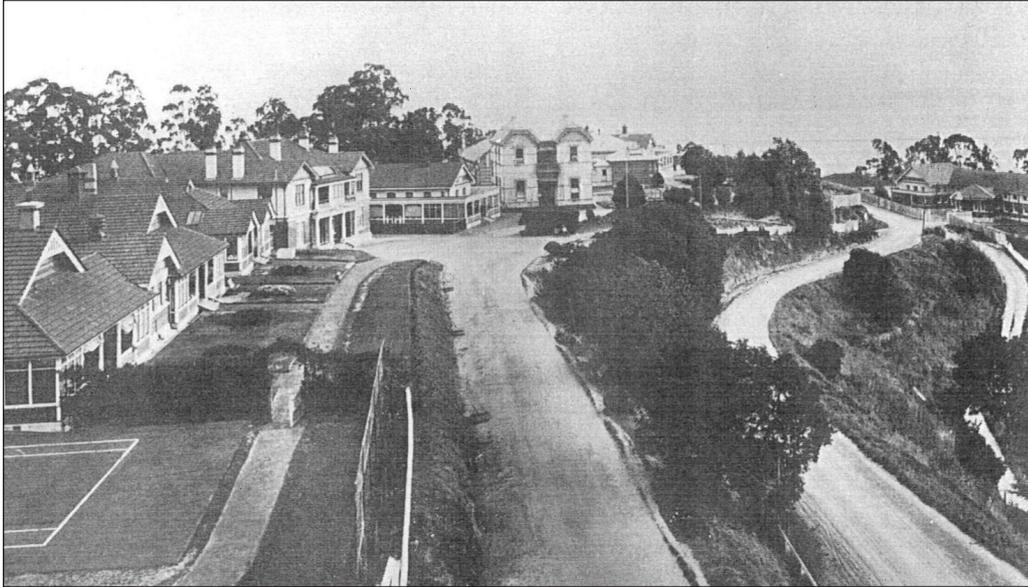


Figure 14: Napier Hospital, circa 1928. The building at centre-top is the original 1880 hospital with two-storey extension. Taken from Conly 1992, p 135.

increasingly from the late nineteenth century on, they had better access to road transport. Small hospitals in Waipukurau and Wairoa partly filled the gap, but travelling distance remained a serious barrier for the more remote Maori communities north of Napier, south of the Heretaunga Plain and in the inland hill country.

By the early twentieth century, the spread of patients matched the profile of the Hawke's Bay County population served by the hospital board, indicating that rural as well as urban Pakeha residents were generally able to reach Napier for hospital treatment. By now, however, Napier and Hastings were growing rapidly and supplied nearly two-thirds of the in-patients. Napier Hospital served the whole of central Hawke's Bay, but its focus became increasingly urban and Napier-centred. Maori numbered only 1262 of a total population of 28,199 in Hawke's Bay County in 1911.

The Maori population remained overwhelmingly rural throughout the period. As late as 1936, only 22 per cent of the 2249 Maori in Hawke's Bay County were recorded as living in the Napier and Hastings urban areas, compared with 79 per cent of Pakeha. Maori comprised a fractional 492 residents out of a Napier and Hastings population of 36,650, or little more than one per cent.⁵⁰ With the upgrading of Memorial Hospital in Hastings in the 1930s, the burgeoning urban communities now had general hospital services on their doorsteps. But improvement was less significant for the great majority of Hawke's Bay Maori, who lived off the main roads in village settlements scattered across the Heretaunga Plain, along the coast north of Napier, and in hill communities such as Te Haroto (see map 7B).

50. Population census 1936



Figure 15: Evacuating Napier Hospital after the 1931 earthquake.
Photograph courtesy Alexander Turnbull Library (1/2-029566).

5.2.6.2 *Doctor's referrals*

Referrals by medical professionals in the community provided an important linkage between urgent medical need and hospital treatment. Because the NMO post at Napier was abolished in 1867, it was only in the first few years that Ahuriri Maori had the services of a subsidised doctor able to refer serious cases to Napier Hospital for treatment. The Maori settlements close to Napier and Hastings were within fairly easy reach of the largely town-based private doctors, but the outlying communities would have been out of reach. In any case, poverty would have made it difficult for many Maori whanau and communities to afford doctors' fees for private consultations, a social exclusion that persisted into the 1930s.

5.2.6.3 *Financial discrimination*

Nationally, the hospital boards' reliance on rates led to Maori being stigmatised in districts with sizeable areas of Maori-owned land, since little rates revenue derived from Maori property. But there is, Mr O'Malley considers, no evidence one way or the other that a policy of exclusion was applied to Maori patients in Hawke's Bay.⁵¹

If there was less discrimination by the Hawke's Bay Hospital Board than some others, one reason was that the Pakeha civic leaders of Napier and Hawke's Bay, as expressed in their 1877 call for Maori financial support for the new hospital, appeared to place some value on maintaining good relations with local Maori. Non-payment of rates was also less of an issue given the small

51. Document U12, p 61

5.2.6.4

area of high-value Maori-owned land remaining in central Hawke's Bay by the late nineteenth century.

There was, however, systematic discrimination against Maori indigents in need of the limited form of welfare support curiously described as charitable aid, which the hospital boards were responsible for administering. Maori were almost totally excluded from such relief until the unemployment crisis of the 1930s.⁵² This exclusion is taken up in section 5.2.8.6.

5.2.6.4 *Hospital fees and debt*

In theory, when Napier Hospital opened its doors in 1860, the general policy was to treat Maori and indigent Pakeha for free and to charge those Pakeha who could afford to pay. However, not until the late 1860s was any serious consideration given to imposing fees on patients. The main reason, as Dr Hitchings pointed out to his provincial superintendent, was that those who could afford to pay refused, and 'the general class of persons who seek & obtain Hospital relief have generally spent their last shilling either during their illness or on their way to Napier in an improvident or other manner'. He made no mention of Maori patients.⁵³

Again in theory, Maori patients might attract a Government subsidy. Block grants were still being paid to State hospitals when Superintendent Fitzgerald sounded out the prospects for Government funding in early 1859. His application carefully pointed out that the hospital would be 'for the reception of Native as well as European patients' and urged that 'the necessity for an establishment of this kind at Napier especially for persons of the Native Race is undoubted'.⁵⁴ After the matter was referred to the Governor, Fitzgerald was told that the hospital would be eligible, on the same basis as the other provincially managed hospitals, for a proportionate refund of the unit costs of its Maori patients:

the whole expense of the Hospital is in the first instance defrayed by the Provincial Government, and the General Government subsequently repays to the Province such a proportion of the total expense as the number of rations issued to Natives bears to the total number of rations issued during the period for which payment is made.⁵⁵

Nothing seems to have come of this initiative. Since from the outset the hospital did not systematically identify Maori patients in the hospital's admissions register, it is difficult to see how the Provincial Council could have solicited per capita reimbursement. The published Government and provincial accounts give no sign of any transfer payments to the province for the hospital treatment of Maori.

By the late 1860s, any discrimination in favour of Maori had disappeared from national policy: Maori, like Pakeha, were expected to pay hospital fees if they could afford to do so. The regime changed, however, following the abolition of the provinces. The new Napier Hospital opened in 1880 under a local board. The board put up a subscription scheme that provided hospital

52. Tennant 1989, pp 99–100

53. Hitchings to McLean, 8 November 1867, doc U12(a), pp 81–84

54. Superintendent to Colonial Secretary, 27 April 1859, doc U12(a), p 348

55. Tancred to Superintendent, Hawke's Bay, 30 June 1859 (quoted in doc U12, p 49–50)

insurance for those who could afford it. Persons subscribing £1 or more had the right to free treatment for the year following, and £100 donors were entitled to free treatment for life. In 1883, there were six such ‘life governors’ and more than 600 subscribers, or roughly 10 per cent of all adults in the hospital’s catchment area of Hawke’s Bay and Wairoa. The only identifiably Maori contribution was 12s 6d from ‘Natives, Tangoio’.⁵⁶

Thus, it appears unlikely that any Maori had a subscription right to free treatment. Non-subscribers, including Maori, were expected to pay a guinea (£1 1s) a week if they could afford to. In 1881, 60 out of 208 non-subscriber patients paid the fee, well above the average for many other hospitals.⁵⁷ Even so, the majority did not pay. Maori were therefore not formally excluded, but the subscription scheme and fee scale would have acted as significant deterrents.

When Napier Hospital was brought under the hospital board regime in 1885, hospital fees were placed on a more regular footing. By law, all local residents of a hospital district were entitled to free hospital treatment but were expected to pay if they could afford it. Many Pakeha failed to pay the full fee, but even fewer Maori patients could afford hospital bills. This increased the reluctance of hospital boards to accept them. Nor would the Government subsidise their Maori patients: free hospital treatment for Maori had ended in the 1860s when policy had settled firmly on placing Maori patients on the same footing as Pakeha, and rendering them liable for hospital fees. A divisive politics of hospital admission persisted until the inauguration of universal entitlements in the late 1930s.⁵⁸

The few Maori willing to make use of Napier Hospital’s services on its own terms encountered a somewhat firmer emphasis on patient payments than prevailed nationally towards the end of the nineteenth century. Daily fees paid per patient were still well above the national average in the late 1890s – by 36 per cent in 1896–97 and by 44 per cent in 1897–98.⁵⁹ That Maori patients were expected to pay on the same basis as Pakeha is suggested by the hospital board’s adamant rejection of the Native Department’s 1888 circular requiring that ‘free medical attendance to indigent persons of the native race must in future be borne by the local bodies receiving subsidies from the Government’.⁶⁰

The non-payment of fees by Maori patients emerged as a major point of controversy between hospital boards and the Government in the late 1920s and early 1930s. The boards’ pressure was triggered in part by a greater Maori willingness to seek hospital treatment. This interest was also evident in Hawke’s Bay, where, over a two-year period in the late 1920s, Napier Hospital treated 136 Maori inpatients. For an estimated catchment population of 1755 Maori, this was a high annual rate of hospitalisation, and at 3.9 per cent it was well above the national Maori average of 2.9 per cent.⁶¹

56. *The Third Annual Report of the Committee of Management of the Napier Hospital* (in doc U12(a), pp 479, 483–485)

57. AJHR, 1882, H-23, p 5

58. Dow 1999, pp 104–107, 161–173

59. Calculated from average daily cost per patient. AJHR, 1897, H-22, p 34; AJHR, 1898, H-22, p 37

60. Dow 1999, p 58; doc U12, p 64

61. Document U12, pp 70–71, 76–77; return enclosed in secretary, Waikato Hospital Board, to Prime Minister, 2 September 1929, doc U12(a), pp 271–272

It is unlikely, as the Minister of Health pointed out to a Hospital Boards Association delegation in September 1929, that the fee recovery rate for Maori patients was any less than for non-Maori.⁶² The 17.5 per cent rate reported by the Hawke's Bay Hospital Board for the previous two years was slightly above the national average.⁶³ During the three years to March 1932, the board raised its average collection rate from Maori patients, notwithstanding the impact of the Great Depression, to an estimated 37 per cent.⁶⁴

Although Maori were making greater use of Napier Hospital, the barriers were still substantial. Hospital treatment for Maori tended to be more expensive in Hawke's Bay than in most other districts. In the late 1920s, a stay in Napier Hospital incurred an average fee of £14 14s 1d per patient, which was well above the national average of £9 18s 7d.⁶⁵ This was a significant burden, given that 61 per cent of Hawke's Bay people older than 15 years had a yearly income of less than £104 at the time of the 1936 census and that most Maori were in the lower income bracket.⁶⁶ Although Maori patients did pay an average £2 11s 6d each, some two-thirds above the national average,⁶⁷ many would have been unable or unwilling to face the risk of being landed with a hefty bill if the hospital adjudged them able to pay.

During the Depression years of the early 1930s, the worsening health status of many Maori communities increased their need for medical services. Official policy, however, stiffened the barriers to obtaining hospital treatment. The hospital board greatly increased its fee recovery rate from Maori patients. At the same time, it tried to hold down the daily fee, rejecting a 1932 Health Department edict and pointing out that, 'seeing that every endeavour is being made at the present time to reduce charges upon the public in every direction, it is very inopportune now to increase the scale of fees'.⁶⁸ But the Government forced the issue, and in August 1933 the board increased its daily in-patient fee to the prescribed minimum of 12 shillings for adults and six shillings for children.⁶⁹

The Director-General of Health attempted to sweeten the pill by advising that 'Boards have full power to compound with debtors and to write off charges where payment in full would involve hardship'.⁷⁰ But it was the hospital management that had the discretion, and all patients were exposed to means testing. A personal protest to the Minister of Health written shortly before universal entitlement under the Social Security Act 1938 came into effect described how the testing was done:

62. Minutes of meeting between New Zealand Hospital Boards Association deputation and Prime Minister and Minister of Health, 5 September 1929, doc U12(a), pp 281–282; doc U12, pp 74–75

63. Return enclosed in secretary, Waikato Hospital Board, to Prime Minister, 2 September 1929, doc U12(a), p 272

64. Secretary, Hospital Boards Association, memorandum, 7 October 1933, doc U12(a), p 260

65. Calculated from return enclosed in secretary, Waikato Hospital Board, to Prime Minister, 2 September 1929, doc U12(a), p 272

66. Calculated from population census 1936, pt XII, table 1

67. Calculated from return enclosed in secretary, Waikato Hospital Board, to Prime Minister, 2 September 1929, doc U12(a), p 272

68. Director-General of Health to secretary, Hawke's Bay Hospital Board, 21 June 1932; secretary, Hawke's Bay Hospital Board, to Director-General of Health, 13 July 1932, doc U12(a), pp 340–341

69. Director-General of Health to secretary, Hawke's Bay Hospital Board, 10 March 1933; secretary, Hawke's Bay Hospital Board, to Director-General of Health, 13 July 1932, doc U12(a), pp 339–340

70. Director-General of Health to secretary, Hawke's Bay Hospital Board, 10 March 1933, doc U12(a), pp 339–340

I understand that it is the practice in the Napier Hospital for a clerk to make a round of the patients, making enquiries as to their financial position. I think that if this is the case it appears that money is much more than human life, and after all the animals in the field are given what attention [is] possible without any thought of payment.⁷¹

5.2.6.5 *Hospital facilities for Maori*

Between the introduction of representative government in the mid-1850s and the outbreak of the First World War, no hospital was built specifically or mainly to serve Maori.⁷² A well-supported plan to establish a network of Maori-staffed cottage hospitals, to which a number of Maori communities were prepared to give land and resources, came to nothing in the 1900s when the Government failed to come up with funding.⁷³

There is only one recorded instance of a specific attempt to provide for the needs of Maori patients at Napier Hospital. It is possible that the initiative came from the resolution of a land dispute between Karaitiana Takamoana and a runholder, who agreed to split the difference of £1000 between Waipukurau and Napier Hospitals, according to Reed, ‘for the purpose of providing a Maori ward in each hospital’.⁷⁴ In any event, in the mid-1880s, Napier Hospital’s visiting committee recommended the establishment of a separate ward for Maori as a matter of ‘urgent necessity’. The hospital’s management committee requested the same 50 per cent Government subsidy that had been secured for the building of the hospital. But, although a fever ward that had been requested at the same time was soon built, the Maori ward was not.⁷⁵

5.2.6.6 *Maori staff*

Maori had little influence on the development or the culture of the town hospitals. An important factor was the lack of Maori representation in hospital staffing. In the early twentieth century, pioneer Maori doctors such as Maui Pomare and Te Rangi Hiroa became influential in fashioning national health programmes for Maori, and a handful of Maori doctors and nurses began to enter primary healthcare. From the late 1890s, several hospitals began to train Maori nurses, but hospital boards were reluctant to employ them. Few Maori professionals were employed at any level of the hospital staff before the Second World War.⁷⁶

In 1898, Napier Hospital took on two Maori nurse probationers from Hukarere Maori girls’ school. This pioneering move was taken in the context of a proposal the previous year from the Te Aute College Students’ Association to establish a corps of Maori nurses.⁷⁷ But the scheme seems to have continued only intermittently and was designed to train Maori nurses for work in Maori communities rather than for employment in the hospital itself.

71. L Maloney to Fraser, 24 January 1939, doc U12(a), p 336. The note was written on a Health Department form and appears to be from a health professional

72. Dow 1999, pp 62–63, 67–68

73. Lange 1999, p 235

74. Reed 1972, p 272. The story is not referenced and is not corroborated in other sources

75. Document U12, pp 63–64

76. Lange 1999, pp 168–176

77. Dow 1999, p 130

5.2.6.7 *Respect for tikanga Maori*

From the 1850s, differing cultural perceptions clouded the positive initial reception that Maori gave to Grey's hospitals. Mid-nineteenth century hospitals, still a couple of decades before the 'antiseptic surgical revolution', were dangerous places.⁷⁸ When Dr John Fitzgerald operated on a Waikanae rangatira under general anaesthetic – then a very new technology – only a week after the opening of Wellington Hospital in September 1847, he was taking a high-risk gamble in order to win chiefly support.⁷⁹

The gamble paid off in the short term. But inevitably deaths did occur. While colonial officials could justifiably point to death rates well below those of British hospitals at the time, the reputation of the hospitals suffered and Maori usage declined in the early 1850s. The death of a Maori patient in 1857 led to New Plymouth Hospital being placed under tapu and switching to a mainly outpatient service. The Wanganui surgeon, Dr George Rees, tried to send mortally ill patients home, to treat as many as possible as outpatients, and to persuade local chiefs to send their sick at the onset of the illness rather than when far gone. But his adaptations met with only limited success in easing Maori concern.⁸⁰

Despite the best efforts of conscientious surgeons such as Rees and Fitzgerald, a cooling of Maori enthusiasm for the hospitals exposed the limitations of Grey's uncompromising assimilationist model. Maori were expected to bring their sick and injured into alien institutions in immigrant towns, there to be exposed to the superior technology and culture of the civilising race. At Napier Hospital, with the exception of military emergencies, Maori needs barely rated a mention in the hospital reports of its superintendent, Dr Hitchings.

Maori had no part in the design or running of the hospitals, which made few concessions to tikanga Maori concerning illness and death. Once admitted, Maori in-patients were wholly subject to the authority of the Pakeha professionals. Some Maori, as in Wellington, preferred to avoid the risks by staying in Maori hostels and attending as outpatients. The limited efficacy of European medicine was also evident in a high outpatient death rate, reported by Fitzgerald to be almost 10 per cent for Wellington in 1851.⁸¹

Ten years later, a settler government dismissive of 'mere pharmaceutical ministrations among the Natives' commented uncomprehendingly that 'as far as yet tried, the Natives have generally exhibited repugnance to resort to those [hospitals] which have been established, owing to no fault in the institutions, but to superstitions or other prejudices'.⁸² Whilst far from rejecting the benefits of hospital treatment, Maori began to adopt a more cautious approach.

The public hospital system was thus open to Maori from the very outset of Governor Grey's hospital programme but, as Grey himself put it, 'upon the European system'.⁸³ This monocultural leitmotif permeated hospital culture far into the twentieth century. It intensified early in the

78. Dow 1999, p 48

79. Ibid, p 27

80. Ibid, pp 30–31

81. Ibid, p 30

82. Fox, memorandum, 31 October 1861, AJHR, 1862 E-2, p 14

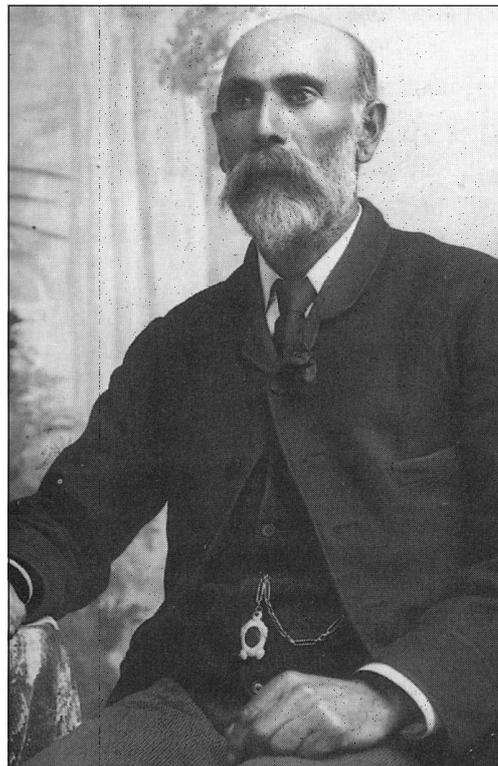
83. Governor Grey to Secretary of State, 5 April 1848, BPP, vol 6, 1849, p 20



Figure 16 (left): Akenehi Hei, the first registered Maori nurse, who trained and worked at Napier Hospital between 1901 and 1908. Taken from Lange 1999, p169.

Figure 17 (below left): Dr Thomas Hitchings, the first superintendent of Napier Hospital and native medical officer from 1857 to 1867. Photograph, Hawke's Bay Hospital Board archive. Taken from Conly 1992, p5.

Figure 18 (below right): Ihaia Hutana of Ngati Kahungunu, chairman of the Tamatea Maori Council during the 1900s and 1910s and chair of successive general conferences of Maori councils. Taken from Lange 1999, p213.



century with the growing authority and power of medical professionals as agents of healing and social discipline, a period that witnessed the outlawing of both European ‘quacks’ and Maori tohunga. Dominated by British-trained professionals and British medical culture, by and large the hospitals served the Pakeha communities which financed their operations, elected their controlling local bodies, and, increasingly, came to regard them as icons of local progress.

The bicultural accommodations that some early hospital superintendents made with tikanga Maori disappeared as hospitals became Pakeha community institutions. Such matters as surgical practice, the disposal of human tissue and the reuse of cooking water were highly sensitive to Maori. Lange considers that ‘in the late nineteenth century most Maori had shown a deeply rooted disinclination to enter hospital’.⁸⁴ Dow depicts a more varied situation, but his counter-examples come mainly in small rural hospitals with which nearby Maori communities became more closely involved. In the opinion of Mr Hiha:

For years, Maori cultural values and principles have been ignored and suppressed. We have experienced this both directly, through legislation such as the Tohunga Suppression Act 1907 or 1908, and indirectly the imposition of monocultural policies and structures and neglect. For too long, Maori values and participation have gone unrecognised and undervalued. Where there is no recognition of Maori cultural structures within the Health service, this makes our people feel disregarded and inadequate.⁸⁵

Not until the 1920s and 1930s did Maori begin gradually to make greater use of the town hospitals.⁸⁶ As indicated in section 5.2.5.2, Ahuriri Maori followed a broadly similar approach towards Napier Hospital. The absence of any explicit indication in the detailed history of Napier Hospital suggests that it followed the established pattern in making little effort to accommodate Maori cultural concerns.⁸⁷

5.2.7 Primary health services

5.2.7.1 *New institutions and nmos*

With the development of responsible government in the late 1850s, medical subsidies joined hospitals in the queue for allocations from the ring-fenced civil list budget for Maori purposes. In 1856, William FitzHerbert, himself a doctor and now the secretary of the new Wellington Province, advocated a more systematic approach to the provision of primary healthcare to Maori. His proposal was to divide the country into medical districts and appoint a resident doctor in each with a part-time salary for services to Maori. The Government did not take up the proposal.⁸⁸ Outside the main towns, NMOS were thin on the ground, although in the late 1850s the Government allowed a modest expansion of the scheme.⁸⁹

84. Lange 1999, pp 233–235

85. Document v15, para 6

86. Lange 1999, pp 234–235

87. Conly 1992

88. Dow 1999, p 39

89. Ibid, pp 39–40

Part-time annual salaries did, all the same, become the normal method of paying the NMOS. Furthermore, the return of Sir George Grey for his second governorship led to a brief revival of interest in a consistent nationwide scheme. In his October 1861 ‘Plan of Native Government’, Grey proposed that ‘The Native portions of the Northern Island . . . be divided into, say, twenty Districts, each under a Civil Commissioner, with a Clerk and Interpreter, and a Medical man as district surgeon attached to his District’. Grey’s budget estimate included annual payments of £150 to the district surgeons, implying an overall annual cost of £3000 to operate the scheme.⁹⁰

Grey’s ‘new institutions’ and the partial transfer of the Native Department to ministerial control led to a sudden increase in the NMO establishment from eight to 20.⁹¹ In the aftermath of the Waikato war, a flurry of new appointments expanded their ranks to 29 in 1866. Dow estimates that at its peak some 20 per cent of all doctors nationwide were receiving subsidies to provide medical services to Maori.⁹²

Numbers alone give little indication of the service actually delivered to Maori, or of its acceptability to Maori. Many NMOS were qualified professionals, and some, such as John Fitzgerald of Wellington, made personal commitments far beyond the remuneration they derived.⁹³ But the implementation of the scheme was riddled with arbitrary practices. Dow comments that ‘workloads varied enormously, as did salaries, though there seems to have been little correlation between the two’.⁹⁴ In historian Alan Ward’s assessment of the scheme as it stood in the early 1860s:

The twenty or so doctors subsidised as part of the “new institutions” gave patchy satisfaction. Though ordered to make regular circuits of the pa in their district, they too often waited in the towns for Maori patients to come to them . . . The sick were frequently unable or disinclined to continue the nursing treatment prescribed by visiting doctors and epidemics continued to take a very heavy toll. Even so, the system of subsidised medical officers represented an advance in the Government’s conception of its responsibilities, creditable in a *laissez faire* age. Most Maori living within 15 miles of a township, and visitors from further afield, could be reasonably sure of free medical treatment. Traditional remedies, including the rituals of the *tohunga* or spiritual healers, were still the norm in rural districts, but many certainly appreciated the availability of a doctor at least as an alternative. When epidemic diseases were reported doctors were usually sent to the area promptly.⁹⁵

The expansion was anyway short-lived. Depressed economic conditions in the late 1860s accompanied a hardening Government disapproval of providing free medical services to Maori.⁹⁶ A H Russell, the Native Minister in a government committed to retrenchment, believed that ‘true

90. *Ibid*, p 40

91. Ward 1995, pp 130–131

92. Dow 1999, p 46

93. *Ibid*, pp 35–36, 46

94. *Ibid*, p 43

95. Ward 1995, pp 141–142

96. Dow 1999, pp 44–45

5.2.7.2

policy requires that all exceptional law should gradually cease and the Natives be encouraged to conform to that of Europeans'.⁹⁷ Retrenchment and a slashing of the Native Department's budget during 1866 and 1867 saw a number of temporary appointments ended and NMOs dismissed.⁹⁸ A slimmed-down scheme nevertheless survived the war-torn 1860s and continued into the uneasy peace that followed.

The sharp cutbacks to the NMO scheme in the late 1860s seriously reduced Maori access to European medical care, although the Wellington and Nelson tenths trust funds paid for some medical services for their beneficiaries. By this time, missionaries played an insignificant role. Patients using the provincial hospitals were overwhelmingly Pakeha. According to Ward:

whereas the subsidised rural doctors, specially designated to care for Maori patients, had often been readily approached by them at all hours of the day and night, Maori people were reluctant, for cultural rather than financial reasons, to approach the private practitioner surrounded by wealthy white patients in his town surgery. Ailing Maori had to make do with the 'medical comforts' dispensed by the Resident Magistrates or the sporadic attention of an idealistic private practitioner or army doctor.⁹⁹

5.2.7.2 An NMO at Napier (1856–67)

The small Napier hospital served a substantial Maori population over a large catchment area. Its outpatient service could address only some of the needs of Maori communities for primary healthcare. This was the mission of the rural doctoring service provided under the NMO scheme. That Ahuriri Maori were well aware of its existence and mandate is evident from Takamoana's request in 1850 for a doctor and from McLean's acknowledgement in 1856 that Hawke's Bay Maori had been pressing for the appointment of an NMO. Colenso's removal from missionary work in 1852 reduced the access of central Hawke's Bay Maori to European medicines, although possible alternative providers emerged with the foundation of the Roman Catholic mission at Pakowhai in 1851 and of Samuel Williams' new Anglican mission at Te Aute in 1854.¹⁰⁰

Nothing happened for nearly five years after the signing of the Ahuriri deed. The measles epidemic of 1854 focused attention once again on the absence of any medical service for Maori in the Wairarapa and Hawke's Bay. Dr William FitzHerbert acknowledged that neither the colonial nor the provincial government had done much to combat the epidemic:

The Provincial Government has adopted such remedial measures as the emergency required, but its efforts have been necessarily restricted, by the absence of special funds at its disposal, and the inadequacy of the existing machinery for native medical treatment.¹⁰¹

97. Russell to Civil Commissioner, Mangonui, 8 February 1866 (quoted in Ward 1995, p 195)

98. Dow 1999, p 45; Ward 1995, p 197

99. Ward 1995, pp 197, 202

100. Document U12, p 42; doc J10, pp 27–28

101. FitzHerbert to Colonial Secretary, 11 July 1854, doc U12(a), p 342

Alleging that the colonial government had contributed no extra resources to combat the epidemic, FitzHerbert claimed that the expectation that the £7000 reserved for Maori purposes would be apportioned amongst the provinces had 'alone prevented the Provincial Legislature of Wellington from making some such provision itself'. As a result, despite 'a considerable native population', no qualified medical practitioner now resided anywhere 'on the East Coast from Wellington to Ahuriri, a distance of 200 miles'. FitzHerbert's proposal was turned down on the basis that the civil list fund was already fully committed.¹⁰² A year later, acknowledging that epidemics were now 'of annual occurrence', Superintendent Isaac Featherston, also a doctor, proposed providing £500 for 'medical attendance for the Natives in the different parts of the Province', but only if the colonial government failed to do so.¹⁰³

It took a local initiative to break the impasse caused by this buck-passing. The catalyst was the arrival of Dr Thomas Hitchings in Napier in March 1856. Three months later, Donald McLean urged the appointment of an NMO at Ahuriri. It was one of three new NMO positions that he recommended for civil list funding and by far the most strongly argued.¹⁰⁴ In August, a public meeting in Napier included in its resolutions a similar call on the colonial government, and recommended Hitchings for the post. It also set up a subscription fund to retain his services for the growing settler population. The NMO subsidy appeared to be seen as part of the package to keep the doctor in Hawke's Bay. Hitchings' appointment as NMO, at a low annual salary of £50, did not occur until August 1857.¹⁰⁵

Hitchings remained NMO in Hawke's Bay for the next 11 years. As superintendent of the new hospital from 1860, he was in sole charge of State medical services to Maori in Hawke's Bay. He also held the posts of coroner and, from January 1859, provincial surgeon, as well as meeting the demands of his private practice, membership of the Provincial Council and, in the mid-1860s, the duties of chief medical officer to the Hawke's Bay Militia.¹⁰⁶

During the 1857–58 conflict, Hitchings tended the Maori wounded, and in 1866 he looked after a flood of Maori casualties from the battle of Omarunui, several of the wounded remaining in Napier Hospital for many months afterwards.¹⁰⁷ Shortly after his appointment in 1857, he demanded that his war duties receive separate recognition from the Government, but reassured McLean:

that I accept the Appointment in its original meaning – and will use what little ability I possess both in discharging my professional duties strictly as called and in ameliorating the sanitary & social condition of the Native race.¹⁰⁸

102. Ibid, pp 342–345

103. Opening speech to Wellington Provincial Council, 27 December 1855, NZGG (Province of Wellington), 1 January 1856

104. McLean to Governor's private secretary, 21 June 1856, doc U12(a), pp 14–19

105. *Wellington Independent*, 16 August 1856, doc U12(a), p 477; notice 21 August 1857, NZGG 1857, p 142

106. Document U12, pp 45–49; doc U12(a), p 73

107. Document U12, pp 47–48, 52

108. Hitchings to McLean, 2 October 1857, doc U12(a), p 352

The province might occasionally reimburse private assistance to Maori, as it did in respect of the provisions supplied by William Colenso to several kainga in 1860 ‘in the severe influenza visitation’.¹⁰⁹ But the principal responsibility for providing a district doctoring service to Maori remained a central government responsibility.

5.2.7.3 *The NMO scheme in practice and Maori concerns*

How zealously NMOs undertook their assignment was, however, largely a function of their personal motivation, since the Government undertook no monitoring and the subsidy was an annual salary rather than reimbursement of costs. Complaints were soon laid against Hitchings’ performance of his NMO duties. Three years after his appointment, Karaitiana Takamoana dispatched a plea to the provincial superintendent:

Kai wea te takuta mo nga Maori e korero ne[i] nga pakeha he takuta ano kai Nepia na Kawana i wakarite mo nga Pakeha mo nga Maori e ta ki te mea he pono tenei korero mau e tono mai te Takuta ki te titiro i te mate o aku tangata ka nui te mate ki te kore mau e tuhi mai te korenga e haere mai

Where is the Doctor for the Maoris? The Settlers say, that there is a Doctor at Napier appointed by the Governor for Whites & for Natives. O Sir, if indeed this saying is true, do thou send the Doctor hither to look at the diseases of my People the sickness is great. If (it, the above saying is) not true, do thou write to me (his) not coming hither.¹¹⁰

Takamoana’s plea reflected a deeper issue. According to a subsequent complaint laid with the Native Minister, presumably by local Maori, Hitchings had refused a call to Pa Whakairo to attend a relative of Te Kerewa Karauria, brother of Te Moananui. The relative died, and ‘therefore they did not send for him to see Moananui in his last illness’.¹¹¹ The association of Hitchings’ negligence with the death in July 1861 of Te Moananui, one of the senior chiefs in central Hawke’s Bay, points to a crisis of confidence in Hitchings and the NMO service. The letter from Karaitiana three months later is less likely to have been a request for information than a challenge to Hitchings through his Provincial Council employer to deliver the NMO service for which he was paid.

The Maori complaint implied that Hitchings did not undertake visiting rounds to their kainga and was selective in responding to call-outs. The outcome of the Native Office’s investigation is unknown, but Superintendent Carter’s reply to Karaitiana made it clear that the doctor would visit, but only when called – the onus was on Maori communities to call him in to attend their sick.¹¹²

A Pakeha correspondent to the *Hawke’s Bay Herald* alleged that the grievance was deep-seated and unresolved. The lack of medical service:

109. Province of Hawke’s Bay, receipt, 10 November 1860, doc U12(a), p 46

110. Takamoana to Captain Carter, 5 October 1861, doc U12(a), pp 65–67

111. Acting Native Secretary to Hitchings, 2 January 1862, doc U12(a), p 69

112. Superintendent to Takamoana, 5 October 1861, doc U12(a), p 64

is a subject on which the natives feel acutely the neglect of the Government . . . and many residents of Hawke's Bay must know how bitterly they have deplored at various times the want of medical aid – though, as they have said, the Governor (Browne) and McLean had told them that a doctor was appointed and paid to attend them.

The correspondent alleged that Hitchings 'quietly pockets the £50 a year without remark and without fulfilling what was expected from him, or remonstrating with his employers on the insufficient remuneration if they intended him to do his duty properly'. The root cause was his growing private practice and the low NMO subsidy:

He did attend them at one time and gave much attention to them; but, being greatly taken up for some years past by his professional engagements about Napier, it can scarcely be supposed he could give up a lucrative practice to attend the natives for a beggarly £50 a year.

In the correspondent's opinion, the main responsibility lay with the colonial government:

The General Government are really to blame in this matter in not taking care that the necessary services were rendered the natives that they had promised, and that fair remuneration was given for the important services required.¹¹³

In mid-1862, the Government attempted to redress the unsatisfactory situation. Hitchings' NMO salary was doubled to £100 and topped up further with a £50 forage and travelling allowance. Expenditure on 'medical attendance on Natives' at Napier was £204 3s 4d in 1862–63.¹¹⁴ In return, he was now expected to deliver and account for an effective free rural medical service to Maori. The Government required:

That the Medical Officer should visit every Native Settlement on this side of the harbour within a radius of 15 miles once a week whether or not there should be any sickness at such settlement and in case of serious illness that the Patient should be visited at least every second day.

That all Natives applying for medical advice or assistance in Napier should receive it gratuitously whether or not they belong to this Province.

That a short journal should be furnished once a month to the Civil Commissioner for transmission to the Honorable the Native Minister.¹¹⁵

But a complaint from the residents of Matahiwi in October 1862, a year after Takamoana's challenge, revealed that Hitchings was far from complying with the prescribed standards. Matahiwi, which lay on the bank of the Tukituki River near the coast, was only 11 kilometres south of Napier. Yet Hitchings had not visited for a month, and this despite a fire accident a week before that had led to the death of a child and the father lying in mortal danger. In his defence, Hitchings contradicted the Maori complainants, asserting that his visits to Maori kainga were 'as a rule constant and regular'. He blamed 'the migratory habits of the people and other causes' for

113. *Hawke's Bay Herald*, 22 February 1862, doc U12(a), p 473; doc U12, pp 56–57; Conly 1992, p 9–11

114. AJHR, 1863 E-8, p 2

115. Civil Commissioner to Hitchings, 31 May 1862 (quoted in doc U12, pp 57–58)

sometimes not being able to reach his patients. Notwithstanding his previous poor record, the Government seems to have accepted his explanation as adequate.¹¹⁶

At the beginning of 1866, the Government cut Hitchings' NMO salary from £150 to £100. The incoming Stafford Ministry had launched a programme of retrenchment and the dismantling of the Native Department.¹¹⁷ In June 1867, the post was disestablished as part of a large clear-out of Native Department officials.¹¹⁸ Donald McLean's rebuilding of the department in the early 1870s resulted in the appointment of an NMO at Wairoa, but the Napier post was not restored. Although the NMO scheme was to survive in varying forms until the 1930s, henceforth State-subsidised doctoring services to Maori in central Hawke's Bay were to depend entirely on the public hospital system.¹¹⁹

5.2.8 Public and community health

5.2.8.1 *The beginnings of State primary healthcare services*

From the 1860s to the end of the nineteenth century, State health services to Maori were limited to the unwelcoming public hospitals and the uneven coverage of the NMO scheme, which persisted until the 1930s.¹²⁰ Many Maori had no effective access to professional medical assistance, and Maori communities continued to rely on their *tohunga* and traditional remedies. Not until the early twentieth century did several new State health programmes begin to achieve a degree of outreach to Maori.

In central Hawke's Bay, by the end of the nineteenth century, the State-funded medical services were making very little contribution towards meeting the health needs of Maori. Subsidised doctoring through the NMO scheme had been discontinued for 30 years, while Napier Hospital was taking few Maori patients. During the first 30 years of the twentieth century, improvements in the delivery of Western medical care to Hawke's Bay Maori came largely from outside the hospital system.

5.2.8.2 *Vaccination*

Although preventive health technology in the mid-nineteenth century was in its infancy, one form in which it was promoted – vaccination against smallpox – was influential in shaping Maori perceptions of European medicine in the early colonial period.

Early vaccination efforts against smallpox were left largely to the local initiative of clergymen and doctors, both groups having commonly conducted vaccinations in Britain. The critical role played in this by the colonial government, as well as by the New Zealand Company, was the procuring and supply of the all-important vaccine. The Government also helped to pay the costs of local vaccination campaigns.¹²¹

116. Civil Commissioner to Native Minister, 23 October 1862 (quoted in doc U12, pp 58–59)

117. Ward 1995, p 195

118. Document U12, p 60

119. Dow 1999, pp 72–73; doc U12, p 60

120. Lange 1999, pp 176–178

121. Dow 1999, pp 50–53

A more organised effort was slower in coming. In 1854, the Government established a Central Board of Vaccination for the Aborigines of New Zealand and allocated £500 to its work, of which £15 was earmarked for Hawke's Bay. Local Maori took a positive interest.¹²² In 1863, a general Vaccination Act was enacted. However, vaccination efforts amongst Maori were episodic and patchy. Lange sums up the general picture thus:

But this campaign was prosecuted only sporadically, and certainly not consistently enough to maintain a fully effective protection against the disease . . . Another wave of activity against smallpox occurred in the 1870s and '80s . . . But the impetus was lost by the end of the century, and a new campaign was necessary after 1900.¹²³

Despite the personal efforts of Maui Pomare, the vaccination programme he launched was allowed to lapse, and, at the time of the 1913 smallpox epidemic, an estimated 85 per cent of Maori were unprotected.¹²⁴

Vaccination against typhoid was stepped up and applied mainly through schools during the 1920s and 1930s. The policy was unilateral and met some resistance, especially from Ratana Church members. However, the appallingly high incidence of typhoid amongst Maori was steadily reduced.¹²⁵

5.2.8.3 Medical services through schools

The earliest of the new community-based medical programmes was delivered through teachers in native schools, who dispensed medicines and basic medical advice to their local Maori communities. The service was initiated in the 1880s by the first organising inspector, James Pope, whose manual *Health for the Maori*, published in 1884 in Maori and widely disseminated in translation amongst Maori communities, provided practical advice on personal and community health measures.¹²⁶

Between Tangoio in the north and Waimarama on the coast to the south, in the 1930s central Hawke's Bay lacked native schools, although the Government funded the majority of pupils at the two church secondary schools for girls in Napier (Hukarere and Saint Joseph's) and at Te Aute College for boys south of Hastings.¹²⁷ Most Maori communities in central Hawke's Bay did not therefore benefit from this ad hoc but influential programme. Benefits were more limited for those whose children attended mainstream State schools. The school medical and dental services that started up in 1920–21 were at first too poorly funded to provide for all rural schools effectively. They had little community outreach. However, Maori children in the mainstream schools were at least brought within their scope.¹²⁸

122. *Wellington Independent*, 16 September 1854, doc U12(a), p 468; doc U12, p 5

123. Lange 1999, p 74

124. *Ibid*, p 154

125. Dow 1999, pp 190–192

126. Lange 1999, pp 75–82

127. For example, *AJHR*, 1930, 1936, E-3

128. Dow 1999, pp 203–207

5.2.8.4 Maori councils

A second programme, this time a direct response to Maori initiative, followed the passage in 1900 of the Maori Councils Act, which focused on preventive health and sanitation in Maori communities and enabled the councils to employ sanitary inspectors. The Maori health reformers who pioneered the programme were responding to a widely felt sense of crisis in Maori communities. More than half a century of epidemics and chronic diseases had decimated the population, and at the turn of the century it was not yet clear that the demographic decline had bottomed out.

While colonial leaders spoke with fatalism of a 'dying race', Maori had their own perspective on the crisis and discussed it widely. In 1896, a tangi oration at Maungapohatu gave it eloquent expression:

This rapid dying of our young people is a new thing. In former times our people did not die so – they knew no disease . . . These diseases which slay our people are all from the Pakeha . . . I see before me, O friends, the end of the Maori people. They will not survive. We can see plainly that our people are fast going from the earth. We have discarded our laws of tapu and trampled upon our mana Maori.¹²⁹

The young Maori reformers shared the sense of crisis, and sought to harness Western medical science for the salvation of their people. It was their major achievement that they succeeded in placing their health improvement proposals under the mana of traditional leaders within their communities. It would be a mistake to measure the success of the programme solely in terms of the number of sanitary inspectors employed or bylaws passed. Much of the health gain resulted from self-help efforts by village communities galvanised into collective action. Equally, some leaders and communities remained sceptical of a medical technology that had proved ineffective in the past and others lost heart for lack of financial resources and Government follow-up.

Government support was critical to success and failure. The Maori Councils Act 1900 provided for limited local self-government, through elected district councils and, under them, komiti marae at the village level. Tribal authority was respected and there was space for Maori initiative. At the same time, Maori medical professionals were appointed for the first time in the newly created Health Department: Dr Maui Pomare as native health officer (1901–11), who carried the campaign to many parts of the country, and Dr Peter Buck (Te Rangi Hiroa) as assistant native health officer (1905–09) and director of Maori hygiene (1920–27).

This new partnership-based approach soon ran out of steam, however, as the Government's political commitment faded and adequate resourcing failed to materialise. Few other Maori officials were appointed. Parsimonious funding allowed the councils to appoint only a handful of sanitary inspectors, who were often senior figures in their communities. A budget cut saw the dismissal in 1911 of the sanitary inspectors.¹³⁰ A modest revival in the 1920s under the Division of

129. Oration of Tutakangahau at a tangi, Maungapohatu, 1896 (quoted in Lange 1999, p 84)

130. Dow 1999, p126



Figure 19: The health reform pioneers pictured in the 1920s – Te Rangihiroa (Peter Buck), Apirana Ngata, and Maui Pomare. Photograph, Gisborne Museum and Arts Centre (020-1-11). Taken from Lange 1999, p260.

Maori Hygiene was also cut short after a decade when the small funding provided was mainstreamed.

In central Hawke's Bay, the home of the Te Aute Association, which galvanised the grassroots health campaign, the Tamatea Maori Health Council was based 'around Napier' and, according to Mr O'Malley, 'appears to have lasted longer and been more effective than some' (see map 8).¹³¹ In 1911, its chairperson, Ihaia Hutana from Waipawa, was one of the few salaried Maori sanitary inspectors. He was a prominent Ngati Kahungunu leader, farmer, newspaper publisher, Maori Land Board member and Te Aute College trustee. As well as every national conference of the Maori councils, Hutana chaired the Tamatea Council from 1901 until at least 1919. Under his leadership, the council was 'a most active and progressive body' and met regularly over a long period.¹³² All the same, 'it too seems to have been seriously hampered by the lack of resources and authority' that generally eroded the credibility of the councils amongst Maori.¹³³

The Maori councils were also pivotal mediators between Western and Maori medical traditions. Tohunga, to whom most Maori still turned in times of illness, had adapted their methods by selectively incorporating Western symbolism and medical techniques, much as untrained

131. Document U12, p 67

132. Lange 1999, pp 212, 227

133. Document U12, p 67; doc J4, pp 85–86; Dow 1999, pp 126–127

5.2.8.5

missionaries like Colenso had done half a century before. Some were skilled herbalists and healers, but others were ineffective and even dangerous. By the turn of the twentieth century, however, they were coming under pressure from reforming doctors and politicians, both Maori and Pakeha.¹³⁴

At first, the Maori councils were empowered to license tohunga. The Tamatea Council, in the progressive tradition of the reformers, scrutinised a number of applicants:

On one occasion the members interviewed a group of Nga Puhī tohunga, questioning them about the illnesses they dealt with, the methods they used, and their success rate; these tohunga called themselves 'takuta' (doctors), and kept notes of each case in a book. After much debate the council decided to license them.¹³⁵

But, in the end, Pakeha political pressure led to the Tohunga Suppression Act 1907, and the Maori councils were stripped of their authority. The wording of the Act attempted to target not classical herbalists so much as modernising tohunga and faith healers, but lumped competent modernisers like the takuta endorsed by the Tamatea Council together with the ineffective and the dangerous. As Mr Hiha pointed out in his brief of evidence, the Act stigmatised indigenous Maori medical practice.¹³⁶

The achievement of the Maori councils in improving community health practices in Maori villages showed that an alternative approach that valued Maori participation was viable. That approach combined three key elements. First, Maori professionals were the chief agents of reform. Secondly, Maori leaders, in particular rangatira, were fully involved in shaping and implementing the programme. Third, there was inclusive community involvement.

The brief flowering of Maori self-government and village sanitary improvement in the opening decade of the twentieth century was in the end a tragically missed opportunity to vest a modicum of medical resources and authority in local Maori communities. It was to have no sequel until late in the century.

5.2.8.5 *District nurses for Maori*

A third initiative followed in 1911, the same year that the Government cut its funding for the Maori council's sanitary inspectors, when the Health Department took up James Carroll's proposal for a Maori nursing scheme serving Maori communities directly.¹³⁷ During the 1890s, the Te Aute College Students' Association had promoted the concept of a community-based Maori nursing scheme, which was championed in the following decade by the Maori health reformers.

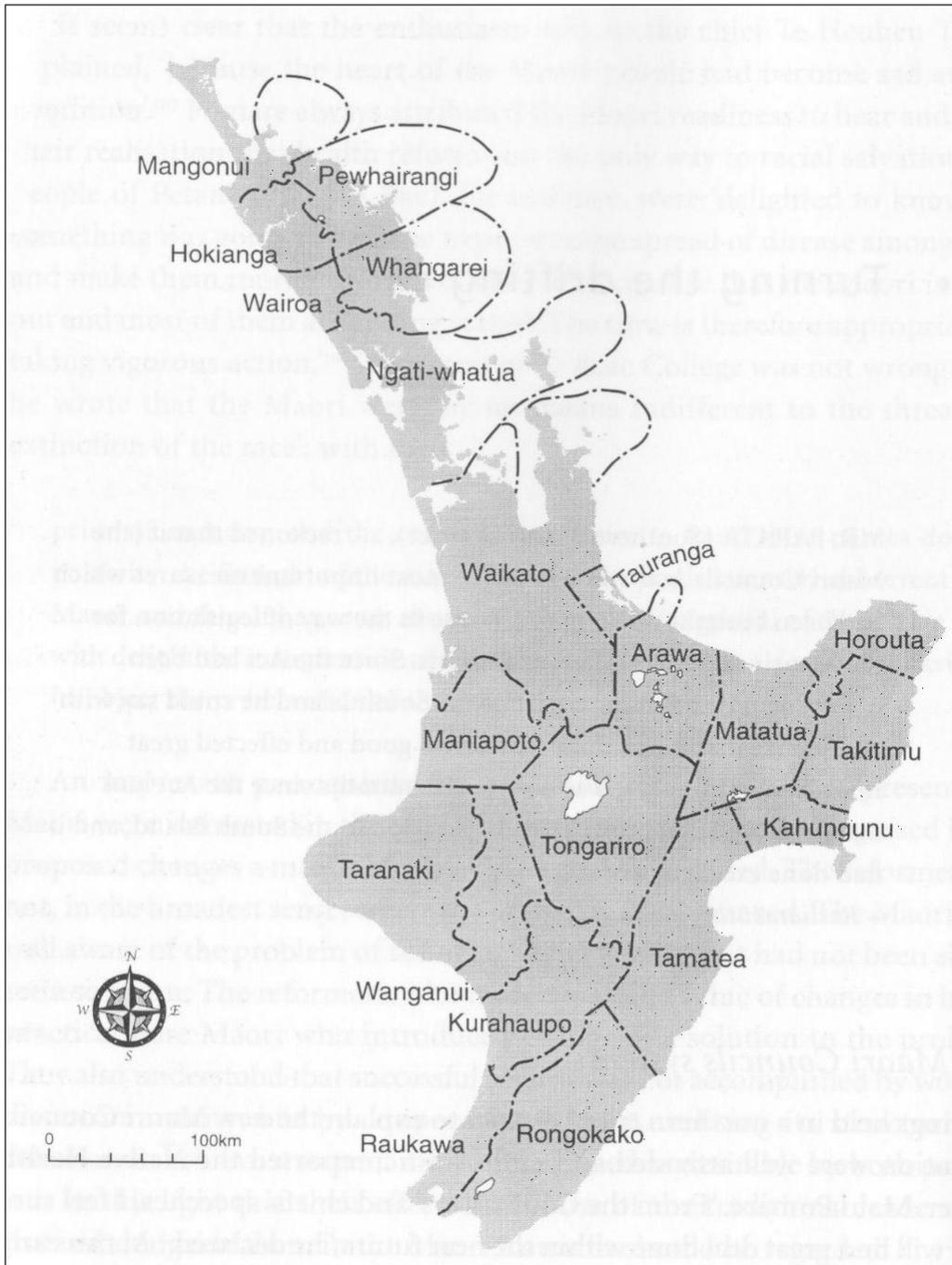
In 1898, Napier Hospital led the way by taking on two Maori nurse probationers. For many years thereafter, the hospital took two or three girls each year from the Anglican Hukarere and Catholic Saint Joseph's boarding schools in Napier. With Auckland Hospital, it was the pioneer of Maori nurse training. But the continuation of its acceptance of trainee Maori nurses was not

134. Lange 1999, pp 242–247

135. Ibid, p 246

136. Ibid, pp 247–250; doc v15

137. Document u12, pp 71–72; McKegg 1992



Map 8: Districts under the Maori Councils Act 1900. Taken from Lange 1999, p190.

helped by the sort of attitude expressed in 1928 by the hospital matron, who wrote that she would 'prefer not to have them at all but of course we have to help to train these girls to help their own people'.¹³⁸

138. Quoted in McKegg 1992, p151

In 1911, the Health Department finally launched a native health nurse scheme after an intricate turf war with the Department of Native Affairs. Maori were not consulted. During the following three decades, the number of nursing stations slowly expanded in rural areas with Maori populations. The scheme was to be largely centrally funded but administered by the hospital boards. Notwithstanding early training initiatives such as Napier Hospital's, few Maori nurses completed State registration before the 1930s, although some served as assistants to Pakeha nurses. Although a few Government scholarships were provided for further training towards State registration, the purpose of the training was not to fill professional nursing posts in hospitals but to serve and educate rural Maori communities. The scheme continued to be staffed mainly by Pakeha nurses.¹³⁹

This was rather different from the vision of the Maori health reformers. McKegg summarises the transformation thus:

From a vision of autonomous health reform, with designated ambassadors given the responsibility of selective acquisition and instruction in new health techniques, the scheme enlarged to one where imported agents for health were to instruct communities in foreign methods of health care. However Maori remained cautious and circumspect, and held on to levels of autonomy.¹⁴⁰

On the whole, Maori in Hawke's Bay responded more positively. A district nurse was stationed in Hastings to cover the whole of central Hawke's Bay. The nursing scheme won at least some local support, to the extent that in the late 1920s Hawke's Bay Maori contributed the not inconsiderable sum of £160 to purchase a car for their district nurse, with the hospital board paying the running costs.¹⁴¹

Some also wanted to bring in people in whom they had confidence. In 1929, 142 Maori from Waiohiki and district petitioned the Native Minister for an unqualified Pakeha nurse whom they trusted to be officially recognised and funded. It was a rare instance of Maori attempting to arrange a partnership with the State health system, but the Health Department rejected it as 'embarrassing', since 'they have a nurse in the district giving excellent service'.¹⁴²

Yet, only three years later, the region's medical officer of health was arguing that a strengthening of the frontline staff in both nursing and sanitary work was needed to begin to tackle the poor housing and health conditions in Hawke's Bay:

I rather incline towards the idea of concentrating the nurses' activities into smaller areas so as to secure definite results at least somewhere. But I am also convinced that our present staff on the Maori hygiene side is totally inadequate . . .¹⁴³

139. Lange 1999, pp 166–167, 173–176; Dow 1999, p 130

140. McKegg 1992, p 146

141. Document U12, p 72

142. Whakaiti Mohi and 141 others to Native Minister, 3 July 1929; marginal note on under-secretary, Native Affairs, to Director General of Health, 20 July 1929, doc U12(a), pp 304–305; doc U12, pp 72–73

143. Medical officer of health, Wellington, to Director-General of Health, 13 October 1932, doc U12(a), pp 300–301

The medical officer of health, speaking of the field supervision needed to eradicate scabies, then a common affliction, considered that ‘except for an occasional district nurse hospital boards are of no assistance in the matter’.¹⁴⁴ Little information is available on the policy of the Hawke’s Bay Hospital Board, but in 1935 it was contributing £50 a year towards rent for the Hawke’s Bay district nurse.¹⁴⁵

5.2.8.6 *Relief for indigents*

Under the hospital board regime introduced in 1885, the Hawke’s Bay Hospital and Charitable Aid Board was responsible not only for medical services at the hospital but also for the relief of the very poor under the rudimentary State welfare system. Illness and disability were major causes of extreme poverty, while poverty was widely associated with poor health.

In 1896–97, the board provided relief, mostly in the form of basic food rations, to 400 people. Unemployment was listed as the chief cause of poverty in 39 per cent of the cases, ‘no male support’ in 18 per cent, and old age in 9 per cent, but accidents and sickness accounted for as much as 27 per cent.¹⁴⁶ Hospital boards continued to administer the relief scheme, although it was largely marginalised in the 1930s by the State unemployment programme and the Social Security Act 1938. Even when Maori were admitted into the national unemployment relief scheme set up to counter the mass unemployment of the Depression, they were paid less on the basis that they could ‘live off the land’. This situation changed only when the first Labour Government equalised the rates after 1935.¹⁴⁷

This last-resort safety-net was in theory open to Maori as well as Pakeha. There are no data to indicate how many Maori, if any, actually used it, but in practice Maori were generally excluded before the 1930s. Even at that late stage, the Hawke’s Bay Hospital Board’s policy was to refuse to assist Maori. It provided no data on such relief for a Hospital Boards Association survey which revealed that over the three years to March 1932, covering the worst of the Depression, the majority of boards had made either small relief payments to Maori or none at all.¹⁴⁸

In 1935, the medical officer of health reported on the case of a Hastings woman who was ‘aged, bedridden and blind’, lacked money, food and clothing, and whose whanau was able to provide care but no material support. He complained that ‘I have approached the Charitable Aid Board, but they deny any responsibility for Maoris’, offering only ‘a little immediate assistance “if possible”’.¹⁴⁹

He requested referral to the Native Department. The department was still assisting ‘indigent natives’ from the £7000 civil list appropriation, which had remained unchanged since 1853, but under stringent conditions:

144. Ibid, p 300

145. Document U12(a), p 241

146. AJHR, 1897, H-22, p 38

147. King 1992, p 293

148. Secretary, Hospital Boards Association, memorandum, 7 October 1932, doc U12(a), p 260

149. Medical officer of health, Wellington, to Director-General of Health, 20 December 1935, doc U12(a), p 295

5.2.9

Necessary food & clothing only are supplied – never cash. Owing to the small amount of money available assistance is restricted to cases of extreme poverty coupled with physical disability.¹⁵⁰

In this case, which should have qualified, the department merely reported back three months later that the woman had recently died.¹⁵¹ To all intents and purposes, Ahuriri Maori had no safety-net to fall back upon, unless judged seriously ill enough for admission to hospital.

5.2.9 Maori ill health and the crisis of survival

5.2.9.1 Disease and depopulation

Maori ill health was widespread in the years before and during the negotiation of the Ahuriri transaction in 1851, and the situation improved little in the years following. Few Maori communities escaped the repeated onslaughts of exotic diseases. The measles epidemic in 1854 hit hard, as a correspondent from Hawke's Bay reported:

Several fatal cases have occurred in almost every Pa along the East Coast. The most important here is the death of Karanema, the eldest son of the principal chief Te Hapuku. The disease has been most fatal among the aged.¹⁵²

Two years later, a public meeting of settlers from the vicinity of Napier noted that 'much sickness has been prevalent for a considerable time amongst the Natives in the District'.¹⁵³ Takamoana pleaded in 1861 for a doctor to be sent, because 'the sickness is great'. For local Maori, the impact of disease and death, despite growing economic prosperity, was relentless.

Hawke's Bay Maori could not escape the crisis of survival that during the three decades following the signing of the Treaty of Waitangi confronted Maori everywhere. The chronic ill health resulted less from poverty than from lack of immunity to exotic diseases. So severe was the impact that the population went into sharp decline. Estimates of the Maori population are imprecise: they vary from 1100 for a wider area around Ahuriri in 1851 (McLean) to 680 from 'Ahuriri to Takitaki [sic] River' in 1858 (Fenton) and 674 from Petane to the Tukituki in 1881 (census).¹⁵⁴ Although the respective areas are only roughly comparable, the figures do point in the direction of a decline.

The most authoritative contemporary assessment available was made by William Colenso, who in 1865 estimated that the tangata whenua between Ahuriri and Palliser Bay had declined by more than a third from 3704 in 1847–48, when he took his own census, to 'under 2,000' in 1865, excluding Maori from other areas.¹⁵⁵ Mr O'Malley considers that, although this estimate may

150. Pearce to Director-General of Health, 5 April 1935, doc U12(a), p 243

151. Under-Secretary of Native Affairs to Director-General of Health, 30 March 1936, doc U12(a), p 294

152. *Wellington Independent*, 16 September 1854, doc U12(a), p 468

153. *Wellington Independent*, 16 August 1856, doc U12a, p 469

154. McLean journal, 3 January 1851, doc A21(e), p 1411; Fenton 1859, table

155. Colenso 1868, p 69. The figure of 3704 may have been derived from the Church Missionary Society's census attributed to 1846. See doc w1, pp 1–3.

have been an exaggeration, it is likely that a substantial decrease did take place and that introduced diseases were a major factor.¹⁵⁶ Colenso's assessment is in fact broadly consistent with Pool's estimate of a decline of some 40 per cent in the national Maori population between 1840 and 1874.¹⁵⁷ By 1868, George Cooper, then the resident magistrate at Napier, thought the rate of decline to be 'much less rapid than amongst other tribes', but 'nevertheless certain and steady'.¹⁵⁸

Colonial officials and politicians were well aware of the urgency of the situation. Throughout the nineteenth century, many adopted a fatalistic attitude, reflecting a general belief that ultimate extinction was inevitable. Maori were widely believed to be a dying race, a belief that remained widespread into the 1910s and 1920s. Notwithstanding the popularity of moral and racial theories of decline, ill health and vulnerability to disease were generally acknowledged to be prime factors.

Some acknowledged a duty of humanitarian intervention, even if they viewed it as a hopeless cause.¹⁵⁹ Walter Buller attributed to Dr Isaac Featherston the remark that has been taken to symbolise the public attitude of the times:

The Maoris are dying out, and nothing can save them. Our plain duty, as good compassionate colonists, is to smooth down their dying pillow. Then history will have nothing to reproach us with.¹⁶⁰

Buller traced Featherston's remark to 1856, at which time he was the superintendent of Wellington Province and responsible for Hawke's Bay, including public health services to its population. In his opening speech to the Provincial Council on 27 December 1855, Featherston expressed a similar sentiment:

Although I myself have long since come to the conclusion that no human means can possibly prevent the extinction at no distant date of the Native Race (an extinction attributable to causes which had their origin in their own savage customs and habits), still humanity and sound policy equally plead in favour of our doing our utmost to retard that event, and especially to prevent them falling victims to those epidemic diseases which colonization appears to have introduced, and which are now of annual recurrence.¹⁶¹

In this succinct statement is found, alongside the fatalism and cultural chauvinism, a clear recognition both of the colonial origins of a principal cause of the Maori demographic crisis (epidemic diseases) and of a moral responsibility to address that crisis.

It is difficult to establish when the demographic decline in the Maori population of central Hawke's Bay began to reverse. The census totals for Hawke's Bay County oscillated between 1200 and 1700 over the 40 years between 1886 and 1926. The 1921 figure was still low at 1396. Boundary

156. Document U12, p 39

157. Pool 1991, pp 58, 60, 76; also Ballara 1991, pp 54–59

158. AJHR, 1868 A-4, p 13

159. Lange 1999, pp 64–67

160. Quoted in Lange 1999, pp 65–66. Buller was speaking in 1884.

161. NZGG (Province of Wellington), 1 January 1856

changes and population movements explain only part of the variation. Not until 1936 did the census total of 2249 confirm that the Maori population was definitely on the increase.

5.2.9.2 Poverty and ill health amongst Hawke's Bay Maori in the 1930s

In the 1930s, the safety-net of basic medical care for Hawke's Bay Maori was still stretched very thin between the Native Department, the Health Department and the hospital boards. Maori had little option but to fall back on their whanau and community resources. As the medical officer of health acknowledged, 'the Maori does not parade his ill-health'. Nor could many Maori afford to pay doctors' fees any more than hospital bills: 'For reasons of poverty the Maoris very seldom consult private medical practitioners or dentists'.¹⁶²

In 1929, the district health nurse gave a succinct pointer to the limitations of frontline health promotion in conditions of deep poverty: 'The Maoris in certain parts of this district are very poor and suffer from malnutrition; as there are few means of remedying this condition it makes the nurse's work often extremely difficult'.¹⁶³ Three years later, the medical officer of health drew attention to the linkages between poor housing and living conditions and pervasive Maori ill health in Hawke's Bay. Noting that, 'from my own observation I know that housing conditions in many pas are appalling', he concluded:

In the aggregate there must be a vast amount of unnecessary suffering, crippling and mortality. The result is set out clearly in the Maori vital statistics concerning general death rate, infant mortality rate, tuberculosis death rate and respiratory diseases death rate for all who care to study them, and these figures reflect little credit on the healthiest country in the world.¹⁶⁴

The Director-General of Health referred the report to the Minister of Health, explaining:

I am bringing this case under your notice to show that the problem is an economic and social, as well as a medical one.

The main obstacles in the way of improving the health of the Maori are the poor housing and deficient dietary due mainly to poverty, and perhaps partly also to apathy and ignorance.¹⁶⁵

Apirana Ngata, the Native Minister, agreed that the issue was socio-economic, but attributed the present poverty rather to economic decline, a shortage of new houses, and the fact that land resources had 'dwindled by sales (mostly private sales) without the Maori population having acquired command of other resources to take their place'. He might also have added the Crown purchase of much of the Mohaka–Waikare raupatu district during the previous two decades. He noted the difficulty in securing public funds for Maori development projects, especially social projects, and concluded bleakly: 'I do not think that any increase of the medical or nursing service will do much good under the circumstances'.¹⁶⁶

162. Medical officer of health, Wellington, to Director-General of Health, 13 October 1932, doc U12(a), pp 300–301

163. Quoted in doc 04, pp 50–51

164. Medical officer of health, Wellington, to Director-General of Health, 13 October 1932, doc U12(a), pp 300–301

165. Director-General of Health to Minister of Health, 20 October 1932, doc U12(a), p 298; doc U12, p 78

166. Ngata to Minister of Health, 22 October 1932, doc U12(a), pp 296–297

5.2.10 Urbanisation and social reform

The circumstances, however, were about to change. After its election in 1935, the first Labour Government expanded the health service. Inoculation and vaccination became a standard feature at primary schools, and Peter Fraser, the Minister of Health, committed additional resources to Maori programmes:

As a result of a conference Fraser attended in 1936 on health and the economic position of Maori, additional health inspectors and district nurses were appointed for Maori schools. Subsidies were made available to improve the standard of drinking water at marae. To improve the nutrition of infant Maori, supplies of dried milk were made available and efforts stepped up to find out why the incidence of tuberculosis was greater amongst Maori than Pakeha.¹⁶⁷

Sectional schemes were soon overlaid by the inclusion of Maori in comprehensive social programmes. The introduction of universal entitlements and benefits, most notably through the Social Security Act of 1938, had an immediate impact on Maori by removing the cost barriers to accessing health services, especially hospitals. A leaflet published in English and Maori explained that the new benefits, including the invalid and sickness benefits, were also open to Maori.¹⁶⁸ However, the poor housing conditions were to take a couple of generations of national effort to resolve amidst growing economic prosperity and massive urbanisation.¹⁶⁹

The four decades from 1940 to 1980 witnessed far-reaching demographic, social and medical change. Urbanisation accelerated nationally, and in Hawke's Bay both Napier and Hastings grew apace. The Maori migration to the towns was even more rapid. In the 1930s, most Maori in central Hawke's Bay lived in rural kainga on the Heretaunga Plains and along the coast north of Napier. By the 1980s, the great majority resided in Hastings and Napier, and most were concentrated in a handful of adjacent suburbs in each town (see map 9). This was also a period of full employment and rising prosperity which saw the harsher consequences of rural poverty largely disappear.

The power of medical technology to advance personal wellbeing also made rapid advances. Many of the scourges of previous generations, such as tuberculosis and polio, could now be treated with drugs and prevented by immunisation. The move to the towns and universal welfare entitlement eased the access barriers. The indices of Maori health nationally and in Hawke's Bay, although still lagging behind the national norms, began to show steady improvement. However, since treatment by general practitioners was not subsidised, many Maori resorted to their local hospital for treatment of minor as well as acute conditions.

Increasing numbers of Maori used the services provided by the general hospitals in Napier and, from the mid-1930s, Hastings. The hospitals also began to employ Maori staff on a growing scale, especially in nursing and support services. By the 1980s, as far-reaching health reforms approached, both Napier and Hastings Hospitals were important facilities in the lives of the

167. Bassett and King 2000, p 152

168. Social Security Department 1939

169. Document U12, p 80

Maori communities they served. They remained, all the same, monocultural institutions that made few concessions to tikanga Maori.

5.3 THE POSITIONS OF THE PARTIES

5.3.1 The case for the claimants

Claimant counsel argued that from 1851 onwards the Crown failed to meet its health service obligations to Ahuriri Maori in respect of either the Treaty or the Ahuriri transaction. The scope of the claim extends both to hospital and to other State-provided health services to Maori. Although the historical breaches of the Treaty alleged by the claimants are not limited in time, in his closing submission counsel concluded his analysis at 1940 and pointed to an improving situation thereafter, partly as a result of changes in Government social policy.

The historical grievances alleged against the Crown by the claimants are expressed in broad terms.¹⁷⁰ The first is that the Crown ‘failed to consult with or otherwise adequately ascertain Maori health needs at Ahuriri’. We take this to mean a failure by the Crown to establish, by means consistent with its Treaty obligations, including consultation with local Maori, what were the health needs of Maori in the Ahuriri area. The grievance is expanded to include ‘failing to provide for adequate Maori representation and participation in health agencies in Ahuriri including the Hawke’s Bay Hospital Board’.

Claimant counsel pointed to a pattern of exclusion of local Maori from any involvement in official decisions affecting their access to State health services, the only exception being an appeal in 1877 for Maori contributions in land to the endowment of the planned new hospital. Counsel argued further that Maori were excluded altogether from representation in the governance of local health agencies, in particular the Hawke’s Bay Hospital Board. Nor did they provide for Maori participation. Counsel did not explain what was meant by ‘participation’ but referred to a pattern of non-existent or very limited hiring of Maori health professionals.¹⁷¹

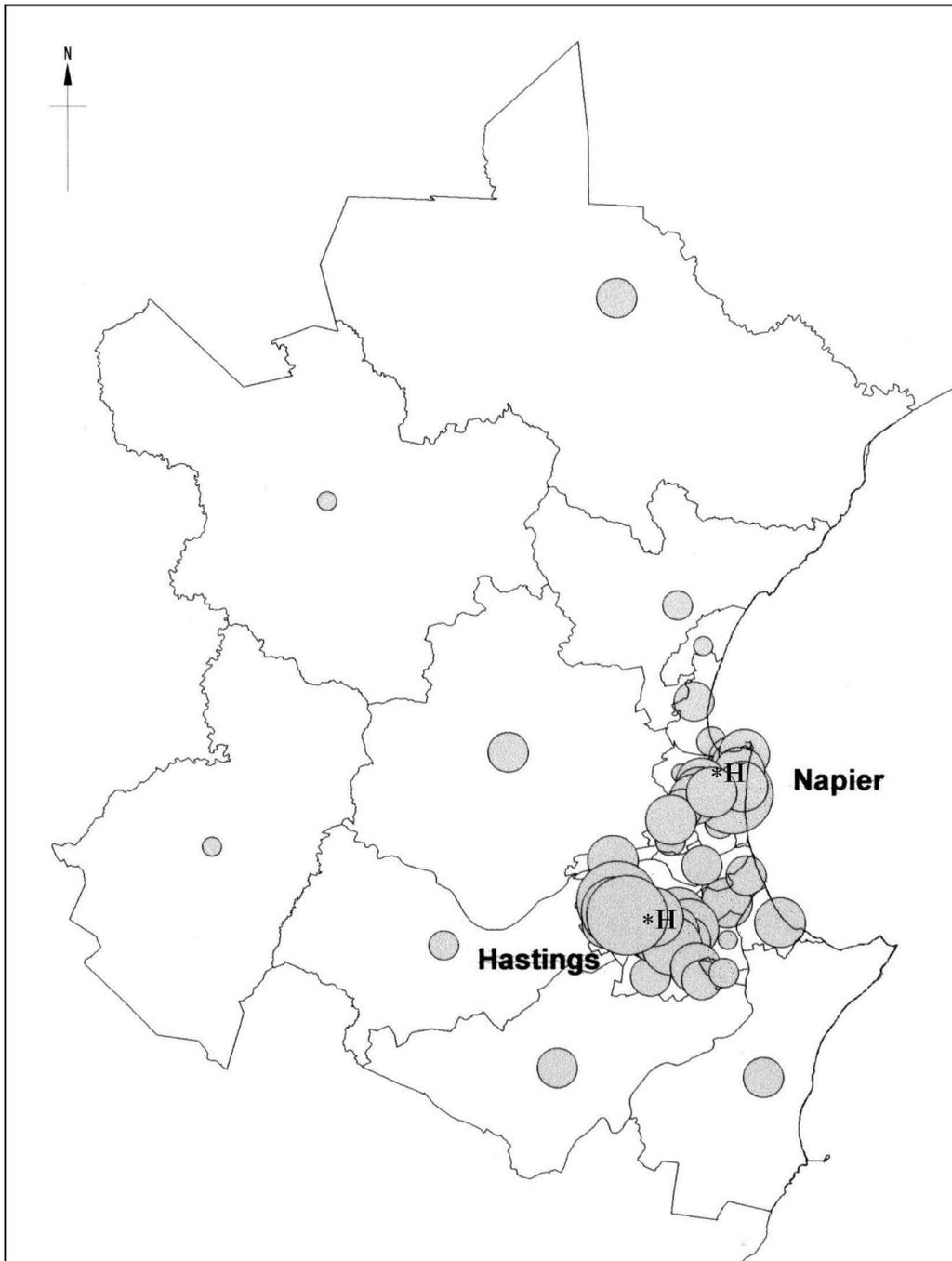
The second historical grievance is that the Crown ‘failed to give any control over the delivery or administration of health services and resources to Maori’. We assume ‘control’ to mean authority exercised alongside or jointly with the agencies identified in the first grievance, and ‘health services and resources’ to refer to all services and resources delivered through public and community channels. Such channels would exclude, for instance, private medical practitioners but include both State agencies and tribal organisations within Maori communities.

Claimant counsel alleged a failure by the Crown to make any provision for Maori to run their own health services or have a degree of control over health service delivery. He conceded that the limited local public health powers assigned under the Maori Councils Act 1900 did lead to the creation of the Tamatea Maori Health Council, but argued that it received limited Government funding and for a period of less than 10 years.¹⁷²

170. Claim 1.57(c), paras 6.1–6.3

171. Document x31, paras 6.21–6.23, 6.26

172. Ibid, paras 6.27–6.29



**Map 9: Distribution of the Maori population in central Hawke's Bay, 1991. Data from the 1991 population census.
The circles show the relative size of the NZ Maori population for each statistical area.**

The third historical grievance is the failure of the Crown 'to fulfill its promise to establish appropriate health services, including hospitals and resources so as to ensure Ahuriri Maori enjoy the same standards of health care as non Maori'.

Counsel argued that the health services provided by the State failed to ensure that Maori received the same standard of health care as non-Maori. In the field of secondary health services,

the colonial government moved belatedly and inadequately to fulfil its promise of a hospital. A hospital located on Mataruahou and, counsel claimed, intended for Maori was indeed built and opened, but not until 1860. It was too small from the start, user charges restricted access, and Maori usage in the 1860s was ‘intermittent’.¹⁷³ Later, discriminatory barriers hindered Maori access to the services provided by Napier Hospital.¹⁷⁴

As regards primary health services, the field doctor service provided under the NMO scheme was inadequate. An appointment was not made until 1857, the appointee neglected his duties to Maori, and the post was then abolished for good in 1867.¹⁷⁵ The only health programmes targeted specifically at Maori needs, sanitary inspectors under the Maori councils in the 1900s and the native health nurse scheme in the 1920s and 1930s, were inadequately resourced for addressing the disproportionately serious needs of Maori communities.¹⁷⁶

5.3.2 The response of the Crown

As we noted in chapter 4, the Crown presented no historical evidence. In his closing submission, Crown counsel stated that there was no evidence that the siting of the first Napier Hospital was an issue for Ahuriri Maori or was linked to the Ahuriri transaction. Nor did Mataruahou have special significance as a place of healing.¹⁷⁷ Crown counsel did not address either the evidence or the claimants’ arguments concerning the period after the building of the first hospital in 1860. He asserted in general terms the Crown’s categorical rejection of the historical aspects of the claim.

5.3.3 The claimants’ reply

In reply, claimant counsel considered that the Crown had not addressed the evidence presented. None of Crown counsel’s particularised comments ‘undermine the clear evidence of promise and expectation which was a part of the wider Ahuriri transaction’. Apart from the narrow question of the promise and siting of the first hospital, Crown counsel had not, in claimant counsel’s opinion, addressed at all the Crown’s alleged failure to meet its Treaty obligations to protect the health of Ahuriri Maori.¹⁷⁸ He submitted that ‘the evidence is comprehensive that the Crown manifestly failed to provide appropriate health care and health outcomes for Maori during the period up to 1940’.¹⁷⁹

173. Document x31, paras 6.13–6.18

174. *Ibid*, paras 6.24, 6.34–6.36

175. *Ibid*, paras 6.1–6.12, 6.19

176. *Ibid*, paras 6.31–6.33, 6.38

177. Document x48, paras 19.3–19.7

178. Document y8, paras 3.3–3.5

179. *Ibid*, paras 3.5–3.6

5.4 FINDINGS, TREATY BREACHES, AND PREJUDICE

5.4.1 The scope of our findings

We came to the conclusion in section 2.7.4 that, during the Crown colony and provincial periods up to 1876, all State medical services were under the control of the central government or the Hawke's Bay Provincial Council and were therefore the direct responsibility of the Crown. We also concluded that, from 1877 until at least the late 1930s, Napier Hospital came under local administration, subject to increasing but limited ministerial direction, and was therefore not the direct responsibility of the Crown. In this latter period, we therefore focus on the legislative framework for the services provided by Napier Hospital, and the effectiveness of central supervision in ensuring that those services fulfilled the Crown's Treaty obligations.

The limitation does not affect services provided by the central government, whose acts and omissions we review to the extent permitted by the evidence available.

Our approach to the assessment of findings, breaches, and prejudice arising in this lengthy historical period requires further comment. We have attempted to avoid the pitfalls of projecting the standards and understandings of the present into the distant past, while at the same time applying the fundamental values of the principles of the Treaty. At one level, modern terminology, carrying its baggage of embedded present-day assumptions, may sometimes obscure accurate meanings. Orthodox terms such as 'culturally appropriate' and 'cultural safety' may seem ill-suited to describing medical practice in the mid-nineteenth century. The underlying value is to be found, however, in responsiveness to tikanga Maori, which can be assessed in its context through all periods.

At another level, the evolution of civil society creates changing expectations of standards of State behaviour. Taking an aspect that features prominently in this report, consultation is today an established and formal part of the relationship between government service agencies and people affected by their actions. In the second half of the nineteenth century, the concept would barely have been recognised in the political language of the times. It would be invidious to criticise the Hawke's Bay Provincial Council for failing to consult Ahuriri Maori over the design and configuration of Napier Hospital by the standard appropriate for the decisions of Healthcare Hawke's Bay in the 1990s.

Yet, the partnership between the Crown and Maori instituted by the Treaty demanded effective communication. In the small-scale Pakeha society of nineteenth-century Hawke's Bay, informal networking and vigorous local body democracy dominated decisions on hospital projects and services. Government and provincial officials also made efforts to meet rangatira and attend hui for as long as they had political agendas to pursue. Established practice, in other words, had much of the flavour of what would today be understood by the concepts of consultation and representation. The underlying value is to be found in enabling the Maori voice to be effectively heard on matters affecting Maori needs and interests. In our view, those needs and interests extended to public health services, as they did for Pakeha.

In setting out our findings thematically, at the end of each section we have given our assessment of the extent of the prejudice arising from any breaches of Treaty principles. In many cases,

5.4.2

the type of prejudice points in broadly the same direction. We have integrated our assessment in the concluding section, which should be read in conjunction with the particular findings as to prejudice.

5.4.2 Consulting Ahuriri Maori and establishing their health needs

Extract from the statement of claim:

6.1 In breach of the duties and obligations set out in paragraphs 4 and 5 hereto, the Crown retained the land subject to the 1851 Ahuriri transaction and failed to consult with or otherwise adequately ascertain Maori health needs at Ahuriri.

5.4.2.1 Were Ahuriri Maori consulted on the siting of Napier Hospital?

Three principal episodes determined the planning and siting of Napier Hospital:

- ▶ the promise of a hospital at Ahuriri in 1851;
- ▶ the location and building of the first Napier Hospital on the Sealy Road site over the years 1854 to 1860;
- ▶ the relocation and building of the second Napier Hospital on the barracks reserve site over the years 1877 to 1880.

On the original promise of a hospital in 1851, our *findings* are:

- ▶ that Donald McLean discussed the creation of a new Pakeha town on the Western Spit with Ahuriri rangatira;
- ▶ that the town, and its public institutions, had the strong approval of the rangatira; and
- ▶ that McLean did not consult the Ahuriri rangatira on the exact site for the hospital that he promised them, but that they were content to leave the laying-out of the town to the Government.

On the location and building of the first Napier Hospital on Sealy Road, our *findings* are:

- ▶ that the commissioner of Crown lands in Napier did not involve Maori at all in the selection of a hill section on Mataruahou for the hospital reserve during 1854 and 1855;
- ▶ that the commissioner took no account of any cultural concerns that Ahuriri Maori might have had about the location of a place of healing; and
- ▶ that local Maori were not consulted on the building of the Sealy Road hospital on Mataruahou in 1859 and 1860.

On the location and building of the second Napier Hospital on the barracks reserve, our *findings* are:

- ▶ that local Maori were invited to contribute land towards the hospital's foundation but not to join its committee of management; and
- ▶ that Ahuriri Maori were otherwise not consulted on the relocation of the hospital to its new site.

Our finding as to *Treaty breaches* is:

- ▶ that the Crown's failure to consult over the siting of the first hospital (1854–55 and 1859–60) and to ensure consultation over the relocation of the second hospital to the barracks reserve (1877–80) breached the principle of *partnership* and the duty of *consultation*, but that at the same time Ahuriri Maori were less concerned about precise location than with opening hospital services.

Our finding as to *prejudice* is that no significant prejudicial effects resulted.

5.4.2.2 *Were Ahuriri Maori consulted on their health needs?*

As to whether Maori were consulted on their health needs, the available evidence is far from comprehensive as regards the situation in Hawke's Bay, and we limit our findings accordingly. On the period up to 1876 our *findings* are:

- ▶ that, during and following the negotiation of the Ahuriri Crown purchase, Maori leaders had and used opportunities to raise their health service needs with Government officials personally and in writing;
- ▶ that the reported experiences at the Government hospitals at Wanganui and New Plymouth during the 1850s made colonial officials aware of the importance of consulting local Maori on respecting tikanga Maori in order to provide them with an effective hospital service;
- ▶ that the provincial administration in Hawke's Bay made no attempt to do the same at Napier Hospital; and
- ▶ that the Government did not consult Ahuriri Maori on the removal of the NMO subsidy from Napier in 1867 or subsequently, when the scheme was expanded again, on whether there was a need for the restoration of the Napier NMO post.

Our findings as to *Treaty breaches* are:

- ▶ that consultation with Ahuriri Maori by the Government on the provision of a hospital and doctor, although largely reactive, was adequate in the 1850s and early 1860s;
- ▶ that the failure of the Hawke's Bay Provincial Council to consult Ahuriri Maori at any time about their health service needs and the configuration of services at Napier Hospital breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that the failure of the Government to consult Ahuriri Maori on the abolition and restoration of the NMO post at Napier breached the principles of *active protection* and *partnership* and the duty of *consultation*.

From 1877 until the 1930s, Napier Hospital was under local control. Our *findings* are:

- ▶ that the governing health legislation imposed no obligations on the authority controlling Napier Hospital, principally the Hawke's Bay Hospital Board from 1885, to consult local Maori on its facilities or services;
- ▶ that, except for the personal initiatives of individual medical professionals from the 1890s, there was little sign of official consultation between the board and Ahuriri Maori on health matters;

5.4.2.2

- ▶ that the Government's hospital inspection and supervision regime made no provision for Maori opinion to be taken into account; and
- ▶ that the dominant political ethos during the late nineteenth and early twentieth centuries accorded minimal importance to consultation, whether with Pakeha or with Maori, but that Maori were virtually excluded from the democratic governance of local bodies and hospital boards exercising delegated powers.

Our finding as to *Treaty breaches* is:

- ▶ that the failure to require, by legislation or other means, the Hawke's Bay Hospital Board to consult or otherwise take account of Ahuriri Maori views of their health needs breached the principle of *partnership* and the duty of *consultation*.

Other State services that operated in Hawke's Bay were centrally provided, mainly after the establishment of the Department of Health in 1900. Our *findings* are:

- ▶ that ministerial accountability to a parliament that included separate representation of Maori provided at minimum a rudimentary oversight of Maori interests in health service planning and delivery;
- ▶ that there was little consultation with Maori in Hawke's Bay on the establishment and operation of primary health care services such as the native health nurse scheme;
- ▶ that Ahuriri Maori were largely restricted to formal written applications to officialdom to convey their needs and proposals;
- ▶ that the methods of face-to-face consultation on village sanitary improvement pioneered under the Maori councils scheme in the 1900s established culturally meaningful and effective means of communication with Maori leaders and communities, including those within the Tamatea Maori Council district, which covered Ahuriri Maori; and
- ▶ that Maori councils, including the Tamatea Maori Council, were not brought into the consultation loop on primary health services despite having tribal legitimacy.

Our findings as to *Treaty breaches* are:

- ▶ that the development of general health programmes without specific local consultation was within the legitimate bounds of *kawanatanga*;
- ▶ that the implementation of health care programmes designed specifically for Maori, such as the native health nurse scheme, without some form of consultation inclusive of Ahuriri Maori breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that, by contrast, the mode of marae-based consultation on village sanitary improvement pioneered by the Department of Health through the Maori councils, including the Tamatea Maori Council, fully conformed to the principle of *partnership* and the duty of *consultation*.

Our findings as to *prejudice* are:

- ▶ that the failure to consult on the establishment of the first and second Napier Hospitals contributed to facilities that were too small to provide for the local Maori population and were not adapted to their needs, and thereby to few Ahuriri Maori receiving hospital treatment, notwithstanding the prevalence of widespread serious illness amongst them; and

- ▶ that the absence of consultation contributed to hospital and primary health services that failed to address the urgency of Maori ill health or to enjoy Maori confidence, resulting in many ill Maori failing to get the treatment they needed.

5.4.2.3 *Were sufficient steps taken to establish the health needs of Ahuriri Maori?*

Consultation was not the only or usually the main method by which the Government informed itself about health status and service needs. Our *findings* are:

- ▶ that, during the late 1840s and 1850s, Government leaders and senior officials were reasonably well informed about the severe impact of exotic diseases on Maori health in Hawke's Bay and the Wairarapa;
- ▶ that they were aware of the continuing Maori demographic decline through the late nineteenth century and the large role played by ill health;
- ▶ that, in the absence of consultation, local staff and ethnically defined hospital data, until the 1920s the Government health administration had no effective means of collecting information on the actual health status of Ahuriri Maori communities; and
- ▶ that, from the 1920s, district health professionals began to inform themselves, albeit anecdotally, of health conditions in Maori communities in Hawke's Bay.

Our findings as to *Treaty breaches* are:

- ▶ that the Government had sufficient broad information at the national level to comprehend the demographic and ill health plight of Maori as a whole; and
- ▶ that, by failing to inform itself of the actual health status of Ahuriri Maori communities until the 1920s and 1930s, and thus of the extent and type of need for primary health services, the Crown breached the principles of *active protection* and *partnership*.

Our findings as to *prejudice* are:

- ▶ that the failure to restore the Napier NMO post, in part due to the lack of specific information on health needs, deprived Ahuriri Maori communities for half a century of the most effective primary health care then available, leaving them at the mercy of the diseases sweeping their communities; and
- ▶ that, when primary health programmes did begin to reach Maori communities in Hawke's Bay in the 1920s and 1930s, the Government lacked sufficient information to configure them so as to deliver sufficient and appropriate services, leaving much Maori ill health untouched by effective medical treatment.

5.4.3 Representation, participation, and rangatiratanga

Extract from the statement of claim:

6.2 In breach of the duties and obligations set out in paragraphs 4 and 5 hereto, the Crown retained the land subject to the 1851 Ahuriri transaction and failed to give any control over the delivery or administration of health services and resources to Maori.

5.4.3.1 Were Ahuriri Maori represented in institutions determining their health services?

Between 1860 and 1876, the first Napier Hospital was run by the Hawke's Bay Provincial Council. The provincial surgeon who managed it was accountable directly to the superintendent of Hawke's Bay. Our *findings* are:

- ▶ that the provincial electoral system marginalised Ahuriri Maori rangatira and disfranchised the great majority of Ahuriri Maori;
- ▶ that no institutional relationships were established with Ahuriri Maori leaders; and
- ▶ that Ahuriri Maori were thereby denied the ability to advance their interests in, and exercise oversight in regard to, the provincial hospital service through the democratic process.

Our finding as to *Treaty breaches* is:

- ▶ that the failure to provide for Ahuriri Maori inclusion in provincial governance, including any say in the management of Napier Hospital, breached the principles of *partnership* and *equity*.

After the abolition of the provinces, from 1877 Napier Hospital fell under a local committee of management and from 1885 under the Hawke's Bay Hospital Board. Our *findings* are:

- ▶ that Ahuriri Maori were not invited to join the hospital committee between 1877 and 1885;
- ▶ that the local body franchise had the effect of excluding many Ahuriri Maori; and
- ▶ that the local electoral system made no provision, whether directly or indirectly, for Maori representation on the Hawke's Bay Hospital Board, either as a Treaty partner or as a minority interest.

Our finding as to *Treaty breaches* is:

- ▶ that the exclusion of Ahuriri Maori from the governance of Napier Hospital breached the principles of *partnership* and *equity*.

At national level, Ministers were from 1854 answerable to the House of Representatives both for nationally administered health services and, after 1876, for legislation governing the hospital services delegated to district boards. Our *findings* are:

- ▶ that, from 1854 to 1867, nearly all Ahuriri Maori were excluded from the franchise, but that the creation of the Napier NMO post, as in a number of other locations, was determined by agreement with Maori leaders;
- ▶ that, from 1868, Maori were represented in the House of Representatives by virtue of the four seats allocated to direct election by Maori, including those in Hawke's Bay through the constituency for Eastern Maori;
- ▶ that the influence of Maori members of Parliament over mainstream health services for Maori was marginal; and
- ▶ that, after 1900, the influence of Maori members of Parliament over programmes specifically for Maori was occasionally substantial, but marginal as regards the allocation of funds.

Our finding as to *Treaty breaches* is:

- ▶ that the failure to ensure any representation in the House of Assembly for Ahuriri Maori between 1854 and 1867, and thus any oversight over Government health services, breached the principles of *partnership* and *equity*.

Our findings as to *prejudice* are:

- ▶ that Ahuriri Maori were unable to influence the level, configuration and cultural sensitivity of services at Napier Hospital, greatly reducing Maori confidence in them and resulting in much untreated serious illness in Maori communities; and
- ▶ that Ahuriri Maori lacked parliamentary means of seeking redress for the poor performance of the Napier NMO and of contesting the withdrawal of the NMO post in 1867, which resulted in the loss of what was potentially the most effective medical service to their communities at the height of the devastation caused by introduced diseases.

5.4.3.2 To what extent did Ahuriri Maori participate in health provider agencies?

The extent to which Maori participated in the health sector workforce had a significant bearing on their acceptance of State health services. Our *findings* are:

- ▶ that, before the late 1890s, few if any Maori were employed at Napier Hospital;
- ▶ that, from 1898, Napier Hospital was a pioneer in training Maori nurses, but for the most part only on a small scale, in basic skills and primarily for service in Maori communities rather than in the hospital itself;
- ▶ that Napier Hospital appears to have taken on no Maori doctors and few other Maori staff until the late 1930s;
- ▶ that the national native health nurse scheme introduced in the 1910s and 1920s was staffed mainly by Pakeha nurses, a pattern that prevailed in Hawke's Bay;
- ▶ that the scarcity of Maori health workers at any level of the public health service in Hawke's Bay, as nationally, made it less sensitive to tikanga Maori in the field of health and reduced Maori confidence in its cultural responsiveness; and
- ▶ that State funding of medical training for Maori after 1900 afforded crucial opportunities for Maori medical pioneers, including those educated in Hawke's Bay, but remained far too limited to promote significant Maori entry into any professional medical field.

Our finding as to *Treaty breaches* is:

- ▶ that, although possibly impracticable in the late nineteenth century, the long-run failure to improve Maori workforce participation at Napier Hospital and in State primary health programmes operating in Hawke's Bay during the early twentieth century breached the principles of *partnership* and *equity*.

Our findings as to *prejudice* are:

- ▶ that, despite the pioneering initiatives of the Maori health reformers in the early twentieth century, Maori were denied equality of opportunity in access to employment at Napier Hospital and in primary health programmes in Hawke's Bay; and
- ▶ that Maori opportunity to influence the development of culturally sensitive hospital and community health care services in Hawke's Bay was reduced, contributing to the low Maori uptake of State health services.

5.4.3.3 To what extent were State health services delivered under Maori control?

The range of State health services provided to Ahuriri Maori was limited at first to Napier Hospital (from 1860), apart from a brief NMO service from Napier (1857–67). Later, schools (from the 1900s) and district nurses (from the 1920s) began to connect Maori communities to primary health care services. Our *findings* are:

- ▶ that the weight of evidence is that, with the exception of the Maori councils after 1900, no mainstream State health service in Hawke's Bay was delivered through or under the authority of Maori community structures before the 1980s;
- ▶ that neither the statutory regime nor Government supervision accorded Ahuriri Maori leaders and organisations any direct role in shaping the services provided by Napier Hospital; and
- ▶ that local Maori were allowed no formal control over primary health services to their communities, such as the native health nurse scheme, but may have been able to exert a limited degree of informal influence, for instance by contributing resources.

Our findings as to *Treaty breaches* are:

- ▶ that the absence of initiatives to give Maori a degree of control over hospital services for Maori at Napier Hospital may have missed significant opportunities to improve Maori uptake of hospital treatment but did not necessarily breach Treaty principles; and
- ▶ that a similar absence in respect of Department of Health programmes specifically for Maori also did not necessarily entail Treaty breaches, and that sufficient information is lacking to arrive at conclusions on the situation in Hawke's Bay.

The one major exception to this pattern of exclusion was the Maori council system, which from 1900 vested local powers of sanitary regulation in district councils and komiti marae. Our *findings* are:

- ▶ that the Maori council movement was the result of a Maori initiative driven by the Maori health reformers, and recognised Maori rangatiratanga over the management of sanitary improvement within Maori communities;
- ▶ that Government support to the movement through legislation, staff and scholarships had a positive impact in Hawke's Bay;
- ▶ that, although an active local force during the 1900s, the Tamatea Maori Council suffered, like others, from the parsimonious level of Government funding, which severely limited the development of the councils, was cut altogether in 1911, and was not sufficiently restored thereafter; and
- ▶ that the Tamatea Maori Council was able briefly to use its delegated powers to afford a degree of protection to Maori medical tohunga, but that these powers were removed by legislation in 1907.

Our findings as to *Treaty breaches* are:

- ▶ that, having launched the Maori council scheme and induced Maori, including Ahuriri Maori through the Tamatea Maori Council, to rely upon it for improving the health of their

communities, the Crown breached the principle of *partnership* by failing to resource the councils adequately or, for some years after 1911, at all; and

- ▶ that the removal of the power to regulate Maori medical *tohunga* and the partial suppression of *tohunga* by legislation from 1907 was in breach of the principles of *partnership* and *active protection*.

Our findings as to *prejudice* are:

- ▶ that the lack of funding for the work of the Tamatea Maori Council and of the Maori health reformers, especially after 1910, severely limited both their effectiveness and health improvement amongst Maori communities in central Hawke's Bay; and
- ▶ that the suppression of indigenous practitioners made it more difficult for Ahuriri Maori to seek alternative forms of medical assistance in a period when most relied on indigenous medicine for healing their afflictions.

5.4.4 The adequacy of State health services for Ahuriri Maori

Extract from the statement of claim:

6.3 In breach of the duties and obligations set out in paragraphs 4 and 5 hereto, the Crown retained the land subject to the 1851 Ahuriri transaction and failed to fulfil its promise to establish appropriate health services, including hospitals and resources so as to ensure Ahuriri Maori enjoy the same standards of health care as non Maori.

5.4.4.1 How adequately did Napier Hospital meet the health needs of Ahuriri Maori?

Ahuriri Maori were promised a hospital at a time when Governor Grey's regional hospitals were providing a service mainly for Maori. When the first Napier Hospital was built a decade later, it was established under provincial auspices mainly to serve the growing settler community. For the provincial period, our *findings* are:

- ▶ that Napier Hospital was a public hospital open to all races and there is no evidence of formal discrimination against Maori;
- ▶ that the provincial administration did not take up the colonial subsidy for Maori patients that it was apparently offered in 1859;
- ▶ that the fact that the hospital superintendent was also the NMO may have assisted referrals for hospital treatment between 1860 and 1867;
- ▶ that, from the outset, the small 10-bed hospital was too small even for the expanding settler community, let alone for local Maori, and was seriously sub-standard by the mid-1870s;
- ▶ that, despite the overcrowding, the hospital was competently run on the European model and provided good care for Maori military casualties from Omarunui and the East Coast; and
- ▶ that it accommodated few Maori civilian in-patients during the 1860s and 1870s.

Our findings as to *Treaty breaches* are:

5.4.4.1

- ▶ that the nine-year delay in fulfilling the promise of a hospital, although failing to take account of the urgent needs of Ahuriri Maori, was not unreasonable given the conditions of the time;
- ▶ that the hospital's open door to Maori conformed to the principle of *equity*;
- ▶ that the space shortage and sub-standard conditions affected Pakeha and Maori alike and so did not breach the principle of equity, but might have breached the principle of *active protection* had Ahuriri Maori sought in-patient treatment at the same rate as Pakeha.

The second Napier Hospital, opened in 1880, was run for the first few years under a local committee then, from 1885, by the Hawke's Bay Hospital Board. Our *findings* are:

- ▶ that, like other public hospitals, it was open to all without formal discrimination;
- ▶ that the distance barrier was small for the rural Maori communities of Ahuriri and Here-taunga, but more difficult for communities inland and to the north of Napier;
- ▶ that there is no evidence one way or the other that the Hawke's Bay Hospital Board succumbed to the bias against Maori as non-ratepayers that developed in a number of hospital districts;
- ▶ that Government policy was to treat Maori and Pakeha on equal terms, and therefore to refuse to subsidise hospital treatment for Maori, but conversely the Government did not assume powers to impose that obligation on hospital boards, including the Hawke's Bay board;
- ▶ that the greater inability of Maori to afford hospital fees and their reluctance to be exposed to debt recovery by hospital board officials discouraged many Maori from entering Napier Hospital as in-patients;
- ▶ that the high death rate in the era before antibiotics did not foster Maori confidence in hospitals as places of healing; and
- ▶ that the number of Maori in-patients at Napier Hospital appears to have been small until the 1920s and 1930s, despite the much higher incidence of ill health and death in Ahuriri Maori communities.

Our findings as to *Treaty breaches* are:

- ▶ that the admission of Maori to Napier Hospital and their treatment there, which were ostensibly on the same basis as Pakeha, were promoted but not fully assured by the controlling legislation and Government policy, and conformed to the principle of *equity*;
- ▶ that there is insufficient evidence to assess whether in practice or in all periods discrimination against Maori in their admission to, and standard of treatment at, Napier Hospital did not occur; and
- ▶ that the national policy of subjecting Maori in-patients to means-testing imposed a financial disincentive to hospital treatment through a period of widespread poverty, endemic ill health, heavy mortality, population decline, and very low uptake of hospital treatment, was applied at Napier Hospital, and breached the principle of *active protection*.

We have little specific information on outpatient and other services provided by the Hawke's Bay Hospital Board and the Government. Our *findings* are:

- ▶ that, until the crisis of mass unemployment in the 1930s, the board was no exception to the prevailing orthodoxy that excluded Maori from the safety net of outdoor relief for the very poor, including medical benefits, despite widespread poverty in Ahuriri Maori communities in the 1920s and 1930s;
- ▶ that Ahuriri Maori thereby also missed out on the medical assistance provided to beneficiaries;
- ▶ that rates of unemployment relief discriminated against Maori until 1935; and
- ▶ that the relief of Maori indigents provided through the Native Department was insufficient to meet Ahuriri Maori needs.

Our findings as to *Treaty breaches* are:

- ▶ that the failure to rectify the Hawke's Bay Hospital Board's exclusion of Ahuriri Maori from outdoor relief by legislation or other means was a breach of the principles of *active protection* and *equity*;
- ▶ that the discrimination against Ahuriri Maori in poor and unemployment relief breached the principles of *active protection* and *equity*; and
- ▶ that the failure to provide adequate relief to Ahuriri Maori indigents breached the principle of *active protection*.

Our findings as to *prejudice* are:

- ▶ that all but a handful of Ahuriri Maori who could have benefited from hospital treatment – battle casualties excepted – did not receive treatment in Napier Hospital during its first half-century, the period of their most urgent need; and
- ▶ that the exclusion of Ahuriri Maori from even the last-resort safety-net of outdoor poor and unemployment relief tightened the circle of exclusion from medical treatment, and worsened the high incidence of disease and death.

5.4.4.2 How adequately did State primary health services meet the health needs of Ahuriri Maori?

The national smallpox vaccination campaign may have touched Hawke's Bay briefly in 1854, and again a couple of decades later. This apart, until the late nineteenth century, all Government provision in the field of primary health care was channelled through the NMO scheme. Our *findings* are:

- ▶ that, although the Government response to the request of Ahuriri Maori for a doctor was less than immediate, in 1856 Donald McLean took advantage of the first realistic opportunity to secure a subsidy for the establishment of an NMO post at Napier in 1857;
- ▶ that, except for brief periods and military casualties, the NMO, Dr Hitchings, seriously neglected his duty to provide a field doctor service to Maori settlements near Napier;
- ▶ that the abolition of the Napier NMO post in mid-1867, and equally the failure to restore it when Government finances improved, stripped Ahuriri Maori of their only access to State-provided primary health care, aside from the outpatients' service at Napier Hospital;
- ▶ that the absence of native schools in the Napier area excluded Ahuriri Maori communities from a basic but significant source of medicines and advice;

5.4.4.3

- ▶ that, from the 1920s, Ahuriri Maori children attending State schools had access to the school medical and dental services to the extent that they were provided;
- ▶ that vaccination, notably against typhoid, may have begun to make an impact by the 1920s and 1930s; and
- ▶ that, from the 1920s, the district nurse based in Hastings achieved some outreach to Ahuriri Maori communities, but that the service was officially assessed in the 1930s as being seriously overstretched.

Our findings as to *Treaty breaches* are:

- ▶ that, in arbitrarily abolishing the NMO post in 1867 and in failing to restore it subsequently, while aware of the severe impact of introduced diseases and of ill health generally on Maori communities, the Crown breached the principle of *active protection*; and
- ▶ that the failure to extend other frontline primary health services to Ahuriri Maori communities in a timely manner and with sufficient resources breached the principle of *active protection*.

Our finding as to *prejudice* is:

- ▶ that Ahuriri Maori were left virtually without State medical assistance through the half-century of their greatest medical distress.

5.4.4.3 *Were State health services responsive to tikanga Maori?*

From the opening of the first of Governor Grey's public hospitals in 1847, the Government provided health services for Maori on the assimilationist model. The experience of hospital superintendents during the late 1840s and 1850s, when Maori formed a substantial proportion of patients, brought home to Government officials the importance of respecting tikanga Maori. Our *findings* are:

- ▶ that there was no attempt to draw on the experience of other public hospitals in assuring cultural sensitivity for Maori patients at Napier Hospital;
- ▶ that the services provided through Napier Hospital were, as in public hospitals generally, uniformly monocultural;
- ▶ that there is no sign in national legislation or policy of any attempt to make State health services responsive to Maori cultural preferences;
- ▶ that, although individual accommodations may have taken place, State primary health services in Hawke's Bay appear also to have been unresponsive; and
- ▶ that official support for the Tamatea Maori Council, as for the Maori councils generally, was restricted to community public health and had little effect on health care.

Our findings as to *Treaty breaches* are:

- ▶ that the failure to accommodate tikanga Maori in Napier Hospital during the provincial period breached the principle of *options* and, at a time of severe ill health and steep demographic decline, also the principle of *active protection*;
- ▶ that the failure to ensure by legislative or other means that Napier Hospital assured cultural responsiveness to Maori patients breached the principle of *options* and, as a major barrier

to Maori uptake of hospital treatment in times of severe ill health and mortality, also the principle of *active protection*; and

- ▶ that a failure to accommodate tikanga Maori in the Department of Health's primary health programmes may have breached the principles of *options* and *active protection*, but there is insufficient evidence from Hawke's Bay for us to reach definite conclusions in respect of Ahuriri Maori.

Our finding as to *prejudice* is:

- ▶ that the failure to accommodate tikanga Maori, especially cultural responsiveness, was a major factor in turning Ahuriri Maori away from Napier Hospital and in reducing the effectiveness of primary health care services, despite their urgent medical need.

5.4.4.4 *Was the delivery of health services to Ahuriri Maori adequately monitored and supervised?*

During the provincial period, our *findings* are:

- ▶ that the rudimentary hospital inspection procedure covered conditions for all patients equally, but not the specific needs of Maori patients;
- ▶ that there was apparently no formal procedure for monitoring Maori usage of Napier Hospital and improving Maori uptake, but that, in view of the small size of Napier Hospital and the provincial administration, informal methods probably sufficed; and
- ▶ that the Government attempted to respond to a formal complaint against the Napier NMO by Ahuriri Maori rangatira by setting performance standards and increasing the NMO subsidy but was unable to exert effective supervision.

Under the hospital board regime from 1885, our *findings* are:

- ▶ that the system of Government hospital inspection paid no attention to the effectiveness of services for Maori patients;
- ▶ that there was no monitoring of Maori hospital usage and the effectiveness of hospital services for Maori in Hawke's Bay and elsewhere; and
- ▶ that, in any case, the governing legislation did not provide powers of supervision over hospital board policy and practice.

Our findings as to *Treaty breaches* are:

- ▶ that there is not sufficient evidence that the provincial monitoring and supervision of Napier Hospital breached Treaty principles;
- ▶ that the failure to ensure a consistent improvement in the poor performance of the Napier NMO breached the principle of *active protection*; and
- ▶ that the failure from 1877 to monitor Maori usage of Napier Hospital and the effectiveness of its services to Maori, and to provide statutory means of remedying any deficiencies found, was a breach of the principle of *active protection*.

Our findings as to *prejudice* are:

- ▶ that the low usage by Ahuriri Maori of Napier Hospital's services was neither measured nor addressed, despite the intensity of their medical needs, resulting in much unalleviated ill health; and

- ▶ that the NMO's neglect of his duties deprived Ahuriri Maori of an effective field doctor service at a time of urgent need.

5.5 OVERVIEW OF PREJUDICIAL EFFECTS

In previous sections, we have found that the Crown breached the principles of the Treaty in a number of fields of policy, action and omission, at widely differing scales of impact, and over periods of time varying from a few years to the best part of a century. We have also assessed, to the extent possible, the specific prejudice arising from each breach.

Assessing the extent of prejudice in terms of the effects on human wellbeing is, however, more elusive than in the case of real property such as land, to which precise quantities and values can be attributed. The concepts of wellbeing and ill health are themselves culturally determined and in constant evolution. The measurement of ill health is the product partly of improving science and technology and partly of cultural perception. The effects of medical treatment are interrelated, greater success in frontline primary care, for example, reducing the incidence of later acute hospital admissions for some diseases and complications. Causes of ill health are also sometimes amenable to medical intervention – for example, by vaccination or by removing environmental sources of infection – but often not at all, or only in combination with other interventions, such as improvements in housing or diet.

We must furthermore bear in mind the limits of scientific understanding and medical technology. During the century following 1840, medical science made enormous advances, but medical therapies remained ineffective against many of the most widespread and devastating diseases, such as tuberculosis – the antibiotic revolution had yet to begin.

We are in no doubt that the impact of ill health on Ahuriri Maori between 1840 and 1940 was devastating. The clearest index of this impact was the effect of high mortality on population. Nationally, the Maori population halved between 1840 and the 1890s and moved into steady recovery only during the 1920s and 1930s. The Maori population of Hawke's Bay County, including the Napier area, followed a roughly similar trend. It took three-quarters of a century to pull through the crisis of survival. Once achieved, widespread ill health continued to affect Maori communities, even though the proportion dying of disease had decreased.

No matter how assiduous the Crown's performance of its duty of active protection through medical services to Maori, there can be little doubt that Maori would not only have suffered greatly from ill health but also have been worse affected than Pakeha. Once connected to the global disease pool, the march of introduced diseases was inexorable. It was probably not until the early twentieth century, according to Pool, that the Maori population approached convergence with Pakeha immunity patterns for most major diseases.¹⁸⁰ Only thereafter did equality of health outcomes become in principle an achievable goal.

180. Pool 1991, pp 86–87, 101, 116–117, 128

We cannot consider in this report the many complex factors in the causation of ill health amongst Ahuriri Maori, which are not the subject of this claim and on which little evidence has been led. The focus is rather on the extent to which medical intervention could have reduced, by prevention, the incidence of disease and, by therapy, the impact of disease and accident in terms of illness, injury and death.

Here, the converse of the bleak picture depicted above, that of the limited preventive and curative powers of European medical technology in the pre-antibiotic age, is its improving effectiveness from a starting base of virtual impotence. Dr Featherston may have been realistic in his appreciation of medical limitations in remarking in the mid-1850s that the colonists' duty to Maori was at least 'to smooth down their dying pillow' but, by the 1920s and 1930s, Western medicine was capable of a great deal more than that. Furthermore, from the time of Governor Grey onwards, each succeeding generation of medical professionals and political leaders believed in its expanding powers.

The chief indictment of the Crown's failure is not that it breached the principle of equity by discrimination against Maori – Napier Hospital was open to all and gave equal standards of treatment. It is that the Crown breached the principle of active protection – like the priest and the Levite in the parable of the Samaritan and the wounded stranger – in passing by on the other side and doing, if not nothing, then very little to help.¹⁸¹ The health plight of Ahuriri Maori was well known from the earliest years. So too was the fact that, despite their plight, few Ahuriri Maori entered Napier Hospital or, after the NMO post at Napier was abolished, could afford private doctors' fees. Yet, aside from the minimally funded Tamatea Maori Council and the overstretched district nurse, little was done between the 1860s and the 1930s to tackle this virtual medical exclusion. Even recourse by Maori to their own medical *tohunga* was hampered under the Suppression of *Tohunga* Act 1907.

We cannot today reconstruct a balance sheet of prejudice in terms of Ahuriri Maori lives lost or blighted from preventable disease between 1840 and 1940. Nevertheless, we do not doubt that the toll was considerable, nor that it mounted as medical capability improved and yet the potential benefits were not provided to Ahuriri Maori. Only late in this century of exclusion did Napier Hospital begin to cure a significant number of sick Maori, the native health nurse scheme reach Maori communities, and the school health service treat Maori children.

Over the following half century, into the 1980s, Maori health improved dramatically. The claimants have raised no grievances concerning this period. But at the end of it, the health disparity between Maori and non-Maori in central Hawke's Bay was still wide. The legacy of the past had yet to be overcome.

181. Luke 10:30–36

CHAPTER 6

CONSULTATION WITH MAORI ON THE CLOSURE OF NAPIER HOSPITAL

6.1 CHAPTER OUTLINE

This chapter covers the 20-year period between the first concrete proposal for a regional hospital in 1980 and the closure of Napier Hospital in 1999. The history of these years is greatly complicated by successive major reforms to the State health system. Accordingly, we begin with a brief outline of the phases of structural change (section 6.2.1).

We review the major decisions that led to the downgrading of Napier Hospital and the extent of the consultation with Ahuriri Maori on each decision. There are eight sections:

- ▶ 1980–May 1989: The final years of the Hawke’s Bay Hospital Board, covering the first proposal to construct a regional hospital and the aftermath of its failure (section 6.2.2).
- ▶ June 1989–July 1991: The short-lived Hawke’s Bay Area Health Board, covering the proposal to regionalise hospital services and the public consultation on the recommendations of the Booz-Allen report (section 6.2.3).
- ▶ August 1991–June 1993: The transitional period under a health commissioner and CHE board-designate, covering the question whether the decision to have a regional acute hospital had already been made in principle before the CHE was formally established (section 6.2.4).
- ▶ July 1993–April 1995: Healthcare Hawke’s Bay’s decisions to build a regional hospital at Hastings and to downgrade Napier Hospital to a non-acute facility (section 6.2.5).
- ▶ April 1995–December 1996: Healthcare Hawke’s Bay’s implementation of the regional hospital in Hastings and the Central RHA’s lifting of the site guarantee for Napier Hospital (section 6.2.6).
- ▶ January–December 1997: Healthcare Hawke’s Bay’s decision in principle to vacate the Napier Hospital site for a downtown health centre (section 6.2.7).
- ▶ January 1998–April 2000: Healthcare Hawke’s Bay’s closure of Napier Hospital and establishment of the Napier Health Centre (section 6.2.8).

We also consider the claimants’ cultural perceptions of the hospital and health centre sites (section 6.2.9).

6.2 ANALYSIS OF THE EVIDENCE**6.2.1 Health reforms and institutional restructuring****6.2.1.1 Phase 1: area health boards (1989–91)**

The first comprehensive reorganisation of public hospitals for more than a century was implemented nationally in the late 1980s. Part of the impetus for the change came from the general State sector reforms of the period. But the concept of larger regional health agencies providing an integrated range of health services had been on the national policy agenda since the publication of a health White Paper in 1974. The end result, completed in mid-1989, was the creation of a nationwide system of area health boards.

Amongst the many changes, four are of particular relevance. First, the new system retained local democratic accountability. Like the hospital boards, the members of the area health boards were elected by their local communities, albeit with additional Government appointees.

Secondly, the reform established explicit financial accountability to the Government. Previously, hospital boards were answerable to their local electors but spent central government funds. Now, area health boards signed contracts with the Minister of Health and had to prepare five-year strategic plans that delivered Government objectives. Performance was assessed and future funding was potentially at risk.

Thirdly, area health boards served larger catchment populations. A wider regional focus supplanted the primacy of parochial interests. Since funding was based on a population formula, boards had an incentive to rationalise their services on the basis of efficiency.

Fourthly, the boards were mandated to provide a more comprehensive range of health services – preventive as well as curative. They included a number usually delivered through non-hospital institutions, such as health education, health promotion, targeted special programmes and community health initiatives. The weight of emphasis shifted from institutional towards service development.

Controlling the fiscal risks of health expenditure was a major Government concern. So too was the impact of a rate of health cost inflation running well ahead of general inflation. Rapid advances in medical technology both increased the costs of existing treatments and extended the frontiers of medical intervention. Embedded in the tighter contractual relationship between the area health boards and the Government was a rationing of health resources to national priorities for public health provision.¹

6.2.1.2 Phase 2: RHAS and CHES (1991–96)

In November 1990, there was a change of government. Early the following year, the new National Government announced a second wave of health sector reform. Based on the recommendations of the 1988 Hospital and Related Services Taskforce, which the previous Labour Government had rejected, the reform applied market principles to State-provided health services. For the first time since the mid-1850s, democratic accountability to regional electorates was removed from the public hospital system.

1. Document v1, pp 3–4; Conly 1992, pp 277–279

The reform inaugurated radical structural change. In the nineteenth and early twentieth centuries, hospital boards had raised part of their own funding as well as providing services. In the second half of the twentieth century, hospital and then area health boards had relied on central government for their funding. The 1993 reform split health service functions between three types of agency: funder (the Ministry of Health), purchaser (RHAS) and provider (CHES, as well as non-State agencies).

This new purchaser–provider system was implemented in two stages. A transitional stage lasted for two years from July–August 1991 to June 1993:

- ▶ at the national level, the National Interim Provider Board oversaw health expenditure and established the RHAS;
- ▶ also at the national level, the Crown Health Enterprise Establishment Unit (CHEEU) worked with appointed CHE boards-designate to take over the area health board organisations; and
- ▶ at the district level, commissioners appointed by the Government managed the area health board operations.

Then, in July 1993, the new institutions took over:

- ▶ The Department of Health was replaced by the Ministry of Health, which provided population-based health service funding as well as policy advice.
- ▶ The Public Health Commission was directly responsible for public health services.
- ▶ Four RHAS, under boards appointed by the Ministry of Health, had population-based grants to disburse. They took responsibility for determining health needs. They then purchased services from providers, which could include not only the established public institutions but also any mix of commercial, community and voluntary organisations. The RHAS were also given an expanded mandate to integrate the purchasing of primary and secondary care for which the Government provided funding.
- ▶ The 14 area health boards were replaced by CHES. The CHES, under boards appointed by the shareholding Ministers (finance and health), now had to negotiate with the RHAS for State funding. They were placed on a competitive footing with other non-State providers (private sector businesses, not-for-profit bodies, and voluntary organisations). Their mandate was to run the Government’s health services, centred on the public hospitals, along commercial lines. User part-charges were introduced.
- ▶ An autonomous wing of Treasury, the Crown Company Monitoring Advisory Unit (CCMAU), succeeded the Crown Health Enterprise Monitoring Unit (CHEMU) to oversee the Crown’s ownership interest in the CHES on behalf of the shareholding Ministers.

6.2.1.3 The health reforms, phase 3 (1997–2000)

Following New Zealand’s first mixed-member proportional election in 1996, the National and New Zealand First political parties formed a governing coalition. As a result of their coalition agreement in December 1996, the purchaser–provider institutional structure was modified in two respects.² At the funder level, the four RHAS were amalgamated into a single national

2. Health and Disability Services Amendment Act 1998

6.2.1.4

organisation. This operated from June 1997 as the Transitional Health Authority, becoming in 1998 the Health Funding Authority.

At the provider level, in 1998 CHES were renamed hospital and health services. Their profit-making business mandate was changed to a non-profit, break-even requirement.

Alongside the structural changes, the mandate of the purchaser and provider agencies was expanded when in 1996 they were assigned the functions of the abolished Public Health Commission.³

6.2.1.4 The health reforms, phase 4 (2001)

The November 1999 election brought about a change of government to a Labour–Alliance coalition. The new government abolished the purchaser–provider split. Under the Public Health and Disability Act 2000, from January 2001:

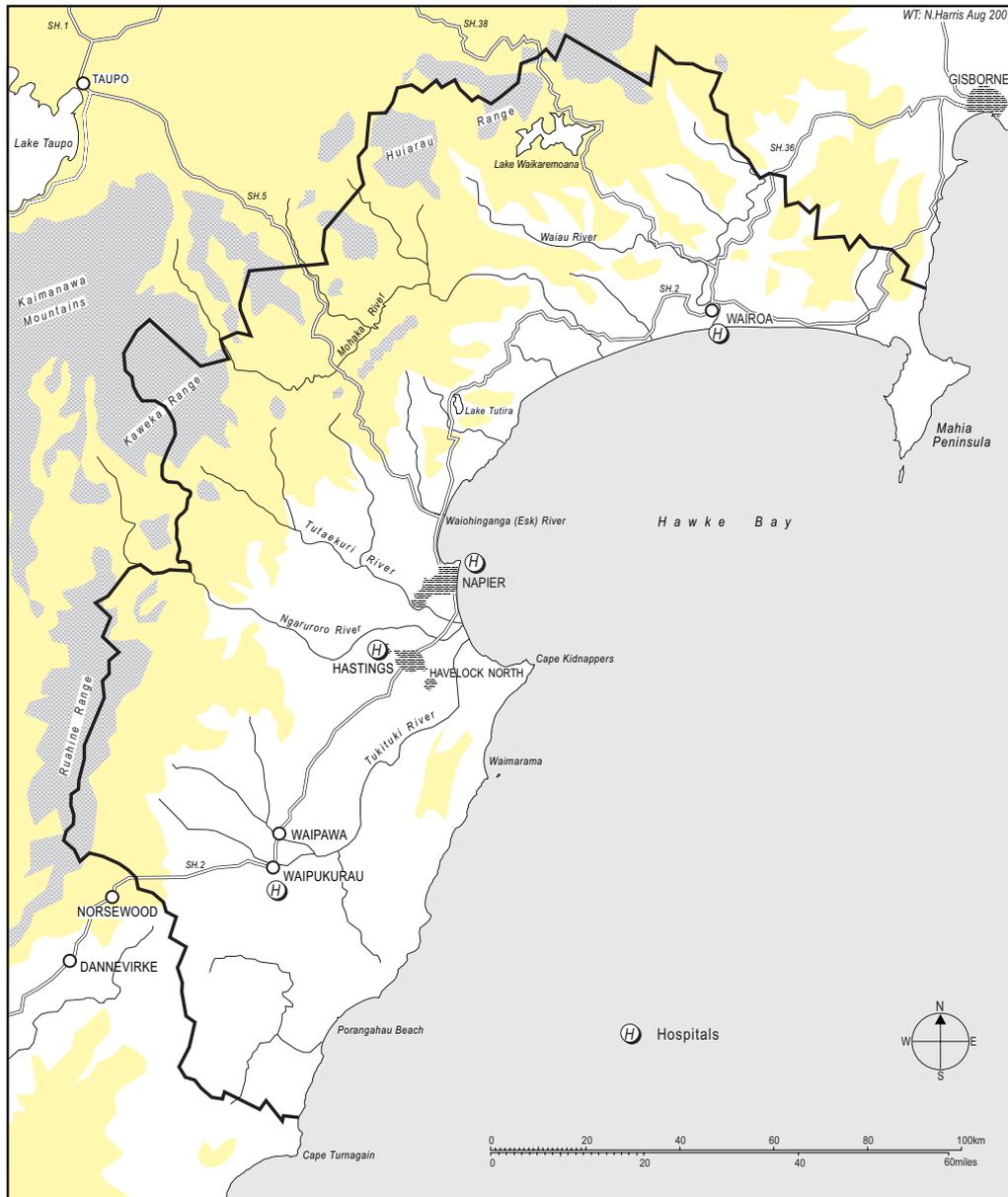
- ▶ the HFA was absorbed into the Ministry of Health; and
- ▶ HHSS were replaced by mixed district health boards with a majority of elected members.

6.2.1.5 Restructuring in Hawke’s Bay

The restructuring of the State health service in Hawke’s Bay followed the national timetable (see chart 3):

- ▶ The Hawke’s Bay Area Health Board took office on 1 June 1989, combining the catchment areas of the Hawke’s Bay and Central Hawke’s Bay Hospital Boards. The new board covered an area from north of Mahia and Lake Waikaremoana south to Takapau and Cape Turnagain, and also took in the Chatham Islands. As well as the two base hospitals in Napier and Hastings, it ran small general practitioner staffed hospitals in Wairoa and Waipukurau. It served a population numbering 137,949 at the 1991 census, of whom 22.4 per cent were of Maori ancestry and 11.7 per cent were affiliated to Ngati Kahungunu (see map 10).
- ▶ The area health board was abolished on 2 August 1991. Its previous chairperson, Andy Train, was appointed as the commissioner to manage health services during the transition. Alongside him, a CHE advisory committee was appointed; it recommended the establishment of a single CHE covering the same region as the area health board. In late 1992, a board-designate was appointed to prepare for the CHE’s incorporation. Both the advisory committee and the board-designate were chaired by Peter Wilson.
- ▶ On 1 July 1993, the Central RHA assumed responsibility as the State funding agency. It covered an area stretching west from Hawke’s Bay to Wanganui and south to the northern South Island.
- ▶ Also on 1 July 1993, the new CHE, initially known as Crown Health Hawke’s Bay Limited and then as Healthcare Hawke’s Bay, took office. In 1998, it became a hospital and health service, in which capacity it continued until it was replaced in January 2001 by the Hawke’s Bay District Health Board.

3. NZG 1996, p 862



Map 10: Service area of Crown health agencies in Hawke's Bay, 1989–2001

6.2.2 The regional hospital concept revived and deferred (1980–89)

6.2.2.1 Prologue: hospital rivalry between Napier and Hastings

The history of the hospitals in Hastings and Napier has been strongly influenced by a rivalry between the two towns that has run, sometimes fiercely, for more than a century. When the first Napier Hospital was established in 1859–60, Hastings did not exist. And when the more substantial replacement hospital was being planned in the late 1870s, Napier had been the provincial capital for a quarter of a century and Hastings was still a fledgling settlement on the Heretaunga Plain.

By the beginning of the twentieth century, however, the rapidly growing prosperity and diversification of the farming economy was building Hastings into the principal commercial service centre of the region. Napier, by contrast, was both isolated by its swampy terrain and increasingly starved of land for expansion. By the 1930s, the population of Hastings was rapidly catching up: comparing their wider urban areas, at the 1936 census Hastings was, at 17,961 residents, less than 1000 short of Napier's 18,689.

As early as 1898, the Hastings Borough Council pushed for a cottage hospital in Hastings. Then, as now, its supporters cited the barrier of distance, in this case from the Hastings area to Napier, as a serious disadvantage. Over the next two decades, a number of municipal and public campaigns made little progress. At the end of the First World War, civic leaders promoted the idea of a cottage hospital and maternity home as a memorial to soldiers killed in action. Owing to a lack of support from the Hawke's Bay Hospital Board, the hospital had to be financed largely from public subscriptions.

The Fallen Soldiers' Memorial Hospital, as it was named, finally opened in 1928. But even then, the hospital board restricted it to maternity and outpatient services and refused to start up an accident and emergency facility, despite space being available for one. An important influence was concern amongst Department of Health officials at the possible loss of efficiency were facilities at the base hospital in Napier to be duplicated in Hastings; departmental policy was to have all specialist services located in base hospitals.⁴

Napier Hospital was virtually destroyed in a major earthquake in 1931 that caused widespread damage to the city. As an alternative to rebuilding it, civic leaders in Hastings campaigned for the regional base hospital to be relocated there. After a bitter inter-town battle, Napier Hospital was restored. However, with the assistance of a large bequest, Hastings also won its case for a general hospital. For the next half-century, both Memorial Hospital and Napier Hospital expanded as independent and fully equipped base hospitals.⁵

The inter-town rivalry intensified after the Second World War as urban growth accelerated and economic and cultural contrasts sharpened. Commercial and industrial development was concentrated in and around Hastings, notably in the form of large meat works and food processing factories and in businesses serving the increasingly intensive agricultural economy of the Heretaunga Plain. At the same time, the uplift of land in the 1931 earthquake released Napier from its swampy straitjacket, and it remained the centre of an expanding governmental and local body bureaucracy, of regional transport and distribution, and of tourism.⁶

By the 1980s, both cities had tripled in size. At the 1981 census, Hastings had drawn slightly ahead with an urban area population of 55,197 compared to Napier's 52,285. This period also witnessed the rapid and almost complete urbanisation of the Maori population of central Hawke's Bay, as well as in-migration from other districts. From under 500 in 1936, the Maori population of the Hastings and Napier urban areas had grown to 17,523 by 1981 and accounted for 94 per

4. Shaikh 1992, pp 5–6; Boyd 1984, pp 210, 220–222; Conly, 1992 pp 71–72, 97–114

5. Shaikh 1992, pp 6–7; Boyd 1984, pp 224–227; Conly 1992, pp 125–138, 192–201, 214–245

6. Boyd 1984, chs 11, 15

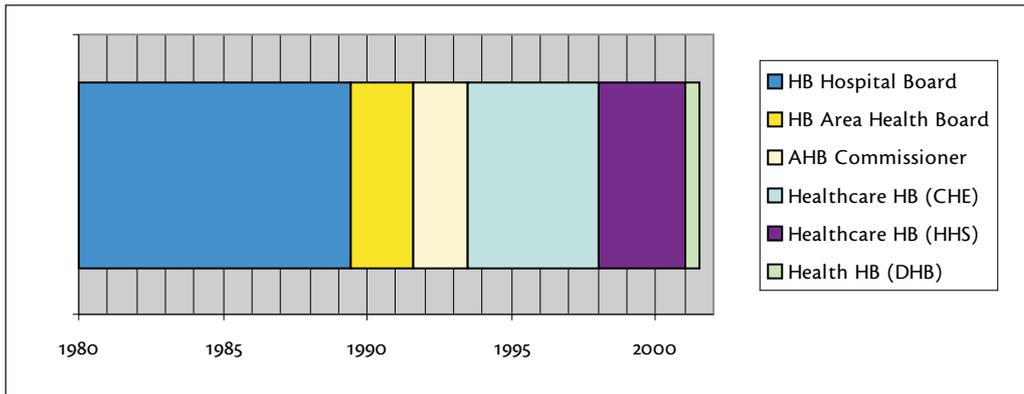


Chart 3: Timeline of health agencies in Hawke's Bay, 1980-2001

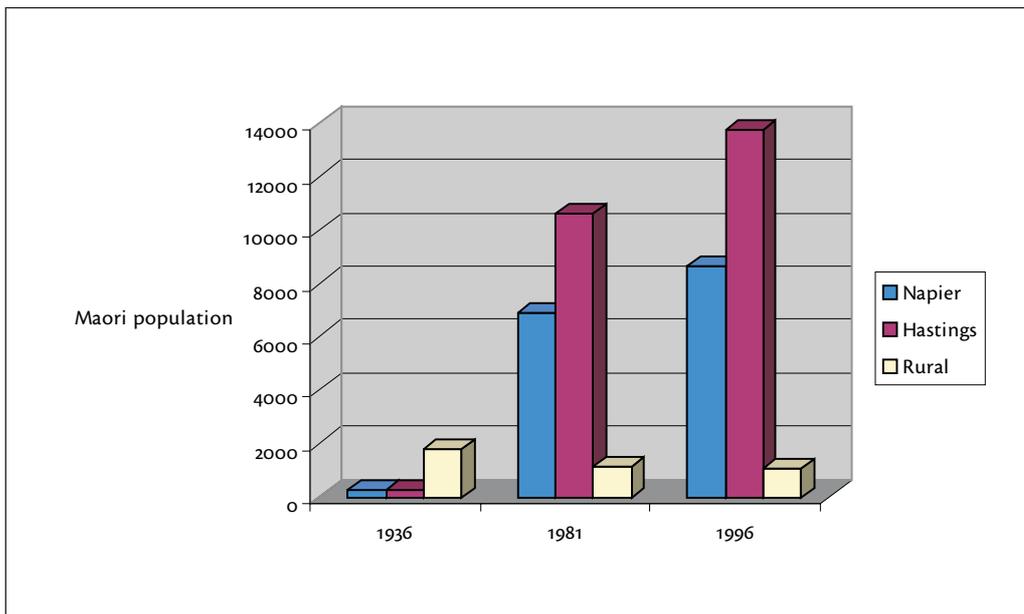


Chart 4: Maori urban and rural population of central Hawke's Bay, 1936-96

cent of the Maori population within the district boundaries.⁷ Maori now comprised a substantial 16.5 per cent of the two cities' population (see chart 4 and table 1).

The majority of Maori moved into Hastings with its concentration of industrial and commercial employment. In 1981, the Hastings urban area, which by now enclosed Clive, Havelock North, and many of the Maori kainga on the coastal Heretaunga plain, had a Maori population of 10,617, or some 61 per cent of the combined urban total. But the 6906 Maori living in the Napier urban area made up a sizeable 13.4 per cent of the Napier population.

During the 1980s and 1990s, the pace of change slowed. Economic liberalisation and factory closures hit Hastings hard, and Maori employment especially. But by the mid-1990s, economic diversification and tourism were generating new regional expansion. The Hastings population continued to grow slightly faster than Napier's, but what is noticeable is that Maori alone

7. The former Hawke's Bay County and present Hastings district.

6.2.2.2

Urban area	Population 1936			Population 1981			Population 1996		
	Total	Maori	%	Total	Maori	%	Total	Maori	%
Napier	18,689	246	1.3	51,498	6906	13.4	54,300	8643	15.9
Hastings	17,961	246	1.4	54,462	10,617	19.5	58,491	13,776	23.6
Total	36,650	492	1.3	105,960	17,523	16.5	112,791	22,419	19.9
Napier %	51.0	50.0	—	48.6	39.4	—	48.1	38.6	—
Rural	9532	1757	18.4	6126	1131	18.5	6,951	1092	15.7
District #	46,182	2249	4.9	112,086	18,654	16.6	119,742	23,511	19.6

Table 1: Growth in the population of Napier and Hastings, 1936–96

1936: Hawke's Bay County; 1981, 1996: Hastings District Council and Napier. Source: Population censuses.

accounted for most of the population increase in both cities. By 1996, the 22,419 Maori comprised a fifth of the combined urban total, and Napier's 8643 Maori were 15.9 per cent of the city's population. During the period in which the regional hospital issue was fought out, Napier and Hastings Hospitals were thus each serving sizeable Maori communities, most of them clustered in suburbs within five kilometres of their campuses.

6.2.2.2 *The hospital board's proposal for a new hospital*

In 1980, as a century of hospital board administration was drawing to a close, the Hawke's Bay Hospital Board still had two fully functional general hospitals under its control at Napier and Hastings. Each was a base hospital that provided a similar range of medical and community services.

Medical specialisation and the rising cost of hi-tech equipment had nevertheless induced the hospital board to integrate several aspects of the two hospitals' operations. These included their training programmes and the sharing of specialist staff, who were appointed to the board rather than to a particular hospital. As well, several specialised services were divided between the hospitals. Their close proximity, being only 18 kilometres apart, widened the scope for practical cooperation. But it also held open the prospect of significantly reducing the board's costs by serving both communities from a single hospital.⁸

In 1980, the Hawke's Bay Hospital Board undertook a strategic review of its hospital services. In March of that year, a paper by Dr Winston McKean, the medical superintendent-in-chief, identified large areas of duplication as well as the developing rationalisation of services between the two hospitals. He noted that 'the situation probably is unequalled elsewhere in New Zealand'. His paper came up with three basic options:

- ▶ keeping the two hospitals but integrating them further;
- ▶ centralising acute facilities at one base hospital and leaving the other as a long-stay institution; or
- ▶ replacing both with an entirely new 500-bed acute hospital.⁹

8. Document v1, p 11; Conly 1992, pp 259–60

9. Conly 1992, pp 259–260

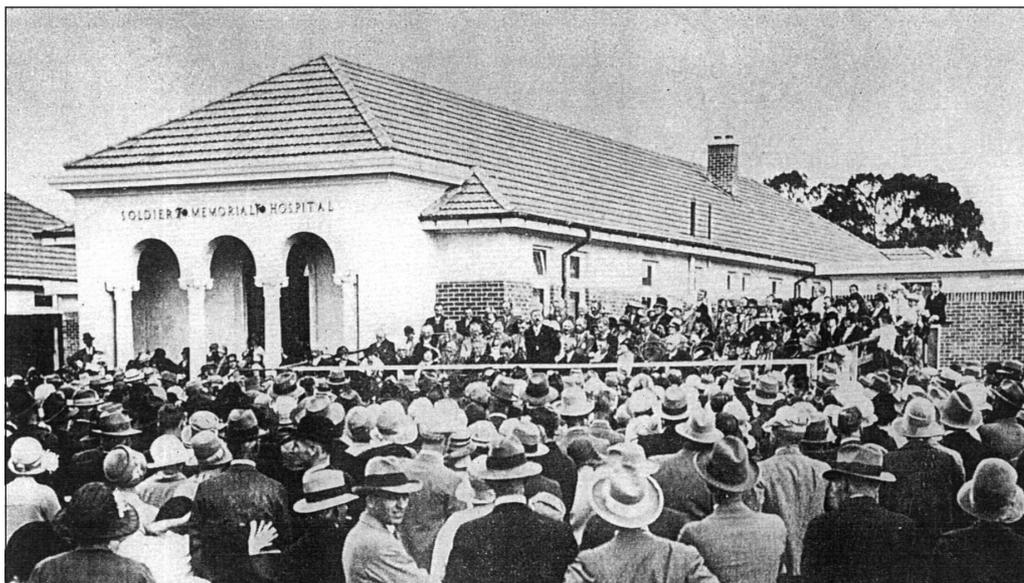


Figure 20: The opening of the Hawke's Bay Fallen Soldiers' Memorial Hospital in Hastings, 25 April 1928.
Taken from Conly 1992, p 105.

Dr McKean favoured building a new acute hospital midway between Napier and Hastings and converting one of the existing hospitals to provide additional long-stay beds. He acknowledged, however, that patients and staff would have to travel further to reach the new hospital and that existing public transport was inadequate.¹⁰

During June and July 1980, the hospital board conducted a round of consultations with local bodies and professional organisations on the concept of a new mid-point hospital, and sounded out Government support. Dr McKean's proposal won the support of local doctors and social workers, but all three local bodies – the Hawke's Bay County Council and the Napier and Hastings City Councils – opposed it. There was also heated local opposition, which resulted in parliamentary questions being asked.

At its August meeting, the board still favoured building a new hospital midway between Napier and Hastings. The following month, however, the Minister of Health, George Gair, killed the proposal, telling the board that a new hospital would be impractical and too expensive. In October–November 1980, the board retreated, deciding to keep both Napier and Hastings as general hospitals but further rationalising clinical services. Upgrades and extensions then proceeded at the existing hospitals.¹¹ During 1981, the board set up a further review, on the basis of which it defined sets of basic and shared services to be delivered at each hospital.¹²

In May 1986, the hospital board issued a discussion document on strategic options for the decade ahead. Although accepting the 'two hospital' framework, it signalled its preference for having a single general hospital, complaining that:

10. Ibid, p 260

11. Document v1, pp 12–13; Conly 1992, pp 260–261

12. Hawke's Bay Hospital Board 1986, pp 232–234



Figure 21: The main block at Hastings Hospital in 1971. Taken from Conly 1992, p 224.

The location of the two acute base hospitals 12 miles apart serving a population of approximately 114,000 is unique for a provincial Hospital Board in New Zealand. The inability to deliver health services from a single institution to a high density area has denied the Board the opportunity of ‘economies of scale’.

Looking towards the future, the board assessed the suitability of each location for a single acute hospital and considered Napier Hospital to be disadvantaged by its cramped site.¹³ It took no further initiative, however, before it went out of existence in May 1989.¹⁴

6.2.2.3 Consultation with Maori

Throughout this planning phase, there is no indication that Maori interests were considered or Maori communities consulted. The deciding factors were medical technology, cost, and the enduring Napier–Hastings municipal rivalry. However, the available information is too sparse to arrive at a definite conclusion.

In 1987, when the hospital board was considering converting to an area health board, it issued a discussion document on which it called for written submissions. The consultative committee of board members that prepared it planned, in addition to the document itself, press feature articles, public meetings in Wairoa, Hastings, and Napier, and ‘one-off meetings for specific groups and organisations’, if requested. The document made no specific mention of Treaty obligations, Maori health needs or Maori organisations, but, under the heading of ‘multicultural sensitivity’, it did recommend that ‘communication be maintained with leaders of those communities and that their advice be sought on cultural matters which impact health’.¹⁵

13. Hawke’s Bay Hospital Board 1986, pp 235–241

14. Document v1, pp 13–14; Conly 1992, p 275

15. Hawke’s Bay Hospital Board 1987, pp 27–28, 51



Figure 22: Napier Hospital, circa 1990, looking southwest. In the foreground are the medical wards and clinical services block; to the rear the entrance to the outpatients and casualty departments. Taken from Conly 1992, p 258.

6.2.3 The area health board and regionalisation revisited (1989–91)

6.2.3.1 Plans to regionalise hospital services

After the new Hawke's Bay Area Health Board was inaugurated in June 1989, the single acute hospital question quickly rose to the top of its agenda. Peter Clark, the general manager, argued the necessity of taking early action in his report to the board in March 1990, which was incorporated into the board's strategic position statement.¹⁶ Funding was already constrained but risked being further constrained by the board's performance obligations.

At the same time, the Government wanted increased activity in health promotion. The New Zealand Health Charter, which was issued by the Minister of Health in December 1989 and set out the Government's long-term public health goals, required the board to get to grips with strategic planning. Present funding would sustain a first-class acute hospital service, but only through the efficiencies gained from a single integrated site.

In Mr Clark's view:

Acute hospital medicine requires specialist *team* work in a situation where all the expensive facilities of a modern hospital can be deployed to meet patient need. ACUTE SERVICES ARE INTER-DEPENDENT AND HAVE TO BE PROVIDED ON ONE CAMPUS. Separate location can only be contemplated for mental illness, the continuing care of the elderly and possibly low risk operative procedures on selected patients.¹⁷

Mr Clark's case amounted to a forthright rejection of the policy of shared specialisation pursued over the previous decade, in terms of which a number of capacities had been divided

16. Document 692(14), 26 March 1990, app D; doc 692(15)

17. Document 692(14), 26 March 1990, app D9; doc 692(15), p 25; doc v1, pp 4, 14–15

acute hospital concept and recommended Hastings Hospital as the preferred site. Napier was to be left with clinics and long-stay geriatric facilities, which would probably be located not at Napier Hospital but in town.

Thus, not only the downgrading but also the closure of Napier Hospital was an option on the report's agenda.²¹ In its information leaflet, published the same day, the board summarised the report's recommendations in five points, one being 'that Napier should retain clinics and long-stay geriatric facilities, probably located in town, closer to the community'.²²

Social impact was one of the criteria set down for evaluation, but the report did not consider it in detail. Under 'socio-economic considerations', it did, however, note a number of disadvantages to regionalisation, including a shift of staff residence towards the regional hospital town and, in the short term, 'unemployment, disruption of hospital services and increased travel time, an issue in particular for the low income/aged population'.²³

The board launched a round of public consultations and submissions. Opposition from Napier was vociferous. In particular, a detailed submission from the Napier City Council severely criticised what it considered to be the narrow terms of reference of the study and deficiencies in the Booz-Allen report, including its social impact and financial assumptions.²⁴

The board set down a special meeting for 11 April to consider and decide on the report's recommendations. That meeting was instead converted into a workshop, at which it became apparent that not all the recommendations had unanimous support. In particular, according to the 'notes' of the meeting, 'a number of Members were of the view that services should be provided from both sites and that they had never envisaged one hospital would close'. Technical and financial issues required further investigation, especially the earthquake risk at the two sites. But the board did reaffirm that it still supported 'the concept of a base hospital' and generally agreed that 'the major acute high-tech services should be concentrated on one site, but the other site could be used for low risk and day cases'.²⁵

At this point, Simon Upton, the Minister of Health, who had previously deferred a response pending the outcome of the consultation, intervened.²⁶ On 12 April 1991, the day after the workshop and a week after meeting a board delegation in Wellington, he wrote to the board expressing his reservations about the financial viability of the single acute hospital proposal, in particular questioning the high level of debt that the board would incur. He considered that 'the cost as it stands is probably too high' and that the criticisms of opponents needed to be assessed. He recommended a further study to explore, amongst other alternatives, 'an "intermediate" option . . . [that] might, for example, place acute surgical services on one site with non-acute services such as long stay and some convalescence being located at the other site'.²⁷

21. Booz-Allen and Hamilton 1990; doc v1, pp 19-21

22. Hawke's Bay Area Health Board 1990, p 2

23. Booz-Allen and Hamilton 1990, *Final report, summary*, p IV-16

24. Napier City Council 1991

25. Document v1, pp 22-23; doc v1(b)(B2)

26. Minister of Health to Andy Train, 13 December 1990 (in doc 692(14), 28 January 1991, app E)

27. Minister of Health to Andy Train, 12 April 1991; 'Visit to Minister of Health, 4 April 1991' (in doc 692(14), 27 May 1991, apps M, E)

6.2.3.2

The Minister's criticism, which questioned the Booz-Allen report's endorsement of the project's feasibility, dealt it a potentially fatal blow. According to Mark Flowers, who later served as chief executive and who attended board meetings during this period, by the time the area health board went out of existence on 2 August 1991, it had not yet made a formal decision on the Booz-Allen recommendations.²⁸ The cycle of 1980 – a medical and financial proposal for a single hospital, strong local opposition, ministerial intervention, and deferral or abandonment of the proposal – had been repeated once more.

6.2.3.2 *Consultation with Maori*

No member of a representative body such as the area health board could fail to have been aware of the controversy likely to be aroused by any move to reorganise hospital services in Napier or Hastings. However, the fact that the board had limited the options at the outset made it more difficult for it to secure public acceptance for whatever plan it eventually adopted. By excluding from the terms of reference for the Booz-Allen study both the status quo and a new hospital on a greenfield site, the board was effectively proposing, subject to feasibility, that one of the two base hospitals would be developed and the other downgraded or closed. This implicit strategic framework was not opened to public consultation.

In contrast, the Booz-Allen study itself was subjected to a round of public consultation. This took place in two stages. In the first phase, the consultants themselves communicated widely with staff, councils, unions, and the media. Community and Maori groups were not included.²⁹

The second and principal phase of consultation followed the publication of the Booz-Allen report in December 1990. This exercise focused on the report's recommendations and preceded any board discussion of the report itself. The sequence was on the face of it perplexing, since people were expected to give their opinion on the consultants' recommendations without knowing what view the board took of them. The board's circular letter to local organisations, issued with the release of the report, indicated that it would 'make a final decision' in March 1991 at the earliest, but did not say whether the proposal on which the board would decide would itself be subject to consultation.³⁰

The board issued a circular, signed by its chairperson Andy Train, inviting written submissions. It set a deadline of 15 February, a period of about eight weeks, which it later extended by a month. Two days (20 and 21 February) were assigned for public hearings, at which people could present their views in person, but no venue was given. It also offered face-to-face meetings:

Area Health Board General Manager Mr Peter Clark and I are willing to come and talk to combined community groups to discuss the recommendations in more detail if this would assist informed debate.³¹

28. Document v1(b)(1), pp 6–7

29. Booz-Allen and Hamilton 1990, *Final report, summary*, p v; Document v1, p 19

30. Document v1(b), (D1); also doc v1(b)(1), p 8

31. Document v1(b), (D1)

The circulation list of 95 civic organisations and individuals included just two Maori groups, the Maori Women's Welfare League (secretary) and the 'taiwhenua' (chairman). The address of the former was given as Flaxmere and the latter as Hastings. In other words, the contact points were with Maori organisations in Hastings. If this was, as Mr Flowers implies, the full circulation list employed to invite submissions, it seems that no Maori organisation in Napier, or for that matter anywhere in the board's catchment area, was approached.³² They may therefore have remained unaware of the board's offer of face-to-face meetings. They also received no documentary information on a proposal that would close their local hospital, since the board's main means of communication with the public was through media reporting and advertisements.³³

Local Maori may have made their own approach. A week after the release of the report, the board's public relations firm noted that the 'Hawke's Bay Maori standing committee' of the regional council, representing 'HB Maori communities and maraes' wanted to 'have a presentation prior to making a submission' – 'They must be followed up'.³⁴ This committee was at one remove from representative Maori organisations, but its chairperson, Bill Bennett, was also vice-chairperson of Te Taiwhenua o Te Whanganui a Orotu. The Tribunal has no information on whether members or officials of the area health board did in fact meet any of the Napier-based Maori groups, or whether any representatives of those organisations presented oral evidence to the board's public hearing.

The board's priority during the period of public consultation seems to have been to establish the credibility of the single acute hospital concept rather than listen to the public debate.³⁵ Shortly before the release of the Booz-Allen report, it 'received' a communications programme prepared by Phoenix Public Relations. The programme was strongly geared towards managed advocacy of the case for a single acute hospital, even though the board had yet to consider the Booz-Allen report's recommendations. It was premised on the assumption that the board had already decided to have a single acute hospital, to the extent that in January 1991 a board member found it necessary to warn the Phoenix representative against presuming the board's eventual decision.³⁶

In the community envisaged by the consultants, local Maori were barely visible. There was only one brief reference to Maori, under the category 'district health committees', and Ngati Kahungunu were not recognized as being entitled to be informed or consulted.³⁷ A striking feature in the documentation from this period available to the Tribunal is the absence of any mention of the Maori health committee that the board set up in mid-1990 to 'assist the board in addressing Maori health issues', especially since it supposedly included 'representatives of key Maori organisations in the area'.³⁸ Aside from the possible contact with the Maori standing

32. Printed list of addresses under doc v1(b)(D1); also doc v1(b)(1), p 8

33. Document v1, p 19

34. Document v1(b)(A1), p 2

35. Document 692(16)

36. Document 692(14), 26 November 1990 (in committee); doc 692(17); doc v1, pp 16–19; doc v1(b)(A1), A2; doc 692(14), 28 January 1991

37. Document 692(17), p 5

38. Document 692(15), p 71

6.2.3.3

committee of the regional council, Napier Maori were left to gain their information on the proposal from media coverage.

6.2.3.3 *The views of Ahuriri Maori*

The call for submissions was widely publicised in the media, and Ahuriri Maori made two written submissions. One was from the Kahui Kaumatua o Te Taiwhenua o Te Whanganui a Orotu. The other was a joint submission from a broad spread of Maori civic organisations,³⁹ adopted at a combined meeting.⁴⁰ There was also a submission from the Wairoa Waikaremoana Maori Trust Board.⁴¹

The Napier combined submission urged that the single acute hospital be located between Napier and Hastings. It also wanted a low risk maternity Unit to be retained in Napier and Napier Hospital to be retained with health Services available to the community, and listed a range of community concerns. These covered the needs of pregnant women, children, and the elderly, as well as the problems of access to a hospital in Hastings for those in Napier – the lack of private vehicles, poor public transport, extra travel costs, restricted visiting hours, lack of overnight accommodation, loss of local whanau support to patients, family stress, burden of doctors' fees and prescription charges, and uncertainty over the continuation of community support services supplied by Napier Hospital (such as meals on wheels, home help and occupational therapy).

The kahui kaumatua objected to 'the proposed closure of the Napier Public Hospital' on the grounds of extra cost, lack of transport, whanau wellbeing, and loss of employment. The Waikaremoana Maori Trust Board urged that, at minimum, 'a community Hospital should be maintained in Napier for minor surgery, convalescence or maternity cases etc'.

On this occasion, the voice of Maori in Napier was heard, even if the board made little effort either to communicate or to listen. Maori were also part of the wider community protest. A march and rally staged in Napier on 19 December 1999 drew more than 6000 people. A subsequent petition opposing the closure of the hospital attracted 30,796 signatures. Given a total population of 52,011 in 1991, the signatories are likely to have included the great majority of both Maori and non-Maori adults in the Napier urban area.⁴²

6.2.3.4 *The beginnings of a convergence*

Amidst the sound and fury of Napier's campaign to save its hospital, in several areas the positions of Napier Maori and the area health board were converging. The former's submissions did not necessarily oppose the concept of a single acute hospital. But they were concerned about the costs and practical difficulties of access and revived the former hospital board's 1980 proposal

39. 'Organisations present': Hau Ora, Maori Mission, Maori Women's Welfare League, Women's Health Committee, Plunket, Ahuriri Wardens, Kaumatua Maraenui, Kohanga Reo e Tupu e Rea, National Council of Maori Nurses (Hawke's Bay branch), Te Taiwhenua o Te Whanganui a Orotu.

40. Documents v1(b)(E)3, E2 respectively

41. Document v1(b)(E)1

42. Document v1, p 45

for a new hospital between Hastings and Napier. They also wanted Napier Hospital retained as a community hospital providing non-acute obstetric, paediatric and geriatric care close at hand to their predominantly low-income local communities.⁴³

For its part, the board acknowledged that, in light of all the public submissions, 'careful consideration of several aspects of the Booz-Allen report would be necessary, including other alternatives'. The minutes of its workshop on 11 April recorded that:

a number of Members were of the view that services should be provided from both sites and that they had never envisaged one hospital would close; and
it was generally agreed that the major acute high-tech services should be concentrated on one site, but that the other site could be used for low-risk and day cases.

Such cases, the board considered, could include low-risk versions of services such as first aid accident and emergency, day surgery, paediatrics, maternity, orthopaedics, gynaecology, ear, nose, and throat and long-stay geriatric, as well as outpatient clinics – a broadly similar agenda to that of the combined submission of Napier Maori.⁴⁴ The Minister of Health's 'intermediate' option would also 'place acute surgical services on one site with non-acute services such as long stay and some convalescence being located at the other site'.⁴⁵

Any emerging consensus was, however, derailed by the second wave of the health reforms, which saw the abolition of the area health boards in mid-1991.

6.2.4 The transitional regime and regionalisation revisited (1991–93)

6.2.4.1 Decisions made during the transitional regime

Information is sparse on the proceedings and decisions made during the two-year transitional period. In August 1991, the government and the Hawke's Bay commissioner inherited an unresolved situation. The area health board had not made any formal decisions on the recommendations of the Booz-Allen report, nor had it adopted any proposal for the regionalisation of its acute hospital services.⁴⁶ Two years later, however, in its statement of corporate intent presented to Parliament on 17 August 1993, Healthcare Hawke's Bay signalled that it had decided in principle in favour of regionalisation, although it had yet to choose between the Napier and Hastings campuses as the site of the regional hospital:

Healthcare Hawke's Bay is to conduct a review of the provision of hospital services in Napier and Hastings. It is intended to develop a regional acute facility on one of the current hospital sites. A decision as to the site will be made by February 1994, and rationalisation of services will then proceed.⁴⁷

43. Documents v1(b)(E1), (E2)

44. Documents v1(b)(B1), (B2)

45. Minister of Health to Andy Train, 12 April 1991 (quoted in doc v1, pp 23–24)

46. Document w12, p 3

47. Document w18(a)(14), p 5066

Exactly when and how the decision to regionalise was made remains wrapped in obscurity. The commissioner, Andy Train, had as chairperson of the area health board been labelled as being personally in favour of the Booz-Allen recommendations, although he later denied this.⁴⁸ During 1992, Michael Laws, a member of Parliament, accused Sir Ron Trotter, the chairperson of the National Interim Provider Board, of indicating his preference for Hastings as the site of the single acute hospital during a visit to Hawke's Bay.⁴⁹

According to Mr Wilson, the board-designate 'in conjunction with the Area Health Board Commissioner [Mr Train] would review the activities of the Area Health Board and develop a statement of intent and business plan'.⁵⁰ No evidence has been led as to the role of Mr Train, who was also a member of the board-designate. However, the minutes of the CHE board-designate, which from late 1992 began to prepare the establishment of the Hawke's Bay CHE, reveal no more than that it recognised the importance of the single acute hospital issue. Mr Wilson none the less confirmed that the statement of intent, with its decision to have a regional hospital, was formally approved by the Government and adopted by the board.⁵¹

The handling of the reserve fund, set up by the former area health board to cover the costs of regionalisation, may have influenced the decision. In May, the board-designate was informed by Brian Roche of the Government's CHEEU that 'the funds set aside by the Area Health Board for the single acute hospital exercise would be recognised in the opening balance sheet for that specific purpose'. However, if the exercise were long delayed, the Government would claw back the funds and reallocate them at the appropriate time.⁵²

At its meeting on 29 June 1993, the board heard from Mr Wilson that he had led a deputation to meet the CHEEU, when 'management of the \$16 million reserve fund was resolved and it was recognised that consolidation of the acute hospital issue had to be addressed quickly'.⁵³ The letter of comfort (ie, financial guarantee) issued to the board-designate on 17 June 1993 by the Ministers of Finance and Crown Health Enterprises referred to the need to 'address the issue of consolidating the acute services currently on the Hastings & Napier campuses onto one site', to undertake a full business appraisal, and to secure the approval of any third parties (such as the Central RHA). Reviewing the documentation, Mr Roche later concluded that 'on balance I am of the view that the \$16 million was linked to the acute services consolidation though this was never made explicit'.⁵⁴

Paul East, the Minister for Crown Health Enterprises, confirmed that the fund would have been provided to Healthcare Hawke's Bay only for a specific purpose:

48. Document 692(19), 21 July 1994

49. Laws to Minister of Health, 22 January 1992; doc v1, pp 24-25

50. Document w12, pp 2-3

51. Ibid, p 3

52. Document 692(18), 17 May 1993

53. Ibid, 29 June 1993; doc v1, p 27

54. Document 692(18), 29 June 1993; Roche to Hunn, CCMAU, 14 June 1994, quoting 'the letter of comfort of 17 June (unsigned)', in doc 692(21)

That is, if the proposal for the review of health services in Hawke's Bay had not been active at the time, the reserve would not have been established. By implication therefore, had there been a continuation of the status quo, the reserve would not have been created at the time HCHB was established.⁵⁵

At the meeting of the board-designate in June 1993, member Kevyn Moore noted 'the Ministers' expectation that the CHE would, within the next 12–18 months, undertake a full business appraisal of the issues surrounding the initiative to consolidate acute services onto one site'.⁵⁶ Mr East endorsed that understanding:

The reserve was agreed to on the basis that the Board of HCHB undertake a full business appraisal of the issues surrounding the initiatives advanced by their predecessor organisation. Having completed the appraisal and obtained support and commitment from the purchaser of the health services, Shareholding Ministers undertook to make funding available, with the exact detail of the funding being determined at that time.⁵⁷

The first funding agreement between Healthcare Hawke's Bay and the shareholding Ministers, effective from 1 July 1993, provided for the reserve fund, now worth \$16 million, to be paid to the CHE on 31 December 1994, or earlier if the CHE were commercially at risk. Ministerial approval duly arrived in November 1993.⁵⁸

There is no record in the documents supplied to the Tribunal of a decision by the board-designate to have a single acute hospital. But the Government had exerted pressure, using the lever of the reserve fund, to have the implementation of the regional hospital concept fully evaluated. Recorded or not, it is apparent that during mid-1993 the board-designate had, with Government support, decided in principle to locate a single acute hospital at either Hastings or Napier, subject to a business appraisal. This was confirmed in evidence by Mr Wilson.⁵⁹

This commitment the new CHE inherited at its inauguration under the same board on 1 July 1993. As noted above, Healthcare Hawke's Bay's statement of intent included its commitment to develop a regional hospital on the Hastings or Napier site. It was tabled in Parliament on 17 August 1993. There is no record in the extracts provided to the Tribunal from the minutes of the board-designate and board that the statement was formally adopted, and neither Mr Wilson nor Mr Flowers has been able to provide more precise information. Mr Wilson pointed out, however, that the period covered by the document started on 1 July 1993.⁶⁰

At its first meeting on 19 July, the new board was informed by Mr Wilson that a task force had already been set up whose focus would be on 'an ideal single structure' and on where that structure would be located.⁶¹ In announcing the task force to his staff a week later, chief executive

55. Document 692(21); doc v1, p 26

56. Document 692(18), 29 June 1993

57. Document 692(21); doc v1, p 26

58. Document v1, p 26; doc 692(22); see also Gwynn 1998, pp 38–39

59. Document x33, p 247

60. Document v1(b)(1), p 2; doc w12, p 4–5

61. Document 692(19), 19 July 1993

6.2.4.2

Alistair Bowes signalled that the board was ‘determined to resolve this question and make an early announcement as to the preferred site’.⁶² The commitment to a single acute hospital was, in other words, already part of the planning framework.

6.2.4.2 Consultation with local Maori

In December 1993, Mr Wilson stated that there had been a measure of public consultation during the transitional period:

The establishment committees and board designate of Crown Health Hawke’s Bay Ltd was [sic] required to consult with its communities. Every interest group which requested a discussion during that planning phase was listened to. I am not aware of any health group who has not been given a reasonable hearing.⁶³

Nevertheless, it appears that interest groups had to request meetings and that Maori, especially representative hapu or iwi organisations, were not specifically included. In his brief, Mr Wilson refers to consultation with ‘some health interest groups’, and in evidence he confirmed that no Maori groups were involved, apart from the Maori members of the district health council.⁶⁴ Nor was there public consultation on the particular issue of regionalisation.

In any case, following the abolition of the area health board, no elected representatives were involved in the decision-making. All decision-making was contained within a closed circuit of centrally appointed executives and Government officials.

6.2.5 The decision to locate the regional hospital at Hastings (1993–95)

6.2.5.1 How Healthcare Hawke’s Bay made the decision

If Healthcare Hawke’s Bay came into existence on 1 July 1993 with a commitment to regionalise its hospital services, the question of where and how to construct the single acute hospital was still no further advanced than it had been in mid-1980 and mid-1991. This was to be the principal assignment for the regional hospital task force comprising Mr Bowes and two other managers.⁶⁵

The task force, according to Mr Wilson, who remained chairperson throughout the period covered by this report, started from scratch and without regard to the Booz-Allen recommendations.⁶⁶ Its first step was to adopt a methodology, prepared by Mr Wilson, for designing a model of what an ideal regional hospital meeting Hawke’s Bay’s requirements over the next 20 years would look like. The upgrading of the existing Napier and Hastings sites and facilities would then be evaluated against the model to establish their comparative suitability as the regional hospital site. The criteria included the effect of future demographic trends and accessibility. Mr

62. Document 692(23)

63. Document w18(a)(17), p 5080

64. Document w12, p 3; doc x33, p 245

65. Document v1, p 28

66. Document w12, p 4

Bowes pressed for a decision on the preferred option to be reached by 30 September, but Mr Wilson insisted that 'it was important to ensure that each step of the planning process was managed with care and deliberation so that it could sustain a defensible debate'.⁶⁷

The task force quickly got down to work. Assisted by consultants Octa Associates, by November 1993 it had prepared a model regional hospital paper for the board, and, by January 1994, discussions had progressed to details of bed numbers and space requirements.⁶⁸

In March 1994, the task force presented its draft report to the board. It had considered as one of its three scenarios continuing the status quo, but only as a baseline. The other two scenarios assessed the regional hospital with either Napier or Hastings as the selected site. Excluded, as in the Booz-Allen report, was the option of building a new hospital on another site. The task force recommended Hastings as the site of the regional hospital but, unlike the Booz-Allen report, proposed retaining Napier Hospital for a range of non-acute functions, including outpatient, community health, and disability services.⁶⁹

During May and June 1994, Healthcare Hawke's Bay, with the support of the Central RHA, led a round of public consultation, which is reviewed in the following sections. On 21 July, the board resolved to have a single regional acute hospital and to locate it on the Hastings campus. Both the Central RHA and the shareholding Ministers of Crown Health Enterprises and Finance gave their formal approval. On 5 August, the decision was announced by the Ministers of Crown Health Enterprises and Health. On the same date, Healthcare Hawke's Bay published a document justifying its decision.⁷⁰

Ms Ferguson concluded that 'no reference was made in the Board's decision-making criteria to the needs or wants of any particular community segment, including Maori'.⁷¹ Nor were they or Treaty considerations amongst the decision factors mentioned in Mr Wilson's briefing to his fellow directors two days prior to the meeting of the board.⁷² The same comment applies to the briefing given by Hutton Peacock, the chairperson of the Central RHA, and the subsequent endorsement of the regional hospital decision by his board.⁷³

The Napier City Council's successful court challenge won it further time to make a submission. Presenting it in February 1995, the council attempted to revive the case for a new hospital situated midway between Napier and Hastings.⁷⁴ The board of Healthcare Hawke's Bay rejected this option as too costly and, on 28 March 1995, confirmed their decision that:

Hastings Memorial Hospital is reconfigured to become the Hawke's Bay Regional Hospital, providing the current range of services available across the two sites in Hastings and Napier, and

67. Document w18(a)(15), pp 5073–5074; doc w18(a)(16), pp 5076–5077; doc w12, p 6

68. Document v1, pp 28–30

69. Document w18(a)(23), pp 5096–5212; doc v1, p 30

70. Document w18(a)(54); Healthcare Hawke's Bay 1994a; doc w18(a)(59); media release, 5 August 1994; doc w18(a)(55)

71. Document v1, p 31

72. Document w18(a)(56)

73. Documents w19(a)(9003), (9004)

74. Document 692(12)

6.2.5.2

Napier Hospital is reconfigured to provide a comprehensive range of outpatient, accident and medical services, continuing and day care for the elderly, Maori health facilities, maternity care, day surgery, and as a base for community care services for the Napier area.⁷⁵

The decision was again approved, and it was announced on 5 April 1995.⁷⁶

6.2.5.2 The Central RHA's assurance on Napier Hospital

When Healthcare Hawke's Bay announced its first decision on 5 August 1994, the Central RHA publicly endorsed it.⁷⁷ It also issued a discussion paper on its purchasing expectations, which contained the assurance that Napier Hospital would be retained in order to provide a range of non-acute services:

The Central RHA has assessed the Board of Healthcare Hawke's Bay's recommendations against the criteria of quality, access and value and has accepted that a regional hospital at Hastings, with complementary services being provided at Napier Hospital, fits with its purchasing expectations.

It listed the non-acute services it expected to be provided from Napier Hospital as covering accident and medical; maternity; outpatient; day surgery; dentistry; care of the elderly; continuing and terminal care; community health; mental health; disability; alcohol and drug; sexual health; public health; child health; and Maori health services. Support services would include, at minimum, pathology, radiology, and pharmacy.⁷⁸

The Central RHA referred briefly but specifically to the continued provision of health services for Maori at Napier Hospital:

. . . Central RHA would expect that Maori Health services will be appropriately emphasised in service provision.

An appropriate Whare Whanau should be available at Napier Hospital. The Maori people of Napier should still have access to Maori staff and services tailored to meet their needs at the Napier site.⁷⁹

The Central RHA did not explain further what the services would provide, but a principal need was for accommodation for members of a patient's whanau, especially those visiting from Wairoa and other areas north of Napier.

6.2.5.3 The hands of the purchaser and the shareholders

In the restructured health system, any project involving major capital expenditure and reorganisation of service delivery bore considerable risks for a CHE. On the one hand, a project had to

75. Document w18(a)(62), pp 5717–5718; doc v1, p 31

76. Healthcare Hawke's Bay, press release, 5 April 1995

77. Document w18(a)(60); doc w19(a)(9006)

78. Document w18(a)(58), pp 5686–5694

79. Ibid, p 5693

align with the purchasing intentions of its RHA. On the other, it had to meet the expectations of its shareholding Ministers. If the project failed in either respect, the resulting loss of efficiency might, in the new competitive environment, lead to some services being transferred to other providers, including private hospitals and neighbouring CHES.

Healthcare Hawke's Bay considered the Central RHA's approval to be critical for the success of the regionalisation project. In late March 1994, it supplied the Central RHA with a confidential copy of the task force's report immediately upon its submission. At the same time, it brought pressure to bear for a concrete assurance of medium-term financial support for the regional hospital project. It demanded an RHA commitment to continue purchasing the current range of services at the same funding level and to contract for core services for the next three years. It also wanted an advance commitment to purchase acute services from a single hospital site.⁸⁰

This, the Central RHA declined to do formally, since, as Mr Peacock pointed out, it would cut across the joint consultation exercise. At its meeting with the board of Healthcare Hawke's Bay on 8 April 1994, the Central RHA considered the task force's report inadequate in several respects, but did nevertheless signal its general support for the regional hospital concept, accepting that 'the recommendations contained in the Taskforce report demonstrated a steady path towards the future'. It agreed to offer a degree of financial reassurance, but hedged this with a number of conditions and reservations.⁸¹

Influence from the Government (as a shareholder) was in the opposite direction. In mid-1993, the CHEEU had pressed, using the \$16 million reserve fund as a lever, for a quick resolution of the regional hospital issue. In early March 1994, before the task force's report was ready, a representative from CCMAU, the successor to the CHEEU, criticised the board for not identifying its preferred site in Healthcare Hawke's Bay's business plan. She also warned that 'the Company would be taking a considerable risk if it announced a decision in principle without the Minister's approval'.⁸²

The board agreed to advise the Minister that Hastings was the regional hospital site for the purposes of the business plan. Mr Wilson also emphasised that prior approval would be sought:

When the Board had received the final report and business critique, it should then seek approval from the Shareholding Ministers and the Central RHA. Once the Shareholders and RHA had indicated their concurrence, the recommendation could then be released for public comment and debate.⁸³

But the shareholder was not happy. On 6 April, the Minister for Crown Health Enterprises sent the board a letter, and a different CCMAU representative, Mr Hartevelt, attended the key board meeting on 8 April 1994 to reinforce the message. Mr Hartevelt launched into a trenchant critique of the task force's report and of the 'status quo' business plan adopted by Healthcare

80. Document w18(a)(32)

81. Document w18(a)(33); doc w47

82. Document w46

83. Ibid

Hawke's Bay. He accused the board of failing to develop a clear corporate strategy and of allowing regionalisation to drive strategic planning. As recorded in the minutes, he urged that:

care should be taken to ensure that options were not softened for reasons of presenting proposals which were more palatable to the community. In particular, he suggested that there might be options for the continuation of proposed services in Napier to be provided off the Hospital campus. Mr Hartvelt believed the Taskforce report should include an evaluation of the consequences of a complete hardline option, ie completely abandoning the Napier site . . .⁸⁴

Mr Wilson agreed to consider an 'abandonment' option, but pointed to the need to exploit the remaining economic life of the CHE's assets, to minimise transitional costs, and to secure political acceptance. A brief discussion of 'abandonment' was added to the task force's report, but the option was rejected on grounds of higher cost.⁸⁵

In the end, the Central RHA's preferences prevailed in configuring the services to be provided at the second site, Napier Hospital. As the submissions closed, Healthcare Hawke's Bay sought to clarify the Central RHA's purchasing intentions. At meetings with the board during June and early July 1994, the Central RHA upgraded the services it intended to tie to the second hospital. These included:

- ▶ a 24-hour level 2 accident and medical service instead of first aid;
- ▶ some day surgery under general anaesthetic instead of minor day surgery, which service the board conceded against its better judgement;
- ▶ a level 2 instead of low-risk birth unit; and
- ▶ the retention of the tower block instead of lower level buildings.⁸⁶

Mr Burns, the chief executive of the Central RHA, also told the board that 'the RHA was looking for services which were culturally appropriate for Maori, and this would apply also to services delivered on the second site'.⁸⁷

6.2.5.4 To consult or not to consult?

Healthcare Hawke's Bay's statement of intent, issued in August 1993, notified its intention to proceed with a regional hospital and added the reassurance that 'good communication will be maintained on this important subject with the people of Hawke's Bay'. It also stated that 'proposed changes to any of Health Care Hawke's Bay's services will be discussed with appropriate representatives of customers and the wider community'.⁸⁸

This amounted to a less than complete commitment to public consultation but to more than the board actually envisaged. Initially, it intended to develop the proposal in-house and away from public scrutiny, and not to expose it to public consultation. In July 1993, it asked the task force to work on defining a vision, which 'should be established to the exclusion of the various

84. Document w47

85. Document w18(a)(23), pp 5145-5149

86. Document 692(19), 9, 10 June, 1 July 1994; doc w12, pp 20-21

87. Document 692(19), 1 July 1994

88. Document w18(a)(14), p 5066

interest groups, to provide the Board with an ultimate long term goal'.⁸⁹ At its August meeting a month later, Mr Wilson explained how he saw the decision-making process:

He believed the Board should first reach its decision and that once a decision had been made, it would then need to market the idea very carefully. He considered it was important that no public debate should be entered into on this issue until such time as the Board had made its decision.⁹⁰

Mr Wilson's methodology for designing a model hospital, evaluating the Napier and Hastings sites, and deciding which to select made no provision for public consultation.⁹¹ In December 1993, he was still publicly defending the closed process by which the board was to make its decision. It would listen to 'the views of our staff, clinical advisers and where appropriate external advisers' but not to the public, except through ongoing occasional contacts with 'health interest groups in our community'.⁹²

A joint intervention by the members of Parliament for Napier, Hastings, and Hawke's Bay led to a change of heart. The board had acknowledged during the task force's evaluation that it regarded 'public acceptance' as an important critical success factor.⁹³

The members told the chairperson and chief executive that 'public input is essential before the final determination of the Hawke's Bay CHE on the siting of the regional/acute hospital issue'. They suggested the publication of a summary of the task force's research and analysis, followed by a month for written submissions, and advised that professional assistance be engaged so that 'the public consultation process is made as direct and simple and effective as possible'.⁹⁴

6.2.5.5 Purchaser, provider, and bridging the consultation split

In mid-December, the board sent a progress report on the task force to the Central RHA and approached it 'on who should be responsible for consulting with the community'.⁹⁵ Following up the parliamentarians' intervention in January 1994, Mr Wilson conceded to the Minister for Crown Health Enterprises that 'we do however have some difficulty in managing the public consultations/political process'. He wanted a coordinated approach:

In principle it may well be desirable for us to agree with yourself and with the RHA to release an information Memorandum along the lines suggested by Michael Laws. We would be happy to subscribe to this process provided it could be managed constructively and was undertaken with the support of the shareholder and the purchaser.

89. Document 692(19), 19 July 1993; doc v1, p 28

90. Document w18(a)(16), p 5076; doc x33, p 253

91. Document w18(a)(15); doc w12, pp 7-8

92. Document w18(a)(17), p 5080; doc w18(a)(19), p 5087

93. Document w18(a)(20), p 5089(a)

94. Document w18(a)(21); doc w18(a)(22); doc w12, pp 8-9

95. Document w12, p 8; doc w18(a)(20), p 5089(a)

. . . The knowledge that a process of consultation is to be followed and that it has the Minister and RHA's approval may well be a politically expedient way of dealing with this very sensitive matter.⁹⁶

The Central RHA endorsed the proposal for public consultation.⁹⁷ A meeting with Healthcare Hawke's Bay in late March 1994 agreed that, given the support of their respective Ministers, their respective public relations consultants would work out a joint consultation programme.⁹⁸ The Central RHA prepared a draft consultation strategy which would cover both purchaser and provider issues. Acknowledging past inadequacies and the importance of a durable result, it explained:

The strategy has been developed to re-build the public's confidence in the process by introducing an element of local input and independence from the health system, to allow the logic of the case for change to be presented rationally, and to promote an opportunity for a final decision once and for all.⁹⁹

The main components of the consultation strategy it proposed were:

- ▶ the preparation by Healthcare Hawke's Bay, 'with comment from the CRHA', of a discussion paper to be distributed in full or summary form to all households in Hawke's Bay;
- ▶ a jointly nominated consultative group, chaired by the Central RHA and originally envisaged as comprising the four local mayors and three local members of Parliament, which would manage the process, hold public meetings and meetings with local groups, receive written and verbal submissions, and report on the options to both parties;
- ▶ a joint submissions review team to analyse the submissions and report to the consultative group; and
- ▶ further consultation during the transition after the decision on a regional hospital.¹⁰⁰

Nowhere in this draft strategy is there any mention of consultation with Maori, although conceivably they might have been subsumed under the category 'Local Health Groups etc'. However, the suggested process incorporated several guarantees of openness, including having local mayors chair the public meetings and making meetings of the consultative group 'open to the public'.

At its meeting on 29 March to consider the report of the task force, Mr Wilson informed his colleagues that 'the RHA had been advised that this suggestion was not acceptable'. He conceded that 'through agreement with the local MPs, the Board had agreed to allow a period of time for written submissions to be made by the public and interest groups'. However, the board saw its role as being 'that of a commercial Board': 'It was not the Board's role to sell the benefits of the

96. Document w18(a)(27)

97. Document w18(a)(28)

98. Document w18(a)(32), pp 5225–5226

99. Document w18(a)(31), p 5222

100. Ibid, pp 5223–5224; doc w18(a)(30). It is not clear whether this paper was discussed at the Central RHA–Healthcare Hawke's Bay meeting, but Mr Peacock introduced his draft strategy by noting to Mr Wilson that, 'following our meeting last week, we have revised our approach in terms of the strategy for consultation'.

health reforms to the public.' The board accepted the responsibility for justifying the conclusions reached in the regional hospital issue, 'however the responsibility for public consultation lay with the RHA'. Geoff Henley of Network Communications, Healthcare Hawke's Bay's public relations firm, who had urged the board to adopt a 'stakeholder consultation process' in a 'joint venture approach', was left to approach the RHA 'and in particular to review the process for public consultation on the regional hospital issue'.¹⁰¹

Mr Wilson now seized the initiative. Writing the next day to Hutton Peacock, he told him that 'there was considerable unease at the suggestion put forward by you'. The board's discussion had 'exposed a high level of concern amongst Board Members'. Healthcare Hawke's Bay would agree to the consultation only with the prior endorsement of Ministers. There was, Mr Wilson said, a ministerial view: Jenny Shipley, the Minister of Health, had expressed her concern 'at the grey area that existed with regard to the respective roles of a CHE and of the RHA in such situations'. The Minister wanted 'a consistent and managed approach'. The process should ensure that cost-saving, clinical, technological, and procedural advantages would be clearly indicated, and reinforce 'the public's understanding of the Purchaser/Provider split and of the respective responsibilities of the parties'.

It was now time, Mr Wilson insisted, for the Central RHA to declare its support: 'It is the view of our Board that it is absolutely essential that the climate in which this decision is to be made is supported by the policy statements from the RHA.' The board demanded that the Central RHA state publicly that it would purchase acute services from a single hospital site, that its contracts would support the establishment of a regional hospital, and that it would expect early implementation.

Healthcare Hawke's Bay was reasserting its lead role:

The process by which consultation is then to take place needs to reflect the respective roles and responsibilities and needs to take into account the Minister's desire that it is a division of roles which is understood by the public. To this end it is our Board's very firm view that we must have ownership of our respective responsibility and not delegate in anyway the responsibilities for that consultation.

Far from leaving public consultation to the Central RHA, the board had now asked Network Communications to liaise and prepare a proposal for a 'co-ordinated approach'.¹⁰²

Replying, Mr Peacock noted that Network Communications was now 'planning the entire process rather than just the "front end"', but had already shifted ground in the RHA's revised draft strategy. He declined to provide the extent of public support requested by Healthcare Hawke's Bay, commenting that 'the Authority would wish, naturally, to keep an open mind, until the consultation is complete'. He explained further:

101. Document 692(19), 29 March 1994

102. Document w18(a)(32)

Legal precedent has clearly established that decision makers must retain an open mind and take due notice of what others have to say and to wait until they have had their say before making a decision.

He would nevertheless allow the Central RHA to be quoted as recognising ‘the merit of the regional hospital concept’ and the ‘potential advantages’ arising therefrom; further, that:

The Authority is keen to purchase improved services from HealthCare Hawke’s Bay, potentially from a Regional Hospital. The Authority however, is keen to hear the views of people in the Hawke’s Bay Region before deciding on a purchase strategy.¹⁰³

Despite holding back from explicit endorsement, the Central RHA agreed to a joint programme to be devised and run by Healthcare Hawke’s Bay, which had announced on 30 March that it would seek public submissions before making a final decision.¹⁰⁴ The RHA was represented at the board meeting on 8 April at which the programme was presented and adopted. In a joint press statement, Messrs Wilson and Peacock confirmed that public submissions would be taken and agreed that ‘there should be a full and transparent consultation process involving a wide range of interest groups in the Hawke’s Bay region’ – a process that ‘has credibility and is sustainable’.¹⁰⁵ Details of the programme were given to local mayors and members of Parliament on 21 April and publicly announced on 22 April.¹⁰⁶

The regional hospital consultation was a tightly managed process with the single aim of selling the regional hospital proposal. It differed significantly from the more open process proposed by the Central RHA. The authority was, all the same, prepared to endorse it publicly:

We are satisfied that the programme is fair, transparent and well thought through and are confident that the final decision, whatever it is, will be in the best interests of the health of the people of Hawke’s Bay.¹⁰⁷

In his brief of evidence, Mr Wilson acknowledged that Healthcare Hawke’s Bay and the Central RHA had differing objectives:

while co-operating in and managing a process of consultation together, [they were] involved for different purposes. HCHB expected to consult in accordance with the announced and agreed process, and no other. Whether the RHA consulted additionally or in a different way over and above what was agreed was a matter for the RHA.¹⁰⁸

The Central RHA was none the less bound into the joint process, and Healthcare Hawke’s Bay attempted to stop it from accepting a direct approach from the Napier City Council.

103. Document w18(a)(33), p 5230

104. Document w18(a)(24)

105. Document 692(19), 8 April 1994; doc w18(a)(25)

106. Document w12, p 11; doc v1, pp 75–76; doc w18(a)(34), 35

107. Media release, April 1994 (quoted in doc v1, p 78)

108. Document w12, pp 10–11; doc x33, p 258

Combining the differing interests and approaches of purchaser and provider into a joint consultation programme made for an uncomfortable fit. The Healthcare Hawke's Bay task force and board members dominated the consultation process, with its focus on the hospital decision. The Central RHA, however, had a broader statutory obligation to consult on its purchasing intentions, which it had yet to begin. Not until after the hospital decision had been announced in August 1994 did it state that it planned further consultation:

In addition to the consultation on the specific issue of the regional hospital which has been done in recent months, further on-going consultation will be undertaken with the public of the Hawke's Bay Region on health and disability matters in order to refine Central RHA's future purchasing expectations. These discussions will be part of our ongoing consultations with communities on what services are required to meet their health needs.¹⁰⁹

6.2.5.6 Informing the public

The consultation programme had been prepared for the board by Network Communications, which was to manage its implementation. Considerable effort went into disseminating information to the public. The task force's report was placed in public libraries and sold at \$20 a copy. Overall, some 500 copies were distributed. In addition, a leaflet was sent to all households, publicity inserts placed in the local newspapers, and talkback radio sessions arranged.¹¹⁰

The object of the exercise was to win public support for the proposal to have a regional hospital at the Hastings campus.¹¹¹ However, Healthcare Hawke's Bay faced a problem of presentation. The task force had operated on the assumption that the two-hospital status quo was not an option,¹¹² since it was excluded from the model hospital methodology and the decision in principle to have a regional hospital had already been taken before the inauguration of the CHE. Yet the public had not previously been consulted on that decision.

Accordingly, a good deal of effort was devoted to arguing the case for a regional hospital, as well as for locating it at the Hastings campus, in the leaflet and newspaper inserts. Two of the four 'key questions' on which people were invited to make submissions were:

Are you prepared to retain two hospitals with a lesser level of quality than a regional hospital would have?

What are the positives and negatives of developing a regional hospital?

People were also asked to indicate at which site the regional hospital should be located and what services should continue at the non-selected site. The pamphlet also painted a positive future for a scaled-down Napier Hospital:

The Napier Hospital site would become the base for quality outpatient, therapy, community health and disability services and have continuing care beds for the elderly, and a low risk

109. Document w18(a)(58, p 5682)

110. Document 692(19), 21 April 1994; doc v1, pp 40-41

111. Document 692(19), 8 April 1994; doc w47

112. Document w18(a)(23), pp 5113-5115

6.2.5.7

maternity unit. It is vital that these sorts of services remain close to the communities they serve. Such services will develop more in the future.¹¹³

The newspaper insert also held out advantages for Maori. It stated that, if the regional hospital were located at Hastings, 'the Whare Whanau would be moved to allow for the greater usage it would receive, and is seen as becoming a Maori Health Centre', and the reduced Napier Hospital would also have a whare whanau. If at Napier, 'on-site development of a Maori Health Centre would not be possible'. Either way, a subsidised bus service between Napier and Hastings would be laid on.¹¹⁴

6.2.5.7 The consultation process

Ms Ferguson described the consultation process as 'a very carefully planned and controlled public information and consultation programme'.¹¹⁵ Geoff Henley of Network Communications, which ran the programme for the Board, described it as 'a stakeholder consultation process'.¹¹⁶ Justice Ellis agreed that the publicity material 'can be taken as designed to sell the Report to the public, and contrived to minimise opposition. On the other hand, it is plainly a substantial effort to explain the report and encourage public participation.'¹¹⁷ It was an intensive process and, as Mr Wilson pointed out, 'Board members and senior staff of HCHB took considerable time and effort to attend these meetings and make themselves available to the public'.¹¹⁸

The process was organised into four streams: public meetings; stakeholder consultation; public submissions; and hearings. The *public meetings* ran between 6 and 12 May 1994. Two general meetings were held in Hastings and Napier, followed by meetings in five localities, which included the Baptist Church Hall in Flaxmere (Hastings) and the Richmond School Hall in Maraenui (Napier) on 10 and 12 May respectively.¹¹⁹ Both were suburbs with large Maori populations. However, the meetings were not open: people wanting to go had to apply via a freephone number.¹²⁰ Altogether, about 800 people attended the five meetings in Napier and Hastings. There were in addition some 25 presentations to community organisations and staff.¹²¹

Under the *stakeholder consultation programme*, various health interest groups were invited to nominate one representative each to the stakeholders group, which met in closed session on 13 and 20 May.¹²² At the suggestion of Mr Henley, Healthcare Hawke's Bay selected the stakeholder groups before the first public meeting. The Joint Advocacy Taskforce, a local body group that included mayors and members of Parliament, was asked to assist. As a safety check, the chairperson of the public meetings was to read out Healthcare Hawke's Bay's stakeholder nominees and

113. Document w18(a)(36)

114. Document w18(a)(37)

115. Document v1, p 75

116. Document 692(19), 29 March 1994; doc v1, pp 32-33

117. *Napier City Council v Healthcare Hawke's Bay et al* High Court, Napier, CP29(94), p 17 (in doc x50)

118. Document w12, p 12

119. Document w18(a)(36), p 5241; docv1(b)(1), pp 1-2

120. Document w18(a)(37), p 5244; doc 692(19), 8 April 1994, doc w47; doc v1, p 76

121. Document w47; doc w18(a)(78), p 6078; Healthcare Hawke's Bay 1995a, p 2; doc w12, pp 12-13

122. Document 692(19), 21 April 1994; doc v1, p 76



Map 11: Distances to hospital – Napier (left) and Hastings (right)

ask if any major groups had been missed, but suggestions from the audience would be accepted only at the chairperson's discretion.¹²³

The board agreed that 'it would be important to ensure that the group of stakeholders comprised a composite representation of the existing health interest organisations'.¹²⁴ Maori were identified as a general category but iwi and hapu organisations were not recognised as stakeholders. In the pamphlet distributed to households, Maori were not listed at all amongst the examples of stakeholders.

The stakeholder meetings provided detailed briefings from Healthcare Hawke's Bay and its external experts (known as 'validators'), as well as from the Central RHA.¹²⁵ The meetings were reported via a newsletter.¹²⁶ The group representatives were supposed to transmit the information and views presented by Healthcare Hawke's Bay back to their groups so as to assist them in preparing submissions. Kevyn Moore explained their role to his fellow board members:

It must be clearly stated what their role is. They have no power and can make no recommendations. The sole aim is to allow a group to get really close and to question the Task Force/Board/RHA/Consultants and report to their groups.¹²⁷

As in 1990 and 1991, *written submissions* were invited. Four weeks were allowed after the release of the task force's report, with a deadline of 1 June 1994. Healthcare Hawke's Bay also provided an 0800 free phone line for inquiries and for the public to register simple expressions of opinion; 534 comments were logged.¹²⁸

Oral submissions were added at the suggestion of the Central RHA and were heard during the first half of June 1994. But the board limited their scope:

With regard to oral submissions, these would be accepted only at the discretion of the Board. Oral submissions would take the form of a half-hour presentation in support of a written submission and would not be open to the public or to the Press.

Groups wishing to present their case in person had to apply or be invited, and would be heard only at the discretion of the board. Responding to the concern of the Central RHA that the process be 'open and transparent', the board agreed to allow media representatives to attend if the presenters requested it. They also authorised the publication of the independent review of the written submissions.¹²⁹

The reprieve granted by Justice Ellis to the Napier City Council allowed it to make a further oral submission, which was supported by expert papers. No further submissions by other parties were allowed.

124. Document w47

125. Document v1, pp 76–78; doc w18(a)(36), p 5239; doc w47. Mr Wilson refers to three such meetings: doc w12, p 13.

126. Document w18(a)(78); doc w18(a)(80); doc w12, p 13

127. Document 692(24); doc v1, p 77; doc w12, p 13

128. Document v1, p 84; doc w18(a)(36), p 5240

129. Document w47; doc 692(19), 21 April, 4 May 1994

6.2.5.8 Consultation with Maori through public and stakeholder meetings

Most Maori had access to representatives of Healthcare Hawke's Bay only through the public meetings. They, like other members of the public, had to apply for invitations. In the list of invitees identified as Maori by Healthcare Hawke's Bay, only 16 out of 81 had addresses in or near Napier. They included Te Taiwhenua o Te Whanganui a Orotu and the Waiohiki and Petane (Te Amiki) Marae.¹³⁰ Walter Wilson, who as the board's only Maori member went to many of the public meetings, noticed that few Maori attended, including at the opening meeting in Napier on 6 May 1994.¹³¹

Like the area health board in 1991, Healthcare Hawke's Bay went no further than to identify 'Maori groups' as a general category for consultation. Iwi were not mentioned either as stakeholders or as a key audience in the validation process.¹³² Nevertheless, one of the talkback sessions arranged was on the Kahungunu iwi radio station.¹³³

No information has been provided in which Maori groups were identified as 'stakeholders', but Mr Peter Wilson named five Maori as having been invited to attend the stakeholder meetings.¹³⁴ According to him, Healthcare Hawke's Bay staff, assisted by Mr Henley, put together the list of stakeholders.¹³⁵ Walter Wilson thought it was a Maori staff member, selecting individuals on the basis of their abilities and their involvement in health issues rather than as delegates of representative organisations.¹³⁶

Healthcare Hawke's Bay gave a number of assurances at the two stakeholder meetings about what would remain at Napier Hospital. They insisted that there was no plan eventually to close the hospital and move the remaining services off-site. A 24-hour first aid facility would cover some 80 per cent of existing accident and emergency cases. 'Virtually all' the existing clinics would remain, as well as a number of day-care and low-risk maternity services.¹³⁷

At the first stakeholder meeting on 13 May, the issue of Maori health improvement was raised, and Healthcare Hawke's Bay made a commitment to upgrade facilities in Hastings but did not address the situation in Napier:

Will a Regional Hospital improve the situation with regard to Maori health?

*The Maori Health unit, Wh[a]re Whanau, will be significantly upgraded. The large population of Maori in Flaxmere will be located near the Regional Hospital. Resources may be released in the future for Maori health programmes.*¹³⁸

At the second meeting a week later, the Maori Health Unit came on the agenda but was discussed only briefly. It was accepted that further consultation was required:

130. Document v1(b)(1), p 9 ; doc v1(b)(G1)

131. Document x33, pp 339, 342

132. Document v1, p 76

133. Document w14, p 4; doc w18(a)(81), p 6104

134. Document w12, p 14; doc w14, p 4

135. Document x33, pp 260–261

136. Ibid, pp 320–321

137. Documents w18(a)(78), (80)

138. Document w18(a)(78), p 6076

6.2.5.9

Issue: Further discussions about the Maori Health Unit should be with Maori people.

Response: The framework and development of the Maori Health Unit would be very much in concert with Iwi groups.¹³⁹

Te Maari Joe, who was one of the five invitees, was critical of the format of the meetings. She considered that they were dominated by technical presentations and question-and-answer exchanges rather than a discussion of issues. This format obstructed effective communication:

Quite often the speakers would talk about very technical things that were difficult for lay people to grasp what was going on. Some of the questions related to, will there be a bus for transport; will there be eye clinics. As I have experience in such things there was no discussion and people did not understand things like primary care as compared to secondary care so consultation by way of a stakeholders meeting was not appropriate. It would have been more appropriate to have consulted the formal structures that existed like the Taiwhenua Boards and the Taiwhenua itself to have a considered response to the CHE.¹⁴⁰

The structure of communication was thus in her view disempowering. Instead of consulting directly with iwi and other established Maori organisations, Healthcare Hawke's Bay selected the stakeholders and convened the meetings on its own terms.

6.2.5.9 Consultation with iwi – the Omaha hui

Healthcare Hawke's Bay held one public consultation with iwi, through a hui convened at Omaha Marae on Wednesday 18 May 1994. It was held on a weekday and lasted about six hours.¹⁴¹ According to Mara Andrews, the hui was advertised once only in the Napier and Hastings newspapers, although she was unable to trace the advertisement.¹⁴² Certainly, it was not listed amongst the meetings prominently notified in Healthcare Hawke's Bay's household pamphlet and newspaper insert. Ms Andrews, at the time a policy analyst in the Central RHA's Maori health group, indicated in evidence to the Tribunal that no consultation plan was drawn up and that the group went no further than to arrange the logistics of the hui in consultation with Healthcare Hawke's Bay.¹⁴³ It remains unclear with whom they communicated and who was invited.

The venue placed the meeting close to the large Maori population in and around Hastings (see map 11a). The attendance of about 40 at the only consultative hui in the whole of Hawke's Bay was not a good indicator of effective outreach even if, as Walter Wilson indicated, it included 'differen[t] representatives of the Maori community'.¹⁴⁴

Mrs Joe stated that many of the Maori participants were 'Kaumatua from Hastings' and that she heard of the hui only by chance, through a friend:

139. Document w18(a)(79), p 6090

140. Document 692(5); doc v1, p 78; doc v17, paras 4.1–4.2

141. Document w19(a)(9001); doc w14, p 5

142. Mara Andrews questioned by Tribunal, doc x33, p 223

143. Mara Andrews cross-examined by Grant Powell, doc x33, pp 196–197

144. Document v1, p 80; doc w14, p 5

The hui was not widely known about . . . The hui was scheduled during working hours and was an inconvenient time for working Maori to attend, local and formally constituted Maori groups were not in attendance. The Taiwhenua were not formally invited. Those attending were in the main retired, unemployed and Maori employees of the CHE. To be a properly constituted hui required calling all Maori from all the Taiwhenua districts and from the Marae. This was never done.¹⁴⁵

The 'summary' of the hui indicates that four representatives of Healthcare Hawke's Bay attended (Mr Bowes, board members Walter Wilson and Kevyn Moore, and task force member Mark Flowers), together with one from the Central RHA (contracts team member Lynne McKenzie). Their presentations focused less on the regional hospital than on the advantages that greater efficiency would bring for community health. They stated that many community services would remain at Napier Hospital and that transport and access to the regional hospital had been assessed. Mr Bowes portrayed the regional hospital as bringing 'opportunities for Maori' and highlighted the proposed new Maori health centre, 'provided Central RHA provide funding'.¹⁴⁶

Mrs Joe considered that this was not effective consultation but:

merely reporting, telling us what was going to happen and we were told by Mr Bowes not to worry. It gave us the feeling that things had already been settled, that decisions had already been made and we were being spoken to as we have for the last 150 years.¹⁴⁷

In an affidavit in support of Healthcare Hawke's Bay, made on behalf of Te Taiwhenua o Heretaunga, Alayna Watene stated that 'the Maori community had a full and uninhibited discussion' at the Omaha hui.¹⁴⁸ However, only a few questions and comments from the floor specifically addressed the Napier situation. Fred Reti made it clear that Napier Maori did not yet support the regional hospital proposal and wanted more information as well as time to study the task force's report. Like several other contributors, he criticised Healthcare Hawke's Bay's poor communication with Maori: 'We as Maori hear very little indeed. Needs to be updated and brought back to the people.' An unidentified speaker, possibly Mrs Joe, said that the Maori Women's Welfare League wanted two hospitals and raised problems regarding transport.

Many of the contributions concerned the proposed Maori health centre. Speakers criticised the lack of consultation on its planning and of accountability in its management. They were also concerned about possible competition with Maori providers of primary healthcare. Out of this debate, a motion was adopted:

That the hui of Maori representatives recommends to the CHE Board of Health Care Hawke's Bay, that they appoint a Maori Advisory Committee to provide advice in Maori policy, the

145. Document v16, paras 3.1–3.2, 3.7, 4.1

146. Document w19(a)(9001)

147. Document 692(5); doc v1, p 82

148. Document w18(a)(81), p 6103

establishment and staffing of a Maori health centre, the Regional Hospital issue, CHE services to Maori and any other issues affecting Maori.¹⁴⁹

The committee was thus conceived as a standing body addressing a wide range of ongoing issues, including the regional hospital. Mr Reti, amongst others, called for the committee to be ‘chosen by the people’. But in Mrs Joe’s opinion, the hui did not have the authority to commit all Maori in the region to its establishment.¹⁵⁰ The advisory committee, which later became the Maori health committee, did not in fact meet until well after the board of Healthcare Hawke’s Bay had made its decision on the regional hospital.

The Omahu hui itself did not express a view on the merits of the regional hospital proposal. The Central RHA did not follow up the hui, leaving it to Healthcare Hawke’s Bay to take matters further. There was no further communication between its Maori health group and those sections actually involved in the regional hospital issue.¹⁵¹

6.2.5.10 Consultation after the event – the kaumatua hui at Hastings Hospital

One other initiative took place at this time under tribal auspices. On 9 August 1994, board members and managers attended a hui of Ngati Kahungunu kaumatua in Mihiroa Whare at Hastings Hospital to discuss establishing the proposed Maori health centre and the advisory committee. At the end of the meeting, Mr Bowes ‘called on the meeting here to support the Hastings site’ in the face of the legal challenge from the Napier City Council. He was supported by the chairperson of the meeting, Arama Puriri. No expression of opinion was recorded, but the meeting nominated Mr Puriri to speak to the media.

At an ‘emergency’ follow-up meeting on 18 August, Mr Puriri secured the support of the meeting for an affidavit to be made in support of Healthcare Hawke’s Bay on the regional hospital issue, which he duly deposed four days later. At the same time, the meeting noted the division of opinion between the taiwhenua on the issue and wished instead ‘to Tautoko the Kaupapa for Maori Health’.¹⁵²

The two hui were, however, convened after the announcement of the hospital decision and were therefore not part of the consultation process. It is not clear how many kaumatua associated with Te Taiwhenua o Te Whanganui a Orotu were present, particularly at the second hui, which had a much smaller attendance. Nor was there any discussion of the status of Napier Hospital. The call to support the regional hospital decision came from Healthcare Hawke’s Bay and Mr Puriri alongside a kaupapa that was primarily concerned with developing Maori health facilities.¹⁵³

149. Document w19(a)(9001)

150. Document v16, para 3.6

151. Mara Andrews cross-examined by Grant Powell, doc x33, pp 193, 199

152. Minutes of kaumatua meeting, 9 August 1994, and of emergency kaumatua meeting, 18 August 1994, doc x5(14); doc w52

153. Arama Puriri cross-examined by Grant Powell, doc x33, pp 357–358

6.2.5.11 Consultation with Maori through written submissions

There were only three written submissions from Maori, two of them from Napier.¹⁵⁴ One was from Tom Hemopo, who, speaking for himself, criticised the regional hospital proposal in terms of the Treaty. His particular concerns were a lack of extensive consultation with the tangata whenua, the inadequate protection of Treaty rights, greater hardship for less well-off Napier Maori, and a ‘monocultural’ approach. He suspected that hospital services in Napier would eventually disappear, despite the assurances given.¹⁵⁵

Mrs Joe also made a written submission. Speaking for Te Taiwhenua o Te Whanganui a Orotu and the Hauora board, she stated their support for the retention of both hospitals, for a Maori advisory committee, and for consultation with Maori people and organisations on any issue affecting Maori. As well, the two bodies stressed ‘the value of People as against bricks and mortar’.¹⁵⁶

There was also a submission from the Napier City Pilot Trust (To Matou Taiwhenua Kokiri o Mataruahou). It pointed to the importance of ready access to health services in tackling social problems. If services were moved to Hastings, ‘the health of Napier’s Tangata Whenua and disadvantaged people will become even more endangered’. The trust criticised what it saw as a monocultural approach and the absence to date of ‘meaningful dialogue with those people who will be most [a]ffected, if their hospital, with full services, is closed’. It was joining others in ‘exploring some way of involving the treaty of Waitangi procedure to stop the regional hospital until some meaningful consul[t]ative process can be established with the Napier Maori people’.¹⁵⁷

There were no submissions from Maori north of Napier. Looking back, Peter Wilson considered that the month allowed for submissions was sufficient in view of the high level of community awareness of the regional hospital issue, and that anyway it was extended by the oral submissions and ‘follow up inquiries’. The board was following experienced advice.¹⁵⁸ However, it did not seek the views of Maori organisations in determining how and over what period to consult them. Mr Hemopo criticised the failure of Healthcare Hawke’s Bay to make contact with the taiwhenua or to supply it with documentation. He stated that the consultation interval was too short to allow the taiwhenua to meet formally and decide on a submission.¹⁵⁹

6.2.5.12 Consultation with Maori through oral submissions

Healthcare Hawke’s Bay followed up the Omaha hui by inviting four of those who attended to make oral submissions to one of the hearings that they were conducting jointly with the Central RHA. This was the only session specifically allocated to Maori. The four people were selected by Healthcare Hawke’s Bay, not by their own organisations. Mr Moore considered that one person from each area (Tamatea, Hastings, Napier, and Wairoa) would suffice: ‘As each was at the hui,

154. Document w18(a)(42), p 5353

155. Document w18(a)(83), pp 6114–6115; doc v17(a)

156. Document v16(a)

157. Document 692(25)

158. Document w12, p 14

159. Document v17, para 2.8

representing the four areas, we feel this to be a reasonable representation of Hawke's Bay Maori'.¹⁶⁰ In fact, Mrs Joe felt that she lacked authorisation to speak as a representative and was accompanied by Mr Hemopo at her own initiative, while Bill Heke had to explain that he had no mandate to represent central Hawke's Bay.¹⁶¹

Mr Wilson conceded that this was so in the case of Mr Heke, but considered the other three submissions 'to be a presentation from tribal representatives'. At the session on 16 June, however, he did not seek to establish whether they were so authorised: two volunteered their position, and 'I understood that Mrs Joe represented Te Whanganui a Orotu'. There was thus a basic misunderstanding as to the status of her submission. The main focus, as at the hui, was on the proposed Maori advisory committee rather than the regional hospital issue that was supposedly under consultation. Even though the committee had that issue on its agenda from the Omaha hui resolution, it was not Healthcare Hawke's Bay's intention that the committee should take it up.¹⁶²

The invitations allowed only two days for the invitees to consult and prepare for their appearance on 16 June. Despite the short notice, all four attended the hearing in person or through a nominee. According to Mrs Joe, she was notified on what subject to speak and for how long. The presentations addressed two distinct issues: the establishment of an advisory committee and the regional hospital proposal. Mrs Joe raised what she saw as the lack of thorough consultation, which she thought should take an inclusive approach to Maori people and organisations, including Maori from outside the region. Mr Hemopo spoke to his written submission, focusing on the Treaty dimension.

Apart from a few clarifications by the Healthcare Hawke's Bay representatives, there was no dialogue on the issues raised.¹⁶³ This was despite the board being informed a few days before by Bridgeport, its consultants evaluating the submissions, that, from the 'four or five' submissions from Maori organisations, 'the general feeling . . . was for the status quo to remain and some references had been made to a perceived inadequacy in the consultation process'.¹⁶⁴

When the Napier City Council took Healthcare Hawke's Bay to court over the regional hospital decision, neither organisation consulted or involved Napier Maori groups. Nor, when it won a reprieve, did the council involve Maori in its further submission in February 1995. Mr Hemopo protested to the council at the time about the omission. Napier Maori were thus unable to join or influence the High Court action.¹⁶⁵

6.2.5.13 An alternative Treaty-based consultation

That the board's handling of the public consultation exercise was not the only possible approach to consulting with Maori on health matters was demonstrated by a more specific exercise on the regional maternity service. It was planned and conducted through August and September 1994,

160. Document v1(b)(F1)

161. Document 692(5); doc v1, p 82; doc w18(a)(83), pp 6116, 6118

162. Document x33, pp 263–264; doc w12, pp 15–16

163. Document w18(a)(83), pp 6114–6116; doc v16, para 5.4

164. Document 692(19), 10 June 1994; doc v1, p 83

165. Document v17(b)

just after the announcement of the regional hospital decision, and was run by a section of the same organisation, Healthcare Hawke's Bay.

The focus of the consultation was the provision of maternity services to Maori. As well as Healthcare Hawke's Bay's general commitment to quality improvement, its Maternity and Child Health Service (MCHS) saw itself as responding to two further obligations:

- ▶ *Contractual requirements*: For the year 1994–95, the Ministry of Health laid down that RHAs should purchase, under maternity, 'services that specifically meet the needs of Maori women and their whanau and enhance their choice'. In turn, the Central RHA expected 'providers of services which are accessed by Maori people . . . to integrate tikanga Maori . . . into the service that they provide', and listed eight 'values and rights'. It advised that 'providers should consult with tangata whenua, and other Maori living in the area, about how the above values are to be reflected in services for Maori'.¹⁶⁶
- ▶ *Treaty of Waitangi*: 'the moral obligation of all institutions in New Zealand to act within the principles of the Treaty of Waitangi is acknowledged by the Maternity and Child Health Service. This acknowledgement has also contributed to the planning for the Maori Maternity Consultation Project'.¹⁶⁷

MCHS took its guideline directly from Justice McGechan's 1992 decision in the Commissioner for the Environment case, to which we referred in section 3.9. Thus the principles of partnership and active protection both required 'genuine consultation', whose 'essential elements' included the provision of sufficient information and time, and a genuine consideration of the issues. MCHS brought the process itself into the criteria of success, affirming that 'for successful consultation to take place both the participants and the decision-makers must be satisfied with both the process and the outcome of the consultation'. Furthermore, MCHS did not seek to monopolise the agenda:

During this consultation process it has been important for the Maternity and Child Health Services to not only consider service objectives and priorities, but to consider in utmost good faith the priorities of those people and groups who have been consulted.¹⁶⁸

MCHS adopted a multilevel strategy in conducting its six weeks of consultation:

- ▶ It organised a questionnaire survey of Maori women who had previously used the maternity service, which was conducted mostly through face-to-face interviews conducted by Maori interviewers. The questionnaire included a 'Treaty section' covering the tikanga values identified by the Central RHA.
- ▶ It involved two kaumatua in the project planning phase as well as Healthcare Hawke's Bay's 'Maori health consultant', Pare Nia Nia, and checked the survey questionnaire 'with key people from the Maori community'. Later, it also sought community feedback on the design and execution of the survey, some of which turned out to be critical.

166. Lauchland and Barcham 1994, p 4, app 1, quoting 'MOH 1994', p 42, 'CRHA 1994, Schedule 3', presumably the Ministry of Health's funding agreement with the Central RHA and the latter's purchase contract with Healthcare Hawke's Bay.

167. Ibid, p 4

168. Ibid, pp 4–5

- ▶ It disseminated information to maternity staff in Napier and Hastings and to community groups.
- ▶ It held two hui at Kohupatiki Marae, midway between Napier and Hastings, at the start and end of the consultation, and consulted other interested groups.
- ▶ It sought views on ‘working out a way to have ongoing liaison and input from the Maori community into maternity services provided by Health Care Hawke’s Bay’.¹⁶⁹

The consultation dealt not with deciding between proposals, such as having a regional hospital, but with identifying priorities. None the less, it resulted in a substantial list of issues to be followed up, and the survey generated ‘a wealth of information . . . that will provide an invaluable database for further analysis and planning for Maternity and Child Health Services’.¹⁷⁰ It also laid the groundwork for future cooperation. A resolution passed at the first hui to establish a regional liaison committee for Maori maternity and child health services led to the election of the committee at the second hui with members from all four districts of the Healthcare Hawke’s Bay region. MCHS assisted the committee to get set up and to meet, and referred the survey report and issues arising to it for recommendations.¹⁷¹

Although long-term outcomes did feature in the objectives of the maternity services consultation project, they need not concern us here. We have described the process in order to illustrate the point that, even within Healthcare Hawke’s Bay itself, an alternative approach to consultation with Maori was both conceivable and had actually been attempted.

6.2.5.14 Taking account of the views expressed

As we observed in section 6.2.5.3, Healthcare Hawke’s Bay upgraded several services in the planned final configuration of the downgraded Napier Hospital. As Peter Wilson points out in his brief, ‘these were significant changes and reflected a concern to meet the community’s desires’. They required ‘some movement’ from the views expressed by clinicians and advisers and in the task force’s report.¹⁷² In part, they reflected public pressure relayed through the Central RHA; in part, they were direct responses by board members who had gone through weeks of intense public debate; and in part they took account of points raised in the public submissions. There was, all the same, no shift of position on any major point.

The board commissioned a number of additional reports following the close of consultation. Most addressed technical or data deficiencies. But just as during the task force phase, little attention was paid to social and community impact, except in refuting the submission from the Napier City Council. The board did not commission a social impact report, despite having little hard data or analysis at its disposal. Nor were the issues before it and the consultation process reviewed in light of Treaty principles. The Omaha hui and the handful of Maori submissions were

169. Lauchland and Barcham 1994, pp 6–9, appendices

170. Ibid, p 10

171. Maternity and Child Health Service Maori Liaison Committee, minutes, 6 October 1994 (in Lauchland and Barcham 1994, app VII)

172. Document w12, pp 20–21

briefly mentioned in the general analysis of submissions prepared by the Bridgeport Group.¹⁷² But there is no sign from the available documentation leading up to the regional hospital decision on 21 July 1994, including the minutes of board meetings, that Maori concerns were either raised or discussed.

6.2.5.15 Public protest, parliamentary redress, and Maori opinion

As in 1991, opposition from the people of Napier to the proposal to downgrade Napier Hospital was vigorous, sustained and widespread. A petition presented to Parliament in June 1994 attracted 33,046 signatures, even more than its 1991 predecessor, and encompassed the great majority of the population of the Napier urban area. In May 1995, some 6000 to 7000 people attended a public rally to protest Healthcare Hawke's Bay's confirmation of its regional hospital decision. In the same month, Geoff Braybrooke, the member of Parliament for Napier, conducted a postal referendum of the 14,000 registered voters in his constituency. Of the 71 per cent who responded, 73 per cent supported the two-hospital status quo and 18 per cent a new greenfield hospital midway between Napier and Hastings.¹⁷³

It is probable that many Maori residents of Napier signed the petition and responded to the referendum. Some would have attended the rally, at which Heitia Hiha 'spoke of the problems a hospital further away would cause, especially for poorer families for whom travel was a burden'.¹⁷⁴

The petition, presented in June 1994, urged Parliament to:

recommend to the Minister of Health and Minister for Crown Health Enterprises to direct Healthcare Hawke's Bay to maintain services at both Hastings and Napier Hospitals, investigate rationalisation of services between both hospitals and ensure adequate public consultation.

The petition was referred to the social services select committee, was held over, and eventually made no further progress.¹⁷⁵

In September 1994, Mr Braybrooke's Continuation of Napier Hospital Bill, for which his 1995 referendum gained 73 per cent approval, was also referred to the committee. It received 70 written submissions. After three years' delay, the Bill was referred to the health committee, which conducted no hearings. In November 1997, the committee reported negatively on the Bill, and the House of Representatives voted it down.¹⁷⁶ By this time, the regional hospital project was well advanced towards implementation, and Healthcare Hawke's Bay was preparing for a further major step affecting the status of Napier Hospital. It does not appear that Maori opinion was sought, presented, or discussed at any stage of the parliamentary proceedings.

172. Document w18(a)(42), p 5345

173. Document v1, pp 45-46, 48-56

174. *Daily Telegraph*, 8 May 1995 (quoted in doc v1, p 48)

175. Document v1, p 46

176. Health Committee, 'Report on the Continuation of Napier Hospital Bill', 12 November 1997, AJHR 1998 1-22; doc v1, pp 49-55

6.2.6 The decision to remove Napier Hospital's site 'guarantee' (1995–96)**6.2.6.1 *An uneasy compromise***

The announcement of the board's reconfirmed decision on 5 April 1995 at last cleared the way for Healthcare Hawke's Bay to implement the regional hospital plan on the site of Memorial Hospital in Hastings. For the next four years, this major project was the CHE's principal development preoccupation. The revamped and greatly expanded Hastings Hospital, renamed Hawke's Bay Hospital, was opened on 15 April 1999.¹⁷⁸

For its part, the Central RHA had appeared to give its stamp of approval by publicising its proposal to keep purchasing a fairly broad range of services from Napier Hospital. This statement, issued at the time of the first regional hospital decision in August 1994, coincided with Healthcare Hawke's Bay's concession in agreeing to retain a higher capacity at Napier Hospital than the task force had recommended. The impression given to the public was of a shared commitment to maintain the reduced schedule of services at Napier Hospital. Nowhere in the Central RHA's publication was there any hint that the services might later be reduced further or moved off site.

The situation was nevertheless an uneasy compromise. Napier Hospital retained a far higher capacity than the outlying community hospitals at Wairoa and Waipukurau. This retention was against clinical opinion, which endorsed a concentration of most services in a single hospital. The Napier Hospital site was also, as the task force had been advised, prime urban real estate.¹⁷⁹

The Central RHA, despite pressing Healthcare Hawke's Bay to keep a higher service level at Napier Hospital, had itself yet to form a final view. It described the purchasing intentions it published in August 1994 as a 'discussion document' and had still to undertake its planned analysis of health needs in the Napier area, although it made no mention of this further work in the document.

There was also pressure from central government. Throughout the two-year period of planning and consulting on its regional hospital project, Healthcare Hawke's Bay was running deficits and projecting more to come. This unwelcome situation invoked the attention of Treasury in a 'workout' process of close financial supervision, and built an incentive to look for opportunities to reduce costs.

6.2.6.2 *Official assurances on the status of Napier Hospital*

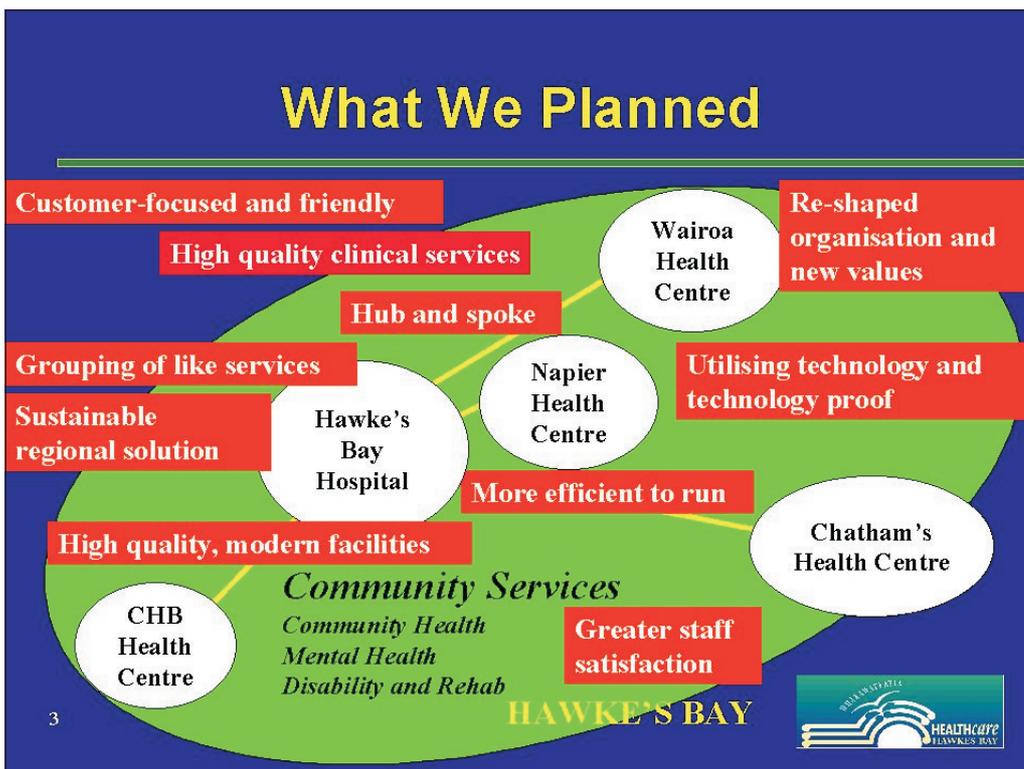
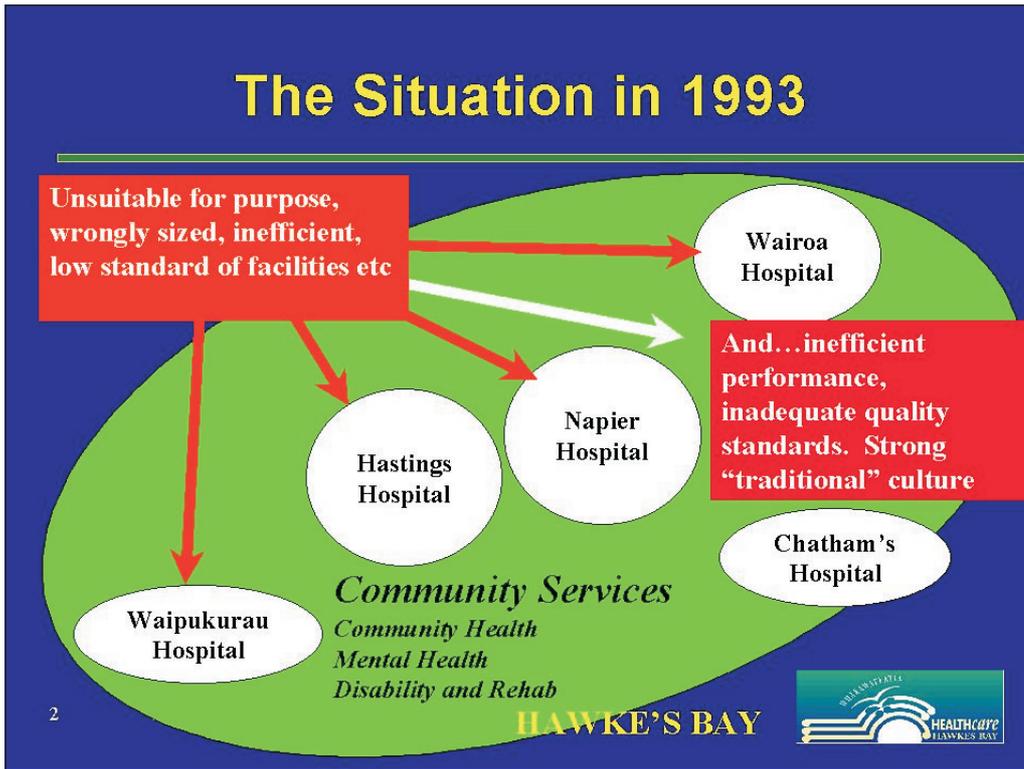
During the consultation on the regional hospital proposal in mid-1994, the general perspective presented in the reports, publicity, statements, and answers to questions from Healthcare Hawke's Bay was that those services remaining in Napier would continue to be based at Napier Hospital. In June 1994, the Minister for Crown Health Enterprises assured a Taradale resident that 'Napier Hospital will not close'. 'On the contrary,' he said, 'the current debate concerns the level of service to be provided by Napier Hospital.'¹⁸⁰ The Central RHA also publicly tied its service range to Napier Hospital.¹⁸¹

178. Document w13, p 3

179. Valuation New Zealand report, app 6 (in doc w18(a)(23), p 5185)

180. Document 692(27)

181. Document v1, pp 33–34



Figures 24 (top) and 25: Healthcare Hawke's Bay's vision of hospital regionalisation. Slides from a presentation at the forum 'Leadership and the Management of Change in Clinical Settings', Auckland, 2 August 2000.

Taken from Flowers 2000.

6.2.6.3

Following the final decision to regionalise in March 1995, official messages continued to give assurances that Napier Hospital would not be closed. In replies to local residents, the Prime Minister stated in July 1995:

Napier Hospital will not be closing down. It will remain a community hospital with a comprehensive range of services and, in practice, many patients will continue to attend the hospital as they do presently.

The Minister of Health wrote in similar vein. As late as September 1996, the Minister for Crown Health Enterprises reported that 'I have been advised that there has been no decision to close down Napier Hospital'.¹⁸²

This high-level reassurance was consistent with the undertakings given by Healthcare Hawke's Bay and the Central RHA in 1994. Healthcare Hawke's Bay repeated the assurance categorically in its 1995–96 statement of intent:

Napier Hospital is to be reconfigured as a community hospital, providing a comprehensive range of outpatient, accident and medical services, continuing and day care for the elderly, Maori health facilities, maternity care, and day surgery. It will provide a base for community care services for the Napier area.¹⁸³

Although Healthcare Hawke's Bay's March 1996 implementation plan raised a degree of uncertainty about the future location of Napier-based facilities, it did so briefly and obliquely. It also stated that 'services in Napier are not being changed until the Regional Hospital is commissioned', and this was scheduled for mid-1998.¹⁸⁴

In the event, Napier Hospital was all but closed before the end of 1998 while Hawke's Bay Hospital was not completed until mid-1999. Yet, Healthcare Hawke's Bay initiated an internal review which led to it beginning to vacate the hill site early in 1997, less than a year after saying publicly that it would not do so. Once again, the effect was to undermine public confidence in Healthcare Hawke's Bay's commitment to maintain both the hospital and service levels in Napier.

6.2.6.3 *The removal of Napier Hospital's guarantee*

When the board of Healthcare Hawke's Bay took its decision in August 1994 and again in March 1995 to regionalise hospital services at Hastings, it also resolved to deliver the services to be retained in Napier from Napier Hospital.¹⁸⁵ These services were described in some detail in the publicity the board issued justifying its decision, which included an explicit commitment to Napier Hospital.¹⁸⁶ The implementation plan issued in June 1995 similarly included 'modify the Napier site' in one of its project goals and made no mention of a possible move off site.¹⁸⁷

182. Letters quoted in doc v1, pp 57–58

183. Healthcare Hawke's Bay 1995b, p 5

184. Document w18(a)(63), p 5740

185. Documents w18(a)(54), (62)

186. Document w18(a)(55); Healthcare Hawke's Bay 1995a; *Hawke's Bay Herald Tribune*, 10 August 1994

187. Document w18(a)(61)

But the goalposts were soon moved. As far back as 1990, the Booz-Allen Hamilton report had raised the prospect of moving Napier's services downtown. There is some evidence that Healthcare Hawke's Bay's managers had already formed their 'hub-and-spoke' vision of a single regional hospital with satellite health centres at least by the time that the planning of the regional hospital got seriously under way in mid-1995, if not before (see figures 24, 25).¹⁸⁸

Interviewed in June 1994, two months before the regional hospital decision was announced, Alistair Bowes gave his opinion that the outpatient clinics remaining in Napier 'could just as easily have been downtown and in many ways that would be quite a good idea'. Mark Flowers, who later succeeded him, agreed that vacating the hospital site 'would have been better in terms of access . . . in fact many of the services would be better in the city really . . . Outpatients would be better downtown'. What had deterred the task force from recommending this option was the much higher estimated cost. Neither mentioned the views of the Napier community.¹⁸⁹

In 1995, Healthcare Hawke's Bay's business plan made a commitment to seek further savings from the regional hospital reorganisation.¹⁹⁰ In March 1996, Peter Wilson warned the Ministers of Finance and Crown Health Enterprises that 'the questions relating to service delivery at Napier do carry some uncertainty'. He continued:

there is a public expectation (which is justified) that the majority of these services will be provided at the existing Napier Hospital site . . . While not in any way wishing to resign from our previously stated willingness to provide services from the existing hospital site we would never-the-less point out that over time the community and the purchaser of services may prefer to see the availability of those services closer to community centres. The nature of our proposed expenditure on the Napier site takes into account that the buildings retained by Healthcare Hawke's Bay should have alternative use options.¹⁹¹

Shortly afterwards, the board finalised its regional hospital plan. It published the results of its regional planning exercise without indicating where Napier Hospital would fit in. Instead, it guaranteed the status quo only until the regional hospital was opened and signalled a further review: 'The time is being taken to think through how best these services should be provided.'¹⁹²

The regional hospital plan provided one possible example of a reconfiguration: a partnership with private providers to transfer a substantial proportion of lower level accident and emergency cases to a general practitioner-run accident and medical centre.¹⁹³ This was in line with the 1994 recommendation of Professor Derek North:

This centre should in time be located close to the centre of Napier with easy access to the greater population of Napier. It could be developed in association with an after hours general practice which is already operating in the city.¹⁹⁴

188. For instance, Gwynn 1998, pp 41, 51–52; Flowers 2000

189. *Daily Telegraph*, 9 June 1994

190. Document v1, p 35

191. Document 692(28)

192. Document w18(a)(63), p 5740

193. Document w18(a)(63), p 5734

194. Document w18(a)(57), p 5668

In the meantime, the plan stated that Napier Hospital was to remain in operation until facilities in the regional hospital progressively came on line.

The Central RHA was also shifting its ground. At a public consultative meeting in Napier on 20 February 1996, Graham Scott, the authority's chairperson since May 1995, acknowledged the force of community sentiment and that the Central RHA's public commitment in August 1994 to locate Napier services at Napier Hospital 'was in response to that clear statement of community preference', which the Central RHA would be obliged to continue to take into account.¹⁹⁵

But Mr Scott also told the meeting that this commitment ran contrary to the Central RHA's general approach: 'The responsibility of the Regional Health Authority is to specify services according to their nature, quality and access. It is not our business to say what . . . particular patch of ground they should be delivered from.' He signalled that the authority had 'a prime obligation to provide quality, accessible and value for money services', and declined to be drawn any further, despite persistent questioning from the audience.¹⁹⁶

By August 1996, Healthcare Hawke's Bay was sufficiently confident of the Central RHA's intentions to inform CCMAU that:

we anticipate that as a consequence of the review there will be opportunities for us to look at a range of options for the services we would wish to provide which are no longer site specific to the existing Napier Hospital site.¹⁹⁷

A month later, Dr Lynne Lane, the Central RHA's public health services manager, stated publicly that it could no longer give an assurance that Napier's health services would continue to be provided from the hospital site.¹⁹⁸

In December 1996, the Central RHA announced a major shift in its approach to purchasing health services for the Napier area. In its published purchasing expectations, it declined to specify the site from which the services would be delivered, and it recognised that this would renew uncertainty about the future of Napier Hospital:

Central RHA has decided not to specify where services should be delivered from in Napier. We are aware of the strength of public commitment to the Napier hospital site, and appreciate that leaving the location of services undetermined is a significant change from what was in the 1994 document.

It is not the Central Regional Health Authority's role to specify the site from which providers will operate. Central RHA is responsible for a range of functions, including monitoring health, assessing the need for health services, and purchasing those services. As such, we can only specify the levels of services that will be purchased, quality standards that providers must meet, and criteria that determine who needs to have easy access.

195. Document 692(29), p19

196. Document 692(29)

197. Document 692(30)

198. *Daily Telegraph*, 11 September 1996 (quoted in Gwynn 1998, p 41); also doc w19(a)(9010)

Central RHA cannot specify the site services should be provided from, as this would mean limiting who could provide the service. Specifying the site would also significantly limit a provider's ability to be innovative and improve services. It could also be seen as anti-competitive and in breach of the Commerce Act.

The Central RHA also stated that clinical safety might require that accident and medical services, day surgery, and outpatient services be provided from the same site.¹⁹⁹

The Central RHA was thus using four main arguments as justification for lifting the site guarantee:

- ▶ It was not the role of an RHA to specify sites. This was a clear policy position but was disingenuous in view of the critical importance ascribed by Healthcare Hawke's Bay in 1994 to a commitment from the Central RHA to purchase services from the new regional hospital.
- ▶ The principle of competition was paramount: tying services to a site would give the owner monopoly rights.
- ▶ Even if the choice of provider were not in question, the provider should have the freedom to innovate and to improve efficiency, including by changing the sites of supply. It was the provider's business to determine how to deliver the contracted services.
- ▶ Clinical safety required a number of services to be grouped together. This justification, of course, partly cut across the provider's freedom of manoeuvre.

The Central RHA made only minor alterations to the range of services that it had required in 1994 to be provided in Napier. But its change of stance meant that services that remained in Napier no longer had to be based at Napier Hospital. At the same time, it gave a cautious push to the concept of an accident and medical centre floated by Healthcare Hawke's Bay nine months earlier, and to the idea of a joint venture involving private providers. It also canvassed the advantages of locating the services to be provided by such a centre 'in the community', arguing that 'There would clearly be advantages to having this service provided close to where people live and work. There will be easy access to diagnostic testing.'²⁰⁰

6.2.6.4 Consultation by the Central RHA

In August 1994, the Central RHA endorsed the fit of the regional hospital plan with its purchasing intentions. At the same time, it promised that:

Further on-going consultation will be undertaken with the public of the Hawke's Bay Region on health and disability matters in order to refine Central RHA's future purchasing expectations. These discussions will be part of our ongoing consultations with communities on what services are required to meet their health needs.²⁰¹

The Central RHA described this publication as a discussion document but never finalised it. In 1995, it published an overview of health status and issues in Hawke's Bay that highlighted a far

199. Document w18(a)(65), p 5765

200. Ibid, p 5767

201. Document w18(a)(58), p 5682

worse health situation amongst Maori than non-Maori – in particular, a much higher rate of hospitalisation in most categories of illness:

It is widely recognised that access to appropriate services has been poor and at times non-existent for Maori. This, together with cultural and cost barriers, has contributed to patterns of ill health and service use which need improvement.²⁰²

Yet, at the Central RHA's community consultation meeting in Napier in February 1996, Graham Scott focused on service provision and deflected persistent questioning from the audience on where those services would be located and especially on the future status of Napier Hospital.

During 1995–96, the Central RHA undertook a wide-ranging needs analysis of the Napier and Hastings areas, the results of which were published in August 1996 in *Nga Ara Poutama: Pathways*.²⁰³ The project involved extensive consultation, which included hui in Hastings and Napier, but these apparently took place in April and May 1995, shortly after the regional hospital decision was reconfirmed and public guarantees given regarding Napier Hospital (see section 7.2.4.1).²⁰⁴ Hospitals were a minor theme in the report, which was mainly concerned with primary health care. In any case, the focus was on health status, community needs and service responses, not the configuration of the services. Napier Hospital and the location of Napier-based services were not covered in the report at all.

The summary of *Nga Ara Poutama*, published in pamphlet form, called for written comments by 10 October 1996 and promised that public meetings would be held at which people could make oral submissions. But it, too, omitted any mention of Napier Hospital or how Napier-based services would be delivered.²⁰⁵ The Central RHA subsequently produced a paper on policy changes affecting its provision of services in Napier. The paper included a set of four geographical questions for public submission. Three raised supposed trade-offs for providing services locally rather than at the regional hospital: greater risk, higher cost, and inconvenience from having to visit several local treatment centres. Only one question, asking whether services should be located in the community, addressed the retention of Napier Hospital, albeit indirectly.²⁰⁶

The Central RHA's analysis of the submissions made no mention of public meetings during its consultation round. Nor, apparently, was a hui convened. At the stakeholder meeting held over 11 and 12 September 1996, members of the public were admitted only as observers without speaking rights. No Maori organisations were listed amongst the stakeholders attending. It was left to Pakeha representatives to raise issues concerning the needs and views of Napier Maori during the sessions devoted to Maori health and service providers. The first of these turned into a dialogue with Wiremu Hodges, Healthcare Hawke's Bay's Maori health manager, in which the role

202. Central RHA 1996a, pp 46–47

203. Document w19(a)(9009)

204. Document w19, pp 8–9

205. Central RHA 1996c

206. Central RHA 1996d. Crown counsel was unable to supply a copy of this document. This assessment draws on information in the Central RHA's 'Analysis of Submissions' (doc w18(a)(69), pp 5920–5928, 5941–5942), which variously describes it as a 'supplementary paper', a 'question sheet' and a 'two page document' with questions.

of the Central RHA was sidelined. The second session was led by Te Maari Joe representing the Maori Women's Welfare League in its capacity as a health service provider.²⁰⁷

No Maori groups made written submissions. The Central RHA's analysis of the consultation and submissions had a section on Maori health services but contributed little more than the conclusion that the services specified in 1994 were still acceptable. The analysis also briefly reported, without identifying either by name, Mrs Joe's plea for the whare whanau service to be extended and Mr Hodge's view that more services for Maori should be moved into the community, whilst omitting various other points that he contributed.²⁰⁸ This individual preference, from a Healthcare Hawke's Bay manager, was then generalised in the Central RHA's published purchasing intentions as support for moving Maori health services 'into the community as requested in submissions'.²⁰⁹ In reality, the Central RHA had no representative Maori opinion to go on, and it is difficult to see how it formed the conclusions that it reported.

The issue of tying Napier-based services to Napier Hospital repeatedly surfaced during the two-day stakeholder meeting in September. Leading the Central RHA team, Dr Lynne Lane made it plain that the authority's preference was to lift its 1994 commitment to Napier Hospital, in order to consider both better options and other providers of some services. Mr Flowers stated that Healthcare Hawke's Bay would live with whichever direction the Central RHA took, but urged the people of Napier to concentrate on flexibility and cost-effectiveness: 'get our minds off buildings and on to configurations. The RHA [d]o have to buy services for Napier city. The issue is not place, the issue is sustainable long term business decisions.'²¹⁰

Although raised, the retention of Napier Hospital was excluded from the main agenda of the Central RHA's Napier meetings in May and September 1996, from the consultations carried out during its needs analysis survey, and from its call for written submissions. Service delivery was a matter for the CHE. Healthcare Hawke's Bay, however, considered itself entitled to consult at its own discretion, and had previously done so only on its own proposals and only after it had finalised them. When in December 1996 the Central RHA announced its intention to lift its previous requirement that services be provided at Napier Hospital, it warned that Healthcare Hawke's Bay would need to take into account the strength of public feeling about the Napier Hospital site.²¹¹ This was nevertheless the conclusion of the Central RHA's process and left Healthcare Hawke's Bay free to proceed with its service configuration review.

6.2.7 The decision to vacate the Napier Hospital site for a downtown centre (1997)

6.2.7.1 *The Napier services working party*

As part of the regional hospital project, services based at Napier Hospital were reduced as equipment and staff were transferred to Hastings. This process of reorganisation began to gather pace

207. Document 692(31)

208. Document w18(a)(69), p 5937

209. Document w18(a)(65), p 5768

210. Document 692(31)

211. Document w18(a)(65), p 5765

during 1997. It was bound to induce an element of unease amongst communities in and north of Napier who had relied on Napier Hospital.

Towards the end of what became a change process lasting more than five years, Healthcare Hawke's Bay prided itself on achieving 'a very efficient configuration, appropriate for service delivery into the next century'. Spatially, it described this configuration as a 'hub and spoke' model linking the regional hospital to health centres in Napier and outlying centres and to a network of community services.²¹¹ Where Napier Hospital fitted into this model remained the most contentious issue throughout the period.

On 6 March 1997, as he informed the board three weeks later, Mark Flowers, now the chief executive of Healthcare Hawke's Bay, convened a Napier services working party. Its mandate was to assess the configuration of services provided in Napier, looking in particular at site options. Mr Flowers stated that he was responding to one of the three aspects of the review of the regional hospital decision proposed by Neil Kirton, the Associate Minister of Health. This was, he said, 'a review of the process and decisions regarding the site and configuration of the Napier services'.

Mr Kirton's review would, in other words, look at past practice. The working party, however, was to consider a future reconfiguration. It was also being launched before the Kirton review had been agreed and announced. In support, Mr Flowers reported that 'the view currently held by Mr Kirton and by Mr Dick [the mayor of Napier] was that the Napier facility should be situated off the Napier Hospital site'.²¹²

In reality, the Kirton review seems to have been peripheral to Healthcare Hawke's Bay's Napier project and is mentioned only in passing in the minutes of the working party's first two meetings in March 1997. There was no suggestion that the working party would provide input for the review, which anyway did not get under way until July 1997. The central focus was the spectrum of services that the Central RHA had required in December 1996 to be provided in Napier and its lifting of any linkage to the Napier Hospital site.²¹³

In the end, the review initiated by Mr Kirton, whose tenure as Associate Minister of Health ended in mid-1997, proceeded but was described as 'personal'. The working party considered that its own process was to be scrutinised and the board took legal advice.²¹⁴ On 15 September 1997, Dr Brian Woodhouse, who had been appointed by Mr Kirton, submitted his report but declared that he had too little information to comment on the services to be provided in Napier.²¹⁵

At its final meeting less than a fortnight previously, a large majority of the members of the working party indicated their preference for a new medical centre.²¹⁶ The subsequent report, although based on the work of its sub-groups, was not in fact signed off by the working party but finalised by Healthcare Hawke's Bay's management.²¹⁷

211. Document w18(a)(76), p 6042; doc w17, p19

212. Document w18(a)(66), p 5774; doc w13, p 11

213. Document w18(a)(68); doc w13, pp 11–12; doc w18(a)(67), p 5795

214. Document w18(a)(70), pp 5944

215. Document 692(32)

216. Document w18(a)(71), pp 5947–5952

217. Document w18(a)(74), p 6018

The report recommended that a purpose-built health centre be located on a central downtown site to provide most of the Napier-based services. It compared this option with the refurbishment of Napier Hospital's tower block. It also divided the services to be provided between those that needed to be co-located (outpatient, accident and medical, allied therapy, support) and those (including 'Maori health') that could be located elsewhere if appropriate. The financial analysis revealed little difference in capital or operating costs. But other considerations told in favour of a downtown medical centre:

The critical factors leading to this decision were issues of access, functionality, public profile, efficiency of design, cost and a recognition that a new facility gives the unique opportunity to provide a long term sustainable solution for Napier.²¹⁹

6.2.7.2 From community hospital to downtown health centre

The board none the less had serious misgivings. It faced risks arising from the higher costs for Napier-based services, the political uncertainty, and the lack of funding commitments. However, both the Ministry of Health and Central Health – by now a division of the Transitional Health Authority – endorsed the site options as meeting their respective clinical and health needs standards.²²⁰ Central Health was also willing to give a qualified assurance that it would continue to purchase the same range and level of health services in Napier for the next five years, but warned that in the long run it might open some or all of them to competition.²²¹

Notwithstanding the uncertainties, the working party's recommendations marked the end of the road for Napier Hospital. On 3 November 1997, Peter Wilson announced a five-week consultation process.²²² At its meeting on 16 December 1997, the board resolved in principle to 'vacate the Napier Hill site in favour of a new health centre to be located on a site in Napier which meets certain specific requirements'. These included finding a suitable downtown site of sufficient size to provide not only for the existing services but also for the transfer of community and public health services and for co-location with other providers. The board also wanted to negotiate a leasing deal with a developer rather than own and build the facility itself.²²³

Alongside technical considerations, two concerns, amongst others, influenced the board's preference for a downtown medical centre. First, it wanted at minimum to allow for cooperation with private providers and was envisaging contracting out its accident and medical service to general practitioners. But local doctors were unwilling to run the service from the hill site. Secondly, the buildings at Napier Hospital were designed for a fully fledged acute hospital operation rather than the outpatient services provided by a health centre. Briefing his fellow directors, Mr Wilson insisted that the primacy of the regional hospital had to be maintained:

219. Document w18(a)(72), pp5959, 5984–5985

220. Document w18(a)(2), 7; doc w18(a)(72), pp 5993–5994, 6013

221. Document v1(b)(c5)

222. Document w18(a)(73), p 6014

223. Document w18(a)(74), p 6031

6.2.7.3

We must be quite clear that there is one hospital only in Hawke's Bay and that is the way it is going to be for the foreseeable future. The services to be purchased are those to be provided by a health centre, not by a hospital facility . . .²²⁴

Asset planning was also a significant factor. The board wanted to reduce its property holdings by leasing just the land and buildings it required, and was also under a statutory obligation to dispose of any surplus assets. With the imminent rundown of Napier Hospital's operations, it would shortly have land and buildings to spare.

However, even if an investment partner could be found, a clutch of obstacles – including a health trust on part of the land, caveats registered by the district land registrar and the Napier City Council, and the Government's policy on surplus assets and land-banking against Treaty settlements – faced any lease-back deal for the Napier Hospital site and buildings. Land-banking also blocked the use of the railway land that Healthcare Hawke's Bay was continuing to seek for its downtown facility, obliging it to negotiate as well for private land.²²⁵ Nor could it afford to raise the capital to build the new health centre itself. The board's decision paved the way for a plan by no means assured of completion.

6.2.7.3 Consideration of Maori health needs

Largely absent from the reviews and decisions made by Healthcare Hawke's Bay between March and December 1997 on Napier-based services was any consideration of the needs and concerns of Maori communities in the Napier area. This was despite the fact that, in its revised purchasing intentions in December 1996, the Central RHA had communicated an increased requirement with the community focus it believed Maori wanted:

Central RHA will purchase a Whare Whanau service in Napier. The size and location of this service will be designed to match the needs of the people of Napier.

We will purchase a mobile Kaupapa Maori addiction service, as well as a specialised Maori mental health service in Napier. Clinics and treatment will be based in the community.

These new services will move Maori health services into the community as requested in submissions.²²⁶

But services to Maori, whether specific or mainstream, rarely featured in the documentation of the discussions. They were not mentioned at all in the minutes of the eight meetings held by the Napier services working party.²²⁷ 'Maori health' was listed but not discussed at all in its report. Nor was it in Peter Wilson's detailed briefing to Healthcare Hawke's Bay's directors or in the lengthy minutes of the board meeting that made the decision to vacate the Napier Hospital site.

224. Document v1(b)(c1)

225. Ibid; doc w18(a)(74)

226. Document w18(a)(65), p 5768

227. Document w18(a)(68) (6 March), (70) (26 June), (71) (4 September 1997); doc 692(33), 20 March, 3 April, 1 May, 24 July, 28 August 1997

In his brief of evidence, Mr Wilson stated that, had he been aware that ‘some Maori people regarded the site as an important place for the delivery of health services for cultural reasons’, he would have included it as a consideration for the board in making its decision in December 1997. Mr Flowers similarly said that he did not become aware that the site held any special significance for Maori.²²⁸ This lack of awareness raises questions about the adequacy both of the consultation process and of the assessment of its messages by the board. This is the subject of the next section.

The only document to refer directly to the needs of Maori through this time was the report of Dr Woodhouse, who went beyond his brief to comment:

I have become aware of a difficulty in providing services for those Maori who most need them. These are the people who are disadvantaged in several ways and who find it very hard to tap into the system. Those whose background and up-bringing has been in a warm and caring environment may fail to cope with a situation which is seen as being cold and impersonal (although designed to be helpful).²²⁹

Dr Woodhouse’s report did not feature in Healthcare Hawke’s Bay’s consideration of how and from which site the Napier-based services were to be delivered.

6.2.7.4 Consultation by the Napier services working party

In March 1997, Healthcare Hawke’s Bay set up its Napier services working party. The review was conceived as an internal process. As in the case of its task force in 1993–94, Healthcare Hawke’s Bay closed the process to public consultation until it had finalised its proposal. This time, however, it sought to encourage the cooperation of local general practitioners, whose support it needed, and Napier City Council, whose opposition it wished to soften, by inviting several practitioners and councillors to participate in the working party itself. It also kept the mayor of Napier informed of its progress. The chairperson nevertheless told the mayor ‘that Health Care Hawke’s Bay would make its judgement on what solution would provide the best clinical outcomes at an affordable cost’.²³⁰

No such invitation was extended to Maori organisations. On 5 June 1997, Healthcare Hawke’s Bay called a meeting in Napier but restricted it to invited groups.²³¹ In late June, the board agreed to keep ‘stakeholders’ informed, but once again these did not apparently include Maori organisations.²³² Nor were any staff responsible for Maori health services, such as the Maori health manager, appointed to the working party, even though most of its members were drawn from the ranks of Healthcare Hawke’s Bay’s health professionals.

The sub-group ‘Maori health’ was assigned to Wiremu Hodges, the Maori health manager, and

228. Document w12, pp 22–23; doc w13, p 16

229. Document 692(32), p 20

230. Document 692(19), 27 May 1997

231. Gwynn 1998, p 42

232. Document 692(19), 24 June 1997

6.2.7.5

the advisory Maori health committee.²³³ However, the minutes of its regular bimonthly meetings between June and October 1997 – earlier minutes have not been made available to the Tribunal – made no mention of the working party or the Napier site review.²³⁴ Unless taken up in the earliest stage of the working party’s programme, it appears that Healthcare Hawke’s Bay took no effective action to seek the committee’s advice. There is no evidence that the committee actually provided any input before the working party’s report was completed in September 1997.

The report, in fact prepared after the working party’s final meeting by Healthcare Hawke’s Bay’s management, indicated that ‘there will be a discussion with the Maori Health Committee in October 1997 as part of the consultation process’. This may have been the ‘extraordinary meeting’ mentioned in the committee’s minutes of 13 October 1997. It remains unclear, however, through what channel the views expressed at this meeting might have been considered, since the working party had completed its work and the public consultation had yet to begin.²³⁵ In any case, listening to the views of its own committee could not be described as part of public consultation.

6.2.7.5 Healthcare Hawke’s Bay’s public consultation

Although set up as an in-house process, it was unlikely – as the Central RHA had warned – that so contentious a proposal as the closure of Napier Hospital would be sustainable without a further round of public consultation. The meeting with local groups in June led to large protest meetings in Napier on 6 July and 3 August.²³⁶ The level of public disquiet was sufficient to reach Cabinet notice in June 1997.²³⁷

While continuing to maintain, as it had to the High Court in 1994, that it had no formal obligation to consult, Healthcare Hawke’s Bay’s board took precautionary legal advice. Geoff Henley, who was already a member of the working party, opposed public consultation, instead recommending ‘a process of seeking comment from interested groups’.²³⁸ The board decided that a limited round of public consultation was appropriate, Mr Wilson stating that ‘the consultation process with the Napier community must be undertaken with credibility’. Eventually, on 28 October 1997 the board agreed to proceed to public consultation on the basis of the working party’s recommendation of a downtown site.²³⁹

On 3 November 1997, Healthcare Hawke’s Bay launched a five-week period of consultation involving:

- ▶ the distribution of an explanatory pamphlet to all Napier households;
- ▶ the distribution of the working party’s full report to libraries and over 100 interest groups;
- ▶ a press feature;

233. Document w18(a)(68), p 5916; doc w18(a)(72), p 5962

234. Document 692(34), 6 June, 11 August, 13 October 1997

235. Document w18(a)(72), p 5962; doc 692(34), 13 October 1997; doc v1, pp 5–6

236. Gwynn 1998, p 43

237. Document w18(a)(2)

238. Document x5(20)

239. Document v1, pp 84–85; doc 692(19), 24 June, 22 July, 26 August, 23 September, 28 October 1997

- ▶ three public meetings (at the War Memorial Centre, Greenmeadows, and Taradale); and
- ▶ written submissions by 5 December.²⁴⁰

This time, there were to be no stakeholder meetings and no face-to-face oral submissions. A suggestion in the August board meeting that a public meeting should also be held in Maraenui, the centre of the Maori population in Napier, was not taken up.

There was no attempt to consult with Maori groups, whether tribal, professional or other. In his brief of evidence, Mr Flowers indicated that this was a deliberate choice, since the working party had sought the input of the Maori health committee, which was an ‘established forum’.²⁴¹ The committee did indeed have elected tribal representatives – two from each taiwhenua district in Healthcare Hawke’s Bay’s catchment area.

However, as concluded in the previous section the working party does not appear to have taken active steps to obtain feedback from the committee. Even if it had, that would not have been good reason to exclude it – or Maori organisations in the Napier area – from specific inclusion in the public consultation. By comparison, the Napier City Council had a councillor in the working party, received personal briefings, and was allowed not only a written submission but also the opportunity to present its case face to face with the board.

For its part, the Maori health committee was not convened during the period of consultation, which began on 3 November 1997. In fact, its members did have views to express. At its regular bi-monthly meeting on 8 December 1997, three days after the closing date for submissions, the minutes record the delegates from Te Taiwhenua o Te Whanganui a Orotu stating: ‘Main issue for Napier is the Hospital site and proposed sites on the flat’. They moved a ‘letter of resolution for retention of Napier Hospital site’. The committee formally approved the resolution.²⁴² No mention is made in either Peter Wilson’s briefing to the directors or the minutes of the board meeting on 16 December, when it decided to close Napier Hospital, of the view of the Maori health committee or of any other expression of Maori opinion.²⁴³

Maori were therefore left to participate as individuals in the three public meetings. There, directors and several other managers and health professionals fronted up in an atmosphere that Mr Wilson described to his board as ‘abrasive and unpleasant’. He estimated the total turnout at no more than 120.²⁴⁴

In his brief of evidence to the hearing of the claimants’ application for urgency in January 1998, Mark Heaney, the development and planning manager for Healthcare Hawke’s Bay, stated that Mr Emery, one of the claimants, had not only requested and received copies of the working party’s report but participated in the public meetings:

240. Document w18(a)(73), p 6014; doc w13, p 13; Healthcare Hawke’s Bay 1997c

241. Document w13, p 14

242. Document w18(a)(13), pp 5058–5059; doc w14, pp 9–10

243. Document w18(a)(74)

244. Document v1(b)(c1), p 4

6.2.8

Mr Emery also attended public meetings in Napier and Taradale and points raised were noted. Hana Loyla Cotter attended the public meeting at Greenmeadows. The Chairman acknowledged the views expressed on both occasions.²⁴⁵

The summary of the issues raised at the meetings, which was prepared for circulation to the members of the board, included only a single reference, in the final meeting (26 November), to Maori perspectives and health issues: 'Ahuriri Maori have an interest in the land, have they been consulted?' The contributor was not identified.²⁴⁶ In a fuller summary of the first meeting (24 November), a Maori contributor asked: 'What are you going to do, over-ride Maori once again?' Mark Flowers was recorded as responding: 'We will be consulting once we decide on a site.' But this exchange did not make it into the meeting summary for the board.²⁴⁷ Outside the public meetings, Healthcare Hawke's Bay made no attempt to consult Ahuriri Maori directly.

6.2.8 The establishment of the Napier Health Centre

6.2.8.1 *The final rundown of Napier Hospital*

Following the board's decision in December 1997, the final rundown of medical facilities at Napier Hospital began. The original deadline of July 1998 was extended to September, but further lengthy delay ensued. The last services were finally moved out of Napier Hospital in early 2000.

6.2.8.2 *The location of the downtown health centre*

Healthcare Hawke's Bay still had to find a site for its planned health centre. It applied to have its preferred site on vacant railway land, a 1.28-hectare section on Munroe Street, removed from the landbank of Crown land reserved for the possible settlement of Treaty claims. Having initially refused, the Minister of Health was reported to have agreed to recommend that the restriction be lifted.²⁴⁸ However, Healthcare Hawke's Bay was also considering the purchase of private land and, by August 1998, had selected the site of an old brewery in Wellesley Road.²⁴⁹ The new Napier Health Centre eventually opened in early 2001.

6.2.8.3 *Consultation with local Maori*

The only meeting between Healthcare Hawke's Bay and Ahuriri Maori during this period took place when Te Taiwhenua o Te Whanganui a Orotu invited Mr Flowers to a hui in April 1998 at their premises.²⁵⁰ The exchange of views between him and the approximately 40 people who attended was full and frank, and focused on the decision to vacate Napier Hospital for a downtown centre. The taiwhenua delegate subsequently reported to the Maori health committee that

245. Document v2, para 15.5

246. Document v1(b)(c7)

247. Document 692(49); doc v1(b)(c7)

248. *Daily Telegraph*, 23 January 1998; *Hawke's Bay Herald Tribune*, 26 February 1998; Document 692(35)

249. Document w18(a)(75)

250. *Daily Telegraph*, 22 April 1998; doc w13, pp 16-17

the 'outcome of the hui was positive in that CEO received a fair knowledge of how community felt'.²⁵¹ The hui does not appear to have discussed the site options for the health centre, which Healthcare Hawke's Bay had not at that point finalised, or Healthcare Hawke's Bay's design concept. According to Te Maari Joe, and notwithstanding Mr Flowers' undertaking at the public meeting on 24 November 1997, there was no further consultation with representative Maori bodies.²⁵²

Mr Flowers stated that Maori advice was sought through the Maori health manager and the Maori health committee: 'The input to that was being managed in a different way, and particularly through the Maori Health Committee, and of course in the Maori staff we've had in the Maori Health Manager, and their input into those processes.'²⁵³ However, there is little sign in the minutes of the Maori health committee between 1998 and mid-1999 that the design of the Napier Health Centre came under sustained review. Nor does the committee appear to have been consulted on cultural considerations relevant to the site and the centre's facilities.

6.2.9 Maori cultural perceptions of the hospital and health centre sites

As well as the historical associations of their tipuna with Mataruahou as a place of healing, the claimants gave evidence on the health values they attributed to the two Napier sites in question, Napier Hospital and the Napier Health Centre.

One of those values was the identification of Maori communities with the hospital as it served a growing number of Maori patients over the last half century or so. Heitia Hiha described the mutual support that whanau members would give each other when visiting:

During and following the Second World War, transport from the rural areas was reasonably good. All the buses would converge on Clive Square and would disgorge their humanity. Clive Square would become the meeting place for whanau/hapu marae members; greetings, news, catching up was the order before dispersing to catch the bus up 'The Hill' to the hospital to visit sick whanau members. These meetings were great social and even healing occasions as people caught up with the news of who was ill and who was in hospital; the caring and the sharing with karakia offered all contributed to the health process.²⁵⁴

Hine Pene explained the strength of Maori feeling for the hospital:

The Maori views a hospital very differently from a pakeha. They have an ongoing relationship with it. If the hospital has treated several generations of a Maori family it is seen as a tradition in much the same way it is a tradition for some pakeha families to attend certain boarding schools. Neither would think of going anywhere else. The hospital has always been on the hill in Napier and it wouldn't be the same if it was shifted anywhere else.²⁵⁵

251. Document 692(34), 15 June 1998

252. Document v16, para 6.2; doc 692(49)

253. Mark Flowers cross-examined by Grant Powell, doc x33, p 400

254. Document v15

255. Hine Pene, interviewed by Pat Parsons, 27 July 1998, in doc v8, p17

Peggy Nelson (Kurupai Kopu) also emphasised the importance of height and outlook:

The old people put a place of healing on a hill. As Granny put it, you're closer to the Almighty. That's why they put a lot of emphasis on a hill – a wahi tapu. Looking out the windows of the Napier hospital is more uplifting than looking out the windows of the Hastings hospital – definitely! It cheers you up. We have a great affection for it.²⁵⁶

Merekingi Ratima, who nursed for 20 years in Napier Hospital, and Pixie Tuhiwai, who was a patient there for several months, stressed the uplifting experience patients would gain from the good wairua of the location and the view of the land and, especially, the sea.²⁵⁷

Mr Hiha identified several spiritual qualities of the hospital site that promoted healing. They included its north-eastern aspect facing the rising sun; its height above the surrounding land; its exposure to cleansing winds; and its outlook over the sea. In his opinion, 'a positive environment is essential to the lifting of one's wairua, which is imperative for the healing of the whole person'. He considered the location of Napier Hospital to have these positive attributes. By the same token, the site of the Napier Health Centre was less satisfactory: 'It has a southern aspect. It was swamp land. It is near the old "gas works" site.'²⁵⁸ Other claimant witnesses and interviewees raised similar concerns.

6.3 THE POSITIONS OF THE PARTIES

6.3.1 The case for the claimants

The case for the claimants is that the consultation with Ahuriri Maori on the series of decisions leading to the downgrading and closure of Napier Hospital was either defective or non-existent. Furthermore, the potential impacts on Maori were not properly evaluated in the reports prepared to inform the decision-makers. Partly as a result, the responsible Crown health agencies, in particular the Central RHA and Healthcare Hawke's Bay, had inadequate information on the views of, and implications for, Ahuriri Maori and took insufficient account of their situation in the decision-making process.

On the decision in principle to regionalise hospital services, counsel concluded on the basis of evidence from Peter Wilson that it had been made before Healthcare Hawke's Bay formally came into existence on 1 July 1993. There was, he stated, no evidence of consultation with Maori or any other party on that decision.²⁵⁹

On the decision to locate the regional hospital in Hastings and downgrade services at Napier Hospital, claimant counsel made the following points, many of which, he stated, were conceded by Crown witnesses in evidence or cross-examination:

256. Peggy Nelson, interviewed by Pat Parsons, 29 May 1998, in doc U8, p14

257. Merekingi Ratima, interviewed by Pat Parsons, 31 July 1998; Pixie Tuhiwai, interviewed by Pat Parsons, 1 July 1998, in doc U8, pp17–20

258. Document v15

259. Document x31, paras 14.3–14.5

- ▶ There was no public consultation on the terms of reference or the methodology of the task force set up to formulate the regional hospital proposal, nor during the compilation of its report (July 1993–March 1994).
- ▶ The terms of reference and methodology did not refer to the particular needs of Maori, nor did the task force’s report (or any other commissioned report) address them. The board did not commission a social impact report.
- ▶ Peter Wilson, as chairperson, initially planned not to consult the public at all.
- ▶ During the exchanges between Healthcare Hawke’s Bay and the Central RHA on the model for the joint public consultation, Maori were not identified ‘as an interest group or as otherwise an important group with special consultation needs’, although many other groups or persons were so identified (March–April 1994).
- ▶ The public consultation meetings ‘were not an appropriate forum to consult with Maori over this important issue . . . In particular there was no opportunity for any one to one discussion between Maori and HCHB’ (May 1994).
- ▶ Only people involved in health service delivery were invited to the stakeholder meetings, and there was no provision for alternates. Those invited were not representative of Maori (May 1994).
- ▶ The single hui convened at Omahu (18 May 1994) was seen by Maori as the start of the consultation process, not their sole opportunity. The Healthcare Hawke’s Bay and Central RHA representatives made no attempt to ascertain Maori views on the regional hospital proposal. They did not call any further hui. The Omahu hui was defective in that:
 - the venue was closer to Hastings than Napier and hence inappropriate;
 - no hui were called in areas most affected by the downgrading of Napier Hospital;
 - holding the hui on a weekday discriminated against working people;
 - the hui was poorly advertised; and
 - the hui drew a low and unrepresentative attendance, to which the convenors should have responded with remedial efforts to make the consultation more effective.
- ▶ The single hearing of oral submissions was from individual Maori invitees and focused not on the regional hospital issue but on setting up a Maori advisory committee (16 June 1994).
- ▶ Lacking adequate consultative input from Maori, Healthcare Hawke’s Bay did not seek further information on Maori concerns through the additional reports it obtained in response to submissions from other parties. Nor did the reports provide such information. In particular, there was no analysis of the social impact on Maori (June–July 1994).
- ▶ The final audit of the process drew attention, prior to the board’s decision, to significant inadequacies in consultation (July 1994).
- ▶ Neither Mr Wilson’s position paper nor the decision to proceed with the regional hospital in Hastings took any account of the health needs of Maori (July 1994).
- ▶ Thus, ‘it is clear that without proper consultation and without specifically considering the impact on Maori, the decision taken by HCHB was fundamentally flawed and inexcusable’.

- ▶ Other Crown agencies were implicated, especially the Central RHA, which endorsed the decision, ‘despite knowing full well that consultation was incomplete’ (August 1994).²⁶⁰

Claimant counsel noted that the legal challenge mounted by the Napier City Council subjected the consultation process to the scrutiny of the High Court. He argued, however, that Maori were not parties to the proceedings and that the judge, Justice Ellis, did not consider the adequacy of the consultation with Maori in his judgment, which was narrowly restricted for the purposes of judicial review (December 1994).²⁶¹

On the decision to remove Napier Hospital’s site guarantee, claimant counsel criticised the consultation process undertaken by the Central RHA during 1996:

- ▶ The Central RHA gave no hint of a site review during its consultation on community health and disability support needs in the Napier and Hastings areas, or the subsequent consultation on its purchasing intentions.
- ▶ There was no direct consultation with Maori on the purchasing intentions, nor were any hui called.
- ▶ Neither of the two published reports considered Maori views on, or the impacts resulting from, a move off the hill site.²⁶²

On the decision to close Napier Hospital and move Napier-based services to a downtown health centre, claimant counsel argued that Healthcare Hawke’s Bay undertook virtually no consultation with Maori during the nine-month process in 1997:

- ▶ The appointment, without consultation, of the Napier services working party with a brief to review the site of Napier services broke Napier Hospital’s guarantee, given also to Maori at Omahu, and therefore breached the Treaty duty of good faith.
- ▶ There was no Maori representation on the working party.
- ▶ The working party did not contemplate any public consultation, let alone with Maori.
- ▶ The public comment sought by Healthcare Hawke’s Bay on the working party’s report was an information programme rather than a consultation, and excluded direct contact with Maori groups.
- ▶ The referral to the Maori health committee amounted both formally and substantively to Healthcare Hawke’s Bay consulting itself.
- ▶ The failure to consult Maori was in breach of Healthcare Hawke’s Bay’s funding contract, which required consultation on any proposal to change the way services were provided.
- ▶ The terms of reference for the working party included no reference to Maori health needs, nor did the report consider them.
- ▶ In the absence of consultation with local Maori, Healthcare Hawke’s Bay did not gain information that board members later regarded as significant, such as Maori views on the cultural significance of the hospital site.

260. Document x31, paras 14.6–14.26

261. Ibid, paras 14.27–14.28

262. Ibid, paras 14.29–14.35

- ▶ As in 1994, neither Mr Wilson’s position paper nor the board’s decision took any account of the views or health needs of Maori.²⁶³

On decisions relating to the design and siting of the Napier Health Centre, claimant counsel stated that no consultation at all took place with local Maori:

- ▶ Again, the failure to consult Maori breached Healthcare Hawke’s Bay’s contractual requirement to consult on any proposal to change the way services were provided.
 - There was no consultation with local Maori on the selection of the site, the design of the centre, or the services to be provided.²⁶⁴

6.3.2 The response of the Crown

In his closing submission, Crown counsel raised doubts about the identity of the claimants and the basis of their claimed right to be consulted, asking ‘what was the “voice” or view of the claimants that may not have been heard?’ Identifying the voice ‘is an issue that goes to defining the nature of the obligation said to be owed’.²⁶⁵

Counsel considered that the alleged failure of the Crown to meet its consultation obligations would provide a ‘superficial answer’, whereas ‘the truth of the matter is more complex’. He acknowledged that ‘with the benefit of hindsight consultation with Maori over the regional hospital development could have been improved’, but in his view ‘that does not mean what was done was necessarily deficient or unreasonable in the circumstances’.

He then considered what he regarded as ‘the truly distinguishing feature of the claimants’ “voice”, the ‘alleged historical promises and the cultural significance of the site’. He urged that little weight be given to the claimants’ explanation that they did not raise these historical grievances earlier than January 1998 because the hospital site was not under threat before then. He argued that, on several occasions in 1991 and 1994, the claimants had expressed concern at the possible closure of Napier Hospital without raising the historical grievance or the cultural association.²⁶⁶

Counsel also stated that any deficiency in consultation with Maori would not have mattered since Healthcare Hawke’s Bay was already sufficiently informed of Maori health needs. Nor was it under statutory obligation to consult, although the Central RHA was.²⁶⁷

On the consultation process actually undertaken in 1994, counsel made or implied the following points:

- ▶ representatives of the claimants were amongst the Maori invited to the public meetings;
- ▶ the health groups participating in the stakeholder meetings included Maori representatives;
- ▶ written submissions from Maori included three from the claimants or claimant groups;

263. Ibid, paras 14.36–14.52

264. Ibid, paras 14.53–14.57

265. Document x48, para 28

266. Ibid, paras 35–43

267. Ibid, paras 44, 48

6.3.3

- ▶ the publicity for the Omaha hui could have been improved; and
- ▶ in general, Crown agencies could have taken a more vigorous approach, but what was done was ‘reasonable in the circumstances’ and ‘There were reasonable opportunities for the claimants to make their voice heard’.²⁶⁸

Counsel for Healthcare Hawke’s Bay stated that it had consulted with Maori in 1994 despite lacking a statutory obligation to do so. He insisted that it had fully consulted all Maori, including the claimants, ‘at the level of its obligation to *all* the people of Hawke’s Bay’ (emphasis in original). As vindication of the integrity of the process, counsel relied on the judgment of Justice Ellis in the case brought by the Napier City Council, which found for Healthcare Hawke’s Bay on all counts except failure to provide certain information. He accused the claimants of failing to notify their historical interest in, and cultural association with, the hospital site on Mataruahou.²⁶⁹

Crown counsel made no specific reference to the decisions taken after April 1995. Counsel for Healthcare Hawke’s Bay stated that, on the decision to move to a downtown health centre, its consultation ‘included specific Maori input which was taken into account’. Once again, he stated, the claimants did not point out the significance to them of the hill site.²⁷⁰

6.3.3 The claimants’ reply

In his reply, claimant counsel stated that Crown counsel had not addressed many of the contemporary issues raised by the claimants, including the adequacy of the consultation on the post-1995 decisions.²⁷¹

On the 1994 consultation process, claimant counsel criticised the Crown’s submission for failing to take into account the Crown health agencies’ non-statutory obligations to consult Maori that arose from the Treaty and from policy and contractual commitments. The evidence was, he asserted, that these had been breached. The claimants’ ‘voice’, however defined, would have been heard had there been proper consultation with all Maori in Hawke’s Bay. He also objected to evidence being taken out of context in respect of the proposals made and the information that was available to Maori when making their submissions.²⁷²

Claimant counsel dismissed the submission of counsel for Healthcare Hawke’s Bay as ‘superficial in the extreme and so brief as to be almost pointless’. Counsel had, he said, failed to address any of the points raised by the claimants concerning the decision of Justice Ellis. Counsel’s reliance on the meeting of kaumatua on 9 August 1994 as further ‘consultation’ was misplaced, since this followed the regional hospital decision.²⁷³

268. Document x48, paras 56–61

269. Document x50, paras 3–4, 6, 8

270. Ibid, paras 10–12

271. Document y8, para 4.2

272. Ibid, paras 4.4–4.5

273. Ibid, paras 6.1–6.2

6.4 FINDINGS, TREATY BREACHES, AND PREJUDICE

6.4.1 The scope of our findings

We now turn to our findings on possible Treaty breaches. In this chapter, we have concentrated on the manner and extent of the Crown's consultation with Ahuriri Maori prior to the making of each of the principal decisions concerning the status of Napier Hospital. In chapter 7, we consider the ongoing obligations of State health agencies to local Maori, which include requirements to consult them on various aspects of their services. In chapter 8, we review the health outcomes resulting in part from the decisions that were subject to consultation. Our assessment of any prejudice arising from the effects of those decisions must, therefore, be for the most part reserved for chapters 7 and 8.

6.4.2 What was the extent of the Crown health agencies' obligation to consult?

Extract from the statement of claim:

10. . . . the Crown through the Crown health entities has adopted policies and contracts for the delivery of health services to Maori and to meet Maori health needs ('Maori health policies') . . .

11. The effect of the obligations under the Treaty and the Maori health policies . . . is to impose obligations on the Crown and the Crown health entities to . . .

11.2 Consult with Maori over issues which affect or are likely to affect Maori health or Maori health outcomes.

We are satisfied that, in terms of the criteria and standards we articulated in section 3.9:

- ▶ State health agencies that are part of the Crown have a Treaty obligation to consult the affected Maori communities on any proposal to make substantial changes to the range or location of services they provide from a hospital that they fund or operate; and
- ▶ the Crown is obliged to ensure that agencies exercising delegated authority consult in like manner.

The chief criterion is the probability that local Maori are highly likely to regard such changes as being of major importance to them. This consideration overrides the agency's discretion to decide that it already possesses sufficient relevant information to proceed to a decision without consulting local Maori.

The duty to consult therefore applied to all the decisions here under review. It applied to all the regional and district health agencies which made or decided upon proposals for change, whether their responsibilities were united or divided: namely, the Hawke's Bay Hospital Board, the Hawke's Bay Area Health Board, the Hawke's Bay commissioner, and both the Central RHA and Healthcare Hawke's Bay. It covered not only the content of the services but also how they were to be delivered.

The health agencies were under a further Treaty obligation to ensure that their proposals and decision-making processes were consistent with Treaty principles. To that end, they needed to

6.4.3

ensure that they had sufficient information on Maori opinion and on the impact of the proposals on local Maori.

In his closing submission, Crown counsel raised doubts as to the standing of the claimants and the issues on which the Crown might be obliged to consult them. We do not accept this attempt at limitation. On the one hand, the obligation to consult was owed to all affected Maori. In this case, the obligation extended to all Maori in Hawke's Bay and, in respect of Napier Hospital, to all Maori communities within its service catchment zone. On the other hand, it is a cardinal principle of consultation that the party consulted is free to have its say. It is irrelevant whether its views are the same as those of any others.

It is abundantly clear that any proposal to expand services at one institution and reduce them at another is inherently divisive, however strong the overall justification. The perceptions of the affected communities are thus likely to differ. In practice, all the health agencies without exception were acutely aware of the lines of division. It was their responsibility to ensure that their Treaty obligation to consult extended to all Maori communities affected by the proposals for Napier Hospital.

We now consider each decision-making episode in turn.

6.4.3 Was there meaningful consultation on the regional hospital decisions?

Extract from the statement of claim:

12.2 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the decision in 1995 to regionalise Hawke's Bay Hospital services in Hastings.

6.4.3.1 *The decision in principle to have a regional hospital*

Three separate proposals to regionalise hospital services in Hawke's Bay emerged over a 15-year period. The *first proposal* affecting Napier Hospital came from the Hawke's Bay Hospital Board in 1980. It envisaged the possible closure of Napier Hospital.

Our *finding* is:

- ▶ that the evidence implies that the board did not undertake any specific consultation with Maori, but is too sparse to allow us to arrive at a definite conclusion.

The *second proposal* came from the Hawke's Bay Area Health Board in December 1990. The Booz-Allen report recommended that a regional hospital be based on the Hastings campus and raised the possibility that the reduced services remaining in Napier might be moved to a downtown site.

Our *findings* are:

- ▶ that the project team communicated with staff and local bodies but apparently not with Maori;

- ▶ that, in the public consultation round during early 1991, local Maori had to rely mainly on media information generated largely by the board's managed advocacy campaign;
- ▶ that there is no evidence, despite informal contact via the regional council, that Ahuriri Maori were afforded the opportunity to present their views face to face at marae-based hui, community meetings or board hearings, although the evidence is insufficient to rule out the possibility; and
- ▶ that the board did not generate information on Maori views or health needs by other means and had no research data on the social impact on Ahuriri Maori communities.

The third proposal emerged in obscurity during the transitional regime that followed the abolition of the area health boards.

Our *findings* are:

- ▶ that the role of the Crown-appointed commissioner remains obscure for lack of Crown evidence;
- ▶ that, by mid-1993, the board-designate of the new CHE in Hawke's Bay had arrived at an understanding with officials in Wellington that amounted to a decision in principle to have a single acute hospital; and
- ▶ that, while there may have been informal soundings of selected local opinion, there was no consultation at all with Maori on this critical strategic decision.

Our findings as to *Treaty breach* are:

- ▶ that, in respect of the first and second proposals, the Crown failed to ensure that the governing health legislation required hospital and area health boards to consult affected Maori communities on major reconfigurations of their services, especially to hospitals, and thereby breached the principle of *partnership* and the duty of *consultation*;
- ▶ that, in respect of the first and second proposals, the Crown failed to invoke its powers of direction to ensure that the Hawke's Bay hospital and area health boards undertook appropriate consultation with Ahuriri Maori, and thereby breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that, in respect of the third proposal, the failure of the responsible Crown agencies (including, but not limited to, the Department of Health, the Hawke's Bay Area Health Board commissioner, and the CHE board-designate) to consult Ahuriri Maori breached the principle of *partnership* and the duty of *consultation*.

6.4.3.2 The decision to base the regional hospital in Hastings

The board of Healthcare Hawke's Bay assumed office in July 1993 with the decision in principle to have a regional hospital already made. But it still had to select the site. We review the conduct of the consultation in terms of the standards outlined in section 3.9.6.

On deciding whether to consult, our *findings* are:

- ▶ that the board planned to reach its decision behind closed doors and then to 'market' the decision; and

6.4.3.2

- ▶ that, in December 1993, the board was persuaded to put its proposal, once finalised, to public consultation.

On establishing who was to undertake the consultation, our *findings* are:

- ▶ that the purchaser–provider split created tension and confusion, since the Central RHA could not purchase from hospitals that did not yet exist or that might be closed down, yet the CHE needed a long-term purchasing commitment in order to invest in major facilities;
- ▶ that the Central RHA was responsible for purchasing the hospital service and was required by statute to consult the people of Hawke’s Bay on its purchasing intentions, but had not yet done so and could not declare its support for the regional hospital proposal in advance;
- ▶ that Healthcare Hawke’s Bay was not required by statute to consult and owned the regional hospital project; and
- ▶ that the two bodies agreed to hold a joint consultation exercise, but that Healthcare Hawke’s Bay effectively took it over and marginalised the Central RHA.

On determining whether to consult local Maori, our *findings* are:

- ▶ that the board of Healthcare Hawke’s Bay can have been under no misapprehension as to the importance of the hospital issue to local Maori, as well as to all other sections of the Hawke’s Bay population;
- ▶ that it perceived Maori not as a Treaty partner but as part of the general population;
- ▶ that it never subjected its proposals or its process to scrutiny in terms of their consistency with its Treaty obligations;
- ▶ that it did not seek to establish whether it already had sufficient information on Maori views and circumstances; and
- ▶ that it did not initiate direct consultation with Maori communities.

On the statement of a proposal not yet finally decided upon, our *findings* are:

- ▶ that no one in the community, including local Maori, was consulted on the terms of reference or the methodology of the regional hospital task force, which effectively excluded the option of not having a single acute regional hospital;
- ▶ that, although the board’s publicity presented the issue of whether to have a regional hospital at all as still being open, the board-designate had in fact already decided the matter in principle;
- ▶ that the publicity campaign was one of managed advocacy driven by Healthcare Hawke’s Bay’s public relations agency;
- ▶ that the board provided fairly comprehensive information, both in popular form, through the media and leaflet drops, and through technical reports, but social impact assessment was lacking;
- ▶ that no information was produced specifically for local Maori, nor were the health issues for Maori communities mentioned in the general publicity; and
- ▶ that Te Taiwhenua o Te Whanganui a Orotu did not receive the further information it requested at the Omahu hui or any assistance from Healthcare Hawke’s Bay in reviewing the proposal.

On listening to what others have to say, our *findings* are:

- ▶ that neither Healthcare Hawke's Bay nor the Central RHA sought advice from recognised local Maori leaders on how best to consult Maori communities in Hawke's Bay or requested their cooperation;
- ▶ that the general public meetings were not appropriate forums for face-to-face consultation with Maori communities, were not fully open, attracted a small Maori attendance, and generated few questions specific to Maori;
- ▶ that the stakeholder meetings failed to provide for Maori views to be heard, were restricted to groups selected by Healthcare Hawke's Bay, excluded representative tribal bodies, and included only one Napier-based group;
- ▶ that the four-week period allowed to prepare written submissions was too short for Te Taiwhenua o Te Whanganui a Orotu to consult its own people and arrive at a collective view;
- ▶ that the Omaha hui, arranged by the Central RHA, was the sole instance of marae-based consultation;
- ▶ that the hui was poorly advertised and Maori communication networks were ignored;
- ▶ that the location was close to Hastings, drew a mainly Hastings-orientated audience, and did not provide a suitable venue for consulting Ahuriri Maori on a deeply divisive issue;
- ▶ that both the poor and unrepresentative turnout and the focus on Hastings at the hui should have alerted the Healthcare Hawke's Bay and Central RHA presenters to the urgent need for further marae-based consultation within the catchment area of Napier Hospital, yet they made no effort to carry out any such consultation;
- ▶ that Maori participants from Napier felt that the presenters were there to give information on a finished proposal rather than to seek input that might change it;
- ▶ that the project presenters diverted from the main issue – the regional hospital proposal – and did not take steps to obtain proper feedback on that proposal;
- ▶ that the Maori participants, whether favouring the proposed Maori advisory committee or not, saw the hui as the start of consultation with Maori, but instead the process was closed down;
- ▶ that there was no further feedback to Maori communities through marae-based hui or documentary reports; and
- ▶ that, for the single session allocated to Maori at its hearing in mid-June, Healthcare Hawke's Bay treated the agenda as a follow-up to the resolution advocating an advisory committee, sidelined the regional hospital issue, selected who was to attend, did not establish their representative status, and allowed them short notice to prepare.

On considering their responses and then deciding what should be done, our *findings* are:

- ▶ that the only point that Healthcare Hawke's Bay took up from its meetings with Maori was the idea of establishing a Maori advisory committee;
- ▶ that, despite being warned by a consultancy report of Maori dissatisfaction with the consultation process, the board did not raise the matter with Maori at its hearing a few days later;

6.4.4

- ▶ that no social impact assessment was undertaken and no further research commissioned in response to Maori views and submissions;
- ▶ that, according to its minutes, the board did not once discuss Maori views, Treaty obligations or potential impacts on Maori, nor did its chairperson do so in his final briefing to the board; and
- ▶ that, apart from assisting with arranging the Omaha hui, the Central RHA played virtually no role in consulting Maori until it was time to issue its public endorsement of the consultation process.

On the consultation process as a whole, our *findings* are:

- ▶ that the consultation process was inadequate;
- ▶ that Maori opinion, especially from the catchment area of Napier Hospital, was marginalised;
- ▶ that Maori organisations and their representatives were ignored;
- ▶ that possible impacts on Maori health were not taken into account; and
- ▶ that the process failed by a wide margin to meet basic standards of consultation with Maori.

Our findings as to *Treaty breach* are:

- ▶ that the failure of the responsible Crown agencies (including, but not limited to, the Central RHA and Healthcare Hawke's Bay) to consult Ahuriri Maori adequately breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that, in presenting the option of whether to have a regional hospital at all as being open when the decision had in fact already been made, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *good faith conduct*.

6.4.4 Was there meaningful consultation on the decisions leading to the closure of Napier Hospital?

Extract from the statement of claim:

12.3 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the decision in 1997 to close Napier Hospital.

6.4.4.1 The decision to remove Napier Hospital's guarantee

In December 1996, the Central RHA lifted its previous requirement that the services it purchased within Napier be provided from Napier Hospital. Our *findings* are:

- ▶ that the consultation with Maori in Napier in April and May 1995 on community health needs did not cover the status of Napier Hospital;
- ▶ that the Central RHA limited face-to-face consultation on its purchasing decisions to a two-day stakeholder meeting in September 1996, to which it invited one Maori provider from Napier but no representative Maori groups;

- ▶ that, in its briefing for written submissions, the Central RHA did not ask for public views on the site guarantee, except possibly through an oblique and ambiguous question in its survey form; and
- ▶ that, despite its statutory obligation to consult, the Central RHA held no hui with Ahuriri Maori, nor did it consult directly with Maori on the proposal in any other manner.

Our finding as to *Treaty breach* is :

- ▶ that, in failing to consult Ahuriri Maori on its decision to lift its linkage of Napier-based services to Napier Hospital, despite its 1994 assurance of continuation, the Central RHA breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*.

6.4.4.2 The decision to close Napier Hospital

The penultimate step in the closure of Napier Hospital was the nine-month process leading to Healthcare Hawke's Bay's decision in December 1996 to vacate the hospital for a downtown health centre. The lifting of the site guarantee freed it to consider alternatives. As in 1994, Healthcare Hawke's Bay proceeded by means of an internal working party. Our *findings* are:

- ▶ that, although selected external representatives were invited to participate in the meetings of the Napier services working party, Maori groups were neither invited nor briefed;
- ▶ that the Maori health committee, which included representatives of Te Taiwhenua o Te Whanganui a Orotu, was not involved in the decision until after the working party had completed its task;
- ▶ that Healthcare Hawke's Bay agreed only late in the process to hold a round of public consultation, with public meetings and written submissions, but approached it primarily as an information campaign;
- ▶ that Healthcare Hawke's Bay supplied, on request, copies of the working party's report to at least one member of the claimant group, who also attended at least one of the public meetings, but that such public meetings were not an appropriate means of adequately consulting Maori;
- ▶ that the board made no attempt to consult with Maori directly, deciding that input from its Maori health committee would suffice;
- ▶ that the Maori health committee did not consider the hospital closure until after the consultation period had closed and shortly before the board made its decision; and
- ▶ that the chairperson's final briefing to the board and the board minutes supplied to the Tribunal omit all consideration of Maori views or possible impacts on Maori.

Our finding as to *Treaty breach* is :

- ▶ that, in failing to consult Ahuriri Maori adequately on its decision in principle to vacate Napier Hospital for a downtown health centre, despite its 1994 assurance of continuation, Healthcare Hawke's Bay breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*.

6.4.5 Was there meaningful consultation on the location and configuration of the Napier Health Centre?

Extract from the statement of claim:

2.4 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the decision to build the new health clinic and the types of health services to be provided at the clinic.

12.5 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the site for the new health clinic in Wellesley Road, Napier.

The Tribunal has been provided with only limited information on the process leading to the making of decisions on the Napier Health Centre. By the time of our hearing of the claim in June 1999, Healthcare Hawke's Bay had selected a site, designed the centre, and planned its construction, which was then under way. Our *findings* are:

- ▶ that, in searching for a site for the centre, Healthcare Hawke's Bay appeared to be taking account of financial and legal factors but not possible Maori concerns;
- ▶ that the location and configuration of the centre did not feature formally in the minutes of the Maori health committee between the making of the board's decision in December 1997 and the hearing of the claim in mid-1999; and
- ▶ that the hui organised by the taiwhenua in April 1998, to which the chief executive of Healthcare Hawke's Bay was invited, did not apparently address the selection of the site or the design of the centre, neither of which had at that point been drawn up into a proposal, and was no substitute for thorough consultation.

Our finding as to *Treaty breach* is:

- ▶ that, in deciding on the site of the Napier Health Centre and on its service configuration without adequate consultation with Ahuriri Maori, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *consultation*.

6.4.6 Were Government undertakings regarding Napier Hospital fulfilled?

Extract from the statement of claim:

12.17 The Crown and the Crown health entities have been inconsistent in their statements and behaviour as to the closure of Napier Hospital, to the detriment of Maori in Ahuriri and Hawke's Bay.

The claimants have raised as a specific grievance the failure of Ministers and Government health agencies to fulfil their assurances that Napier Hospital would remain open. Our *findings* are:

- ▶ that, between the decision in August 1994 to downgrade Napier Hospital until close to the lifting of its site guarantee in December 1996, various Ministers stated publicly or to correspondents that it would continue as a community hospital;

- ▶ that Healthcare Hawke's Bay's managers had apparently formed their 'hub-and-spoke' vision of a single regional hospital with satellite health centres, including Napier, at least by the time that the planning of the regional hospital got seriously under way in mid-1995, if not earlier;
- ▶ that it is not clear at what point Ministers and the Central RHA became aware of the different long-term vision of Healthcare Hawke's Bay's change managers; and
- ▶ that, in a competitive and divided health sector, strategic incoherence in the management of structural change in Hawke's Bay rather than any intention to deceive may have been responsible for creating the impression of bad faith.

Our findings as to *Treaty breach* are:

- ▶ that, while the Government must be able to exercise *kawanatanga* by changing its policies and resource allocations, that right must be tempered by due respect for *rangatiratanga*, a condition which in this case had been seriously compromised by the repeated failure to ensure adequate consultation with Maori in Hawke's Bay and with Ahuriri Maori in particular;
- ▶ that there is in this case insufficient evidence of a ministerial intention to deceive; and
- ▶ that the continued failure of Ministers, having given such assurances, to ensure that the Central RHA and Healthcare Hawke's Bay consulted appropriately with Ahuriri Maori on the decisions in 1996 and 1997 that led to the closure of Napier Hospital amounted to a breach by the Crown of the principle of *partnership* and the duty of *consultation*.

6.4.7 Is there a distinctive cultural association with the Napier Hospital site?

Extract from the statement of claim:

(d) Relief sought: . . . A finding that Mataruahou (Napier Hill hospital site) is of importance to Maori health.

Several claimant witnesses and interviewees gave evidence of Maori cultural associations with the Napier Hospital site and the values they associated with it as a place of healing. We do not discount such values simply because they have, it appears to us, strengthened mainly over the last half century as the urban Maori population of Napier has grown. Our *findings* are, however:

- ▶ that many of the healing associations are shared in common with other sections of the community served by Napier Hospital;
- ▶ that, on the basis of the evidence presented, we are not able to identify a distinctive cultural association between the claimants and the hospital site;
- ▶ that the evidence of more general and traditional cultural values is insufficient for us to arrive at a firm view of their applicability; and
- ▶ that similar comments apply to the negative values attributed to the Napier Health Centre site.

6.4.8 Were the descendants of the 1851 signatories adequately consulted?

Extract from the statement of claim:

12.7 The Crown by itself and through the Crown health entities has continued to fail to give effect to its obligations under the 1851 Ahuriri transaction including providing effective health services and facilities for Ahuriri Maori from the site at Mataruahou.

We concluded in section 4.4.5 that in 1851 Ahuriri Maori were promised a Government hospital in Napier as part of the consideration for the Ahuriri block. Our *findings* are:

- ▶ that, since the hospital promise was an enduring condition, the Crown had a particular obligation to consult the hapu of the descendants of the signatories to the Ahuriri deed, being the kaitiaki of the hospital promise, regarding its proposals for a major downgrading of Napier Hospital or the transfer of services to another site;
- ▶ that the obligation extended to all tribal organisations representing the hapu, in this case the Heretaunga and Ahuriri taiwhenua; and
- ▶ that the favouring by Crown agencies of Maori organisations and marae in the Hastings area, and the neglect of those in Napier, was divisive and precluded an even-handed approach.

Our finding as to *Treaty breach* is:

- ▶ that the failure of Crown agencies to fulfil their obligation to consult all the representative tribal organisations of the descendants of the Ahuriri signatories even-handedly breached the principles of *partnership* and *active protection* and the duty of *good faith conduct*.

6.5 FINDINGS ON PREJUDICIAL EFFECTS

As we explained above, prejudice is more likely to arise from the decisions or actions to which the defective consultation relates rather than from the process of consultation itself. These decisions and actions are reviewed in the following two chapters. However, the repeated failures to consult adequately or at all with Ahuriri Maori have resulted in several prejudicial effects that are directly attributable to the consultation process:

- ▶ confidence in the commitment of successive Crown health agencies in Hawke's Bay to working in partnership with Ahuriri Maori has been seriously eroded, damaging the cooperation needed to achieve faster improvements in health status;
- ▶ confidence in the good faith of consultation itself has been damaged by the belief that the agencies have little interest in taking Maori views seriously into account; and
- ▶ the rangatiratanga of Ahuriri Maori, and especially the capacity to sustain the demanding practical obligations of partnership, has been placed under strain by their experience of repeated marginalisation from decisions on health service issues they view as important.

We cannot second-guess the possible outcomes had Ahuriri Maori been properly consulted. We are not persuaded, however, by the aura of inevitability that permeates some of the critical

commentary on the decisions regarding Napier Hospital – that the Government and the health bureaucrats would have closed it down regardless of opposing views. We note, for example, that the Hawke’s Bay Area Health Board intended to reach a decision on a regional hospital but had failed to do so before its abolition in mid-1991. Ahuriri Maori had begun to formulate an alternative view of Napier Hospital that might have contributed to the shape of a regional reorganisation had they been fully consulted.

A similar observation applies to Healthcare Hawke’s Bay’s decision in 1994 to downgrade Napier Hospital. By Mr Wilson’s own account, it did respond – by raising the proposed service configuration at Napier Hospital – to information and arguments put up during the consultation, and might have responded further had it seriously listened to the voice of Ahuriri Maori.

In 1996 (the Central RHA) and 1997 (Healthcare Hawke’s Bay), there was hardly any listening. Yet, Mr Wilson and Mr Flowers both indicated that they considered the claimants’ assertion of their association with Mataruahou and the hospital site as significant information. It might have influenced their decision to vacate the hospital site entirely.

In 1998, Healthcare Hawke’s Bay made no effort to hear the views of Ahuriri Maori on a suitable site for the Napier Health Centre or on its service configuration. Yet, they had more than one site option, and Ahuriri Maori were a sizeable part of the centre’s service population. Had they consulted properly, it is conceivable that a different site and a service arrangement more acceptable to Ahuriri Maori might have resulted.

Mr Wilson insisted that his board had to balance the needs of the whole population of Hawke’s Bay, Pakeha and Maori. Taking into account the wider context, it is probable that a regional hospital in Hastings would have eventuated even had Ahuriri Maori been properly consulted at every step. We think it rather less self-evident where Napier Hospital itself might have ended up, or alternatively where and how the health centre might have been configured, had such consultation taken place.

We conclude, therefore, that the claimants were doubly prejudiced by what was a repeated and manifest failure of consultation. On the one hand, the hospital they valued was closed and a health centre constructed about which they had serious reservations. The impact of the removal of acute and some outpatient services to Hastings we analyse further in chapter 8. On the other, their confidence in the good faith of the Crown was eroded and their ability to participate in a health partnership with Crown agencies was damaged, contributing to a failure adequately to address the acknowledged poor health status of Ahuriri Maori. We assess the health outcomes further in chapter 8.

CHAPTER 7

HEALTH SERVICES FOR AHURIRI MAORI IN THE ERA OF HEALTH SECTOR REFORM

7.1 CHAPTER OUTLINE

In this chapter, we review the extent to which the State health system met the Crown's Treaty obligations to Ahuriri Maori during the modern era of health reforms. We concentrate, save for occasional excursions, on the period during which the claimants say most of their grievances arose – from the replacement of the Hawke's Bay Area Health Board with a commissioner in mid-1991 through to our hearing of evidence on the claim in mid-1999. For most of this period, the purchaser-provider split created by the 1993 health reform governed the delivery of health services to Maori (section 7.2.1).

We consider first the statutory framework, identifying the formal obligations owed to Maori by the Crown, the agencies created to deliver the Crown's health objectives, and those agencies' accountabilities for fulfilling their obligations (section 7.2.2). As a postscript, we review the relevant aspects of the Public Health and Disability Act 2000, in particular the extent to which it recognises Treaty principles in respect of Maori health (section 7.2.2.3).

We turn next to the obligations owed by the Crown. We review national policy on Maori health, then the contracts and institutional policies devised at each level of the health system down to the State provider, Healthcare Hawke's Bay (section 7.2.3).

We then assess the performance of the Central RHA/HFA and Healthcare Hawke's Bay in fulfilling their obligations in respect of Maori health (section 7.2.4).

Finally, we examine the mechanisms of accountability by which the various agencies monitored performance and sought to improve outcomes (section 7.2.5). We consider the treatment of Maori health obligations at each interface between the responsible health agencies.

7.2 ANALYSIS OF THE EVIDENCE

7.2.1 Four phases of health sector reform

The institutional history of the modern health reforms is at times bewilderingly complicated. As a reference point, we briefly outline its evolution. Table 2 provides a timeline of the principal developments. We emphasise that neither provides anything like a complete account.

THE NAPIER HOSPITAL AND HEALTH SERVICES REPORT

7.2.1

Year	Ownership	Funder	In Hawke's Bay			
			Purchaser	Provider		
1980–89	Treasury	Department of Health		Hawke's Bay Hospital Board 1885		
1989				Hawke's Bay Area Health Board 1 June 1989		
1990						
1991				Hawke's Bay Area Health Board commissioner 2 August 1991		
1992	CHE Establishment/ Management Unit			Commissioner + CHE board-designate November 1992		
1993	Crown Company Monitoring Advisory Unit 1 July 1993	Ministry of Health 1 July 1993	Central Regional Health Authority and Public Health Commission 1 July 1993	Healthcare Hawke's Bay (CHE) 1 July 1993		
1994						
1995						
1996				Central Regional Health Authority 4 March 1996		
1997				Transitional Health Authority 1 July 1997		
1998				Health Funding Authority 1 January 1998	Healthcare Hawke's Bay (HHS) 1 January 1998	
1999						
2000						
2001					Health Hawke's Bay (DHB) 1 January 2001	

Table 2: Summary of institutional restructuring in the health sector, 1980–2001

Phase 1: Area health boards (1983–91)

- ▶ Area health boards created piecemeal, then nationwide in 1989.
- ▶ Hawke's Bay Hospital Board replaced by the larger Hawke's Bay Area Health Board in June 1989.

Phase 2: The purchaser–provider split (1991–97)

- ▶ Elected area health boards replaced by commissioners in August 1991.
- ▶ CHE boards-designate established in November 1992, together with a central CHEEU.
- ▶ From July 1993, purchaser and provider agencies established – for Hawke's Bay, the Central

RHA and Healthcare Hawke's Bay. Purchasers permitted to contract with non-governmental providers, including Maori.

- ▶ At national level, the Department of Health replaced by the Ministry of Health, the Public Health Commission created, and CCMAU set up within Treasury.
- ▶ The Public Health Commission abolished and its functions assigned in March 1996 to the RHAS.

Phase 3: A modified purchaser-provider regime (1997–2000)

- ▶ The RHAS amalgamated in July 1997 into the national Transitional Health Authority then, from January 1998, the Health Funding Authority.
- ▶ Crown health enterprises renamed hospital and health services in 1998 and their commercial objective removed.

Phase 4: District health boards (2001–present)

- ▶ The HFA merged into the Ministry of Health in late 2000.
- ▶ Elected district health boards established from January 2001, initially by appointment. Healthcare Hawke's Bay renamed Health Hawke's Bay.

7.2.2 The statutory framework

7.2.2.1 Hospital and area health boards

Before the 1993 health reforms, the core legislation governing the State health system contained no reference to the Treaty. Nor did it accord any specific recognition to Maori health needs. The service obligations placed on hospital boards by the Hospitals Act 1957 and on area health boards by the Area Health Boards Act 1983 were general in character and set no particular priorities in addressing health needs.

Maori had little participation in board governance. The hospital boards were wholly elected, and area health boards largely elected. But, unlike national elections, there was no Maori electoral roll, and the first-past-the-post system led to the minority voice of Maori being heard only indirectly. However, an amendment to the Area Health Boards Act in 1989 created a ministerial power to appoint a minority of up to five members to an area health board, and in the same year the Minister of Health used that power to appoint Maori members to all boards.¹

Area health boards were given several functions and powers that implied an obligation to take due account of the health needs and priorities of Maori communities within their catchment zones. In particular, a board was required:

- ▶ 'to investigate and assess health needs in its district';
- ▶ 'to support, encourage, and facilitate the organisation of community involvement in the planning of [health] services'; and
- ▶ at its discretion, 'to grant financial or other assistance' to individuals or organisations providing health services or training.²

1. Section 8 of the Area Health Boards Amendment Act (No 2) 1989; Durie 1998, p 87

2. Section 10(b), (c)(ii), (h) of the Area Health Boards Act 1983

The Act also enabled a board to set up local community health committees as ‘a forum for the various community groups working in the health field’ and to act as ‘a liaison between such groups and the board’.³

7.2.2.2 RHAS CHES

The Health and Disability Services Act 1993, which inaugurated the purchaser–provider split, also made no mention of the Treaty. It did, however, specify as one of the five categories for which the Minister of Health was required to notify the Crown’s objectives to the purchaser:

The special needs of Maori and other particular communities or people for [health and/or disability] services.⁴

The other categories, covering community health status, the services to be purchased, and the terms of access and their standard, were also relevant when taken in conjunction with the ‘special needs’. It was the combination of this requirement with a cautiously Treaty-based national health policy, as declared in *Whaia te ora mo te iwi* in 1992, that opened the agenda to the incremental integration of Treaty principles into health service purchasing as the 1990s progressed.

For their part, each of the four RHAS was required ‘to meet the Crown’s objectives notified to it under section 8 of this Act’. At the service delivery level, each CHE had, as one of its two ‘principal objectives’, to:

assist in meeting the Crown’s objectives under section 8 of this Act by providing such services in accordance with its statement of intent and any purchase agreement entered into by it.⁵

Both purchaser and provider agencies were thus bound to any objective set by the Minister for meeting ‘the special needs of Maori’. RHAS were limited by the funds provided and CHES by the edict to operate ‘as a successful and efficient business’. Each CHE had a further objective implying obligations to Maori, that being ‘to exhibit a sense of social responsibility by having regard to the interests of the community in which it operates’.⁶

The Health and Disability Services Act ended all direct accountability to the populations served by the new two-tier agencies. The boards at both levels were centrally appointed, those of RHAS by the Minister of Health and those of CHES by the ‘shareholding’ Ministers of Finance and Crown Health Enterprises.⁷ The community health committees disappeared, as did any requirement to involve local communities in health service planning.

RHAS were none the less required ‘to monitor the need for health services and disability services of the people who are described for this purpose in its funding agreement’.⁸ These needs included, once again, ‘the special needs of Maori’, and implied an obligation to inform themselves adequately as to the health needs of the Maori communities they served. In addition:

3. Section 31 of the Area Health Boards Act 1983

4. Section 8(e) of the Health and Disability Services Act 1993

5. Section 10(d), 11(b) of the Health and Disability Services Act 1993

6. Section 11(2)(a), (c) of the Health and Disability Services Act 1993

7. Sections 35(2), 39(2) of the Health and Disability Services Act 1993

8. Section 33(a) of the Health and Disability Services Act 1993

Every regional health authority shall, in accordance with its statement of intent, on a regular basis consult in regard to its intentions relating to the purchase of services with such of the following as the authority considers appropriate:

- (a) Individuals and organisations from the communities served by it who receive or provide health services or disability services;
- (b) Other persons including voluntary agencies, private agencies, departments of State, and territorial authorities.⁹

RHAS were thus required to consult, but had discretion as to whom they consulted. Maori were not specifically mentioned, but, since their 'special needs' had to be identified, it would have been difficult for the RHAS to have met their obligations without consulting both Maori communities and Maori health service providers. No such obligations were placed on CHES.

One further provision in the Act had a bearing on Maori participation. CHES, but not, for reasons not explained, RHAS, were enjoined to be 'good employers'. The statutory interpretation of this term specified a personnel policy that included:

- (e) Recognition of—
 - (i) The aims and aspirations of Maori; and
 - (ii) The employment requirements of Maori; and
 - (iii) The need for greater involvement of Maori as employees of the employer; and
- (f) Recognition of the aims and aspirations, and the cultural differences, of ethnic or minority groups.¹⁰

The 1998 amending Act, which merged the RHAS into the national HFA and redesignated CHES as HHSS, made no significant changes to the actual or implied obligations to Maori.¹¹

7.2.2.3 District health boards

Two years later, the new Labour Government's Public Health and Disability Act 2000 brought in a further round of structural change. It merged the HFA with the Ministry of Health and replaced HHSS with majority elected district health boards.

The Act gave, for the first time, statutory recognition to the Treaty in the State health sector:

In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Maori, Part 3 provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in the delivery of, health and disability services.¹²

The wording is cautious. Rather than establish Treaty principles as a formal standard for Crown action, the Act referred to particular provisions in later sections. It took further care, as

9. Sections 18(4), 34 of the Health and Disability Services Act 1993

10. Sections 2, 11(2)(c) of the Health and Disability Services Act 1993

11. Health and Disability Services Amendment Act 1998

12. Section 4 of the Public Health and Disability Act 2000

we noted in section 3.6, to rule out any preferential individual entitlement on the ground of ethnicity:

To avoid any doubt, nothing in this Act—

- (a) entitles a person to preferential access to services on the basis of race; or
- (b) limits section 73 of the Human Rights Act 1993 (which relates to measures to ensure equality).¹³

But it also declared an explicit and general Crown objective as being ‘to reduce health disparities by improving the health outcomes of Maori and other population groups’. It used the same wording as one of the objectives of district health boards. Moreover, it stated equality of health status as the ultimate objective and cooperation with the disadvantaged groups, thus including Maori, in achieving it:

Every DHB has the following objectives . . .

- to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.¹⁴

The Act further recognised community as well as personal health, and required each board:

- to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services;
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services.¹⁵

In pursuing their objectives, boards were assigned a number of functions, several of which set out explicit obligations towards Maori. Boards were:

- to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement;
- to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori.

The main thrust was thus to bring Maori into strategic planning and programmes for reducing their health disparities. Maori health providers were also to be encouraged and assisted. In performing these functions, boards had ‘to provide relevant information to Maori’.¹⁶

The Act gave boards an active mandate to investigate and monitor the health needs of their catchment populations and the factors adversely affecting them. It also looked beyond the

13. Section 3(3) of the Public Health and Disability Act 2000

14. Sections 3(1)(b), 5(3)(c), 22(1)(e), (f) of the Public Health and Disability Act 2000

15. Section 22(1)(g), (h) of the Public Health and Disability Act 2000

16. Section 23(1)(b), (d)–(f) of the Public Health and Disability Act 2000

medical cycle of disease by directing boards to ‘promote the reduction of adverse social and environmental effects on the health of people and communities’.¹⁷

The Act attempted to assure balanced Maori representation in the governance of district health boards, a weakness under the previous hospital and area health board Acts. Its method was to use ministerial appointments – up to four, in addition to the seven elected members – to compensate:

In making appointments to a board, the Minister must endeavour to ensure that—

- (a) Maori membership of the board is proportional to the number of Maori in the DHBs resident population (as estimated by Statistics New Zealand); and
- (b) in any event, there are at least 2 Maori members of the board.¹⁸

Maori membership was to extend to board committees, ‘where appropriate’. Board members were asked to be familiar with, amongst other things, ‘Maori health issues, Treaty of Waitangi issues, or Maori groups or organisations in the district of the DHB concerned’ or else to receive relevant training.¹⁹

Each of the three standing committees required by the Act – the community and public health advisory committee, the disability support advisory committee, and the hospital advisory committee – also had to provide for Maori representation.²⁰

The Act carried over the ‘good employer’ provisions of its predecessor vis-à-vis Maori employees of district health boards.²¹

7.2.2.4 Protection of surplus health agency land

Two modern trends have led to a widespread disposal of the land and buildings belonging to State health agencies. The first is the downsizing and centralisation of hospital capacity as advances in medical technology have shortened hospital stays and raised the threshold for admission and retention as in-patients. The second is the successive waves of health sector restructuring, which resulted in the transfer of assets from abolished to successor institutions with different mandates.

The regionalisation of hospital services in Hawke’s Bay was a conspicuous example of the first trend. Whether any assets passed out of the ownership of health agencies in Hawke’s Bay at the creation of the Hawke’s Bay Area Health Board in 1989, Healthcare Hawke’s Bay in 1993, or the Hawke’s Bay District Health Board in 2001 is not known. The Napier Hospital site has remained intact, although the adjacent Hinepare Nurses’ Home was sold in the late 1990s.

Until recently, statutory protection has been lacking. The State-owned Enterprises Act 1986, as amended in 1988, prevented the Crown from acting ‘in a manner that is inconsistent with the principles of the Treaty of Waitangi’, and made detailed provisions for the handling of Maori

17. Section 23(1)(g), (h) of the Public Health and Disability Act 2000

18. Section 29(4) of the Public Health and Disability Act 2000

19. Schedule 3, sections 5(1), 38(2) of the Public Health and Disability Act 2000

20. Sections 34–36 of the Public Health and Disability Act 2000

21. Section 6 of the Public Health and Disability Act 2000

Treaty claims and Waitangi Tribunal recommendations.²² But at no stage of the health reforms were health agencies classed as State enterprises. Area health boards and CHES were nevertheless given corporate powers, and could therefore acquire and dispose of their assets.

In late 1992, during the run-up to the introduction of RHAS and CHES, the Government issued a policy statement on health services to Maori that remained in place for the rest of the decade. The statement acknowledged Maori interests in surplus health sector land that had arisen from ‘Treaty claims and from historic donations of land’. The Crown undertook to ensure that such land was subject to the Treaty protection mechanism it had instituted for the alienation of other Crown-owned land.²³

There was, however, no explicit provision in the 1993 health reform legislation. Area health board assets not transferred to CHES were automatically vested in a holding entity, the Residual Health Management Unit. The unit was given corporate powers and placed under ministerial direction.²⁴ CHES were incorporated as companies and placed under the general oversight of shareholding Ministers.²⁵ Nowhere was the Treaty mentioned or provision made for the interest of Maori claimants to surplus land. CHES were, however, required to include in their statements of intent ‘provisions stating the procedure for any disposal of land transferred to, or vested in, the enterprise pursuant to the Health Reforms (Transitional Provisions) Act 1993’. This proviso was, according to Professor Mason Durie, tied into the land-banking mechanism set up through the Department of Survey and Land Information.²⁶

The Public Health and Disability Act 2000 imposed stronger controls. It also gave the Minister of Health a general power of direction over district health boards.²⁷ More particularly, it made all land alienations and leases of more than five years subject to ministerial approval, a restriction that also applied to the Residual Health Management Unit. Furthermore, the Minister had to meet specific standards regarding the purpose of the disposal and community consultation:

Before approving the sale or exchange of any land under subclause (1), the Minister must be satisfied that—

- (a) the DHB concerned is, as a result of consultations with its resident population, aware of the views within the population about the proposed sale or exchange; and
- (b) the sale or exchange of the land will assist the DHB to meet its objectives under section 22; and
- (c) the DHB will comply with any applicable requirement under subclause (5).²⁸

22. Sections 9, 27 of the State-owned Enterprises Act 1986

23. Document 18(b)(8001); doc 18(b)(8002)

24. Sections 16–20, 22, 27(3) of the Health Reforms (Transitional Provisions) Act 1993

25. Sections 37–40, 44 of the Health and Disability Services Act 1993

26. Section 42(1)(a) of the Health and Disability Services Act 1993; Durie 1998, p 93

27. Section 32 of the Public Health and Disability Act 2000

28. Section 45(1), schedule 3, section 43 (DHBS), section 70, schedule 6, section 28 (RHMTU) of the Public Health and Disability Act 2000

This last provision required district health boards, unless given dispensation by the Minister, to apply the proceeds of any alienation ‘for the purchase, improvement, or extension of publicly-owned facilities for health purposes’.²⁹

Like its predecessors, the Public Health and Disability Act 2000 did not refer explicitly to the interests of Maori claimants in health agency land. But it did bind the Crown to ‘recognise and respect’ Treaty principles and provide comprehensive powers of ministerial supervision of all land alienations by health agencies exercising delegated powers. The Napier Hospital site, which was still in the ownership of Healthcare Hawke’s Bay when it became a district health board, was therefore subject to the new regime.

7.2.3 Maori health services – what was promised

7.2.3.1 *The Department of Health and the Hawke’s Bay Area Health Board (1984–91)*

It is well beyond the scope of this report to trace the multi-faceted evolution of perspectives and policy on Maori health over the last two decades, which is authoritatively covered in Professor Mason Durie’s historical account of Maori health development.³⁰ Our purpose here is to outline the national policy framework governing the agencies delivering State health services in central Hawke’s Bay.

During the 1980s, a combination of Maori initiative and greater willingness by the Government to recognise Treaty principles led to major changes in official perspectives on Maori health. The Department of Health’s Hui Whakaoranga in 1984 opened the door to Maori views on future directions. By 1989, all area health boards had at least one Maori member.³¹ In a circular to hospital and area health boards in May 1988, the Director-General of Health declared:

The Government has signalled its commitment to honour the Treaty and to ensure that its departments and agencies are responsive to the needs of Maori people and communities. The implementation of that commitment is in our hands.³²

This, and companion circulars of the time, saw as significant the two general obligations of partnership and culturally appropriate services. As well as initiatives then being taken by the Department of Health itself, the memorandum raised a number of proposals for area health boards to take up:

- ▶ commitment to the Treaty in their mission statements and plans;
- ▶ biculturalism integrated into human resource development, including training;
- ▶ adequate Maori representation in professional staff;
- ▶ culturally appropriate services developed with input from Maori staff and communities, including recognition of traditional healers;

29. Schedule 3, section 43(5) of the Public Health and Disability Act 2000

30. Durie 1998

31. Pomare and others 1995, pp 23–24

32. Document 692(36), p7

7.2.3.2

- ▶ improving Maori representation at board level by appointing additional members selected by their communities, a policy promoted by the Board of Health in October 1986;
- ▶ establishing Maori health committees with formal advisory roles;
- ▶ consulting with iwi authorities on specific issues; and
- ▶ resources for tribal organisations and Maori health providers, in addition to those supported from central funds.³³

The Hawke's Bay Area Health Board was one of the last to be inaugurated and functioned for less than two years before it was swept away in the national abolition of August 1991 and replaced by a commissioner. During that short period, it nevertheless began to respond to the various national initiatives on Maori health. Its Community Health Services section, for instance, recognised the relevance of the Treaty in integrating the Government's health goals and targets into its 1990–91 operating plan for health promotion, then a new initiative. The national priority accorded to Maori health influenced its selection of at least one programme and the local goals it set for several others.³⁴

More particularly, sometime in 1990 the Hawke's Bay Area Health Board took steps to establish an advisory Maori Health Committee. The committee published a Maori health charter in 1991 that articulated its philosophy, mission, and broad objectives. One of these objectives was 'to recommend health policies that are consistent with positive Maori development and with the Treaty of Waitangi'. The committee adopted the 'four cornerstones' concept of Maori health and recognised the four Ngati Kahungunu taiwhenua within the area health board's region. It also prepared a proposal to establish a Maori health unit.³⁵

7.2.3.2 *Maori health services policy in the purchaser–provider era (1991–2000)*

Some of the foundations for the development of health services for Maori during the 1990s had already been laid down at the national level before the area health boards were abolished in 1991. One main proposal that did not survive was the introduction of tribally elected Maori members, since both CHE and RHA boards were centrally appointed. The principal innovation was the system of interlocking contracts that governed the relationships between the health agencies, which now included obligations in respect of Maori health.

The national policy framework for the delivery of State health services to Maori through most of the second and third phases of the health reforms (1991–2000) was the 1992 Government statement *Whaia te Ora mo te Iwi*. This statement appeared, confusingly, in two documents, a broad outline of policy followed by a summary of objectives designed to guide the new purchasing agencies.³⁶ The policy statement made an explicit commitment:

33. Document 692(36)

34. Document 692(38)

35. Documents 692(39), (40), (41)

36. Document w18(b)(8001); doc w18(b)(8002), pp 13–14; doc w16, pp 5–6

The Government regards the Treaty of Waitangi as the founding document of New Zealand, and acknowledges that it must meet the health needs of Maori and help address the improvement of their health status.

At the same time, it rejected the argument that Maori health was a taonga entitled to special protection:

The claim that the protection of the health of Maori has (through Article 2) a special claim on New Zealanders as a whole, over and above the responsibility of the Crown to secure the health of all citizens is, however, not one the Government accepts.

The policy statement indicated three general objectives that it attributed to Maori opinion:

- ▶ greater participation of Maori at all levels of the health sector;
- ▶ resource allocation priorities which take account of Maori health needs and perspectives; and
- ▶ the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services.

Much of the policy statement was devoted to outlining the new mechanisms under the pending health reforms and the roles of the various Government agencies. The statement of objectives fleshed out the implications for the purchasing agencies. It defined the overarching goal designed 'to meet the special needs of Maori' that they would need to take into account in framing their contracts:

The Crown will seek to improve Maori health status so in the future Maori will have the same opportunity to enjoy at least the same level of health as non-Maori.

The statement outlined a number of 'relevant' objectives for purchasing plans, which included:

- ▶ contracting and developing Maori health providers;
- ▶ purchasing services and allocating resources 'to meet Maori health needs when Maori health status is particularly poor';
- ▶ culturally appropriate services and practices, taking account of holistic Maori values;
- ▶ Maori participation in developing service procedures and practices; and
- ▶ an equal opportunity employment policy.

Purchasers were expected to inform themselves of the demographic profile of their Maori populations and to consider 'the socio-economic and cultural factors which deter Maori from using health services in accordance with their health needs'. They were also to consult Maori in developing their purchase plans, which should specify the consultation process and the Maori and iwi groups to be involved.

The statement laid down a number of monitoring requirements:

- ▶ provider performance in addressing Maori health needs;
- ▶ standards for monitoring culturally appropriate service provision;

7.2.3.3

- ▶ standards for monitoring 'good employer' policies;
- ▶ performance measures for monitoring and evaluating consultation with Maori;
- ▶ mechanisms for involving Maori in monitoring purchase plans and in developing service performance measures; and
- ▶ the collection of Maori health information 'sufficiently comprehensive to ensure that effective monitoring of the Government's objectives is possible at funder, purchaser and provider levels'.

In subsequent years, policies relating to State health services for Maori proliferated in an expanding array of documents – annual guidelines for Maori health, components of successive medium-term health strategies, annual and strategic Maori health plans of the purchaser agencies, and guides on particular aspects, such as *He Taura Tieke*.³⁷ A number of these documents are lengthy, complex and highly formalised. There is ample information on broad intentions and priorities. But specific detail on what was to be done and with what outcomes is sparse. The Ministry of Health's 1996 accountability review commented:

There are multiple different frameworks for articulating policy in relation to Maori health that have a degree of overlap, but the 'bottom line' performance expectations do not come through clearly. Other Maori health policy documents . . . add to the complexity of expressions of policy.³⁸

7.2.3.3 *A house of contracts*

Alongside the array of policy documents, health programmes and services were now framed in a complex web of contractual relationships between the various health agencies. The contractual accountability within which all State agencies must operate today is the product of the regime constructed by the State sector reforms of the last two decades. In the era of hospital boards, Government subsidies were regulated as transfers within the annual budget round. By the end of the 1980s, area health boards were being required to sign funding contracts and produce strategic plans.

The 1993 health reform brought in a more elaborate regime of annual contracts and reporting. It set up an explicit hierarchy of statutory instruments, which included:

- ▶ written notices of the Crown's objectives, given by the Minister of Health to RHAS;
- ▶ statements of owners' expectations, given annually to CHES by the Ministers for Crown Health Enterprises and Finance, then by the Minister of Health (1996/97–1998/99) ;
- ▶ statements of intent, produced annually, but with a three-year horizon, by both RHAS and CHES;
- ▶ funding agreements, entered into between the Minister of Health and RHAS; and
- ▶ purchase agreements, entered into between RHAS and CHES or other health service providers.³⁹

37. An extensive annotated list is provided in document w16, app 1.

38. Document x5(16), p 24

39. Sections 8, 14, 20–22, 24 of the Health and Disability Services Act 1993; doc w17, pp 7–8, 11–12

The 2000 health reform simplified the hierarchy of standard instruments and placed greater emphasis on long-term strategic planning. These instrument included:

- ▶ national health and disability strategies, to be determined and reported on by the Minister of Health;
- ▶ Crown funding agreements between the Minister of Health and district health boards;
- ▶ service agreements, under which district health boards funded other service providers;
- ▶ district strategic plans, prepared by district health boards for a five- to 10-year period and reviewed at least every three years;
- ▶ district annual plans, agreed between the Minister of Health and district health boards; and
- ▶ statements of intent, financial statements, and annual reports, as required from district health boards under the Public Finance Act 1989.⁴⁰

Alongside these primary instruments, the system generated an array of planning, business and compliance documents for differing reporting cycles. The system's full complexity is far beyond the scope of this report to examine, but we note here a few of the more important documents:

- ▶ business plans, negotiated annually by CHES with the shareholding Ministers through CCMAU; and
- ▶ annual reports and financial statements of RHAS and CHES.

7.2.3.4 Central government – statements of owners' expectations

The annual statements of shareholders' (later owners') expectations set the financial and business guidelines by which CHES had to operate. Between 1996–97 (the first such statement) and 1998–99, there was little mention of Treaty obligations. The single exception, in 1998–99, reminded CHES that, in disposing of any resulting surplus assets, they had to comply both with the offer-back provisions of the Public Works Act 1981 and with 'the relevant protection mechanism which addresses the Crown's obligations under the Treaty of Waitangi, and good governance requirements over Maori sites of significance'.⁴¹

The 1999–2000 statement was greatly expanded and set down specific requirements on Maori health for HHSS. It required HHSS to cooperate with the HFA and with other providers, thus including Maori health providers, 'to develop and improve health services that can effectively address Maori health priorities'. It wanted Maori customer satisfaction recognised in business practice. It encouraged HHSS to seek appropriate advice when making health service decisions affecting Maori. It expected them to 'maintain appropriate links with Maori customers and with Maori providers', and to keep patients and communities informed about services. It also required consultation with Maori on new services and changes to existing services affecting Maori.⁴²

40. Sections 8, 10, 25(1)–(2), 38(1), 39(1)–(3), 42(1) of the Public Health and Disability Act 2000

41. Document x1(9040), p 3

42. Document w18(b)(8010), pp 12–14

The statements cover the period in which Healthcare Hawke's Bay closed Napier Hospital and planned its downtown health centre. They reveal that CHES were under considerable pressure to improve their efficiency, streamline their hospital and other facilities, reduce costs, and stay within budget. In proportion as they failed, they were exposed to an escalating scale of Government supervision exercised through CCMAU.

CCMAU was the principal adviser to 'shareholding' Ministers on the ownership dimension. It exerted considerable influence over the shape of CHE/HHS statements of intent and business plans. As late as 1998, however, its self-presentation contained no reference at all to the Crown's Treaty of Waitangi obligations.⁴³

7.2.3.5 Central government – the Crown's health objectives

Annually from 1993 to 2000, the Government notified the Crown's objectives to its purchasing agencies, including the Central RHA and its successor, the HFA.⁴⁴ These top-level statements laid down the priorities for purchasing health services in Hawke's Bay, both from Healthcare Hawke's Bay and from Maori providers. We analyse the manner in which they articulated the official approach to Maori health needs and preferences, highlighting seven topics: recognition of the Treaty relationship; improving Maori health; integrated approaches to health improvement; Maori health policy; access to health services; recognition of tikanga Maori; improving Maori participation in mainstream service delivery; and fostering Maori health providers.

For most of the period, there was no mention of *the Treaty*. Not until 1999–2000 did the statement, drawing on the Government's medium-term strategy, indicate that 'the Crown recognises the Treaty of Waitangi as the founding document of New Zealand'. In March 2000, the new Labour Government substituted both the current (1999–2000) and following (2000–01) statements. The replacement statement remained in force until the abolition of the HFA in December 2000. It contained an explicit commitment to a Treaty-based relationship:

The Treaty of Waitangi is recognised as New Zealand's founding document and as a basis of constitutional government in this country. The Government recognises Maori as tangata whenua and is committed to fulfilling its obligations as a Treaty partner.

Notwithstanding the absence of a Treaty foundation, *improving Maori health* was from the outset an explicit aim. The 1993–94 statement set medium-term objectives, one of which was to 'seek to improve the health status of Maori, so that in future Maori will have the opportunity to enjoy the same level of health as non-Maori'. This aim, described in 1994–95 as a 'health gain priority area', was repeated in similar wording annually for the rest of the 1990s. Several of the statements also included equity amongst their declared guiding principles.

To achieve impact, this broad aim had to be translated into more specific directives. Here, the record is more patchy. In 1993–94, the Central RHA was asked merely to see that 'particular

43. Document w18(b)(8007); doc w17, pp 12–14

44. The statements were published in the *New Zealand Gazette* and are listed in the reference section at the end of this report.

consideration is given to the needs of Maori', and to 'seek to improve the health status of Maori, as far as reasonably possible in the transitional year'. In 1996–97, Maori 'expectations' appeared alongside 'needs' and, in the following year, so too did 'aspirations'.

But the directives remained vague: other than targeting resources and service development on Maori health needs, the purchasers were given few guidelines for action. The first statement (1993–94) asked the Central RHA to 'purchase services and encourage initiatives that promote better health for Maori; [and] allocate resources to take account of Maori health needs'. These rather general directives were not developed in the following years. Typical was the 1995–96 instruction to have regard to 'the particular characteristics, special needs . . . of the communities, in particular Maori'.

At the close of the 1990s, the statements became more specific. For 1999–2000, the HFA was to prioritise by 'implementing programmes and services that offer the most potential for health gain for Maori and Pacific peoples'. For 2000–01:

The HFA should continue work, including allocating resources, on its eight Maori health gain priority areas, with particular priority to immunisation, smoking and diabetes, and others of those priority areas targeted elsewhere in this document. The Government wishes to see the HFA work closely with the Ministry of Health to improve Maori health through promotion and early intervention initiatives in these priority areas. Further, specific responses and new ways of delivering services in disability support services, young people's health (including sexual health), areas of high deprivation and primary health care are sought.

Health services alone could not tackle all the causes of ill health, especially amongst the more disadvantaged communities in which Maori were concentrated. However, even after the purchasing agencies took over responsibility for public health in 1996, *integrated approaches to health improvement* received little articulation until the 1999–2000 statement. This incorporated the recently revised medium-term objectives. One of the 12 listed goals called for 'intersectoral collaboration between agencies and providers to achieve social policy objectives'. There was also a specific objective to 'strengthen links between Maori health and other aspects of Maori development'.

Lacking, however, was any clear indication as to how such collaboration was intended to improve health outcomes. However, the 2000–01 statement cast health services in a wider perspective of health improvement. It argued that 'because good health is the result of complex inter-relationships, it is important to have a comprehensive approach of both prevention and treatment'. Furthermore:

The most powerful determinants of health are economic and social conditions. At the broadest level, macro social and economic policies that are beyond the direct influence of the health sector are likely to have the greatest impact on health.

The HFA was directed to:

Reduce inequalities in health associated with socio-economic factors through working with other sectors to reduce the risk factors that people are exposed to;

Reduce the adverse health effects of socio-economic factors through health promotion and early identification and intervention.

It was also to focus health improvement efforts on population groups, including Maori, that 'have consistently poorer health than the rest of New Zealanders'. It was to 'look to the total situation of those population groups', and particular approaches 'should be provided within appropriate community settings where practicable'.

Throughout the period, the *national policy framework* for health services to Maori was *Whaia te Ora mo te Iwi*, published in 1992 (see section 7.2.3.2). The first statement of objectives (1993–94) instructed the Central RHA to 'have regard' to the policy, and similar wording appeared in most of the years following. The 2000–01 statement confirmed that it should remain the guideline until the planned New Zealand health strategy had been finalised.

The statements also covered *service access*, although in most cases without mentioning Maori. 'Equitable access' was a standard requirement. In 1996–97, extending a provision applied to the public health services taken over the previous year from the Public Health Commission, health services were to be targeted, 'as appropriate, to particular individuals or populations in relation to need'. Geography and culture were amongst the factors that could be used for targeting. In the only specific example referring to Maori, the 1999–2000 statement listed 'improving access to services for all children as appropriate, with special emphasis on access for tamariki Maori'. It also mentioned 'continuing work to progressively develop a fair, effective and nationally consistent travel policy designed to make reasonable access fair to all people in New Zealand no matter where they are located'.

Recognising and respecting *tikanga Maori* was a consistent and strengthening theme. In 1993–94, the Central RHA was expected to 'develop culturally appropriate practices and procedures for delivery of health and disability services to Maori'. It was also to produce a quality standard 'on purchasing culturally appropriate health and disability services'. Subsequent statements required it to recognise Maori cultural values and to ensure that the services it purchased from providers were 'culturally appropriate'. The 1995–96 statement spoke of respect and empowerment, and the 1998–99 statement expanded further in requiring the HFA to 'contract for services which are responsive and sensitive to the cultural and social beliefs, values and practices of Iwi, hapu and Maori'.

Improving *Maori participation* in the mainstream health sector was less of a priority until late in the period. The initial statement kicked off with a firm and broadly defined commitment to 'encourage greater participation of Maori at all levels of the health and disability support sector'. Following statements had little to say on participation until the same objective was restated in 1999–2000, directing the HFA to 'continue efforts, where appropriate and after consulting Maori, to encourage greater participation by Maori at all levels of the health sector, including in health service delivery for Maori'. The 2000–01 statement made a more categorical commitment,

directing the HFA to ‘allocate resources to increase Maori participation in service delivery across the health and disability sector’.

Support to *Maori health providers* followed a similar path. The first statement required the Central RHA to:

Recognise Maori aspirations and structures, and the desire of Maori to take greater responsibility for some of their own health care; . . . [and]

Encourage greater participation of Maori in the development of health solutions and be aware of successful Maori health service delivery models.

The objective then vanished for several years. But in his accompanying letter of expectations in 1997, the Minister of Health made it clear that he wanted emphasis placed on developing Maori providers and their funding increased.⁴⁵ This was repeated in the 1998–99 instruction to the HFA to place ‘an immediate emphasis on provider development’. The 2000–01 statement committed the Government to ‘building the capacity of Maori, through provider, workforce and professional development, to deliver health and disability support services’.

The broad pattern of Crown objectives is of a light-handed regime from 1993 to 1999, interrupted in 2000 by the adoption of a more explicit and interventionist approach. The light-handed regime did none the less set three common objectives for the Central RHA and HFA:

- ▶ to give priority to measures for improving Maori health;
- ▶ to deliver culturally appropriate mainstream services; and
- ▶ to be guided by the Government’s 1992 Maori health policy.

7.2.3.6 Purchasing agencies – statements of intent and plans

The relationship between the Ministry of Health and the Central RHA was regulated by a large array of policy statements, annual funding agreements, purchase plans and statements of intent, extended by references to a wider collection of documents running to thousands of pages. The 1996 accountability review criticised the complexity and inconsistency of the system. It remarked that ‘Treaty issues, particularly those related to Articles 1 and 2, are not perceived to be resolved or well articulated in the policy and monitoring frameworks yet’. It recommended that ‘a clear set of expectations for RHAs in relation to Article 1 and 2 obligations . . . be included as ownership-related expectations’, and that equivalent article 3 obligations be included in performance expectations for purchasing. It acknowledged the risk of obligations to Maori losing visibility but argued that ‘there does seem to be potential benefit in the Maori health area, as in other areas, from having fewer words but words which carry a clearer message’.⁴⁶

It was in their annual statements of intent, covering a rolling three-year planning horizon, that the purchasing agencies translated the Crown’s health objectives and Maori health policy into purchasing priorities and programmes. The Central RHA’s early appraisal of the task it faced in improving Maori health in Hawke’s Bay was bleak:

45. Document x5(17)(2); also doc w16, pp 9–11

46. Document x5(16), pp 20–21, 24–25, 49–50

While some isolated examples of effective health services for Maori exist within the region, there is much to be done to address the low health status of Maori. The Authority is committed to improving access to service to improve their health status. Maori frequently only access services when their health problem has advanced to such a stage that it is difficult and complex to treat which often results in more costly services being required.⁴⁷

The Central RHA began with two main regional objectives:

- ▶ to expand the number of Maori providers so as to improve Maori participation at all levels; and
- ▶ to ensure that both mainstream and community providers delivered culturally appropriate services.

To those objectives, the Central RHA added two more in 1995 and 1996:

- ▶ to improve responsiveness and Maori participation in mainstream service provision, and to 'target areas of low health status for Maori'; and
- ▶ to reduce access barriers for Maori.⁴⁸

Setting up and strengthening Maori providers was an early priority.⁴⁹ The Central RHA remained open in principle to Maori organisations becoming purchasers in their own right but considered the timing premature. A three-year strategic plan for Maori health was produced in 1996.⁵⁰ Components targeted for Maori were also placed within other high-priority programmes, notably mental health and child health.

When the HFA took over in 1998, its first statement continued the focus on improving Maori participation, delivering culturally appropriate mainstream services, and developing Maori providers, but omitted reducing access barriers and targeting low health status areas. It produced both a Maori health policy and a Maori health strategic plan.⁵¹ The policy statement prescribed standard Treaty-based texts for inclusion in purchase contracts. The HFA also committed itself to resource its Maori provider development fund adequately and to support provider development, to Maori workforce development, and to internal accountability for delivering Maori health gains.

This policy was then articulated in a strategic plan. The plan identified three strategies similar to those of the mid-1990s: greater Maori participation; Maori provider development; and enhancing mainstream providers. These, it aimed to implement in terms of six strategic objectives:

- ▶ increased Maori participation at all levels;
- ▶ targeted funding to achieve health gains;
- ▶ Maori provider and workforce development;
- ▶ national research and development for Maori health;

47. Document w19(a)(9002), p 6

48. Documents x5(8), (9), (10)

49. Document w19(a)(9000), p 9; Mara Andrews cross-examined by Grant Powell, doc x33, p 202

50. Document w19(a)(9011)

51. Document x5(11); docs w19(a)(9013), (9014); also doc w18(b)(8008), p 10; doc w19, pp 15–16

- ▶ mainstream enhancement; and
- ▶ consultation, communication and intersectoral relationships.⁵²

In addition to the clear recognition of Treaty principles, the key differences in the HFA's approach appeared to be its willingness to prioritise mainstream funding across the board to achieve improvements in Maori health and to focus research effort on Maori health issues. It highlighted its concern at 'the impact of multiple issues that affect Maori health' and the 'clear relationship between the socio-demographic influences faced by Maori and their poor health status', factors that lay outside its strategic framework to address.⁵³ Dr Colin Feek and Ria Earp also highlighted the importance of current work on intersectoral collaboration to address underlying health issues.⁵⁴

7.2.3.7 The State provider – purchase contracts with Healthcare Hawke's Bay

Details of the annual purchase contracts between the Central RHA and Healthcare Hawke's Bay have not been made available to the Tribunal. It is therefore possible to determine little of what services relevant to Maori health were purchased or how adequately they were funded.

Selective extracts are, however, available for some years from the quality standards that Healthcare Hawke's Bay was expected to meet. Those applicable to services for Maori are tabulated below (see table 3). It appears that few requirements were made in the first two years: the 1994–95 schedule simply asked generally that tikanga Maori be integrated into services in consultation with local Maori. A 1995 guide on disability support services defined tikanga Maori in terms of a set of eight core values: wairua (spirit or spirituality), aroha (compassionate love), turanga-waewae (a place to stand), whanaungatanga (the extended family), tapu/noa (sacred/profane), mana (authority, standing, or prestige), manaaki (to care for and show respect to), and kawa (protocol).⁵⁵

In 1995, however, the Central RHA's Maori health group finalised a model quality improvement plan for CHES that in turn drew substantially from the Ministry of Health's guide *He Taura Tieke*.⁵⁶ As a result, from 1995–96 the quality standards appended to the annual purchase became more comprehensive and specific. Healthcare Hawke's Bay's quality plan was to include recognition and application of the principles of the Treaty of Waitangi in consultation with local Maori. It was required to incorporate tikanga Maori into all levels of service planning, development, and implementation. Specific provisions applied to information in te reo Maori; appropriate complaints procedures; whare whanau and whanau support; provision for children and adolescents; Maori staff development; cultural training; and support for Maori patients at sensitive times. Healthcare Hawke's Bay was expected to consult local Maori not only on Treaty and tikanga issues but, from 1997, on service changes with significant impact.⁵⁷

52. Document w19(a)(9014), p 45

53. Ibid, pp 56–57

54. Document w8, pp 13–17; Ria Earp questioned by Tribunal, doc x33, p 173

55. Document x5(13) (translations as in source)

56. Document w19(a)(9011), p 84, app B: CHE quality improvement plan, February 1996, draft; doc w18(b)(8006)

57. Documents x4, x5(13), w19(a)(9032)

From 1998, this quality specification was carried over into HFA contracts with HHSS, including Healthcare Hawke's Bay. The HFA strengthened its Treaty commitment:

As a Crown agency the Health Funding Authority considers the Treaty of Waitangi principles of partnership, proactive protection of Maori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the internal organisation of the Health Funding Authority responds to Maori health issues.

Expressing these principles, the HFA required contracted providers serving Maori to 'demonstrate how the policies and practices of their provider organisation and service delivery shall benefit that Maori clientele'. The provider had to formulate and implement a Maori health policy that took into account the purchaser's 'minimum requirements for Maori health based on the Treaty of Waitangi, Crown objectives for Maori health and specific requirements'. The provider was to specify how it would implement the policy, what services it would deliver, and how Maori health gains would be measured.⁵⁸

By early 1999, the HFA's integration of what it called 'Maori specificity' into its provider quality contracts was comprehensive and specific, extending across all dimensions of governance, equal opportunity employment, training, cultural integration, service development, health gain priorities, complaints procedure, whanau involvement, and consultation and relationships with tangata whenua and other Maori.⁵⁹

7.2.3.8 The State provider – Healthcare Hawke's Bay's Maori health policy

The principal instrument of accountability for Healthcare Hawke's Bay was its statement of intent, presented annually to Parliament since July 1993.⁶⁰ At the outset, there was no reference to Treaty principles amongst the listed goals, nor of the obligation to promote Maori health improvement. The aim of 'providing high quality services in a culturally sensitive manner' could be taken to imply a commitment to ensure that Healthcare Hawke's Bay delivered culturally appropriate services to Maori patients. This indirect reference and the commitment to 'social responsibility' supplied the only clues that Healthcare Hawke's Bay had taken into account the Government's stated policy objective of improving Maori health. The statement noted the need to improve access to services for Maori in the Wairoa area but otherwise gave no indication in its service descriptions of how it proposed to address 'special needs' priorities, including those of Maori.

Little changed for several years. The cultural audit undertaken by the Central RHA in December 1996 revealed that:

- ▶ there was no formal statement recognising the Treaty or the application of Treaty principles; and

58. Document w19(a)(9033), app A

59. Ibid, app B

60. Document w18(a)(14), (76); Healthcare Hawke's Bay 1995b, 1996a, 1997a

- ▶ the business plan lacked either a Treaty statement or strategies for addressing Maori health improvement, and was kept within senior management, thus excluding Maori staff input.⁶¹

It is unlikely that the cultural review had much impact because it was not considered by the board or followed up by the chief executive.⁶² Not until 1997–98 did Healthcare Hawke's Bay's statement refer to Treaty principles, 'particularly those of partnership and protection'. However, it ascribed that commitment to the Government and did not make one of its own. Instead, it focused on respecting Maori values, stating that 'the company recognises Tikanga Maori values as being the key to Maori health outcomes that are appropriate, accessible and affordable'. Healthcare Hawke's Bay repeated this formulation the following year.

Recognition of Maori health obligations at the service level also took several years to materialise. In its 1996–97 statement of intent, Healthcare Hawke's Bay omitted cultural sensitivity from its goals but for the first time recognised Maori as one of its service communities. It signalled that one of its planned changes would be 'the provision of services that meet the needs of Maori in Hawke's Bay' and, for the first time, focused on the Government's health gain areas, including Maori health. The following year, it also proposed to adopt 'new Maori Health strategic policies'. For 1998–99, it set itself the further ambition to 'be recognised professionally as a leading contributor to the achievement of sustainable Maori Health gain'.

This scant recognition of Treaty principles and Maori health gain priorities is consistent with the predominance in statements of intent of what the Crown defined as its ownership interest. The main advice to Ministers and influence on CHES came from CCMAU, which as we noted in section 7.2.3.4 did not see the Crown's Treaty obligations as relevant to its financial and business efficiency focus.

The lack of recognition was none the less surprising, given that in August 1993, shortly after Healthcare Hawke's Bay came into existence, board member Walter Wilson proposed a Maori health policy. Mr Wilson envisaged a commitment by Healthcare Hawke's Bay to achieving a 'significant improvement' in Maori health and to delivering health and disability services to Maori 'consistent with the objects and principles of the Treaty of Waitangi (being partnership perspectives, and cultural awareness)'. Healthcare Hawke's Bay would 'encourage and assist Maori in the planning and development of appropriate health and disability initiatives, that through partnership will address the special needs of Maori'. To this end, it would appoint a Maori health manager and create a Maori health unit. Mr Wilson stressed the need to consult local Maori before finalising the policy and involving Maori in future health initiatives.⁶³

The status of this policy document is not entirely clear. Mr Wilson stated in evidence that it was accepted by the board.⁶⁴ It was, however, headed 'draft for consultation', and there is no evidence either that any significant consultation with local Maori took place or that the 'policy' was published.⁶⁵

61. Document w19(a)(9030), pp 15–16

62. Document x33, pp 288–291, 330–331, 412–413

63. Document w51

64. Document x33, p 317. Complete board minutes were not filed for this period.

65. See comments in doc w19(a)(9001)

Healthcare Hawke's Bay's board had other major preoccupations competing for its attention during its first two years, including the battle over its regional hospital project and its serious financial predicament. A new initiative did not emerge until 1996, the year in which the new Maori health centre opened on the Hastings campus. In March 1996, Bill Hodges, the Maori health manager, proposed the philosophical foundations for a Maori health policy. He called for it to be based on Maori values and Treaty principles, especially those of partnership and the protection of rangatiratanga. He defined the core values of tikanga Maori for Ngati Kahungunu as being wairuatanga, whanaungatanga, rangatiratanga, kotahitanga, and manaakitanga.⁶⁶

These values, but not the Treaty principles, were incorporated into Healthcare Hawke's Bay's statements of intent for 1997–98 and 1998–99. But both values and principles were integrated into the Maori business and service plans that were produced annually from 1997.⁶⁷

7.2.3.9 Consultation with Maori

The purchasing agencies were, as we saw in section 7.2.2.2, obliged by statute to consult the communities they served. From the outset, the Central RHA identified consultation as an important part of developing its relationship with Maori:

Service delivery will take into account the needs and cultural values of the community particularly for Maori and youth. The Authority will achieve this by:

- ▶ being aware of and responsi[v]e to the aspirations and interests of Maori
- ▶ working sensitively with Maori and Iwi through consultation
- ▶ recognising the tikanga and mana of the tangata whenua in the region
- ▶ being aware that Maori have their own vision of health, often linked to their history.

It pledged to follow culturally appropriate modes and to take account of the results in its 'needs assessments, service development and purchasing strategy'.⁶⁸ Initially organised at a district level, of which Hawke's Bay was one, by 1996 its approach had evolved into an ongoing marae-based round:

Central RHA has adopted the 'kanohi kitea' principle in its interactions with Maori. This means interacting with Maori face-to-face and allows Central RHA to establish personal relationships with Maori at all levels, whether iwi, hapu, whanau, pan-tribal, private trusts or individuals.

Central RHA has sought to identify the needs and opinions of Maori in developing its strategies and purchasing plans through a marae-based consultation programme. The consultation hui also provide an appropriate forum for disseminating information on changes to services which impact on Maori consumers and for assessing the quality of locally provided services.⁶⁹

66. Document 692(42); doc w53

67. Document w18(b)(8011); doc w54; doc w18(b)(8012)

68. Document x5(8), pp 6, 27

69. Document x5(10), p 57

Quality standard	1994	1995	1996	1997	1998
Quality plan covers the recognition and application of the principles of the Treaty of Waitangi developed in consultation with local Maori		Yes	Yes	Yes	Yes
Services accessed by Maori integrate tikanga Maori (1997: in all levels of service planning, development, implementation)		Yes	Yes	Yes	Yes
Tangata whenua and other Maori living in the area are consulted about how tikanga Maori is to be reflected in services for Maori		Yes	Yes	Yes	Yes
Information on service development or changes is provided to Maori at hui where appropriate		Yes	Yes		
For service changes with significant impact, a consultation plan developed and implemented with all affected communities, including iwi/Maori				Yes	Yes
Annual written plan for consultation with communities and iwi		Yes	Yes		
Written code of client rights and responsibilities in Maori				Yes	Yes
Appropriate complaints resolution processes available to Maori (eg, whanau hui)		Yes	Yes	Yes	Yes
Service information brochure available in Maori (1997: including access; also to families, care-givers, visitors)	Yes	Yes	Yes	Yes	Yes
Admission signs and notices in Maori		Yes	Yes	Yes	Yes
Kaumatua or Maori staff are available where necessary to assist with admissions processes		Yes	Yes		
Policies are in place supporting Maori health workers, Maori service advisory positions, the recruitment of Maori staff, and training and continuing education of employees in Maori culture		Yes	Yes		
Employees trained in collecting and recording ethnicity data (1997: accuracy ensured)		Yes	Yes	Yes	Yes
Staff educated and/or Maori (kaumatua, staff, healers, ministers) available 'to advise in situations of cultural sensitivity, ie birth and death'				Yes	Yes
Support for Maori staff and advisers in the application of tikanga (eg, powhiri, karakia, waiata)				Yes	Yes
<i>He Taura Tieke</i> incorporated into quality improvement process				Yes	Yes
Cultural review recommendations incorporated into Maori health development planning				Yes	Yes
Whanau/caregivers recognised 'as integral to the healing process'; support to Maori patients when accessing, using, leaving				Yes	Yes
A family/whanau room provided (1997: whare and/or other social support)		Yes	[Yes]	Yes	Yes
Provision for children, adolescents and their caregivers in accordance with the Well Child Care conference report <i>Tamariki Ora</i>		Yes	[Yes]	Yes	Yes

Table 3: Quality standards in purchase contracts covering services to Maori

After the amalgamation of the four RHAs, the initial statements of intent of the new national purchasing agencies gave little specific information on how they would consult Maori communities.⁷⁰

70. Document x5(17)(3), 11

7.2.4 Performance – what was delivered**7.2.4.1 The Hawke's Bay hospital and area health boards – services for Maori**

In order to respond to the demand for Maori improvement that was being expressed with growing urgency during the 1980s and early 1990s, the State health agencies needed more thorough information on Maori health needs and priorities. An early initiative was a comparative health status study of Maraenui and Napier in 1978.⁷¹ One of the first general studies of health status in Hawke's Bay was undertaken in 1989 for the information of the incoming Hawke's Bay Area Health Board and the general community. It referred only incidentally to the health of Maori, usually to note their far worse incidence of ill health in particular categories.⁷² In 1991, the board's recently established Maori health committee called attention to the very poor state of Maori health in the region.⁷³

Information from particular area health board programmes highlighted the dramatic disparity in Maori health, such as the fact that Maori women had the second highest rate of cervical cancer in an international comparison of 39 populations, and that their rate was 2.5 times higher than that of non-Maori.⁷⁴ The board recognised in 1990 that 'Maori health status is lower than the average in many areas of health'.⁷⁵ In 1991, the Maori health committee included in its proposal for a Maori health unit an investigation to 'measure [the] depth and breadth of Maori Health Status in terms of causes'.⁷⁶ Direct feedback from Maori communities came from the occasional marae-based consultation process, such as the cervical screening programme and the Maori health consultant's round of hui at local marae.⁷⁷

Before the 1990s, the Hawke's Bay hospital and area health boards utilised virtually all their resources for their own services, and funded few community-based providers, including Maori groups. The Maraenui Family Centre, established under a local trust by the hospital board and the Department of Health in the early 1980s, acted as a vehicle for their own community health services. In 1984, Maraenui, with the most concentrated Maori population in Napier, was included in the Department of Health's priority area programme. Visiting public health nurse and doctor services were provided at the family centre, but the doctor was not allowed to prescribe medicines. Although Maori were the principal users, there was criticism from local Maori that the services were not culturally sensitive and that health professionals tended to dominate at the expense of community involvement.⁷⁸

In 1990, the area health board recognised the need to adopt a partnership approach that explicitly recognised Maori community groups, especially in health promotion. For the first time, in 1991 the area health board employed a specialist in the post of Maori health consultant under community services. The consultant set up a regular programme of hui at local marae and

71. Ponter 1989, p 1

72. Napier Health Development Unit 1989

73. Document 692(39)

74. Document 692(43), pp 19–20

75. Document 692(15), p 71

76. Document 692(41)

77. Document 692(43), pp 17, 19, 46–51; doc 692(44), p 2

78. Ponter 1989, pp 1–3, 35–36

assisted in developing a Maori focus within community health programmes of high priority for Maori health improvement, such as those dealing with diabetes, asthma, smoking reduction, glue ear amongst children, addiction, and mental health.⁷⁹ In 1992, the cervical screening programme began to reach out to Maori women by taking clinics at marae and kohanga reo. The report on its implementation commented: ‘The high percentage of Maori women with a lapsed screening history at these clinics clearly demonstrates the need for a culturally-appropriate service for Maori.’⁸⁰

The area health board’s community funding in the early 1990s included making small grants for specific purposes to several Maori groups in Napier, including Te Taiwhenua o Te Whanganui a Orotu. In 1992, it began to extend its grants to cover ongoing operational costs.⁸¹ But the board was abolished before these initiatives could make much headway.

7.2.4.2 The Central RHA – needs assessment and consultation

In mid-1993, the Central RHA began a new round of marae-based consultation with Maori communities. By way of background for participants in a hui at Moteo on 12 July 1993, it compiled basic demographic, social and medical data that for the first time profiled the status of Maori health in central Hawke’s Bay. Promising a needs assessment with community consultation, it conceded that the data were inadequate:

There are some health and disability areas where there are significant gaps in the existing information. Primary health care is an example. This is acknowledged as an area of particular importance for Maori health.⁸²

The memorandum of understanding signed by officials and participants at the close of the hui drew attention to ‘the sense of helplessness felt by local people at the standard of Maori health in the Hawke’s Bay area’.⁸³

The promised needs assessment, although delayed, was undertaken during 1995, and the results were eventually published in August 1996.⁸⁴ The project focused on Napier and Hastings and included extensive community consultation. Meetings were widely advertised and hui were held in each city. The project’s advisory group had several representatives from Maori organisations, including two from Napier – Apera Clarke, a rongoa Maori practitioner associated with Te Taiwhenua o Te Whanganui a Orotu, and Te Maari Joe, of Te Kupenga Hauora. Te Taiwhenua o Te Whanganui a Orotu was not involved, although its Heretaunga counterpart was.

The project report covered the whole population but devoted a section to Maori health issues and identified Maori issues and disparities throughout its text and tables. Much of the report comprised summaries and analysis of the feedback received from the community consultation

79. Document 692(44)

80. Egermayer 1992, p 12

81. Document 692(15), pp 59–60; doc 692(44), pp 12–13

82. Document w19(a)(9020), app A3

83. Ibid, app A1

84. Document w19(a)(9009); doc w19, pp 8–10

and a discussion of the health service issues raised. Although it provided no primary survey data, and therefore lacked a thorough analysis of the causes of ill health, it contained a substantial range of data on demographics, ill health, and health services. It provided broad pointers to health issues and community priorities for health service planning at all levels of the health system. In his testimony, Wi Keelan, Healthcare Hawke's Bay's Maori health manager, thought that more comprehensive information was needed on Maori health, particularly on the wider causes of ill health, but that it might best be undertaken at the national level.⁸⁵

Alongside this area survey, a second and more numerous type of needs assessment conducted by the Central RHA was issue based, focusing on particular diseases or service categories. A number of these were problem areas for Maori. Some 27 assessments had been completed by early 1996. Their frame of reference, however, was regional.⁸⁶

Healthcare Hawke's Bay itself conducted few field investigations. When it did, the focus was usually on service delivery. A few such projects may have been relevant to improving services to Maori. A good example was the 1994 review of maternity services to Maori women, which featured marae-based consultation and feedback.⁸⁷

7.2.4.3 The Central RHA – mainstream services

Concrete information on services purchased in Hawke's Bay and Napier that were relevant to Maori health is sparse. Many of the programme descriptions apply to the whole Central RHA region, which stretched from Mahia to the northern South Island and across to Wanganui. Similarly, after amalgamation in 1997 most reporting was done on a national scale. Details of local initiatives in Napier and central Hawke's Bay are scattered and incomplete.

Over its four years of existence the Central RHA set two principal objectives for the mainstream providers. One was ensuring that they delivered culturally appropriate services. The other was to reduce access barriers for Maori.⁸⁸ The Central RHA's Maori health unit was advised by a kaumatua advisory group, Te Roopu Awhina, which in 1996–97 it reinforced by adding 'three consumer representatives [who] were identified and affirmed by iwi'.⁸⁹

The main instrument used by the Maori health unit to ensure that culturally appropriate services were delivered was quality standards. Following a round of meetings with CHE managers and board members, it formulated and, for the 1995–96 year, contracted a standard quality performance plan. It devised specific standards for several services heavily used by Maori (in particular maternity, alcohol and drug, and mental health). It produced a model outline for a CHE Maori health plan.⁹⁰

The capacity of the Maori health unit remained limited, however. Initially, it had only two members of staff, neither with previous health sector experience, to cover the entire central

85. Wi Keelan cross-examined by Grant Powell, doc x33, pp 382–383

86. Document w19(a)(9011), p 25

87. Lauchland and Barcham 1994

88. Document w19(a)(9011), p 12; doc w19(a)(9012), pp 13, 22

89. Central RHA, 'Annual Report, 1996–97', AJHR, 1998, E-52, p 59

90. Document w19(a)(9011), pp 14, 84, app B

region. A third was added in 1995, but only in 1997 was the staff complement increased to six.⁹¹ Over 1993–95, much of the unit's effort was committed to conducting consultation hui and setting up Maori provider contracts, and little attention was paid to mainstream providers.⁹²

The Central RHA purchased few mainstream services from CHES specifically for Maori. The principal targeted services that it purchased from Healthcare Hawke's Bay were kaupapa Maori mental health and mobile addiction services. Both were provided in Napier from community bases.

In its early 1996 publication on Hawke's Bay, the Central RHA listed a number of services geared wholly to improving Maori health or to at-risk groups with a high proportion of Maori. Most fell under the community health umbrella, and some may have been delivered by Maori providers. The Central RHA targeted areas noted for poor Maori access and placed emphasis on communication and consultation. But there was little information on the extent to which these services reached Ahuriri Maori. They included:

- ▶ For tamariki (children): improved well child services, asthma management, immunisation, hearing testing aimed at glue ear, cot death prevention, detecting and preventing rheumatic fever.
- ▶ For rangatahi (youth): mental health services with a youth focus, sexual health education and contraception, alcohol and drugs, health education on diet and nutrition, anti-smoking promotion.
- ▶ Pakeke (adults): asthma and diabetes management, lifestyle health promotion.
- ▶ Wahine (women): maternity, support for young and new mothers, expanded cervical screening.
- ▶ Koroua and kuia (older people): a liaison service for home support to disabled and elderly Maori, health education on diet and nutrition, asthma and diabetes management.⁹³

It is not clear to what extent the Central RHA incorporated Maori health priorities into its purchasing of mainstream services, especially in allocating resources to those priorities. The lack of information on service delivery in the Central RHA's reports implies that little was either done or monitored.⁹⁴ During the early years, Maori health issues were marginalised and channelled through the small Maori health unit. The Central RHA's 'mainstream' service sections were able largely to bypass issues concerning Maori. The perspective began to change in late 1995 when the Maori health gain priority was integrated into the strategic planning and purchasing of the main service groups. The reorganisation repositioned what became the Maori health group into a monitoring, coordination and strategic planning role.⁹⁵

Mara Andrews, the senior Maori development manager in the HFA's Maori health group and formerly a policy analyst for the same group in the Central RHA, reported recent crude estimates calculated by the HFA for overall spending on Maori health across the whole of the State health

91. Mara Andrews cross-examined by Grant Powell, doc x33, pp 204–205

92. Ibid, pp 210–215

93. Document w19(a)(9011), pp 13–14; doc x5(5), pp 11–12; Central RHA 1996a, pp 48–50; doc w19, pp 22–23

94. Document w19(a)(9011), pp 35–51

95. Ibid, pp 16–17

7.2.4.4

system. The figures suggested that \$45 million was going to Maori providers and \$30 million to mainstream programmes specifically for Maori. Most of the total of roughly \$665 million was spent on general Maori use of mainstream health services. The total amounted to about 12 per cent of Vote Health. This was below the proportion of Maori in the national population and substantially below the anticipated level of need, given the much poorer health status of Maori as a whole.⁹⁶

7.2.4.4 *The Central RHA – Maori healthcare providers*

In contrast to the bits-and-pieces handouts from the Hawke's Bay Area Health Board, from the outset the Central RHA's principal effort went into establishing a network of Maori health providers. Planned and implemented by its Maori health unit, its strategy was based on a community development approach of establishing direct local relationships and fostering iwi and community providers. During 1993 and 1994, it consulted Maori communities and organisations to devise an acceptable contract form and negotiation process, and held several workshops across the region to develop service proposals. The number of providers that it funded across the whole central region grew rapidly from a starting base of 13 in July 1993 before levelling off at around 52 in 1995.⁹⁷

In 1996, the Central RHA shifted its emphasis to a support and capacity-building role, which included running training workshops. Much of its workforce development programme was aimed at community-based professional and lay health workers, some 300 of whom it planned to put through training courses between mid-1995 and mid-1998.⁹⁸

Three Napier-based Maori providers were contracted:

- ▶ The Maori Women's Welfare League, Heretaunga branch (Te Kupenga Hauora), for child and family mental health services focusing on child abuse, in conjunction with Healthcare Hawke's Bay's Child and Family Services (from 1994–95); for providing well child services in kohanga reo; for maternity support and parenting (from 1993–94); and for Napier Hospital's Whare Whanau (from 1993–94).
- ▶ Te Whare Whakapikiora o te Rangimarie, for a rongoa Maori service as a 12-month pilot project (1995–96), one of the first such initiatives in the country. The service was provided by a traditional healer with supporting kaiawhina.
- ▶ Hine Kou Tou Ariki Trust, for a residential service for people with psychiatric illness and marae-based day activities for turoro.⁹⁹

In her evidence, Ms Andrews provided data indicating that the number of Maori providers located in Napier or providing services to Napier had grown from six to 14 over the years 1993 to 1999, holding contracts worth \$3.2 million by 1998–99 (see table 4).

The Central RHA's general assessment in early 1996 of primary and public health services delivered by Maori providers was that many Maori were using them, especially children, that

96. Mara Andrews questioned by Tribunal, doc x33, p 229

97. Document w19(a)(9020); doc x5(5), pp 11, 46, 49; Central RHA 1996a, p 50; doc w19(a)(9011), p 13; doc w19, p 18

98. Document w19(a)(9011), pp 80–81

99. Document x5(4), pp 20–21; doc x5(5), p 12; Central RHA 1996a, p 49; doc w19(a)(9011), p 31; doc w19(a)(9012), p 33

Contracts	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99
Service:	6	8	12	14	14	14
Providers	6	10	15	18	26	48
Service contracts Value (\$m)	0.44	0.76	1.69	1.92	2.46	3.20
Maori Provider Development:					14	14
Providers					1.11	0.62
Value (\$m)						

Table 4: Maori provider contracts in and for Napier, 1993–99. Source: document w19.

early intervention and prevention strategies were working, and that access was being significantly improved.¹⁰⁰

The Maori health unit was responsible for community consultation with Maori. It carried out an ongoing round of consultative hui, ‘over 53’ between July 1993 and early 1996, ‘to meet Maori and hear their aspirations and needs; and to report or discuss specific service issues’. In addition, meetings with Maori providers were usually held on-site. It is clear that major effort was devoted to the process, which included written report-backs to hui participants and information through a variety of media. According to the Central RHA, concerns raised at the hui had a significant influence on priorities and programme development, notably in the areas of mental health, maternity services, support for mothers, liaison with the elderly, and the rongoa Maori pilot project.¹⁰¹

But the consultation effort largely passed Ahuriri Maori by. In central Hawke’s Bay, the hui were held mainly on marae in and around Hastings – at Mangaroa, Waipatu, Omahu, Moteo, and Mihiroa at Hastings Memorial Hospital. Several also took place at marae to the north – at Tangoio, Raupunga, Waikaremoana, and Wairoa. But none took place in Napier itself, for all that some 37 per cent of the Maori population within the Hastings District Council boundaries resided there in 1996.¹⁰²

The budgetary resources allocated to services provided specifically for Maori through both Maori and mainstream providers, though increasing, were not substantial. Expenditure had risen to approximately \$15 million by January 1996, excluding Maori use of generic services. The bulk of these funds went to Maori provider contracts (\$5.8 million) and mental health and public health services (\$4.5 million and \$1.4 million respectively), with smaller amounts going to maternity, disability support, asthma and diabetes, and well child services, as well as to Maori providers of alcohol and drug services (\$500,000). Spread across the whole region, this expenditure was comparatively small, and would expand only slowly with the planned annual increase of \$500,000 from 1996–97.¹⁰³ In 1998–99, contracts let to Maori providers in Hawke’s Bay amounted to \$3.2 million, of which \$750,000 went to the three Napier-based providers.¹⁰⁴

100. Document w19(a)(9011), p 38

101. Ibid, pp 13, 65; hui reports in docs w19(a)(9018)–(9029)

102. Document w19(a)(9011), p 64; census 1996; also docs w19(a)(9018)–(9029)

103. Document w19(a)(9011), p 70

104. Document x5(15)

The incipient recognition by the Hawke's Bay Area Health Board of the need to develop a partnership relationship with Maori groups to provide community health services did not survive the purchaser-provider split of 1993. There were small exceptions, mainly in collaboration with Maori providers in community programmes. But on the whole, Healthcare Hawke's Bay concentrated on its mainstream services and its regional hospital project.

Ambiguities persisted, however. When Healthcare Hawke's Bay beefed up its Maori-oriented services in Hastings during 1996 and 1997, successive Maori health managers needed to fund their proposals for expanded services and capacities. Inevitably, they saw themselves to a certain extent as being in competition for Central RHA funds with Maori providers, whose number and service range developed rapidly in the mid-1990s.¹⁰⁵ A countervailing influence came from the Maori health committee, whose elected members not only articulated the broader needs of the communities they served but were commonly themselves involved in Maori provider organisations.

During 1998 and 1999, Healthcare Hawke's Bay's management returned to the path tentatively opened at the start of the decade towards a more formal partnership with iwi organisations and cooperation with Maori providers. In his evidence, Wi Keelan saw potential in a collaborative approach, cooperating in particular with Maori integrated care organisations coordinating a range of providers and services.¹⁰⁶ For the claimants, Matthew Bennett also saw integrated care as a promising way forward and cited the example of Tui Ora Limited in Taranaki.¹⁰⁷

7.2.4.5 Healthcare Hawke's Bay – Hastings Memorial Hospital and services for Maori

It appears that no specific provision for Maori was made in the services and facilities of Hastings Memorial Hospital before the 1990s. In 1991, a Maori initiative led to an empty ward being set aside for what became the Mihiroa Whare.¹⁰⁸ It was supplemented with rooms for visiting whanau attached to a medical and surgical ward. The pre-school of the children's ward incorporated kohanga reo activities.¹⁰⁹

Little specific information has been provided to the Tribunal on the services provided by Healthcare Hawke's Bay to Maori. Peter Wilson, its chairperson throughout the period, gave a positive view of the effectiveness of the Maori health services unit:

The work of this Unit has considerably advanced the service responsiveness of HCHB to Maori. Developments have necessarily been incremental but demonstrate, in my view, a firm and tangible commitment by HCHB to the Crown's Maori health gain priorities.

He cited in support:

- ▶ the go-ahead given, in advance of a funding commitment, for the new Maori health centre incorporating a whare whanau and a marae and meeting room facility;

105. Document w18(b)(8011); doc w54; doc w18(b)(8012)

106. Document w15, p 5

107. Documents v19, v19(a)

108. Arama Puriri cross-examined by Grant Powell, 2 August 1999, doc x33, p 355. Dated to 1993 in Healthcare Hawke's Bay 1998, p 5.

109. Document 692(44)

- ▶ the establishment of dedicated kaupapa Maori mental health and addiction programmes;
- ▶ the incorporation of tikanga Maori values into the operational culture (for example, kau-matua in wards and the hospital design); and
- ▶ the inclusion of specific Maori health objectives in the business cycle.¹¹⁰

According to Mr Keelan's evidence, for the first couple of years after the startup of Healthcare Hawke's Bay in July 1993, little changed. The two Maori health advisers were employed within the community health team. The Mihiroa Whare continued to be run partly by volunteer effort from the founding whanau. Then, in response to a proposal from the Maori health committee in 1995, the Maori health services unit was established and a manager appointed in February 1996. The manager post was subsequently promoted to the second level, reporting directly to the chief executive. As of mid-1999, the unit had five full-time equivalent posts: kaiwhakahaere, kau-matua kaitakawaenga, receptionist, kaimahi, and tumuaki.¹¹¹

Mr Keelan listed the unit's core functions as providing cultural services, whare whanau accommodation, and advice on monitoring and evaluation and Maori leadership. From July 1996, the unit was based at the new Maori health centre, which, as well as providing accommodation and a meeting space, was the venue for health education and training programmes.¹¹²

The cultural audit undertaken by the Central RHA in December 1996 painted a picture of an ad hoc, ill-coordinated approach to the incorporation of tikanga Maori into mainstream services, with a lack of senior management commitment and services well short of meeting the quality standards in the annual purchase contract. The report exposed a number of shortcomings:

- ▶ the business plan was kept within senior management and had no input from Maori staff;
- ▶ there was no mechanism for Maori input into the quality plan, 'and again if the quality planning process does not include Maori input, then it is unclear how quality issues for Maori are addressed';
- ▶ the Maori health service unit lacked a formal mandate for coordinating Maori service development and implementation in areas of high Maori usage;
- ▶ no regular consultation with iwi or other Maori groups was undertaken other than through meetings of the Maori health committee;
- ▶ the complaints procedure appeared to lack a specific policy on whanau support;
- ▶ there was no consultation, outside formal training, on integrating tikanga Maori into clinical practices and services, although a cultural awareness education programme was being prepared;
- ▶ the support available to Maori at admission and as in-patients was ad hoc and sometimes not known to them; and
- ▶ there was no training programme for staff collecting ethnicity data and no evaluation of the quality of the data.¹¹³

110. Document w12, pp 23–24

111. Document w15, pp 3–4

112. Document w18(a)(76), p 6050; Health Committee, '1996/97 Financial Review of Healthcare Hawke's Bay Limited', AJHR, 1998, I21-B, pp 5–6

113. Document w19(a)(9030)

The review noted that Healthcare Hawke's Bay was only now developing an equal employment opportunity policy. In fact, it was not: its reply in early 1998 to the health committee's annual questionnaire confirmed that it had only 'separate components' of a policy in place and undertook to prepare one 'in 1998'.¹¹⁴

In the same 1998 document, Healthcare Hawke's Bay claimed that it had advanced a long way towards contract and Treaty compliance:

Maori health policies that take into account the Treaty of Waitangi principles and Tikanga Maori values are now in place and provide the basis for a Kaumatua Kaitakawaenga service and other Kaitakawaenga services. Under these policies Maori staff provide the interface between client/whanau and other staff in a way that:

- ▶ enhances quality of service in cultural terms
- ▶ improves acceptability and accessibility of services for Maori clients
- ▶ encourages earlier presentation by Maori clients.

It also invited 'Maori input into all CHE projects', citing several examples; had bilingual signage and documents and forms in te reo Maori; and gave cultural sensitivity training to all new staff.¹¹⁵

These rather general assertions can be set in the context of the case histories presented by claimant supporters, several of which date from the year following (see section 7.2.4.4). Mr Keelan, the Maori health manager in mid-1999, agreed that there was still some way to go in extending Maori participation beyond the Maori health service unit and across the whole workforce. He took a similar view of developing cultural responsiveness. A couple of service units had tried to implement the *Te Taura Tieke* clinical competence and measurement framework but had not succeeded because its importance had not been sufficiently understood and supported. He had now, however, convinced management, and *He Taura Tieke*, together with a formal set of quality standards for Maori health services, was on the medium-term planning horizon.¹¹⁶ Both had in fact been prescribed in the annual purchase contract since 1997–98.

Mr Keelan stated in mitigation that the prescriptions in Government policy statements, plans, and contracts left providers with insufficient guidance for translating them into operational guidelines at the coalface:

But its not always clear what is expected of providers who wish to introduce Maori cultural input, or how cultural components are lent to the other service variables within hospital and health services like Healthcare Hawke's Bay.

He agreed that little work had been done at the central or local level on developing the tools needed for effective implementation.

114. Healthcare Hawke's Bay 1998, p 12

115. Ibid, pp 5–6

116. Wi Keelan cross-examined by Grant Powell, doc x33, pp 374–376, 379–380

He went on to criticise what he saw as the narrowness of the targeting mechanisms in purchase contracts:

though kaupapa Maori services are purchased, the actual contractual purchase units for those contracts are no different than for the non-Maori services. So it kind of defeats the purpose, particularly when you're trying to progress kaupapa Maori within health . . .¹¹⁷

7.2.4.6 Healthcare Hawke's Bay – the Maori hospital experience

Little information is available on how effectively Hastings Hospital moved to deliver culturally appropriate services to its Maori patients. The mid-1990s was a period of upheaval and stress at the Hastings campus: under financial pressure, Healthcare Hawke's Bay was cutting costs and staff; it was implementing a radically new patient care system; it was constructing the regional hospital; and its staff were undergoing a major reorganisation.

The effects of this pressure may have been reflected in the experiences of what was now Hawke's Bay Hospital reported by several people who gave evidence for the claimants. When his son was moved there in 1998 after eight years in Napier Hospital, Mr January Roberts encountered what he interpreted as 'an extreme difference in the type of care and treatment he received in comparison to that received previously from Napier Hospital'. Mr Roberts, a frequent visitor over a period of a year, considered the standard of patient care to be unsatisfactory.

Three other supporters of the claimants gave similar case examples from early 1999 of poor and insensitive patient care.¹¹⁸ Together, they painted a picture of long delays during admission; indifference towards the patient and their accompanying whanau; the persistent neglect of routine patient care in the ward, including the medical treatment and cleaning of incontinent patients; and the culturally unsafe management of patients after death.

Several underlying problems stand out from the evidence. One was inexperience. Mr Roberts formed the view that 'the staff were trainees I think, as most of the nurses didn't know how to do the simplest of tasks . . . As a result, the nurses became extremely reliant on me to ensure that my son's needs were accommodated. I became notably cautious of leaving him alone, for fear that he may not be cared for.'

A second problem was shorthanded staffing. According to Mr Roberts, 'to my observations, the staff at the regional hospital were either extremely overworked and understaffed, or inexperienced. I wouldn't like to say which'. Mrs Rose Whenuaroa found that the nurses 'always seemed very busy with other issues, and it looked to me that they were extremely understaffed and overworked'.¹¹⁹ In his testimony, Mr Flowers conceded that 'we had been too aggressive on the levels of nursing staff' at the new regional hospital through 1998 and 1999.¹²⁰

A third problem was the absence of a culture of respect for the mana of patient and whanau, leaving both on occasion in distressing circumstances.

117. Wi Keelan, oral evidence, doc x33, pp 364, 366, 377–378

118. Documents w24–w28; also doc v1(c), p 38

119. Document w24, paras 4.3–4.4; doc w26, para 2.5

120. Mark Flowers cross-examined by Grant Powell, doc x33, pp 396–397

A fourth problem, related to the third, was a willingness to take advantage of whanau support to substitute for nursing care. As Mrs Whenuaroa put it:

I appreciate the fact that as whanau, we have a responsibility to awhi and manaaki our sick, this is part of our culture. We all know that whanau support is imperative to the healing process. However for Hospital staff to take advantage of this, and neglect their own duties, is in my opinion appalling. These concepts can easily be abused if they are not managed in the correct way.¹²¹

Although Hastings Hospital relied on whanau support, it restricted visiting hours and permitted visitors. At the time of our visit there in July 1999, general visiting was limited to between 1 and 8pm in the maternity and medical and surgical wards and to between 2 and 7pm in the children's ward. Outside these hours, close family were allowed in from 7am to the maternity wards and parents had access any time to children, but medical and surgical patients were allowed only one 'support person', who had to be notified prior to surgery or at admission. Relatives staying overnight in the whare whanau faced a charge of \$10 per night, since the Central RHA did not fund the service.¹²² This regime did not make it easy for whanau members to provide effective support to those in hospital.

In the absence of more broadly based data, it is unclear how representative the case histories presented by the claimants were. Crown counsel dismissed them as 'anecdotal'. They bring to bear, none the less, a mix of lengthy observation and considerable experience of the local health system. Some of the difficulties may have arisen from the reassignment of simple nursing and patient care tasks from enrolled or registered nurses to non-professional 'clinical associates', who received only six weeks' training before starting. It is not known whether either the preliminary or on-the-job training included cultural awareness.¹²³

Relevant monitoring and survey information is sparse (see section 7.2.5.6). One of the few survey-based indicators to be compiled, the overall index of hospital patient satisfaction after discharge, reveals that, after rising from a low starting point in mid-1993 to well above the national CHE average in mid-1995, the index for Healthcare Hawke's Bay fell away and remained for the most part well below the national average from mid-1995 to mid-1998, the period during which the regional hospital project was being implemented (see chart 5).¹²⁴

The CCMAU surveys did not distinguish the Maori view. Only one vaguely formulated question ('How well were your cultural needs met?'), to which perhaps a third of the answers given came from Maori, gave some indication. The results over 1993 to 1998 suggest that most patients who found the question relevant were satisfied with the service provided by Healthcare Hawke's Bay's hospitals. However, the incomplete and frequently changing data definition make it difficult to assess any trend.¹²⁵

121. Document w26, para 2.5

122. Healthcare Hawke's Bay, *Map and Visiting Hours*, [1999], leaflet; doc v1(c), pp 24-25

123. Health Committee, '1996/97 Financial Review of Healthcare Hawke's Bay Limited', AJHR, 1998, I-21B, pp 6-7

124. Data from doc series 692(45)

125. Document v1(c), pp 7-10

An opinion survey, taken in early 1994 and covering the whole community rather than recent patients, gave some indication of Maori perceptions of the quality of the service provided by Napier and Hastings Hospitals. The survey ranked how important people considered different aspects of the hospitals' services and how well they thought those services were being delivered.¹²⁶ In all categories, both Maori and Pakeha rated delivery well short of the importance they attributed, implying a desire for marked improvement. Amongst those areas in which the gap for Maori was large, and also wider than for Pakeha, were facilities and information in accident and emergency reception, and information for, prompt attention to, and professional time spent with, patients. 'Handling cultural needs sensitively' was also ranked negatively. In general, Maori rated the human interface of service delivery and the cultural appropriateness of services as most in need of improvement (see figure 7.2).

7.2.4.7 Healthcare Hawke's Bay – Napier Hospital and the Napier Health Centre

There is no evidence that any facilities or services geared specifically to Maori needs were provided at Napier Hospital before Healthcare Hawke's Bay took over in mid-1993. Work in 1991–92 was limited to occasional cultural awareness training for nurses.¹²⁷

When the Central RHA published its interim purchasing intentions in August 1994, it required that:

An appropriate Whare Whanau should be available at Napier Hospital. The Maori people of Napier should still have access to Maori staff and services tailored to meet their needs at the Napier site.¹²⁸

It had contracted Te Kupenga Hauora during 1993–94 to provide the whare whanau service.¹²⁹

Little information is available on the extent to which Healthcare Hawke's Bay met its obligation to provide appropriate services for Maori patients over the remaining four years that Napier Hospital remained open. As we noted in section 6.2.9, a number of supporters of the claimants' case have testified in recorded interviews, written briefs and before the Tribunal to the healing values of the Napier Hospital environment and to their positive experiences while in-patients or caregivers there. Mr Roberts, referring to the treatment of his son between 1990 and 1998, stated that:

while my son was in the Napier Hospital I was confident that he was receiving competent care. The nurses were accommodating and very courteous when attending to him. They always went that extra mile for him.¹³⁰

126. Document 692(46), tables 5, 6. Lower socio-economic households, and thus Maori, were under-represented in the telephone sample survey.

127. Document 692(44), p 45

128. Document w18(a)(58), p 5693

129. Central RHA, 'Annual Report, 1993–94', AJHR, 1993–96, E-52, pp 29–30

130. Document w24

A contrasting view came from Matthew Bennett, who described aspects of his elderly parents' treatment in Napier Hospital in 1997. He recalled:

the fear that prevailed throughout the wards amongst the other kaumatua Pakeha as much as Maori as to the cursory treatment that they were receiving when the emphasis seemed to them to be turning them out into the community even before they were restored to able health.

Mr Bennett's account pointed to a patient care system by then under considerable strain, to the risks and indignities of an over-rigorous emphasis on 'care in the community' for elderly patients, and a lack of effort to respect the mana of elderly patients, Pakeha and Maori alike. In his view, 'it is inconceivable to me that a health facility could be so user unfriendly'.¹³¹

In its revised purchasing intentions published in December 1996, the Central RHA repeated its commitment to purchase a whare whanau service in Napier, adding that 'the size and location of this service will be designed to match the needs of the people of Napier'. It would also purchase a mobile kaupapa Maori addiction service and a specialised Maori mental health service in Napier, with clinics and treatment based in the community.¹³²

Both these services were provided by Healthcare Hawke's Bay, initially out of the Tuakana block on Hospital Terrace. When in 1998 it finalised its plan for a downtown health centre, it proposed to regroup all its community-based services there, except for residential mental health houses.

Healthcare Hawke's Bay faced major problems in financing its Napier project. One consequence was lengthy delay. The original target for completion was August 1998, but the new downtown centre was still under construction during the Tribunal's site visit in July 1999.¹³³ In mid-1997, Healthcare Hawke's Bay contracted out its urgent medical service to a general practitioner-run health centre, City Medical. Public health and several community-based services continued. But, since few services remained at Napier Hospital, apart from those in the Tuakana block, Napier residents now had to travel to Hawke's Bay Hospital in Hastings for a number of outpatient services. The new Napier Health Centre eventually came into operation in January 2000, and was opened officially on 26 April 2000.¹³⁴

From early 1998, Healthcare Hawke's Bay's management based its planning of the health centre on a 'health village' concept that envisaged co-locating most of its own services and combining them with private health providers in the same building. In late 1998, Healthcare Hawke's Bay entered into a 12-year lease with a private developer, Calan Healthcare Properties Trust, which built the facility.¹³⁵

131. Document v19

132. Document w18(a)(65), p 5768

133. Healthcare Hawke's Bay, *Napier Services Project: Project Structure and Terms of Reference*, 8 July 1997 (doc w18(a)(4), p 5025)

134. *Dominion*, 12 January, 27 April 2000

135. Document 692(35); *Daily Telegraph*, 23 January 1998; *Hawke's Bay Herald Tribune*, 26 February 1998; doc w37; doc 692(47)

The information published by Healthcare Hawke's Bay on the layout of the Napier Health Centre and the services to be located there mentioned the two existing services for Maori (addiction and mental health), but no other specific provision for Maori users of the centre. It offered space in the centre to Te Kupenga Hauora, but Mrs Joe declined on the grounds that the centre would be 'far too crowded', and thus not 'an appropriate place for a Maori Health Service to work from'. The whare whanau displaced from Napier Hospital had to find alternative premises.¹³⁶

7.2.4.8 Healthcare Hawke's Bay – representation and advisory committees

Although by the late 1980s the Department of Health was contemplating the appointment of tribally elected Maori representatives to area health boards, no such appointment appears to have been made to the Hawke's Bay board. The Maori members appointed to boards nationwide in 1989 were accountable to and removable by the Minister of Health.¹³⁷

From 1991 to 1993, the area health board was run by a commissioner, and the board of Healthcare Hawke's Bay, like those of all CHES, was centrally appointed and accountable to its shareholding Ministers. The fact that one of its members, Walter Wilson, was Maori and may often have acted as the channel of communication between Maori communities in Hawke's Bay and Healthcare Hawke's Bay's management and board did not alter the fact that he was, in common with his fellow directors, not locally accountable.¹³⁸ Not until mid-1999 did Healthcare Hawke's Bay begin seriously to contemplate entering into partnership agreements with Hawke's Bay iwi and Maori health provider organisations. Throughout the 1990s, therefore, the main ongoing channel of communication between the State healthcare provider and Maori communities was through ad hoc and advisory committees.

In mid-1990, a Maori health committee started up under the auspices of the Hawke's Bay Area Health Board.¹³⁹ The committee got as far as preparing a health charter and draft strategic plan but disappeared with the abolition of the area health board in mid-1991. Mrs Joe later criticised what she saw as its lack of effectiveness: 'we have been on an advisory board to the Area Health authority and we had no teeth. We just didn't get anywhere.' In her brief of evidence, she said that she had served on the committee and found it a 'redundant position': 'Our advice was hardly ever sought, and when it was it was to merely give lip service to a policy which had already been decided upon.'¹⁴⁰

The proposal for a committee was revived three years later at the Omaha consultation hui on 18 May 1994. It emerged mainly in response to the announcement to the hui by Alistair Bowes that Healthcare Hawke's Bay proposed to build a Maori health centre and appoint a Maori health manager. That proposal originated in Walter Wilson's outline of a Maori health policy of August 1993. Participants criticised the fact that planning had proceeded without consultation, the need

136. Document w37; doc 692(47); doc v16, paras 6.1–6.2

137. Section 8(3) of the Area Health Boards Amendment Act (No 2) 1989; Durie 1998, p 87

138. Document w12, p 6; Peter Wilson cross-examined by Grant Powell, 2 August 1999, doc x33, pp 249–252; doc w14, p 2

139. Document 692(15), p 71

140. Document w18(a)(83), p 6115; doc v16, para 3.5

7.2.4.8

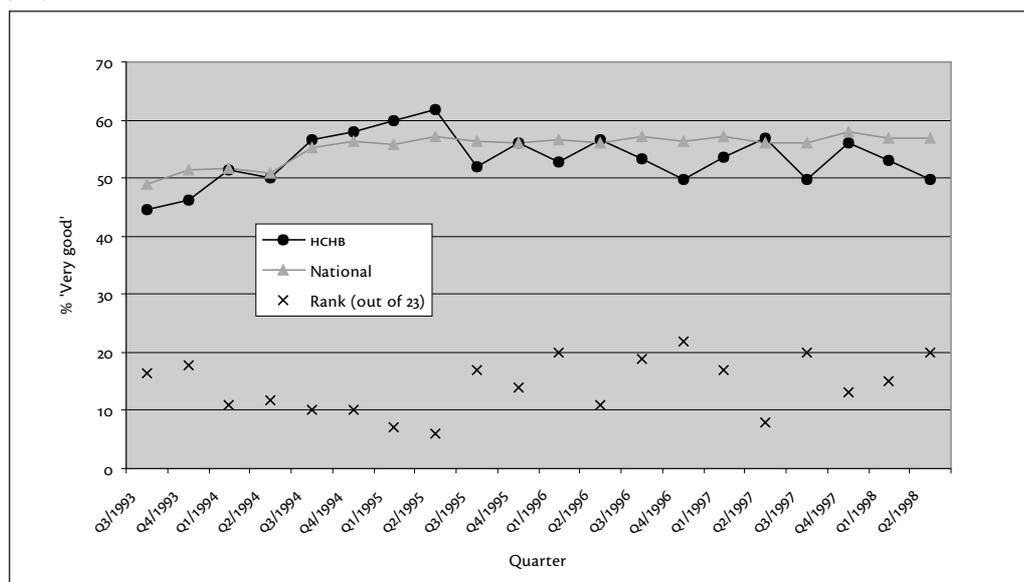


Chart 5: Customer satisfaction surveys, 1993–98

for which Mr Wilson had stressed. The final resolution, passed unanimously, recommended the appointment of a Maori advisory committee to ‘provide advice in Maori policy, the establishment and staffing of a Maori health centre, the Regional Hospital issue, CHE services to Maori and any other issues affecting Maori’.¹⁴¹

A meeting of Ngati Kahungunu kaumatua on 9 August 1994 endorsed the proposal presented by Walter Wilson for a Maori advisory committee, which he was to take to Healthcare Hawke’s Bay’s board the following week. Its representation would be divided between the four taiwhenua, each determining the mode of election of its two delegates.¹⁴²

Consultation hui and elections in each taiwhenua were completed during November 1994, and the committee held its inaugural meeting on 19 December. Its first chairperson was Bill Bennett from Te Taiwhenua o Te Whanganui a Orotu, and delegates from the taiwhenua have continued to participate. Renamed the Maori health committee in March 1996, it met monthly at Napier Hospital until July 1996, thereafter meeting every two months at Mihiroa Whare in Hastings. Its mandate was:

- ▶ to act as a two-way conduit of information between Healthcare Hawke’s Bay and Maori communities;
- ▶ to liaise with Maori health providers;
- ▶ to give advice and recommendations on Maori health policy and issues;
- ▶ to support the Maori health manager and Maori staff; and
- ▶ to monitor and evaluate Maori health services when required.¹⁴³

141. Document w51; doc w19(a)(9001)

142. Document w14, pp 7–8; doc x5(14)

143. Document u2, annexures 3.1–3.4

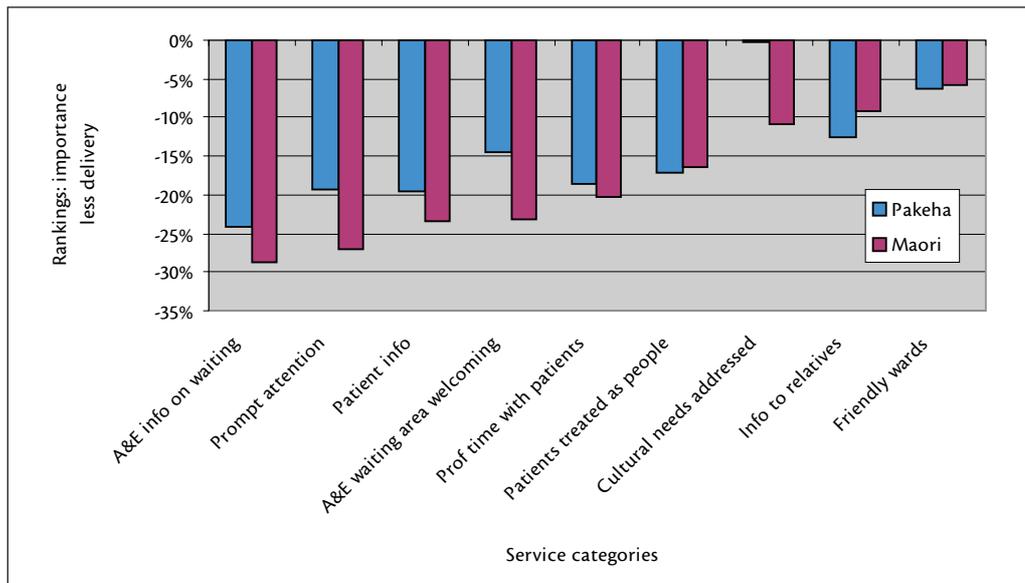


Chart 6: The 'expectations gap' in hospital services, early 1994

The Maori health committee was, amongst other matters, involved in the establishment of the new Mihiroa Whare in 1996, the development of the Maori health services section and the appointment of the Maori health manager in 1996, as well as the promotion of that post to second-tier management.¹⁴⁴

A second committee, Te Komiti Maori Awhina, was formed to provide Maori cultural input into the design of the regional hospital and, in particular, the Maori health centre. It functioned from July 1996 to August 1997. The Maori health manager and at least one Healthcare Hawke's Bay manager usually attended, but the basis of its Maori membership was not clear.

The minutes of the Maori health committee indicate that its effectiveness and its impact on Healthcare Hawke's Bay's decision-making on matters affecting Maori health was at times questioned by its elected Maori members. In Mr Wilson's starting proposal, a Healthcare Hawke's Bay sub-committee, a combination of board members and managers, was to work with the committee. In practice, the members and managers joined meetings of the committee, which to some extent became a joint forum. Their attendance was, on the whole, regular, allowing direct communication at both senior management and board levels.¹⁴⁵ The range of topics discussed was broad and, after the appointment of a Maori health manager in 1996, increasingly detailed and operational. The committee remained advisory but appears to have succeeded in exerting some influence over the development of Healthcare Hawke's Bay's services for Maori.

The Central RHA's cultural audit in December 1996 exposed three structural problems with the Maori health committee:

- ▶ the absence of a clear and formalised relationship and senior management, enabling input into business planning and service development;

144. Ibid, annexure 3.3

145. Document w14, pp 8-9

7.2.5

- ▶ uncertainty as to the committee's role in relation to the clinical sections and quality planning; and
- ▶ a potential conflict of interest in the large proportion of Maori providers amongst the committee's membership, which squeezed out Maori service users.¹⁴⁶

There was little sign of any follow-up action to address the issues raised until 1999, when Healthcare Hawke's Bay began a review of the committee's role.¹⁴⁷ It also contemplated exploring partnership arrangements, for which, the review had pointed out, the provider membership of the committee offered a possible starting point.

7.2.5 Performance monitoring and accountability

7.2.5.1 Institutional relationships in the purchaser-provider health system

The institutional structure created by the 1993 health reform was undoubtedly more complex than that of its predecessor. Both Crown and claimant counsel supplied diagrams to assist the Tribunal in understanding what the former described as 'the main lines of accountability' and the latter as 'the complex web of control' (see figures 26 and 27).

Neither diagram, in our view, fully captures the essential relationships. These we summarise in simplified form in table 5. By no means all the intricacies are captured there: in particular, non-governmental providers (private companies, voluntary organisations, community trusts, and Maori providers) are excluded and, from 1993 to 1996, so is the Public Health Commission. There was also a partial restructuring during 1997-98 (see section 7.2.1 and table 2). We note further that we have not considered at all the role of Te Puni Kokiri, which had varying responsibilities throughout this period for monitoring mainstream departments, researching social issues concerning Maori, and providing policy advice.

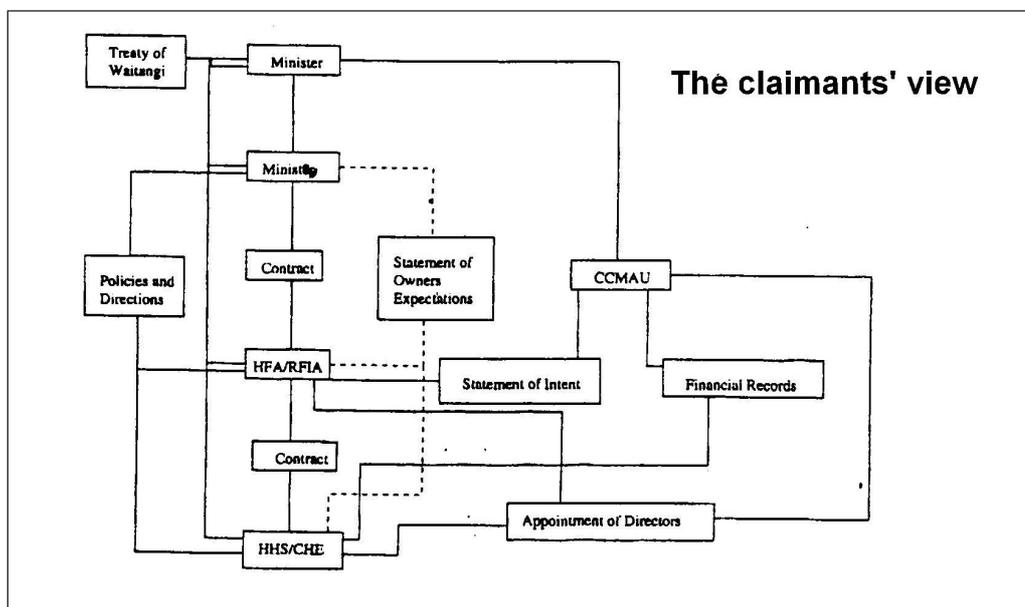
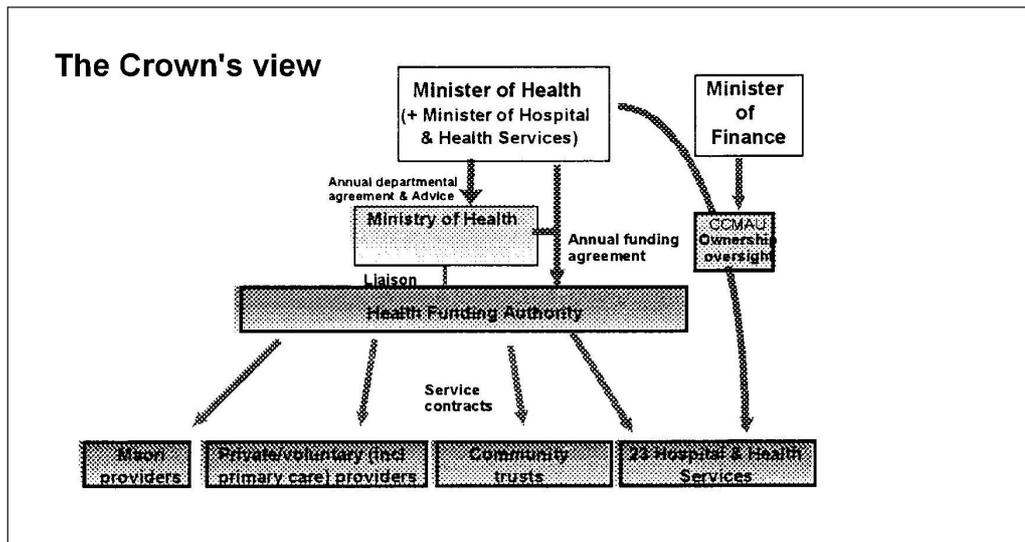
We discern not one but two core axes in the configuration of State health sector agencies during the funder-provider era. The first was service provision:

- ▶ the Minister of Health determined core health services, who was eligible to receive them, and Crown health objectives, and signed a population-based funding agreement with the purchasing agency;
- ▶ the Ministry of Health provided policy and technical advice to the Minister, negotiated funding agreements, and monitored the purchasing agencies' performance;
- ▶ the purchasing agency (the Central RHA, Transitional Health Authority, or HFA) conducted community consultations on health needs, negotiated purchase contracts with State and non-governmental providers, and monitored their performance; and
- ▶ CHES negotiated purchase contracts with their purchasing agencies and accounted for their performance.¹⁴⁸

146. Document w19(a)(9030), pp13-14

147. Peter Wilson cross-examined by Grant Powell, doc x33, p 292

148. Document w8, pp 2-4; doc w17, pp 3-12, 16-17



Figures 26 (top) and 27: Crown and claimant perceptions of the structure of the State health sector after the 1993 health reform. Taken from document x31, p 56, and document x48, p 42.

The second axis was ownership:

- ▶ the shareholding Ministers, jointly the Minister of Finance and the Minister for Crown Health Enterprises (until 1996), then of Health (from 1997), determined ownership expectations, decided appointments to both purchaser and CHE boards, and signed statements of intent and business plans with CHES;
- ▶ CCMAU provided policy advice to the shareholding Ministers, identified candidates for purchaser and CHE boards, negotiated statements of intent and business plans with CHES, and monitored the financial and organisational performance of CHES; and

- ▶ CHES negotiated statements of intent and business plans and accounted for their performance.¹⁴⁹

7.2.5.2 Political accountability – Ministers and Parliament

Throughout the upheavals of successive health sector reforms, the core features of ministerial accountability to Parliament remained in place. After mid-1993, however, ministerial accountability was divided between the ‘service’ (Minister of Health) and ‘ownership’ (Ministers for Crown Health Enterprises and Finance) portfolios. Although the Minister of Health replaced the Minister for Crown Health Enterprises in 1998, this structural division remained intact.

From the late 1980s, the reporting obligations placed on Crown agencies, and hence their exposure to parliamentary scrutiny, became more extensive and more specific. Whereas hospital boards were required to do little more than submit audited annual accounts, area health boards had to prepare annual reports and, from 1989, more comprehensive financial statements. From 1993, both the RHAs and the CHES were required to submit binding annual statements of intent covering the following three years, as well as annual reports and financial statements. These were tabled in the House and thus subject to parliamentary scrutiny.

The annual reporting cycle ostensibly promoted greater transparency in the arms-length contractual relationships between central government and the various health agencies. The statements of intent and annual reports were to include information on objectives, performance targets and measures.¹⁵⁰ This they did, and Maori health initiatives featured prominently in the Central RHA’s documents. But the criteria of assessment and the depth of information provided were geared to a general level of evaluation rather than to a detailed scrutiny of particular programmes or districts. Typically, Central RHA documents would report performance with a simple descriptor (‘achieved’, ‘substantially achieved’, or ‘not achieved’) and a short explanatory paragraph. The descriptive sections of the report provided brief programme overviews and only selective detail on activities, such as Maori provider contracts. After the RHA’s amalgamation into the HFA, little locally specific information was given.¹⁵¹

Much of the burden of scrutiny fell on the standing select committees, the social services committee to 1996 and the health committee thereafter. Both purchaser and provider levels of the health system came within their annual review round. Usually, the committee would distribute questionnaires and call the chief executive to appear. The questionnaires required specific answers, and Healthcare Hawke’s Bay’s written response for 1996–97, while defensive, contained substantial information, including summary details of its services for Maori.¹⁵²

Reviewing the Central RHA and the HFA, in 1997 the committee first reported on services to Maori only in 1997, but thereafter covered policy, strategy, and major programmes fairly

149. Document w17, pp 10–15

150. Sections 41C–41I, 44, 44A of the Public Finance Act 1989

151. Central RHA, annual reports, 1993–97; Health Funding Authority, ‘Annual Report, 1997–98’, AJHR, 1996–2000, E-52, E-67

152. Healthcare Hawke’s Bay 1998

prominently. The coverage of Healthcare Hawke's Bay was more episodic. There were no written reports for 1993–94, 1995–96, and 1997–98.¹⁵³

For the two intervening years (1994–95, 1996–97), the committee's reports were quite detailed. For the 1994–95 year, it covered the controversy over the regional hospital decision in depth. Its report, however, uncritically reproduced Healthcare Hawke's Bay's position. There was no mention of any possible impact upon local Maori or, more generally, of whether Healthcare Hawke's Bay was meeting its service obligations towards Maori. By contrast, the 1996–97 report did review its Maori health initiatives, and drew attention to its lack of a system for measuring Maori health outcomes. The committee noted, which its predecessor had not, the filing of a Treaty claim relating to the closure of Napier Hospital. It also criticised its failure to consult before deciding to cut part of its home help service.

Looking at the reports as a whole, it is apparent that, from 1997, the health committee took a more proactive interest in Maori health issues. It also picked up broad issues such as community consultation and the effectiveness of performance monitoring procedures, for instance, severely criticising a stand-off between the Transitional Health Authority and the Ministry of Health in 1997. This scrutiny offered a degree of general assurance to Maori communities in central Hawke's Bay that the performance of the State health agencies and the effectiveness of their monitoring were under high-level review.

Only the voice of the agencies was heard, however. Local issues, unless highly controversial, struggled to gain attention. Here, the organisational split created an imbalance of scale between district providers, whose local activities attracted attention, and regional and then national purchasers, whose programmes were reviewed at a much broader level. Purchasing issues of local importance to Ahuriri Maori, such as the adequacy of the Central RHA's consultations, needs assessment and support for local Maori providers, were unlikely to register.

7.2.5.3 Services – the Ministry of Health

The Ministry of Health had general oversight over the health sector and specific responsibility for the performance of the RHAs. Three main dimensions of its monitoring are relevant for the purposes of this report:

- ▶ achieving the general policy goal, set in 1992, of improving Maori health so as to remove adverse disparities;
- ▶ monitoring the funding agreements with the purchasing agencies; and
- ▶ specific monitoring of the health situation of Ahuriri Maori.

The evidence given by Ria Earp, deputy director-general (Maori health) at the Ministry of Health, indicated that the Ministry attempted to keep itself well informed of trends in Maori health status and the effectiveness of strategies of health service interventions.¹⁵⁴ She considered, however, that sufficient specific research and data on Maori health were lacking, particularly at

153. Social Services and Health Committees, financial reviews (various titles), AJHR, 1993–96, I-24B, I-24C, 1997, I-21A, 1998, I-21B, 1999, I-21C

154. Ria Earp cross-examined by Grant Powell, doc x33, pp 119–120

the local level. One of the eight strategic priorities she recommended was to ‘improve the quality of information on Maori populations, health status, service utilisation and effectiveness of interventions’.¹⁵⁵

On the monitoring of the funding agreements with the RHAs and the HFA, Ms Earp stated that, while the early emphasis had been on articulating policy guidelines, since 1996 it had ‘shifted to tightening the core accountabilities of the various players’.¹⁵⁶ This had followed criticism in the 1996 accountability review, which concluded that:

the RHA–central government relationship has developed a rather clumsy and onerous approach to accountability, which reduces the clarity of signals about performance expectations. There is ambiguity about roles in the relationship between RHAs and the Ministry.¹⁵⁷

The review considered that:

current monitoring indicators in relation to Maori health and related issues (such as workforce) raise similar issues as other parts of the current monitoring framework: they are not as well linked to policy, as measurable or as outcome-oriented as Ministry and RHAs would like.¹⁵⁸

The revised approach included securing a stronger focus in HFA purchase contracts on improving responsiveness to Maori in the mainstream services provided by CHES. The Ministry’s 1997–98 funding agreement with the Transitional Health Authority, the only such agreement filed in evidence, indicated that ‘tightening the core accountabilities’ had some way yet to go towards becoming fully operational. It set only broad monitoring procedures for its ‘policy priority area’ in respect of Maori health, requiring the authority:

- ▶ to provide quarterly confirmation of its achievements, noting exceptions and remedial steps;
- ▶ to demonstrate how its strategic plan for Maori health satisfies the Crown’s expectations and, after ministerial approval, to set implementation milestones; and
- ▶ to report quarterly expenditure on Maori providers and Maori-specific programmes and services.¹⁵⁹

In addition, the baseline service specification included a summary of the Crown’s objectives for Maori health as one of the ‘overarching obligations’ applicable to all services.¹⁶⁰ However, references to Maori appeared only sparingly in the detailed specifications.¹⁶¹

Ms Earp stated that the monitoring of purchase contracts providing mainstream services to Maori needed to be improved and the Ministry was currently working with the HFA on upgrading the contract design. A key deficiency was translating national goals for Maori health

155. Document w16, p 15; Ria Earp questioned by Grant Powell, doc x33, pp 129–130, 172

156. Document w16, p 6; Ria Earp cross-examined by Grant Powell, doc x33, pp 146–147

157. Document x5(16), p 2

158. Ibid, p 24

159. Document x5(17)(4), pp 24, 39

160. Document x5(17)(5), p 9

161. Document x5(17)(5)

into specific targets, and the targets into contract components that could be evaluated against performance. The monitoring of policy development across health sector organisations was far from comprehensive. Nor was the reviewing of formal HHS agreements for consistency with the Crown's Maori health objectives and Treaty obligations, or of HHS performance. But the Ministry did, in addition to the HFA, undertake some monitoring of particular components of mainstream programmes that were devoted to Maori.¹⁶²

Ms Earp also said that, during 1998 and 1999, the Ministry paid attention to the ownership dimension by working with the Maori Health Commission and CCMAU to improve the focus of the key performance indicators on Maori health needs in the statement of owners' expectations, but gave no details. Further improvement, she indicated, was needed to 'incorporate Maori values and issues in public health measures that specially target Maori communities'.¹⁶³

The only point at which the Ministry engaged directly with developments in Hawke's Bay was in providing technical advice requested by Healthcare Hawke's Bay on the Napier services working party's site options for Napier facilities.¹⁶⁴ Sitting at the head of the devolved health system, the Ministry was at least twice removed from the front line of health service delivery, separated by autonomous layers of purchasing and provider agencies. Even when the Minister of Health resumed a 'shareholding' relationship with HHS in 1998, it was not the Ministry that provided the advice and the monitoring. However, greater collaboration did ensue from that point, CCMAU sharing HHS business plans, for instance, with the Ministry.¹⁶⁵

The Ministry's indirect influence was none the less considerable. On the one hand, the statements of intent it negotiated with the Central RHA and the HFA introduced progressively greater range and precision to their Maori health initiatives, quality standards and performance measures. On the other, it developed performance monitoring guidelines, such as *He Taura Tieke*, that purchaser and provider agencies could incorporate into their purchase contracts and quality plans.

7.2.5.4 Ownership – CCMAU

Since its creation in 1993, CCMAU has played an influential role in the health system. Its formal reporting line remains obscure. Chris Clarke, who gave evidence as the team leader of its targeted assistance group working with the hospital and health services, described CCMAU as 'an independent unit administratively attached to the Treasury'. Since it is not, however, defined as a 'Crown entity' under the Public Finance Act 1989, its formal status appears rather to be that of an autonomous unit within Treasury, with delegated authority to enter into agreements with other shareholding Ministers.¹⁶⁶

As explained by Mr Clarke, CCMAU's primary role is to 'monitor and advise on the business and organisational performance of Crown companies' against their statements of intent and

162. Ria Earp cross-examined by Grant Powell, questioned by Tribunal, doc w16, pp 132–135, 146–149, 166–167

163. Document w16, pp 6, 12–14

164. Document w8, pp 8–13

165. Chris Clarke cross-examined by Grant Powell, doc x33, p 41

166. Document w17, p12; doc 692(48)

business plans and the shareholding Minister's statement of ownership expectations. Its principal focus during this period was financial, including both monitoring performance against business plans and advising on capital injections. It also monitored organisational capability, for instance, the capability to respond to patient needs, but not the health status of communities.¹⁶⁷

The influence of CCMAU on the delivery of health services to Ahuriri Maori was more direct than its counterpart central agency, the Ministry of Health. CCMAU related directly to the State health provider, Healthcare Hawke's Bay, to the extent of having a staff observer sitting in on board meetings and exercising hands-on supervision as Healthcare Hawke's Bay entered financial difficulties. It also had a strong hand in advising the shareholding Ministers on the negotiation of the statement of intent and business plan. Mr Clarke's evidence confirmed CCMAU's close involvement in the sequence of decisions leading to the closing of Napier Hospital.¹⁶⁸

We noted in section 7.2.3.4 the virtual absence of either a Treaty or a Maori health gain dimension in the Crown's ownership expectations until 1999. The quarterly patient satisfaction survey, part of the performance reporting required by CCMAU, included a single, general 'cultural sensitivity' question. Ethnicity data were collected but not used. In any case, the Maori response rate to the mail-out questionnaires was low. In November 1998, CCMAU and the HFA began a project aimed at improving the monitoring of Maori patients, with advice from an unidentified Maori reference group. The project was 'likely to result in the development of separate guidelines for obtaining patient feedback from Maori'.¹⁶⁹

Mr Clarke indicated that, in certain circumstances, especially the building of new facilities such as hospitals, CCMAU would monitor the extent to which the HHS had consulted its service communities, including Maori. It had done so in respect of the recent proposal to build a new hospital in Auckland, checking that Maori communities were being informed and consulted on such aspects as culturally appropriate hospital design factors.¹⁷⁰ There is no evidence that CCMAU applied a similar focus to the design of Hawke's Bay Hospital or the Napier Health Centre.

7.2.5.5 Purchasing – the Central RHA and the HFA

In the contract-based environment set up by the 1993 health reform, one of the Central RHA's key functions was to monitor and ensure compliance with its purchase contracts with CHES and to devise effective standards and methods for conducting the monitoring. Mara Andrews stated that 'the development of standards or clauses for CHE contracts was very minimal in early years'. The 1993–94 contracts rolled over whatever was in place the previous year.¹⁷¹ But, by 1996, the quality standards for health services to Maori were much more comprehensive and precise and, under the HFA, evolved into sophisticated specifications.¹⁷²

167. Document w17, p12; Chris Clarke, oral evidence and cross-examined by Grant Powell, doc x33, pp 9, 32

168. Document w17, pp 19–23; Chris Clarke cross-examined by Grant Powell, doc x33, pp 45–47, 57–62

169. Document w17, p17; Chris Clarke cross-examined by Grant Powell, doc x33, p 40; doc x1(9043), p 5

170. Chris Clarke cross-examined by Grant Powell, doc x33, pp 38–39

171. Document w19, p 23; Mara Andrews cross-examined by Grant Powell, doc x33, p 195

172. Document w19, p 23; docs x4, x5(13), docs w19(a)(9032), (9033)

Service provision		Ownership	
Minister of Health		Minister of Crown Health Enterprises (until 1997)	Minister of Finance
		Minister of Health (from 1998)	
<i>Departmental agreement: policy advice, monitoring, appointments etc</i>	<i>Statement of Crown objectives; funding agreement; board appointments</i>	<i>Statement of owners' expectations; CHE statement of intent and business plan; board appointments</i>	<i>Departmental agreement: policy advice, monitoring, board appointments</i>
Ministry of Health			CCMAU
<i>Policy priorities, purchase monitoring</i>			<i>Negotiation, financial, and organisational monitoring</i>
Central RHA/ HFA			
<i>Purchase contract: services, quality standards, service monitoring</i>			
Healthcare Hawke's Bay			

Table 5: Main accountabilities within the State health care sector, 1993–2000

In an information booklet on Hawke's Bay published in early 1996, the Central RHA listed a number of its contract quality requirements for CHES and made the commitment that it would 'continue to monitor CHES against these measures'.¹⁷³ Its annual reports provided few details on monitoring until 1995–96, when it held a series of meetings with CHE Maori health managers on quality standards for cultural effectiveness in mainstream hospital services.¹⁷⁴ During 1996–97, it carried out cultural audits of all CHES, including Healthcare Hawke's Bay in December 1996, and included a requirement in the following year's contract that the recommendations of the audit be implemented.

The Central RHA faced major problems in setting up an effective monitoring regime. One was establishing a methodology for matching expenditure to medical output. Ms Andrews said that, in her experience of working on Maori health service development with the Central RHA since its inception, one of the more intractable difficulties in establishing workable standards for monitoring mainstream performance was the inconsistency and lack of definition of the content of the funded services. There was also little information on where the expenditure was going. In setting up what was an entirely new purchasing institution, they had been obliged to proceed piecemeal, and the process of definition was still not complete.¹⁷⁵

A second problem was integrating explicit quality standards into service practice. Ms Andrews stated that implementing quality standards for services to Maori was not yet finished. CHES were required to prepare a quality plan, but 'in many cases the implementation of standards occurs over a number of years'. She agreed that the Central RHA bore the obligation to ensure that Healthcare Hawke's Bay complied with its purchase contract.¹⁷⁶

173. Central RHA 1996a, p 50

174. Central RHA, 'Annual Report, 1995–96', 44, AJHR, 1997, E-52, pp 40

175. Mara Andrews cross-examined by Grant Powell, doc x33, pp 184–186

176. Ibid, pp 194–195

Although implementing the recommendations of the 1996 cultural audit was a contractual requirement from 1997–98, it appears that no ongoing monitoring took place. Ms Andrews indicated that monitoring would not begin until 2000–01. The baseline for Healthcare Hawke's Bay would then be the cultural audit conducted in December 1996.¹⁷⁷ The audit exposed a number of shortcomings and failures to comply with the quality standards of the purchase contract. Ms Andrews stated, however, that the Central RHA's approach had been not to threaten breach of contract but to work informally with the Maori health manager on developing improved policies and practices. Healthcare Hawke's Bay would be included in a national round of cultural audits planned by the HFA during 1999 and 2000.¹⁷⁸

A similar *laissez-faire* approach is evident in the Central RHA's lack of monitoring of consultation by CHES, notwithstanding the fact that several specific obligations were written into successive purchase contracts. In particular, the quality standards schedule in the 1997–98 purchase contract required Healthcare Hawke's Bay to plan a consultation with those affected, 'including iwi/Maori', if it wished to 'change the way that [it] provide[d] services which will have a significant impact on clients'. Ms Andrews stated that the Central RHA made no attempt to ensure that Healthcare Hawke's Bay fulfilled that obligation in respect of its decision to close Napier Hospital and build a downtown health centre.¹⁷⁹

As well as CHES, the Central RHA began to monitor the rapidly growing number of Maori providers that it supported. During 1995–96, it set up output monitoring procedures for all Maori providers and outcome monitoring for some of them, for instance, in meeting immunisation targets.¹⁸⁰ In the following year, it evaluated several pilot projects, including the rongoa Maori service in Napier, for which support was discontinued pending the development of a national purchasing framework.¹⁸¹

The Central RHA lacked effective tools for assessing the contribution of services for Maori towards the overall goal of improving Maori health. During 1997–98, the Central RHA started to compile a 'planning document on Maori health status identifying demographic and key health status indicators for sub-regions and iwi to enable clear benchmarks to be set for health gain measurement'. Though it may have been completed, this potentially useful report has not been filed in evidence.¹⁸²

Ms Andrews pointed to significant problems in gathering reliable and complete ethnicity data for planning and monitoring purposes. Historically, ethnicity data had been narrowly limited to hospital admissions and discharges. Even these data were of poor quality, with research by the Eru Pomare Research Group revealing inconsistent methods and error rates in the region of 30 per cent.¹⁸³ She stated that, in response, purchase contracts now placed emphasis on training

177. Document w19, p 23

178. Mara Andrews cross-examined by Grant Powell, doc x33, pp 210–214

179. *Schedule 3. General Quality Requirements*, 9 October 1997 (doc x4); Mara Andrews cross-examined by Grant Powell, doc x33, p 208

180. Central RHA, 'Annual Report, 1995–96', 44, AJHR, 1997, E-52, pp 40

181. Central RHA, 'Annual Report, 1996–97', AJHR, 1998, E-52, p 59

182. Central RHA, 'Annual Report, 1996–97', AJHR, 1998, E-52, pp 59–60

183. Central RHA, 'Annual Report, 1996–97', AJHR, 1998, E-52, p 60

admissions staff. Outside the hospital system, few data were collected at all. Such information was important for more comprehensive assessments of effectiveness and health issues for Maori. Independent providers and general practitioners resisted collecting and providing patient ethnicity data, in part because they feared the diversion of Government funding to rival providers. However, the HFA had recently negotiated the inclusion of ethnicity data in standard general practitioner contracts, with a financial penalty for non-compliance.¹⁸⁴

7.2.5.6 Providing – Healthcare Hawke’s Bay

The extent to which Healthcare Hawke’s Bay attempted to meet its obligations and monitor its contract compliance is scantily covered in the evidence presented and documentation filed, which did not include business plans, annual reports, quality plans and other relevant documents. The Central RHA’s review team that undertook the 1996 cultural audit noted that it had not been given access to the current service quality plan, the core document for implementing the quality stipulations for services to Maori, on the ground that it was then under revision.¹⁸⁵ We note that the Hawke’s Bay District Health Board now publishes the principal accountability documents – the annual report, statement of intent, and business plan – on its website.¹⁸⁶

The cultural audit remarked that Healthcare Hawke’s Bay undertook no additional patient monitoring beyond the quarterly consumer satisfaction surveys required by CCMAU.¹⁸⁷ These collected ethnicity data but did not identify Maori in the reports sent back to the CHES. Section managers and quality advisers in Healthcare Hawke’s Bay thus lacked any feedback from Maori ex-patients on the service provided. In its 1996–97 report, the parliamentary health committee noted that Healthcare Hawke’s Bay did not then have a ‘system for measuring health outcomes for Maori’, and urged it ‘to develop outcome measures so that the impact of its Maori health initiatives can be assessed’.¹⁸⁸

7.3 THE POSITIONS OF THE PARTIES

7.3.1 The case for the claimants

In his closing submission, claimant counsel began his case from two starting points. On the one hand, however simple or complex the frequently restructured health system was, all the agencies within it were responsible for implementing the Crown’s Treaty obligations. The umbrella of responsibility reached from Ministers and central Ministries and departments to funding bodies and service delivery agencies:

184. Mara Andrews cross-examined by Grant Powell, doc x33, pp 186–190

185. Document w19(a)(9030), p 15

186. Healthcare Hawke’s Bay 2000a, 2000b, 2000c; Hawke’s Bay District Health Board 2001

187. Document w19(a)(9030), p 17

188. Health Committee, ‘1996/97 Financial Review of Healthcare Hawke’s Bay Limited’, AJHR, 1998, 1-21B, p 6

Treaty of Waitangi obligations include the terms and principles of the Treaty of Waitangi. While these are generally not legally enforceable through the Courts they are binding upon the honour of the Crown and are binding on each of the relevant entities in this claim.¹⁸⁹

On the other hand, the general Treaty obligations were extended, directly and indirectly, by:

- ▶ statutory requirements;
- ▶ policies operating at different levels of the system; and
- ▶ contractual relationships between the various institutions implementing the statutory requirements and policies.

Irrespective of any doubt as to the legal effect of the policies:

It is submitted that having promulgated policy or directions particularly where such are relevant to health delivery to Maori, the Crown and its health entities, pursuant to the Treaty duty to act in good faith towards Maori, are obliged to give effect to such policies.¹⁹⁰

Counsel directed his remarks to the reformed health system that came into full operation in July 1993. The complexity of the system and absence of centralised monitoring, he argued, made it difficult to establish the full extent of the obligations prevailing at any one point in time.¹⁹¹ He identified three principal levels at which the system functioned:

- ▶ central government (the Ministers of Health and Crown Health Enterprises, the Ministry of Health, CCMAU);
- ▶ funding or purchasing agencies (the Central RHA in 1998 merged into the national HFA); and
- ▶ service provider agencies or CHES (from 1998, HHSS, like Healthcare Hawke's Bay).

Turning first to *statutory requirements*, at the central level counsel pointed out that the Minister of Health had a 'clear statutory obligation to maintain overall charge of the health system, ensure appropriate objectives are issued and to ensure that performance is both monitored and enforced'. One key statutory responsibility of the Minister under the 1993 Health and Disability Services Act was to issue written notice of the Crown's objectives to the funder. These were to include 'the special needs of Maori' for health and disability services, of which the Minister had to be aware in order to issue directives to meet them. The Act further made the Minister responsible for fulfilling the objectives of the Crown and the purchasing agency and, as one of the shareholding Ministers, for the performance and actions of the CHES. The Ministry of Health shared responsibility for this implementation.¹⁹²

Alongside the Ministry, CCMAU monitored the financial performance of the CHES and assisted in selecting their directors but had no statutory role in the health system.¹⁹³

189. Document x31, para 11.4

190. Ibid, para 11.7

191. Ibid, paras 10.2–10.3, 10.7, 11.2, 11.5–11.6

192. Ibid, paras 13.8–13.13 (quoting sections 8, 12, 13 of the Health and Disability Services Act 1993)

193. Ibid, paras 13.14–13.15

At the purchaser level, the 1993 Act set general health promotion objectives for the RHAs that, counsel argued, were ‘not inconsistent with obligations to Maori’. Furthermore, the requirement to meet the Crown’s notified objectives imported the statutory obligation under section 8 to ‘meet the special needs of Maori’ and, with it, any Ministry of Health policy applying to the provision of health services to Maori.¹⁹⁴ The RHAs were responsible for translating these objectives and policies into purchase contracts with the CHES within their regions, and for monitoring their performance under the contracts. The Act also required RHAs to identify and monitor the needs of Maori and to consult with Maori.¹⁹⁵

At the provider level, the 1993 Act bound CHES to the Crown’s general objectives and thus also imported the obligation to meet Maori needs. In providing health and disability services, a CHE had to conform to its statement of intent and any purchase contract with an RHA. Amongst the set general objectives, it was to have regard to ‘the interests of the community in which it operates’. Counsel argued that ‘the community’ included Maori and that ‘the relevant interests of Maori’ included the principles of the Treaty of Waitangi. CHES were also:

bound to give effect to relevant Crown policy, either because that policy specifically applied or because in accordance with the Treaty principle of utmost good faith, it would be inconsistent for the Crown to issue policies . . . which part of the Crown then acted inconsistently with.¹⁹⁶

Turning to applicable policy, counsel identified as the principal guideline on Maori health for RHAs the document *Whaia te Ora mo te Iwi*, published by the Ministry of Health in 1992 and in force throughout the period. He summarised its main provisions, including its main objectives; the obligation to consult, and to involve Maori in reviewing and monitoring purchasing plans; the prescriptions for purchase contracts; and the requirement to gather Maori health information.¹⁹⁷

Counsel surveyed the resulting contractual obligations imposed on Healthcare Hawke’s Bay by quality standards schedules to its annual purchase agreements with the Central RHA. They included, to varying degrees, the integration into services accessed by Maori of values representing tikanga Maori; consultation on this and other aspects of service provision; the incorporation of Treaty principles; and, in 1997–98, the building in of the results of cultural reviews and of the national guideline for measuring health services effectiveness for Maori.¹⁹⁸

This guideline, *He Taura Tieke*, was published by the Ministry of Health in 1995 as a checklist for health service providers and, counsel argues, was important for service delivery to Maori patients.¹⁹⁹ In addition, counsel pointed to several specific policies adopted by Healthcare Hawke’s Bay, including a 1993 policy statement on Maori health services that recognised Treaty

194. Ibid, paras 13.16–20 (quoting sections 8, 10 of the Health and Disability Services Act 1993)

195. Ibid, para 13.24 (citing sections 33, 34 of the Health and Disability Services Act 1993)

196. Ibid, paras 13.31–13.36 (quoting section 11 of the Health and Disability Services Act 1993)

197. Ibid, paras 12.11, 12.13, 13.20–13.23

198. Ibid, para 13.41

199. Ibid, paras 13.37–13.38

principles, and the need for partnership, consultation, and monitoring and reporting systems. Similar commitments were included in Maori business plans from 1997.²⁰⁰

Counsel submitted that the health system as a whole and agencies at all levels had failed to deliver on their statutory, policy and contractual obligations regarding health services to Maori. Part of his criticism was directed at what he saw as a lack of national commitment. He argued that reducing disparity in Maori health status had been set in 1992 as a medium-term objective, to be achieved over three to five years, yet was simply restated in similar form in 1999 despite little progress having been achieved in the interim.²⁰¹

At the top level, counsel states that successive *Ministers of Health* ‘must accept responsibility for the specific breaches of the Treaty and failures of the health system that have occurred while they respectively held the portfolio’. Considering statutory requirements, these included:

- ▶ a failure to ensure that information was available on the special needs of Maori in Hawke’s Bay;
- ▶ a failure to ensure that the 1992 policy objectives for Maori health were met; and
- ▶ a health system that was ‘in considerable disarray with no clear chain of command and little responsibility being taken by the Minister or the Ministry’.

He concluded that Ministers ‘acquiesced or actively approved in the making all decisions that were made by HCHB while taking no steps whatsoever to ensure that its obligations were met or that the other Crown health entities properly supervised HCHB’.²⁰²

The *Ministry of Health* he accused, on the basis of the evidence of Crown witnesses, of having:

only a very general understanding of the health issues in Hawke’s Bay and certainly no detailed understanding of the special needs of Maori as required by s8 [of the 1993 Health and Disability Services Act]. The Ministry’s direct involvement was limited to production of policy documents for the guidance of CRHA/HFA or HCHB without any monitoring to see if such policies were being implemented and adhered to and simply relied blindly on the lower levels of the health system fulfilling their respective duties and obligations.²⁰³

He concluded:

As a result the Ministry had no knowledge of the extent to which HCHB and the CRHA/HFA had breached their respective obligations to Maori. Instead the Ministry appears to have simply reissued medium term goals with no reasonable belief that such were any more attainable than earlier policies and goals issued.²⁰⁴

CCMAU, on the other hand, played in his view a significant role, despite having no statutory responsibility: ‘it is an agency with no statutory structure or statutory responsibility for health, wielding immense power over the CHE/HHS and RHA/HFA with only a shadowy line of

200. Document x31, para 13.40

201. Ibid, para 12.11–12.15

202. Ibid, paras 13.7–13.12, 15.3.1

203. Ibid, para 13.13

204. Ibid, para 15.3.2

accountability of its own, quite separate from the remainder of the health system'. Counsel argued that in performing this informal role it took no account of Treaty, statutory, policy or contractual obligations to Maori in respect of health services.²⁰⁵

Counsel criticised the *Central RHA/HFA* in forthright terms, again largely on the basis of Crown evidence:

It is submitted that the evidence is overwhelming that the CRHA/HFA have not met their obligations . . . Both in terms of identifying the needs of the Maori community of Hawke's Bay and Ahuriri, and monitoring the performance of HCHB, CRHA (and later the HFA) have fallen woefully short in complying with the relevant Treaty principles, the obligations set out in *Whaia te ora* and their other obligations.²⁰⁶

In his view, the Central RHA:

- ▶ employed too few and inexperienced staff (two only) to investigate Maori health needs and undertake consultation with Maori throughout the region;
- ▶ did not attempt to implement the 1992 Maori health policy;
- ▶ failed to undertake a comprehensive assessment of Maori health needs in Hawke's Bay or to set up the collection of ethnicity data;
- ▶ neither monitored effectively the Maori service requirements in the annual purchase contracts with Healthcare Hawke's Bay nor took action regarding breaches;
- ▶ did not follow up the one cultural audit of Healthcare Hawke's Bay undertaken; and
- ▶ failed to undertake or ensure that Healthcare Hawke's Bay undertook adequate consultation before the various decisions on Napier Hospital and Napier services were made.²⁰⁷

At the service delivery end of the hierarchy, counsel argued that *Healthcare Hawke's Bay* had 'spectacularly failed to meet its obligations to Maori in the period under review'. These obligations included consultation on the Napier Hospital decisions and on service provision to Maori, as required in its annual purchase contracts, its Maori health policy statement, and its Maori business plans. He cited Crown evidence that Healthcare Hawke's Bay had not proceeded with *He Taura Tieke* beyond initial unsuccessful trials for lack of understanding or support from management.²⁰⁸

In addition, Healthcare Hawke's Bay had 'significantly failed to encourage Maori participation at all levels within HCHB'.²⁰⁹

In his view:

it is clear that many of the 'minimum quality requirements' have not been met including the adoption of *He Taura Tieke*, accurate ethnic data collection and the implementation of cultural

205. Ibid, paras 10.7, 13.14–13.15, 15.3.3

206. Ibid, para 13.25

207. Ibid, paras 13.26–13.30, 15.3.4–15.3.7

208. Ibid, paras 13.38–13.39, 13.40.2–13.40.5, 15.3.8–15.3.9

209. Ibid, para 15.3.9

reviews. No evidence whatsoever has been tendered on behalf of the Crown that HCHB made any attempt to comply with the various Maori protection provisions in its contracts . . .²¹⁰

Counsel also attributed part of the failures he detected in organisational performance to *the overall design of the reformed health system* :

The picture which emerged by the end of the Crown evidence and particularly through the admissions of the key personnel involved, was of a system which has spectacularly failed to meet the needs of Maori in Ahuriri and in Hawke's Bay generally. The aims of the reforms to increase accountability throughout the health service through the creation of a clear command structure, efficient monitoring and enforcement of relevant obligations and accountability has demonstrably and utterly failed.²¹¹

The Crown's expert witnesses, he argued, had accepted that the purchaser-provider split had applied equally to previous models of health service delivery and that 'it was not the new structures themselves that would provide additional accountability, but rather the type of controls and accountability mechanisms imposed upon the new entities and as between the funder and the provider'. The Crown evidence had also revealed 'the absence of any overall system of control of the health system, including an absence of systems in place at a national level to monitor if in fact the systems adopted in the reforms were or are working'. This absence, coupled with the complexity of the health system's design, had resulted in 'a system where no one entity has either overall responsibility or authority to ensure all relevant obligations are adhered to'.²¹² As an example of the consequences, he quoted a critique in a 1996 RHA accountability review that pointed to serious procedural shortcomings.²¹³

Counsel drew attention to the broad range of significant issues in health service delivery that were identified at the five hui held for Maori involved in the health system as part of a 1998 Ministry of Health review of Maori health issues. In his view, these issues indicated that little had been done since the health reforms began, and Crown evidence was that there had been no official follow-up to the October 1998 national hui that concluded the project.²¹⁴

Counsel's case was that the various shortcomings and failures resulted in actual prejudice being suffered by Ahuriri Maori. This took the form of the series of decisions made on the status of Napier Hospital and of continuing large disparities between the health status of Maori and non-Maori.

Counsel summarised his submission on contemporary grievances thus:

In conclusion it is submitted that it is beyond dispute that no Crown entity has ever taken responsibility to ensure that Maori health needs are identified or catered for in Hawke's Bay. The evidence has shown that the CRHA and its successor the HFA are demonstrably incompetent

210. Document x31, para 13.42

211. Ibid, para 8.3

212. Ibid, paras 9.4, 9.6, 10.2

213. Ibid, paras 10.3-10.6

214. Ibid, paras 12.1-12.12

and under resourced in their ability to deal with Maori health needs in Hawke's Bay while HCHB have been shown to be demonstrably indifferent to Maori health needs in Ahuriri and Hawke's Bay despite ample warning. The complete absence of appropriate consultation is symptomatic of the complete failure to give effect to Crown health policy towards Maori or to the principles of the Treaty of Waitangi. It is submitted that all key decisions that have been made in relation to the delivery of health services in Ahuriri and Hawke's Bay have been made in breach of the principles of the Treaty of Waitangi.²¹⁵

7.3.2 The response of the Crown

Like claimant counsel, Crown counsel directed part of his closing submission to a general assessment of the health reforms:

In this area there is a fundamental difference between the position of the Crown and the claimants. The Crown believes that the health reforms of the 1990's have laid a foundation to achieve real progress. The Crown submits that significant progress has already been made in a number of key areas.²¹⁶

He argued that Maori had participated in those gains:

None of the Crown witnesses pretended that these structural changes were easy or without problems. On the other hand it was also clear that some aspects of the reforms have produced significant gains for Maori. In particular the purchaser/provider split has significantly enhanced the sophistication of targeted resources to Maori in a more equitable and transparent manner.²¹⁷

He chastised claimant counsel for stridency and overstating his case:

To a large degree the claimant closing submissions are an unrelenting counsel of perfection. All points are taken. Nothing is conceded. Life, health, and the Treaty are not like that.²¹⁸

He also accused claimant counsel of constructing his criticisms in a formalistic manner and of ignoring the compromises needed in practice:

In one sense it is easy to take technical points but unless they are balanced by proper consideration of the actual context in which these events took place, and the genuine efforts being made, they are of little assistance in arriving at the substance of the issues before the Tribunal.²¹⁹

Crown counsel placed considerable emphasis on what he saw as the improved accountability

215. Ibid, para 15.6

216. Document x48, para 75

217. Ibid, para 85

218. Ibid, paras 89-90

219. Ibid, para 111

achieved under the health reforms. Quoting extensively from the evidence of Crown witnesses, he made the following points:

- ▶ The purchaser–provider split clarified institutional roles, especially on the purchaser side.
- ▶ The removal of elected local boards ended democratic accountability but improved efficiency in delivering ‘better health services and outcomes’ through centralised control. Larger catchment areas transcended local rivalries. Accountability to Maori was not worsened since elected boards excluded Maori anyway.
- ▶ Healthcare Hawke’s Bay had, since 1994, worked with a Maori advisory committee comprising representatives appointed by Maori, as well as with kaumatua.
- ▶ Healthcare Hawke’s Bay had developed its services and responsiveness to Maori, notably through its Maori health centre.
- ▶ Responsiveness and quality standards appropriate for services to Maori were not static but ‘evolving or emergent’, and there was good recent evidence of progress in Healthcare Hawke’s Bay. The same evolution took place in the Central RHA, which had to start from scratch.²²⁰

Counsel insisted that the structural design of the health reforms was pushing the health sector in the right direction and was consistent with Treaty principles:

The Crown expressly rejects the proposition that the structural arrangements put in place by the 1993 reforms were inconsistent with the Treaty. The structural changes laid a foundation for improvement. Implementation is difficult and takes time but that does not mean that the legislation or policy is deficient.²²¹

Other points made by counsel in conclusion were:

- ▶ the Crown is under no enduring obligation to Ahuriri Maori to provide health services from Mataruahou;
- ▶ Healthcare Hawke’s Bay’s decisions on Napier Hospital in 1994 and 1997 were made consistently with the Crown’s Treaty obligations to the claimants;
- ▶ the claimants have not been able to demonstrate prejudice arising from those decisions; and
- ▶ the legislation and policy arising from the health reforms did address poor Maori health status and delivered benefits.

7.3.3 The claimants’ reply

In reply, claimant counsel alleged that ‘the Crown submissions alternate between obfuscating or simply ignoring the issues that have been raised on behalf of the claimants’. Furthermore:

Rather than addressing the issues that are before the Tribunal, throughout his submissions Crown counsel has posed his own questions which are generally quite different from those

220. Document X31, paras 73–117

221. *Ibid*, para 106

pleaded in the third amended statement of claim, fully supported by evidence and articulated in the closing submissions presented on behalf of the claimants.²²²

Counsel rejected the general assertion that the claimants had suffered no prejudice and criticised the Crown's refusal to acknowledge, in light of concessions by Crown witnesses, that any Treaty breaches at all had occurred.²²³ Counsel also rejected the notion that, if problems in Napier were also national in scope, the Crown could escape its responsibilities to local Maori.²²⁴

Counsel insisted that there was either no evidence or contrary evidence from Crown witnesses on a number of assertions by Crown counsel, which were therefore unsupported or contradicted. These included the conclusions that:

- ▶ the 1996 *Nga Ara Poutama* survey provided adequate information on the health needs of Ahuriri Maori;
- ▶ health service changes in Hawke's Bay had brought benefits;
- ▶ the health reforms had laid the foundation for real progress;
- ▶ no failure of policy or process affected the decisions to regionalise hospital services in Hastings and to relocate services from Napier Hospital;
- ▶ benefits were derived from the purchaser-provider split;
- ▶ the health reforms had generated the growth of Maori health providers, which in any case comprised only three small providers in Napier, leaving local Maori dependent on mainstream services;
- ▶ the pre-reform health system was not a 'golden age' and the reforms were taking service delivery on an improving path; and
- ▶ in a complex social field, Crown agencies were making honest efforts to improve their performance and delivery'.²²⁵

Claimant counsel joined Crown counsel in inviting the Tribunal:

to consider and rely upon the evidence of the Crown witnesses. This of course is the approach urged on the Tribunal by the claimants. The evidence of the Crown witnesses, and in particular the cross examination transcript of those witnesses, provides overwhelming proof of the claimants' case.²²⁶

7.4 FINDINGS, TREATY BREACHES, AND PREJUDICE

7.4.1 The scope of our findings

In this section, we consider most of the contemporary grievances, excluding those relating to consultation over the status of Napier Hospital. We make findings and determine whether

222. Document Y8, paras 1.2–1.3

223. Ibid, paras 2.6–2.7

224. Ibid, para 4.15

225. Ibid, paras 4.12–4.24

226. Ibid, para 4.22

Treaty breaches have occurred. Where we find that a breach has occurred, we limit our assessment of the prejudice arising to the particular breach. Since many grievances share the same indicators of outcome, we defer to chapter 8 our consideration of health outcomes and the extent to which they can be said to reflect prejudicial effects.

7.4.2 What Treaty obligations did post-1993 Maori health policies and contracts place upon the Crown?

Extract from the statement of claim:

10. . . . the Crown through the Crown health entities has adopted policies and contracts for the delivery of health services to Maori and to meet Maori health needs ('Maori health policies') . . .

11. The effect of the obligations under the Treaty and the Maori health policies . . . is to impose obligations on the Crown and the Crown health entities to—

11.1 Ensure that the obligations under the Treaty and Maori health policies are monitored and enforced.

11.2 Consult with Maori over issues which affect or are likely to affect Maori health or Maori health outcomes.

11.3 Ensure that the delivery of health services and health outcomes for Maori are effectively monitored.

11.4 Establish and address Maori health needs.

11.5 Deliver a reasonable standard of health to Maori.

11.6 Continue to improve the delivery of health services to Maori.

11.7 Continue to improve health outcomes for Maori.

11.8 Ensure that health services and outcomes for Maori are delivered in a manner which is culturally sensitive or appropriate.

The claimants argue that Ahuriri Maori were entitled to rely on the Crown to act in good faith by delivering on policies and contracts adopted by any of its agencies that were responsible, whether directly or indirectly, for addressing their health needs. Failure to deliver would of itself amount to a breach of Treaty principles. Here, we discuss the extent of the Crown's obligations before considering in the following sections the particular grievances arising from the Crown's alleged failure to fulfil those obligations in respect of Ahuriri Maori. Since the question of Treaty breaches does not arise, we enter no findings at this point.

The claimants identified a broad array of obligations in respect of Maori health that, they say, derived not only from the application of Treaty principles but also from the policies adopted by the Crown and from the contracts devised to implement them. Policies and contracts adopted by any agency acting for and on behalf of the Crown are also applicable. This spreads the net wide, since, claimant counsel argued, service agencies such as area health boards and CHES were

part of the Crown. And, even if they were not, the Crown was responsible for ensuring their Treaty compliance by contract or other means.

The issue arises principally from the modern revolution in public administration brought about by the State sector reforms of the 1980s. Previously, the State system functioned under command hierarchies connecting the lowest level of operation ultimately to the responsible Minister. The reforms, by contrast, severed the chain of command, distinguished each type of State entity, and established explicit accountability between them. The relationship was regulated by standardised agreements or contracts, both between Ministers and State agencies and between controlling and subsidiary agencies. Instead of issuing orders, the funder negotiated priorities with the purchasing agencies, which in turn negotiated terms with provider agencies, which also negotiated with the 'ownership' arm of government. Tying the whole edifice together was the monitoring of compliance and performance.

In the State health sector, the Government was beginning to bring the area health boards under such a contractual regime by the close of the 1980s. But the accountability regime came into full flower with the 1993 health reform. Not only did the health agencies multiply; so too did the instruments of accountability. The result was an elaborate formal structure of binding obligations. Even the making of policy was partially formalised: the Minister of Health had to notify the Crown's health objectives annually. Usually, the formal statements both covered the statutory requirement to address the 'special needs' of Maori and embedded the Government's 1992 declaration on Maori health policy.

These top-level prescriptions were then supposed to cascade through the funding agreements and purchasing contracts to the delivery of health services to Maori. The various Crown health agencies could also establish specific policies of their own that might affect Maori or be applied to services geared to Maori needs. The Central RHA's 1994 site guarantee of Napier Hospital and its withdrawal in 1996 are examples of such policies.

The obligations created were none the less fundamentally a closed loop of interlocking accountabilities within the machinery of government. Maori, like all other citizens, were not parties to the contractual arrangements except distantly through the ballot box. Should a Healthcare Hawke's Bay, for instance, fail to comply with a stipulation in its purchase contract to present its hospital signage in te reo Maori as well as English, it was the Central RHA that was entitled to call it to account, not local Maori.

The fulfilment of the Crown's Treaty obligations is, however, a matter not primarily of contract compliance but of acting consistently with Treaty principles, to which contract compliance may often contribute. Expanding the hypothetical example above, a national policy objective geared to a Treaty obligation (improving service responsiveness to Maori) might be translated through a sector strategy (respecting tikanga Maori in hospital services) and a sub-sectoral programme (providing public information in te reo Maori) into a component of a hospital action plan (having bilingual signs).

We make the following observations:

- ▶ The formal architecture of accountability should not detract from the substantive obligations of the Crown that the accountability regime is supposed to deliver. (Whether a command- or contract-based system delivers the signage is immaterial.)
- ▶ Failures at any level are ultimately traceable to the top, but may be so attenuated by distance as to be rendered insignificant. (Direct responsibility for missing signage fades many steps before the Minister's door.)
- ▶ If a failure is not detected, and thus is not open to be remedied, the accountability system may itself be brought into question. Here, the indirect linkages of a contract-based system place much greater emphasis on performance monitoring and contract compliance. (Picking up on a hospital's missing signage would depend on the funder having a detailed monitoring regime in place.)
- ▶ There is no limitation of vertical scale in the scrutiny of policies, acts, and omissions of the Crown in terms of Treaty principles. But the narrower the scope and the smaller the prejudice arising, the more limited the significance of the breach in question. (While missing signage might be held to breach Treaty principles, all other aspects of the policy or programme might be working well.)
- ▶ There is no limitation of geographical scale either. But a localised failure of performance or monitoring has no automatic bearing on a failure elsewhere. (The missing signage, and the failure to detect its absence, might be restricted to the hospital in question.)
- ▶ Conversely, evidence of more widespread systemic failure may point to a local failure too. (If the sector strategy was never implemented, the hospital in question was less likely to have put up the signage.)

The claim before us concerns a local group of claimants, representing Ahuriri Maori, and two hospitals, in Napier and Hastings. Commonly, the claimants rely on locally specific evidence but on some issues invoke wider failures or locate responsibility at higher levels of the health system. In both respects, the contractual and accountability arrangements between the various Crown agencies become relevant to the Crown's fulfilment of its Treaty obligations.

In general, we consider that inter-agency contracts can be plausibly interpreted as instruments of the policy they were designed to implement. In so far as the contracts detailed actions promoting the Government's declared policy on Maori health, it was incumbent upon Crown contractors, acting in good faith, to make every reasonable effort to meet their obligations. Equally, the contracting agencies were under an obligation to ensure that the contracted services and quality standards for Maori were delivered.

The test of 'reasonable effort' is in our view a critical criterion. It would plainly not be reasonable to expect perfect fulfilment to the last subclause of every complex contract. On the other hand, a habit of treating contracts as optional rhetorical exhortations able to be disregarded at will might bring the good faith of both the parties to it into question. It is also apparent that, the more detailed the promise, the more precise the possible grounds of grievance arising from any failures to deliver.

We consider that the obligations respecting Maori health that are listed in the third amended statement of claim provide, on the whole, a reasonable summary of the Crown's general Treaty and policy commitments since 1992, and in many respects before that date as well.²²⁷

7.4.3 Were adequate Treaty protection mechanisms incorporated into health legislation?

Extract from the statement of claim:

12.21 The Crown has omitted to incorporate adequate Treaty protection mechanisms within the legislative framework for health restructuring.

Statutory protection has two modern aspects. The first concerns surplus land resulting from the disposal of health agency assets. Our *findings* are:

- ▶ that, prior to 1993, neither health nor general legislation provided for the interests of Maori claimants in the land of health agencies exercising delegated authority;
- ▶ that, in 1992, the Government adopted a declared policy position that all such surplus assets would be subject to the general Treaty protection mechanism applicable to the disposal of Crown lands;
- ▶ that, between 1993 and 2000, the health sector legislation neither obliged CHES to take account of the Crown's Treaty obligations in alienating their land nor provided the shareholding Ministers with adequate powers to ensure that the CHES fulfilled those obligations;
- ▶ that the Public Health and Disability Act 2000 made all land alienations and leases of more than five years by health agencies exercising delegated powers subject to ministerial approval and required community consultation by district health boards, which by implication would include appropriate consultation with Maori; and
- ▶ that, in making decisions on any such land alienations, the Minister of Health was bound by the Crown's undertaking under the Public Health and Disability Act 2000 to 'recognise and respect the principles of the Treaty of Waitangi'.

Our findings as to *Treaty breaches* are:

- ▶ that the health reform legislation did not provide the Minister of Health sufficient powers over land disposals by CHES to ensure that the Crown's Treaty obligations were met;
- ▶ that Healthcare Hawke's Bay undertook no alienations at the Napier Hospital site that affected the Crown's obligations to the present claimants; and
- ▶ that the Public Health and Disability Act 2000, by providing for ministerial oversight, established direct Crown responsibility for protecting the interests of Treaty claimants in health agency land, including the interest of the present claimants in any proposed disposal of the Napier Hospital site.

The second aspect of statutory protection is the extent of recognition of the Treaty in health sector legislation. Our *findings* are:

227. Claim 1.57(c), paras 11.1–11.8

7.4.4

- ▶ that statutory recognition of the Treaty is fundamental to the accountability of the Crown's Treaty obligations;
- ▶ that health legislation prior to 1993 did not recognise the Treaty;
- ▶ that the Health and Disability Services Act 1993 did not mention the Treaty either, but it did place Maori in a 'special needs' category on the same footing as 'other particular communities or people';
- ▶ that the Government was obliged to include these special needs in its statement of objectives for health services to be funded by its purchaser agencies; and
- ▶ that, while not requiring the Crown to act consistently with the principles of the Treaty, the Public Health and Disability Act 2000 gave explicit recognition to the Treaty and incorporated Treaty principles, especially that of partnership, into a number of its operational provisions.

Our findings as to *Treaty breaches* are:

- ▶ that the controlling health sector legislation applicable during the 1980s and 1990s did not incorporate any explicit recognition of Treaty principles, but neither did it prescribe any actions inconsistent with Treaty principles or prevent the Crown from meeting its Treaty obligations; and
- ▶ that the Public Health and Disability Act 2000 commits the Crown and its health agencies to a number of specific obligations consistent with the principles of *partnership* and *equity*.

7.4.4 Is the Napier Health Centre adequate and appropriate for Maori health needs?

Extract from the statement of claim:

12.8 The health clinic under construction in Napier is inadequate and inappropriate to meet Maori health needs at Ahuriri and the obligations of the Crown under the 1851 Ahuriri transaction.

The Napier Health Centre was still under construction at the time of our hearings in mid-1999. Our review has therefore been restricted to the design and prospectus of the centre. On the cultural values associated with the site by Maori, our *findings* are:

- ▶ that no evidence was advanced as to how far the negative cultural associations with the site perceived by claimant witnesses might be shared by Maori residents of Napier Hospital's catchment zone; and
- ▶ that we lack any factual basis for arriving at conclusions one way or the other.

On the suitability of the centre's design, our *findings* are:

- ▶ that it is difficult to discern from the site plan and service lists how Healthcare Hawke's Bay intended to provide either for Maori service providers or for the needs of Maori patients; and
- ▶ that the Maori provider of the whare whanau service at Napier Hospital found the layout of the centre too cramped to relocate there.

On geographical access to the centre, our *findings* are:

- ▶ that the site in Wellesley Road is about half a kilometre closer to the suburbs of Maraenui and Marewa where most Ahuriri Maori reside, and is on the flat rather than up a steep hill;
- ▶ that the great majority of Ahuriri Maori in fact live between 1.5 and three kilometres from the centre and thus within walking distance or a few minutes' driving of it; and
- ▶ that geographical access to the centre for most Ahuriri Maori is easier than to the hill site.

On the services provided for Maori through the centre our *findings* are:

- ▶ that, according to Healthcare Hawke's Bay, it would continue to provide almost all the services specified for Napier in the Central RHA's 1994 and 1996 purchasing decisions, including those previously located in Napier Hospital;
- ▶ that we lack evidence on how well suited the range and capacity of these services were for meeting the health needs of Ahuriri Maori; and
- ▶ that the overall adequacy for Maori of the centre's services is also affected by the distance barrier to other services relocated to Hastings.

Our findings as to *Treaty breaches* are:

- ▶ that, while Healthcare Hawke's Bay failed to consult Ahuriri Maori and missed a worthwhile opportunity to build partnerships with Maori health care providers, in general the location and service configuration that it adopted for the centre do not appear to have been in breach of Treaty principles; and
- ▶ that the design of the centre may have made insufficient accommodation for tikanga Maori but that, on this and other aspects, the evidence is insufficient for us to arrive at particular conclusions.

7.4.5 Were Maori adequately represented at decision-making levels in Hawke's Bay's Crown health agencies?

Extract from the statement of claim:

12.6 The Crown has failed to ensure adequate representation of Maori in the relevant Crown health entities to ensure that Maori have an effective say in the decision making structure affecting their health and well being.

Both the Hawke's Bay Hospital Board (to May 1989) and the Hawke's Bay Area Health Board (June 1989 to July 1991) were governed by locally elected boards. Our *findings* are:

- ▶ that the first-past-the-post electoral regime meant that few Maori candidates volunteered and fewer, if in fact any, were elected to the board;
- ▶ that not many Maori professionals were appointed to senior clinical or managerial posts;
- ▶ that, nearly a century after the Maori health reform campaign inspired by graduates of Hawke's Bay's Te Aute College, effective Maori representation at the governance and managerial levels was virtually absent in the State health care agency in Hawke's Bay;

- ▶ that, in the late 1980s, the Department of Health began to encourage improved Maori representation amongst professional staff and on the board, and that in 1989 the Crown took statutory powers of appointment, which the Minister of Health used to appoint Maori to area health boards, presumably including the Hawke's Bay Area Health Board; and
- ▶ that the Hawke's Bay Area Health Board established an advisory Maori health committee in 1990, but otherwise had made little progress before the board's abolition in 1991.

Our finding as to *Treaty breaches* is:

- ▶ that the failure of the Crown over a prolonged period to rectify the imbalance of Maori representation on the Hawke's Bay Hospital Board was, in our view, inconsistent with the principles of *partnership* and *equity*.

In 1993, the restructuring into purchaser and provider bodies replaced local electoral accountability with centrally appointed boards. In respect of the Central RHA, our *findings* are:

- ▶ that the purchaser board, whether regional or national, was too remote for local Maori organisations to exert much influence over it, even at iwi level;
- ▶ that the addition of three Maori 'consumer' representatives to the Central RHA's advisory committee, Te Roopu Awhina, even if they were tribally sanctioned, was no substitute for a properly mandated and representative Maori consultative forum; and
- ▶ that the only substantive input to the Central RHA from Hawke's Bay Maori came via the energetic but ad hoc programme of district and marae consultations conducted by the authority's Maori health group.

In respect of Healthcare Hawke's Bay, our *findings* are:

- ▶ that the Crown Company Monitoring Advisory Unit, which advised on the appointment of board directors, had no direct connection with Maori communities and no means of canvassing representative Maori opinion;
- ▶ that Maori appointees, like other directors, were accountable not to Maori constituencies but to the Crown for the general interests of the CHE;
- ▶ that, despite having a Maori member, in all the key decisions concerning Napier Hospital, Maori concerns scarcely featured in the board's discussions;
- ▶ that the advisory Maori health committee established in December 1994 was more than a token body, having tribally elected representatives of the four Ngati Kahungunu taiwhenua, including Te Taiwhenua o Te Whanganui a Orotu, and regular meetings with board and manager attendance;
- ▶ that, on occasion, the committee did achieve some impact, one instance being the creation of the post of Maori health manager at Hawke's Bay Hospital in 1996 and its subsequent elevation to senior level;
- ▶ that the committee none the less had no power, a vaguely defined mandate, no formal agreements with iwi or other Maori bodies, and for several years poor reporting back procedures from management, who seem to have treated it mainly as an ad hoc source of cultural advice upon their initiative; and

- ▶ that, for the big decisions concerning Napier Hospital and the Napier Health Centre, the committee was kept at arm's length.

Looking at the purchaser and provider agencies together, our *findings* are:

- ▶ that local democracy in health agency governance does not automatically assure adequate Maori representation;
- ▶ that the replacement between 1991 and 2000 of locally elected boards by centrally appointed boards did not remove the Crown's obligation to assure adequate Maori representation in agency decision-making; and
- ▶ that ad hoc Maori advisory committees, however well intentioned, cannot be expected to substitute entirely for properly constituted channels of direct communication with Maori organisations representing the rangatiratanga of Maori communities.

Our findings as to *Treaty breaches* are:

- ▶ that the CHE board appointments regime run by CCMAU conformed to the principle of *equity* but breached the principle of *partnership*;
- ▶ that the failure of the statutory framework until 2000 to provide for formal channels of communication between purchaser and provider agencies on the one hand and representative Maori organisations on the other breached the principle of *partnership*;
- ▶ that, in failing to vest sufficient authority in their advisory committees and, in the case of the Central RHA, adequate representation, the Central RHA and Healthcare Hawke's Bay breached the principle of *partnership*; and
- ▶ that the explicit provisions in the Public Health and Disability Act 2000 for ensuring proportional Maori representation on district health boards and standing committees are fully consistent with the principle of *partnership*.

Our findings as to *prejudice* are:

- ▶ that Ahuriri Maori, whether directly or through a larger Maori grouping, were inadequately represented or not represented at all on the governing bodies of the district health agencies on which they relied for most State-provided health services;
- ▶ that they were denied the opportunity to have their views considered and to influence decisions affecting their health services, notwithstanding their greater need for such services; and
- ▶ that their exclusion from health sector governance weakened their institutional ability to exercise rangatiratanga, and thus to participate effectively in other partnership processes such as consultation.

7.4.6 Did the Hawke's Bay health agencies sufficiently promote Maori workforce participation?

Extract from the statement of claim:

12.10 Healthcare Hawke's Bay and the Health Funding Authority and their predecessors have not offered Maori in Ahuriri or Hawke's Bay an opportunity through effective consultation, participation, and representation to effectively join in the decision making processes affecting their health and health care.

The claimants' grievances concerning representation and consultation are replicated in other clauses of their statement of claim (see sections 7.4.5, 7.4.8). Here, we restrict our findings to the question of participation, which we interpret as Maori participation in the workforces of health agencies. We concluded earlier that the Hawke's Bay Hospital Board and the State health programmes in Hawke's Bay employed very few Maori health workers until the 1930s. During the second half of the century, Maori began to enter nursing, community, and hospital support services. For the post-1993 period, our *findings* are:

- ▶ that, from 1992, the Government's national Maori health policy promoted equal employment opportunities and greater Maori workforce participation at all levels;
- ▶ that funding agreements and purchase contracts articulated with increasing precision a range of obligations for the Central RHA/HFA and Healthcare Hawke's Bay;
- ▶ that the Central RHA/HFA had moved by about 1997 to implement the policy fully;
- ▶ that, in late 1996, Healthcare Hawke's Bay had yet to formulate an equal employment opportunity policy and appears not to have accorded a high priority to improving the participation of Maori in the workforce;
- ▶ that, at the time of our hearings in mid-1999, Healthcare Hawke's Bay's board and senior managers were only just beginning to recognise the scope of their obligations to promote Maori participation at all levels of their organisation; and
- ▶ that little concrete information is available on the performance of the two agencies in improving Maori staff participation, in part because the Tribunal's commissioned researcher was denied the opportunity to interview their staff (see section 2.6).

Our findings as to *Treaty breaches* are:

- ▶ that, in the case of the Central RHA/HFA, the lag between policy and performance in taking steps to improve Maori workforce participation brought its commitment into question in the early years, but taken over the whole period may have been reasonable in the circumstances, given that it was starting from scratch as a new type of agency; and
- ▶ that the lack of effort made by Healthcare Hawke's Bay to improve the participation and development of its Maori workforce breached the principles of *partnership* and *equity*.

Our finding as to *prejudice* is

- ▶ that the inadequate participation of Maori in the workforce, especially at senior levels, made the development of culturally appropriate services for Maori patients at both Napier and Hastings Hospitals more difficult.

7.4.7 Did Crown health agencies give sufficient priority to the improvement of Maori health in their service planning and delivery?

Extract from the statement of claim:

12.12 The Crown and Crown health entities have failed to provide for Maori health as a health gain priority in their health service planning and delivery.

12.9 Healthcare Hawke's Bay and its predecessors have not considered the health care and health status of Maori as a significant issue in their service delivery planning.

As the century-long hospital board era entered the 1980s, Maori health status, although markedly improved, still lagged far behind that of Pakeha according to most indicators. Our *findings* are:

- ▶ that the Hawke's Bay Hospital Board deviated little from the monocultural orthodoxy that subsumed the health needs of Maori into those of the general population;
- ▶ that, responding in part to the Treaty perspective being articulated by the Department of Health in the late 1980s, the Hawke's Bay Area Health Board began to deploy a few more resources into local health services in Maori communities and suburbs with high Maori densities;
- ▶ that improving Maori health was a cornerstone commitment of the Maori health policy that accompanied the 1993 health reform;
- ▶ that this overarching goal featured in most statements of the Crown's health objectives and was translated into components of funding agreements, purchase contracts, statements of intent and strategic plans;
- ▶ that, by the end of the decade, the HFA had built tools to integrate Maori health gain priorities into its planned expenditure on mainstream health services and was targeting nationally a number of causes of ill-health to which Maori were heavily exposed;
- ▶ that the absence of hard planning and performance data in the annual reports of the various agencies is singularly unhelpful for evaluating anything other than financial performance;
- ▶ that insufficient data has been provided for us to make a general assessment of the extent to which health expenditure was adjusted to address the Maori health gain priority, either nationally or in Hawke's Bay;
- ▶ that nevertheless the disposition of national health expenditure on Maori points to small proportions going to Maori providers and Maori-specific programmes, and to an overall share that is below the proportion of Maori in the general population, despite their much greater health needs;
- ▶ that, with a handful of exceptions, there was little evidence of expansion in those community programmes directed at significant causes of Maori ill-health in Napier;
- ▶ that, apart from providing cultural support to Maori patients through its Maori health services staff, Healthcare Hawke's Bay seems to have made no particular provision for Maori in planning its mainstream services; and

7.4.8

- ▶ that, at the same time, the lack of information on how Healthcare Hawke's Bay's managers set about planning the services that they were contracted to deliver makes it difficult to arrive at firm conclusions.

Our findings as to *Treaty breaches* are:

- ▶ that, although it took more than five years to develop a comprehensive planning methodology for addressing the statutory Maori health gain priority, the development period was not unreasonable in light of the structural disruptions and the pioneering role of the purchaser agencies;
- ▶ that, by the late 1990s, the Maori health gain priority was adequately integrated into health expenditure planning methods;
- ▶ that, although committing resources to identified targets was a key implication of the general Government aim of reducing Maori health disparities, insufficient information is available on the volume and allocation of health expenditure in Hawke's Bay to enable us to reach a definite conclusion on how adequately the health agencies met their obligations; and
- ▶ that nevertheless the available evidence suggests a failure both nationally and in the Napier area to match expenditure and targeting to Maori health needs, and a breach by the Crown of the principles of *active protection* and *equity*.

Our finding as to *prejudice* is:

- ▶ that, at least until the late 1990s, it is likely that insufficient resources were committed to addressing the health needs of Ahuriri Maori and that the targeting of those resources was deficient.

7.4.8 Did the Hawke's Bay health agencies adequately consult with Maori on their health service needs and delivery?

Extract from the statement of claim:

12.15 The Crown and Crown health entities have consistently failed to consult with Maori over changes in health delivery and outcomes in Ahuriri and Hawke's Bay.

We have addressed the lack of consultation with local Maori on the major hospital decisions in other sections. Here, we consider the extent of consultation with Maori communities on their health needs and service priorities. The 1993 health reform placed on the purchaser a statutory obligation to consult communities on their health needs. Our *findings* are:

- ▶ that, from the outset, the Central RHA, through its Maori health unit, embarked on an active and ongoing round of marae-based consultation;
- ▶ that it held a number of district-wide and local hui in and near Hastings, and a couple at rural marae north of Napier, but none in Napier itself, despite Napier having the second largest Maori population in Hawke's Bay; and

- ▶ that the only hui the Central RHA held in Napier was a one-off component of the Napier–Hastings needs analysis and that the authority’s contacts with Ahuriri Maori were at best tenuous and occasional.

The 1993 health reforms did not place any statutory obligation upon providers such as Healthcare Hawke’s Bay to consult. Our *findings* are:

- ▶ that the purchase contracts that Healthcare Hawke’s Bay signed annually with the Central RHA and its successors imposed on it specific obligations to consult with local Maori;
- ▶ that these obligations included, from July 1995, carrying out consultation on applying Treaty principles, on integrating tikanga Maori into mainstream services, and, from July 1997, on significant changes to the configuration of local services;
- ▶ that, in mid-1994, Healthcare Hawke’s Bay conducted one Treaty-based consultation on maternity services for Maori women;
- ▶ that this latter initiative appears to have been an exception to a pattern of non-consultation; and
- ▶ that senior managers treated meetings of the Maori health committee and informal communication by the Maori health manager as a substitute for properly conducted consultation with representative Maori organisations.

Our findings as to *Treaty breaches* are:

- ▶ that, although its consultation programme was proactive, in failing to ensure regional balance – in particular, by including Ahuriri Maori – the Central RHA breached the principle of *partnership* and the duty of *consultation*;
- ▶ that, by failing to meet its contractual obligations to consult local Maori, Healthcare Hawke’s Bay breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*; and
- ▶ that, in failing to consult on issues significant to local Maori, irrespective of the lack of a statutory obligation to do so, Healthcare Hawke’s Bay breached the principle of *partnership* and the duty of *consultation*.

Our findings as to *prejudice* are:

- ▶ that Ahuriri Maori were denied sufficient opportunity to communicate their views and health needs to the State purchaser;
- ▶ that the Napier health services on which Ahuriri Maori relied were reconfigured without their effective input and, they believed, to the detriment of those health services; and
- ▶ that Healthcare Hawke’s Bay lacked proper advice from Ahuriri Maori on Treaty perspectives and tikanga Maori to develop culturally appropriate hospital services for local Maori.

7.4.9 Were appropriate Maori structures developed for the delivery of mainstream services to Ahuriri Maori?

Extract from the statement of claim:

12. . . .the Crown and Crown health entities . . . have failed to give effect to the principles of the Treaty and Maori health policies including failure to deliver health services to Maori in Ahuriri and Hawke's Bay in a manner consistent with tikanga Maori—

12.11 The Crown and Crown health entities have failed to provide for appropriate Maori structures for the provision of health and hospital services for Maori in Ahuriri and Hawke's Bay.

Notwithstanding the rapid emergence of Maori health care providers during the 1990s, Maori in Napier and throughout Hawke's Bay remained overwhelmingly dependent on the State health system both for hospital treatment and for primary or community-based services. On the establishment of Maori structures at the hospitals, our *findings* are:

- ▶ that at neither Hastings nor Napier Hospital had the hospital board made any special provision for the cultural needs of Maori patients and their whanau before its demise in 1989;
- ▶ that the area health board appointed its first 'Maori health consultant' only in 1991, and Healthcare Hawke's Bay had only a couple of Maori posts in its community services section until 1995;
- ▶ that whare whanau were established on Maori initiative at both hospitals in the early 1990s and were sustained largely by voluntary Maori effort, at Napier Hospital until its closure and at Hastings Hospital until 1996;
- ▶ that not until 1996 did Healthcare Hawke's Bay appoint a Maori health manager and establish a Maori health service at Hastings Hospital, while Napier Hospital was apparently ignored until its closure;
- ▶ that the Maori health service was a positive development but was insufficiently supported by the Central RHA/HFA and in 1999 was still limited in capacity and scope;
- ▶ that for several years the Central RHA expected just two staff to cover all consultation with Maori and all purchasing from Maori providers across the entire region;
- ▶ that only from 1996 was its Maori health group staff expanded and refocused towards service development and strategic planning across all purchasing; and
- ▶ that the HFA's efforts to build up Maori units providing specialised advice, services, planning and Maori staff networking had achieved significant advances by the end of the 1990s.

On the incorporation of tikanga Maori into mainstream hospital services, our *findings* are:

- ▶ that the 1992 national Maori health policy committed the State health sector to providing 'culturally appropriate' mainstream services;
- ▶ that it nevertheless took several years for the Central RHA to articulate a detailed set of quality standards for services to Maori and to incorporate them into its annual purchase contracts;
- ▶ that it took rather longer for Healthcare Hawke's Bay to integrate the quality standards into its clinical practice and patient care, a process that had barely begun by the time of our hearing of the Crown's evidence in July 1999;

- ▶ that Government prescriptions tended to give insufficient operational guidance to front-line professionals and that little work had been done on developing practical guidelines for implementation;
- ▶ that the targeting mechanisms in purchase contracts were narrow and their kaupapa Maori components underfunded;
- ▶ that attempts to implement the Ministry of Health's 1995 cultural guidelines *He Taura Tieke*, contractually required from 1997, initially failed for lack of managerial support; and
- ▶ that clinical leaders and managers did not give high priority to achieving culturally appropriate service standards across all mainstream services, formal endorsement arriving, at least in principle, only in 1999.

Our findings as to *Treaty breaches* are:

- ▶ that the Central RHA's failure to employ sufficient staff to sustain its Maori health unit's assigned objectives, especially in Maori provider development, verged upon being inconsistent with the principle of *partnership* and the duty of *good faith conduct*;
- ▶ that the limited and tardy efforts of Healthcare Hawke's Bay to develop its Maori health service breached the principles of *active protection* and *options*;
- ▶ that the failure to ensure by statutory or other means before July 1993 that hospital and area health boards implemented culturally appropriate services for Maori breached the principles of *active protection* and *options*;
- ▶ that the eventual incorporation by the Central RHA/HFA of specific quality standards into their CHE purchase contracts provided an adequate framework for CHES to develop culturally appropriate services;
- ▶ that nevertheless the failure to develop operational guidelines for implementing the policies and standards breached the principles of *active protection* and *options*; and
- ▶ that the failure of Healthcare Hawke's Bay to make a serious effort to implement kaupapa Maori quality standards in mainstream services at either Napier or Hastings Hospital before 1999 breached the principles of *active protection* and *options*.

Our findings as to *prejudice* are:

- ▶ that the short-staffing of the Central RHA's Maori health programme contributed to insufficient consultation with Ahuriri Maori, to limited support being given to the development of Maori providers, including in Napier, and to inadequate monitoring of Healthcare Hawke's Bay's services to Maori;
- ▶ that, under the hospital and area health board regime, monocultural practices persisted as a significant barrier to Ahuriri Maori gaining the full benefits of hospital treatment; and
- ▶ that the slow and incomplete introduction of culturally appropriate services at Napier and Hastings Hospitals perpetuated that barrier and caused distress to Ahuriri Maori patients and their whanau.

7.4.10 Did Crown agencies adequately assess the health needs of Ahuriri Maori?

Extract from the statement of claim:

12.13 The Crown and the Crown health entities including the Crown Company Monitoring Advisory Unit and Healthcare Hawke's Bay have not analysed or analysed adequately changes in Maori health in Ahuriri or Hawke's Bay.

During the 100 years of the Hawke's Bay Hospital Board, little information was collected or research undertaken on the health situation of Ahuriri Maori. Our *findings* are:

- ▶ that the Department of Health's health status review of Hawke's Bay in 1989, and successive official publications in the 1990s, contained only brief fragments of information on the health status of Maori;
- ▶ that the Central RHA's needs analysis of Hastings and Napier, published in 1996 as *Nga Ara Poutama*, compiled an extensive range of community opinion and data but this was drawn mainly from institutional sources – population censuses, hospital admissions, causes of death, and so on – rather than primary data collected in field surveys; and
- ▶ that, in all the evidence presented on this claim, there is no sign of a thorough empirical investigation of the much poorer health status of Ahuriri and Hawke's Bay Maori and its causes, and little evidence that insights from research on Maori health status undertaken in other areas have been taken into account.

Our findings as to *Treaty breaches* are:

- ▶ that, in failing to inform themselves adequately of the health situation of Ahuriri Maori by means of empirical research or by applying the insights of previous research from similar contexts, successive Crown health agencies have breached the principle of *active protection*; and
- ▶ that, in failing to publish sufficiently detailed and well-founded health status information on the communities they serve – in this case, Maori communities in the Napier area – the responsible Crown health agencies have breached the principle of *partnership*.

Our findings as to *prejudice* are:

- ▶ that, in the absence of adequate local information, Crown health agencies have not sufficiently adapted their services, especially in the field of primary health care, to the health needs of Ahuriri Maori; and
- ▶ that Ahuriri Maori have lacked sufficient information on their health status to participate fully as citizens and as partners of the Crown.

7.4.11 Did monitoring systems adequately assure agency performance and provide for Maori input?

Extract from the statement of claim:

12.14 The Crown and Crown health entities have failed to involve Maori in the monitoring or

development of monitoring systems for the provision of health services and health outcomes for Maori provided by the Crown health entities.

The 1993 health reform created a network of contract-based relationships between the various State agencies. The network's corollary was effective monitoring to ensure performance and assess outcomes, in particular for Ahuriri Maori. In respect of service performance, our *findings* are:

- ▶ that, in their annual reports on performance monitoring, national and regional agencies rarely considered information on local programmes or on local components of regional and national programmes, and then only by way of snapshot illustration rather than detailed analysis;
- ▶ that, in respect of most hospital services and community programmes, both the inter-agency performance monitoring system and the published annual reports provide at best broad, not specific, assurance to local Maori communities;
- ▶ that, apart from ad hoc cultural audits of CHES and informal contact with their Maori health managers, it appears that the Central RHA developed no formal methods of monitoring the increasingly detailed quality standards in its purchase contracts with CHES;
- ▶ that the Central RHA carried out only one perfunctory cultural audit of Healthcare Hawke's Bay, did not follow it up, and did not monitor the development of culturally appropriate services, let alone exhort or enforce compliance;
- ▶ that no information is available on any internal monitoring that Healthcare Hawke's Bay may have undertaken; and
- ▶ that Maori staff at the Ministry of Health, Central RHA/HFA and Healthcare Hawke's Bay were involved in such monitoring as was designed and carried out, but representative Maori organisations, including Te Taiwhenua o Te Whanganui a Orotu, had no formal role.

On the monitoring of health outcomes for Maori, our *findings* are:

- ▶ that significant advances were made during the 1990s in developing monitoring methodologies at the national level, but at the local level monitoring data were limited mainly to hospital patients and causes of death, and thus to people with acute conditions;
- ▶ that ethnicity data were largely limited to hospital admissions and discharges and were inaccurate, unpublished, and not actively used for monitoring Maori health outcomes;
- ▶ that hospital patient satisfaction monitoring by the Crown Company Monitoring Advisory Unit collected ethnicity data but made little use of it to assess Maori perceptions;
- ▶ that the monitoring of health outcomes for Maori from primary health services appears to have been non-existent, at least at the local level; and
- ▶ that, in consequence, few data are available on health outcomes for Ahuriri Maori.

Our findings as to *Treaty breaches* are:

- ▶ that the Central RHA's failure to monitor effectively Healthcare Hawke's Bay's performance of its Treaty and contractual obligations to provide culturally appropriate services breached the principles of *active protection* and *options*;

7.4.12

- ▶ that the Central RHA/HFA's reliance on informal persuasion and its reluctance to enforce strict contract compliance was understandable while developing and bedding in the new purchasing system, but that its failure to exert any leverage on Healthcare Hawke's Bay over a prolonged period amounted to a breach of the principles of *active protection* and *options*;
- ▶ that the failure to address adequately the known problems and limitations of ethnicity data and health outcome monitoring breached the principles of *active protection* and *equity*; and
- ▶ that the failure to involve representative local Maori organisations in designing or assisting the performance monitoring breached the principle of *partnership*.

Our findings as to *prejudice* are:

- ▶ that the Central RHA's failure to monitor and ensure compliance with the kaupapa Maori quality standards that it prescribed in its purchase contracts resulted in poorer hospital service for Ahuriri Maori patients and whanau and decreased the effectiveness of those services;
- ▶ that, similarly, the failure to ensure that the required consultation obligations were fulfilled led to a culture of non-consultation becoming entrenched and Ahuriri Maori being excluded from input into decisions affecting services on which they relied; and
- ▶ that the low priority and lack of Maori input, at least until 1999, for the monitoring of health outcomes for Maori retarded the ability of the health sector to improve its performance and its responsiveness to Maori.

7.4.12 Was sufficient assistance provided to local Maori health service provider development?

Extract from the statement of claim:

12.16 The Crown and Crown health entities have failed to assist or assist adequately Ahuriri Maori to develop their own capacities to provide health care.

The Maori Councils Act 1900 opened a small door, briefly, to self-help public health reform by Maori communities, but it offered minimal resources by way of assistance. As late as the early 1980s, that door was still firmly closed. It opened a little under the Hawke's Bay Area Health Board, but the assistance given to Hawke's Bay and Napier providers amounted to little more than small ad hoc grants for specific projects.

Assisting Maori providers was a high-profile objective of the 1993 health reform, part of a Government policy of diversifying the range of health providers in a competitive health services market. Our *findings* are:

- ▶ that at first the Central RHA rapidly multiplied the number of contracted Maori providers, but they were mostly community-based, small and scattered, faced a compliance burden, and received little development assistance;
- ▶ that these problems were to some extent addressed in the late 1990s, in particular, with separate funding for training and capacity-building;

- ▶ that the Maori provider programme was generally welcomed by Maori, was developed in consultation with Maori, was community focused, and was innovative to the extent of pilot funding a Napier-based traditional healer providing rongoa Maori;
- ▶ that Maori providers still received a small fraction of the health budget, were haphazardly dispersed, lacked service integration and infrastructure, and, to some extent, had to compete with each other as well as the CHES;
- ▶ that only three Maori providers located in Napier secured contracts between 1993 and 1999, and they were for small and disconnected services;
- ▶ that services provided in Napier by external Maori providers were also narrow in scope;
- ▶ that, although Healthcare Hawke's Bay did collaborate in particular programmes, for instance, with Te Kupenga Hauora at Napier Hospital, it seems to have regarded itself as in competition with Maori providers; and
- ▶ that the statutory requirement, from 2001, for district health boards to assist Maori health providers may help to promote partnership between State and Maori providers.

Our findings as to *Treaty breaches* are:

- ▶ that, up to the end of the hospital board era in Hawke's Bay, an effective partnership with Maori as providers to their own communities barely existed, the result of a statutory and policy regime that in this respect breached the principle of *partnership*;
- ▶ that, for all its flaws and limitations, the Maori provider programme as it developed during the 1990s did not breach Treaty principles – to the contrary, it affirmed the principles of *partnership* and *options* as well as the duty of *consultation*; and
- ▶ that the retarded state of the scheme in Napier and the failure to establish a relationship with a representative Maori organisation, in this case, Te Taiwhenua o Te Whanganui a Orotu, breached the principle of *partnership*.

Our findings as to *prejudice* are:

- ▶ that, with minor exceptions, Ahuriri Maori have not been empowered to provide primary health care services for their own communities; and
- ▶ that Maori providers in Napier have not received adequate assistance for their service development.

7.4.13 Did the purchaser–provider system restrict health service benefits for Ahuriri Maori?

Extract from the statement of claim:

12.20 The creation of a separation of funder and provider roles . . . brought about through the health restructuring has not worked to the benefit of Maori in Ahuriri or Hawke's Bay.

Over the past two decades, the health sector has undergone a succession of radical transformations. It is beyond the scope of this Tribunal either to express a system preference or to review the performance of the purchaser–provider model as a whole. Our *findings* are:

7.4.14

- ▶ that purchasing and ownership functions were not aligned in respect of the Crown's Treaty obligations and Maori health objectives;
- ▶ that, in consequence, Healthcare Hawke's Bay negotiated its purchase contract with the Central RHA but its statement of intent and business plan, the primary accountability documents, with its shareholding Ministers, who were advised by CCMAU;
- ▶ that, while the purchase contract reflected the Crown's health objectives in increasing detail, those objectives, including improving Maori health and honouring Treaty obligations, received much less attention, if any, in the accountability documents;
- ▶ that the fundamental State sector change from command- to contract-based relationships between Ministers and Crown agencies made effective monitoring an indispensable guarantor of performance;
- ▶ that the absence of effective monitoring of Healthcare Hawke's Bay raised multiple risks of its non-compliance with the official Maori health objectives;
- ▶ that the separation of purchaser from provider created space for State support to be given to Maori providers;
- ▶ that, in practice, only small resources went to Maori providers in Napier and little effort went into building an effective local partnership to improve the health of Ahuriri Maori;
- ▶ that the competitive provider model worked against partnership arrangements between State and Maori providers; and
- ▶ that Healthcare Hawke's Bay was not thereby precluded from ad hoc cooperation with Maori providers to their mutual advantage, but lacked either formal obligations or incentives to foster health service provision by Maori for Maori.

Our findings as to *Treaty breaches* are:

- ▶ that the structural flaws in the purchaser-provider model were not in themselves inconsistent with Treaty principles; and
- ▶ that particular policies, acts or omissions arising from the health sector reforms are, as indicated in previous sections, open to scrutiny in terms of their consistency with Treaty principles.

7.4.14 Was there a significant gap between policy and practice concerning Maori health improvement?

Extract from the statement of claim:

12.18 Since the beginning of the health restructuring process there has been a consistent gap between political statements, Maori health policy, and the practice of Crown health entities, including Healthcare Hawke's Bay, CCMAU, and the HFA (or their predecessors) to the detriment of Maori in Ahuriri and Hawke's Bay.

We do not consider that the gap between policy and practice, if established, can constitute a grievance distinct from the particular circumstances that define it. These have been fully

elaborated in other clauses of the statement of claim and analysed elsewhere in this report. We accordingly make no findings here, and reserve our general comments for section 7.5.

7.5 FINDINGS ON PREJUDICIAL EFFECTS

Ahuriri Maori entered the modern era of health sector reform in a better state of health, generally, than half a century before, but they still lagged far behind non-Maori according to many indicators of ill health and mortality. We consider health outcomes in chapter 8. Here, we review the extent to which health sector agencies moved to address the large acknowledged gap, in this case affecting Ahuriri Maori.

The successive waves of structural reform in the health sector inevitably took their toll on its ability to deliver concrete results. Each disruption stalled previous initiatives and required time for the new organisations to get up to speed. The 1993 reform was perhaps the most far-reaching, inaugurating fundamentally new types of health agency across the board and a complete overhaul of the accountability relationships between them. The latest reform, inaugurated in 2001, was not far behind.

We do not of course question the right of democratically elected governments to initiate reforms. The dislocations in the health sector did, however, have concrete impacts on health services for Ahuriri Maori. The Hawke's Bay Hospital Board was derailed before it had much chance to get moving. The Treaty-aware circulars from the Department of Health in the late 1980s vanished from the agenda. So did the fledgeling Maori health committee, re-emerging in late 1994 only after key decisions affecting Napier Hospital had been taken without effective consultation.

We do not wish to quibble here about precise timings – whether the objectives of particular plans were, for instance, to be realised within the medium rather than the long term. There are in our view two essential Treaty dimensions to the overall performance of the health system in delivering its stated objectives regarding Maori health:

- ▶ Having declared a policy, were reasonable steps taken to implement it?
- ▶ In implementing the policy, did the Crown and its health agencies act in conformity with Treaty principles?

In defining its aim as the improvement of Maori health towards equal outcomes with non-Maori, the Government set itself an ambitious policy agenda. Our review of institutional progress at each level of the health hierarchy suggests that it took more than half a decade to acquire sufficient in-house experience and expertise to do this, and to develop effective methods of policy articulation and programme planning. In some areas, such as integrating tikanga Maori into mainstream services, the evidence we heard suggested that methods of implementation were even in mid-1999 still in their infancy.

By the late 1990s, the prescriptive instruments – agreements, purchase contracts, strategic plans, and to a lesser degree statements of intent and business plans – contained quite detailed

commitments and covered most dimensions of national policy. Thus, support for Maori providers now extended to their development needs; *He Taura Tieke* was written into purchase contracts as a means of assuring cultural responsiveness in hospital clinical services; and Maori priorities were being integrated into mainstream service planning.

But there was a rhetorical dimension to this elaborate apparatus of planning and prescription. Like the Department of Health's circulars of a decade before, the Central RHA's contract quality standards were treated as guides to improvement rather than enforceable conditions. In the absence of effective monitoring or enforcement, at no level did the Crown health agencies have much knowledge of whether Ahuriri Maori were helped, neglected, or harmed or of how they experienced the health services, or of what improvements they thought were needed or which contributions they might themselves make.

The limitations of top-down reform became more evident with time as the cascading of Maori health policy failed to bridge the distance between promise and result. There were advances. Several new community health programmes targeted for Maori started up. An occasional campaign tackled a priority Maori health issue, such as the glue ear treatment backlog. The Hastings whare whanau was better accommodated. Contracts with two Maori providers in Napier were renewed.

But our overall impression is that, alongside the considerable effort devoted to high-tech facilities in the regional hospital and the Napier Health Centre, and despite the prospect held out to Maori of greater priority to be accorded community services, the gains on the ground were modest. Making all due allowance for the disruptions of restructuring, it would be reasonable – and no 'counsel of perfection' – to anticipate more substantial effort to address the scale of Maori health improvement needed to meet the prominently declared goal of equality of health outcomes. Little emerged that could improve the everyday experience of ill-health in Ahuriri Maori communities.

The dominant leitmotif of that experience was marginalisation. Ahuriri Maori were kept on the periphery of consultation on all the major decisions affecting their health services. Consultation on their health needs was occasional and ad hoc. Healthcare Hawke's Bay was not held to account for its failures of consultation. Apart from through the powerless Maori health committee, the voice of Maori was not represented in decision-making circles. Few steps were taken by either the Central RHA or Healthcare Hawke's Bay to develop a lasting partnership relationship. Napier-based Maori providers were small and peripheral. Progress in making hospital services and practice culturally appropriate was slow and incomplete. The range and outreach of primary health services remained limited. However effective particular programmes might have been, an integrated approach to tackling the causes of ill health was lacking, especially in the low-income suburbs in which Napier Maori were concentrated. Viewed from a local perspective, Maori communities in and around Napier had reason to doubt the Government's commitment to delivering on its policy goal of improving Maori health.

CHAPTER 8

HEALTH STATUS AND OUTCOMES FOR AHURIRI MAORI

8.1 CHAPTER OUTLINE

In this chapter, we address two issues:

- ▶ the adequacy of access to hospital and non-hospital services for Napier Maori following the closure of Napier Hospital (section 8.2.1); and
- ▶ the health status of and health outcomes for Ahuriri Maori during the health reform period (section 8.2.2).

8.2 ANALYSIS OF THE EVIDENCE

8.2.1 Access to health services

8.2.1.1 *The reconfiguration of State health services in Napier (1998–99)*

The regionalisation of hospitals in Hawke's Bay changed the configuration of the services available to the residents of Napier and the catchment zone of Napier Hospital in four main ways:

- ▶ all acute services were transferred to Hastings;
- ▶ some outpatient services were moved to Hastings;
- ▶ the remaining outpatient services continued to be provided in Napier but were available on a day-care basis only and, after the closure of Napier Hospital, from the new Napier Health Centre; and
- ▶ additional acute services, some upgraded and others new, were established at the regional Hawke's Bay Hospital.

There was, however, a transitional period through 1998 and 1999 while Napier Hospital's services were moved to Hastings:

- ▶ January 1998: Emergency department.
- ▶ September–October 1998: Nearly all outpatient services.
- ▶ October 1998: The final medical in-patients.
- ▶ December 1998: The dentistry clinic.
- ▶ April 1999: Orthotics.
- ▶ August 1999: High-dependency geriatric patients from the James Foley ward.

Finally, during December 1999–January 2000, the Napier Health Centre was commissioned and some outpatient clinics were moved back from Hastings.

8.2.1.2

From late 1998 until the opening of the Napier Health Centre more than a year later, visiting specialists from Hastings took weekly clinics at Napier Hospital in some specialities. All that remained at Napier Hospital were low-risk maternity services at Arohaina, minor day surgery, x-ray facilities, various therapies (physio, speech-language, occupational), blood testing and donation facilities, a pharmacy, and a cafeteria.¹

Outside the hospital, Healthcare Hawke's Bay provided several other services:

- ▶ City Medical in Station Street in the town centre: a general practitioner-run urgent medical service sub-contracted from March 1998 by Healthcare Hawke's Bay.²
- ▶ In the Tuakana building opposite the hospital on Hospital Terrace: community services, including rehabilitation, mental health and addiction, and the whare whanau and other services provided by Te Kupenga Hauora.
- ▶ In the Napier Library building and the Health Promotion Centre in Herschell Street in the town centre: addiction, including the kaupapa Maori programme, Lifespan, and the Public Health Unit.

Thus, between October 1998 and January 2000, Napier residents had only a limited outpatient service available locally and had to travel to Hastings if it did not suffice. Those outpatient clinics designated for Napier then moved back to the new Napier Health Centre. So too did the urgent medical service contracted to City Medical.

In mid-1999, Healthcare Hawke's Bay listed the range of sub-acute services it would provide in Napier, mainly at the Napier Health Centre (see table 6). They covered accident and medical services, low-risk maternity services, outpatient clinics, health promotion, and public health services. Included were two services specifically for Maori: mental health and kaupapa Maori addiction. The various service lists published by the Central RHA and Healthcare Hawke's Bay between 1994 and 1999 showed a few variations in services and service levels, but the overall range remained quite extensive. In addition, community-based facilities such as residential mental health houses continued to be provided, as did in-home services such as district nursing and chemotherapy.³

In 1999, Healthcare Hawke's Bay claimed that the services it would provide at the Napier Health Centre included all those published in August 1994 and subsequently, except for continuing care for the elderly. It had expanded the original list with several additional services (see table 6). But several specialist and outpatient services were listed by the Central RHA in 1996 as being available only in Hastings (see table 7).

8.2.1.2 *Transport to the regional hospital*

Up to 1997, Napier residents had a nearly complete State medical service on their doorstep. They needed to travel to Hastings only for a few speciality treatments not provided at Napier Hospital. At the 1991 census, a fifth of Napier's Maori population resided within a two-kilometre radius of

1. *Daily Telegraph*, 2 February, 18 September, 16, 27 October, 5, 30 December 1998

2. *Ibid*, 2, 3 February, 2 March 1998; doc 692(26)

3. Documents w18(a)(65), w18(a)(75), w37

Accident and medical, maternity	
Urgent medical (originally first aid only)*	Minor surgery (local anaesthetic)
Laboratory	Pharmacy
Radiology (X-ray)	Low-risk maternity (incl birthing and post-natal care)
Outpatient clinics	
Audiology (part)	Geriatric medicine
Blood donor*	Gynaecology
Cardiology (except specialist tests)	Neurology
Cervical screening	Occupational therapy
Child health	Ophthalmology (to be confirmed)
Child development	Orthopaedics
Dental*	Ostomy
Dermatology	Paediatric medicine
Diabetes	Physiotherapy (incl hydrotherapy)
Dietetics	Podiatry
Ear, nose, and throat (ENT)	Respiratory medicine
Endocrinology	Rheumatology
Gastroenterology	Sexual health
General medicine	Speech-language therapy
General surgery	Urology
Community mental health and addiction (assessment, counselling, treatment)	Lifespan
Child, adolescent, and family	Well child health
Adult mental health	Pre-school
Maori mental health *	School
Forensic *	School dental
Crisis (mobile assessment and intervention)*	Community diabetes
Mental health promotion	Sexual health (incl STD and HIV clinics)
Addiction	Family planning
Methadone	
Kaupapa Maori addiction *	
Public Health Unit (for all Hawke's Bay)	
Environmental health	Immunisation promotion
Food safety and quality	Smokefree environments
Nutrition and exercise	Injury prevention
Cervical screening	Melanoma protection
Communicable disease control	Health information and education
In-home health services	
District nursing (incl palliative)	Home support (incl cleaning, meals on wheels)
Social work	Oncology (incl chemotherapy, counselling, support)
Therapies (incl occupational, physiotherapy)	Renal (dialysis monitoring)
Specialist (incl oxygen, continence management)	

* Added to the list of services to be provided in Napier since the publication of the Central RHA's list in August 1994.

'Maori health services' were specified by the Central RHA in 1996 but do not appear in Healthcare Hawke's Bay's 1999 list.

Table 6: Services listed in 1999 to be provided at the Napier Health Centre. Source: documents w37, w18(a)(75).

8.2.1.2



Figure 28: Napier Health Centre. Taken from Flowers 2000.

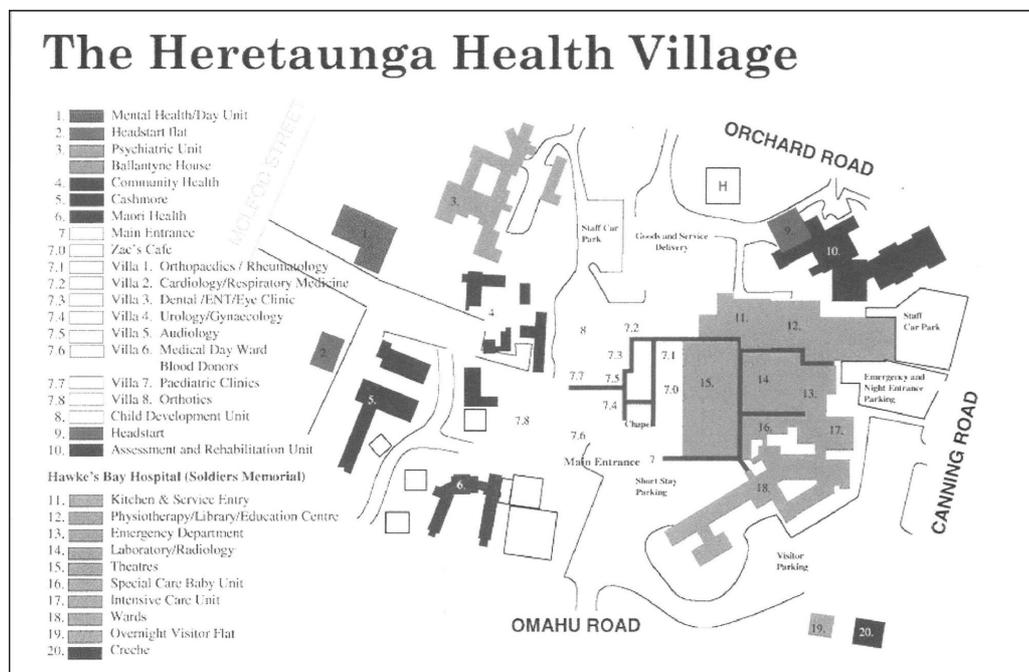


Figure 29: Site layout of Hawke's Bay Hospital in 1999. Taken from document w36.

Napier Hospital and another two-thirds between two and five kilometres – only 14 per cent were more than five kilometres distant. The most concentrated suburban area, Maraenui, Onekawa South, and Marewa, which together housed about half the Maori population of Napier, lay between one and 3.5 kilometres from the hospital, well within walking distance or a few minutes away by car (see map 11 and chart 7).

The transfer of services to Hastings during 1998 and 1999 added around 12 to 15 kilometres to the travel distance from the inner city suburbs. Two-thirds of Napier Maori lived between 10 and

15 kilometres from Hawke's Bay Hospital in 1991 and another quarter more than 15 kilometres away (see map 11). Some form of motorised transport was now essential in order for them to reach the hospital facilities in Hastings. The effect of the one-hospital solution was also evident in the distance from Hastings Hospital of the Hawke's Bay Maori population as a whole (see chart 8).

At several stages during the hospital reorganisation in the 1990s, the adequacy of access was reviewed against the prevailing national standards for the various communities served. In each case, Napier fell within the prescribed travelling time limits (see table 8). In 1994, Professor North, a principal consultant for Healthcare Hawke's Bay, commented that 'many thousands of people in metropolitan regions of New Zealand suffer a significantly greater disadvantage in the time taken from home to reach their acute general hospital'.⁴

The access standards set by the Ministry of Health in the mid and late 1990s – for instance, in its 1997–98 service agreement with the Transitional Health Authority – typically indicated maximum travel times to both primary and hospital services 'by car'.⁵ The standards, however, took no account of variations in access to motorised transport.⁶ For travelling beyond the neighbourhood, most people in both Napier and Hastings, as in many medium-sized regional towns, relied on using a private vehicle. Those without such access faced potential difficulties in reaching essential facilities. At the 1991 census, 12.6 per cent of private dwellings in Napier did not have a motor vehicle available. This was close to the national average. But, in five inner suburbs with a high proportion of Maori residents, a higher percentage of households lacked vehicles (see chart 9).

In Maraenui, where Maori formed 46 per cent of the population in 1991, 23 per cent of dwellings had no available vehicle. This compared with 9 per cent for the rest of Napier. A community survey in late 1998 of people aged 15 years and older found that only 64 per cent of respondents had access to a car at all times. Of the others, 18 per cent had access 'sometimes' and 15 per cent, especially single parents, had no access at all.⁷ Mr Jim Pearcey, the principal of Maraenui School since 1990, highlighted the transport problem. In his experience, 'many families within our school community do not own vehicles, and are unable to transport their children themselves to the Regional Hospital, should it be necessary, and retrieve them after work'.⁸

The inner suburbs in which Maori were concentrated by the 1990s were, as we discuss further in section 8.2.2.1, low-income communities, in which the high proportion of households without available vehicles was one attribute of relative deprivation. But their proximity to the city centre and commercial employment eased the impact that the lack of a vehicle had on daily life: work, shops and key public institutions were all near to hand. The transfer of hospital facilities to Hastings, however, removed easy access to parts of an essential social service.

4. Document v1(c), pp 19–21

5. Document x5(17)(5), dated 1 August 1997

6. Document v1(c), p 21

7. Ponter 1989, p 8

8. Document v10

Services as listed by the Central RHA in December 1996:

Neurosurgery	Clinical haematology
Paediatric surgery	Ophthalmology (possibly in Napier)
Renal medicine*	Plastic surgery (including maxillo-facial)
Secondary maternity	

* Originally listed for Napier

Table 7: Outpatient services available only at Hawke's Bay Hospital. Source: document w18(a)(65).

Service level	Proportion of population within driving time limit		
	90%	95%	99%
Primary care, laboratory, pharmacy	30 minutes	60 minutes	180 minutes
Secondary care, local surgical and medical	60 minutes		
District hospital	90 minutes		

Table 8: Travelling time access standards, 1995. Source: document v1(c), table 7.

The Maori community of Napier was caught in a transport bind. The regional hospital concept treated the two adjacent towns of Napier and Hastings as a single conurbation. But the towns did not sustain the public transport infrastructure that might be expected for a combined population of around 110,000. Each functioned separately, and a frequent connecting bus service was lacking.⁹ The problem was not new. The Department of Health's 1989 health status review had remarked that the absence of public transport at weekends prevented carless families from visiting family members who required treatment provided at one hospital only, such as Napier parents with an ill child in Hastings Hospital.¹⁰

In 1996, the Central RHA acknowledged that transport was seen as 'a particular concern for people on low incomes and some people with disabilities, infirmities or illnesses'.¹¹ It attempted to overcome the problem by funding a free inter-hospital minivan service for patients, caregivers, and whanau. As advertised in early 1998, the service ran a two-hourly shuttle from Napier between 7am and 6pm on weekdays and 11am and 3pm at weekends, the last return trip departing Hastings at 7pm and 4pm respectively. Pickups along or near the route could be arranged.¹²

This service provided a basic facility, but did not cover people delayed at hospital admission or treatment, or working people who needed to travel at weekends outside the restricted timetable. In 1996, the Central RHA stated that vouchers were available for taxis and other transport when needed but did not say from which organisation or how many were eligible.¹³ This option

9. Document v1(c), p 21

10. Napier Health Development Unit 1989, p 1.36

11. Document w19(a)(9009), p 75

12. Document 692(26); doc v1(c), p 22

13. Document w19(a)(9009), p 76

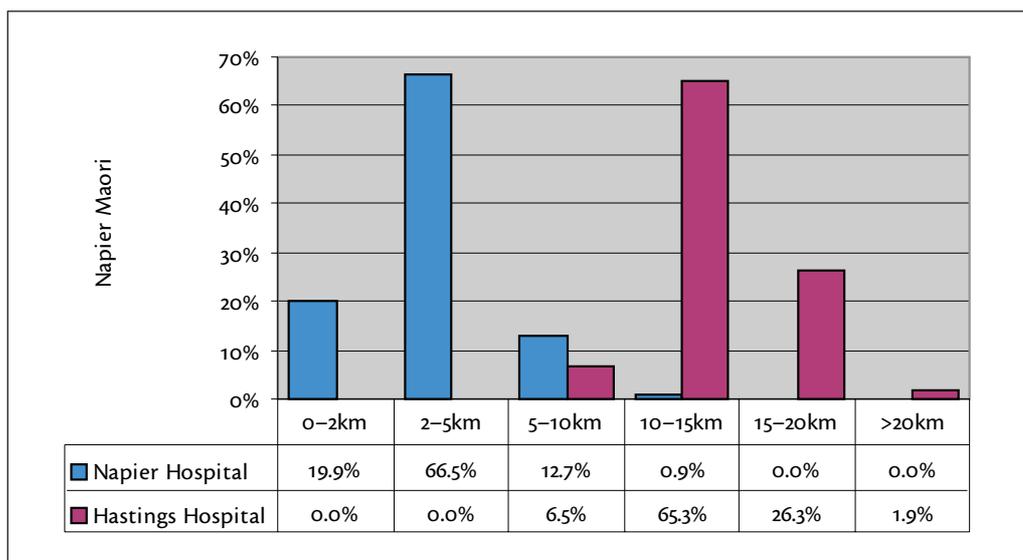


Chart 7: Napier Maori population by distance from Napier and Hastings Hospitals, 1991

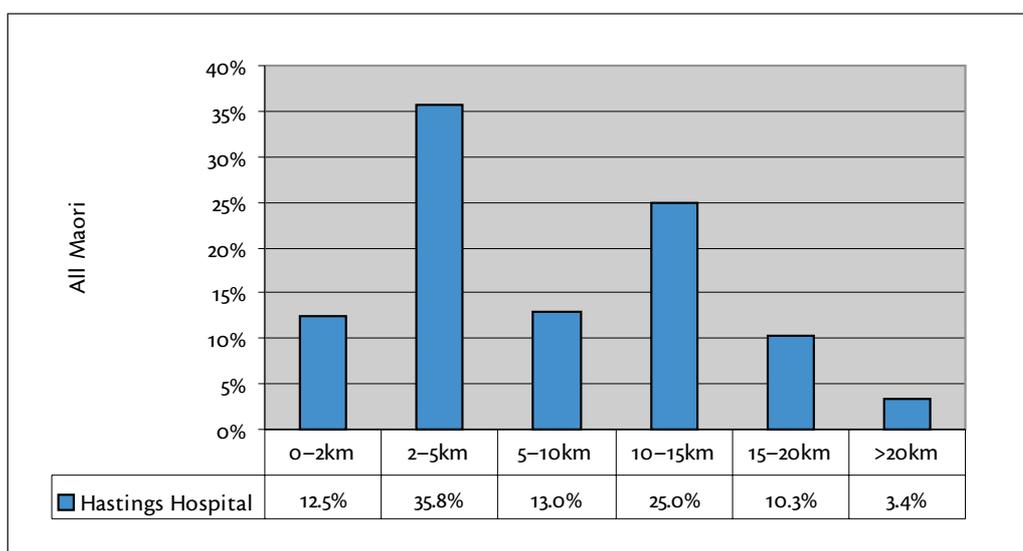


Chart 8: Maori population of central Hawke's Bay by distance from Hastings Hospital, 1991

was not mentioned by any of the claimant supporters who faced transport problems in reaching Hastings Hospital.

8.2.1.3 The impact of distance on Maori access to services in Hastings

The standard for emergency access was ostensibly little affected by the transfer of acute facilities to Hastings since pickup would usually be by ambulance. However, the greater distance made it more likely that people, especially those in households without cars, would need to call an ambulance. While accident victims were not charged, in 1998–99 medical patients taken by ambulance

8.2.1.3

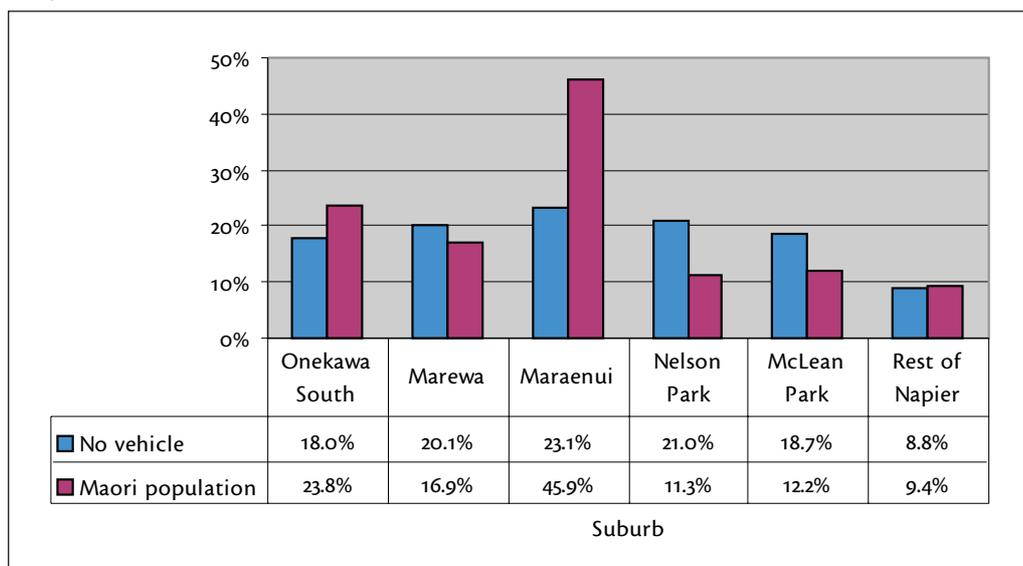


Chart 9: Napier households without vehicles and Maori share of population, 1991

for admission or to outpatient clinics faced a \$56 charge each way.¹⁵ This was a significant cost for a low-income household, especially if repeat journeys were needed.

Where an ambulance was not needed but the bus service did not suffice, the only recourse for patients and their whanau was a taxi. The ‘typical cost’ was said to be \$40 per one-way trip (in 1996), and around \$25 after working hours (in 1998–99). This cost was a burden for low-income families, especially those making frequent visits.¹⁶ It was sufficient to deter some from seeking or completing treatment. Ms Ferguson cited the example of a Maori mother who, facing an indeterminate wait for a medical assessment of her injured daughter, discharged her in order to make the last bus back to care for her family in Napier.¹⁷ It also complicated the organisation of whanau support, since family commitments did not always allow everyone to stay overnight in the hospital’s whare whanau.

Several claimant supporters described their difficult experiences in travelling to and from Hastings during 1998 and early 1999. Their problems were exacerbated by what they considered to be under-resourced nursing care in Hawke’s Bay Hospital, inducing them to visit frequently and for long periods to awhi (support) those relatives who were in-patients for lengthy periods. Mr January Roberts, a pensioner, whose son was frequently in and out of hospital, had his own transport but faced additional stress when he also had to care for his sick wife and adopted son at home, sometimes making the journey several times a day. Ms Rose Whenuaroa recounted a similar experience in caring for her husband.¹⁸

15. Document v1(c), p 25

16. Document w19(a)(9009), p 75; doc v1(c), p 22

17. Document v1(c), p 25–26

18. Documents w24, w26

Outpatient treatment could also be taxing for people without access to a car. Christine Te Kahika had to rely on her son's teacher aide at Maraenui School to get him to a dental appointment and on whanau to look after her other son. Travel and waiting time extended a 40-minute procedure, to which she could have walked had it been offered in Napier, to some eight hours. Her reliance on external assistance often extended to her son's frequent audiology clinic appointments. Both the dental and audiology clinics featured in Healthcare Hawke's Bay's specification for its Napier Health Centre. But it appears that Healthcare Hawke's Bay did not include them in its temporary arrangements at Napier Hospital during 1998–99.

Margie Russell, the teacher aide concerned, said that Ms Te Kahika's situation was a common one:

there are numerous parents within our school in the same situation. Where extended family are unable to assist, a teacher aide such as myself will step in and act as driver and/or support person for the child in question. I realise this is above and beyond my required duty as teacher aide within the classroom, however, I believe it is a necessary measure, if you are fully committed to the development of the child's education. In my experience, behaviour problems can be avoided where health issues are dealt with promptly.¹⁹

Jim Pearcey, the principal of Maraenui School since 1990, confirmed Ms Russell's account. Teacher aides frequently had to accompany pupils to hospital for injury treatment or audiology appointments. These could now be lengthy excursions. They took teacher aides out of the classroom, disrupted teaching timetables, and required much time to be devoted to organising the travel and contacting the caregivers. Pupils were more likely than before to be taken to hospital without whanau support, and their distress affected the wider school community.²⁰

8.2.1.4 Other cost and cultural barriers

The impact of distance was magnified by another underlying factor: the tendency for Maori in low-income communities to turn to the free hospital accident and emergency service for their primary health care needs instead of to private doctors. A 1997 survey of Napier Hospital's accident and emergency service found that 43 to 46 per cent of a sample of its patients between July 1996 and May 1997 could probably have been treated by general practitioners and another 14 to 19 per cent by a non-hospital accident and medical service. The survey estimated that 68 per cent of general practitioner referrals were admitted, but only 19 per cent of self-referrals. The majority both of people coming directly to hospital and of those not admitted were classed as orthopaedic, of whom many would have been the victims of injuries and accidents.²¹

A similar cost barrier affected Maori usage of the sub-contracted urgent medical service at City Medical during 1998–99. The service provided free assessment by a triage nurse, and onward referral to Hawke's Bay Hospital was also free. But if assessed to require only general

19. Document w28

20. Document v10

21. Documents 692(37); v1(c), p 28

8.2.2

practitioner treatment, the callout fee ranged from \$35 until 9pm to \$55 up to 12pm and \$75 between 12pm and 8am. This exposed patients or their caregivers to uncertainty as to whether they would end up paying for the urgent treatment they believed was needed, and acted as a deterrent to low-income families who could previously have gone to the free accident and emergency service at Napier Hospital. In early 1999, Ms Ferguson found a belief amongst Napier Maori that an automatic fee of \$75 applied and this was discouraging some from taking sick children to the after-hours service.²²

Amongst the conclusions that it drew from its 1995 health service needs assessment in Napier and Hastings, the Central RHA considered that ‘people [were] seeking help too late in the course of an illness’, and that amongst the barriers to access were ‘transport, information, quality and cost’.²³ The summarised feedback from its consultations with Maori, which were conducted mainly during April and May 1995, abounds with references to cultural factors inhibiting effective communication between Maori patients and health professionals and deterring Maori from seeking or continuing with medical treatment, in both hospital and primary services.

The Central RHA recognised that access barriers were still a major problem for Hawke’s Bay Maori:

It is widely recognised that access to appropriate services has been poor and at times non-existent for Maori. This, together with cultural and cost barriers, has contributed to patterns of ill health and service use which need improvement.²⁴

Its 1996 needs assessment report came to the same conclusion for Napier and Hastings Maori in respect of primary health care services:

Although many Maori access a range of mainstream services (such as GP services), there is still substantial evidence that many are not accessing services well. Health status indicators prove this to be true.²⁵

8.2.2 Health status and outcomes

8.2.2.1 *Socio-economic indicators of health status*

Claimant counsel argued that the failure of the Crown to address the health needs of Ahuriri Maori had two broad consequences during the period of the health reforms: a general health status much worse than that of non-Maori; and a gap that was failing to close and was possibly even widening.

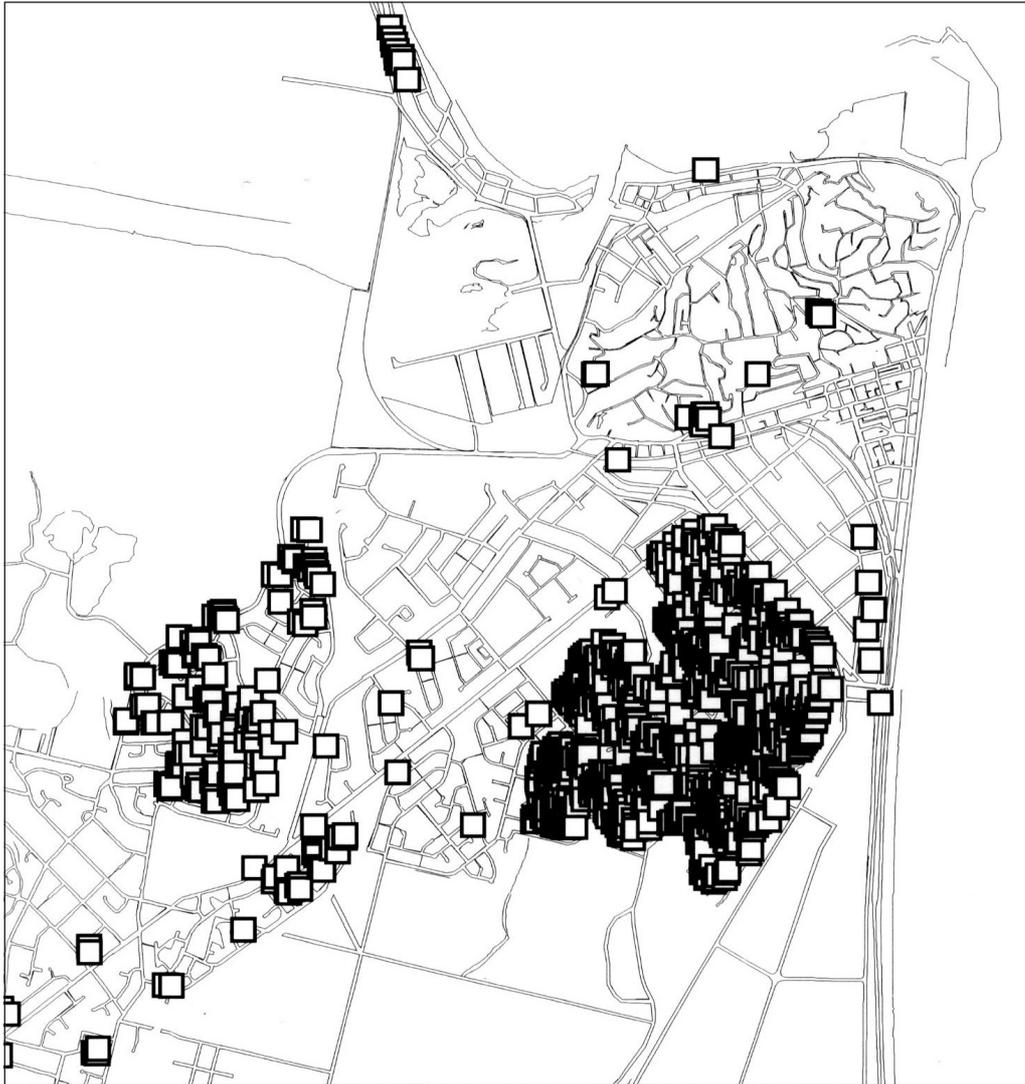
Any attempt to assess the health status of Ahuriri Maori in modern times encounters serious limitations of data. Most of the available data on Maori health are national, or at best broken down to district level and thus applicable to Hawke’s Bay as a whole. Local information on

22. Document v1(c), pp 23, 39–40; doc 692(26)

23. Central RHA 1996c, pp 7–8; doc v1(c), pp 28–29

24. Central RHA 1996a, p 47

25. Document w19(a)(9009), p 120



Map 14: State housing in central Napier, mid-1990s. The map represents Housing New Zealand titles found in Land Information New Zealand's digital cadastral database.

Napier and vicinity is restricted to a few fragments. Often, however, the local context of Ahuriri Maori is sufficiently similar to the district or national situation that the broader data can be held to yield reasonably accurate insights into their health status.

Reinforcing how few health data have been gathered, social and economic indicators can provide strong pointers to exposure to ill health. The authors of the *Atlas of Socioeconomic Deprivation*, based on 1996 census data, reported that 'many researchers have found that deprivation, as measured by area-based composite indexes, correlates with measures of health status'. They continued:

New Zealand research evidence demonstrates a strong association between small area deprivation and other health outcomes. Increasing area deprivation is associated with increased

8.2.2.1

total mortality, injury-related mortality, asthma prevalence in adults, sudden infant death syndrome, and mortality due to causes amenable to medical treatment – including lung cancer, diabetes, rheumatic fever, ischaemic heart disease, pneumonia, chronic obstructive respiratory disease, asthma, peptic ulcer, alcoholic liver damage, complications of pregnancy and perinatal causes.²⁶

The authors argued that ‘aspects of lifestyle and disease risk factors are also patterned according to level of deprivation’. These include increased smoking, high blood pressure, cardiovascular risk factors, and diabetes. Household food security was also at risk.

The use of health services was correspondingly higher:

There is strong evidence related to the association between area deprivation and the use of hospital services. Increasing levels of area deprivation are associated with increasing total hospitalisations and hospitalisations avoidable through good primary care or outpatient care, including hospitalisations for pneumonia, asthma, cellulitis, kidney infections, ruptured appendix, congestive heart failure, immunisable infections and diabetes. There is less published research related to area deprivation and use of primary care services. While there is evidence that preventive services such as immunisation are taken up less by people in deprived areas, frequent use of general practitioner services is higher in deprived areas.²⁷

In brief, the greater the level of deprivation in an area, the higher the likelihood that its population would on average suffer preventable deaths and ill health, be exposed to poor nutrition, go to hospital, and use primary health care services.

Population census data provide the one source that has comprehensive coverage and can be broken down into small geographical units. People stating Maori ancestry at the 1991 census formed 16.2 per cent of the total population of Napier and 23.6 per cent in Hastings. Of the Napier Maori population of 8280, the 3333 affiliated to Ngati Kahungunu made up 40 per cent, though, in some cases, they also affiliated with other iwi. Some 28 per cent did not give an iwi affiliation (see table 9).

The Central RHA’s health services needs assessment, which was published in 1996, used data from the 1991 census to generate a number of social indicators. The report focused on Napier and Hastings and further broke down the data from each city into three suburban clusters: Maraenui–Onekawa South, which have a high Maori population; the central- and inner-city area, labelled ‘Napier South’; and the rest of Napier (see table 10).

The Napier clusters adopted in the report are not entirely apposite, since an area of dense Maori population in Marewa is included in ‘Napier South’. The data none the less reveal several striking social patterns:

- ▶ the indicators were broadly similar for Napier and Hastings;
- ▶ Maori were heavily concentrated in a few inner suburbs (Maraenui–Onekawa South), but much less so in the city centre;

26. Document z7, p 16

27. Ibid, p 17

- ▶ Maraenui–Onekawa and the city centre had much higher proportions of poorer households and unemployment and a significant number of people without a private car;
- ▶ across all zones, a much higher proportion of Maori families than Pakeha families were single-parent families with dependent children, and this family configuration was higher in the poorer suburbs with a dense Maori population; and
- ▶ in Maraenui–Onekawa, the Maori population was increasing as the Pakeha population declined.

Although these are no more than rough and ready indicators, they show some of the classic signs of ghetto formation – of ‘white flight’ and intensifying ethnic concentrations of multiple deprivation in inner-city suburbs. Also using 1991 census data, Ms Ferguson painted a similar picture of socio-economic disadvantage.²⁸

The 1996 relative deprivation index, known as NZDep96, brings the results of this tendency into sharper focus. The index is a composite of a number of socio-economic indicators drawn from the 1996 census and averaged for ‘small areas’ of one or more census meshblocks containing at minimum a population of 100 residents. Each area was given a decile rank from 1 to 10 (1 = the least deprived 10 per cent, 10 = the most deprived 10 per cent) and a score relative to a mean of 1000. The *NZDep96 Atlas* aggregated the results for larger census area units, typically averaging about 2000 residents.

Some two-thirds of Napier’s 22 census areas ranked in the top six deciles and scored better than the national mean. But the remaining third, mostly in the city centre and inner suburbs, were in the bottom three deciles. Not only was Maraenui in decile 10, but it ranked in the bottom 2.5 per cent of census areas nationally – only 36 out of 1665 areas nationwide had worse index scores. By any standard, this was intense deprivation.

Comparing the 1991 population on the basis of the 1996 deprivation index,²⁹ it is immediately apparent that, both nationally and in Napier, a much higher proportion of Maori lived in areas of higher deprivation. In Napier, a tenth were in the top decile areas (1–4) compared to nearly a quarter of Pakeha, but more than half were in the bottom decile areas (9–10), double the proportion of Pakeha (see table 11).

The most concentrated zone of relative deprivation, covering Onekawa South, Marewa, and Maraenui, also had the highest density of Maori residents. In 1991, nearly half Napier’s Maori population lived there, making up more than a quarter of the zone’s population (see map 12 and table 12).

The detailed NZDep96 map of Napier reveals a solid block of decile 9 and 10 areas stretching across the southern end of Onekawa, Maraenui and southern Marewa (see table 13 and map 13). Nearly all the 1991 population lived in decile 6 to 10 areas. This deeply deprived zone had a high concentration of State houses originating from the 1950s, many of which had been allocated to Maori and low-income households, although by the late 1980s the Housing Corporation had begun to upgrade its housing stock and had sold some into private ownership (see map 14).³⁰

28. Document v1(c), pp 32–33

29. The distribution five years earlier was slightly skewed towards the lower deciles.

30. Ponter 1989, pp 1, 16–17

	Napier City		Hastings urban area		Hawke's Bay	
	Number	Per cent	Number	Per cent	Number	Per cent
All iwi affiliations*	3333	40.3	7065	52.7	11067	48.2
Ngati Kahungunu	4674	56.4	7560	56.4	12915	56.2
Other iwi						
Maori affiliating	5991	72.4	10689	79.8	17691	77.0
Don't know/no iwi	2289	27.6	2706	20.2	5289	23.0
Total Maori ancestry	8280	100	13395	100	22980	100

* Including multiple affiliations, thus totalling more than the number of Maori affiliating

Table 9: Population of Maori ancestry and iwi affiliations, 1991. Source: census 1991.

Non-Maori made up two-thirds of the residents, but Maori were far more heavily concentrated in the most deprived decile 10 areas, to the extent of three-quarters of the zone's Maori population and two-fifths of the decile 10 area population. Napier was and, notwithstanding improved regional economic conditions since 1991, remains a city of marked inequalities, with many Maori on the wrong side of the deprivation divide.

8.2.2.2 Maori health status and trends

The inferior socio-economic indicators for many Maori residents of Napier meant that their chances of suffering ill health were increased and that they had a higher mortality rate. The only substantial source of health status data on Napier remains the Central RHA's needs assessment report of 1996. The mortality and hospitalisation data on which it relied were compiled in the early 1990s, and therefore would have tended to understate the overall Maori mortality rates and overstate the rate of Maori hospitalisation, in both cases by substantial margins. Because of the major change to the definition of ethnicity that was introduced in 1995, more recent data are not comparable.³¹

The pre-1995 data used by the Central RHA none the less serve to describe the broad differences between Maori and non-Maori health experiences in Napier and Hawke's Bay. They tend to confirm the greater impact of ill health amongst Maori in Napier and especially those living in the deprived Maraenui–Marewa inner suburbs (see table 14):

- ▶ The overall death rate in Maraenui–Onekawa, with its high Maori population, was much higher than the rates for Hawke's Bay and the central region. It was also a lot higher than the rate for the also severely deprived city centre zone with its much lower Maori population.
- ▶ The death rates for ischaemic (coronary) heart disease and malignant neoplasms were also much higher in Maraenui–Onekawa.
- ▶ The overall hospitalisation rate in Maraenui–Onekawa was much the same as for the rest of Napier and Hawke's Bay, but the rate for cancers was lower and the rate for such typically poverty-associated conditions as chronic obstructive respiratory disease, pregnancy complications, ear disorders, and acute respiratory infections was higher.

31. Ministry of Health 1999, pp 59–60; doc v6, app 3, pp 6–7

	Napier City			Hastings urban area			Central region
	Maraenui Onekawa	Napier S Ahuriri	Rest of Napier	Northwest	South central	Rest of Hastings	
Area populations:	2625	1371	3066	6351	1050	5034	
—Maori	186	103	213	801	99	474	
—Pacific	4956	8172	30393	6321	5886	30750	
—European	7767	9651	33669	13482	7041	36264	
—total							
Percent							
Area/total:	15	19	66	24	12	64	
Area populations:							
—Maori	34	14	9	47	15	14	13
—Pacific	2	1	1	6	1	1	3
—European	62	83	88	46	81	83	84
Increase 1981–91:							
—Maori	9	12	-3	39	-5	2	12
—Pacific				70	-8	18	48
—European and other	-22	-2	5	-7	-3	2	1
Single parents:*							
—Maori	47	39	29	46	36	37	30
—Pacific				25	50	21	20
—European and other	18	18	8	17	13	8	24 [†]
Household income							
\$30,000 or less	56	60	42	47	60	45	41
Unemployed	10	9	6	11	7	5	6
Dwellings with no private car	20	20	9	16	20	10	13

* Single parents as a proportion of all families with dependent children in each ethnic group

† Corrected

Table 10: Demographic and social indicators for Napier and Hastings, 1991.

Source: document W19(a)(9009), pp 57–58, 174 (using 1991 census data; Central RHA 1996a, p15).

- ▶ Despite the high death rate in Maraenui–Onekawa, the rate of hospitalisation for ischaemic heart disease was more or less the same as for the rest of Napier and Hawke’s Bay.
- ▶ The indicators for Hawke’s Bay were in most cases significantly worse than for the central region as a whole.

These figures are for all residents. The overall hospitalisation rate for Maori was higher by a long margin than for non-Maori across all areas, and therefore in both low and high deprivation populations. It suggests a pattern of Maori tending to seek medical assistance only once a condition has become acute. After the 1995 downward revision, however, the national pattern is of a Maori rate of hospitalisation slightly higher overall than that of non-Maori, and slightly below that of non-Maori in most deprivation deciles.³² Given the much poorer health status of Maori

32. Ministry of Health 1999, pp 29–30, 197–200, using 1996–1997 data and NZDep96

Percent	National population		Napier urban area	
	European	Maori	European	Maori
Decile 1–4	42.3	14.6	23.1	10.5
Decile 5–8	42.3	38.1	51.7	37.3
Decile 9–10	15.4	47.3	25.2	52.2

Table 11: Distribution of 1991 population by NZDep96 decile. Source: 1991 census; document z7.

	Maori population 1991			NZDep96		
	Number	Maori/ area %	Maori/ total %	Decile	Ranking %	Index score
Onekawa South	1011	23.8	14.2	9	87.8	1090
Marewa	717	16.9	10.1	9	88.5	1094
Maraenui	1614	45.9	22.7	10	97.8	1206
Sub-total	3342	27.8	47.0			
Napier	7110	13.8	100			

Table 12: NZDep96 measures for Onekawa, Maraenui, and Marewa. Source: 1991 census; document z7.

as a whole, this may imply that Maori tended to use hospital services less than their level of health need would suggest.

Unexpectedly, the hospitalisation rate for Maori was markedly higher in the better-off Napier suburbs. This difference may suggest that Maori in more deprived areas were making less use of hospital services despite their greater need of them. The Central RHA's data appear, however, to be well out of line with the post-1995 national pattern reported by the Ministry of Health, which showed the overall hospitalisation rate strongly increasing with higher deprivation.³³

Comparative hospitalisation data for the population of Hawke's Bay, of which Napier and Hastings make up some 80 per cent, reveal Maori rates often 50 to 100 per cent higher across a wide range of injuries and diseases. For asthma, the Maori rate was almost three times that of non-Maori, and for diabetes it was five times (see table 17). The rates for Maori in Hawke's Bay were also higher in nearly all categories than those for Maori in the central region as a whole. The Central RHA warned further:

Because ethnicity is often not documented accurately, there is probably considerable under-reporting of Maori deaths and hospitalisations – which may mean that an even wider disparity in health status exists between Maori and non-Maori.³⁴

The Ministry of Health's more recent hospitalisation data paint a similar national pattern but, following the radical definitional adjustment in 1995, with a lower overall difference of 10 to 20 per cent between Maori and 'European/Others'.³⁵

33. Ministry of Health 1999, pp 29–30, 197–200, using 1996–1997 data and NZDep96

34. Central RHA 1996a, pp 47–48

35. Ministry of Health 1999, p 29

	Population		Share of population %		Share of each decile band %	
	Non-Maori	Maori	Non-Maori	Maori	Non-Maori	Maori
Deciles 6–8	1161	231	17.8	7.2	85.0	15.0
Decile 9	1698	543	26.1	17.0	75.8	24.2
Decile 10	3525	2406	54.2	75.3	59.4	40.6
Deciles 6–10	6384	3180	98.1	99.5	66.8	33.2
Total	6507	3195	100	100	67.1	32.9

Table 13: Distribution by decile of Maraenui–Marewa–Onekawa population, 1991. Zone bounded by Willowbank Avenue–Chambers Street–Georges Drive–Kennedy Road–Wycliffe Street–Oldham Avenue.

Source: 1991 census; document 27.

	Napier City				Hawke's Bay	Central region
	Maraenui Onekawa	Napier S Ahuriri	Rest of Napier	Total		
Death rate 1988–92*	996	839	711		832	811
— ischaemic heart disease	297	210	180		228	210
— malignant neoplasms	232	213	172		196	196
Hospitalisation 1989–94 [†]	1870	1880	1780	1814	1820	1502
— cancers	59	79	96		94	82
— ischaemic heart disease	53	49	57		55	48
— CORD [‡]	72	92	51		65	51
— pregnancy complications	86	65	52		67	57
— ear disorders	48	41	35		31	24
— acute respiratory infections	43	32	23		33	24
Hospitalisation 1989–94 [†]	2266	2510	3382	2864	2766	2417
— Maori	1692	1793	1676	1699	1646	1421
— non-Maori						

* Total rate: per 100,000 age-standardised to New Zealand total population 1991; individual causes: age-specific rate per 100,000 population

† Rate per 10,000 age-standardised to New Zealand total population 1991

‡ Chronic obstructive respiratory disease

Table 14: Death and hospitalisation rates for Napier, 1988–94. Source: document W19(a)(9009), pp 67–69, 177.

Comments on the poorer health or higher rates of hospitalisation for Maori in Napier and Hastings are scattered throughout the Central RHA's report. Although hard data are often lacking, few of the life-cycle categories and particular conditions of ill health that the report covers escape the disparity. At the front line of primary health care, the 1988 community health survey of Maraenui found that a far higher proportion of Maori than Pakeha were using the free visiting doctor and nurse services at the local family centre, despite criticism in the Maori community that they were not sufficiently culturally appropriate.³⁶

For child-bearing Maori women, the risks were considerable. According to the report, 'pregnancy and childbirth related conditions account for around 45 percent of hospitalisations for

36. Ponter 1989, pp 26, 36

THE NAPIER HOSPITAL AND HEALTH SERVICES REPORT

8.2.2.2

Rate per 10,000 *	Maori	Non-Maori
Asthma	96	34
Diabetes	64	13
Strokes	48	24
Coronary heart disease	55	55
Other heart disease†	103	35
All cancers	114	91
Head injuries	47	30
Fractures	89	70
Motor vehicle crashes	60	29
Intentional self-harm	13	9
Assault	35	12

* Age-standardised to New Zealand population 1991

† All except coronary, chronic rheumatic, and hypertensive diseases

Table 15: Significant causes of hospitalisation in Hawke's Bay, 1989–94. Source: Central RHA 1996a, p 47.

Age-specific rates per 10,000 female population	Normal delivery		Pregnancy complications		Labour complications	
	Maori	Non-Maori	Maori	Non-Maori	Maori	Non-Maori
Maraenui/Onekawa	268	107	130	64	45	28
Napier S/Ahuriri	250	141	156	51	52	40
Rest of Napier	279	133	117	46	60	37

Table 16: Hospitalisations relating to pregnancy and childbirth, 1989–94.

Source: document w19(a)(9009), p 113.

women aged 15–44 in Hastings and Napier'. While Maori women had a far higher rate of normal delivery, when abnormal, they suffered many more complications (see table 16). The report attributed this in part to the fact that Maori women started having babies much younger, 'and complications are higher in younger age groups'. In addition, 'it also reflects the association found elsewhere that women living in poorer households are more likely to have poorer pregnancy outcomes'.³⁷

Maori women were also at higher risk of breast and cervical cancer. In the Central RHA region, Maori women were 1.5 times more likely to be admitted to hospital with breast cancer and 3.5 times more likely to be admitted with cervical cancer.³⁸

As for diseases, diabetes took a heavy toll of Maori, and in younger age-groups than amongst non-Maori. The hospitalisation rate for Napier, although for some reason lower than in Hastings, was still several times that of non-Maori (see table 17). The Central RHA report noted that diabetes was estimated to be twice as prevalent amongst Maori nationally, and that it featured far higher amongst hospital admissions as an underlying condition than as a primary cause.³⁹

37. Document w19(a)(9009), p 113

38. Ibid, p 118

39. Ibid, p 153

Rate per 10,000 *	Maori	Non-Maori
Napier	38	12
Northwest Hastings	105	12
Hawke's Bay	64	13
Central region	41	8

* Age-standardised to the New Zealand total population 1991

Table 17: Diabetes hospitalisations, 1989–94. Source: document w19(a)(9009), p 153.

Rate	Unit	Year	Maori	Non-Maori	Ratio
Infant mortality	per 1000 live births	1996	9.5	4.2	2.3
Premature mortality*	per 1000	1996	136	61	2.2
Presenescent mortality†	per 1000	1996	47	21	2.2
Mortality (age-standardised)	per 100,000	1998	888	451	2.0

* Gap between age at death and life expectancy at that age

† Deaths before 65 years old

Table 18: Mortality rates, 1996–98. Source: Ministry of Health 1999, p 14.

8.2.2.3 National indicators of Maori health outcomes

Hospitalisation provides but a narrow window on the extent of ill health, capturing only the acute end of the spectrum. Nationally, the key health outcome indicators calculated by the Ministry of Health remain sharply adverse for Maori (see tables 18 and 20):

- ▶ In the mid-1990s, life expectancy at birth for Maori males was 8.1 years less than for non-Maori and an even greater 9.0 years less for Maori females.
- ▶ In 1996–97, the overall Maori mortality rate was double the European/Other rate.
- ▶ Unavoidable Maori deaths were 1.9 times those of European/Others, but avoidable Maori deaths showed an even larger gap at 2.5 times those of European/Others.⁴⁰
- ▶ The rates of Maori infant mortality (1998), premature death, and pre-65 death (1996) were all more than double the European/Other rates.⁴¹
- ▶ Using its new integrated life expectancy (ILE) indicator, which integrated dependent disability, the Ministry of Health estimated that the gaps between Maori and non-Maori increased further – slightly so for males and markedly so for females. Functioning as ‘a single, whole of population indicator of the inequality in health status between the two groups’, the ratio of Maori to non-Maori ILEs at birth was approximately 86 per cent in 1996–97, a ‘health gap’ of 14 per cent.⁴²
- ▶ Using disability adjusted life years (DALY), a second indicator measuring the loss of healthy life over a lifetime, the Ministry calculated the overall Maori rate for 1996–97 to be as much

40. Ministry of Health 1999, p 320

41. Ibid, pp 14–15; Signal and others 1998, p 65

42. Ministry of Health 1999, pp 31–32

8.2.2.3

NZDep96 decile	Male			Female		
	Maori	Non-Maori	Gap	Maori	Non-Maori	Gap
All	67.2	75.3	8.1	71.6	80.6	9.0
1	70.7	78.4		76.1	82.3	
2		77.7			81.9	
3		76.9			81.6	
4		76.2			81.6	
5		75.9			81.3	
6		75.3			80.7	
7		74.8			80.6	
8	66.1	73.6		70.9	79.7	
9		73.0			79.8	
10	63.3	71.5	8.2	68.1	78.2	10.1

Table 19: Ethnic and deprivation gaps in life expectancy at birth, 1995–97.

Source: Ministry of Health 1999, pp 15, 117.

	Male			Female		
	Maori	Non-Maori	Gap	Maori	Non-Maori	Gap
1950–52	54.1	68.3	14.2	55.9	72.4	16.5
1960–62	59.1	69.2	10.1	61.4	74.5	13.1
1970–72	61.0	69.1	8.1	65.0	75.2	10.2
1980–82	65.1	70.8	5.7	69.5	76.9	7.4
1990–92	68.0	73.4	5.4	73.0	79.2	6.2
1995–97*	67.2	75.3	8.1	71.6	80.6	9.0

* Not comparable with pre-1995 data

Table 20: Trends in life expectancy at birth for Maori and non-Maori, 1950–92.

Source: Pomare and others 1995, p 36; Ministry of Health 1999, p 15.

as two-thirds higher than the non-Maori rate (200 compared to 120 DALYs lost per 1000).

Moreover, the disparity applied across most contributing causes of ill health.⁴³

One feature of the recently published life tables requires further comment. Based on the 1996 census and the deprivation index, the data show that life expectancy at birth decreased steeply in proportion to socio-economic deprivation. But it decreased even more steeply for Maori than for European/Others. In other words, the Maori residents of a local area, whatever its deprivation status, could anticipate on average a far worse life expectancy than the Pakeha residents. The difference is sufficiently wide that Maori living in decile 1 to 7 areas had a lower life expectancy than Pakeha in the most deprived (decile 10) areas. At the extreme range, a Maori male in a decile 10 area had a life expectancy 19 years lower than a Pakeha female in a decile 1 area.⁴⁴

43. Ministry of Health 1999, pp 33–34

44. Ibid, pp 116–117

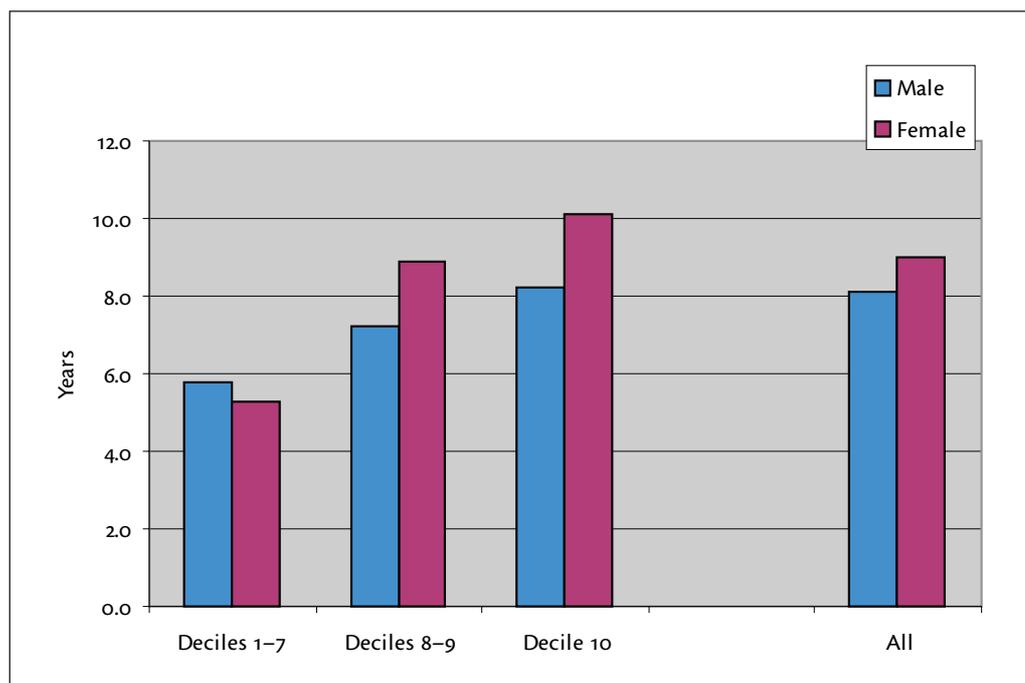


Chart 10: The life expectancy gap between Maori and non-Maori

Thus, the relatively worse Maori life expectancy cannot be explained solely by the fact that a higher proportion are in low-income groups. Dr Papaarangi Reid, director of the Eru Pomare Maori Health Research Centre, attributed this disparity to ‘institutional racism’. The Ministry of Health published the data without attempting an explanation.⁴⁵ However complex that explanation, the ethnic difference is stark. It is unlikely that Ahuriri Maori were an exception to the national pattern.

8.2.2.4 Recent trends in Maori health outcomes

The persisting and large disparity between the health status of Maori and non-Maori is recognised by most experts and opinion-leaders. There is less agreement on whether Maori health has continued to improve over the period of the health reforms, both in absolute terms and relative to non-Maori. The analysis of long-term trends is compromised by unreliable ethnicity data and in particular by a change in 1995 in the definition of ethnicity.

A Ministry of Health review of Maori health issues in late 1998 took a positive long-term view of the trend in Maori health status:

There has been a steady improvement in infant mortality and life expectancy, for Maori, over the last four decades. The ill health status for Maori, in a number of areas, has also improved over time, for example, reduced death rates for sudden infant death syndrome (SIDS) and higher immunisation rates.⁴⁶

45. Ibid, pp 116–117; doc v13

46. Document w18(b)(8000), p 5; also doc w18(a)(11)

The long-term trend in life expectancy shows a steady narrowing of what can only be described as the horrendous disparity with which Maori began the post-Second World War era. Within the space of 40 years, the faster rate of Maori improvement saw 14 years added to the life expectancy of Maori males and 17 years to that of Maori females (see table 20). It is necessary to bear in mind, however, that the pre-1995 figures seriously underestimated Maori mortality, and that the real gap is now thought to be rather greater.

Most other main indicators – infant mortality, causes of death, hospitalisation – show similar trends from the 1970s to the early 1990s: steady improvement for both Maori and non-Maori, and gaps that narrow in some but not all cases and remain wide in a number of major categories.⁴⁷ Some have argued that the improving Maori trends stalled or reversed in the 1990s. The picture painted in a Te Puni Kokiri report in 1998 was decidedly mixed as to trends.⁴⁸ An article published by the Ministry of Health in 1998 noted that one of the key indicators, the infant mortality rate, had ceased to improve after 1992 for the general population, and by implication for Maori too.⁴⁹ Dr Reid argued that, since 1991, post-neonatal mortality had been increasing for Maori whilst decreasing for non-Maori.⁵⁰

There is a stronger expert consensus that the disparity between Maori and non-Maori (principally Pakeha) health status has recently been growing. According to the Ministry of Health:

the gap between Maori and non-Maori has still widened across the whole spectrum of ill health, including SIDS, immunisation rates, glue ear, asthma, youth and teenage pregnancy, youth suicide, self injury and motor vehicle injuries, cancer, diabetes, stroke, pneumonia and influenza, and mental ill health.⁵¹

The difference between Maori and non-Maori infant mortality rates, warned an article by senior Ministry officials in 1998, had widened from a ratio of 1.7 in 1984 to 2.2 in 1994.⁵² According to Dr Reid, the long-term rise in Maori life expectancy at birth halted in 1990 whilst it continued to increase for non-Maori. She concluded that ‘the gap is widening’.⁵³

In 1998, the Ministry of Health took a similar view in attributing the diverging health outcomes in part to growing socio-economic inequality:

There is evidence that economic disparities have resulted in increasing health disparities between Maori and non-Maori, and it has been argued that worsening socioeconomic conditions for Maori are the main cause of worsening health for Maori.⁵⁴

47. Data in Pomare and others, 1995

48. Te Puni Kokiri, 1998, pp 21–25

49. Signal, Durham, and Linton 1998, p 65

50. Document v6, app 3, p 13

51. Document w18(b)(8000), p 5; also Signal, Durham, and Linton, 1998, p 65

52. Signal, Durham, and Linton 1998, p 65

53. Document v6, app 3, p 13

54. Document w18(b)(8000), p 7

8.3 THE POSITIONS OF THE PARTIES

8.3.1 The case for the claimants

One of the grievances raised by the claimants is that the Ministry of Health has failed to take into account the differential impact of socio-economic status when making its transport assumptions on the minimum standards of access to health services. The claimants criticise in particular the assumption that people have access to a private vehicle.⁵⁵ Claimant counsel did not proceed further in his closing argument, but the alleged shortcoming was part of a wider allegation that Ahuriri Maori, especially those residing in Napier, had suffered adverse consequences from the downgrading and closure of Napier Hospital by virtue of having to travel to Hastings for hospital treatment.

Counsel's case was that the various shortcomings and failures of the State health system during the health reforms resulted in actual prejudice suffered by Ahuriri Maori. This took the form of adverse consequences arising from the series of decisions made on the status of Napier Hospital, and of continuing large disparities between the health status of Maori and non-Maori. He conceded that specific data on the situation of Ahuriri and Hawke's Bay Maori were hard to find. This deficiency he attributed to the failure of Crown health agencies to assess Maori health needs or to collect monitoring data.⁵⁶ In addition, the two-year gap between the closure of Napier Hospital and the opening of the Napier Health Centre left Ahuriri Maori without a local public health facility, causing hardship and access difficulties for those needing treatment.⁵⁷

The claimants also assert that Maori health status has worsened both absolutely and in comparison with non-Maori since the beginning of the health reforms.⁵⁸ Counsel advanced his case mainly in terms of the national situation rather than the local health status of Maori in Napier or Hawke's Bay. In addition to the individual cases given in claimant evidence, he relied principally on a 1998 Ministry of Health review of Maori health issues that indicated improving Maori health in some areas but at the same time a widening gap between Maori and non-Maori. The review, he asserted, provided 'shocking reading and an immediate and damning indictment of the health system's record in delivery of health outcomes to Maori'.⁵⁹

This situation, he considered, applied equally in Hawke's Bay:

The evidence on behalf of both Crown and Claimants gives no reason to believe that the health status of Hawke's Bay Maori is in any way better than the national picture identified in 'Bridging the Gap' . . . , and on the basis of the evidence that does exist suggests that it is probably worse.⁶⁰

55. Claim 1.57(c), para 12.19

56. Document x31, paras 13.2–13.4

57. *Ibid*, para 14.56

58. Claim 1.57(c), para 12.1

59. Documents w18(b)(8000); x31, para 12.2

60. Document x31, para 13.5

8.3.2 The case for the Crown

Crown counsel argued that the available evidence as to whether Maori health status had improved or deteriorated during the health reform period was inconclusive. Furthermore, the extent to which national data could be applied to the local situation in Napier was ‘very limited’. He pointed to expert evidence from Dr Colin Feek, chief adviser (medical) at the Ministry of Health, on the complexity of causal links between factors causing ill health and changes in health status, and on the sometimes lengthy, multi-generational timescale of response to changes in those factors. He argued that health services were just part of the spectrum of interventions needed to improve health status, and could sometimes exert only a minor leverage alongside other social programmes and socio-economic change.⁶¹

Counsel rejected the argument that the health status of Maori in Napier had been adversely affected by the regional hospital project. He accused claimant counsel of ignoring the benefits that the regional hospital was able to provide. The benefits extended beyond the acute hospital facilities to primary health programmes based in or near to the community, which were likely to be relevant to addressing a number of the health problems that hospitals only encountered in their final, acute manifestations.⁶²

8.3.3 The claimants’ reply

In reply, claimant counsel insisted that there was no information to back up the positive results claimed by the Crown. This deficiency was present in the quotations selected by Crown counsel in support. Nor was causal complexity a valid defence, since it was accepted that Maori health status was ‘appalling’ and that there was no evidence of recent improvement. Whether the identified health problems were national as well as local was irrelevant:

The issue is whether the Crown has met its obligations to the Maori of Ahuriri and Hawke’s Bay. Crown counsel is unable to point to any evidence that it has or indeed to undermine the criticisms that have been made by the claimants.⁶³

8.4 FINDINGS, TREATY BREACHES, AND PREJUDICE**8.4.1 The scope of our findings**

In this chapter, we concentrate on two health outcome aspects of the changes in the 1990s. The first is geographical access to services following their relocation off the Napier Hospital site. The second is the health status of Ahuriri Maori, and in particular the extent to which the policy goal of improvement was achieved. Both aspects are relevant to some of the structure and process grievances reviewed in chapter 7.

61. Document x48, paras 69–72

62. Ibid, paras 66–68

63. Document y8, paras 4.14–4.15

8.4.2 Did Healthcare Hawke's Bay make adequate transitional arrangements for its Napier-based services?

Extract from the statement of claim:

12.9 Healthcare Hawke's Bay and its predecessors have not considered the health care and health status of Maori as a significant issue in their service delivery planning.

The regionalisation of hospital services required that all acute and some outpatient services be transferred from Napier Hospital to Hastings. At the same time, the Central RHA's purchasing decisions in December 1996 specified a range of sub-acute and community services that Healthcare Hawke's Bay had to provide within Napier.

The question arises whether Healthcare Hawke's Bay made adequate arrangements to provide these services between the start of its shutdown of Napier Hospital in early 1998 and the opening of its new health centre in January 2000. Our *findings* are:

- ▶ that the closure of the accident and emergency department at Napier Hospital in January 1998 made Napier Maori dependent on Hawke's Bay Hospital in Hastings;
- ▶ that the charging regime for using the temporary accident and medical service may have acted as a significant deterrent to Ahuriri Maori in need of it;
- ▶ that Healthcare Hawke's Bay went ahead with its progressive closure of services at Napier Hospital even though its planned Napier Health Centre was some time away from opening;
- ▶ that outpatient clinics at Napier Hospital were scaled down in late 1998 and some were provided only at Hastings;
- ▶ that the quality of acute and outpatient hospital services for Maori patients at Hastings was at times less than adequate, as a result both of transitional stress in the midst of the regional hospital project and of poor integration of tikanga Maori into patient care; and
- ▶ that Healthcare Hawke's Bay made insufficient effort to keep Ahuriri Maori communities informed of its transitional service arrangements.

Our finding as to *Treaty breaches* is:

- ▶ that, in failing to make adequate provision for the transitional interval between reducing or closing non-acute services at Napier Hospital and opening those services at the Napier Health Centre, thereby disadvantaging low-income Maori communities disproportionately, Healthcare Hawke's Bay breached the principles of *active protection* and *equity*.

Our findings as to *prejudice* are:

- ▶ that, during 1998 and 1999, Ahuriri Maori, especially in low-income households, experienced additional hardship and emotional stress as in-patients of Hastings Hospital, as supporting whanau and as outpatients of clinics temporarily moved to Hastings; and
- ▶ that the additional burden on school staff, especially in Maraenui, in providing support to pupils travelling to Hastings placed extra stress on their educational work.

8.4.3 Does the transport-based access standard take sufficient account of socio-economic status?

Extract from the statement of claim:

12.19 The Crown through the Ministry of Health has not taken adequate account of the effects of socio-economic status in setting access targets for the health services, based on transport assumptions, particularly the ownership of or access to a private vehicle.

The claimants argue that, by setting access to a private vehicle as the transport criterion for travel to a health service, the national access standard discriminates against low-income communities and households, which are more likely not to have access to a vehicle. Maori thereby suffer disproportionately by virtue of being strongly represented in low-income categories. In respect of Ahuriri Maori, our *findings* are:

- ▶ that the low-income suburbs of Napier in which many Ahuriri Maori resided had a high incidence of carless households;
- ▶ that, during the period under review, the alleged distance barrier to access did not apply to accident emergencies, which were catered for by an ambulance service accessible to all;
- ▶ that, in urgent medical situations the standard call-out charge for an ambulance acted as a disproportionate burden on many Maori households;
- ▶ that, in the absence of a regular public transport link or a subsidised equivalent (see section 8.4.4), the chief barrier for non-urgent outpatients and for whanau visiting in-patients at Hastings was financial, since taxi services afforded round-the-clock urban cover; and
- ▶ that the cost of using a private vehicle for frequent trips to hospital could become a significant cost barrier for low-income Maori households.

Our findings as to *Treaty breaches* are:

- ▶ that the transport standard, assessing travelling distance by car as the most commonly available mode of transport, was on the whole practicable and reasonable; and
- ▶ that significant cost barriers may arise in low-income suburbs with a much higher incidence of carless households, a large Maori population, and little or no public transport to the district hospital, and may give rise to breaches of the principle of *equity* if not adequately addressed within the overall framework of social policy.

8.4.4 Has hospital and clinic access been adversely affected for Ahuriri Maori?

Extract from the statement of claim:

12.7 The Crown by itself and through the Crown health entities has continued to fail to give effect to its obligations under the 1851 Ahuriri transaction including providing effective health services and facilities for Ahuriri Maori from the site at Mataruahou.

12.8 The health clinic under construction in Napier is inadequate and inappropriate to meet Maori health needs at Ahuriri and the obligations of the Crown under the 1851 Ahuriri transaction.

For residents of Napier, the ‘hub-and-spoke’ model implemented by Healthcare Hawke’s Bay held out the prospect of an improved range and quality of acute services being available at the regional hospital, with some outpatient clinics also being located there, while most outpatient and community services would be provided through the Napier Health Centre. The implementation of that model for Napier was completed with the opening of the centre in early 2000. Our *findings* are:

- ▶ that, until the mid-1990s, most acute and outpatient services had been provided at Napier Hospital within walking or short driving reach of the great majority of Ahuriri Maori;
- ▶ that the common resort to its accident and emergency department as a free source of non-emergency treatment was important for some low-income Maori households;
- ▶ that, although access from Napier to all services at Hawke’s Bay Hospital was within the Ministry of Health’s transport standard and was no worse than in most metropolitan areas, it required Maori households in Napier to take longer road trips to reach acute, specialist, and some outpatient services once they had moved to Hastings;
- ▶ that the free bus between Napier and Hastings Hospitals provided a limited-hours service for non-urgent outpatients and for whanau supporting in-patients at Hastings;
- ▶ that those unable to use the free bus service faced additional financial and organisational stress, which also increased the demand for informal social support from schools such as Maraenui; and
- ▶ that, if opened as listed at the Napier Health Centre, many of the State-provided primary and public health services would be located no further from the main Maori communities of Napier than they had been at Napier Hospital.

Our findings as to *Treaty breaches* are:

- ▶ that, in balancing the unavoidable trade-offs between longer and more difficult journeys on the one hand and more and better acute hospital services on the other, equitable access for Maori communities facing greater transport hardship and higher health service needs remains a prime consideration;
- ▶ that, in the absence of regular public transport, the provision of a free or low-cost bus service to the regional hospital, as laid on, was in accord with the principles of *active protection* and *equity*; and
- ▶ that, beyond the transitional period (discussed in section 8.4.3), the provision of additional support for those patients and whanau obliged to travel outside the bus schedule and facing hardship would be consistent with the principles of *active protection* and *equity*.

8.4.5 Has Maori health status worsened over the health reform period?

Extract from the statement of claim:

12.1 Since the reforms began Maori health measured by mortality and morbidity has become worse in absolute terms and relative to non Maori.

The general aim of Government policy since 1992 has been to improve Maori health outcomes so as to reduce disparities in health status between Maori and non-Maori. The claimants assert that Maori health has worsened in both relative and absolute terms since the start of the health reforms in the late 1980s and in particular since 1993. Our *findings* are:

- ▶ that little evidence has been presented on local trends in the health status of Maori in Napier and Hawke's Bay;
- ▶ that Ahuriri Maori are nevertheless likely to have shared in the broad trends experienced by Maori nationally;
- ▶ that relevant ethnicity data are, however, either incomplete or compromised by definitional changes;
- ▶ that, in any case over short spans of five to 10 years, the period argued by the claimants, causal links between health interventions and changes in health status can often only be clearly demonstrated for narrowly specific cases, such as clearing an elective surgery waiting list;
- ▶ that on the available evidence it is not possible for us to draw conclusions on trends in Maori health status, whether nationally or locally, over the period of the health reforms;
- ▶ that the relative gap between Maori and non-Maori is, in our view, the more significant indicator, since it was this disparity that national policy on Maori health has been aiming to reduce from at least as far back as 1992;
- ▶ that during the 1990s the relative gap was not closing in many causes of ill health and may have widened in some;
- ▶ that in any case the size of the health disparity was and remains large, Maori lagging far behind in most significant categories of ill health;
- ▶ that the available socio-economic and ill health measures suggest that the disparity for most Ahuriri Maori is just as large as for Maori nationally;
- ▶ that, since the disparities persist across the whole spectrum of relative deprivation, a wider array of institutional and especially cultural factors may be worsening health outcomes for Maori and reducing the effectiveness of State health services for Maori;
- ▶ that both the size of the disparities and their relative widening have been known throughout the health reform period, and in increasing detail since the early 1990s;
- ▶ that, although other sectors have a major role in tackling the causes of Maori ill health, the responsiveness of the health system remains a vital factor; and
- ▶ that the urgency of the Crown's response to the clearly identified level of Maori health needs is a key indicator of its commitment to Treaty principles.

Our findings as to *Treaty breaches* are:

- ▶ that, in failing since 1980 and, more particularly, from 1993 to 1998 to address with urgency the improvement of the health status of Ahuriri Maori, the Crown and its health agencies have breached the principles of *active protection* and *equity*; and
- ▶ that the greater urgency shown by the HFA and the Ministry of Health since 1999 and the explicit statutory requirement for district health boards to tackle the disparity by improving Maori health outcomes afford some hope of more effective long-term action.

Our finding as to *prejudice* is:

- ▶ that, whether the health status of Ahuriri Maori has improved or worsened over the last decade, the disparity in health status between Ahuriri Maori and non-Maori nationally has probably shown little if any reduction and has remained markedly adverse;
- ▶ that the health outcomes for many Ahuriri Maori remain poor; and
- ▶ that a significant proportion of the ill health suffered by Ahuriri Maori was preventable but not prevented.

8.5 FINDINGS ON PREJUDICIAL EFFECTS

The extent to which the Crown can be held responsible for the health status of Maori being worse than that of non-Maori, even by a long margin, is necessarily limited. We need not repeat here the general issues of equity that we discussed in section 3.6. Several considerations affecting our use of health disparity as a measure of prejudicial effect must, however, be clarified.

The first is the issue of agency, or individual responsibility. In general, individual health outcomes cannot be laid at the door of the State. There are obvious exceptions, notably in cases of medical misconduct or the failure of a programme providing specific treatment for a defined group, such as the cervical screening programme. But commonly, individuals from either side of a disparity divide may experience equally poor or beneficial outcomes. At the same time, the general obligation to reduce the disparity between the respective groups is not diminished.

The second is the issue of particularity. Poor health outcomes may be associated with particular lifestyles or cultural associations. The much higher incidence of smoking amongst Maori is an example. Here too, the principles of active protection and equity rule out inaction. However, reducing the causal factor may be a very long-term aim and may depend, short of coercion, on a varying balance of State intervention and individual responsibility.

The third is the issue of causal timelag. Were an antismoking campaign to equalise Maori and non-Maori smoking rates overnight, the heavier health burden of past smoking would not finally dissipate for the adult Maori population for half a century or more, and the effects of passive smoking on their children would remain even longer. Conversely, equalising other conditions may have quick results. Both cases demand remedial action. The difference is that, in the first, the health consequences of smoking, the emphasis transfers from tackling the cause to mitigating the effects, until the equality of health outcomes is eventually achieved. During that time-lag, the overall health gap will remain but, crucially, will gradually close.

The fourth is the issue of multifactorial causation. Typically, a higher proportion of Maori living in low-income households and in poor housing is associated with marked health status disparities between Maori as a whole and non-Maori. Health interventions cannot directly address the low income and bad housing. Nevertheless, the poor health effects demand additional health sector effort across the appropriate mix of preventive, educational, and curative initiatives. So long as the effects of the non-medical causal factors are also taken into account, it is therefore acceptable to assess health outcomes as a measure of the effectiveness of health sector programmes.

From the patchy array of social and ill health indicators to hand, we find it reasonable to suppose that the health status of Ahuriri Maori remains sharply worse than that of non-Maori residents of the Napier area. Social and economic conditions have improved for Ahuriri Maori over the last decade. Their health status may have begun to follow suit. But non-Maori outcomes have improved faster, and large socio-economic and health disparities persist. Despite improvements and innovations in particular programmes, the State health system has yet to make much progress in achieving its goal of equitable outcomes.

CHAPTER 9

FINDINGS ON TREATY BREACHES

9.1 CHAPTER OUTLINE

In this chapter, we bring together from previous chapters all the findings we have made as to Treaty breaches and prejudice arising. In all cases, we have reproduced the exact text, adding brief prefatory notes in a few cases to set the context. For ease of reference, we have grouped Treaty breaches and prejudice under separate headings (sections 9.2 and 9.3 respectively), and the sequence follows the arrangement of the chapters. We conclude the chapter with an overview of our findings on the claim as a whole.

9.2 TREATY BREACHES

9.2.1 Chapter 5: The State health system and Ahuriri Maori, 1852–1980

On consultation regarding Napier hospital (section 5.4.2.1)

- ▶ that the Crown's failure to consult over the siting of the first hospital (1854–55 and 1859–60) and to ensure consultation over the relocation of the second hospital to the barracks reserve (1877–80) breached the principle of *partnership* and the duty of *consultation*, but that at the same time Ahuriri Maori were less concerned about precise location than with opening hospital services.

On consultation regarding health needs (section 5.4.2.2)

(Up to 1876)

- ▶ that consultation with Ahuriri Maori by the Government on the provision of a hospital and doctor, although largely reactive, was adequate in the 1850s and early 1860s;
- ▶ that the failure of the Hawke's Bay Provincial Council to consult Ahuriri Maori at any time about their health service needs and the configuration of services at Napier Hospital breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that the failure of the Government to consult Ahuriri Maori on the abolition and restoration of the NMO post at Napier breached the principles of *active protection* and *partnership* and the duty of *consultation*.

(After 1876)

- ▶ that the failure to require, by legislation or other means, the Hawke's Bay Hospital Board to consult or otherwise take account of Ahuriri Maori views of their health needs breached the principle of *partnership* and the duty of *consultation*;
- ▶ that the development of general health programmes without specific local consultation was within the legitimate bounds of *kawānata*;
- ▶ that the implementation of healthcare programmes designed specifically for Maori, such as the native health nurse scheme, without some form of consultation inclusive of Ahuriri Maori breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that, by contrast, the mode of marae-based consultation on village sanitary improvement pioneered by the Department of Health through the Maori councils, including the Tamatea Maori Council, fully conformed to the principle of *partnership* and the duty of *consultation*.

On establishing health needs (section 5.4.2.3)

- ▶ that the Government had sufficient broad information at the national level to comprehend the demographic and ill health plight of Maori as a whole; and
- ▶ that, by failing to inform itself of the actual health status of Ahuriri Maori communities until the 1920s and 1930s, and thus of the extent and type of need for primary health services, the Crown breached the principles of *active protection* and *partnership*.

On representation (section 5.4.3.1)

- ▶ that the failure to provide for Ahuriri Maori inclusion in provincial governance, including any say in the management of Napier Hospital, breached the principles of *partnership* and *equity*;
- ▶ that the exclusion of Ahuriri Maori from the governance of Napier Hospital breached the principles of *partnership* and *equity*; and
- ▶ that the failure to ensure any representation in the House of Assembly for Ahuriri Maori between 1854 and 1867, and thus any oversight over Government health services, breached the principles of *partnership* and *equity*.

On participation (section 5.4.3.2)

- ▶ that, although possibly impracticable in the late nineteenth century, the long-run failure to improve Maori workforce participation at Napier Hospital and in State primary health programmes operating in Hawke's Bay during the early twentieth century breached the principles of *partnership* and *equity*.

On health services under Maori control (section 5.4.3.3)

- ▶ that the absence of initiatives to give Maori a degree of control over hospital services for Maori at Napier Hospital may have missed significant opportunities to improve Maori uptake of hospital treatment but did not necessarily breach Treaty principles;
- ▶ that a similar absence in respect of Department of Health programmes specifically for Maori also did not necessarily entail Treaty breaches, and that sufficient information is lacking to arrive at conclusions on the situation in Hawke's Bay;

- ▶ that, having launched the Maori council scheme and induced Maori, including Ahuriri Maori through the Tamatea Maori Council, to rely upon it for improving the health of their communities, the Crown breached the principle of *partnership* by failing to resource the councils adequately or, for some years after 1911, at all; and
- ▶ that the removal of the power to regulate Maori medical tohunga and the partial suppression of tohunga by legislation from 1907 was in breach of the principles of *partnership* and *active protection*.

On the adequacy of Napier Hospital (section 5.4.4.1)

(Up to 1876)

- ▶ that the nine-year delay in fulfilling the promise of a hospital, although failing to take account of the urgent needs of Ahuriri Maori, was not unreasonable given the conditions of the time;
- ▶ that the hospital's open door to Maori conformed to the principle of *equity*; and
- ▶ that the space shortage and sub-standard conditions affected Pakeha and Maori alike and so did not breach the principle of equity, but might have breached the principle of *active protection* had Ahuriri Maori sought in-patient treatment at the same rate as Pakeha.

(After 1876)

- ▶ that the admission of Maori to Napier Hospital and their treatment there, which were ostensibly on the same basis as Pakeha, were promoted but not fully assured by the controlling legislation and Government policy, and conformed to the principle of *equity*;
- ▶ that there is insufficient evidence to assess whether in practice or in all periods discrimination against Maori in their admission to, and standard of treatment at, Napier Hospital did not occur;
- ▶ that the national policy of subjecting Maori in-patients to means-testing imposed a financial disincentive to hospital treatment through a period of widespread poverty, endemic ill health, heavy mortality, population decline, and very low uptake of hospital treatment, was applied at Napier Hospital, and breached the principle of *active protection*;
- ▶ that the failure to rectify the Hawke's Bay Hospital Board's exclusion of Ahuriri Maori from outdoor relief by legislation or other means was a breach of the principles of *active protection* and *equity*; and
- ▶ that the discrimination against Ahuriri Maori in poor and unemployment relief breached the principles of *active protection* and *equity*; and
- ▶ that the failure to provide adequate relief to Ahuriri Maori indigents breached the principle of *active protection*.

On the adequacy of state primary health services (section 5.4.4.2)

- ▶ that, in arbitrarily abolishing the NMO post in 1867 and in failing to restore it subsequently, while aware of the severe impact of introduced diseases and of ill health generally on Maori communities, the Crown breached the principle of *active protection*; and

9.2.2

- ▶ that the failure to extend other frontline primary health services to Ahuriri Maori communities in a timely manner and with sufficient resources breached the principle of *active protection*.

On responsiveness to tikanga Maori (section 5.4.4.3)

- ▶ that the failure to accommodate tikanga Maori in Napier Hospital during the provincial period breached the principle of *options* and, at a time of severe ill health and steep demographic decline, also the principle of *active protection* ;
- ▶ that the failure to ensure by legislative or other means that Napier Hospital assured cultural responsiveness to Maori patients breached the principle of *options* and, as a major barrier to Maori uptake of hospital treatment in times of severe ill health and mortality, also the principle of *active protection* ; and
- ▶ that a failure to accommodate tikanga Maori in the Department of Health's primary health programmes may have breached the principles of *options* and *active protection*, but there is insufficient evidence from Hawke's Bay for us to reach definite conclusions in respect of Ahuriri Maori.

On monitoring and supervision (section 5.4.4.4)

- ▶ that there is not sufficient evidence that the provincial monitoring and supervision of Napier Hospital breached Treaty principles;
- ▶ that the failure to ensure a consistent improvement in the poor performance of the Napier NMO breached the principle of *active protection* ; and
- ▶ that the failure from 1877 to monitor Maori usage of Napier Hospital and the effectiveness of its services to Maori, and to provide statutory means of remedying any deficiencies found, was a breach of the principle of *active protection*.

9.2.2 Chapter 6: Consultation with Maori on the closure of Napier Hospital*On the decision in principle to have a regional hospital (section 6.4.3.1)*

Three separate proposals to regionalise hospital services in Hawke's Bay emerged over a 15-year period: from the Hawke's Bay Hospital Board in 1980; from the Hawke's Bay Area Health Board in December 1990; and from the Healthcare Hawke's Bay Board-designate during the first half of 1993. Our findings as to *Treaty breaches* are:

- ▶ that, in respect of the first and second proposals, the Crown failed to ensure that the governing health legislation required hospital and area health boards to consult affected Maori communities on major reconfigurations of their services, especially to hospitals, and thereby breached the principle of *partnership* and the duty of *consultation* ;
- ▶ that, in respect of the first and second proposals, the Crown failed to invoke its powers of direction to ensure that the Hawke's Bay hospital and area health boards undertook appropriate consultation with Ahuriri Maori, and thereby breached the principle of *partnership* and the duty of *consultation* ; and

- ▶ that, in respect of the third proposal, the failure of the responsible Crown agencies (including, but not limited to, the Department of Health, the Hawke's Bay Area Health Board commissioner, and the CHE board-designate) to consult Ahuriri Maori breached the principle of *partnership* and the duty of *consultation*.

On the decision to base the regional hospital in Hastings (section 6.4.3.2)

- ▶ that the failure of the responsible Crown agencies (including, but not limited to, the Central RHA and Healthcare Hawke's Bay) to consult Ahuriri Maori adequately breached the principle of *partnership* and the duty of *consultation*; and
- ▶ that, in presenting the option of whether to have a regional hospital at all as being open when the decision had in fact already been made, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *good faith conduct*.

On the decision to remove Napier Hospital's guarantee (section 6.4.4.1)

- ▶ that, in failing to consult Ahuriri Maori on its decision to lift its linkage of Napier-based services to Napier Hospital, despite its 1994 assurance of continuation, the Central RHA breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*.

On the decision to close Napier Hospital (section 6.4.4.2)

- ▶ that, in failing to consult Ahuriri Maori adequately on its decision in principle to vacate Napier Hospital for a downtown health centre, despite its 1994 assurance of continuation, Healthcare Hawke's Bay breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*.

On the location and configuration of the Napier Health Centre (section 6.4.5)

- ▶ that, in deciding on the site of the Napier Health Centre and on its service configuration without adequate consultation with Ahuriri Maori, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *consultation*.

On fulfilling Government undertakings (section 6.4.6)

- ▶ that, while the Government must be able to exercise *kawanatanga* by changing its policies and resource allocations, that right must be tempered by due respect for *rangatiratanga*, a condition which in this case had been seriously compromised by the repeated failure to ensure adequate consultation with Maori in Hawke's Bay and with Ahuriri Maori in particular;
- ▶ that there is in this case insufficient evidence of a ministerial intention to deceive; and
- ▶ that the continued failure of Ministers, having given such assurances, to ensure that the Central RHA and Healthcare Hawke's Bay consulted appropriately with Ahuriri Maori on the decisions in 1996 and 1997 that led to the closure of Napier Hospital amounted to a breach by the Crown of the principle of *partnership* and the duty of *consultation*.

On consulting the descendants of the 1851 signatories (section 6.4.8)

- ▶ that the failure of Crown agencies to fulfil their obligation to consult all the representative tribal organisations of the descendants of the Ahuriri signatories even-handedly breached the principles of *partnership* and *active protection* and the duty of *good faith conduct*.

9.2.3 Chapter 7: Health services for Ahuriri Maori in the era of health sector reform*On statutory Treaty protection mechanisms (section 7.4.3)*

- ▶ that the health reform legislation did not provide the Minister of Health sufficient powers over land disposals by CHES to ensure that the Crown's Treaty obligations were met;
- ▶ that Healthcare Hawke's Bay undertook no alienations at the Napier Hospital site that affected the Crown's obligations to the present claimants;
- ▶ that the Public Health and Disability Act 2000, by providing for ministerial oversight, established direct Crown responsibility for protecting the interests of Treaty claimants in health agency land, including the interest of the present claimants in any proposed disposal of the Napier Hospital site;
- ▶ that the controlling health sector legislation applicable during the 1980s and 1990s did not incorporate any explicit recognition of Treaty principles, but neither did it prescribe any actions inconsistent with Treaty principles or prevent the Crown from meeting its Treaty obligations; and
- ▶ that the Public Health and Disability Act 2000 commits the Crown and its health agencies to a number of specific obligations consistent with the principles of *partnership* and *equity*.

On the adequacy of the Napier Health Centre (section 7.4.4)

- ▶ that, while Healthcare Hawke's Bay failed to consult Ahuriri Maori and missed a worthwhile opportunity to build partnerships with Maori healthcare providers, in general the location and service configuration that it adopted for the centre do not appear to have been in breach of Treaty principles; and
- ▶ that the design of the centre may have made insufficient accommodation for tikanga Maori but that, on this and other aspects, the evidence is insufficient for us to arrive at particular conclusions.

On representation at decision-making levels (section 7.4.5)

- ▶ that the failure of the Crown over a prolonged period to rectify the imbalance of Maori representation on the Hawke's Bay Hospital Board was, in our view, inconsistent with the principles of *partnership* and *equity*;
- ▶ that the CHE board appointments regime run by CCMAU conformed to the principle of *equity* but breached the principle of *partnership*;
- ▶ that the failure of the statutory framework until 2000 to provide for formal channels of communication between purchaser and provider agencies on the one hand and representative Maori organisations on the other breached the principle of *partnership*;
- ▶ that, in failing to vest sufficient authority in their advisory committees and, in the case of the Central RHA, adequate representation, the Central RHA and Healthcare Hawke's Bay breached the principle of *partnership*; and
- ▶ that the explicit provisions in the Public Health and Disability Act 2000 for ensuring proportional Maori representation on district health boards and standing committees are fully consistent with the principle of *partnership*.

On Maori workforce participation (section 7.4.6)

- ▶ that, in the case of the Central RHA/HFA, the lag between policy and performance in taking steps to improve Maori workforce participation brought its commitment into question in the early years, but taken over the whole period may have been reasonable in the circumstances, given that it was starting from scratch as a new type of agency; and
- ▶ that the lack of effort made by Healthcare Hawke's Bay to improve the participation and development of its Maori workforce breached the principles of *partnership* and *equity*.

On incorporating the Maori health gain priority (section 7.4.7)

- ▶ that, although it took more than five years to develop a comprehensive planning methodology for addressing the statutory Maori health gain priority, the development period was not unreasonable in light of the structural disruptions and the pioneering role of the purchaser agencies;
- ▶ that, by the late 1990s, the Maori health gain priority was adequately integrated into health expenditure planning methods;
- ▶ that, although committing resources to identified targets was a key implication of the general Government aim of reducing Maori health disparities, insufficient information is available on the volume and allocation of health expenditure in Hawke's Bay to enable us to reach a definite conclusion on how adequately the health agencies met their obligations; and
- ▶ that nevertheless the available evidence suggests a failure both nationally and in the Napier area to match expenditure and targeting to Maori health needs, and a breach by the Crown of the principles of *active protection* and *equity*.

On consultation regarding health service needs and delivery (section 7.4.8)

- ▶ that, although its consultation programme was proactive, in failing to ensure regional balance – in particular, by including Ahuriri Maori – the Central RHA breached the principle of *partnership* and the duty of *consultation*;
- ▶ that, by failing to meet its contractual obligations to consult local Maori, Healthcare Hawke's Bay breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*; and
- ▶ that, in failing to consult on issues significant to local Maori, irrespective of the lack of a statutory obligation to do so, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *consultation*.

On Maori structures for the delivery of mainstream services (section 7.4.9)

- ▶ that the Central RHA's failure to employ sufficient staff to sustain its Maori health unit's assigned objectives, especially in Maori provider development, verged upon being inconsistent with the principle of *partnership* and the duty of *good faith conduct*;
- ▶ that the limited and tardy efforts of Healthcare Hawke's Bay to develop its Maori health service breached the principles of *active protection* and *options*;

- ▶ that the failure to ensure by statutory or other means before July 1993 that hospital and area health boards implemented culturally appropriate services for Maori breached the principles of *active protection* and *options*;
- ▶ that the eventual incorporation by the Central RHA/HFA of specific quality standards into their CHE purchase contracts provided an adequate framework for CHES to develop culturally appropriate services;
- ▶ that nevertheless the failure to develop operational guidelines for implementing the policies and standards breached the principles of *active protection* and *options*; and
- ▶ that the failure of Healthcare Hawke's Bay to make a serious effort to implement kaupapa Maori quality standards in mainstream services at either Napier or Hastings Hospital before 1999 breached the principles of *active protection* and *options*.

On assessing the health needs of Ahuriri Maori (section 7.4.10)

- ▶ that, in failing to inform themselves adequately of the health situation of Ahuriri Maori by means of empirical research or by applying the insights of previous research from similar contexts, successive Crown health agencies have breached the principle of *active protection*; and
- ▶ that, in failing to publish sufficiently detailed and well-founded health status information on the communities they serve – in this case, Maori communities in the Napier area – the responsible Crown health agencies have breached the principle of *partnership*.

On monitoring agency performance and providing for Maori input (section 7.4.11)

- ▶ that the Central RHA's failure to monitor effectively Healthcare Hawke's Bay's performance of its Treaty and contractual obligations to provide culturally appropriate services breached the principles of *active protection* and *options*;
- ▶ that the Central RHA/HFA's reliance on informal persuasion and its reluctance to enforce strict contract compliance was understandable while developing and bedding in the new purchasing system, but that its failure to exert any leverage on Healthcare Hawke's Bay over a prolonged period amounted to a breach of the principles of *active protection* and *options*;
- ▶ that the failure to address adequately the known problems and limitations of ethnicity data and health outcome monitoring breached the principles of *active protection* and *equity*; and
- ▶ that the failure to involve representative local Maori organisations in designing or assisting the performance monitoring breached the principle of *partnership*.

On assisting local Maori health service provider development (section 7.4.12)

- ▶ that, up to the end of the hospital board era in Hawke's Bay, an effective partnership with Maori as providers to their own communities barely existed, the result of a statutory and policy regime that in this respect breached the principle of *partnership*;
- ▶ that, for all its flaws and limitations, the Maori provider programme as it developed during the 1990s did not breach Treaty principles – to the contrary, it affirmed the principles of *partnership* and *options* as well as the duty of *consultation*; and

- ▶ that the retarded state of the scheme in Napier and the failure to establish a relationship with a representative Maori organisation, in this case, Te Taiwhenua o Te Whanganui a Orotu, breached the principle of *partnership*.

On the merits of the purchaser/provider health system (section 7.4.13)

- ▶ that the structural flaws in the purchaser–provider model were not in themselves inconsistent with Treaty principles; and
- ▶ that particular policies, acts or omissions arising from the health sector reforms are, as indicated in previous sections, open to scrutiny in terms of their consistency with Treaty principles.

9.2.4 Chapter 8: Health status and outcomes for Ahuriri Maori

On transitional arrangements for Napier-based services (section 8.4.2)

- ▶ that, in failing to make adequate provision for the transitional interval between reducing or closing non-acute services at Napier Hospital and opening those services at the Napier Health Centre, thereby disadvantaging low-income Maori communities disproportionately, Healthcare Hawke's Bay breached the principles of *active protection* and *equity*.

On the transport-based service access standard (section 8.4.3)

- ▶ that the transport standard, assessing travelling distance by car as the most commonly available mode of transport, was on the whole practicable and reasonable; and
- ▶ that significant cost barriers may arise in low-income suburbs with a much higher incidence of carless households, a large Maori population, and little or no public transport to the district hospital, and may give rise to breaches of the principle of *equity* if not adequately addressed within the overall framework of social policy.

On access for Ahuriri Maori to hospital and clinic services (section 8.4.4)

- ▶ that, in balancing the unavoidable trade-offs between longer and more difficult journeys on the one hand and more and better acute hospital services on the other, equitable access for Maori communities facing greater transport hardship and higher health service needs remains a prime consideration;
- ▶ that, in the absence of regular public transport, the provision of a free or low-cost bus service to the regional hospital, as laid on, was in accord with the principles of *active protection* and *equity*; and
- ▶ that, beyond the transitional period (discussed in section 8.4.3), the provision of additional support for those patients and whanau obliged to travel outside the bus schedule and facing hardship would be consistent with the principles of *active protection* and *equity*.

On the trend of Maori health status over the health reform period (section 8.4.5)

- ▶ that, in failing since 1980 and, more particularly, from 1993 to 1998 to address with urgency the improvement of the health status of Ahuriri Maori, the Crown and its health agencies have breached the principles of *active protection* and *equity*; and

- ▶ that the greater urgency shown by the HFA and the Ministry of Health since 1999 and the explicit statutory requirement for district health boards to tackle the disparity by improving Maori health outcomes afford some hope of more effective long-term action.

9.3 PREJUDICE

9.3.1 Chapter 5: The State health system and Ahuriri Maori, 1852–1980

On consultation regarding the siting of Napier hospital (section 5.4.2.1)

- ▶ that no significant prejudicial effects resulted.

On consultation regarding health needs (section 5.4.2.2)

- ▶ that the failure to consult on the establishment of the first and second Napier Hospitals contributed to facilities that were too small to provide for the local Maori population and were not adapted to their needs, and thereby to few Ahuriri Maori receiving hospital treatment, notwithstanding the prevalence of widespread serious illness amongst them; and
- ▶ that the absence of consultation contributed to hospital and primary health services that failed to address the urgency of Maori ill health or to enjoy Maori confidence, resulting in many ill Maori failing to get the treatment they needed.

On establishing health needs (section 5.4.2.3)

- ▶ that the failure to restore the Napier NMO post, in part due to the lack of specific information on health needs, deprived Ahuriri Maori communities for half a century of the most effective primary healthcare then available, leaving them at the mercy of the diseases sweeping their communities; and
- ▶ that, when primary health programmes did begin to reach Maori communities in Hawke's Bay in the 1920s and 1930s, the Government lacked sufficient information to configure them so as to deliver sufficient and appropriate services, leaving much Maori ill health untouched by effective medical treatment.

On representation (section 5.4.3.1)

- ▶ that Ahuriri Maori were unable to influence the level, configuration and cultural sensitivity of services at Napier Hospital, greatly reducing Maori confidence in them and resulting in much untreated serious illness in Maori communities; and
- ▶ that Ahuriri Maori lacked parliamentary means of seeking redress for the poor performance of the Napier NMO and of contesting the withdrawal of the NMO post in 1867, which resulted in the loss of what was potentially the most effective medical service to their communities at the height of the devastation caused by introduced diseases.

On participation (section 5.4.3.2)

- ▶ that, despite the pioneering initiatives of the Maori health reformers in the early twentieth century, Maori were denied equality of opportunity in access to employment at Napier Hospital and in primary health programmes in Hawke's Bay; and

- ▶ that Maori opportunity to influence the development of culturally sensitive hospital and community healthcare services in Hawke's Bay was reduced, contributing to the low Maori uptake of State health services.

On health services under Maori control (section 5.4.3.3)

- ▶ that the lack of funding for the work of the Tamatea Maori Council and of the Maori health reformers, especially after 1910, severely limited both their effectiveness and health improvement amongst Maori communities in central Hawke's Bay; and
- ▶ that the suppression of indigenous practitioners made it more difficult for Ahuriri Maori to seek alternative forms of medical assistance in a period when most relied on indigenous medicine for healing their afflictions.

On the adequacy of Napier Hospital (section 5.4.4.1)

- ▶ that all but a handful of Ahuriri Maori who could have benefited from hospital treatment – battle casualties excepted – did not receive treatment in Napier Hospital during its first half-century, the period of their most urgent need; and
- ▶ that the exclusion of Ahuriri Maori from even the last-resort safety-net of outdoor poor and unemployment relief tightened the circle of exclusion from medical treatment, and worsened the high incidence of disease and death.

On the adequacy of State primary health services (section 5.4.4.2)

- ▶ that Ahuriri Maori were left virtually without State medical assistance through the half-century of their greatest medical distress.

On responsiveness to tikanga Maori (section 5.4.4.3)

- ▶ that the failure to accommodate tikanga Maori, especially cultural responsiveness, was a major factor in turning Ahuriri Maori away from Napier Hospital and in reducing the effectiveness of primary healthcare services, despite their urgent medical need.

On monitoring and supervision (section 5.4.4.4)

- ▶ that the low usage by Ahuriri Maori of Napier Hospital's services was neither measured nor addressed, despite the intensity of their medical needs, resulting in much unalleviated ill health; and
- ▶ that the NMO's neglect of his duties deprived Ahuriri Maori of an effective field doctor service at a time of urgent need.

9.3.2 Chapter 6: Consultation with Maori on the closure of Napier Hospital

On consultation with Ahuriri Maori (section 6.5)

The repeated failures to consult adequately or at all with Ahuriri Maori have resulted in several prejudicial effects that are directly attributable:

- ▶ confidence in the commitment of successive Crown health agencies in Hawke's Bay to working in partnership with Ahuriri Maori has been seriously eroded, damaging the cooperation needed to achieve faster improvements in health status;

9.3.3

- ▶ confidence in the good faith of consultation itself has been damaged by the belief that the agencies have little interest in taking Maori views seriously into account;
- ▶ the rangatiratanga of Ahuriri Maori, and especially the capacity to sustain the demanding practical obligations of partnership, has been placed under strain by their experience of repeated marginalisation from decisions on health service issues they view as important; and
- ▶ Napier Hospital was downgraded and then closed, acute and some outpatient services moved to Hastings, Napier services reconfigured, and the Napier Health Centre located and designed all without the input of Ahuriri Maori and the effective opportunity to advocate alternative options.

9.3.3 Chapter 7: Health services for Ahuriri Maori in the era of health sector reform*On representation at decision-making levels (section 7.4.5)*

- ▶ that Ahuriri Maori, whether directly or through a larger Maori grouping, were inadequately represented or not represented at all on the governing bodies of the district health agencies on which they relied for most State-provided health services;
- ▶ that they were denied the opportunity to have their views considered and to influence decisions affecting their health services, notwithstanding their greater need for such services; and
- ▶ that their exclusion from health sector governance weakened their institutional ability to exercise rangatiratanga, and thus to participate effectively in other partnership processes such as consultation.

On Maori workforce participation (section 7.4.6)

- ▶ that the inadequate participation of Maori in the workforce, especially at senior levels, made the development of culturally appropriate services for Maori patients at both Napier and Hastings Hospitals more difficult.

On incorporating the Maori health gain priority (section 7.4.7)

- ▶ that, at least until the late 1990s, it is likely that insufficient resources were committed to addressing the health needs of Ahuriri Maori and that the targeting of those resources was deficient.

On consultation regarding health service needs and delivery (section 7.4.8)

- ▶ that Ahuriri Maori were denied sufficient opportunity to communicate their views and health needs to the State purchaser;
- ▶ that the Napier health services on which Ahuriri Maori relied were reconfigured without their effective input and, they believed, to the detriment of those health services; and
- ▶ that Healthcare Hawke's Bay lacked proper advice from Ahuriri Maori on Treaty perspectives and tikanga Maori to develop culturally appropriate hospital services for local Maori.

On Maori structures for the delivery of mainstream services (section 7.4.9)

- ▶ that the short-staffing of the Central RHA's Maori health programme contributed to insufficient consultation with Ahuriri Maori, to limited support being given to the development

of Maori providers, including in Napier, and to inadequate monitoring of Healthcare Hawke's Bay's services to Maori;

- ▶ that, under the hospital and area health board regime, monocultural practices persisted as a significant barrier to Ahuriri Maori gaining the full benefits of hospital treatment; and
- ▶ that the slow and incomplete introduction of culturally appropriate services at Napier and Hastings Hospitals perpetuated that barrier and caused distress to Ahuriri Maori patients and their whanau.

On assessing the health needs of Ahuriri Maori (section 7.4.10)

- ▶ that, in the absence of adequate local information, Crown health agencies have not sufficiently adapted their services, especially in the field of primary healthcare, to the health needs of Ahuriri Maori; and
- ▶ that Ahuriri Maori have lacked sufficient information on their health status to participate fully as citizens and as partners of the Crown.

On monitoring agency performance and providing for Maori input (section 7.4.11)

- ▶ that the Central RHA's failure to monitor and ensure compliance with the kaupapa Maori quality standards that it prescribed in its purchase contracts resulted in poorer hospital service for Ahuriri Maori patients and whanau and decreased the effectiveness of those services;
- ▶ that, similarly, the failure to ensure that the required consultation obligations were fulfilled led to a culture of non-consultation becoming entrenched and Ahuriri Maori being excluded from input into decisions affecting services on which they relied; and
- ▶ that the low priority and lack of Maori input, at least until 1999, for the monitoring of health outcomes for Maori retarded the ability of the health sector to improve its performance and its responsiveness to Maori.

On assisting local Maori health service provider development (section 7.4.12)

- ▶ that, with minor exceptions, Ahuriri Maori have not been empowered to provide primary healthcare services for their own communities; and
- ▶ that Maori providers in Napier have not received adequate assistance for their service development.

9.3.4 Chapter 8: Health status and outcomes for Ahuriri Maori

On transitional arrangements for Napier-based services (section 8.4.2)

- ▶ that, during 1998 and 1999, Ahuriri Maori, especially in low-income households, experienced additional hardship and emotional stress as in-patients of Hastings Hospital, as supporting whanau and as outpatients of clinics temporarily moved to Hastings; and
- ▶ that the additional burden on school staff, especially in Maraenui, in providing support to pupils travelling to Hastings placed extra stress on their educational work.

On the trend of Maori health status over the health reform period (section 8.4.5)

- ▶ that, whether the health status of Ahuriri Maori has improved or worsened over the last decade, the disparity in health status between Ahuriri Maori and non-Maori nationally has probably shown little if any reduction and has remained markedly adverse;
- ▶ that the health outcomes for many Ahuriri Maori remain poor; and
- ▶ that a significant proportion of the ill health suffered by Ahuriri Maori was preventable but not prevented.

9.4 OVERVIEW OF PREJUDICIAL EFFECTS

The evidence adduced in respect of the claim before us, both supporting and opposing, falls into two unevenly balanced periods. The first, ‘historical’, period covers nearly a century in the aftermath of the 1851 Ahuriri transaction. The grievances are broadly framed, and the evidence on local health services and outcomes for Maori in central Hawke’s Bay is far from comprehensive, although generally sufficient for us to reach findings on most issues arising. The second, ‘contemporary’, period focuses on the 1980s and 1990s and especially on the seven-year period 1993 to 1999. The grievances are more numerous and specific, and the evidence is voluminous.

A second imbalance works in the opposite direction. In the mid-nineteenth century, Western medical technology was virtually helpless against disease and bodily malfunction. Even in the 1920s and 1930s, its strengthening powers were restricted until the post-war antibiotic revolution. By contrast, the surgical and curative powers of conventional medicine seem today almost boundless, limited only by the ability to fund them. The lengthy historical period of limited potential for medical intervention is thus juxtaposed with a short contemporary period with scope for intervention on many fronts.

We are in no doubt that Ahuriri Maori, in common with Maori nationally, suffered grievous ill health during the century following the signing of the Treaty of Waitangi. Foreign diseases were the dominant and inevitable cause. Yet, throughout the period, State medical services barely reached Maori people and communities in central Hawke’s Bay. By the 1920s and 1930s, the yawning gap in health status persisting between Maori and non-Maori exposed the extent of the failure to protect Maori health – the ‘vast amount of unnecessary suffering, crippling and mortality’ attributed in 1932 by the responsible medical officer of health to Maori communities in Hawke’s Bay.¹ Even if the strongest potential for improving Maori health lay in other fields of social action, such as housing and nutrition, the absence of medical outreach was telling.

By the 1980s and 1990s, Ahuriri Maori were benefiting from both hospital and primary healthcare services, though not always in proportion to the intensity of their needs. In absolute terms, their state of health had improved vastly during the second half of the twentieth century. But so had that of non-Maori – the gap was still wide and, in the 1990s, was ceasing to close in

1. Quoted in doc U12, p78

many areas of ill health. The gap was, moreover, only partly explicable in terms of the higher proportion of Maori living in more deprived areas.

As in the 1930s, the agenda for State intervention had many fronts. Environmental and socio-economic changes, in particular to family incomes and to housing conditions, were still powerful levers for health improvement. Even so, the scope of medical action and health services was now very much wider and more effective, and its potential was growing exponentially. That potential was at the disposal of the Crown to meet its Treaty obligation to improve Maori health. As public health policy evolved through the 1980s and 1990s, it connected with increasing precision with a growing official willingness to recognise that obligation.

We encounter here a paradox of Treaty responsiveness. As governments have translated Treaty principles into specific policies and programmes, here, in the sophisticated and complex field of healthcare, so they have multiplied yardsticks of accountability. Many of the contemporary grievances advanced in this claim are concerned with the apparatus of obligation and performance. Their absence would, however, in no way diminish the extent of the Crown's Treaty obligations. The adoption in 1992 of an overarching policy goal of improving Maori health outcomes towards equality with non-Maori did not excuse the Crown from attempting to achieve that result in previous periods.

Our review of the evidence bearing on the contemporary grievances has yielded mixed conclusions. Some of the recent policy development and planning methodology has been impressive. Much appears, none the less, to have remained on a rhetorical plane, especially at the operational coalface. Ahuriri Maori communities have yet to see significant improvements in many aspects and have suffered a worsening of access with the closure of their local hospital. It is unlikely that their health outcomes have improved much over the past decade. Their community-based providers remained small and isolated, their representative organisations marginalised. A key index of prejudice is how much more could have been achieved – through appropriate services, partnership and empowerment – in redressing the health disparities that all agreed were unacceptable.

CHAPTER 10

RECOMMENDATIONS

10.1 CHAPTER OUTLINE

In this chapter, we present our recommendations on the relief sought by the claimants. We assess each distinct request presented in the statement of claim, and end by recording several general conclusions relevant to the application of Treaty principles in the health sector.

10.2 A STUDY OF THE HEALTH NEEDS OF AHURIRI MAORI

Extract from the statement of claim:

(e) A recommendation that an independent specialist body consisting of Maori and Health specialists including the named claimants in this claim be set up to undertake a comprehensive inquiry on terms of reference set by the Tribunal into Maori health needs in the Hawke's Bay and Ahuriri in particular, including health and cultural needs and including an investigation as to whether an appropriately funded facility for Maori health on the Napier Hospital site is appropriate. Further details of the relief sought under this head will be provided in due course.

Claimant counsel submitted that a comprehensive study of the health needs of Ahuriri and Hawke's Bay Maori was urgently required. We agree that the information gathered over the previous decade was limited and its analysis weak. Good empirical information on the health status of Maori in Napier or Hawke's Bay or nationally has been conspicuous by its absence in the evidence presented to this inquiry. We are inclined to agree with Mr Keelan that data can best be gathered and analysed on a national basis, but local survey-based research and case-studies are essential for a deeper understanding of problem issues and the progress made in addressing them. Since it is clearly unrealistic to expect that every community in the land be subjected to intensive research, it is important that the Hawke's Bay District Health Board, and boards elsewhere, take full account of relevant case-study insights.

We note that district health boards are required as a matter of course to assess the health status of their populations, which include Maori as an identified group in need of health improvement towards parity.¹ Herein, we think, may lie an opportunity to generate at least part of the information requested by the claimants.

1. Section 38(3)(a) of the Public Health and Disability Act 2000

The particular purpose that the claimants have in mind for the study they propose is to investigate whether a Maori health facility should be set up on the Napier Hospital site. We are sceptical as to what practical assistance a comprehensive study can be expected to give towards this investigation. The ill health profile of Ahuriri Maori communities is not likely to differ dramatically from that of similar Maori urban and rural populations elsewhere.

Speaking for the claimants, Matthew Bennett argued the case for a more focused investigation:

We deserve and demand the opportunities to address the health plight of our people. Therefore it is necessary that a feasibility study be done, so as to acquire a localised understanding of what our health plight is. Only then, will we be fully capable, of adequately addressing the lacking needs.²

There is, we believe, some merit in this proposal. We do not think it necessary to complete a socio-economic and ill health profile of Ahuriri Maori in order to make a decision in principle on establishing a health facility of the kind advocated by the claimants. At the same time, such a study would provide useful information for both Maori and official decision-makers in the planning of such a facility, which we discuss in section 10.3. Sufficient information is available in socio-economic indicators such as the deprivation index, in the various local and national health datasets, and in patient data from particular health programmes. The insights of national surveys, data analysis and case-study research from other regions can be brought to bear on the local situation. Complementing this desk-based analysis, there is ample scope for community-based field research in which the claimants and local Maori organisations should be full participants.

We recommend:

- ▶ that neither a specialist body nor a comprehensive study of health needs is required for the particular purpose proposed by the claimants, that of assessing the need for a Maori health facility on the Napier Hospital site;
- ▶ that the Hawke's Bay District Health Board discuss with the claimants and with other representative Maori groups in Hawke's Bay the need for a study of Maori health status with a view to fulfilling its statutory obligation to inform itself appropriately;
- ▶ that any such study be disconnected from decisions on the proposed Maori health facility, but be timed so as to contribute to its planning if it proceeds; and
- ▶ that the Hawke's Bay District Health Board give serious consideration to a participatory approach to health status research, enabling representative Maori groups and Maori providers to make effective contributions.

2. Document v19

10.3 ESTABLISHING A MAORI HEALTH CENTRE IN NAPIER

Extract from the statement of claim:

(e) . . . including an investigation as to whether an appropriately funded facility for Maori health on the Napier Hospital site is appropriate . . .

(f) A recommendation that the findings of the specialist body be acted upon.

(g) A recommendation that the Ahuriri Maori be adequately and appropriately funded to carry out research and make submissions to the body set out in paragraph (e) hereto.

In previous chapters, we concluded that some of the claimants' grievances against the Crown are well-founded in both the historical and the contemporary periods of their claim. The claimants do not request relief by way of monetary compensation. Their key proposal is that the Crown assist them to establish a Maori health facility on the Napier Hospital site.³

We endorse the proposal for a health facility for five main reasons:

- ▶ Its cost would be modest, while the prejudice arising from historical and recent breaches of Treaty principles by the Crown has in some respects been substantial and prolonged. Ahuriri Maori have suffered prejudice, and compensation by the Crown is appropriate.
- ▶ It would directly address their main objective, which is to accelerate the improvement of the health of Ahuriri Maori towards equality with non-Maori. This is in line with the long declared central goal of national health policy for Maori.
- ▶ It would complement the Napier-based services and facilities provided by the Hawke's Bay District Health Board, largely through the Napier Health Centre. These have been located and developed for the most part to the exclusion of Ahuriri Maori.
- ▶ It would fit well with the national encouragement given to the development of Maori health providers and, in particular, integrated primary care. Provision by Maori for Maori, which has expanded elsewhere, has been retarded in Napier.
- ▶ It would bring under Ahuriri Maori management some of those services most directly relevant to improving their health status. Inadequate access to appropriate primary healthcare has been one of the central issues in historical and modern times for Ahuriri Maori.

As indicated in section 10.2, we do not think that a study of the health needs of Ahuriri Maori is an essential precursor to a decision in principle on the merits of the proposal. Those needs, we believe, are likely to be substantial, concentrated and urgent:

- ▶ Ahuriri Maori constitute a sizeable population, which is most heavily concentrated in the inner Napier suburbs of Maraenui, Marewa and Onekawa South; and
- ▶ the majority of Maori in the inner suburbs live in decile 9 or 10 areas, which together make up one of the most deprived urban zones in New Zealand.

Mr Bennett proposed a mix of primary and secondary health services for the health facility.⁴ We do not believe that it is any longer feasible to locate acute hospital services away from the regional hospital, nor in-patient care, whether short- or long-term, with the possible exception of

3. Ibid

4. Ibid

overnight stays. Furthermore, although we have not seen it in operation, we have no reason to doubt that the accident and medical facility at the Napier Health Centre provides a fully professional service that would be expensive to duplicate at another site. A second accident and medical unit would in any case do little to enhance the service already provided to local Maori.

The most appropriate facility, in our view, would be one capable of providing a variety of primary, public, promotional, educational, and rongoa Maori health services. A suitable model would be an integrated care organisation similar to Tui Ora in Taranaki, referred to by Matthew Bennett in his evidence; Raukura Hauora o Tainui Trust; or Te Puna Hauora o Te Raki Pae Whenua on Auckland's North Shore.⁵ The facility would best function if it were to:

- ▶ operate from a common base as a community health centre;
- ▶ be managed by Maori on a bicultural basis but be open to all; and
- ▶ be governed by trustees on behalf of Ahuriri Maori.

A key question, one resonant with the history of this claim, is that of where the community health centre should be located. The claimants wish to make use of the Napier Hospital site. In our view, this is not the best option. On the one hand, Napier Hospital's buildings are configured for the functions of a general hospital and are not well suited to the purposes of a primary healthcare facility. On the other, we think that the most appropriate location for a community health centre is within the community that it serves. Since the densest concentration of people and health needs is centred in Maraenui–Marewa–Onekawa South, a location in that area would place the centre within walking distance of the majority of Ahuriri Maori residing in Napier.

We are acutely aware of the strong association with Napier Hospital felt by the claimants and Ahuriri Maori, as well as by the citizens of Napier generally. The association with the hospital on the hill stretches back to its foundation in 1860 and to the promise of a hospital in 1851 that, while not site-specific, was earmarked for the town that emerged as Napier. We are none the less convinced that it is now time to move on. Napier Hospital cannot be restored. The priority now should be to fashion a solution best suited to the needs of Ahuriri Maori.

That solution, as we have indicated, is likely to take the form of a health centre based in the middle of the Ahuriri Maori community. The premises for such a facility are likely to require modest space and technical adaptation. It might be possible to allocate space within the Napier Health Centre. However, the evidence that we have reviewed does not suggest that this option would be practicable or that it would be desired by either the claimants or the district health board. Every effort should be made to place the centre in the community.

We consider that the Crown should endow the community health centre by financing its capital costs. The principal purpose is to establish a secure, long-term foundation for the centre's operations in an unstable environment of short-term service contracts and governmental policy change. We recommend a means of funding the proposed endowment in section 10.4.

We also believe that there is merit in the claimants' suggestion that the health centre should include a research and information capacity to assist in configuring its services to a localised un-

5. Document v19(a); doc w18(b)(8000), p 24; Te Puni Kokiri 1993

derstanding of the health issues amongst the communities it serves.⁶ Our review of the evidence highlights the importance of such an understanding, and its absence in the Ahuriri context. We consider that a fund dedicated to carrying out community-based research and providing information might form part of the centre's endowment.

We see the endowment we propose as historically apposite. The promise of a public hospital was part of the consideration given for the Ahuriri block in 1851. Now the hospital which has stood on that land since the years of Napier's foundation has been shut down. It is fitting that the Crown should assist Ahuriri Maori to establish a health facility of their own to tackle health disparities that remains disturbingly wide in this 150th anniversary year of the Ahuriri deed.

Drawing together our conclusions, we *recommend*:

- ▶ that the 'facility for Maori health' proposed by the claimants be established as a community health centre;
- ▶ that the centre be governed by trustees on behalf of Ahuriri Maori and be bicultural in character, and that it address in particular the special health needs of Ahuriri Maori but open to all;
- ▶ that it function as an integrated healthcare organisation providing a variety of primary, public, promotional, educational and rongoa Maori health services;
- ▶ that the Crown endow the capital costs of the centre and a fund dedicated to community-based research and information; and
- ▶ that the centre be located within the inner suburban zone of Maraenui–Marewa–Onekawa South.

10.4 FUNDING THE HEALTH CENTRE AND HOLDING THE HOSPITAL SITE

Extract from the statement of claim:

(h) A recommendation that the Mataruahou site be retained for Maori health purposes and the current facilities maintained in good condition and properly secured until the review set out in paragraph (e) above is completed.

We note the sense of urgency expressed by both the claimants and the Crown in resolving in particular all matters affecting the disposition of the Napier Hospital site. The claimants wish to begin without delay to address the serious health issues persisting amongst Ahuriri Maori communities. The Crown wishes to dispose of the hospital site and, in the interim, to reduce the maintenance costs of the empty hospital.

We agree that retaining Napier Hospital in mothballs is currently a costly liability and can no longer be justified. The cost of holding and maintaining the site falls on the hard-pressed health budget, which serves Maori and Pakeha alike. Early progress towards a solution would be in the interests of both parties. We are aware, however, that negotiations for the settlement of Treaty

6. Document v19

claims commonly take a lengthy period to complete and, especially in the case of non-iwi claims such as this, may be further delayed by linkages to other claims. Current Government policy, as stated by the Office of Treaty Settlements, is that:

The Crown strongly prefers to settle claims at the iwi level. The Crown also needs to negotiate all the historical claims of an iwi at the same time. That is what we mean by comprehensive negotiations.

We are also mindful of the demands of natural justice that the settlement of grievances be not unduly prolonged, or, as the Minister in Charge of Treaty of Waitangi Negotiations recently commented, 'justice delayed is justice denied'.⁷

Accordingly, we have devised our recommendations in a manner designed to facilitate quick action. We are of course aware that the claim has historical as well as contemporary components. The claimants, however, do not request compensation for prejudice arising from their historical grievances. Rather, they seek remedies related to the current health disparities suffered by Ahuriri Maori.

As an alternative to the usual procedure for the direct negotiation of historical claims, we think that current Government policy on Maori health and the governing health legislation together provide an adequate framework for the action that we recommend the Crown take. Three of the six recently stated *key Government goals* for the public sector are applicable:

- ▶ Strengthen national identity and uphold the principles of the Treaty of Waitangi:
... resolve at all times to endeavour to uphold the principles of the Treaty of Waitangi.
- ▶ Restore trust in government and provide strong social services:
Restore trust in government by working in partnerships with communities, providing strong social services for all, ... promoting community development ...
- ▶ Reduce inequalities in health, education, employment and housing:
Reduce the inequalities that currently divide our society and offer a good future for all by better coordination of strategies across sectors and by supporting and strengthening the capacity of Maori and Pacific Island communities.⁸

If the community health centre that we recommended in section 10.3 is to become a reality in the near future, the most pressing need is to fund its endowment. The most constructive approach in our view would be for the Crown to utilise its powers under existing legislation. We noted in section 7.2.2.4 that the Public Health and Disability Act 2000 ties the disposal of district health board land to public health purposes:

Every DHB must use the proceeds of a sale of land, and any payments received in connection with an exchange of land, for the purchase, improvement, or extension of publicly-owned facilities for health purposes unless the Minister, by written notice to the DHB, approves a different use.⁹

7. Margaret Wilson 2000

8. Department of the Prime Minister and Cabinet 2001

9. Schedule 3 to and section 43(5) of the Public Health and Disability Act 2000

This would, we presume, also apply to any transfers of district health board land to other Crown agencies, including the Residual Health Management Unit.

We consider that the endowment of the proposed community health centre would be an eminently suitable call on the proceeds of the alienation of any part of the Napier Hospital site. Such an endowment would further one of the main objectives of Maori health policy, that being to build the capacity of Maori groups to provide for their own needs. It would establish a direct connection between the final departure from the Napier Hospital site and the empowering of Ahuriri Maori. And it would recognise the historical linkage to the original Ahuriri transaction, in which the promise of a hospital was part of the consideration for the land on which Napier Hospital has stood for 140 years.

In our opinion, the necessary decisions can and should be made without further delay. The most appropriate modality would be an agreement in principle between the claimants and the Crown on the establishment, governance and endowment of a community health centre. The principal parties to such an agreement are likely to be Te Taiwhenua o Te Whanganui a Orotu and the Hawke's Bay District Health Board. We encourage both parties to negotiate in good faith with the aim of reaching an early agreement. In our view, no steps should be taken to change the present status and ownership of any part of the hospital site until such an agreement in principle has been concluded.

We note also that other Maori claimants may have an interest in the hospital site. They include claimants appearing in the Mohaka ki Ahuriri regional inquiry, on which we are preparing our main report. It would be appropriate in our view for the Crown to retain ownership of the hospital land until such claims have been finally settled.

In respect of the Napier Hospital site and the funding of the proposed community health centre, we *recommend*:

- ▶ that the Crown and claimants take early steps to conclude an agreement in principle on the concept, general location and endowment of a community health centre within the framework of current Government policy on reducing health inequalities and building the capacity of Maori health providers;
 - ▶ that, once an agreement has been reached, the Napier Hospital site be transferred to the Residual Health Management Unit at a price equivalent to the full commercial value of the property;
 - ▶ that the agreed part of the proceeds be vested in trust for the purposes of endowing the community health centre;
 - ▶ that the fulfilment of the agreement in its entirety be regarded as a full and final settlement of this claim;
 - ▶ that, after the agreement is concluded, steps be taken to extinguish the existing health trust on part of the hospital land, which would then serve no further purpose;
 - ▶ that, if an agreement cannot be reached, the health trust be kept in place and the hospital site retained in district health board ownership pending a final settlement of this claim;
- and

- ▶ that, if it is proposed at any future time to alienate all or part of the hospital site from Crown ownership, the interests of other Maori claimants to the land be taken into account.

10.5 HEALTH POLICY AND SERVICE PARTNERSHIP WITH AHURIRI MAORI

Extract from the statement of claim:

- (k) A recommendation that pending the report of the specialist body set out in paragraph (e) hereto that the Crown and Crown health entities implement an effective partnership with Maori for the creation of appropriate policies and the provision of health services in Ahuriri and Hawke's Bay. Further details of the relief sought under this head will be provided in due course.

Since the close of our hearings, the Government has passed new legislation that provides for Maori representation on district health boards and their statutory committees. It also requires boards to consult local Maori, to enable them to participate in strategies for Maori health improvement, and to assist Maori providers. But it stops short of calling for partnership arrangements with Maori organisations.

In our view, the Public Health and Disability Act 2000, although rather vaguely worded, goes a considerable distance towards meeting the claimants' request. It encourages district health boards to enter into ongoing relationships with Maori groups in order to meet their statutory obligations. We note that the proposal mentioned by Mr Keelan – that Healthcare Hawke's Bay enter into a formal partnership agreement with Ngati Kahungunu Iwi Incorporated – has reportedly since been put into effect.

We endorse the claimants' view that partnership arrangements should be 'effective'. A purely nominal agreement will usually not be consistent either with the statute or with the principle of partnership. Nor does an iwi-level relationship remove the obligation for district health boards to take due account of the standing of significant representative Maori organisations in districts and large towns.

Maori input into the development of mainstream health services designed to improve Maori health is one principal dimension of partnership. Another is the development of Maori health providers. Because the latest health reform postdated our hearings, we have little evidence to hand on how it has affected the funding of Maori providers. The Public Health and Disability Act provides both for the Ministry of Health to provide direct funding and for district health boards to 'foster the development of Maori capacity'.

In the absence of evidence, it would be inappropriate to make specific recommendations. We note, however, that there is an obvious potential conflict of interest between district health boards as providers in their own right and boards as agencies of community development. This risk is exacerbated by the competitive culture inherited from their former manifestation as CHES. In the local context, if the scope of primary healthcare services delivered by Maori in

Napier is to expand from its present very small base, the volume of services delivered by the district health board through the Napier Health Centre may be reduced.

Enabling Maori to develop their own provider capacity will, in our view, be an acid test of the ability of the Hawke's Bay District Health Board to build a durable partnership with Ahuriri Maori. Self-evidently, there would be little point in endowing a community health centre under Maori management if it were not, like the Napier Health Centre, to receive State funding for at least some of its services. Whatever the current modality, we consider that a stable agreement on the range and volume of services to be funded at the proposed centre will be an essential platform for ensuring its reputation and viability.

We recommend:

- ▶ that the Hawke's Bay District Health Board establish a Treaty-based relationship with Te Taiwhenua o Te Whanganui a Orotu as a representative Maori urban and district organisation;
- ▶ that the Ministry of Health and the Hawke's Bay District Health Board enter into a framework agreement with Te Taiwhenua o Te Whanganui a Orotu on the scope of the health services to be provided at the proposed community health centre; and
- ▶ that the Ministry and board provide appropriate start-up and development assistance to the centre to build up its capacity as an integrated primary healthcare provider.

10.6 TREATY PRINCIPLES INCORPORATED INTO HEALTH LEGISLATION

Extract from the statement of claim:

- (i) A recommendation that the Crown amend the Health and Disability Services Act 1993 to include a section requiring the Crown and Crown health entities to give effect to the principles of the Treaty of Waitangi.

Since our hearing of the claim in 1999, the latest health reform has brought in a further round of major change. As we noted in section 8.2.2.3, the Public Health and Disability Act 2000, which repealed the Health and Disability Services Act 1993, included an explicit commitment to 'recognise and respect the principles of the Treaty'. The Act included a number of provisions promoting Maori participation in decision making and service delivery. It set district health boards the objective of reducing health disparities affecting Maori, and any other population group, by improving their health outcomes, and, more generally, of removing such disparities through targeted services developed in consultation with the groups concerned.¹⁰ We consider that the Act makes sufficient provision for the recognition and application of Treaty principles in the State health sector.

10. Section 22(1)(e), (f) of the Public Health and Disability Act 2000

10.7 TREATY MONITORING PROGRAMME IN THE HEALTH SECTOR

Extract from the statement of claim:

(j) A recommendation that the Crown and Crown health entities introduce a specific monitoring program to ensure compliance with the principles of the Treaty of Waitangi and Maori health policy consistent with the Treaty of Waitangi.

Performance and compliance monitoring are important in any system of public administration, and in our view are vital in the decentralised, contract-ruled regime that underpins inter-agency relationships in the reformed State sector. The evidence given in this inquiry has exposed a number of failures and deficiencies in health sector monitoring. We are uncomfortable at the ease with which one agency could pass the buck to another, and at how many opportunities for doing so were created during the purchaser-provider experiment.

The internal monitoring of one State agency by another, and ultimately by Parliament, tends to be preoccupied with financial management. We note that by the late 1990s some of the weaknesses of design and implementation were being addressed in the monitoring of policy and Treaty obligations to Maori. We are aware, however, that inadequate monitoring has been identified as a key weakness by other inquiries into health sector performance.

We do not think it appropriate for us to make detailed prescriptions. At the same time, we are inclined to support the spirit of the claimants' request. We *recommend*:

- ▶ that health service planning incorporate Treaty compliance into its methodologies;
- ▶ that results for Maori be identified in the monitoring of health programmes intended specifically or partly to benefit Maori;
- ▶ that representative Maori organisations participate in the design of monitoring procedures for programmes or programme components intended to benefit Maori;
- ▶ that sufficient and accurate ethnicity data be gathered to the extent needed to measure health service results for Maori;
- ▶ that monitoring results be collated and published at national and district levels in forms conveying clear and relevant information to Maori leaders and communities;
- ▶ that data on health outcomes for Maori at national and district levels be regularly published; and
- ▶ that periodic independent evaluations be undertaken both of programme performance and of the effectiveness of monitoring systems.

10.8 GUARANTEE OF CONSULTATION ON FUTURE HEALTH SERVICE DECISIONS

Extract from the statement of claim:

(1) A recommendation that the Crown and Crown health entities involved in provision of health services to Maori consult with Maori and relevant Maori organisations including

relevant hapu and iwi organisations affected before taking any decision which will effect the provision of such services.

Failures of consultation have been a major issue in this claim. In section 3.9, we concluded that the Crown is not obliged to consult Maori on all issues and every service change, but that a Treaty obligation to consult will arise quite frequently.

In section 3.9.3, we noted that the Public Health and Disability Act 2000, which was enacted after the close of our hearings, imposed explicit requirements on district health boards to consult with the communities they served. They included consultation with Maori and other population groups suffering adverse health disparities on 'services and programmes designed to raise their health outcomes to those of other New Zealanders'. The Act set a standard of consultation on changes to its strategic and annual plans that ensured an open and accessible process. We consider that the provisions in this Act go a long way towards providing the relief sought by the claimants.

Some ground, however, remains to be covered. Iwi and hapu organisations are not mentioned. Nor is there a requirement for culturally appropriate modes of consultation. We have previously given our view that the general methods of public consultation – written submissions, public meetings, public hearings or oral presentations – may not suffice to enable the Maori voice to be fully heard. Specific consultation with Maori communities and organisations, *kanohi ki te kanohi*, will often be essential. Depending on the context, this consultation may take a variety of forms, commonly including *hui* at *marae* or community venues and meetings with representative Maori organisations.

There is no need for us to repeat here the consultation standards we outlined in section 3.9.6. At the same time, we wish to highlight several lessons arising from the history of this claim, lessons which extend beyond the immediate process of consultation into the conduct of ongoing relationships in the spirit of partnership:

- ▶ The approach should be even-handed and consistent. Both the Central RHA and Healthcare Hawke's Bay were at times arbitrary as to whom they consulted and when, and Ahuriri Maori often missed out.
- ▶ The outreach should be sufficiently comprehensive. It may not suffice, for example, to restrict consultation to a top-level iwi organisation if groups representing substantial local Maori communities, be they iwi- or hapu-based or non-tribal, are thereby kept at the margin. Direct communication and meetings, *kanohi ki te kanohi*, will commonly be the methods preferred by Maori communities and leaderships.
- ▶ All communities affected by a specific change, particularly the reconfiguring of services or the closing or opening of a facility, should be included. Ahuriri Maori were often marginalised in favour of Hastings-based groups.
- ▶ Consultation overload can be eased by the relevant agency working to establish flexible partnership relationships with representative Maori organisations. These would afford Maori some say in whether consultation is in fact needed in a particular instance, and if it

is, by what process and with whom. The practice of unilaterally calling one-off hui by press panui can be disempowering as well as unsustainable for Maori communities and leaderships. Multi-agency coordination will also assist in this area.

Little evidence has been presented in this inquiry on what standards and guidelines – as opposed to ad hoc practice – have been adopted by the various health agencies on the conducting of consultation, apart from a brief guide published by the Ministry of Health in the mid-1990s.¹¹ We note that other agencies have published practical guides for use by their staff.¹²

We *recommend*:

- ▶ that the Ministry of Health prepare and publish an updated consultation guide for general use by Government agencies in the health sector;
- ▶ that each district health board prepare and publish its own district guideline;
- ▶ that in all cases the guidelines be drawn up in cooperation with representative Maori organisations;
- ▶ that the guidelines provide clearly articulated standards and operational information for practical use, covering such matters as type of issue, information to be provided, scope, frequency, meeting context, and process; and
- ▶ that the guidelines be widely distributed and regularly updated.

10.9 COSTS OF THE CLAIM

Extract from the statement of claim:

(m) The costs of this claim.

We have concluded that some of the grievances alleged by the claimants in this claim are well-founded and that the claimants have suffered prejudice thereby. We are also aware that a lengthy period has elapsed since the claimants submitted their first claim to the Waitangi Tribunal in 1994. During the intervening seven years, the claimants have incurred costs in submitting two claims and an urgency application and in preparing for the hearings on their and the Crown's evidence and closing submissions. We also note that, although this is not a generic claim, it has raised issues relevant to the application of the principles of the Treaty within the health sector as a whole, and has therefore served a wider public purpose.

We therefore *recommend*:

- ▶ that the claimants' reasonable costs in bringing both the Wai 473 and the Wai 692 claims be reimbursed in full.

11. Ministry of Health 1995

12. For example, Ministry of Justice 1997

Dated at *Wellington* this *30th* day of *August* 2001

W. Isaac

W W Isaac, presiding officer

John Clarke

J Clarke, member

Raja C.A. Maaka

RCA Maaka, member

M.P.K. Sorrenson

MPK Sorrenson, member

Elizabeth M. Stokes

EM Stokes, member

JJ Turei

JJ Turei, member



APPENDIX I

CHRONOLOGY

Timeline of developments in State healthcare for Maori in central Hawke's Bay	
1847–51	Widespread epidemics and illness in Hawke's Bay and the Wairarapa. Amateur doctoring by the missionary Colenso.
1849 (April)	Tareha and others offered to sell land to attract the organised settlement proposed by the Governor.
1851 (September)	A doctor and a hospital requested by Karaitiana Takamoana on behalf of Ahuriri Maori.
1851 (17 November)	Ahuriri deed signed, with verbal promise by Donald McLean of public reserves, including a hospital, in the town planned on the Northern Spit (the present Westshore).
1857 (August)	Dr Hitchings appointed native medical officer at Napier.
1860 (May)	First Napier Hospital opened on the top of Mataruahou, a 10-bed facility on Sealy Road. Built and run by Hawke's Bay Province.
1867 (June)	Native medical officer subsidy for Napier abolished and not restored.
1880 (July)	New Napier Hospital opened on the former barracks site. Financed by a mix of Government grants and fund-raising under a local hospital committee. Maori invited to donate but not to participate.
1885	Hawke's Bay Hospital Board established, which was to run Napier Hospital for the next century. Few Maori patients until the 1920s.
1898	Training of Maori nurse probationers pioneered by Napier Hospital for community service.
1900	Tamatea Council established in central Hawke's Bay under the Maori Councils Act, and active for at least a couple of decades.
1920s	District nurse supported financially by Hawke's Bay Maori.
1928	Hastings Memorial Hospital finally opened after a long campaign, but with limited services.
1931	Napier Hospital destroyed in Hawke's Bay earthquake, rebuilt in tandem with an expanded Memorial Hospital in Hastings to establish a two-hospital system.
1980	Hospital board's proposal for a new regional hospital situated between Napier and Hastings scuppered by local opposition and a ministerial veto. No consultation with Maori.
1989 (June)	Hospital board replaced by Hawke's Bay Area Health Board with a wider catchment zone and broader service mandate.
1990 (December)	Booz-Allen report, commissioned by area health board, proposed regional hospital at Hastings campus and possible move of remaining Napier-based services to a downtown location.
1991 (January–March)	Public consultation, but no direct consultation with Maori.
1991	Mihiroa Whare founded at Hastings Memorial Hospital on Maori initiative. A Maori health committee set up by the area health board but cut short.

THE NAPIER HOSPITAL AND HEALTH SERVICES REPORT

APPI

Timeline of developments in State healthcare for Maori in central Hawke's Bay—*continued*

1991 (2 August)	Area health board replaced by a commissioner without a decision on the regional hospital concept.
1993 (June)	Decision in principle to regionalise acute hospital services taken by the Crown health enterprise board-designate and carried over when Healthcare Hawke's Bay inaugurated (1 July). No public consultation.
1993 (July)–1994 (April)	A single acute hospital on the Hastings campus recommended by the Regional Hospital Task Force, with limited services remaining at a downgraded Napier Hospital. Task force project kept behind closed doors, public consultation not planned but accepted after intervention by local members of Parliament.
1994 (May–June)	Round of public consultation. Joint programme negotiated with Central Regional Health Authority but in practice run by HealthCare Hawke's Bay. Maori, especially from Ahuriri and northern Hawke's Bay, marginalised. Single inconclusive hui at Omahu (18 May) not followed up. Attention diverted to proposal for a Maori advisory committee.
1994 (July–August)	Regional hospital proposal approved and announced by HealthCare Hawke's Bay's board (21 July, 5 August), with limited increase in Napier-based services. These tied to Napier Hospital by Central Regional Health Authority.
1994 (October)	First Waitangi Tribunal claim, alleging inadequate consultation, filed by Tom Hemopo on behalf of Te Taiwhenua o Te Whanganui a Orotu. Registered as Wai 473, but not until 2 March 1995.
1994 (December)	HealthCare Hawke's Bay's Maori Advisory Committee established with elected representatives from four taiwhenua districts.
1994 (December)– 1995 (April)	Successful High Court challenge by Napier City Council followed by limited further consultation. Ahuriri Maori excluded from the process. Decision reconfirmed and announced by HealthCare Hawke's Bay's board (28 March, 5 April 1995).
1995 (June)	Planning of regional hospital begun in earnest. Upgrading of Mihiroa Whare into a Maori health centre included.
1996	Maori health manager appointed (February) and Maori health centre opened at Hastings Hospital (July).
1996 (September)	Central Regional Health Authority's consultation on its purchasing intentions for Napier limited to a stakeholder meeting and written submissions. Its scepticism about retaining the Napier Hospital site guarantee publicly signalled. Maori groups excluded and no direct consultation carried out, nor any explicit proposal made to remove the guarantee.
1996 (December)	Napier Hospital site guarantee nevertheless removed in the Central Regional Health Authority's published purchasing intentions for Napier-based services.
1997 (March–September)	Napier Services Working Party set up by HealthCare Hawke's Bay to report on options for vacating Napier Hospital for a downtown health centre. Run as an internal process, but local general practitioners and council drawn in. No input from Maori staff, the Maori Health Committee, or Maori groups.
1997 (November)	Limited public consultation belatedly decided and undertaken, Maori marginalised. No direct consultation with Maori groups.
1997 (16 December)	Decision in principle taken by HealthCare Hawke's Bay's board to vacate Napier Hospital for a new downtown health centre. A suitable site and financing not yet lined up.
1998 (January)	Second Waitangi Tribunal claim filed and registered as Wai 692. Application for urgent hearing declined.

Timeline of developments in State healthcare for Maori in central Hawke's Bay—*continued*

Early 1998	Transfer of most of Napier Hospital's acute services to Hastings completed. Accident and medical services contracted out to the general practitioner-run City Medical (March 1998).
1999 (June–July)	Wai 692 claim heard in Napier as part of the Mohaka ki Ahuriri regional inquiry (8–10 June), followed by Crown evidence (29–30 July, 2 August).
2000 (January)	Services started at the new Napier Health Centre, last services at Napier Hospital closed, the centre formally opened on 26 April.
2000	Treaty partnership agreement concluded between HealthCare Hawke's Bay and Ngati Kahungunu Iwi Incorporated.
2001 (January)	Hawke's Bay District Health Board established.

Timeline of developments in the State healthcare sector

1840	Treaty of Waitangi signed.
1841	Supplementary Crown Colony instructions required 15–20 per cent of Crown land sale proceeds to go into an endowment fund for Maori welfare that included ‘promoting the health . . . of the natives’.
1847	Governor Grey’s public hospital programme, intended mainly for Maori, started in four settler towns. Complemented by subsidised native medical officer scheme.
1852	The endowment fund replaced by the Constitution Act with a fixed £7000 per annum Civil List appropriation for Maori purposes.
1854	Public hospitals transferred to provincial control, with hospital subsidies for Maori patients and the native medical officer scheme paid from the Civil List. Efforts to respect tikanga Maori were short-lived.
1860s	Hospital subsidies ended, Maori patients placed on same footing as Pakeha, native medical officer posts reduced.
1875	Provinces abolished, hospitals left under local control.
1885	Hospital board regime set up by the Hospitals and Charitable Institutions Act with local body control and mixed income sources, including Government subsidies. All patients, including Maori, means-tested for payment of hospital fees. Boards directly elected from 1909.
1900	Maori Councils Act led to limited Maori empowerment to mount community public health schemes under district councils and komiti marae.
1907	Maori health practitioners put at risk by Tohunga Suppression Act.
1911	Government funding of Maori sanitary inspectors ended. Maori district nurse scheme started, initially on a small, ad hoc basis.
1938	Universal entitlement to free hospital treatment provided under the Social Security Act, but primary healthcare not covered.
1989 (June)	The remaining hospital boards replaced countrywide by elected area health boards delivering most State health services to larger regions. State funding tied to contracts and strategic planning.
1991 (August)	Area health boards replaced by commissioners to oversee the planned health sector restructuring.
1992	Government health policy for Maori published in <i>Whaia te Ora mo te Iwi</i> , recognising the Treaty and setting broad guidelines for action by Stage agencies to improve Maori health.
1993 (July)	The purchaser–provider split implemented through Crown health enterprises delivering State health services on a commercial model, and regional health authorities purchasing services from Crown health enterprises and other providers, including Maori groups. Both agencies run by centrally appointed boards. No explicit Treaty recognition in the Health and Disability Services Act, but Maori ‘special needs’ written in. Ownership interest overseen by Crown Company Monitoring Advisory Unit.
1997 (July)	Regional health authorities merged into Transitional Health Authority.
1998	Crown health enterprises renamed hospital and health services and placed on non-profit basis. The Transitional Health Authority established as national Health Funding Authority.
2001 (January)	Local democratic control re-established by the Public Health and Disability Act 2000. hospital and health services replaced by district health boards. The Health Funding Authority absorbed into the Ministry of Health. The Treaty recognised in the Act and obligations to promote Maori health improvement incorporated.

APPENDIX II

STATEMENTS OF CLAIM

WAI 473

Re: Healthcare Hawke's Bay Ltd –
Breach of the Treaty of Waitangi

We act for Mr Tom Hemopo and for the Te Taiwhenua o Whanganui-A-Orotu with the support of Runanga Wahine ki Whanganui A Orotu ('the Claimants').

The claimants submit to the Waitangi Tribunal the following claim which is that Healthcare Hawke's Bay Ltd has failed to consult with the tangata whenua and has breached the Treaty of Waitangi.

.

Jurisdiction

Section 6(1)(c) of the Treaty of Waitangi Act 1975 ('the Act') it is submitted gives the claimants in this particular claim jurisdiction. The thrust of the claim is aimed at the policy and practice adopted by or on behalf of the Crown or by any policy or practice proposed to be adopted on behalf of the Crown. It is respectfully submitted that the omission is to consult. The adoption of the decision dated 5 August 1994 to devolve the hospital services at Napier Hospital without consultation with the tangata whenua is covered by the Act and the Tribunal has jurisdiction to hear this claim. The practice involved was the act and/or omission of the CHE to improperly and to fail to consult. The failure to consult was inconsistent with the terms of the Treaty of Waitangi and is a claim that can and is being made by the claimants.

It is submitted further that the CHE, as a Crown Owned Company (CROC), is an SOE in terms of Section 9 of the State Owned Enterprises Act 1986. That leads to the further submission that the CHE has breached Section 9 of that Act.

WAI 692

STATEMENT OF CLAIM

Dated 8 January 1998.

We,

Hana Loyla Cotter, (Ngati Kahungunu), Te Kahu Korowai o Te Kohanga Reo, of 10 Lowry Cres, Marewa,

Takuta Hohepa Mei Emery, (Ngati Maniapoto/ Kahungunu/ Rangitane/ Te Arawa), a School Teacher, of 3 Rose St, Ahuriri,

Pirika Tom Hemopo, (Rongomaiwahine/ Kahungunu/Waikato/Maniapoto), a Probationary Officer, of 19 Geddis Ave, Maraenui,

for ourselves, and Te Taiwhenua o Te Whanganui a Orotu, and the peoples within the Ngati Kahungunu tribal region, claim we are prejudicially affected by the Healthcare Hawke's Bay Ltd decision to remove hospital services from the present hill site, and we claim that this matter is contrary to the principles of the Treaty of Waitangi.

We seek the following relief

that the above decision be reversed, ie all former services be reinstated at the Napier Hospital.

that all processes involving a) the removal of equipment and/or material, and b) the demolition, change to, sale and/or rental of buildings, paths, lanes and roading, cease immediately.

that an audit be immediately undertaken by an independent committee of the consultation procedures of Healthcare Hawke's Bay Ltd with Maori of the Ngati Kahungunu tribal region.

that urgency be given to this claim because of the adverse effects this decision has had, and will continue to have on Maori health.

We believe that Healthcare Hawke's Bay Ltd is in breach of articles one and three of the Treaty of Waitangi, and that its actions and activities to date,

APPII

are in direct violation of the spirit and intent underlying the partnership forged by our ancestors.

We ask permission to amend this claim if necessary.

WAI 692

FIRST AMENDED STATEMENT OF CLAIM

Dated 27 January 1998.

PLEASE TAKE NOTICE that we HANA LOYLA COTTER (Ngati Kahungunu), Te Kahu Korowai o Te Kohanga Reo, of Napier, TAKUTA HOHEPA MEI EMERY (Ngati Maniapoto/Kahungunu/ Rangitane/Te Arawa), School Teacher of Ahuriri and PIRIKA TOM HEMOPO, Probation Officer of Napier being the claimants under CLAIM WAI 692/O HEREBY AMEND that claim by the additional claim as follows:

CLAIM for ourselves and Te Taiwhenua o Te Whanganui a Orotu and the peoples within the Ngati Kahungunu tribal region claim that we are prejudicially affected by the action of the Crown through its agent or assignee, Health Care Hawke's Bay Limited, in its decision to cease provision of and effect removal of hospital services and facilities from the present hill site on Mataruahau and we claim that, in addition to the breaches claimed in our claim dated 8 January 1998, that such action or actions are a breach of Article Two of the Treaty of Waitangi in that:

1. The action and decisions undertaken or made by the Health Care Hawke's Bay Ltd to the date of this claim and proposed to be made hereafter do amount to a fundamental breach of the agreements entered into between our tipuna and the Crown to provide a hospital and associated services for the people of the region from the site of Mataruahau.

2. If such action is permitted to continue, and the actions so far committed not reversed, then the Crown will have obtained an unjust enrichment from our people in contravention of the spirit of all Articles of the Treaty of Waitangi.

Relief Sought

In addition to the relief sought in our claim dated 8 January 1998 we seek that the Tribunal do make recommendations as follows:

(a) Restoration of full medical and hospital facilities and services from the Mataruahau site to a standard required to comply with the agreements made between the Crown and our tipuna.

(b) In the event that the Crown, whether through its agent and assignee Health Care Hawke's Bay Limited or otherwise, do not revoke its decisions made and do not restore such facilities and services then we seek return to those persons rightfully entitled, of all hospital services and facilities in the region comprising the Ahuriri Block and such further or other resources as may be required to enable Maori to hereafter provide full medical and hospital services to the people of that region.

(c) In the alternative, provision by the Crown of compensation sufficient to replace the services and facilities so lost including sufficient compensation to continue provision of such services and facilities for the future.

Urgent Interim Relief

In addition to the substantive relief sought we seek that this Tribunal do make AN URGENT RECOMMENDATION to the Crown to direct its agent or assignee, Health Care Hawke's Bay Limited to:

(a) Refrain from implementation of any action by it which would have the effect of diminishing the provision of full hospital services and facilities to the people of the Ahuriri Block.

(b) Do all such things as may be required to be done by it to immediately restore full hospital services and facilities to the site on Mataruahau.

(c) In particular to immediately refrain from the disposition of any items of equipment, land or buildings required to provide such services or facilities and the demolition or destruction of such equipment or buildings.

Confirmation Of Original Claim

In all other respects we confirm the content of our claim dated 8 January 1998.

WAI 692

**SECOND AMENDED
STATEMENT OF CLAIM**

Dated 31 May 1999.

IN THE WAITANGI TRIBUNAL

IN THE MATTER OF The Treaty of Waitangi
Act 1975

AND

IN THE MATTER OF a claim to the Waitangi
Tribunal by Hana Loyla
Cotter, Takuta Hohepa
Mei Emery and Pirika
Tom Hemopo on behalf
of themselves, Te Tai-
whenua o te Whanganui
a Orotu and the peoples
within the Ngati Kahu-
ngunu tribal rohe of
Ahuriri.

1. INTRODUCTION

1.1 This second amended statement of claim amends, incorporates and substitutes the original statement of claim dated 8 January 1998 and the first amendment to the claim dated 27 January 1998.

2. THE CLAIMANTS

2.1 This claim is lodged by Hana Loyla Cotter (Ngati Kahungunu), Te Kahu Korowai o te Kohanga Reo of Napier, Takuta Hohepa Mei Emery (Ngati Maniapoto / Kahungunu / Rangitane / Te Arawa), School teacher of Ahuriri and Pirika Tom Hemopo (Rongomaiwahine / Kahungunu / Waikato / Maniapoto), Probation Officer of Napier.

2.2 The claimants claim for themselves and Te Taiwhenua o te Whanganui a Orotu and the peoples within the Ngati Kahungunu tribal rohe of Ahuriri who claim to be prejudicially affected by, inter alia, practices, policies, actions and omissions by and on behalf of the Crown that are or are likely to be inconsistent with the principles of Te Tiriti o Waitangi/Treaty of Waitangi.

3. THE CLAIM

3.1 The claim has two main limbs:

(a) the first limb deals with the historical breaches by the Crown and its failure to provide adequate hospital and health services to the claimants and their tupuna following the purchase of the Ahuriri Block in 1851, including but not limited to, breach of promises that Ahuriri Maori would significantly benefit from hospital and health services to be provided as a consequence of European settlement; and

(b) the second limb of the claim deals with contemporary breaches by or on behalf of the Crown including in general the poor health status of Ahuriri Maori and in particular, the decision to cease provision of and effect removal of hospital and health services and facilities from the present hill site on Mataruahau (today known as Napier Hill).

3.2 The particulars of these historical and contemporary breaches are set out below.

3.3 In general, the claimants say that they and their tupuna they have been, are, or are likely to be prejudicially affected by Ordinances, Acts, Regulations, Proclamations, Notices and other statutory instruments and policies, practices, acts or omissions of the Crown which were and are inconsistent with the principles of Te Tiriti o Waitangi/Treaty of Waitangi and which inconsistencies created and continue to create Treaty breaches as particularised in this statement of claim.

4. FIRST LIMB: HISTORICAL BREACHES

Background to Historical Breaches

4.1 As has already been covered in evidence in the Wai 400 claim, Ahuriri Maori were induced to sell the Ahuriri Block grossly under its true value, on the strength of promises made by the Crown that Ahuriri Maori would benefit from the long term advantages to be gained from European settlement, including the provision of health services and a hospital at Ahuriri.

4.2 As noted by the Crown Purchasing Agent, Donald McLean, in a letter dated 21 June 1856:

At Ahuriri a Medical man to attend to the Natives is very much required. They have made frequent applications to the Government, and very justly urged as a reason for making the application that they had alienated large tracts of land to the Crown in the expectation of deriving various advantages which they have not yet realised. Amongst others they expected to have an hospital at Ahuriri, and it may be stated in favor of the application of these Natives for Medical aid that

they have alienated a million of acres to the Crown at a cost of less than three pence per acre, and that beyond the price paid for their lands, and the advantages they derive from the residence of Europeans among them, no thing to signify has as yet been done by the Government for their amelioration or improvement, if I may except a pension of Sixty pounds per annum promised to one of the principal chiefs. [O'Malley Report, page 4]

4.3 To Ahuriri Maori, the 1851 Agreement signified an enduring compact between themselves and their Treaty partner under which both would benefit in a mutually beneficial and prosperous partnership.

4.4 These expectations of Ahuriri Maori were well understood and specifically encouraged by Donald McLean who was acting in accordance with declared Crown policy of the day.

4.5 Ahuriri Maori had knowledge of western medicine through their contact with missionary William Colenso and had shown a willingness to embrace the use of these new medicines and technology. Traditional medicines were less effective against the range of new diseases introduced by the Europeans. Ahuriri Maori legitimately expected that their new relationship with the Crown would result in an enhanced level of health care and protection. These expectations were fostered and encouraged by McLean to gain Maori support for the sale of their lands at Ahuriri.

4.6 In the 1850s all hospitals then in existence in New Zealand had been established specifically for the care of Maori patients. It was an integral part of the Crown's policy to use European institutions 'both as a tool of civilisation and as an inducement to further land alienation'.

4.7 McLean would have known of this policy, yet in 1875, in giving evidence to the Native Affairs Committee, McLean asserts that no specific promises were made to Maori to establish hospitals for their benefit but rather that the establishment of townships and their amenities were for the benefit of the European settlers only.

4.8 Although a hospital was eventually established on Napier Hill in 1859, the increased use of the hospital by European settlers and the costs associated with using the hospital operated as barriers to Maori accessing the hospital services.

4.9 Prior to 1857, the only medical provision made for Ahuriri Maori was the payment of £15 for small-pox vaccinations in the district. In the same year, a Native Surgeon was appointed following persistent requests from Maori but this service proved ineffective for Maori and the office was finally abolished in 1867.

4.10 The impoverished state of Ahuriri Maori meant that their ability to afford and access medical care was severely impaired. This was accentuated after 1865 with the establishment of the Native Land Court and the continuing alienation of Maori land and the dire economic consequences that wrought for Maori.

4.11 Between 1848 and 1865 there was a dramatic decline in the Maori population in the Hawke's Bay District as a consequence of the introduction of new diseases. Ahuriri Maori had a well founded expectation that their health needs would be properly catered for in the new partnership arrangement and that they could expect to enjoy at least comparable health with Pakeha.

4.12 In the 1930s the majority of Hawke's Bay Maori were living in chronic poverty. The increase in hospital fees ordered by the government in 1932, made access to health services for Maori even more difficult.

5. PARTICULARS OF HISTORICAL TREATY BREACHES

5.1 The Crown induced Maori to alienate the Ahuriri lands with the explicit promise that a hospital and other health services would be established at Ahuriri for their use and benefit. Those promises were an integral part of the bargain struck between Ahuriri Maori and the Crown in 1851. The Crown are in breach of the Treaty:

- (a) for failure to fulfil their promise to establish hospital and health services so as to ensure Ahuriri Maori enjoyed the same standards of care and health as non-Maori;
- (b) for failure to fulfil their side of the bargain implicit in the Ahuriri purchase transaction;
- (c) for failing to ensure that Maori access to health care was not inhibited by their impoverished economic circumstances;
- (d) for the lack of good faith shown by the Crown agent Donald McLean in fraudulently representing to Ahuriri Maori that they would benefit over the long term from European settlement including the

establishment of hospitals when there was no apparent intention to deliver on that promise. 'Fraud' is used here in the sense of a false representation to gain unjust economic advantage;

(e) failure by the Crown to ensure that an endowment fund of 'not less than 15 nor more than 25 per cent', of the purchase monies received by the Crown from the sale of lands in the Ahuriri Block to settlers was established for Maori purpose including ongoing health needs;

(f) failure to ensure adequate Maori representation and participation on the Hawke's Bay Hospital Board established under the Public Health Act in 1876 and ongoing inadequacies in Maori representation on health authorities in the Hawke's Bay region.

6. SECOND LIMB OF CLAIM: CONTEMPORARY TREATY BREACHES

Background to Contemporary Breaches

6.1 The Treaty of Waitangi guaranteed to Maori protection of their health and wellbeing. The health and well being of Maori is a taonga in terms of Article II. In developing policies and law for the administration of health, the Crown are required to consult with their Treaty partner. Article III gives to Maori the same protection and status under the law as non-Maori.

6.2 With the general improvement in the overall economic prosperity of the country from the 1940s through to the 1970s, the gap between poor Maori health statistics and those of non-Maori had begun to lessen. However, the generally lower socio-economic status of Maori coupled with institutional prejudice within the health sector has meant that the gap has remained.

6.3 The health reforms in the past decade and the adoption of commercial models for health, have failed to improve the poor health status of Maori as compared to non-Maori. There are signs from recent national census data figures that the gap between Maori and non-Maori is beginning to widen for the first time this century.

6.4 The early emphasis on giving recognition to the Treaty partnership in the health sector has dissipated. This, coupled with loss of institutional memory as a consequence of the reforms, have all adversely impacted on delivery of health services to Maori.

6.5 Recent health statistics also reveal that in addition to social and economic factors resulting in poor Maori health, institutional prejudice within the health sector generally, has also contributed to the lower standards of Maori health.

CLOSURE OF NAPIER HOSPITAL

6.6 In June 1990 the Hawke's Bay Area Health Board commissioned consultants Booz Allen to undertake a study on the feasibility and cost of locating all acute hospital services in Hawke's Bay onto one site. In December 1990 the consultants recommended that a single acute hospital facility be developed on the site of the present Hastings Hospital.

6.7 In 1993 a Taskforce was established by the new CHE (Healthcare Hawke's Bay) to consider the regionalisation of hospital services. The Taskforce came up with essentially the same recommendations as the Booz Allen report for the relocation of hospital services to Hastings.

6.8 Healthcare Hawke's Bay made a decision on 21 July 1994 to adopt the Hastings hospital site as the site of the Regional Acute Hospital.

6.9 Considerable concern was being expressed by the Napier community about the process of consultation followed by Healthcare Hawke's Bay which included a challenge by the Napier City Council to the High Court in November 1994.

6.10 There were also two petitions presented to Parliament from the people of Napier, supporting the retention of the Napier Hospital. The first had 30,796 signatures and the second 33,046 signatures or approximately 60% of the adult population in Napier.

6.11 Following the petitions, a Private Member's Bill was introduced to the House of Representatives called the Continuance of Napier Hospital Bill. After 3 years, this Bill was shelved without the people of Napier having had an opportunity to be heard before a Select Committee.

6.12 In 1995 the Prime Minister and Minister of Health gave separate assurances to concerned citizens from the Napier community that the Napier Hospital would not be closing down and would remain as an 'active community hospital with a comprehensive range of services'.

APPII

6.13 On 28 March 1995 the Board of Directors of Healthcare Hawke's Bay confirmed their earlier decision to shift all acute hospital services to Hastings.

6.14 The 28 March 1995 decision included a decision that Napier Hospital would be re-configured to provide a range of outpatient and other services including provision of Maori health facilities.

EFFECT ON MAORI OF CLOSURE OF NAPIER HOSPITAL

6.15 The relocation of essential health services to Hastings has caused major difficulties for many Maori families because of transport difficulties and financial constraints. It has also made it more difficult to provide the necessary whanau support for those who are ill. These factors combined to place additional stress and considerable inconvenience on Maori living in Napier.

6.16 The site on Mataruahau is traditionally known as a place of healing. There is a history and relationship that Maori have with that site that assist with the overall healing process.

6.17 There is not the same mauri or healing properties associated with the Hastings Hospital site which is located next to an urupa and crematorium.

7. PARTICULARS OF CONTEMPORARY TREATY BREACHES

Policies and Legislative Framework

7.1 In developing policy and implementing the legislative framework to give effect to the health reforms of the early 1990s, the Crown has:

- (a) failed to ensure adequate Maori participation and representation within the Crown Health Enterprise structure;
- (b) omitted to incorporate adequate Treaty protection mechanisms within the Health reform legislative framework;
- (c) failed to ensure that the comparatively poor state of Maori health would be redressed by specific programmes and policies aimed at improving the poor Maori health status;
- (d) failed to develop policies to increase ability of Maori to better access and deliver health services;
- (e) failed to address the fundamental issue of worsening Maori health standards compared to those of non-Maori.

7.2 The Crown has failed in its obligations to Ahuriri Maori, partly as a consequence of the breaches outlined in the previous paragraph but also as a direct consequence of actions and omissions of the Central Regional Health Authority and Healthcare Hawke's Bay:

- (a) by failing to consult with Ahuriri Maori over the decision to close Napier Hospital and regionalise Hospital services in Hastings;
- (b) by failing to ensure adequate representation of Maori on the Central Regional Health Authority and the Crown Health Enterprise (Healthcare Hawke's Bay) in order to ensure that Maori have effective say in the decision making structures affecting their health and well-being;
- (c) by failing to take into account its obligations stemming from the 1851 Agreement to continue to provide effective health services and facilities for Ahuriri Maori from the site on Mataruahou.

7.3 The disadvantaged socio-economic circumstances and poor health statistics of Ahuriri Maori, have resulted and will continue to result in their being prejudicially affected by the decision to close Napier Hospital. In making its decision, the Crown has failed to have regard to these factors in breach of its Treaty obligations.

8. FINDINGS SOUGHT BY THE CLAIMANTS

8.1 The claimants seek the following findings from the Tribunal:

- (a) That the Treaty of Waitangi embodies a guarantee to Maori of their continued health and well being.
- (b) That the 1851 Agreement signed between Ahuriri Maori and the Crown was entered into on the understanding by both parties, that the Crown would provide and maintain hospital and health services from Mataruahau at sufficient levels as to ensure reasonable health status for Ahuriri Maori. That this 'promise' was an essential part of the bargain struck in 1851.
- (c) That the 1851 Agreement and collateral promises by the Crown, created a compact or treaty between Ahuriri Maori and the Crown which could not be departed from without the prior informed consent of Ahuriri Maori.
- (d) That the legislative framework governing the administration of health is defective in that it does not provide for adequate participation and representation of Maori within the health sector.
- (e) That the decision to close Napier Hospital was in breach of the Crown's obligations to Ahuriri

Maori both in terms of the Treaty of Waitangi and the 1851 Agreement.

(f) That any of these factors or a combination of them have caused or a likely to cause a decline in Maori health status.

9. RELIEF

9.1 The claimants seek the following recommendations and relief from the Tribunal:

- (a) That the Crown make available to the claimants sufficient financial and other resources to enable the claimants to research, develop and implement a partnership model for the establishment of hapu and community development initiatives from the Mataruahau site which incorporate as an essential component the establishment of health facilities and services for Ahuriri hapu and the general community, The new facilities to be known as the Mataruahau Community Health and Research Centre;
- (b) That in recognition of the enduring compact entered into between Ahuriri Maori and the Crown in 1851, that the Crown pay to the claimants compensation sufficient to establish an Ahuriri endowment fund for the purpose of maintaining hospital and health services and facilities at the Mataruahau Community Health and Research Centre to a standard sufficient to guarantee an improvement of Maori health to a standard at least equivalent to that of non-Maori;
- (c) That legislation be immediately introduced to formally establish the Mataruahau Community Health and Research Centre as an embodiment of the Treaty partnership between Ahuriri Maori, the Crown and the general community;
- (d) That Ahuriri Maori are accorded full partnership status in the ownership, management, operation and decision making process affecting or relating to the Mataruahau Community Health and Research Centre;
- (e) That the current legislative framework governing the administration of health be amended to incorporate appropriate Treaty protection mechanisms to ensure the ongoing active protection and representation of Maori within the health sector;
- (f) Costs in relation to this claim;
- (g) Such other relief as the Tribunal may recommend.

WAI 692

THIRD AMENDED STATEMENT OF CLAIM

Dated 22 July 1999.

IN THE WAITANGI TRIBUNAL
WELLINGTON

IN THE MATTER OF The Treaty of Waitangi
Act 1975

AND

IN THE MATTER OF a claim to the Waitangi
Tribunal by Hana Loyla
Cotter, Pirika Tom
Hemopo and Takuta
Hohepa Mei Emery on
behalf of themselves, Te
Taiwhenua o te Whanga-
nui a Orotu and the peo-
ples within the Ngati
Kahungunu tribal rohe
of Ahuriri

The claimants say:

1. This claim is lodged by Hana Loyla Cotter (Ngati Kahungunu), Te Kahu Korowai o Te Kohanga Reo of Napier, Pirika Tom Hemopo (Rongomaiwahine/Kahungunu/Waikato/ Maniapoto), probation officer of Napier and Takuta Hohepa Mei Emery (Ngati Maniapoto / Kahungunu / Rangitane / Te Arawa), school teacher of Ahuriri.
2. The claimants claim for themselves and Te Taiwhenua o Te Whanganui a Orotu and the peoples within the Ngati Kahungunu tribal rohe of Ahuriri who claim to be prejudicially affected by, inter alia, practices, policies, actions and omissions by and on behalf of the Crown that are likely to be inconsistent with the principles of the Treaty of Waitangi.

THE CLAIM

3. The claimants say that they and their tupuna have been, are, or are likely to be prejudicially affected by the ordinances, acts, regulations, proclamations, notices and other statutory instruments and the policies, practices, acts or omissions of the Crown which were and are inconsistent with the principles of the Treaty of Waitangi as further set out in this third amended statement of claim.

FIRST CAUSE OF ACTION – HISTORICAL BREACHES

4. Pursuant to the terms and principles of the Treaty of Waitangi, from 1840 the Crown was and remains under an obligation to provide for the health and well-being of Maori, including:

4.1 Consulting with Maori on substantive matters effecting Maori health (Article 1).

4.2 Ensuring that Maori are given control of adequate and appropriate health resources within their communities (Article 2).

4.3 Ensuring that Maori are in receipt of the same standards of health care and health outcomes as other citizens of New Zealand (Article 3).

5. In addition to the obligations set out in paragraph 4 hereto, the Crown was under a further obligation to the Maori of Ahuriri, including the claimants and their tupuna (‘Ahuriri Maori’), in accordance with the terms of the Ahuriri Block transaction as pleaded in paragraph 16 and 17 of the amended statement of claim filed in the Wai 400 claim in respect of Ahuriri lands (which paragraphs are relied on in this claim as if pleaded in full), namely to provide health and hospital services to the Maori of Ahuriri.

6. In breach of the duties and obligations set out in paragraphs 4 and 5 hereto, the Crown retained the land subject to the 1851 Ahuriri transaction and:

6.1 Failed to consult with or otherwise adequately ascertain Maori health needs at Ahuriri including failing to provide for adequate Maori representation and participation in health agencies in Ahuriri including the Hawke’s Bay Hospital Board, and

6.2 Failed to give any control over the delivery or administration of health services and resources to Maori, and

6.3 Failed to fulfill its promise to establish appropriate health services, including hospitals and resources so as to ensure Ahuriri Maori enjoy the same standards of health care as non Maori.

7. As a result of the breaches set out in paragraph 6 hereto Ahuriri Maori have consistently experienced significantly inferior health and hospital services than non Maori or health and hospital services that were otherwise inappropriate and that the result of such inferior or inappropriate health care has resulted in substantially worse health outcomes for Ahuriri Maori.

SECOND CAUSE OF ACTION – CONTEMPORARY TREATY BREACHES

8. Since 1988 the Crown has reorganised the provision of public health and hospital services through the creation of a number of entities variously described as Area Health Boards, Commissioners, Ministry of Health, Public Health Commission, Regional Health Authorities, Health Funding Authority, CHE Board Designate, Crown Health Enterprises, Health and Hospital Services, and (to the extent that it is involved in the provision of or monitoring of health services) the Crown Company Monitory Advisory Unit (‘Crown health entities’).

9. The Crown health entities are Crown entities pursuant to the Fourth Schedule of the Public Finance Act 1989 and are accordingly subject to the Treaty duties set out in paragraph 4 hereto and the duties to Ahuriri Maori set out in paragraph 5 hereto.

10. Pursuant to the obligations under the Treaty set out in paragraphs 4 and 5 hereto, the Crown through the Crown health entities has adopted policies and contracts for the delivery of health services to Maori and to meet Maori health needs (‘Maori health policies’).

Particulars

- Whaia te ora mo te iwi
- Policy Guidelines for Maori Health
- He Taura Tieke
- Maori Health Services Business Plans Healthcare Hawke’s Bay
- The Government’s Medium Term Strategy for Health and Disability Support Services
- Statements of Intent
- Statement of Owners expectations of Hospital Health Services
- He Matariki
- Central Regional Health Authority Purchasing Directions
- Central Regional Health Authority Purchasing Intentions
- Regional Health Authority/Health Funding Authority Funding Agreements including standards/clauses for Crown Health Authority/Health and Hospital Service Contracts
- Te Kite Aronga
- Tauira Whakahaere
- Health Funding Authority Maori Health Policy
- National Strategic Plans for Maori Health
- Further relevant Policies as may be identified.

11. The effect of the obligations under the Treaty and the Maori health policies set out in paragraphs 9 and 10 hereto is to impose obligations on the Crown and the Crown health entities to:

11.1 Ensure that the obligations under the Treaty and Maori health policies are monitored and enforced.

11.2 Consult with Maori over issues which affect or are likely to affect Maori health or Maori health outcomes.

11.3 Ensure that the delivery of health services and health outcomes for Maori are effectively monitored.

11.4 Establish and address Maori health needs.

11.5 Deliver a reasonable standard of health to Maori.

11.6 Continue to improve the delivery of health services to Maori.

11.7 Continue to improve health outcomes for Maori.

11.8 Ensure that health services and outcomes for Maori are delivered in a manner which is culturally sensitive or appropriate.

12. In breach of the obligations under the Treaty and the Maori health policies the Crown and Crown health entities (including individual entities) have failed to give effect to the principles of the Treaty and Maori health policies including failing to deliver health services to Maori in Ahuriri and Hawke's Bay in a manner consistent with tikanga Maori.

Particulars

12.1 Since the reforms began Maori health measured by mortality and morbidity has become worse in absolute terms and relative to non Maori.

12.2 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the decision in 1995 to regionalise Hawke's Bay hospital services in Hastings.

12.3 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the decision in 1997 to close Napier Hospital.

12.4 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the decision to build the new health clinic and the types of health services to be provided at the clinic.

12.5 The Crown and/or the Crown health entities failed to consult or adequately consult with Ahuriri Maori over the site for the new health clinic in Road, Napier.

12.6 The Crown has failed to ensure adequate representation of Maori in the relevant Crown health entities to ensure that Maori have an effective say in the decision making structure affecting their health and well being.

12.7 The Crown by itself and through the Crown health entities has continued to fail to give effect to its obligations under the 1851 Ahuriri transaction including providing effective health services and facilities for Ahuriri Maori from the site at Mataruahau.

12.8 The health clinic under construction in Napier is inadequate and inappropriate to meet Maori health needs at Ahuriri and the obligations of the Crown under the 1851 Ahuriri transaction.

12.9 Healthcare Hawke's Bay and its predecessors have not considered the health care and health status of Maori as a significant issue in their service delivery planning.

12.10 Healthcare Hawke's Bay and the Health Funding Authority and their predecessors have not offered Maori in Ahuriri or Hawke's Bay an opportunity through effective consultation, participation, and representation to effectively join in the decision making processes effecting their health and health care.

12.11 The Crown and Crown health entities have failed to provide for appropriate Maori structures for the provision of health and hospital services for Maori in Ahuriri and Hawke's Bay.

12.12 The Crown and Crown health entities have failed to provide for Maori health as a health gain priority in their health service planning and delivery.

12.13 The Crown and the Crown health entities including the Crown Company Monitoring Advisory Unit and Healthcare Hawke's Bay have not analysed or analysed adequately changes in Maori health in Ahuriri or Hawke's Bay.

APPII

12.14 The Crown and Crown health entities have failed to involve Maori in the monitoring or development of monitoring systems for the provision of Health Services and health outcomes for Maori provided by the Crown health entities.

12.15 The Crown and Crown health entities have consistently failed to consult with Maori over changes in health delivery and outcomes in Ahuriri and Hawke's Bay.

12.16 The Crown and Crown health entities have failed to assist or assist adequately Ahuriri Maori to develop their own capacities to provide health care.

12.17 The Crown and the Crown health entities have been inconsistent in their statements and behaviour as to the closure of Napier Hospital, to the detriment of Maori in Ahuriri and Hawke's Bay.

12.18 Since the beginning of the health restructuring process there has been a consistent gap between political statements, Maori health policy, and the practice of Crown health entities, including Healthcare Hawke's Bay, CCMAU, and the Health Funding Authority (or their predecessors) to the detriment of Maori in Ahuriri and Hawke's Bay.

12.19 The Crown through the Ministry of Health has not taken adequate account of the effects of socio-economic status in setting access targets for the health services, based on transport assumptions, particularly the ownership of or access to a private vehicle.

12.20 The creation of a separation of funder and provider roles (Health Funding Authority/Health and Hospital Service or Regional Health Authority/Crown Health Enterprise) bought about through the health restructuring has not worked to the benefit of Maori in Ahuriri or Hawke's Bay.

12.21 The Crown has omitted to incorporate adequate Treaty protection mechanisms within the legislative framework for health restructuring.

13. As a result of the breaches set out in paragraph 12 hereto Ahuriri Maori continue to receive inferior health and hospital services and/or health and hospital services which are otherwise inappropriate or detrimental to the ongoing health of Ahuriri Maori.

RELIEF SOUGHT

(a) A finding that the Crown has breached the principles of the Treaty of Waitangi and the terms of the Ahuriri transaction of 1851 and in its provision of health services to Ahuriri Maori since 1851.

(b) A finding that the Crown and the Crown health agencies have breached the principles of the Treaty of Waitangi and Maori health policy in deciding to regionalise Hawke's Bay hospital services at Hastings without first consulting or adequately consulting with Maori.

(c) A finding that the Crown and Crown health entities have breached the Treaty and Maori health policy in deciding to close Napier Hospital without consulting or adequately consulting Maori.

(d) A finding that Mataruahau (Napier Hill hospital site) is of importance to Maori health.

(e) A recommendation that an independent specialist body consisting of Maori and Health specialists including the named claimants in this claim be set up to undertake a comprehensive inquiry on terms of reference set by the Tribunal into Maori health needs in the Hawke's Bay and Ahuriri in particular, including health and cultural needs and including an investigation as to whether an appropriately funded facility for Maori health on the Napier Hospital site in appropriate. Further details of the relief sought under this head will be provided in due course.

(f) A recommendation that the findings of the specialist body be acted upon.

(g) A recommendation that the Ahuriri Maori be adequately and appropriately funded to carry out research and make submissions to the body set out in paragraph (e) hereto.

(h) A recommendation that the Mataruahau site be retained for Maori health purposes and the current facilities maintained in good condition and properly secured until the review set out in paragraph (e) above is completed.

(i) A recommendation that the Crown amend the Health and Disability Services Act 1993 to include a section requiring the Crown and Crown health entities to give effect to the principles of the Treaty of Waitangi.

(j) A recommendation that the Crown and Crown health entities introduce a specific monitoring program to ensure compliance with the principles of the Treaty of Waitangi and Maori health policy consistent with the Treaty of Waitangi.

(k) A recommendation that pending the report of the specialist body set out in paragraph (e) hereto that the Crown and Crown health entities implement an effective partnership with Maori for the creation of appropriate policies and the provision of health services in Ahuriri and Hawke's Bay. Further

details of the relief sought under this head will be provided in due course.

- (l) A recommendation that the Crown and Crown health entities involved in provision of health services to Maori consult with Maori and relevant Maori organisations including relevant hapu and iwi organisations affected before taking any decision which will effect the provision of such services.
 (m) The costs of this claim.

WAI 400

AMENDED STATEMENT OF CLAIM

Dated 26 September 1997.

IN THE

WAITANGI TRIBUNAL WELLINGTON

IN THE MATTER OF The Treaty of Waitangi
Act 1975

AND

IN THE MATTER OF Claims by Nga Hapu o
Ahuriri in respect of
Ahuriri Lands

.

16. The true nature of the Ahuriri transaction –
tuku whenua

16.1 The intention of Ahuriri hapu was that the transaction would create an on-going partnership between Ahuriri hapu and the Crown and settlers. It was viewed as a political compact involving reciprocity and exchange, incorporating the fundamental elements of customary transfer of land or tuku whenua. From the perspective of the hapu of Ahuriri the transaction obliged the Crown to ensure that Ahuriri hapu obtained the collateral advantages and expected benefits of settlement. The agreement was formed on the basis of the respective mana of Ahuriri hapu and the Crown, and depended on trust and faith of Ahuriri hapu in the integrity and honour of the Crown. The Crown's obligations by the Ahuriri transaction were to ensure in particular:

(a) The facilitation of the economic and social development of Ahuriri hapu, including the provision of educational and economic opportunities and access to European technology;

- (b) The responsibility to ensure that Ahuriri hapu retained a sufficient land base, including inalienable reserves to benefit from the development opportunities set out above,
 (c) A reciprocal acknowledgement of mana and partnership involving equality of status between the Crown and Ahuriri hapu,
 (d) The retention and protection of the rangatiratanga of Ahuriri hapu, and the maintenance of iwi and hapu social and political structures,
 (e) The protection of tikanga Maori and the simultaneous provision of access to the beneficial aspects of Pakeha culture and technology.

16.2 The expectation of Ahuriri hapu that they would receive the above benefits was actively encouraged by the Crown which emphasised the future benefits of settlement to Ahuriri hapu. Crown agents informed Ahuriri hapu that the land sales would introduce settlers which would diffuse wealth and prosperity amongst hapu. Ahuriri hapu were specifically promised a town and told that the price obtained for their land was handsome given future advantages. The Crown created the impression that Maori and Pakeha would share the land and become prosperous together on it.

17. Obligations of the Crown

17.1 The ongoing obligations of the Crown were fundamental to the Maori understanding of the transaction. Unless they were delivered the consideration for the transfer was inadequate. If the Crown failed to fulfil those obligations, the agreement was breached and Ahuriri hapu had the right to renegotiate or repudiate the agreement.

17.2 In breach of its duties under the Treaty, the Crown has consistently refused to acknowledge the right of Ahuriri hapu to repudiate the agreement made in 1851 in the event that Maori expectations were not met. This refusal has been despite continuous protest by Ahuriri hapu through letters, petitions, political movements and other methods.

17.3 In breach of the terms of the transfer of the Ahuriri Block in 1851 the Crown has failed to meet its ongoing obligations to Ahuriri hapu.

(a) The Crown has failed to deliver its promise of development involving benefits to Ahuriri hapu of economic and social advantages from European settlement. Conversely, the Crown pursued an active policy to ensure that the benefits of settlement accrued only to the settlers and Government, knowing that those benefits would be secured at the expense of Ahuriri hapu.

(b) The Crown actively undermined the rangatira-tanga of Ahuriri hapu because such undermining was consistent with the Crown's interest in breaking up the Ahuriri estate. Such active undermining was achieved primarily through the post-1865 individualisation of 'title, the introduction of economic concepts of debt and debt enforcement and the general introduction of those aspects of British law inimical to the interests of Ahuriri hapu.

(c) The Crown allowed and encouraged economic competition and interaction between Ahuriri hapu and settlers without advising Ahuriri hapu of its possible consequences, particularly in relation to the credit system. The cycle of land alienation and debt which resulted from the individualisation of land title and its private acquisition was known to the Crown but the Crown failed or actively refused to prevent the negative consequences of it. By 1880 Ahuriri hapu had lost the power to enforce their relationship with the Crown and settlers, their economic base was radically eroded by 1900, and by 1910 Ahuriri hapu depended on waged labour under Pakeha employment, subsistence farming and credit. Ahuriri hapu were therefore subject to economic deprivation, poor health and general social dislocation.

(d) Throughout the twentieth century, the policies and actions of the Crown in relation to health, education and other relevant areas such as housing have failed to remedy the situation of Ahuriri hapu. Ahuriri hapu have been vulnerable to economic shocks, unable to develop their little remaining land due to a lack of resources and are still today socially, politically and economically marginalised in comparison with the Pakeha population of Ahuriri.

(e) The Crown failed to adequately investigate the extent of land required by Ahuriri hapu for their present and future needs or to identify those needs. The Crown's attitude was to persist in put chasing until it obtained all the land of the Ahuriri hapu.

(f) The Crown failed or actively refused to ensure that adequate reserves were provided. Not only were the reserves insufficient for the reciprocal relationship of mutual benefit the Crown promised to Ahuriri hapu as consideration for the Ahuriri transaction of 1851, they were wholly inadequate for subsistence.

(g) The Crown failed or actively refused, after the Ahuriri purchase to ensure that adequate provision was made to prevent further alienation of land. Instead, in breach of its duty of active protection of Ahuriri hapu and its duty to act in good faith following the Ahuriri transaction of 1851, the Crown actively adopted a process of progressive alienation of Ahuriri hapu land. In the 1850s, the Crown exploited existing political competition between Ahuriri hapu to obtain land. It persisted in a cynical

manner, to place Crown interests above the interests of Ahuriri hapu. The Crown's purchasing policy in the 1850s involved the exploitation of Maori debt and the acquisition of land for the lowest possible price. Increasing opposition to Crown purchases was deliberately ignored until the Crown was forced to cease purchasing activities in 1860.

(h) In breach of Maori expectations arising out of the Ahuriri transaction the Native Land legislation progressively destroyed Ahuriri hapu land tenure, by individualising title and creating a destructive cycle of debt and land alienation. Ahuriri hapu were prejudiced by the failure of the Crown to adequately investigate members of hapu interested in the land, the high cost of survey, the expense and inconvenience of participation in the proceedings of the Native Land Court and the fragmentation of land holdings through partitions and subsequent sale. The transactions were generally cajoled or threatened and did not involve willing sellers. By allowing the alienation of Ahuriri lands through the Native Land Court, the Crown actively participated in ensuring that Ahuriri hapu did not retain a land base sufficient for development. In particular, the Crown allowed the alienation of reserved land in the Ahuriri Block which it was under a special obligation to protect.

(i) In breach of the Ahuriri transaction, Ahuriri hapu have consequently been deprived of sufficient land base to take advantage of the opportunities offered by European settlement.

(j) Despite persistent and prolonged protest at the losses by Ahuriri hapu, and in breach of the principles of the Treaty of Waitangi the Crown has failed to take any or any adequate steps to remedy the loss to Ahuriri hapu of their land and resources. Since 1851, many protests have been made regarding the alienation of the land of Ahuriri hapu. In the 1850s the Crown was aware of the wish of Ahuriri hapu to repudiate the Ahuriri transaction. The complaints were treated with derision and contempt by Crown agents. A groundswell of grievances due to the alienation of land through the Native Land Court forced the Crown to investigate land alienations after 1866. However the Hawke's Bay Land Alienation Commission of 1873 was ineffective in addressing these. It was limited to transactions after 1866, and so refused to investigate the Ahuriri transaction of 1851. It had no power to decide disputes or determine title to land. The Maori Commissioners' opinions and comments (largely supportive of the Maori case) were ignored and disregarded, and the Commission criticised Maori in bringing claims. By 1880 the Crown took advantage of the newfound Pakeha political dominance which had developed to ignore Maori protest, and Ahuriri hapu were subsequently unable to enforce their view of the land transaction.

APPENDIX III

THE TREATY OF WAITANGI

THE TEXT IN ENGLISH

The following version of the Treaty of Waitangi is taken from the first schedule to the Treaty of Waitangi Act 1975.

Preamble

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

Article the First

The Chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation cede to Her Majesty the Queen of England absolutely and without reservation all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively

exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole Sovereigns thereof.

Article the Second

Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof the full exclusive and undisturbed possession of their Lands and Estates Forests Fisheries and other properties which they may collectively or individually possess so long as it is their wish and desire to retain the same in their possession; but the Chiefs of the United Tribes and the individual Chiefs yield to Her Majesty the exclusive right of Preemption over such lands as the proprietors thereof may be disposed to alienate at such prices as may be agreed upon between the respective Proprietors and persons appointed by Her Majesty to treat with them in that behalf.

Article the Third

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

W HOBSON Lieutenant Governor.

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

THE NAPIER HOSPITAL AND HEALTH SERVICES REPORT

APPIII

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

[Here follow signatures, dates, etc.]

THE TEXT IN MAORI

The following version of the Treaty of Waitangi is taken from the first schedule to the Treaty of Waitangi Act 1975.

Preamble

KO WIKITORIA, te Kuini o Ingarani, i tana mahara atawai ki nga Rangatira me nga Hapu o Nu Tirani i tana hiahia hoki kia tohungia ki a ratou o ratou rangatiratanga, me to ratou wenua, a kia mau tonu hoki te Rongo ki a ratou me te Atanoho hoki kua wakaaro ia he mea tika kia tukua mai tetahi Rangatira hei kai wakarite ki nga Tangata maori o Nu Tirani-kia wakaetia e nga Rangatira maori te Kawanatanga o te Kuini ki nga wahikatoa o te Wenua nei me nga Motu-na te mea hoki he tokomaha ke nga tangata o tona Iwi Kua noho ki tenei wenua, a e haere mai nei. Na ko te Kuini e hiahia ana kia wakaritea te Kawanatanga kia kua ai nga kino e puta mai ki te tangata Maori ki te Pakeha e noho ture kore ana. Na, kua pai te Kuini kia tukua a hau a Wiremu Hopihona he Kapitana i te Roiara Nawi hei Kawana mo nga wahi katoa o Nu Tirani e tukua aiane, amua atu ki te Kuini e mea atu ana ia ki nga Rangatira o te wakaminenga o nga hapu o Nu Tirani me era Rangatira atu enei ture ka korerotia nei.

Ko te Tuatahi

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

Ko te Tuarua

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

Ko te Tuatoru

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

(Signed) WILLIAM HOBSON,
Consul and Lieutenant-Governor.

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

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

Ko nga Rangatira o te wakaminenga.

TRANSLATION OF THE MAORI TEXT

The following translation of the Maori text of the Treaty was done by Professor Sir Hugh Kawharu.

Victoria, the Queen of England, in her concern to protect the chiefs and the subtribes of New Zealand and in her desire to preserve their chieftainship¹ and their lands to them and to maintain peace² and good order considers it just to appoint an administrator³ one who will negotiate with the people of New Zealand to the end that their chiefs will agree to the Queen's Government being established

1. 'Chieftainship': this concept has to be understood in the context of Maori social and political organization as at 1840. The accepted approximation today is 'trusteeship'.

2. 'Peace': Maori 'rongo', seemingly a missionary usage (rongo - to hear: ie, hear the 'Word' - the 'message' of peace and goodwill etc).

3. Literally, 'chief' ('rangatira') here is of course ambiguous. Clearly, a European could not be a Maori, but the word could well have implied a trustee-like role rather than that of a mere 'functionary'. Maori speeches at Waitangi in 1840 refer to Hobson being or becoming a 'father' for the Maori people. Certainly, this attitude has been held towards the person of the Crown down to the present day - hence the continued expectations and commitments entailed in the Treaty.

over all parts of this land and (adjoining) islands⁴ and also because there are many of her subjects already living on this land and others yet to come. So the Queen desires to establish a government so that no evil will come to Maori and European living in a state of lawlessness. So the Queen has appointed 'me, William Hobson a Captain' in the Royal Navy to be Governor for all parts of New Zealand (both those) shortly to be received by the Queen and (those) to be received hereafter and presents⁵ to the chiefs of the Confederation chiefs of the subtribes of New Zealand and other chiefs these laws set out here.

The first

The Chiefs of the Confederation and all the Chiefs who have not joined that Confederation give absolutely to the Queen of England for ever the complete government⁶ over their land.

The second

The Queen of England agrees to protect the chiefs, the subtribes and all the people of New Zealand in the unqualified exercise⁷ of their chieftainship over their lands, villages and all their treasures.⁸ But on the other hand the Chiefs of the Confederation and all the Chiefs will sell⁹ land to the Queen at a price agreed to by the person owning it and by the person buying it (the latter being) appointed by the Queen as her purchase agent.

The third

For this agreed arrangement therefore concerning the Government of the Queen, the Queen of England will protect all the ordinary people of New Zealand and will give them the same rights and duties¹⁰ of citizenship as the people of England.¹¹

[signed] William Hobson Consul & Lieut Governor

So we, the Chiefs of the Confederation of the subtribes of New Zealand meeting here at Waitangi having seen the shape of these words which we accept and agree to record our names and our marks thus. Was done at Waitangi on the sixth of February in the year of our Lord 1840.

4. 'Islands': ie, coastal, not of the Pacific.

5. Literally, 'making': ie, 'offering' or 'saying' – but not 'inviting to concur'.

6. 'Government': 'kawanatanga'. There could be no possibility of the Maori signatories having any understanding of government in the sense of 'sovereignty': ie, any understanding on the basis of experience or cultural precedent.

7. 'Unqualified exercise' of the chieftainship – would emphasise to a chief the Queen's intention to give them complete control according to their customs. 'Tino' has the connotation of 'quintessential'.

8. 'Treasures': 'taonga'. As submissions to the Waitangi Tribunal concerning the Maori language have made clear, 'taonga' refers to all dimensions of a tribal group's estate, material and non-material – heirlooms and wahi tapu (sacred places), ancestral lore, and whakapapa (genealogies), etc.

9. Maori 'hokonga', literally 'sale and purchase'. 'Hoko' means to buy or sell.

10. 'Rights and duties': Maori at Waitangi in 1840 refer to Hobson being or becoming a 'father' for the Maori people. Certainly, this attitude has been held towards the person of the Crown down to the present day – hence the continued expectations and commitments entailed in the Treaty.

11. There is, however, a more profound problem about 'tikanga'. There is a real sense here of the Queen 'protecting' (ie, allowing the preservation of) the Maori people's tikanga (ie, customs), since no Maori could have had any understanding whatever of British tikanga (ie, rights and duties of British subjects.) This, then, reinforces the guarantees in article 2.

APPENDIX IV

RECORD OF INQUIRY

RECORD OF HEARINGS

CLAIMANT HEARING, TE TAIWHENUA O TE WHANGANUI A OROTU, 8–10 JUNE 1999

Counsel

Counsel appearing were: for the Crown, Michael Doogan, with assistant counsel Craig Linkhorn and, for the Wai 400 claim, co-counsel Fergus Sinclair; for Healthcare Hawke's Bay, Magnus Macfarlane; and, for the claimants, Maui Solomon, assisted by Sarah Reo, and Peter Callinicos.

Claimant witnesses

The claimant witnesses who gave traditional evidence were:

- ▶ Pirika Tom Hemopo (Ngati Kahungunu), chairperson of Te Taiwhenua o Te Whanganui a Orotu's housing board, chairperson of St Joseph's Maori Girls College Trust Board, executive member of Te Reo Irirangi o Ngati Kahungunu, and member of the Omaha Marae Committee;
- ▶ Hana Cotter (Ngati Kahungunu), Te Kahu Korowai o Te Kohanga Reo, Napier;
- ▶ Ruruarau Heitia Hiha (Ngati Kahungunu ki Heretaunga);
- ▶ Peggy Nelson, also known as Kurupai Kopu (Ngati Hinepare / Ngati Hikawera / Ngati Hinemanu);
- ▶ Hine Pene (Ngati Paarau), granddaughter of Tareha Te Moananui; and
- ▶ Fred Reti (Ngati Tu/Ngati Kurumokihi/Ngati Hineuru).

The claimant witnesses who gave evidence on other aspects of the claim were:

- ▶ Te Maari Joe (Ngati Hinepare ki Ngati Kahungunu / Tuwharetoa / Ngai Tai ki Torere), manager of Te Kupenga Hauora, founder member of Te Ropu Wahine Maori Toko i Te Ora, and kaumatua representative with Te Taiwhenua o Te Whanganui a Orotu;
- ▶ Ngahiwi Tomoana (Ngati Kahungunu ki Heretaunga), at various times secretary of Waipatu

Marae, chairperson of Te Taiwhenua o Heretaunga, and board member, and, since 1997, chairperson of Ngati Kahungunu Iwi Incorporated; and

- ▶ Matthew Bennett (Ngati Pikiāo / Ngati Whakaue / Ngati Pahauwera / Ngati Maniapoto), claim manager, secretary of Kohupatiki Marae, and member of the Hawke's Bay Ethics Committee.

Several other people from the claimant group did not appear but filed briefs of evidence on their personal experience or knowledge of the hospital services provided at Napier and Hastings. They were:

- ▶ January Roberts (Tainui/Ngati Hineuru), a resident of Onekawa, Napier;
- ▶ Naresh Colin James (Tuwharetoa), a resident of Taradale, Napier;
- ▶ Rose Whenuaroa (Ngati Hine o roto o Tuwharetoa), a resident of Onekawa, Napier;
- ▶ Christine Te Kahika (Ngati Kahungunu), a resident of Maraenui, Napier; and
- ▶ Margie Russell (Ngati Porou/Ngati Kahungunu), a resident of Taradale and teacher aide at Maraenui School.

Supporting evidence from community and expert witnesses came from:

- ▶ Jim Pearcey, principal since 1990 of Maraenui School, on the impact of the closure of Napier Hospital on his students and the residents of a poor suburb of Napier with a high Maori population;
- ▶ Janice Wenn, manager of Whaiora Whanui of the Wairarapa Taiwhenua and previously assistant general manager (community health) at Mid Central Health, on Maori health providers, the effects of socio-economic status on access to health services, and Maori participation and representation in regional health institutions;
- ▶ Irihapeti Ramsden (Ngai Tahu/Rangitane/Ngati Raukawa), Maori health specialist, Maori adviser to the Nursing Council, and board/committee member of, amongst others,

APP IV

the Health Research Council and the Health Promotion Committee, on Maori health status and initiatives under the health reforms;

- ▶ Dr Papaarangi Reed, director since 1994 of the Eru Pomare Maori Health Research Centre, Wellington, on the current state of Maori health nationally;
- ▶ Dr Robin Gwynne, formerly associate professor of history at Massey University and Alliance candidate for the Napier constituency, on the history of the closure of Napier Hospital and the adequacy of community health services in Hawke's Bay; and
- ▶ Professor Whatarangi Winiata (Ngati Raukawa/Ngati Marutuahu), Tumuaki of Te Wananga o Raukawa, Otaki, and professor of accountancy at Victoria University of Wellington, on partnership perspectives and concepts of health.

In addition, a written brief was filed but not presented in person from Neil Kirton, at the time a list member of Parliament and formerly the Associate Minister of Health and the general manager of the private surgical Princess Alexandra Hospital in Napier, on the consultation issue and a possible transfer of Napier Hospital to Maori health provision.

Two professional historians presented summaries of their reports:

- ▶ Vincent O'Malley, researcher at the Crown Forestry Rental Trust, on historical aspects of the claim; and
- ▶ Lisa Ferguson (Ngati Reko/Ngati Tamaoho), researcher commissioned by the Tribunal, on contemporary aspects of the claim.

CROWN HEARING, WAR MEMORIAL CENTRE, NAPIER, 29–30 JULY, 2 AUGUST 1999

Counsel

Counsel appearing were: for the Crown, Michael Doogan, with assistant counsel Craig Linkhorn; for Healthcare Hawke's Bay, Magnus Macfarlane; for the claimants, Grant Powell, assisted by Sarah Reo, and Peter Callinicos.

Crown witnesses

The witnesses who appeared for the Crown were:

- ▶ Chris Clarke, team leader of the Targeted Assistance Group (working with public hospitals) in the Crown Company Monitoring Advisory Unit;
- ▶ Colin Feek, since 1994 chief adviser (medical), Ministry of Health;

- ▶ Ria Earp (Ngati Pikiao/Ngati Whakaue), since October 1996 deputy director-general (Maori health), Ministry of Health;
- ▶ Mara Andrews (Ngati Kahungunu/Ngati Raukawa/Whakatohea), senior Maori development manager in the Maori Health Group of the HFA and formerly a policy analyst for the same group in the Central RHA;
- ▶ Peter Wilson, company director and chairperson of the board of Healthcare Hawke's Bay since its establishment in 1993;
- ▶ Tumanako Walter Wilson (Ngati Kahungunu ki Wairoa), director on the board of Healthcare Hawke's Bay from 1993 to May 1999;
- ▶ Arama Puriri, kaumatua consultant to the chief executive of Healthcare Hawke's Bay on community services, and also to the Ministry of Commerce;
- ▶ Wi Keelan, since December 1998 Maori health services manager, Healthcare Hawke's Bay; and
- ▶ Mark Flowers, since 1996 chief executive of Healthcare Hawke's Bay, previously its surgical services manager and employed by its predecessors the Area Health Board and the Hawke's Bay Hospital Board.

RECORD OF PROCEEDINGS

1. CLAIMS

1.57 Statement of claim (Wai 692)

- (a) Addition to claim, 27 January 1998
- (b) Amendment to claim, 31 May 1999
- (c) Amendment to claim, 22 July 1999

2. PAPERS IN PROCEEDINGS

2.261

- (a) Direction to register claim, 14 January 1998
- (b) Notice of claim, 14 January 1998
- (c) Direction to appoint Judge Savage to conduct conference, 27 January 1998
- (d) Direction to register addition to claim, 27 January 1998
- (e) Notice of addition to claim, 28 January 1998
- (f) Submissions of counsel for claimants concerning urgency application, 30 January 1998
- (g) Submissions of Crown counsel to oppose urgency application, 30 January 1998
- (h) Direction following urgency conference of 30 January 1998, 3 February 1998

- 2.298** Direction following judicial conference of 22 October 1998, 23 October 1998
- 2.303** Direction consolidating Wai 692 in the Mohaka ki Ahuriri Inquiry, 17 November 1998
- 2.310** Direction following the ninth hearing of the Mohaka ki Ahuriri inquiry, 26 November 1998
- 2.312** Direction release Ferguson report (doc U7), 18 December 1998
- 2.317** Memorandum of Wai 692 counsel concerning Wai 692 hearing, 4 February 1999
- 2.323** Memorandum from Crown regarding access of Ms Lisa Ferguson to information, 22 March 1999
- 2.325** Letter from Richard Moorsom to Crown Law regarding access of Lisa Ferguson to information, 18 February 1999
- 2.326** Letter of Crown Law to Registrar responding to Moorsom request (paper 2.325), 1 March 1999
- 2.327** Lisa Ferguson report expressing concerns regarding access to information, 5 March 1999
- 2.329** Direction requesting parties address concerns raised by Lisa Ferguson, 12 March 1999
- 2.330** Lisa Ferguson report regarding access to information, 16 March 1999
- 2.331** Memorandum from Wai 692 counsel regarding access of Lisa Ferguson to information, 17 March 1999
- 2.332** Direction defining issue regarding access of Lisa Ferguson to information, 24 March 1999
- 2.334** Direction following conference of 29 April 1999, 3 May 1999
- 2.336** Direction to release Ferguson report (doc v1), 7 May 1999
- 2.337** Direction following conference of 10 May 1999, 11 May 1999
- 2.339** Memorandum from Lisa Ferguson to Richard Moorsom on research process, 22 April 1999
- 2.340** Letter from Richard Moorsom to Lisa Ferguson on access to official information, 9 May 1999
- 2.341** Letter from Lisa Ferguson to Richard Moorsom replying to 2.27 above, 9 May 1999
- 2.342** Memorandum from Lisa Ferguson concerning interviews with officials, 9 May 1999
- 2.344** Notice of eleventh hearing, 24 May 1999
- 2.346** Memorandum from Crown regarding Lisa Ferguson questions, 21 June 1999
- 2.347** Direction following pre-hearing conference of 18 June 1999, 22 June 1999
- 2.350** Memorandum from Wai 692 counsel regarding closing submissions, 5 July 1999
- 2.355** Memorandum from Crown regarding amendment to Wai 692 claim dated 22 July 1999, 22 July 1999
- 2.356** Memorandum from Wai 692 counsel responding to Crown memo regarding an amendment to the Wai 692 claim, 23 July 1999
- 2.357** Direction regarding Crown objection to the filing of an amendment to the Wai 692 claim (claim 1.57(c)), 23 July 1999
- 2.361** Direction to register second and third amendments to Wai 692, 27 July 1999
- 2.362** Notice of second and third amendments to Wai 692, 20 August 1999
- 2.370** Memorandum from counsel for Wai 119, 400, 436, 692, 731 regarding late filing of closing submissions, 3 November 1999
- 2.375** Letter from counsel for Wai 119, 400, 430, 692, and 731 to Crown regarding the late filing of closing submissions, 15 November 1999
- 2.377** Direction requesting a stay in proceedings regarding the disposal of Napier hospital, 9 December 1999
- 2.382** Direction regarding claimant request for an interim decision, 15 February 2000
- 2.394** Letter from Crown to Tribunal concerning sale of Napier hospital, 8 November 2000
- 2.395** Letter from counsel for Wai 692 to Crown concerning the transfer of Napier hospital, 23 January 2001
- 2.396** Letter from Crown to counsel for Wai 692 responding to their concerns on the transfer of Napier hospital, 23 January 2001
- 2.397** Media release – Napier hospital transfer deferred, 26 January 2001
- 2.398** Direction concerning the Napier hospital transfer, 26 January 2001
- 2.399** Letter from counsel for Wai 692 to Crown concerning a letter of 8 January 2001 from the Property Group Limited to the Environmental Management Services Limited, 8 February 2001
- 2.400** Memorandum from Crown counsel responding to Tribunal direction of 26 January 2001, 9 February 2001
- 2.401** Memorandum from Wai 692 counsel responding to Crown in respect of the transfer of Napier hospital, 23 February 2001
- 2.402** Letter from counsel for Wai 692 to Crown requesting a stay in disposal proceedings pending release of the Tribunal report, 1 March 2001
- 2.403** Letter from Crown to counsel for Wai 692 responding to counsel's request of 1 March 2001 (paper 2.402), 2 March 2001

THE NAPIER HOSPITAL AND HEALTH SERVICES REPORT

APP IV

2.406 Memorandum from Crown counsel responding to counsel for Wai 692 (paper 2.50), 16 March 2001

2.407 Direction requesting submissions as to whether or not health entities responsible for Napier hospital between 1876 and 1991 should be regarded as part of the Crown, 11 April 2001

2.408 Memorandum from counsel for Wai 692 responding to Tribunal direction of 11 April 2001, 23 April 2001

2.409 Memorandum from Crown responding to Tribunal direction of 11 April 2001, 23 April 2001

3. RESEARCH COMMISSIONS

3.34

(a) Direction authorising Peter Callinicos to commission Lisa Ferguson to undertake research, 24 July 1998

(b) Direction extending Lisa Ferguson commission, 5 August 1998

3.47 Direction commissioning Lisa Ferguson, 18 December 1998

3.48 Direction extending Lisa Ferguson commission, 17 March 1999

4. TRANSCRIPTS AND TRANSLATIONS

4.25 Transcript of the questioning of Hana Cotter by Joe Williams in Maori at the Wai 692 hearing held 8–10 June 1999

4.26 Translation of the questioning of Hana Cotter by Joe Williams in Maori at the Wai 692 hearing held 8–10 June 1999

RECORD OF DOCUMENTS

A. TO END OF FIRST HEARING, TE WHANGANUI A OROTU INQUIRY

Documents received up to the end of the first hearing of the Te Whanganui a Orotu inquiry, held at the Waitangi Tribunal's offices, Wellington, 15 April 1992.

A2 H H Turton. 1878. *Maori Deeds of Land Purchases in the North Island of New Zealand*. vol 2, pp 483–496

Copies of original deeds

Waipukurau block, 4 November 1851 (Wai 161)

Ahuriri block, 17 November 1851 (Wai 55)

Mohaka block, 5 December 1851 (Wai 119)

A21 Supporting documents to the evidence of Stephanie McHugh in relation to Te Whanganui a Orotu

(a) Volume 1: official publications (*British Parliamentary Papers*, Acts and ordinances, Bills, *New Zealand Parliamentary Debates*, *Journals of the House of Representatives*, *Journals of the Legislative Council*)

(b) Volume 2: official publications (*Appendix to the Journals of the House of Representatives*, *New Zealand Government Gazette*, *Hawke's Bay Provincial Council Votes and Proceedings*)

(c) Volume 3: other published material and Department of Survey and Land Information records (newspapers, *Turton's Deeds*, pamphlets, deed receipts, Crown grants)

(d) Volume 4: National Archives files and correspondence (CS, G, LE, MA, NM, NZC, W series)

(e) Volume 5: library manuscript material (Alexander Turnbull: Colenso, Tiffen and McLean papers, Auckland Public Library: Grey letters)

(f) Volume 6: maps

A22 J Hippolite Wairoa ki Wairarapa (pt1) 12 November 1991 commissioned by the Waitangi Tribunal

(a) Supporting papers to document A22

(b) Supporting papers to document A22

C. TO END OF SECOND HEARING, TE WHANGANUI A OROTU INQUIRY

Documents received up to the end of the second hearing of the Te Whanganui a Orotu inquiry, held at Mohaka Marae, Mohaka, and Te Taiwhenua o Te Whanganui a Orotu, Napier, 4 May–12 May 1992.

c2 Evidence of Stephanie McHugh on McLean's Hawke's Bay purchase instructions 1848–1850 (Wai 201)

c3 Evidence of Stephanie McHugh on the purchase of the Ahuriri block, November 1851 (Wai 55)

(a) Supporting documents to document c3

J. TO END OF FIRST HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the first hearing of the Mohaka ki Ahuriri inquiry, held at Tangoio Marae, Tangoio, 11–15 November 1996.

J4 RP Boast, 'Mohaka–Waikare Confiscation and its Aftermath: Social and Economic Issues', report commissioned by Crown Forestry Rental Trust

J10 Vincent O'Malley, overview report on Ahuriri purchase, 1995

J12 DCowie, report on Mohaka ki Ahuriri, 8 August 1996

J29 Richard Boast. 1996. 'Mohaka-Waikare Blocks'. Vol2 of 'Mohaka-Waikare Confiscation Consolidated Report'

M. TO END OF SECOND HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the second hearing of the Mohaka ki Ahuriri inquiry, held at Te Haroto Marae, Te Haroto, 27–30 January 1997.

M2 Report by Te Taite Cooper and Lee Smith, 'Ki a Te Makarini, Correspondence between Donald McLean and Maori Leaders prior to and following the Ahuriri Purchase 1851', November 1996

N. TO END OF THIRD HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the third hearing of the Mohaka ki Ahuriri inquiry, held at Waiohiki Marae, Waiohiki, 23–26 June 1997.

N25

(c) Obituary of Tareha Te Moananui, *Daily Telegraph*, 30 December 1880

N26

(a) Article by Charles Tareha, *The Watchtower*, 15 September 1979

N28

(c) Supporting evidence of David Erueti Pene regarding Te Whanganui a Orotu

O. TO END OF FOURTH HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the fourth hearing of the Mohaka ki Ahuriri inquiry, held at Omaahu Marae, Hastings, 13–17 October 1997.

O2 Vincent O'Malley. 1997. 'The Treaty of Ahuriri: Supplementary Evidence of Vincent O'Malley in relation to the Ahuriri Purchase of 1851'

O4 John Hutton. 1997. 'Ahuriri: A Social Impact Study for the Twentieth Century'

O5 Tony Walzl. 1997. 'Ahuriri Land Issues'

(a) Supporting papers to document O5

R. TO END OF SEVENTH HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the seventh hearing of the Mohaka ki Ahuriri inquiry, held at Te Haroto Marae, Te Haroto, 14–17 April 1998.

R8 Patrick Parsons. 1997. 'Maori Customary Interests'. Amended version

U. TO END OF TENTH HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the tenth hearing of the Mohaka ki Ahuriri inquiry, held at the Great Wall Conference Centre, Napier, 24 May 1999.

U1 Brief of evidence of Takuta Hohepa Mei Emery, 29 January 1998

U2 Evidence of Mark Heaney, Health Care Hawke's Bay, 31 January 1998, including annexures 3.1–3.4: Maori Health Committee: role description and terms of reference, not dated

CHE Maori Health Advisory Committee

U3 Central RHA. 1996. 'Health Care in Napier'. Booklet

U4 'Report from Donald McLean, Land Commissioner to the Colonial Secretary, Wellington', AJHR, 1862, C-1, pp 315–316

U7 Scoping report by Lisa Ferguson for the Napier Hospital Services Claim, 17 December 1998

U8 Patrick Parsons. 1998. 'Wai 692: The Downgrading of Napier Hospital Services and Sale of Assets'

U12 Vincent O'Malley. 1999. 'Where is the Doctor for the Maoris? Te Tiriti o te Ahuriri and the Provision of Health Services to Central Hawke's Bay Maori, 1851–1940'

(a) Supporting papers to document U12

V. TO END OF ELEVENTH HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the eleventh hearing of the Mohaka ki Ahuriri inquiry, held at the office of Te Whanganui-a-Orotu Taiwhenua, 8–10 June 1999.

V1 Lisa Ferguson. 1999. 'Wai 692: Napier Hospital Services Claim; Contemporary Aspects; Part 1: Provisional Draft'

(a) Memorandum from Lisa Ferguson submitting questions in regard to official information required for her report, 11 May 1999

THE NAPIER HOSPITAL AND HEALTH SERVICES REPORT

APP IV

- (b) Memorandum from Crown attaching documents in response to directions of 11 May 1999 (paper 2.337), 18 May 1999
Documents included:
- (i) Flowers to Crown counsel, 17 May 1999
 - (A1) Jennie Langley, Phoenix Public Relations, to Peter Clark, 19 December 1990
 - (A2) Jennie Langley, Phoenix Public Relations to Andy Train, 14 January 1991
 - (B1) Notes of a workshop held at 10.00 am on 11 April 1991 to discuss single acute hospital report
 - (B2) Notes of Hawke's Bay Area Health Board workshop, 11 April 1991
 - (C1) Peter Wilson to directors, 11 December 1997
 - (C2) Extract of Board minutes of 21 July 1994
 - (C3) Section 1: the decision
 - (C4) Comparison of expectations and purchasing intentions
 - (C5) Lynne Lane, acting chief executive officer, Central Health, to Mark Flowers, 14 October 1997
 - (C6) Michael Quinlivan, CHE relationship manager, Medical Surgical Services, Central Health, to Mark Flowers, 18 November 1997
 - (C7) Karalyn van Deursen. 1997. 'Public Consultation Meetings on Siting of Napier Health Facility'. Summary for Healthcare Hawke's Bay board of directors
 - (C8) Press clippings
 - (C9) Submission from Gerald Lewis
 - (C10) Draft Napier City Council submission
 - (C11) Financial implications
 - (D1) Circular letter, 12 December 1990, under-printed 'A Train, chairman'
 - (E1) Submissions concerning Hawke's Bay acute hospital, not dated
 - (E2) Submission dated 11 February 1991
 - (E3) Submission dated 14 March 1991
 - (F1) Moore to Central RHA, 13 June 1994, covering invitation letters, 13 June 1994
 - (F2) Oral submission: iwi – submission 581 (also doc w18(a)(83))
 - (G1) Circular letter, 4 May 1994
 - (c) Lisa Ferguson. 1999. 'Wai 692: Napier Hospital Services Claim; Contemporary Aspects; Part 2'
 - (d) Memorandum from Lisa Ferguson on documents presented by Crown counsel in response to previous questions, 30 June 1999
- v4 Summary of Vince O'Malley. 1999. 'Where is the Doctor for the Maoris? Te Tiriti o te Ahuriri and the Provision of Health Services to Central Hawke's Bay Maori, 1851–1940'
- v5 Summary of Lisa Ferguson. 1999. 'The Napier Hospital Services Claim: Contemporary Aspects'
- v6 Evidence of Papaarangi Reid, undated
- v7 Evidence of Irihapeti Merenia Ramsden, undated
- v8 Evidence of Neil Francis Kirton, undated
- v9 Evidence of Whatarangi Winiata, 2 June 1999
- v10 Evidence of Jim Pearcey, undated
- v11 Evidence of Janice Wenn, undated
- v12 Evidence of Professor Robin Gwynn, undated
(a) Professor Robin Gwynn. 1998. *The Denial of Democracy*. Napier: Cosmos Publications. Two chapters
- v13 Supplement to the evidence of Dr Papaarangi Reid, undated
- v14 Claimant counsel opening submissions, 8 June 1999
- v15 Evidence of Ruruarau Heitia Hiha, June 1999
- v16 Evidence of Te Maari Joe, undated
(a) Letter from Te Maari Joe to Hawke's Bay Health regarding regional hospital taskforce report, 10 October 1994
- v17 Evidence of Pirika Tom Hemopo, undated
(a) Letter from Pirika Tom Hemopo to chairman, Crown health enterprise, concerning Napier Hospital, 1 June 1994
(b) Letter from Pirika Tom Hemopo to mayor of Napier concerning consultation process in respect of Napier Hospital, 15 February 1995
- v18 Evidence of Ngahiwi Tomoana, undated
- v19 Evidence of Matthew Matuakore Petuha Bennett, undated
(a) Information on Tui Ora Limited, an iwi health initiative, 19 April 1999
(b) Statement of support for the Wai 692 claim by Viv Lawton (Grey Power), 10 May 1999
(c) Letter from the Mayor of Napier to J R Gardiner (Napier Returned Services Association Incorporated) concerning Napier City Council's position on Wai 692 claim, 25 May 1999
(d) Letter of support for Wai 692 claim by Keith Selar (Committee of Concerned Citizens for Hospital Services), 9 May 1999

W. TO END OF TWELFTH HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the twelfth hearing of the Mohaka ki Ahuriri inquiry, held at the War Memorial Centre, 26–30 July and 2 August 1999.

w8 Dr Colin Feek. 1999. Report concerning Napier Hospital Services claim

w10 Crown documents concerning the Mohaka ki Ahuriri inquiry, Meurant diaries

- w12** Evidence of Peter Wilson for the Crown concerning Napier hospital services claim, 8 July 1999
- w13** Evidence of Mark Flowers for the Crown concerning Napier hospital services claim, 8 July 1999
- w14** Evidence of Tumanako Walter Wilson for the Crown concerning Napier hospital services claim, 8 July 1999
- w15** Evidence of Wi Keelan for the Crown concerning Napier hospital services claim, 9 July 1999
- w16** Evidence of Ria Earp for the Crown concerning Napier hospital services claim, 9 July 1999
- w17** Evidence of Chris Clarke for the Crown concerning Napier hospital services claim, 9 July 1999
- w18**
- (a) Documents supplied by the Crown concerning the Napier Hospital Services Claim. July 1999. Vol1, pp 5000–6118
- Documents included:
- 1** Central RHA. 1996. 'Healthcare in Napier: Purchasing of Healthcare in Napier on the Establishment of the Regional Hospital in Hastings', at 5000
 - 2** CAB(97) M20/29, at 5020
 - 3** Mark Flowers to Dr Colin Feek, 3 July 1997, at 5021
 - 4** Mark Flowers to Dr Colin Feek, 8 July 1997, at 5022
 - 5** Report from Dr Colin Feek to Health Ministers, 14 July 1997, at 5031
 - 6** Facsimile from Mark Heaney to Dr Colin Feek, 15 August 1997, at 5036
 - 7** Dr Colin Feek and Frances Hughes to Mark Flowers, 2 September 1997, at 5037
 - 8** Report from Ministry of Health to Minister of Health, 3 September 1997, at 5039
 - 9** Discharges by socio-economic deprivation – standardised discharges (case-mix adjusted), at 5045
 - 10** Service coverage document (at p8), at 5046
 - 11** Ministry of Health, 'Lower SIDS Rates: Infant Death Rates Continue to Fall', media release, 18 June 1999, at 5049
 - 12** Document containing the role description and terms of reference of the Maori Advisory Committee, at 5055
 - 13** Maori Health Committee, 'Minutes', 8 December 1997, at 5057
 - 14** Healthcare Hawke's Bay, 'Statement of Intent, 1993–94', at 5062
 - 15** Methodology for planning regional hospital, 6 August 1993, at 5073
 - 16** 'Board Minutes', 23 August 1993, at 5075
 - 17** Peter Wilson to editor, *Daily Telegraph*, 20 December 1993, at 5079
 - 18** Alan Dick, mayor of Napier, to Peter Wilson, 20 December 1993, at 5082
 - 19** Wilson to mayor of Napier, 23 December 1993, at 5087
 - 20** Briefing for RHA, 16 December 1993, at 5089(a)
 - 21** Michael Laws to Peter Wilson, 22 December 1993, at 5093
 - 22** *Hawke's Bay Herald Tribune*, 23 December 1993, at 5095
 - 23** Regional Hospital Task Force, Hawke's Bay regional hospital: superior services for the future, March 1994, at 5096
 - 24** Press release, 30 March 1994, at 5213.
 - 25** Joint press statement, 8 April 1994, at 5214.
 - 26** Peter Wilson to Hutton Peacock, 14 January 1994, at 5215
 - 27** Wilson to Minister of Crown Health Enterprises, 14 January 1994, at 5216
 - 28** Hutton Peacock to Wilson, 1 February 1994, at 5218.
 - 29** Murray Burns to Alistair Bowes, 2 February 1994, at 5219
 - 30** Murray Burns, 'Draft Strategy for Consultation', not dated, at 5220
 - 31** Peacock to Wilson, 30 March 1994, at 5222
 - 32** Wilson to Peacock, 30 March 1994, at 5225
 - 33** Wilson to Peacock, 30 March 1994; Peacock to Wilson, 7 April 1994, at 5230
 - 34** Media release, 22 April 1994, at 5236
 - 35** Healthcare Hawke's Bay, 'Freephone for Public Consultation', media release, 22 April 1994, at 5237
 - 36** Public consultation on a regional hospital for Hawke's Bay, at 5239
 - 37** 'Healthcare HB: The Future', 29 April 1994, at 5244
 - 38** Professor Derek North, 'Evaluation of Clinical Services in Hawke's Bay', February 1994, at 5248
 - 39** Healthcare Management Associates. 1994. 'The Proposal to Develop a Regional Hospital for the People of Hawke's Bay', at 5268
 - 40** Healthcare Hawke's Bay Regional Hospital Consultation Project. 1994. *Newsletter 1: First Stakeholder Meeting*, at 5285
 - 41** Healthcare Hawke's Bay Regional Hospital Consultation Project. 1994. *Newsletter 2: Second Stakeholder Meeting*, at 5306
 - 42** Bridgeport Group, 'Proposed Hawke's Bay Regional Hospital: Analysis of Submissions', at 5312
 - 43** 'Proposed Hawke's Bay Regional Hospital: Analysis of Submissions, Preliminary Report', 30 May 1994, at 5359
 - 44** 'Proposed Hawke's Bay Regional Hospital: Analysis of Submissions, Preliminary Report', 17 June 1994, at 5364
 - 45** Validation of transport cost estimate and inclusion of two return Napier–Hastings trips on Saturdays, at 5369

APP IV

- 46 Octa Associates Limited. 1994. 'Hastings Hospital Redevelopment: Final Report for Healthcare Hawke's Bay', at 5371
- 47 Octa Associates Limited. 1994. 'Napier Hospital Redevelopment: Final Report for Healthcare Hawke's Bay', at 5430
- 48 Octa Associates Limited. 1994. 'Regional Hospital Redevelopment, Second Site Facilities: Final Report', at 5499
- 49 Healthcare Management Associates. 1994. 'Quality Measures: The Impact of Developing a Regional Hospital', at 5526
- 50 Healthcare Management Associates. 1994. 'A Report Responding to the Issues Raised by the RHA and the Napier City Council in June 1994', at 5530
- 51 Beca Carter Hollings and Ferner Limited. 1994. 'Audit: Hawke's Bay Regional Hospital', at 5550
- 52 Octa Associates Limited. 1994. 'A Two Hospital Solution: Status Quo Scenario: Final Report', at 5581
- 53 Professor Derek North. 1994. Evaluation from a Clinical Perspective of the Hawke's Bay Regional Hospital Proposals, at 5593
- 54 'Board Minutes', 21 July 1994, at 5600
- 55 Healthcare Hawke's Bay. 1994. 'Board Decision on Hospital Reconfiguration', at 5615
- 56 Wilson to directors, 19 July 1994, at 5657
- 57 Professor Derek North. 1994. 'Accident and Medical Services: Napier', at 5664
- 58 Central RHA. 1994. 'Purchasing Expectations: Healthcare Hawke's Bay's Regional Hospital, at 5680
- 59 Minister for Crown Health Enterprises to Wilson, 4 August 1994, at 5696
- 60 Hutton Peacock to Peter Wilson, 5 August 1994, at 5697
- 61 Healthcare Hawke's Bay. 1995. 'Regional Hospital Project: Implementation Framework', at 5698
- 62 'Board Minutes', 28 March 1995, at 5708
- 63 Healthcare Hawke's Bay. 1996. 'Looking Forward: The Plan for a Regional Hospital and a Regional Health Service', at 5720
- 64 Healthcare Hawke's Bay, 'Board Minutes, 12 December 1996', at 5761
- 65 Central RHA. 1996. 'Health Care in Napier', at 5763
- 66 'Board Minutes', 17 March 1997, at 5773
- 67 Healthcare Hawke's Bay. 1997. 'Submission to the Hawke's Bay Regional Hospital Review of the Consultation Process', at 5755.
- 68 Napier Services Working Party, 'Minutes', 6 March 1997 at 5914
- 69 Central RHA. 1996. 'Analysis of Submissions: Purchasing Intentions for Services to be Provided in Napier', at 5918
- 70 Napier Services Working Party, 'Minutes', 26 June 1997, at 5943
- 71 Napier Services Working Party, 'Minutes', 4 September 1997, at 5947
- 72 Napier Services Working Party. 1997. 'Recommendation to Healthcare Hawke's Bay Board of Directors: Napier Services', at 5955
- 73 Media release, 3 November 1997, at 6014
- 74 Board minutes, 16 December 1997, at 6015
- 75 'For the record: Planned Health Services in Napier', advertisement, August 1998, at 6034
- 76 Healthcare Hawke's Bay. 'Statement of Intent for the Years 1998-99 to 2000-2001', at 6039
- 77 Tumanako Walter Wilson, affidavit in support of first defendant's defence to the plaintiff's claim, at 6071
- 78 Regional Hospital Consultation Project. 17 May 1994. *Newsletter 1*, at 6075
- 79 Stakeholder meeting, 20 May 1994, at 6079
- 80 Regional Hospital Consultation Project. 23 May 1994. *Newsletter 2*, at 6096
- 81 Affidavit of Alayna Ann Watene, 17 October 1994, at 6102
- 82 Central RHA. 1994. 'Report of Hui Held at Omaha Marae, Hastings', at 6105
- 83 Iwi - submission 581, at 6112
- w18**
- (b) Documents supplied by the Crown concerning Napier hospital services claim, July 1999, vol2 (items 8000-8012)
- Documents included:
- (8000) Ministry of Health, 1998. *Action for Health and Independence: Bridging the Gap between Actions and Outcomes: The Population Perspective - Maori Health Issues*. Wellington: Ministry of Health
- (8001) Department of Health. 1992. *Whaia te Ora mo te Iwi. Strive for the Good Health of the People. Government's Response to Maori Issues in the Health Sector*
- (8002) Department of Health and Te Puni Kokiri. 1993. *Whaia te Ora mo te Iwi: Maori Health Policy Objectives of Regional Health Authorities and the Public Health Commission*
- (8003) Ministry of Health. 1994-95. *Policy Guidelines for Maori Health*
- (8004) Ministry of Health. 1995-96. *Policy Guidelines for Maori Health*
- (8005) Ministry of Health. 1996-97. *Policy Guidelines for Maori Health*
- (8005A) Minister of Health. 1999. *The Government's Medium-term Strategy for Health and Disability Support Services*
- (8006) Ministry of Health. 1995. *He Taura Tieke. Measuring Health Effectiveness for Maori*
- (8007) Crown Company Monitoring Advisory Unit. Not dated. *CCMAU*

- (8008) HFS's funding agreement with the Minister of Health: service coverage document, 1998–1999, app c
- (8009) Minister of Health. 1998. *Hospital Services Plan: Securing Better Hospital Services into the Future*
- (8010) Minister of Health, 1999. *Statement of Owners' Expectations of Hospital and Health Services*
- (8011) Healthcare Hawke's Bay. 1998. *Maori Health Services: Business Plan*
- (8012) Healthcare Hawke's Bay. 1999–2000. *Maori Service Plan*
- w19** Evidence of Mara Andrews, July 1999
- (a) Supporting documents
- Documents included:
- (9000) Central RHA. 1993. *Purchasing Directions*
- (9001) Central RHA, 1994. 'Report of Hui Held at Omaha Marae, Hastings'
- (9002) Central RHA. 1994. *Purchasing Intentions for Hawke's Bay*
- (9003) Peacock to board of directors, 26 July 1994
- (9004) Minutes of meeting by telephone conference call, 29 July 1994
- (9005) Regional Hospital Task Force. 1994. 'Report Back to the Board of Healthcare Hawke's Bay'
- (9006) Media release, 5 August 1994
- (9007) Schedule of provider meetings (in addition to public meetings), 9–25 May 1995
- (9008) Handwritten minutes from Maori hui, 6 May 1995
- (9009) Central RHA. 1996. *Nga Ara Poutama: Pathways*
- (9010) 'Napier Purchasing Intentions – Medical and Social Services', 8 November 1996
- (9011) Central RHA. 1996. *Tē Kite Aronga: Directions – Three Year Strategic Plan for Maori Health, 1996–1999*, draft
- (9012) Te Kete Tuputahi Whakakaokao Korero. 1995. *Our First Two Years, 1993–1995*
- (9013) Maori health policy, June 1998
- (9014) Health Funding Authority. 1998. *National Strategic Plan for Maori Health, 1998–2001*
- (9015) Central RHA, public notice and newspaper advertisement detailing public hui on Maori health
- (9016) Example of hui checklist
- (9017) Health Funding Authority. September 1998. *Tē Hononga*
- (9018) Central RHA. 1993. 'Report on Maori Consultation Hui at Waikaremoana Kuha Marae'
- (9019) Central RHA. 1993. 'Report on Maori Consultation Hui at Wairoa Taihoa Marae'
- (9020) Central RHA. 1993. 'Report on the Maori Consultation Hui at Moteo Marae'
- (9021) Central RHA. 1993. 'Report on Maori Consultation Hui at Kahuranaki Marae'
- (9022) Central RHA. 1995. 'Report on Regional Hui at Taupunga Marae, Waimarama'
- (9023) Central RHA. 1995. 'Report on Maori Consultation Hui at Raupunga Marae'
- (9024) Central RHA. 1995. 'Report on Hui Held at Taihoa Marae, Wairoa'
- (9025) Central RHA. 1997. 'Report on Consultation Hui at Mihiroa Marae, Pakipaki'
- (9026) Central RHA. 1997. 'Report on Consultation Hui at Kahuranaki Marae, Te Hauke, Hastings'
- (9027) Health Funding Authority. 1998. Report of Consultation Hui at Kuha Marae, Waikaremoana'
- (9028) Health Funding Authority, 1998. 'Report of Consultation Hui at Mihiroa Marae, Hastings'
- (9029) Health Funding Authority 1998. 'Health and Disability Services for Wairoa District: Notes from a Two-day Hui Held at Kaiuku Marae, Mahia'
- (9030) Transitional Health Authority (Central Health), Crown Health Enterprise. 1996–97. 'Cultural Review Report of Healthcare Hawke's Bay'
- (9031) Central RHA. 1995. 'Report from CHE Maori Managers' Hui, Mihiroa Marae, Hastings Hospital'
- (9032) Health Funding Authority. 'General Quality Requirements, Schedule 3, 1998/1999' (example of previous clauses)
- (9033) Health Funding Authority. 'Standard Terms and Conditions of Contract', app A
- (9034) Central RHA, Maori Health Group. 1994–95. *Tauira Whakahaere Business Plan: Tē Kite Aronga*
- (9035) Central RHA, Maori Health Group. 1995–96. *Tauira Whakahaere Business Plan: Tē kite Aronga*
- (9036) Central RHA, Maori Health Group. 1996–97. *Tauira Whakahaere, Business Plan*
- (9037) Central RHA, Maori Health Group. 1997–98. *Tauira Whakahaere, Business Plan*
- w24** Evidence of January Roberts, undated
- w25** Evidence of Colin James, undated
- w26** Evidence of Rose Whenuaroa, undated
- w27** Evidence of Christine Te Kahika, undated
- w28** Evidence of Margie Russell, undated
- w36** Leaflet on Heretaunga Health Village and Hawke's Bay Hospital (Hastings)
- w37** Booklet on construction of Napier Health Centre
- w44** Crown opening submissions for the Wai 692 claim, undated
- w45** A1 colour map, NZDep 96, 'Index of Deprivation for Small Areas in New Zealand', Critchlow Associates, 1998
- w46** Extract of minutes of meeting of board of directors of Crown Health Hawke's Bay Limited, 2 March 1994

APP IV

- w47** Extract of Healthcare Hawke's Bay minutes of 9 June 1999
- w48** Letter from Brian Roche (Coppers Lybrand) to Dr Mike Ashby (CCMAU), 19 April 1995
- w49** Ministry of Health Internal memo from Lindsay Sales regarding CHE business plans – Canterbury and Hawke's Bay, 6 May 1995
- w50** Memorandum from Mark Flowers (Network Public Relations Consultants) concerning Napier services consultation, 19 June 1997
- w51** Walter Wilson. 1993. 'Maori Health Policy Consultation Document' (draft)
- w52** Affidavit of Arama Puriri for High Court proceedings, 22 August 1999
- w53** Healthcare Hawke's Bay. *Application of Tikanga Maori within Ngati Kahungunu*. Pamphlet
- w54** Letter from Healthcare Hawke's Bay enclosing chapters 1–6 of *Maori Health Services Plan*, 25 February 1998

X. TO END OF THIRTEENTH HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the thirteenth hearing of the Mohaka ki Ahuriri inquiry, held at the Great Wall Conference Centre, Napier, 22–25 and 29–30 November 1999.

x1 Supplementary evidence of Chris Clarke, 17 August 1999

Documents included:

- (9038)** Statement of shareholders' expectations of Crown health enterprises, April 1996
- (9039)** Statement of owners' expectations of Crown health enterprises, February 1997
- (9040)** Statement of owners' expectations of Crown health enterprises, March 1998
- (9041)** Land transfer document
- (9042)** Land transfer document
- (9043)** CCMAU. 1999. *New Zealand Crown Owned Hospital and Health Services: Patient Satisfaction Survey Draft Guidelines*
- (9044)** David Hay. 'Satisfaction Guaranteed: Quarterly Patient Satisfaction Surveys by CCMAU'. *Health Manager*, vol 6 no 2

x4 Health Funding Authority and Healthcare Hawke's Bay contract quality requirements for 1994 and 1998–1999

x5 Crown documents responding to matters raised at Crown hearing held 26 July–2 August 1999

Documents included:

(1) Auckland Healthcare. Not dated. *A New Shape for Public Health Care in Auckland*

(2) Auckland Healthcare. 1999. *Health Services Delivery Plan*, pp 86–89

(3) Crown Company Monitoring Advisory Unit. 1999. 'Advice on the Health Services Delivery Plan Submitted by Auckland Healthcare Services Limited'

(4) Central RHA. 1995. *Annual Report 1994–1995*

(5) Central RHA. 1997. *Annual Report 1996–1997*

(6) Transitional Health Authority. 1997. 'Financial Report for the Period Ended 30 June 1997'

(7) Health Funding Authority. 1998. *Annual Report 1998*

(8) Central RHA. 1994. *Statement of Intent*

(9) Central RHA. 1995–98. *Statement of Intent*

(10) Central RHA. 1996–99. *Statement of Intent*

(11) Health Funding Authority. 1998–99. *Statement of Intent*

Health Funding Authority. 1999–2000. *Statement of Intent*

Health Funding Authority. 2000–01. *Statement of Intent*

(12) Facsimile from Mark Flowers, Healthcare Hawke's Bay, to Mike Doogan, Crown counsel, concerning estimated rental for Napier Health Centre, 10 September 1999

(13) Healthcare Hawke's Bay. 1995–96. Central RHA, *Contract for the Purchase and Provision of Health and Disability Support Services and Public Health Services*, apps 1, 11, schedules 3, 7

(14) Healthcare Hawke's Bay. 'Minutes of Kaumatua Meetings Held during August 1994'

(15) Letter from Crown counsel to Walters Williams concerning Maori health provider data, 15 September 1999

(16) Ministry of Health. 1996. *Accountability Review*

(17)(1) Minister of Health 1997–98. Accountability documents

(17)(2) Minister of Health to chair, Transitional Health Authority, 11 August 1997, *Ministerial Expectations for 1997/98*, circular letter.

(17)(3) Transitional Health Authority. 1997–98. *Statement of Intent*

Transitional Health Authority. 1998–99. *Statement of Intent*

Transitional Health Authority. 1999–2000. *Statement of Intent*

(17)(4) Transitional Health Authority and Minister of Health. 1997. *Annual Funding Agreement, 1997/1998*.

(17)(5) Transitional Health Authority. 1997. *Evergreen Document, 1 August 1997*.

(18) Minister of Health, 'Notice to the Health Funding Authority of the Crown's Objectives for Health and Disability Services for 1998/99', NZG 14, p348, 29 January 1998

(19) Minister of Health, 'Notice to the Transitional Health Authority of the Crown's Objectives for Health and Disability Services for 1997/98', NZG 14, p348, 29 January 1998

(20) Memorandum from Geoff Henley to Mark Flowers, 24 June 1997

x31 Closing submissions from counsel for Wai 692, 1 October 1999

x32 Supporting documents to closing submissions from counsel for Wai 692, undated

x33 Further supporting documents to closing submissions from counsel for Wai 692 (draft transcript of Crown hearing)

x43 Crown statements of objectives for the former RHAS for 1993 to 1997

x48 Crown closing submissions for Wai 692, 4 November 1999

x50 Outline of submissions from Healthcare Hawke's Bay, 4 November 1999

x51 Crown closing submissions, vol c, November 1999

x52 Crown closing submissions, vol e, November 1999

x54 Crown closing submissions, vol b, November 1999

x55 Crown closing submissions, vol d, November 1999 (Wai 119 ROI, D9; Wai 436 ROI, doc c1; Wai 731 ROI, doc c2)

x56 Crown closing submissions, vol a, November 1999

x57 Documents supplied by the Crown, November 1999

x58 Crown closing submissions, vol a(i), November 1999

Y. TO END OF FOURTEENTH HEARING, MOHAKA KI AHURIRI INQUIRY

Documents received up to the end of the fourteenth hearing of the Mohaka ki Ahuriri inquiry, held at the office of the Taiwhenua o Te Whanganui a Orotu, Napier, 31 January–1 February 2000.

Y1 Covering letter of Crown documents inadvertently omitted from earlier documents filed by the Crown, 6 December 1999

(a) Notes of oral submissions on the implications of earlier Tribunal reports, undated

(d) Documents extracted from Colenso correspondence with McLean, (ms papers 0032-221) including Colenso's letter of 15 April 1850, which was incorporated in the Crown's closing submissions

Y8 Wai 692 claimant closing submissions in reply, 1 February 2000

Z. SUBSEQUENT TO 1 FEBRUARY 2000

Documents received subsequent to 1 February 2000.

Z5 Derek A Dow. 1999. *Maori Health and Government Policy, 1840-1940*. Wellington: Victoria University Press

Z6 Rayburn Lange. 1999. *May the People Live: A History of Maori Health Development, 1900-1920*. Auckland: Auckland University Press

Z7 P Crampton et al. 2000. *Degrees of Deprivation in NZ: An Atlas of Socioeconomic Difference*. Auckland: David Bateman

DOCUMENTS FROM OTHER INQUIRIES

Wai 27 record of inquiry

T1 Alan Ward. 1989. 'A Report on the Historical Evidence: The Ngai Tahu Claim, Wai 27'

Wai 473 record of inquiry

1.1 Statement of claim, 25 October 1994

2.1 Direction to register claim, 2 March 1995

2.2 Notice of claim, 6 March 1995

BIBLIOGRAPHY

LEGAL CASES

- New Zealand Maori Council v AG* [1987] 1 NZLR 641 (CA)
New Zealand Maori Council v AG [1989] 2 NZLR 142 (CA)
New Zealand Maori Council v Attorney-General [1991] 2 NZLR 129 (CA)
New Zealand Maori Council v Attorney-General [1994] 1 NZLR 513 (PC)
Tainui Maori Trust Board v AG [1989] 2 NZLR 513 (CA)
Te Heu Heu v AG [1999] 1 NZLR 98 (CA)
Te Runanga o Muriwhenua Inc v Attorney-General [1990] 2 NZLR 641 (CA)
Te Runanga o Te Ika Whenua Inc Society v AG [1994] 2 NZLR 20 (CA)
Te Runanga o Wharekauri Rekohu Inc v AG [1993] 2 NZLR 301 (CA)
Wellington International Airport Ltd v Air New Zealand [1993] 1 NZLR 671 (CA)
West Coast United Council v Prebble [1988] 12 NZTPA 399 (HC)

OFFICIAL DOCUMENTS

- ‘Report of the Select Committee on Aborigines’, House of Commons, Reports from Committees, vol 7, 1837 [425]
Minister of Health, Statements of Crown Objectives:
Notice to the Central Regional Health Authority under Section 8(1) of the Health and Disability Services Act 1993 of the Crown’s objectives in relation to health and disability services and other matters, [1993–94], 25 June 1993, NZG 1993, pp 1954–1956
Notice to the Central Regional Health Authority of the Crown’s objectives, [1994–95], 19 May 1994, NZG 1994, pp 1903–1904
Notice to the Central Regional Health Authority of the Crown’s objectives for health and disability services, [1995–96], 4 July 1995, NZG 1995, pp 1906–1907
Amendment to the Notice, 4 March 1996, NZG 1996 p 862
Notice to the Central Regional Health Authority of the Crown’s objectives for health and disability services in 1996–97, 25 June 1996, NZG 1996, pp 1753–1754
Notice to the Transitional Health Authority of the Crown’s objectives for health and disability services for 1997–98, 11 August 1997, NZG 1997, pp 2328–2329
Notice to the Health Funding Authority of the Crown’s objectives for health and disability services for 1998–99, 23 January 1998, NZG 1998, p 348
Notice to the Health Funding Authority of the Crown’s objectives for health and disability services for 1999–2000, 2 June 1999, NZG 1999, pp 1602–1605
Notice to the Health Funding Authority of the Crown’s statement of objectives for health and disability services for 2000–01, 30 September 1999, NZG 1999, pp 3386–3389
Notice to the Health Funding Authority of the Crown’s statement of objectives for health and disability services, March 2000, 26 March 2000, NZG 2000, pp 796–798
Native Land Court. Napier minute book, vols 19, 26
New Zealand Government, The Crown and the Treaty of Waitangi: a Short Statement of the Principles on which the Crown Proposes to Act, Wellington [1989]

BIBLIOGRAPHY

PUBLISHED LITERATURE

- Adams, Peter. 1977. *Fatal Necessity: British Intervention in New Zealand, 1830–1847*. Auckland: Auckland University Press
- Belich, James. 1986. *The New Zealand Wars and the Victorian Interpretation of Racial Conflict*. Auckland: Penguin
- . 1996. *Making Peoples: A History of the New Zealanders*. Auckland: Penguin
- Bohan, Edmund. 1998. *To Be A Hero: A Biography of Sir George Grey, 1812–1898*. Auckland: Harper Collins
- Bolger, James. 1994. [Prime Minister James Bolger interviewed by Paul Holmes on 1ZB]. Newztel log, 15 August 1994
- Booz-Allen and Hamilton. 1990. *Evaluation of the Feasibility of Consolidating Acute-care Hospital Services: Hawke's Bay Area Health Board*. [Napier]: Hawke's Bay Area Health Board, December 1990
- Boyd, Mary. 1984. *City of the Plains: A History of Hastings*. Wellington: Victoria University Press for the Hastings City Council
- Campbell, M N D. 1975. *The Story of Napier, 1874–1974*. Napier: Napier City Council
- Central Regional Health Authority. 1996a. *Towards A Healthier Hawke's Bay*. Wellington: Central RHA, January 1996
- . 1996c. *Primary Health Care Services in Napier and Hastings: Have Your Say*. Wellington: Central RHA, August 1996
- . 1996d. *Development During 1994–1996 Impacting on Central RHA's Purchasing Intentions for Napier*. Wellington: Central RHA
- Clark, Helen. 2001. *Achieving Equality in New Zealand*, Lecture at St Andrew's on the Terrace, Wellington, 3 April 2001, at www.executive.govt.nz
- Colenso, William. 1868. On the Maori Races of New Zealand, in *Transactions and Proceedings of the NZ Institute*, vol 1, May 1869
- Colenso, William. 1889. A Few Brief Historical Notes and Remarks Concerning the Early Christian Church at Ahuriri. Napier
- Conly, Geoff. 1992. *A Case History: the Hawke's Bay Hospital Board, 1876–1989*, Napier: Hawke's Bay Area Health Board
- . 1980. *The Shock of '31: the Hawke's Bay Earthquake*. Wellington: AH and AW Reed
- Cowie, Dean. 1996. *Hawke's Bay*, Wellington: Waitangi Tribunal. Rangahaua Whanui Series
- Crampton, Peter and Peter Davis. 1998. 'Measuring Deprivation and Socioeconomic Status: Why and How?' *NZ Public Health Report*, 5(11/12), pp 81–84
- Crampton, Peter and Others. 2000. *Degrees of Deprivation in New Zealand: An Atlas of Socioeconomic Difference*, Auckland: David Bateman
- Department of Prime Minister and Cabinet. 2001. *Key Government Goals to Guide Public Sector Policy and Performance*, May 2001, at www.dPMC.govt.nz/publications/key_goals.html
- Dow, Derek A. 1995. *Safeguarding the Public Health: A History of the New Zealand Department of Health*, Wellington: Victoria University Press
- . 1999. *Maori Health and Government Policy, 1840–1940*, Wellington: Victoria University Press
- . 1998. "'Specially Suitable Men'? Subsidised Medical Service for Maori, 1840–1940', *NZJH*, 32(2), pp 163–188
- Durie, Mason. 1998. *Whaiora: Maori Health Development*, Auckland: Oxford University Press. Second Edition
- Egermayer, Robyn. 1992. Two Years of the Cervical Screening Programme in Hawke's Bay, June 1990 to June 1992, Napier: Hawke's Bay Area Health Board, September 1992
- Fenton, F D. 1859. *Observations on the State of the Aboriginal Inhabitants on New Zealand*, Auckland: WC Wilson for the Government
- Flowers, Mark. 2000. *A Tale of Two Cities – and Two Hospital Cultures: Management of Complex Organisational and Clinical Change*. Presentation at the Forum 'Leadership and the Management of Change in Clinical Settings', Auckland, 2 August 2000, on the *Healthcare Review – Online* web site at www.enigma.co.nz/hcro_articles/0008/vol4no8_007/index.htm
- Gardner, W J. 1992. 'A Colonial Economy', in Rice 1992
- Gluckman, L K. 1976. *Medical History of New Zealand Prior to 1860*, Auckland: the Author
- Goldsmith, Paul J. 1996. 'Medicine, Death and the Gospel in Wairarapa and Hawke's Bay, 1845–1852', *NZJH*, 30(2), pp 163–181
- Graham, Sir Douglas. 2000. 'Taking the Treaty Too Far'. *Dominion*, 30 August 2000
- Gwynn, Robin. 1998. *The Denial of Democracy*, Napier: Cosmos Publications
- Hawke's Bay Area Health Board. 1990. *A Guide to the Recommendations for A Single Acute Hospital*. Napier: the Board, 12 December 1990

BIBLIOGRAPHY

- Hawke's Bay District Health Board. 2001. *Statement of Intent, 6 Months to 30 June 2001*. Napier: the Board, February 2001.
Subject to ministerial approval
- Hawke's Bay Hospital Board. 1986. *Strategic Planning Issues 1986–1996*. Napier: the Board, May 1986
- . 1987. *Hawke's Bay Health Services: A New Direction*. Napier: Area Health Board Consultative Committee
- Hawke's Bay Provincial Centennial Committee. 1958. *Picture of A Province*, Napier: the Committee
- Health Funding Authority. 2000. *Improving Our Health: the Challenge for New Zealand*. Wellington: the Authority
- Healthcare Hawke's Bay. 1994a. *Board Decision on Reconfiguration*. Napier: Healthcare Hawke's Bay, 5 August 1994
- . 1995a. The Decision of the Board of Healthcare Hawke's Bay on the Establishment of A Regional Hospital for Hawke's Bay. Napier: Healthcare Hawke's Bay, 5 April 1995
- . 1995b. *Statement of Intent for the Years 1995/96, 1996/97, 1997/98*. Napier: Healthcare Hawke's Bay
- . 1996a. *Statement of Intent for the Years 1996/97, 1997/98, 1998/99*. Napier: Healthcare Hawke's Bay
- . 1997a. *Statement of Intent for the Years 1997/98, 1998/99, 1999/2000*. Napier: Healthcare Hawke's Bay
- . 1997b. Submission to the Hawke's Bay Regional Hospital Review of the Consultation Process Conducted by Dr Woodhouse on Behalf of Neil Kirton MP. Napier: Healthcare Hawke's Bay, August 1997
- . 1997c. *Locate Napier's Health Facility in the Central City?* Napier: Healthcare Hawke's Bay, November 1997
- . 1998. Health Select Committee, 1996/97 Financial Review of Crown Health Enterprises: Crown Health Enterprise Questionnaire for the Year 1996/97. Napier: Healthcare Hawke's Bay, February 1998
- . 2000a. *Annual Report, 1999/2000*. Napier: Healthcare Hawke's Bay
- . 2000b. *Business Plan, 2000/01*. Napier: Healthcare Hawke's Bay
- . 2000c. *Statement of Intent, 2000/2001*. Napier: Healthcare Hawke's Bay
- Hill, Elizabeth. 1990. *Between the Rivers*. Hastings: the Author
- Kawharu, Sir Hugh. 1987. 'Translation of the Maori Text of the Treaty', in: 1 NZLR 1987 at 662–663 and at www.govt.nz/aboutnz/treaty.php3
- King, Michael. 1992. 'Between Two Worlds', in Rice 1992
- Lange, Rayburn. 1999. *May the People Live: A History of Maori Health Development 1900–1920*. Auckland: Auckland University Press
- Lauchland, Mairi, and Rangi Barcham. 1994. *Report on Maori Maternity Consultation Project*. Napier: Healthcare Hawke's Bay, Maternity and Child Health Services
- Mckegg, Alexandra. 1992. 'The Maori Health Nursing Scheme: An Experiment in Autonomous Health Care', NZJH, 26(2), pp 145–160
- Maling, Peter B. 1999. *Historic Charts and Maps of New Zealand, 1642–1875*. Auckland: Reed. Second Edition
- Mills, Ian. 1999. *What's in A Name: A History of the Streets of Napier*. Napier: Thinker Publications
- Ministry of Health. 1994a. *Kia Whai Te Maramatanga: the Effectiveness of Health Messages for Maori*. Wellington: the Ministry
- . 1995. *Kawe Korero: Guidelines for Communicating with Maori*. Wellington: the Ministry
- . 1997. *Progress on Maori Health Outcome Targets, 1996*. Wellington: the Ministry, February 1997
- . 1999. *Progress on Health Outcome Targets, 1998*. Wellington: the Ministry
- . 1999. *Our Health, Our Future: the Health of New Zealanders, 1999*. Wellington: the Ministry, December 1999
- . 2000a. *The New Zealand Health Strategy*. Wellington: the Ministry, December 2000
- . 2000b. *Health Needs Assessment for New Zealand: An Overview and Guide*. Wellington: the Ministry, December 2000
- . 2000c. *Progress on Health Outcome Targets, 1999*. Wellington: the Ministry
- . 2000d. *Social Inequalities in Health: New Zealand 1999*. Wellington: the Ministry, September 2000
- . 2001. *The Primary Health Care Strategy*. Wellington: the Ministry, February 2001
- Ministry of Justice, 1997. *A Guide for Consultation with Maori*. Wellington: the Ministry, December 1997
- Mooney, Kay, and Margaret Henderson. 1984. *A Picture Book of Old Hawke's Bay*. Auckland: Benton Ross
- Napier City Council. 1991. *Hospital Submission: Submission to the Hawke's Bay Area Health Board*. Napier: the Council, March 1991
- . 1996. *Residual Health and Hospital Services for Napier City: A Submission From the Napier City Council to the Central Regional Health Authority*. Napier: the Council, October 1996
- Napier Health Development Unit. 1989. *Health in Hawke's Bay: A Health Status Review*. Napier: [Department of Health], May 1989

BIBLIOGRAPHY

- Oppenheim, R.S. 1973. *Maori Death Customs*. Wellington: AH and AW Reed
- Orange, Claudia. 1987. *The Treaty of Waitangi*. Wellington: Bridget Williams
- Pool, Ian. 1991. *Te Iwi Maori: A New Zealand Population Past, Present and Projected*. Auckland: Auckland University Press
- Pomare, Eru and Others. 1995. *Hauora: Maori Standards of Health Iii, A Study of the Years 1970–1991*. Wellington: Eru Pomare Maori Health Research Centre
- Ponter, Elizabeth. 1989. *Maraenui Community Health Survey*. Napier: Maraenui Family Centre
- Race Relations Conciliator. 2000. Submission to the Health Select Committee
- Reed, A.H. 1958. *The Story of Hawke's Bay*. Wellington: AH and AW Reed
- Rice, Geoffrey W, ed. 1992. *The Oxford History of New Zealand*. Auckland: Oxford University Press
- . 1987. 'The Making of New Zealand's 1920 Health Act'. *NZJH* 22(1):3–22
- Royal Commission on Social Policy. 1988. *The Treaty of Waitangi*. In *the April Report: Volume 11, Future Directions*. Wellington: April 1988
- Salmond, Anne. 1991. *Two Worlds*. Auckland: Penguin
- Signal, Louise, Gillian Durham and Marianne Linton. 1998. 'Action to Improve the Health of New Zealanders'. *NZ Public Health Report*, 5(9), September 1998
- Smith, Dr Nick. 2000. 'Treaty Would Be Folly in Education'. *Dominion*, 25 September 2000
- Social Security Department. 1939. *Monetary Benefits to Maori: Benefits Under the Social Security Act, 1938*. Wellington: Government Printer
- Stenhouse, John. 1996. "'A Disappearing Race Before We Came Here": Doctor Alfred Kingcome Newman, the Dying Maori, and Victorian Scientific Racism'. *NZJH*, 30(2)
- Taylor, Nancy M. 1966. *The Journal of Ensign Best*. Wellington: Government Printer
- Tennant, Margaret. 1989. *Paupers and Providers*. Wellington: Allen and Unwin and Historical Branch, Department of Internal Affairs
- Te Puni Kokiri. 1993. *E Mua Kai Mai: the Experience of the Raukura Hauora Tainui Trust*. Wellington: TPK
- . 1998. *Progress Towards Closing Social and Economic Gaps Between Maori and Non-Maori*. Wellington: TPK
- Turton, H.H. 1877–1878. *Maori Deeds of Land Purchases in the North Island of New Zealand*. Wellington: Government Printer
- Ward, Alan. 1997. *National Overview: Waitangi Tribunal Rangahaua Whanui Series*. Wellington: Waitangi Tribunal
- Walter, Helen. 1996. *Land Purchase Policy and Administration, 1846–56*. Wellington: Waitangi Tribunal. Rangahaua Whanui Series, Preliminary Report National Theme B
- . 1995. *A Show of Justice: Racial 'Amalgamation' in Nineteenth Century New Zealand*. Auckland: Auckland University Press
- Ward, Alan. 1999. *An Unsettled History: Treaty Claims in New Zealand Today*. Wellington: Bridget Williams
- Wilson, J.G. 1939. *The History of Hawke's Bay*. Dunedin and Wellington: A.H. and A.W. Reed
- Wilson, Margaret. 2000. 'Twenty-fifth Anniversary of the Waitangi Tribunal'. Speech, 10 October 2000, at www.executive.govt.nz
- Wright, Matthew. 1994. *Hawke's Bay: the History of a Province*. Palmerston North: Dunmore Press

THESES

- Ballara, H.A. 1991. 'The Origins of Ngati Kahungunu'. PhD thesis, Victoria University of Wellington
- Shaikh, Jill M. 1992. 'The Influence of Local Government Politics on the Strategic Planning of a Health Authority: A Case Study of Acute-care Health Services in Hawke's Bay'. Research report for MBusStud, Massey University, Palmerston North

UNPUBLISHED DOCUMENTS

- * Supplied to or obtained by the Tribunal's commissioned researcher, Lisa Ferguson, and archived at the Waitangi Tribunal

BIBLIOGRAPHY

- 692/1* Toro Waka, chairperson to Graham Hill, solicitor, Callinicos Gallagher, 16 August 1994
- 692/2* Graham Hill to Tom Hemopo, 15 September 1994
- 692/3* Brief of evidence of treasurer Roy Pewhairangi, [1994]. Prepared for the Wai 473 claim
- 692/4* Brief of evidence of Toru Edward Waaka, not dated
- 692/5* Brief of evidence of Te Maari Joe, not dated
- 692/6 Registrar to Hemopo, 16 January 1996, Wai 473/o
- 692/7 Hill to Hemopo, 8 March 1995, Wai 473/o
- 692/8 Hill to registrar, 18 May 1995, Wai 473/o
- 692/9 Registrar to Hill, 19 May 1995, Wai 473/o
- 692/10 Registrar to Sainsbury, Logan and Williams, 8 June 1995, Wai 473/o
- 692/11 Sainsbury, Logan and Williams to Tribunal, 8 June 1995, covering press clippings, Wai 473/o
- 692/12* Presentation of Napier City Council submission to the Board of Health Care Hawke's Bay on hospital reconfiguration held on Wednesday, 15 February 1995, [minutes of meeting]
- 692/13 Albert Walker, chairperson of the Wairoa Taiwhenua. Statement, 28 January 1998, Wai 473/o
- 692/14* Hawke's Bay Area Health Board, board minutes
- 692/15* Hawke's Bay Area Health Board, Strategic position statement and draft operating plan, June 1990
- 692/16* Andy Train (chairperson), Background to consultants' recommendations for a single acute hospital in the Hawke's Bay region, December 1990
- 692/17* Phoenix Public Relations, public relations programme for Hawke's Bay Area Health Board, 5 November 1990
- 692/18* Healthcare Hawke's Bay, board-designate minutes
- 692/19* Healthcare Hawke's Bay, board minutes
- 692/20* Laws to Minister of Health, 22 January 1992
- 692/21* Minister for Crown Health Enterprises to Sellar, 28 June 1994
- 692/22* Ministers of Finance and Crown Health Enterprises to Peter Wilson, 16 November 1993
- 692/23* Bowes to all staff, memorandum, 29 July 1993
- 692/24* Kevyn Moore to board members et al, 3 May 1994
- 692/25* Pat Magill, Napier City Pilot Trust Facilitator, to Peter Wilson, 30 May 1994
- 692/26* *City Medical News* [April–May] 1998
- 692/27* Minister for Crown Health Enterprises to M R Winter, 3 June 1994
- 692/28* Peter Wilson to Minister for Crown Health Enterprises, 14 March 1996
- 692/29* Regional Health Authority Napier community meeting, 20 February 1996 [transcript]
- 692/30* Peter Wilson to chief executive, CCMAU, 12 August 1996
- 692/31* Summary of Central Regional Health Authority consultation regarding service provision in Napier, Greenmeadows East Community Hall, 11–12 September 1996
- 692/32* Brian Woodhouse, *The hospital issue: review of Napier health services*, 15 September 1997, pp 13, 15
- 692/33* Napier Services Working Party, *Minutes*
- 692/34* Maori Health Committee, *Minutes*
- 692/35* Mark Flowers to Justine Tringham, CCMAU, 2 February 1998
- 692/36* Director-General of Health, *The Treaty of Waitangi and its implications for the health services*, 9 May 1988, 1988/61, appendices
- 692/37* Dr Phil White and Liz Wall, *Napier A&E survey*, June 1997. Prepared for Healthcare Hawke's Bay and Central Health
- 692/38* Hawke's Bay Area Health Board, Community Health Services, *Health Promotion Unit Operating Plan, 1990–91*, 1990
- 692/39* Maori Health Committee, *Maori Health Charter*, not dated
- 692/40* Maori Health Committee, *Draft Strategic Plan*, not dated
- 692/41* Maori Health Committee, *Maori Health Unit: Proposal*, not dated
- 692/42* Wiremu Hodges, *Foundations for Maori Health Policy within Healthcare Hawke's Bay*, discussion paper (1st draft), 8 March 1996
- 692/43* Robyn Egermayer, implementation plan of the Hawke's Bay Area Health Board cervical screening programme, November 1990
- 692/44* Pare Nia Nia and Robyn Egermayer, *Maori Health Activities and Initiatives, 1991–1992*, December 1992

BIBLIOGRAPHY

- 692/45* CMAU, Crown health enterprises: performance reporting measures
- 692/46* IMS (NZ) Ltd, Public image monitor: Healthcare Hawke's Bay, quarter 1 1994, April 1994
- 692/47* Healthcare Hawke's Bay, *Celebrate Health*, issue 2, November 1998
- 692/48* Assistant Crown Counsel to Lisa Ferguson, 7 May 1999. CRO204/17
- 692/49* Consultation on location of Napier health services: public meeting #1, 24 November 1997

WAITANGI TRIBUNAL REPORTS

- Waitangi Tribunal. 1983. *Report of the Waitangi Tribunal on the Motunui–Waitara Claim*. Wellington: Government Printer
- . 1987. *Report of the Waitangi Tribunal on the Orakei Claim*. Wellington: Department of Justice
- . 1988. *Report of the Waitangi Tribunal on the Muriwhenua Fishing Claim*. Wellington: Department of Justice
- . 1990. *Report of the Waitangi Tribunal on Claims Concerning the Allocation of Radio Frequencies*. Wellington: Brooker and Friend Limited
- . 1991. *The Ngai Tahu Report 1991*. 3 vols. Wellington: Brooker and Friend Limited
- . 1992a. *The Mohaka River Report 1992*. Wellington: Brooker and Friend Limited
- . 1992b. *The Ngai Tahu Sea Fisheries Report 1992*. Wellington: Brooker and Friend Limited
- . 1994. *Maori Electoral Option Report 1994*. Wellington: Brooker's Limited
- . 1995a. *Te Whanganui-a-Orotu Report 1995*. Wellington: Brooker's Limited
- . 1995b. *The Turangi Township Report 1995*. Wellington: Brooker's Limited
- . 1996. *The Taranaki Report: Kaupapa Tuatahi*. Wellington: GP Publications
- . 1997. *The Muriwhenua Land Report 1997*. Wellington: GP Publications
- . 1998. *Te Whanau o Waipareira Report*. Wellington: GP Publications
- . 1999. *The Radio Spectrum Final Report 1999*. Wellington: Legislation Direct
- . 2000. *The Mokai School Report*. Wellington: Legislation Direct