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]

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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 latters' 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]

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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

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.

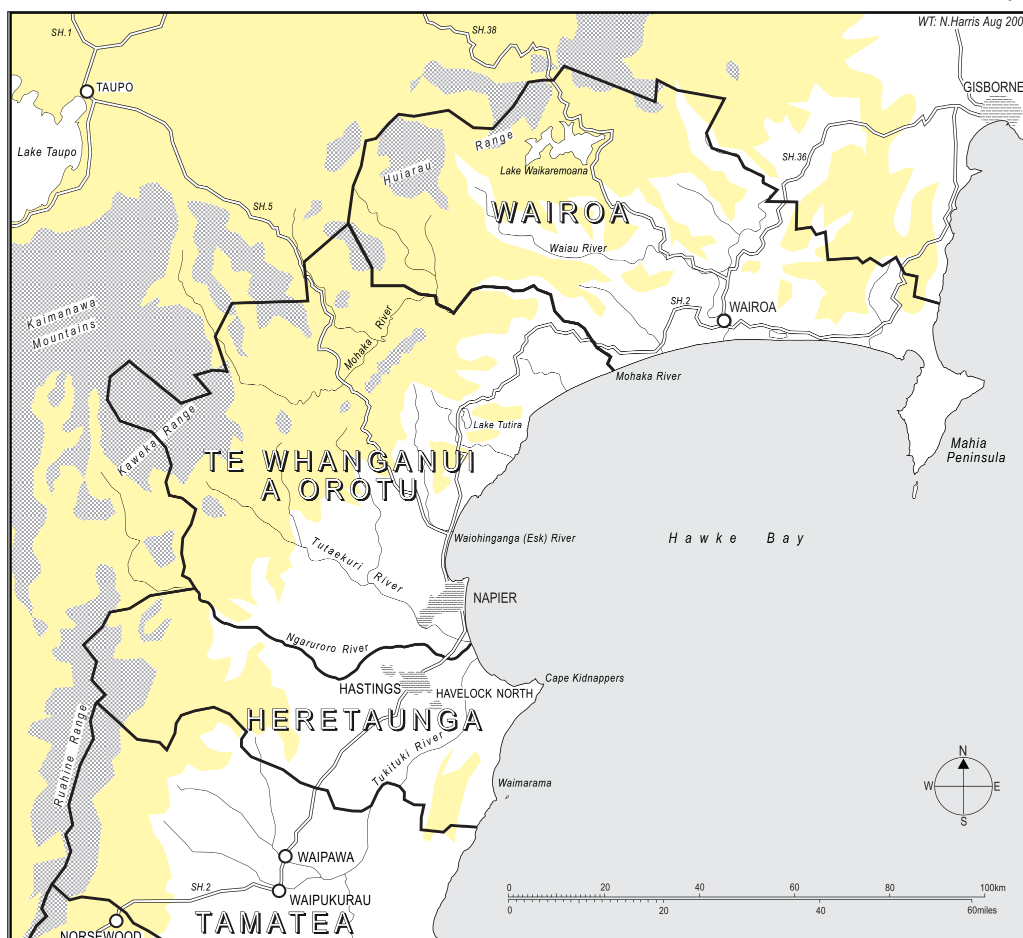
We commented in section 2.6 on the problems caused by the restrictions placed on research access to official information. Despite the procedural difficulties that arose, we do not believe that any of the parties attempted to withhold relevant information from the scrutiny of the Tribunal. We would like 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 z5, z6, z7
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 Tataraakina 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 Tataraakina. 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]

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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; *Te Heu Heu v AG* [1999] 1 NZLR 98, 118, per Robertson J

> 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.

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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:

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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