

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.