

## CHAPTER 10

### RECOMMENDATIONS

#### 10.1 CHAPTER OUTLINE

In this chapter, we present our recommendations on the relief sought by the claimants. We assess each distinct request presented in the statement of claim, and end by recording several general conclusions relevant to the application of Treaty principles in the health sector.

#### 10.2 A STUDY OF THE HEALTH NEEDS OF AHURIRI MAORI

*Extract from the statement of claim:*

(e) A recommendation that an independent specialist body consisting of Maori and Health specialists including the named claimants in this claim be set up to undertake a comprehensive inquiry on terms of reference set by the Tribunal into Maori health needs in the Hawke's Bay and Ahuriri in particular, including health and cultural needs and including an investigation as to whether an appropriately funded facility for Maori health on the Napier Hospital site is appropriate. Further details of the relief sought under this head will be provided in due course.

Claimant counsel submitted that a comprehensive study of the health needs of Ahuriri and Hawke's Bay Maori was urgently required. We agree that the information gathered over the previous decade was limited and its analysis weak. Good empirical information on the health status of Maori in Napier or Hawke's Bay or nationally has been conspicuous by its absence in the evidence presented to this inquiry. We are inclined to agree with Mr Keelan that data can best be gathered and analysed on a national basis, but local survey-based research and case-studies are essential for a deeper understanding of problem issues and the progress made in addressing them. Since it is clearly unrealistic to expect that every community in the land be subjected to intensive research, it is important that the Hawke's Bay District Health Board, and boards elsewhere, take full account of relevant case-study insights.

We note that district health boards are required as a matter of course to assess the health status of their populations, which include Maori as an identified group in need of health improvement towards parity.<sup>1</sup> Herein, we think, may lie an opportunity to generate at least part of the information requested by the claimants.

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1. Section 38(3)(a) of the Public Health and Disability Act 2000

The particular purpose that the claimants have in mind for the study they propose is to investigate whether a Maori health facility should be set up on the Napier Hospital site. We are sceptical as to what practical assistance a comprehensive study can be expected to give towards this investigation. The ill health profile of Ahuriri Maori communities is not likely to differ dramatically from that of similar Maori urban and rural populations elsewhere.

Speaking for the claimants, Matthew Bennett argued the case for a more focused investigation:

We deserve and demand the opportunities to address the health plight of our people. Therefore it is necessary that a feasibility study be done, so as to acquire a localised understanding of what our health plight is. Only then, will we be fully capable, of adequately addressing the lacking needs.<sup>2</sup>

There is, we believe, some merit in this proposal. We do not think it necessary to complete a socio-economic and ill health profile of Ahuriri Maori in order to make a decision in principle on establishing a health facility of the kind advocated by the claimants. At the same time, such a study would provide useful information for both Maori and official decision-makers in the planning of such a facility, which we discuss in section 10.3. Sufficient information is available in socio-economic indicators such as the deprivation index, in the various local and national health datasets, and in patient data from particular health programmes. The insights of national surveys, data analysis and case-study research from other regions can be brought to bear on the local situation. Complementing this desk-based analysis, there is ample scope for community-based field research in which the claimants and local Maori organisations should be full participants.

*We recommend:*

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

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2. Document v19

**10.3 ESTABLISHING A MAORI HEALTH CENTRE IN NAPIER**

*Extract from the statement of claim:*

(e) . . . including an investigation as to whether an appropriately funded facility for Maori health on the Napier Hospital site is appropriate . . .

(f) A recommendation that the findings of the specialist body be acted upon.

(g) A recommendation that the Ahuriri Maori be adequately and appropriately funded to carry out research and make submissions to the body set out in paragraph (e) hereto.

In previous chapters, we concluded that some of the claimants' grievances against the Crown are well-founded in both the historical and the contemporary periods of their claim. The claimants do not request relief by way of monetary compensation. Their key proposal is that the Crown assist them to establish a Maori health facility on the Napier Hospital site.<sup>3</sup>

We endorse the proposal for a health facility for five main reasons:

- ▶ Its cost would be modest, while the prejudice arising from historical and recent breaches of Treaty principles by the Crown has in some respects been substantial and prolonged. Ahuriri Maori have suffered prejudice, and compensation by the Crown is appropriate.
- ▶ It would directly address their main objective, which is to accelerate the improvement of the health of Ahuriri Maori towards equality with non-Maori. This is in line with the long declared central goal of national health policy for Maori.
- ▶ It would complement the Napier-based services and facilities provided by the Hawke's Bay District Health Board, largely through the Napier Health Centre. These have been located and developed for the most part to the exclusion of Ahuriri Maori.
- ▶ It would fit well with the national encouragement given to the development of Maori health providers and, in particular, integrated primary care. Provision by Maori for Maori, which has expanded elsewhere, has been retarded in Napier.
- ▶ It would bring under Ahuriri Maori management some of those services most directly relevant to improving their health status. Inadequate access to appropriate primary healthcare has been one of the central issues in historical and modern times for Ahuriri Maori.

As indicated in section 10.2, we do not think that a study of the health needs of Ahuriri Maori is an essential precursor to a decision in principle on the merits of the proposal. Those needs, we believe, are likely to be substantial, concentrated and urgent:

- ▶ Ahuriri Maori constitute a sizeable population, which is most heavily concentrated in the inner Napier suburbs of Maraenui, Marewa and Onekawa South; and
- ▶ the majority of Maori in the inner suburbs live in decile 9 or 10 areas, which together make up one of the most deprived urban zones in New Zealand.

Mr Bennett proposed a mix of primary and secondary health services for the health facility.<sup>4</sup> We do not believe that it is any longer feasible to locate acute hospital services away from the regional hospital, nor in-patient care, whether short- or long-term, with the possible exception of

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3. Ibid

4. Ibid

overnight stays. Furthermore, although we have not seen it in operation, we have no reason to doubt that the accident and medical facility at the Napier Health Centre provides a fully professional service that would be expensive to duplicate at another site. A second accident and medical unit would in any case do little to enhance the service already provided to local Maori.

The most appropriate facility, in our view, would be one capable of providing a variety of primary, public, promotional, educational, and rongoa Maori health services. A suitable model would be an integrated care organisation similar to Tui Ora in Taranaki, referred to by Matthew Bennett in his evidence; Raukura Hauora o Tainui Trust; or Te Puna Hauora o Te Raki Pae Whenua on Auckland's North Shore.<sup>5</sup> The facility would best function if it were to:

- ▶ operate from a common base as a community health centre;
- ▶ be managed by Maori on a bicultural basis but be open to all; and
- ▶ be governed by trustees on behalf of Ahuriri Maori.

A key question, one resonant with the history of this claim, is that of where the community health centre should be located. The claimants wish to make use of the Napier Hospital site. In our view, this is not the best option. On the one hand, Napier Hospital's buildings are configured for the functions of a general hospital and are not well suited to the purposes of a primary healthcare facility. On the other, we think that the most appropriate location for a community health centre is within the community that it serves. Since the densest concentration of people and health needs is centred in Maraenui–Marewa–Onekawa South, a location in that area would place the centre within walking distance of the majority of Ahuriri Maori residing in Napier.

We are acutely aware of the strong association with Napier Hospital felt by the claimants and Ahuriri Maori, as well as by the citizens of Napier generally. The association with the hospital on the hill stretches back to its foundation in 1860 and to the promise of a hospital in 1851 that, while not site-specific, was earmarked for the town that emerged as Napier. We are none the less convinced that it is now time to move on. Napier Hospital cannot be restored. The priority now should be to fashion a solution best suited to the needs of Ahuriri Maori.

That solution, as we have indicated, is likely to take the form of a health centre based in the middle of the Ahuriri Maori community. The premises for such a facility are likely to require modest space and technical adaptation. It might be possible to allocate space within the Napier Health Centre. However, the evidence that we have reviewed does not suggest that this option would be practicable or that it would be desired by either the claimants or the district health board. Every effort should be made to place the centre in the community.

We consider that the Crown should endow the community health centre by financing its capital costs. The principal purpose is to establish a secure, long-term foundation for the centre's operations in an unstable environment of short-term service contracts and governmental policy change. We recommend a means of funding the proposed endowment in section 10.4.

We also believe that there is merit in the claimants' suggestion that the health centre should include a research and information capacity to assist in configuring its services to a localised un-

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5. Document v19(a); doc w18(b)(8000), p 24; Te Puni Kokiri 1993

derstanding of the health issues amongst the communities it serves.<sup>6</sup> Our review of the evidence highlights the importance of such an understanding, and its absence in the Ahuriri context. We consider that a fund dedicated to carrying out community-based research and providing information might form part of the centre's endowment.

We see the endowment we propose as historically apposite. The promise of a public hospital was part of the consideration given for the Ahuriri block in 1851. Now the hospital which has stood on that land since the years of Napier's foundation has been shut down. It is fitting that the Crown should assist Ahuriri Maori to establish a health facility of their own to tackle health disparities that remains disturbingly wide in this 150th anniversary year of the Ahuriri deed.

Drawing together our conclusions, we *recommend*:

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

#### 10.4 FUNDING THE HEALTH CENTRE AND HOLDING THE HOSPITAL SITE

*Extract from the statement of claim:*

(h) A recommendation that the Mataruahou site be retained for Maori health purposes and the current facilities maintained in good condition and properly secured until the review set out in paragraph (e) above is completed.

We note the sense of urgency expressed by both the claimants and the Crown in resolving in particular all matters affecting the disposition of the Napier Hospital site. The claimants wish to begin without delay to address the serious health issues persisting amongst Ahuriri Maori communities. The Crown wishes to dispose of the hospital site and, in the interim, to reduce the maintenance costs of the empty hospital.

We agree that retaining Napier Hospital in mothballs is currently a costly liability and can no longer be justified. The cost of holding and maintaining the site falls on the hard-pressed health budget, which serves Maori and Pakeha alike. Early progress towards a solution would be in the interests of both parties. We are aware, however, that negotiations for the settlement of Treaty

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6. Document v19

claims commonly take a lengthy period to complete and, especially in the case of non-iwi claims such as this, may be further delayed by linkages to other claims. Current Government policy, as stated by the Office of Treaty Settlements, is that:

The Crown strongly prefers to settle claims at the iwi level. The Crown also needs to negotiate all the historical claims of an iwi at the same time. That is what we mean by comprehensive negotiations.

We are also mindful of the demands of natural justice that the settlement of grievances be not unduly prolonged, or, as the Minister in Charge of Treaty of Waitangi Negotiations recently commented, 'justice delayed is justice denied'.<sup>7</sup>

Accordingly, we have devised our recommendations in a manner designed to facilitate quick action. We are of course aware that the claim has historical as well as contemporary components. The claimants, however, do not request compensation for prejudice arising from their historical grievances. Rather, they seek remedies related to the current health disparities suffered by Ahuriri Maori.

As an alternative to the usual procedure for the direct negotiation of historical claims, we think that current Government policy on Maori health and the governing health legislation together provide an adequate framework for the action that we recommend the Crown take. Three of the six recently stated *key Government goals* for the public sector are applicable:

- ▶ Strengthen national identity and uphold the principles of the Treaty of Waitangi:  
... resolve at all times to endeavour to uphold the principles of the Treaty of Waitangi.
- ▶ Restore trust in government and provide strong social services:  
Restore trust in government by working in partnerships with communities, providing strong social services for all, ... promoting community development ...
- ▶ Reduce inequalities in health, education, employment and housing:  
Reduce the inequalities that currently divide our society and offer a good future for all by better coordination of strategies across sectors and by supporting and strengthening the capacity of Maori and Pacific Island communities.<sup>8</sup>

If the community health centre that we recommended in section 10.3 is to become a reality in the near future, the most pressing need is to fund its endowment. The most constructive approach in our view would be for the Crown to utilise its powers under existing legislation. We noted in section 7.2.2.4 that the Public Health and Disability Act 2000 ties the disposal of district health board land to public health purposes:

Every DHB must use the proceeds of a sale of land, and any payments received in connection with an exchange of land, for the purchase, improvement, or extension of publicly-owned facilities for health purposes unless the Minister, by written notice to the DHB, approves a different use.<sup>9</sup>

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7. Margaret Wilson 2000

8. Department of the Prime Minister and Cabinet 2001

9. Schedule 3 to and section 43(5) of the Public Health and Disability Act 2000

This would, we presume, also apply to any transfers of district health board land to other Crown agencies, including the Residual Health Management Unit.

We consider that the endowment of the proposed community health centre would be an eminently suitable call on the proceeds of the alienation of any part of the Napier Hospital site. Such an endowment would further one of the main objectives of Maori health policy, that being to build the capacity of Maori groups to provide for their own needs. It would establish a direct connection between the final departure from the Napier Hospital site and the empowering of Ahuriri Maori. And it would recognise the historical linkage to the original Ahuriri transaction, in which the promise of a hospital was part of the consideration for the land on which Napier Hospital has stood for 140 years.

In our opinion, the necessary decisions can and should be made without further delay. The most appropriate modality would be an agreement in principle between the claimants and the Crown on the establishment, governance and endowment of a community health centre. The principal parties to such an agreement are likely to be Te Taiwhenua o Te Whanganui a Orotu and the Hawke's Bay District Health Board. We encourage both parties to negotiate in good faith with the aim of reaching an early agreement. In our view, no steps should be taken to change the present status and ownership of any part of the hospital site until such an agreement in principle has been concluded.

We note also that other Maori claimants may have an interest in the hospital site. They include claimants appearing in the Mohaka ki Ahuriri regional inquiry, on which we are preparing our main report. It would be appropriate in our view for the Crown to retain ownership of the hospital land until such claims have been finally settled.

In respect of the Napier Hospital site and the funding of the proposed community health centre, we *recommend*:

- ▶ that the Crown and claimants take early steps to conclude an agreement in principle on the concept, general location and endowment of a community health centre within the framework of current Government policy on reducing health inequalities and building the capacity of Maori health providers;
  - ▶ that, once an agreement has been reached, the Napier Hospital site be transferred to the Residual Health Management Unit at a price equivalent to the full commercial value of the property;
  - ▶ that the agreed part of the proceeds be vested in trust for the purposes of endowing the community health centre;
  - ▶ that the fulfilment of the agreement in its entirety be regarded as a full and final settlement of this claim;
  - ▶ that, after the agreement is concluded, steps be taken to extinguish the existing health trust on part of the hospital land, which would then serve no further purpose;
  - ▶ that, if an agreement cannot be reached, the health trust be kept in place and the hospital site retained in district health board ownership pending a final settlement of this claim;
- and

- ▶ that, if it is proposed at any future time to alienate all or part of the hospital site from Crown ownership, the interests of other Maori claimants to the land be taken into account.

#### 10.5 HEALTH POLICY AND SERVICE PARTNERSHIP WITH AHURIRI MAORI

*Extract from the statement of claim:*

- (k) A recommendation that pending the report of the specialist body set out in paragraph (e) hereto that the Crown and Crown health entities implement an effective partnership with Maori for the creation of appropriate policies and the provision of health services in Ahuriri and Hawke's Bay. Further details of the relief sought under this head will be provided in due course.

Since the close of our hearings, the Government has passed new legislation that provides for Maori representation on district health boards and their statutory committees. It also requires boards to consult local Maori, to enable them to participate in strategies for Maori health improvement, and to assist Maori providers. But it stops short of calling for partnership arrangements with Maori organisations.

In our view, the Public Health and Disability Act 2000, although rather vaguely worded, goes a considerable distance towards meeting the claimants' request. It encourages district health boards to enter into ongoing relationships with Maori groups in order to meet their statutory obligations. We note that the proposal mentioned by Mr Keelan – that Healthcare Hawke's Bay enter into a formal partnership agreement with Ngati Kahungunu Iwi Incorporated – has reportedly since been put into effect.

We endorse the claimants' view that partnership arrangements should be 'effective'. A purely nominal agreement will usually not be consistent either with the statute or with the principle of partnership. Nor does an iwi-level relationship remove the obligation for district health boards to take due account of the standing of significant representative Maori organisations in districts and large towns.

Maori input into the development of mainstream health services designed to improve Maori health is one principal dimension of partnership. Another is the development of Maori health providers. Because the latest health reform postdated our hearings, we have little evidence to hand on how it has affected the funding of Maori providers. The Public Health and Disability Act provides both for the Ministry of Health to provide direct funding and for district health boards to 'foster the development of Maori capacity'.

In the absence of evidence, it would be inappropriate to make specific recommendations. We note, however, that there is an obvious potential conflict of interest between district health boards as providers in their own right and boards as agencies of community development. This risk is exacerbated by the competitive culture inherited from their former manifestation as CHES. In the local context, if the scope of primary healthcare services delivered by Maori in

Napier is to expand from its present very small base, the volume of services delivered by the district health board through the Napier Health Centre may be reduced.

Enabling Maori to develop their own provider capacity will, in our view, be an acid test of the ability of the Hawke's Bay District Health Board to build a durable partnership with Ahuriri Maori. Self-evidently, there would be little point in endowing a community health centre under Maori management if it were not, like the Napier Health Centre, to receive State funding for at least some of its services. Whatever the current modality, we consider that a stable agreement on the range and volume of services to be funded at the proposed centre will be an essential platform for ensuring its reputation and viability.

*We recommend:*

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

#### 10.6 TREATY PRINCIPLES INCORPORATED INTO HEALTH LEGISLATION

*Extract from the statement of claim:*

- (i) A recommendation that the Crown amend the Health and Disability Services Act 1993 to include a section requiring the Crown and Crown health entities to give effect to the principles of the Treaty of Waitangi.

Since our hearing of the claim in 1999, the latest health reform has brought in a further round of major change. As we noted in section 8.2.2.3, the Public Health and Disability Act 2000, which repealed the Health and Disability Services Act 1993, included an explicit commitment to 'recognise and respect the principles of the Treaty'. The Act included a number of provisions promoting Maori participation in decision making and service delivery. It set district health boards the objective of reducing health disparities affecting Maori, and any other population group, by improving their health outcomes, and, more generally, of removing such disparities through targeted services developed in consultation with the groups concerned.<sup>10</sup> We consider that the Act makes sufficient provision for the recognition and application of Treaty principles in the State health sector.

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10. Section 22(1)(e), (f) of the Public Health and Disability Act 2000

**10.7 TREATY MONITORING PROGRAMME IN THE HEALTH SECTOR**

*Extract from the statement of claim:*

(j) A recommendation that the Crown and Crown health entities introduce a specific monitoring program to ensure compliance with the principles of the Treaty of Waitangi and Maori health policy consistent with the Treaty of Waitangi.

Performance and compliance monitoring are important in any system of public administration, and in our view are vital in the decentralised, contract-ruled regime that underpins inter-agency relationships in the reformed State sector. The evidence given in this inquiry has exposed a number of failures and deficiencies in health sector monitoring. We are uncomfortable at the ease with which one agency could pass the buck to another, and at how many opportunities for doing so were created during the purchaser-provider experiment.

The internal monitoring of one State agency by another, and ultimately by Parliament, tends to be preoccupied with financial management. We note that by the late 1990s some of the weaknesses of design and implementation were being addressed in the monitoring of policy and Treaty obligations to Maori. We are aware, however, that inadequate monitoring has been identified as a key weakness by other inquiries into health sector performance.

We do not think it appropriate for us to make detailed prescriptions. At the same time, we are inclined to support the spirit of the claimants' request. We *recommend*:

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

**10.8 GUARANTEE OF CONSULTATION ON FUTURE HEALTH SERVICE DECISIONS**

*Extract from the statement of claim:*

(1) A recommendation that the Crown and Crown health entities involved in provision of health services to Maori consult with Maori and relevant Maori organisations including

relevant hapu and iwi organisations affected before taking any decision which will effect the provision of such services.

Failures of consultation have been a major issue in this claim. In section 3.9, we concluded that the Crown is not obliged to consult Maori on all issues and every service change, but that a Treaty obligation to consult will arise quite frequently.

In section 3.9.3, we noted that the Public Health and Disability Act 2000, which was enacted after the close of our hearings, imposed explicit requirements on district health boards to consult with the communities they served. They included consultation with Maori and other population groups suffering adverse health disparities on 'services and programmes designed to raise their health outcomes to those of other New Zealanders'. The Act set a standard of consultation on changes to its strategic and annual plans that ensured an open and accessible process. We consider that the provisions in this Act go a long way towards providing the relief sought by the claimants.

Some ground, however, remains to be covered. Iwi and hapu organisations are not mentioned. Nor is there a requirement for culturally appropriate modes of consultation. We have previously given our view that the general methods of public consultation – written submissions, public meetings, public hearings or oral presentations – may not suffice to enable the Maori voice to be fully heard. Specific consultation with Maori communities and organisations, *kanohi ki te kanohi*, will often be essential. Depending on the context, this consultation may take a variety of forms, commonly including *hui* at *marae* or community venues and meetings with representative Maori organisations.

There is no need for us to repeat here the consultation standards we outlined in section 3.9.6. At the same time, we wish to highlight several lessons arising from the history of this claim, lessons which extend beyond the immediate process of consultation into the conduct of ongoing relationships in the spirit of partnership:

- ▶ The approach should be even-handed and consistent. Both the Central RHA and Healthcare Hawke's Bay were at times arbitrary as to whom they consulted and when, and Ahuriri Maori often missed out.
- ▶ The outreach should be sufficiently comprehensive. It may not suffice, for example, to restrict consultation to a top-level iwi organisation if groups representing substantial local Maori communities, be they iwi- or hapu-based or non-tribal, are thereby kept at the margin. Direct communication and meetings, *kanohi ki te kanohi*, will commonly be the methods preferred by Maori communities and leaderships.
- ▶ All communities affected by a specific change, particularly the reconfiguring of services or the closing or opening of a facility, should be included. Ahuriri Maori were often marginalised in favour of Hastings-based groups.
- ▶ Consultation overload can be eased by the relevant agency working to establish flexible partnership relationships with representative Maori organisations. These would afford Maori some say in whether consultation is in fact needed in a particular instance, and if it

is, by what process and with whom. The practice of unilaterally calling one-off hui by press panui can be disempowering as well as unsustainable for Maori communities and leaderships. Multi-agency coordination will also assist in this area.

Little evidence has been presented in this inquiry on what standards and guidelines – as opposed to ad hoc practice – have been adopted by the various health agencies on the conducting of consultation, apart from a brief guide published by the Ministry of Health in the mid-1990s.<sup>11</sup> We note that other agencies have published practical guides for use by their staff.<sup>12</sup>

*We recommend:*

- ▶ that the Ministry of Health prepare and publish an updated consultation guide for general use by Government agencies in the health sector;
- ▶ that each district health board prepare and publish its own district guideline;
- ▶ that in all cases the guidelines be drawn up in cooperation with representative Maori organisations;
- ▶ that the guidelines provide clearly articulated standards and operational information for practical use, covering such matters as type of issue, information to be provided, scope, frequency, meeting context, and process; and
- ▶ that the guidelines be widely distributed and regularly updated.

#### 10.9 COSTS OF THE CLAIM

*Extract from the statement of claim:*

(m) The costs of this claim.

We have concluded that some of the grievances alleged by the claimants in this claim are well-founded and that the claimants have suffered prejudice thereby. We are also aware that a lengthy period has elapsed since the claimants submitted their first claim to the Waitangi Tribunal in 1994. During the intervening seven years, the claimants have incurred costs in submitting two claims and an urgency application and in preparing for the hearings on their and the Crown's evidence and closing submissions. We also note that, although this is not a generic claim, it has raised issues relevant to the application of the principles of the Treaty within the health sector as a whole, and has therefore served a wider public purpose.

*We therefore recommend:*

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

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11. Ministry of Health 1995

12. For example, Ministry of Justice 1997