CHAPTER 9

FINDINGS ON TREATY BREACHES

9.1 Chapter Outline

In this chapter, we bring together from previous chapters all the findings we have made as to Treaty breaches and prejudice arising. In all cases, we have reproduced the exact text, adding brief prefatory notes in a few cases to set the context. For ease of reference, we have grouped Treaty breaches and prejudice under separate headings (sections 9.2 and 9.3 respectively), and the sequence follows the arrangement of the chapters. We conclude the chapter with an overview of our findings on the claim as a whole.

9.2 Treaty Breaches

9.2.1 Chapter 5: The State health system and Ahuriri Maori, 1852–1980

On consultation regarding Napier hospital (section 5.4.2.1)

- that the Crown's failure to consult over the siting of the first hospital (1854–55 and 1859–60) and to ensure consultation over the relocation of the second hospital to the barracks reserve (1877–80) breached the principle of *partnership* and the duty of *consultation*, but that at the same time Ahuriri Maori were less concerned about precise location than with opening hospital services.

On consultation regarding health needs (section 5.4.2.2)

(Up to 1876)

- that consultation with Ahuriri Maori by the Government on the provision of a hospital and doctor, although largely reactive, was adequate in the 1850s and early 1860s;
- that the failure of the Hawke's Bay Provincial Council to consult Ahuriri Maori at any time about their health service needs and the configuration of services at Napier Hospital breached the principle of *partnership* and the duty of *consultation*; and
- that the failure of the Government to consult Ahuriri Maori on the abolition and restoration of the NMO post at Napier breached the principles of *active protection* and *partnership* and the duty of *consultation*.

(After 1876)

- that the failure to require, by legislation or other means, the Hawke's Bay Hospital Board to consult or otherwise take account of Ahuriri Maori views of their health needs breached the principle of *partnership* and the duty of *consultation*;
- that the development of general health programmes without specific local consultation was within the legitimate bounds of kawanatanga;
- that the implementation of healthcare programmes designed specifically for Maori, such as the native health nurse scheme, without some form of consultation inclusive of Ahuriri Maori breached the principle of *partnership* and the duty of *consultation*; and
- that, by contrast, the mode of marae-based consultation on village sanitary improvement pioneered by the Department of Health through the Maori councils, including the Tamatea Maori Council, fully conformed to the principle of *partnership* and the duty of *consultation*.

On establishing health needs (section 5.4.2.3)

- that the Government had sufficient broad information at the national level to comprehend the demographic and ill health plight of Maori as a whole; and
- that, by failing to inform itself of the actual health status of Ahuriri Maori communities until the 1920s and 1930s, and thus of the extent and type of need for primary health services, the Crown breached the principles of *active protection* and *partnership*.

On representation (section 5.4.3.1)

- that the failure to provide for Ahuriri Maori inclusion in provincial governance, including any say in the management of Napier Hospital, breached the principles of *partnership* and *equity*;
- that the exclusion of Ahuriri Maori from the governance of Napier Hospital breached the principles of *partnership* and *equity*; and
- that the failure to ensure any representation in the House of Assembly for Ahuriri Maori between 1854 and 1867, and thus any oversight over Government health services, breached the principles of *partnership* and *equity*.

On participation (section 5.4.3.2)

- that, although possibly impracticable in the late nineteenth century, the long-run failure to improve Maori workforce participation at Napier Hospital and in State primary health programmes operating in Hawke's Bay during the early twentieth century breached the principles of *partnership* and *equity*.

On health services under Maori control (section 5.4.3.3)

- that the absence of initiatives to give Maori a degree of control over hospital services for Maori at Napier Hospital may have missed significant opportunities to improve Maori uptake of hospital treatment but did not necessarily breach Treaty principles;
- that a similar absence in respect of Department of Health programmes specifically for Maori also did not necessarily entail Treaty breaches, and that sufficient information is lacking to arrive at conclusions on the situation in Hawke's Bay;

- that, having launched the Maori council scheme and induced Maori, including Ahuriri Maori through the Tamatea Maori Council, to rely upon it for improving the health of their communities, the Crown breached the principle of *partnership* by failing to resource the councils adequately or, for some years after 1911, at all ; and
- that the removal of the power to regulate Maori medical tohunga and the partial suppression of tohunga by legislation from 1907 was in breach of the principles of *partnership* and *active protection*.

On the adequacy of Napier Hospital (section 5.4.4.1)

(Up to 1876)

- that the nine-year delay in fulfilling the promise of a hospital, although failing to take account of the urgent needs of Ahuriri Maori, was not unreasonable given the conditions of the time ;
- that the hospital's open door to Maori conformed to the principle of *equity* ; and
- that the space shortage and sub-standard conditions affected Pakeha and Maori alike and so did not breach the principle of equity, but might have breached the principle of *active protection* had Ahuriri Maori sought in-patient treatment at the same rate as Pakeha.

(After 1876)

- that the admission of Maori to Napier Hospital and their treatment there, which were ostensibly on the same basis as Pakeha, were promoted but not fully assured by the controlling legislation and Government policy, and conformed to the principle of *equity* ;
- that there is insufficient evidence to assess whether in practice or in all periods discrimination against Maori in their admission to, and standard of treatment at, Napier Hospital did not occur ;
- that the national policy of subjecting Maori in-patients to means-testing imposed a financial disincentive to hospital treatment through a period of widespread poverty, endemic ill health, heavy mortality, population decline, and very low uptake of hospital treatment, was applied at Napier Hospital, and breached the principle of *active protection* ;
- that the failure to rectify the Hawke's Bay Hospital Board's exclusion of Ahuriri Maori from outdoor relief by legislation or other means was a breach of the principles of *active protection* and *equity* ; and
- that the discrimination against Ahuriri Maori in poor and unemployment relief breached the principles of *active protection* and *equity* ; and
- that the failure to provide adequate relief to Ahuriri Maori indigents breached the principle of *active protection*.

On the adequacy of state primary health services (section 5.4.4.2)

- that, in arbitrarily abolishing the NMO post in 1867 and in failing to restore it subsequently, while aware of the severe impact of introduced diseases and of ill health generally on Maori communities, the Crown breached the principle of *active protection* ; and

- that the failure to extend other frontline primary health services to Ahuriri Maori communities in a timely manner and with sufficient resources breached the principle of *active protection*.

On responsiveness to tikanga Maori (section 5.4.4.3)

- that the failure to accommodate tikanga Maori in Napier Hospital during the provincial period breached the principle of *options* and, at a time of severe ill health and steep demographic decline, also the principle of *active protection* ;
- that the failure to ensure by legislative or other means that Napier Hospital assured cultural responsiveness to Maori patients breached the principle of *options* and, as a major barrier to Maori uptake of hospital treatment in times of severe ill health and mortality, also the principle of *active protection* ; and
- that a failure to accommodate tikanga Maori in the Department of Health's primary health programmes may have breached the principles of *options* and *active protection*, but there is insufficient evidence from Hawke's Bay for us to reach definite conclusions in respect of Ahuriri Maori.

On monitoring and supervision (section 5.4.4.4)

- that there is not sufficient evidence that the provincial monitoring and supervision of Napier Hospital breached Treaty principles ;
- that the failure to ensure a consistent improvement in the poor performance of the Napier NMO breached the principle of *active protection* ; and
- that the failure from 1877 to monitor Maori usage of Napier Hospital and the effectiveness of its services to Maori, and to provide statutory means of remedying any deficiencies found, was a breach of the principle of *active protection*.

9.2.2 Chapter 6 : Consultation with Maori on the closure of Napier Hospital

On the decision in principle to have a regional hospital (section 6.4.3.1)

Three separate proposals to regionalise hospital services in Hawke's Bay emerged over a 15-year period : from the Hawke's Bay Hospital Board in 1980 ; from the Hawke's Bay Area Health Board in December 1990 ; and from the Healthcare Hawke's Bay Board-designate during the first half of 1993. Our findings as to *Treaty breaches* are :

- that, in respect of the first and second proposals, the Crown failed to ensure that the governing health legislation required hospital and area health boards to consult affected Maori communities on major reconfigurations of their services, especially to hospitals, and thereby breached the principle of *partnership* and the duty of *consultation* ;
- that, in respect of the first and second proposals, the Crown failed to invoke its powers of direction to ensure that the Hawke's Bay hospital and area health boards undertook appropriate consultation with Ahuriri Maori, and thereby breached the principle of *partnership* and the duty of *consultation* ; and

- that, in respect of the third proposal, the failure of the responsible Crown agencies (including, but not limited to, the Department of Health, the Hawke's Bay Area Health Board commissioner, and the CHE board-designate) to consult Ahuriri Maori breached the principle of *partnership* and the duty of *consultation*.

On the decision to base the regional hospital in Hastings (section 6.4.3.2)

- that the failure of the responsible Crown agencies (including, but not limited to, the Central RHA and Healthcare Hawke's Bay) to consult Ahuriri Maori adequately breached the principle of *partnership* and the duty of *consultation*; and
- that, in presenting the option of whether to have a regional hospital at all as being open when the decision had in fact already been made, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *good faith conduct*.

On the decision to remove Napier Hospital's guarantee (section 6.4.4.1)

- that, in failing to consult Ahuriri Maori on its decision to lift its linkage of Napier-based services to Napier Hospital, despite its 1994 assurance of continuation, the Central RHA breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*.

On the decision to close Napier Hospital (section 6.4.4.2)

- that, in failing to consult Ahuriri Maori adequately on its decision in principle to vacate Napier Hospital for a downtown health centre, despite its 1994 assurance of continuation, Healthcare Hawke's Bay breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*.

On the location and configuration of the Napier Health Centre (section 6.4.5)

- that, in deciding on the site of the Napier Health Centre and on its service configuration without adequate consultation with Ahuriri Maori, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *consultation*.

On fulfilling Government undertakings (section 6.4.6)

- that, while the Government must be able to exercise kawanatanga by changing its policies and resource allocations, that right must be tempered by due respect for rangatiratanga, a condition which in this case had been seriously compromised by the repeated failure to ensure adequate consultation with Maori in Hawke's Bay and with Ahuriri Maori in particular;
- that there is in this case insufficient evidence of a ministerial intention to deceive; and
- that the continued failure of Ministers, having given such assurances, to ensure that the Central RHA and Healthcare Hawke's Bay consulted appropriately with Ahuriri Maori on the decisions in 1996 and 1997 that led to the closure of Napier Hospital amounted to a breach by the Crown of the principle of *partnership* and the duty of *consultation*.

On consulting the descendants of the 1851 signatories (section 6.4.8)

- that the failure of Crown agencies to fulfil their obligation to consult all the representative tribal organisations of the descendants of the Ahuriri signatories even-handedly breached the principles of *partnership* and *active protection* and the duty of *good faith conduct*.

9.2.3 Chapter 7: Health services for Ahuriri Maori in the era of health sector reform

On statutory Treaty protection mechanisms (section 7.4.3)

- that the health reform legislation did not provide the Minister of Health sufficient powers over land disposals by CHEs to ensure that the Crown's Treaty obligations were met;
- that Healthcare Hawke's Bay undertook no alienations at the Napier Hospital site that affected the Crown's obligations to the present claimants;
- that the Public Health and Disability Act 2000, by providing for ministerial oversight, established direct Crown responsibility for protecting the interests of Treaty claimants in health agency land, including the interest of the present claimants in any proposed disposal of the Napier Hospital site;
- that the controlling health sector legislation applicable during the 1980s and 1990s did not incorporate any explicit recognition of Treaty principles, but neither did it prescribe any actions inconsistent with Treaty principles or prevent the Crown from meeting its Treaty obligations; and
- that the Public Health and Disability Act 2000 commits the Crown and its health agencies to a number of specific obligations consistent with the principles of *partnership* and *equity*.

On the adequacy of the Napier Health Centre (section 7.4.4)

- that, while Healthcare Hawke's Bay failed to consult Ahuriri Maori and missed a worthwhile opportunity to build partnerships with Maori healthcare providers, in general the location and service configuration that it adopted for the centre do not appear to have been in breach of Treaty principles; and
- that the design of the centre may have made insufficient accommodation for tikanga Maori but that, on this and other aspects, the evidence is insufficient for us to arrive at particular conclusions.

On representation at decision-making levels (section 7.4.5)

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

On Maori workforce participation (section 7.4.6)

- that, in the case of the Central RHA/HFA, the lag between policy and performance in taking steps to improve Maori workforce participation brought its commitment into question in the early years, but taken over the whole period may have been reasonable in the circumstances, given that it was starting from scratch as a new type of agency; and
- that the lack of effort made by Healthcare Hawke's Bay to improve the participation and development of its Maori workforce breached the principles of *partnership* and *equity*.

On incorporating the Maori health gain priority (section 7.4.7)

- that, although it took more than five years to develop a comprehensive planning methodology for addressing the statutory Maori health gain priority, the development period was not unreasonable in light of the structural disruptions and the pioneering role of the purchaser agencies;
- that, by the late 1990s, the Maori health gain priority was adequately integrated into health expenditure planning methods;
- that, although committing resources to identified targets was a key implication of the general Government aim of reducing Maori health disparities, insufficient information is available on the volume and allocation of health expenditure in Hawke's Bay to enable us to reach a definite conclusion on how adequately the health agencies met their obligations; and
- that nevertheless the available evidence suggests a failure both nationally and in the Napier area to match expenditure and targeting to Maori health needs, and a breach by the Crown of the principles of *active protection* and *equity*.

On consultation regarding health service needs and delivery (section 7.4.8)

- that, although its consultation programme was proactive, in failing to ensure regional balance – in particular, by including Ahuriri Maori – the Central RHA breached the principle of *partnership* and the duty of *consultation*;
- that, by failing to meet its contractual obligations to consult local Maori, Healthcare Hawke's Bay breached the principle of *partnership* and the duties of *consultation* and *good faith conduct*; and
- that, in failing to consult on issues significant to local Maori, irrespective of the lack of a statutory obligation to do so, Healthcare Hawke's Bay breached the principle of *partnership* and the duty of *consultation*.

On Maori structures for the delivery of mainstream services (section 7.4.9)

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

- that the failure to ensure by statutory or other means before July 1993 that hospital and area health boards implemented culturally appropriate services for Maori breached the principles of *active protection* and *options*;
- that the eventual incorporation by the Central RHA/HFA of specific quality standards into their CHE purchase contracts provided an adequate framework for CHES to develop culturally appropriate services;
- that nevertheless the failure to develop operational guidelines for implementing the policies and standards breached the principles of *active protection* and *options*; and
- that the failure of Healthcare Hawke's Bay to make a serious effort to implement kaupapa Maori quality standards in mainstream services at either Napier or Hastings Hospital before 1999 breached the principles of *active protection* and *options*.

On assessing the health needs of Ahuriri Maori (section 7.4.10)

- that, in failing to inform themselves adequately of the health situation of Ahuriri Maori by means of empirical research or by applying the insights of previous research from similar contexts, successive Crown health agencies have breached the principle of *active protection*; and
- that, in failing to publish sufficiently detailed and well-founded health status information on the communities they serve – in this case, Maori communities in the Napier area – the responsible Crown health agencies have breached the principle of *partnership*.

On monitoring agency performance and providing for Maori input (section 7.4.11)

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

On assisting local Maori health service provider development (section 7.4.12)

- that, up to the end of the hospital board era in Hawke's Bay, an effective partnership with Maori as providers to their own communities barely existed, the result of a statutory and policy regime that in this respect breached the principle of *partnership*;
- that, for all its flaws and limitations, the Maori provider programme as it developed during the 1990s did not breach Treaty principles – to the contrary, it affirmed the principles of *partnership* and *options* as well as the duty of *consultation*; and

- that the retarded state of the scheme in Napier and the failure to establish a relationship with a representative Maori organisation, in this case, Te Taiwhenua o Te Whanganui a Orotu, breached the principle of *partnership*.

On the merits of the purchaser/provider health system (section 7.4.13)

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

9.2.4 Chapter 8: Health status and outcomes for Ahuriri Maori

On transitional arrangements for Napier-based services (section 8.4.2)

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

On the transport-based service access standard (section 8.4.3)

- that the transport standard, assessing travelling distance by car as the most commonly available mode of transport, was on the whole practicable and reasonable; and
- that significant cost barriers may arise in low-income suburbs with a much higher incidence of carless households, a large Maori population, and little or no public transport to the district hospital, and may give rise to breaches of the principle of *equity* if not adequately addressed within the overall framework of social policy.

On access for Ahuriri Maori to hospital and clinic services (section 8.4.4)

- that, in balancing the unavoidable trade-offs between longer and more difficult journeys on the one hand and more and better acute hospital services on the other, equitable access for Maori communities facing greater transport hardship and higher health service needs remains a prime consideration;
- that, in the absence of regular public transport, the provision of a free or low-cost bus service to the regional hospital, as laid on, was in accord with the principles of *active protection* and *equity*; and
- that, beyond the transitional period (discussed in section 8.4.3), the provision of additional support for those patients and whanau obliged to travel outside the bus schedule and facing hardship would be consistent with the principles of *active protection* and *equity*.

On the trend of Maori health status over the health reform period (section 8.4.5)

- that, in failing since 1980 and, more particularly, from 1993 to 1998 to address with urgency the improvement of the health status of Ahuriri Maori, the Crown and its health agencies have breached the principles of *active protection* and *equity*; and

- that the greater urgency shown by the HFA and the Ministry of Health since 1999 and the explicit statutory requirement for district health boards to tackle the disparity by improving Maori health outcomes afford some hope of more effective long-term action.

9.3 Prejudice

9.3.1 Chapter 5: The State health system and Ahuriri Maori, 1852–1980

On consultation regarding the siting of Napier hospital (section 5.4.2.1)

- that no significant prejudicial effects resulted.

On consultation regarding health needs (section 5.4.2.2)

- that the failure to consult on the establishment of the first and second Napier Hospitals contributed to facilities that were too small to provide for the local Maori population and were not adapted to their needs, and thereby to few Ahuriri Maori receiving hospital treatment, notwithstanding the prevalence of widespread serious illness amongst them; and
- that the absence of consultation contributed to hospital and primary health services that failed to address the urgency of Maori ill health or to enjoy Maori confidence, resulting in many ill Maori failing to get the treatment they needed.

On establishing health needs (section 5.4.2.3)

- that the failure to restore the Napier NMO post, in part due to the lack of specific information on health needs, deprived Ahuriri Maori communities for half a century of the most effective primary healthcare then available, leaving them at the mercy of the diseases sweeping their communities; and
- that, when primary health programmes did begin to reach Maori communities in Hawke's Bay in the 1920s and 1930s, the Government lacked sufficient information to configure them so as to deliver sufficient and appropriate services, leaving much Maori ill health untouched by effective medical treatment.

On representation (section 5.4.3.1)

- that Ahuriri Maori were unable to influence the level, configuration and cultural sensitivity of services at Napier Hospital, greatly reducing Maori confidence in them and resulting in much untreated serious illness in Maori communities; and
- that Ahuriri Maori lacked parliamentary means of seeking redress for the poor performance of the Napier NMO and of contesting the withdrawal of the NMO post in 1867, which resulted in the loss of what was potentially the most effective medical service to their communities at the height of the devastation caused by introduced diseases.

On participation (section 5.4.3.2)

- that, despite the pioneering initiatives of the Maori health reformers in the early twentieth century, Maori were denied equality of opportunity in access to employment at Napier Hospital and in primary health programmes in Hawke's Bay; and

- that Maori opportunity to influence the development of culturally sensitive hospital and community healthcare services in Hawke's Bay was reduced, contributing to the low Maori uptake of State health services.

On health services under Maori control (section 5.4.3.3)

- that the lack of funding for the work of the Tamatea Maori Council and of the Maori health reformers, especially after 1910, severely limited both their effectiveness and health improvement amongst Maori communities in central Hawke's Bay; and
- that the suppression of indigenous practitioners made it more difficult for Ahuriri Maori to seek alternative forms of medical assistance in a period when most relied on indigenous medicine for healing their afflictions.

On the adequacy of Napier Hospital (section 5.4.4.1)

- that all but a handful of Ahuriri Maori who could have benefited from hospital treatment – battle casualties excepted – did not receive treatment in Napier Hospital during its first half-century, the period of their most urgent need; and
- that the exclusion of Ahuriri Maori from even the last-resort safety-net of outdoor poor and unemployment relief tightened the circle of exclusion from medical treatment, and worsened the high incidence of disease and death.

On the adequacy of State primary health services (section 5.4.4.2)

- that Ahuriri Maori were left virtually without State medical assistance through the half-century of their greatest medical distress.

On responsiveness to tikanga Maori (section 5.4.4.3)

- that the failure to accommodate tikanga Maori, especially cultural responsiveness, was a major factor in turning Ahuriri Maori away from Napier Hospital and in reducing the effectiveness of primary healthcare services, despite their urgent medical need.

On monitoring and supervision (section 5.4.4.4)

- that the low usage by Ahuriri Maori of Napier Hospital's services was neither measured nor addressed, despite the intensity of their medical needs, resulting in much unalleviated ill health; and
- that the NMO's neglect of his duties deprived Ahuriri Maori of an effective field doctor service at a time of urgent need.

9.3.2 Chapter 6: Consultation with Maori on the closure of Napier Hospital

On consultation with Ahuriri Maori (section 6.5)

The repeated failures to consult adequately or at all with Ahuriri Maori have resulted in several prejudicial effects that are directly attributable:

- confidence in the commitment of successive Crown health agencies in Hawke's Bay to working in partnership with Ahuriri Maori has been seriously eroded, damaging the cooperation needed to achieve faster improvements in health status;

- confidence in the good faith of consultation itself has been damaged by the belief that the agencies have little interest in taking Maori views seriously into account;
- the rangatiratanga of Ahuriri Maori, and especially the capacity to sustain the demanding practical obligations of partnership, has been placed under strain by their experience of repeated marginalisation from decisions on health service issues they view as important; and
- Napier Hospital was downgraded and then closed, acute and some outpatient services moved to Hastings, Napier services reconfigured, and the Napier Health Centre located and designed all without the input of Ahuriri Maori and the effective opportunity to advocate alternative options.

9.3.3 Chapter 7: Health services for Ahuriri Maori in the era of health sector reform

On representation at decision-making levels (section 7.4.5)

- that Ahuriri Maori, whether directly or through a larger Maori grouping, were inadequately represented or not represented at all on the governing bodies of the district health agencies on which they relied for most State-provided health services;
- that they were denied the opportunity to have their views considered and to influence decisions affecting their health services, notwithstanding their greater need for such services; and
- that their exclusion from health sector governance weakened their institutional ability to exercise rangatiratanga, and thus to participate effectively in other partnership processes such as consultation.

On Maori workforce participation (section 7.4.6)

- that the inadequate participation of Maori in the workforce, especially at senior levels, made the development of culturally appropriate services for Maori patients at both Napier and Hastings Hospitals more difficult.

On incorporating the Maori health gain priority (section 7.4.7)

- that, at least until the late 1990s, it is likely that insufficient resources were committed to addressing the health needs of Ahuriri Maori and that the targeting of those resources was deficient.

On consultation regarding health service needs and delivery (section 7.4.8)

- that Ahuriri Maori were denied sufficient opportunity to communicate their views and health needs to the State purchaser;
- that the Napier health services on which Ahuriri Maori relied were reconfigured without their effective input and, they believed, to the detriment of those health services; and
- that Healthcare Hawke's Bay lacked proper advice from Ahuriri Maori on Treaty perspectives and tikanga Maori to develop culturally appropriate hospital services for local Maori.

On Maori structures for the delivery of mainstream services (section 7.4.9)

- that the short-staffing of the Central RHA's Maori health programme contributed to insufficient consultation with Ahuriri Maori, to limited support being given to the development

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

- that, under the hospital and area health board regime, monocultural practices persisted as a significant barrier to Ahuriri Maori gaining the full benefits of hospital treatment; and
- that the slow and incomplete introduction of culturally appropriate services at Napier and Hastings Hospitals perpetuated that barrier and caused distress to Ahuriri Maori patients and their whanau.

On assessing the health needs of Ahuriri Maori (section 7.4.10)

- that, in the absence of adequate local information, Crown health agencies have not sufficiently adapted their services, especially in the field of primary healthcare, to the health needs of Ahuriri Maori; and
- that Ahuriri Maori have lacked sufficient information on their health status to participate fully as citizens and as partners of the Crown.

On monitoring agency performance and providing for Maori input (section 7.4.11)

- that the Central RHA's failure to monitor and ensure compliance with the kaupapa Maori quality standards that it prescribed in its purchase contracts resulted in poorer hospital service for Ahuriri Maori patients and whanau and decreased the effectiveness of those services;
- that, similarly, the failure to ensure that the required consultation obligations were fulfilled led to a culture of non-consultation becoming entrenched and Ahuriri Maori being excluded from input into decisions affecting services on which they relied; and
- that the low priority and lack of Maori input, at least until 1999, for the monitoring of health outcomes for Maori retarded the ability of the health sector to improve its performance and its responsiveness to Maori.

On assisting local Maori health service provider development (section 7.4.12)

- that, with minor exceptions, Ahuriri Maori have not been empowered to provide primary healthcare services for their own communities; and
- that Maori providers in Napier have not received adequate assistance for their service development.

9.3.4 Chapter 8: Health status and outcomes for Ahuriri Maori

On transitional arrangements for Napier-based services (section 8.4.2)

- that, during 1998 and 1999, Ahuriri Maori, especially in low-income households, experienced additional hardship and emotional stress as in-patients of Hastings Hospital, as supporting whanau and as outpatients of clinics temporarily moved to Hastings; and
- that the additional burden on school staff, especially in Maraenui, in providing support to pupils travelling to Hastings placed extra stress on their educational work.

On the trend of Maori health status over the health reform period (section 8.4.5)

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

9.4 Overview of Prejudicial Effects

The evidence adduced in respect of the claim before us, both supporting and opposing, falls into two unevenly balanced periods. The first, 'historical', period covers nearly a century in the aftermath of the 1851 Ahuriri transaction. The grievances are broadly framed, and the evidence on local health services and outcomes for Maori in central Hawke's Bay is far from comprehensive, although generally sufficient for us to reach findings on most issues arising. The second, 'contemporary', period focuses on the 1980s and 1990s and especially on the seven-year period 1993 to 1999. The grievances are more numerous and specific, and the evidence is voluminous.

A second imbalance works in the opposite direction. In the mid-nineteenth century, Western medical technology was virtually helpless against disease and bodily malfunction. Even in the 1920s and 1930s, its strengthening powers were restricted until the post-war antibiotic revolution. By contrast, the surgical and curative powers of conventional medicine seem today almost boundless, limited only by the ability to fund them. The lengthy historical period of limited potential for medical intervention is thus juxtaposed with a short contemporary period with scope for intervention on many fronts.

We are in no doubt that Ahuriri Maori, in common with Maori nationally, suffered grievous ill health during the century following the signing of the Treaty of Waitangi. Foreign diseases were the dominant and inevitable cause. Yet, throughout the period, State medical services barely reached Maori people and communities in central Hawke's Bay. By the 1920s and 1930s, the yawning gap in health status persisting between Maori and non-Maori exposed the extent of the failure to protect Maori health – the 'vast amount of unnecessary suffering, crippling and mortality' attributed in 1932 by the responsible medical officer of health to Maori communities in Hawke's Bay.[1] Even if the strongest potential for improving Maori health lay in other fields of social action, such as housing and nutrition, the absence of medical outreach was telling.

By the 1980s and 1990s, Ahuriri Maori were benefiting from both hospital and primary healthcare services, though not always in proportion to the intensity of their needs. In absolute terms, their state of health had improved vastly during the second half of the twentieth century. But so had that of non-Maori –the gap was still wide and, in the 1990s, was ceasing to close in

1. Quoted in doc U12, p78

many areas of ill health. The gap was, moreover, only partly explicable in terms of the higher proportion of Maori living in more deprived areas.

As in the 1930s, the agenda for State intervention had many fronts. Environmental and socio-economic changes, in particular to family incomes and to housing conditions, were still powerful levers for health improvement. Even so, the scope of medical action and health services was now very much wider and more effective, and its potential was growing exponentially. That potential was at the disposal of the Crown to meet its Treaty obligation to improve Maori health. As public health policy evolved through the 1980s and 1990s, it connected with increasing precision with a growing official willingness to recognise that obligation.

We encounter here a paradox of Treaty responsiveness. As governments have translated Treaty principles into specific policies and programmes, here, in the sophisticated and complex field of healthcare, so they have multiplied yardsticks of accountability. Many of the contemporary grievances advanced in this claim are concerned with the apparatus of obligation and performance. Their absence would, however, in no way diminish the extent of the Crown's Treaty obligations. The adoption in 1992 of an overarching policy goal of improving Maori health outcomes towards equality with non-Maori did not excuse the Crown from attempting to achieve that result in previous periods.

Our review of the evidence bearing on the contemporary grievances has yielded mixed conclusions. Some of the recent policy development and planning methodology has been impressive. Much appears, none the less, to have remained on a rhetorical plane, especially at the operational coalface. Ahuriri Maori communities have yet to see significant improvements in many aspects and have suffered a worsening of access with the closure of their local hospital. It is unlikely that their health outcomes have improved much over the past decade. Their community-based providers remained small and isolated, their representative organisations marginalised. A key index of prejudice is how much more could have been achieved – through appropriate services, partnership and empowerment – in redressing the health disparities that all agreed were unacceptable.