

1 February 2016

## Submission

To the

### Health Select Committee

On the

### Inquiry into ending one's life in New Zealand

*Genuine laws are made to protect the weakest;  
those who, without the law, are prey to the powerful.*

Blessed Oscar Romero

#### Summary of main points

- Caritas adds our voice to those in the community who oppose physician-assisted suicide
- We approach the issue primarily from the perspective of working with people experiencing marginalisation and powerlessness. People do not experience real choice in this or other matters whenever there is an imbalance of power.
- New Zealand's unacceptable levels of child abuse, sexual abuse and elder abuse show there are many situations in which vulnerable people do not have equitable power in families.
- We do not believe there are sufficient protections that can be put in place to ensure that vulnerable people's lives are not cut short.
- There are numerous examples of exploitative situations in New Zealand despite legal protections – including extreme labour exploitation, tenancies in very poor quality housing, and sexual abuse and rape.
- Human beings are a collective family, and decisions made by one individual or by one section of society inevitably have consequences for others.
- Physician-assisted suicide is not currently a preoccupation of the poor, and those seeking "choice" are primarily well-off and white. The Select Committee must ensure it hears from Māori, Pacific and other non-Pākehā experiences and perspectives.
- Poverty is a factor in the increased suffering of many seriously ill people. The physical suffering of illness becomes amplified if a person is living in isolation or is cut off from the community, has inadequate transport or other barriers to healthcare, or is living with inadequate food or heating. Poverty is the worst reason for a person to take their own life.
- Youth-suicide prevention programmes cannot be effective in a society which legalises suicide and promotes it as a solution to pain. New Zealand suicide rates are higher in the most deprived areas, and are 1.8 times higher for Māori than non-Māori.
- We need equitable access to palliative and health care, to ensure that all people can receive all the support they need at the end of their lives.

## **Introduction**

1. Caritas is the Catholic agency for justice, peace and development. We are mandated by the New Zealand Catholic Bishops to undertake advocacy, development, education and humanitarian work both globally and locally.
2. We add our voices to those in the community who oppose moves to enable physician-assisted suicide. We are approaching this issue primarily from our experience of working with marginalised and powerless people in Aotearoa New Zealand and overseas. In our experience and observation, people do not experience real choice in this or other matters whenever there is an imbalance of power. This is inherent in decisions being made at the end of life.
3. We are also approaching this question from the perspective of the need to adequately resource palliative care and health care, and to ensure equitable access to these services. We also approach it from the perspective of the grief and anguish that accompany suicides, particularly of young people.

## **Protecting the vulnerable**

4. Many people are vulnerable in relation to their caregivers, and in times of illness or disability are particularly vulnerable to abuse or undue pressure. New Zealand's unacceptable levels of child abuse, elder abuse and sexual abuse show that there are many situations in which vulnerable people do not have equitable power in family dynamics.
5. The most important role of the Health Select Committee in considering this question must be the protection of the most vulnerable. We do not believe there are sufficient protections that can be put in place to ensure that vulnerable people's lives are not cut short – and, short of miracles, there are no remedies to reverse death.
6. Human beings are a collective family, and decisions made by one individual or by one section of society inevitably have consequences for others. Physician-assisted suicide is not currently a preoccupation of the poor, or of non-Pākehā communities – those seeking “choice” are predominantly well-off and white. However, if introduced, physician-assisted suicide will inevitably have a greater impact on vulnerable groups who have fewer resources to navigate the health system. We believe these groups would end up being over-represented in euthanasia, as they are in so many other areas of vulnerability.
7. It is very important that the Health Select Committee hears from Māori, Pacific and other non-Pākehā perspectives and viewpoints. If there is not a representative sample of these viewpoints generated by the Select Committee process, it is vital that you seek out these perspectives.

## **Powerlessness**

8. In Aotearoa New Zealand at present there are numerous examples where people are in exploitative situations despite legal protections. These arise where there are significant power imbalances. A few examples:
9. *Extreme labour exploitation:* News media stories have brought to the surface situations of exploitative labour, particularly concerning the use of migrant labour. Many of these situations are clearly outside New Zealand's labour laws, such as pay rates well below the New Zealand minimum wage, or cases where the movement of workers is physically restrained, even outside working hours. Sometimes the power imbalance is multiplied if employers withhold passports. These situations occur despite the existence of labour laws, a labour inspectorate and unions.
10. *Powerlessness in tenancies:* Caritas has just made a submission to the Social Services Select Committee supporting moves which will take some steps towards restoring the imbalance between the most vulnerable tenants and the most unscrupulous landlords. These include enabling MBIE to take action against continually offending landlords independently of the tenants, as can happen with unsafe or exploitative employers. The most vulnerable tenants are reluctant to take action in the Tenancy Tribunal against the worst landlords, despite legal protections and remedies available to them in law.
11. *Child abuse, sexual abuse and rape:* New Zealand has some of the highest rates of child maltreatment in the OCED. This is despite having a clear legal framework in which child abuse, sexual abuse and rape are explicitly outlawed, and despite having a range of experienced professionals in the police, CYFS and a range of social work organisations whose jobs include identifying situations of abuse, protecting the victims and prosecuting offenders. Our society is unable to overcome power imbalances within families that enable so much silent suffering to go on undetected and unprosecuted.
12. There are numerous other examples of powerlessness, which remove real choice and autonomy from the most vulnerable. Sometimes these situations are presented as being a matter of mutual agreement – for example, that a migrant worker has signed an employment agreement which includes sub-standard pay and conditions; or a tenant has signed a tenancy agreement for a cold, mouldy, leaky home; or that a sexual relationship with an underage child appears to be taking place by mutual consent. In many of these situations, there is no real “choice” – a worker is choosing between unemployment or poor working conditions, or between a poor home and homelessness, or because a young person feels under physical or emotional pressure to take part in sexual activity. However, it is clear to us that such conditions are not a matter simply for agreement between worker and employer; tenant and landlord; or unequally matched sexual partners.

13. Our whole society is affected when such situations of exploitation are revealed in New Zealand – for example, an employer paying illegal wage rates or operating below legal minimums for health and safety undermines the competitiveness of good, safe, legal employers. The common good requires that we set standards which apply to all, because apparent “choice” for a few creates the conditions for harm for many.
14. We oppose physician-assisted suicide because in the same way something that may appear a “choice” for one person may be a decision made under pressure for another. Some of the elements that may contribute to this in relation to physician-assisted suicide include the difference between an articulate, legally educated person who knows how to navigate their way through the health and legal systems, and a person who lacks these skills who is not confident or articulate to argue with health professionals or family members.
15. Poverty is a factor in the increasing suffering of many seriously ill people. It is important also to note that the physical suffering of illness also becomes amplified if a person is living in isolation; has a difficulty accessing health care because of distance or lack of transport; is living with inadequate food or heating; is cut off from community supports and whanau, or alternatively feels a burden on their community or whanau. Situations that are best overcome through community or social solidarity, income support, or assistance with transport to hospital may be overlooked in favour of a person’s self-assessment that they cannot cope with their illness. Poverty is the worst reason for a person to take their own life.
16. The common good of society is not served by passing laws that primarily consider this issue from the point of view of the most capable and empowered. We need the Health Select Committee to consider this primarily from the point of view of the most vulnerable. We note that although there may be some people who remain confident in their abilities to make their own decisions when they are ill, for most of us the experience of illness and disability increases our vulnerability.

### **Attitudes to suicide**

17. We also approach this issue from the experience of the intense pain and anguish experienced by many New Zealand families who have lost family members to suicide, especially young people. We do not believe youth suicide-prevention programmes can be effective in a society which legalises suicide and promotes it as a solution to pain.
18. While New Zealand’s youth suicide rates have reduced from their peak in the late 1990s, we still experience around 500 deaths classified as suicide each year (Ministry of Health website quoting latest data from 2011). Suicide rates are higher in deprived areas (14 per 100,000 of population compared to 8 per 100,000 of population in higher socio-economic areas), and is 1.8 times higher for Māori than non-Māori.

19. The experience of suicide reveals over and over again that this is not a personal or individual matter without impact on the wider community. Schools now very carefully consider the support required to give young people to ensure a suicide does not have flow-on effects, including copy-cat suicides. To the grief and anguish which accompanies any loss is the added consequence that a life that has ended without the opportunity to address issues that could have overcome despair and hopelessness.

**Adequate resourcing of, and equitable access to, palliative care**

20. We do not address everyone's needs at the end of their lives adequately. We need equitable access to palliative and health care, to ensure that all people can receive all the support they need at the end of their lives. All pain relief and palliative care options need to be considered and adequately funded.

**Conclusion**

21. The Health Select Committee will hear many examples of end of life experiences and perspectives through this submission process. It is very important that these experiences and perspectives are analysed carefully to understand what would be the impact of any change on the most powerless and vulnerable people in our society.