

Office of the Minister of Health
Cabinet Social Wellbeing Committee

Implementing the End of Life Choice Act and providing for assisted dying services

Proposal

- 1 This paper provides an overview of how the End of Life Choice Act 2019 (the Act) is being implemented to enable the availability of assisted dying from 7 November 2021.
- 2 It also seeks Cabinet's endorsement of an approach to provide and fund assisted dying services, as the Act is silent on how this should be delivered.

Relation to government priorities

- 3 The information and decisions in this paper give effect to the results of End of Life Choice Referendum, which occurred alongside the 2020 General Election.

Executive Summary

- 4 Work to implement the Act is proceeding at pace, with all the elements needed to allow assisted dying to take place on track to be ready when the Act comes into effect on 7 November 2021.
- 5 These elements include administrative systems, professional guidance and training for the health workforce, s 9(2)(b)(ii) establishment of statutory entities, provision of public information, and the introduction of required regulations. A wide range of stakeholders are being engaged in the implementation.
- 6 The Act is silent on which organisations or entities should provide assisted dying. I am proposing that the Government should make provision for assisted dying services, to ensure New Zealanders can access this like other health services. The alternative is *de facto* private provision, and I do not believe a person's access to assisted dying to alleviate their suffering should depend on where they live, or whether they can afford to pay or fundraise to meet costs.
- 7 I also propose that the Government takes a national approach to funding and providing for assisted dying services, which involves:
 - 7.1 allowing any suitable individual practitioner who is willing, to receive funding for providing assisted dying services, on a fee-for-service basis – this is similar to the approach currently taken for maternity services
 - 7.2 ensuring that willing practitioners employed by district health boards (DHBs) are supported to provide assisted dying services by providing

information, resources, and updating relevant accountability documents, and

s 9(2)(b)(ii)

- 8 This approach will support access and equity by maximising the number of practitioners who can provide funded services. Provision of a travel allowance will enable practitioners to provide assisted dying in areas where access might otherwise be limited. This approach will also support choice by allowing patients to choose the practitioner they receive services from.

s 9(2)(b)(ii)

- 10 The implementation of assisted dying is a small component of wider work to address known sustainability, quality and equity issues with palliative and end of life care in New Zealand. The structural changes announced as part of the Health System reforms should provide the foundations to address these longstanding issues, and I expect to receive advice shortly on initiatives that could improve the palliative care system in the short term.

Background

- 11 The Act will come into force on 7 November 2021. The Ministry of Health (the Ministry) is responsible for administering the Act and implementing a system that allows for the provision of assisted dying for eligible people.
- 12 The Act establishes the apparatus needed to enable assisted dying in New Zealand, including the eligibility criteria for people to receive assisted dying, the process that people seeking assisted dying need to follow, entities to support and oversee the provision of assisted dying, and safeguards to ensure that people only receive assisted dying where they meet the criteria.

Implementation of the Act is proceeding well

- 13 Work to implement provisions in the Act has been proceeding at pace, and all of the essential elements to allow assisted dying to take place are on track to be ready by 7 November.
- 14 This will include:
- 14.1 administrative systems to allow the required forms to be completed and submitted electronically
 - 14.2 the development of models of care and professional guidance to support and inform the provision of assisted dying

- 14.3 information and training for the health workforce including talks and workshops at professional conferences, online training modules, and peer networking sessions
- 14.4 the establishment of the entities set out in the Act – the Support and Consultation for End of Life in New Zealand (SCENZ) Group and the End of Life Review Committee

s 9(2)(b)(ii)

- 14.6 the provision of public information about the Act and how people can exercise the choices and rights that it provides – information will be available through online channels, printed guidance materials, and alternate formats, and will include translations into a variety of languages including te reo Māori and New Zealand Sign Language
- 14.7 regulations required to support the administration and operation of assisted dying in New Zealand.

There are a wide range of stakeholders to consider

- 15 There is a lot of interest in how the Act is being implemented, from those who work in the health system who will be directly involved, those involved in providing end of life care generally, and the wider community.
- 16 Engagement with a range of stakeholders on the implementation is ongoing, including engagement with advocacy groups, regulatory authorities, unions, professional colleges and professional bodies, palliative care organisations, Māori and disability groups.
- 17 While the emphasis of feedback has varied between stakeholders, the common themes that have come up are:
 - 17.1 enabling equitable access and outcomes, including for Māori and rural populations
 - 17.2 how assisted dying will interact with existing end of life care services, such as palliative care
 - 17.3 interest in the model of care and guidelines that will apply to assisted dying, and how safeguards will be implemented
 - 17.4 the importance of comprehensive training being available for health professionals, both on process and engagement with patients and whānau
 - 17.5 the need to support practitioners to establish networks that provide ongoing learning and support.
- 18 The Ministry is addressing this feedback through the ongoing implementation work they are doing, which includes:

- 18.1 determining how access to assisted dying can be supported across New Zealand including in both existing health settings as well as in communities – this is the main focus of the approach set out in this paper
- 18.2 developing training and guidance for health practitioners informed by feedback and expert input across a range of areas relating to assisted dying – an initial training module about the Act was recently released with over 800 individuals enrolled, and over 600 people having completed it (as of 10 June 2021)
- 18.3 providing online seminars (webinars) with practitioners to respond to and address specific questions – the first took place on 2 June with positive feedback, and a national forum is planned for practitioners on 29 and 30 September 2021
- 18.4 developing information and responding to questions about safeguards related to assisted dying – a summary of safeguards that apply to assisted dying (both related to the Act itself but also wider health and disability system safeguards) is provided in Appendix B.

Measures to enable assisted dying will continue to develop after November

- 19 Because assisted dying is entirely new to New Zealand, I anticipate that some unexpected issues may arise as New Zealanders adjust to it being available. These might include responding to unexpected (higher/lower) levels of demand for services, addressing additional needs for the health workforce, responding to issues or concerns for particular groups, or responding to legal challenges to parts of the process.
- 20 The system and settings which will be available on 7 November 2021 will continue to develop over time to ensure assisted dying is provided in the most responsive and appropriate way as we learn from experience.
- 21 A post-implementation review will take place from November 2022 to ensure that the provision of assisted dying is occurring as expected, and identify any improvements that can be made. The Ministry will respond to any issues that come up before the review through interim measures.

Analysis

There is a need for government to make provision for assisted dying services

- 22 While the Act requires the establishment of the apparatus to enable assisted dying, it is silent on which organisations or entities should actually provide it.
- 23 Without government action the provision of assisted dying would be left to individual practitioners, with the costs of providing assisted dying to be met through a combination of private fees and charitable donations, and access likely dependent on whether there are willing practitioners in particular areas.

- 24 As a Government we have committed to ensuring that health services in New Zealand are accessible, support equitable outcomes for all, and meet the government's obligations under Te Tiriti o Waitangi. Access should not depend on where people live, whether they can afford to pay or fundraise to meet costs, and should not be limited by social or cultural barriers.
- 25 I propose that the Government makes provision for assisted dying services, to ensure New Zealanders can access this, in line with other health services.

Our approach needs to take account of some complicating factors

- 26 The number of people seeking assisted dying is expected to be small. The Ministry of Health estimates that up to 950 people could apply for assisted dying each year, with up to 350 being assisted to die. This figure is based on an assumption that assisted dying could account for up to one percent of all deaths in New Zealand. This number is based on experiences in Victoria - Australia, Oregon - United States and Canada, where assisted dying accounts for between 0.3 and 2 percent of all deaths.
- 27 However, while numbers will be small, providing assisted dying will be complicated because:
- 27.1 these people will be spread across New Zealand and may be unable to travel due to care needs
- 27.2 many will want to be supported to die at home, or in another community setting such as a marae or church, though this won't always be appropriate.
- 28 The critical factor determining access will be the availability of willing practitioners. The number of practitioners willing to provide assisted dying is expected to be small, as a majority have indicated through a recent workforce survey that they conscientiously object to assisted dying. Many of those who support it in principle may be cautious about providing it in practice.
- 29 The workforce survey received responses from 1,980 health workers, including 1,516 medical and nurse practitioners. Of these, a total of 115 medical and nurse practitioners were 'definitely' willing to provide assisted dying, while 273 indicated they would 'possibly' be willing to provide assisted dying.
- 30 The way non-government organisations respond to assisted dying will also influence access. These organisations are not required to provide or permit assisted dying, and some hospice and aged care organisations have stated that they will not provide or allow assisted dying in their facilities. These decisions mean that people who want the option to seek assisted dying may not be able to receive care in certain facilities, or may need to be transferred to other services to receive assisted dying.

National funding for assisted dying services will support access, equity, and effective implementation

- 31 I considered two potential approaches to provide for assisted dying services. A summary of these and the criteria I used is provided in Appendix A.
- 32 I propose that the Government takes a national approach to funding and providing for assisted dying services that will involve:
- 32.1 allowing any suitable individual practitioner who is willing, to receive funding for providing assisted dying services, on a fee-for-service basis
 - 32.2 ensuring that willing practitioners employed by DHBs are supported to provide assisted dying services by providing information, resources, and updating the service coverage schedule to the DHB Crown Funding Agreement to include assisted dying, and

s 9(2)(b)(ii)

- 33 Responsibility for provision would sit with the Ministry initially, and transition to Health New Zealand alongside other national service arrangements currently managed by the Ministry as part of our health system reforms.

Using a fee-for-service approach

- 34 Under this approach, fee-for-service funding would be provided to individual practitioners by the Ministry, allowing people to choose the provider and setting where they receive services, with the service available both within DHBs, in primary care, and through other providers. This is similar to funding arrangements for maternity services.
- 35 Individual practitioners will be able to claim for funding when they complete parts of the assisted dying process.
- 36 Practitioners would also be able to receive an allowance for travel costs so that they can provide services to people in their homes, in other community locations (such as marae), and in other care settings.
- 37 Funding assisted dying services in this way will support access, equity and choice by:
- 37.1 maximising the number of practitioners who can provide funded services – any suitable individual practitioner will be able to receive funding for providing services
 - 37.2 allowing people to access assisted dying in a range of geographic areas, and settings – anywhere there are suitable practitioners
 - 37.3 giving patients some choice about the practitioner they receive services from – this might include their regular general practitioner if they are willing, or a kaupapa Māori health service

37.4 minimising cost as a barrier to access.

- 38 There is a potential for gaps in access to assisted dying in areas where there are no willing practitioners available, but providing funding to support practitioners to travel should address this to some extent.
- 39 Funding will be conditional on individual practitioners meeting service standards that will apply to assisted dying. These will be developed with the health and disability sector over coming months.
- 40 To receive funding, individual practitioners will also need to agree not to charge additional co-payments. This means that while someone may need to pay a normal primary care co-payment when they first see their doctor to discuss assisted dying, they will not be charged any additional co-payments once the process has commenced. Practitioners will still be free to provide entirely privately funded services if they want to.
- 41 Assisted dying will be a new service within the health and disability system, and I am mindful of the need to align funding for assisted dying services with the way services are funded in the wider health and disability system.
- 42 Setting funding at a level that does not appropriately address the costs associated with providing assisted dying could deter individual practitioners from participating, resulting in reduced access and equity, while funding at a level that might be seen as more generous than other services might be viewed as favouring assisted dying, which is certainly not the intention.
- 43 The level of funding that individual practitioners can claim for completing parts of the assisted dying process will be determined by the Ministry through a process that will include considering independent advice on an appropriate costing methodology. I expect that the level of funding that is set will reflect reasonable costs associated with providing assisted dying, while being broadly aligned with funding for other health services.
- 44 Willing practitioners who are directly employed by DHBs (eg. specialists working in hospitals) will not receive additional compensation through the fee-for-service arrangement when providing assisted dying services, as they are already employed directly by DHBs.
- 45 The Ministry is working with DHBs to support them in implementing assisted dying services by providing information and resources for clinicians, managers and executives. The cost of providing the service will be met through existing funding arrangements, and the DHB service coverage schedule will be updated to include this as part of the range of publicly funded health services.

s 9(2)(b)(ii)

s 9(2)(b)(ii)

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s 9(2)(b)(ii)

Wider work is happening to improve palliative and end of life care

- 56 The implementation of assisted dying should be viewed as a small component of wider work by the Government to improve palliative and end of life care in New Zealand. Everyone in New Zealand who needs palliative care should be able to access what they need, to a suitable standard, so that access to palliative care does not influence a person's decisions around assisted dying.
- 57 The relationship between assisted dying and palliative care is complex, as many of those who work in palliative care have expressed opposition to assisted dying, noting that this goes against the principle that palliative care should neither hasten or postpone death.
- 58 The approach proposed in this paper recognises this situation, by seeking to fund assisted dying specifically, rather than seeking to directly integrate it into funding and service requirements for palliative and end of life care. The funding approach proposed in this paper allows assisted dying to be provided in a wider range of settings and by willing practitioners.
- 59 There are well recognised sustainability, quality and equity issues with provision of palliative care. The Ministry has estimated that palliative care services are needed by 24,000 people in New Zealand, but there is a group of about 11,000 people who are living in the community (including up to 1,600 Māori), whose access to care we have very little information about. It is highly likely that a large proportion of people in this group are not getting sufficient care, or are missing out altogether.
- 60 Many of the changes announced in the Health System reforms should help address these issues. The Ministry has been doing policy work on palliative care and I expect to receive proposals shortly to improve the palliative care system in the short term while the wider reforms are implemented.

Financial Implications

- 61 As part of Budget 2021, \$11.86 million was appropriated to implement assisted dying during 2021/22. This includes:
- 61.1 \$7.26 million for costs associated with implementing the Act, including IT system development, the establishment and operation of the statutory entities and workforce development and training
 - 61.2 \$4.6 million to meet the cost of providing assisted dying services including funding for individual practitioners, s 9(2)(b)(ii)

s 9(2)(b)(ii)

- 63 I propose that Joint Ministers will approve final funding settings and the drawdown of contingency funding for the provision of assisted dying once work has been done on funding levels for practitioners and other costs such as s 9(2)(b)(ii)

Legislative Implications

- 64 There are no legislative implications associated with the proposals in this Cabinet paper.
- 65 Officials identified a risk that an assisted death under the Act would be treated as a wilfully self-inflicted injury or suicide for the purposes of the Accident Compensation Act, impacting the fatal injury entitlements the whānau of a person who chooses an assisted death may receive from ACC. I am advised that an operational solution to this issue has been identified and will be implemented by ACC. However, officials are doing further work to explore whether an amendment to the Act or the Accident Compensation Act is necessary and appropriate to enhance legislative certainty.

Impact Analysis

- 66 Regulatory impact analysis requirements do not apply, as the decisions sought in this paper do not involve the introduction of new legislation, or changes to or the repeal of existing legislation. A Climate Implications of Policy Assessment (CIPA) is not required for the proposals in this paper.

Population Implications

- 67 There is uncertainty about the extent to which Māori and Pacific peoples may seek assisted dying.
- 68 Māori and Pacific peoples experience higher rates of cancer and poorer health outcomes than the general population, and can experience difficulty accessing health services including palliative care. This might suggest that these groups could be more likely to access assisted dying, however cultural norms related to the end of life including tikanga Māori and the significant role that religion plays in the lives of Pacific peoples might suggest otherwise.
- 69 The proposed approach will support participation and equity for Māori and Pacific peoples by:
- 69.1 allowing Māori and Pacific peoples to exercise choice about the practitioner they receive services from, and supporting practitioners who are not Māori or Pacific to provide culturally responsive services with guidance and training
 - 69.2 allowing practitioners who work in Māori or Pacific health services, or other settings where Māori and Pacific peoples are served, to access

funding to provide assisted dying on the same basis as other providers, while also protecting the right of practitioners to conscientiously object if they do not wish to be involved in providing assisted dying services

- 69.3 funding practitioners for transport costs, allowing them to provide services in more isolated and remote areas, and in community settings such as in homes or on marae if this is appropriate
 - 69.4 providing public information on assisted dying including information for Māori and Pacific peoples who are seeking assisted dying and their whānau.
- 70 Some disabled people will be eligible to apply for assisted dying, but only where they meet all of the criteria to qualify, including suffering from a terminal illness that is likely to end their life within six months. The eligibility criteria do not make people eligible for assisted dying based on a disability alone. See Appendix B for further information about safeguards.
- 71 For some people, the presence of a disability could potentially limit or complicate their ability to access, be assessed for, and receive assisted dying. Measures to address potential barriers to disabled people accessing assisted dying include:
- 71.1 funding practitioners to travel to patients – this should improve access for people with physical disabilities or medical conditions that prevent them from travelling, or limit where they can be cared for
 - 71.2 developing guidance for practitioners to support them to assess the competence of people to seek assisted dying in situations where factors, such as an intellectual disability or mental health issue, could make this more complicated
 - 71.3 ensuring that public information about assisted dying is provided in a range of accessible formats including braille, audio, Easy Read, New Zealand Sign Language and html format.
- 72 Information will be collected about people who seek assisted dying, and this will be used to monitor and report on the representation of groups including Māori and people with disabilities among those seeking assisted dying.

Human Rights

- 73 The Attorney General reported to parliament on the consistency of the (then) End of Life Choice Bill with the rights and freedoms affirmed in the New Zealand Bill of Rights Act 1990 (pursuant to Section 7). The report found that:
- 73.1 the Bill engaged the right not to be deprived of life (section 8 of the Bill of Rights Act), but did not limit that right
 - 73.2 to the extent the Bill limited the right to freedom of conscience and expression (sections 13 and 14 of the Bill of Rights Act), the limits were justified

73.3 the Bill appeared to be inconsistent with section 19(1) (freedom from discrimination) of the Bill of Rights Act in respect of age, and the limit could not be justified.

74 The measures to implement the End of Life Choice Act outlined in this paper are consistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

75 The following agencies were consulted on this paper: the Department of the Prime Minister and Cabinet, the Treasury, Ministry of Justice, New Zealand Police, Department of Corrections, Accident Compensation Corporation, Department of Internal Affairs, Ministry of Social Development, Te Puni Kokiri, Ministry for Pacific Peoples and the Office for Disability Issues.

Communications

76 Public information about the End of Life Choice Act implementation, and how people can exercise the choices and rights that the Act provides, is being published online by the Ministry throughout the implementation process.

77 Detailed information about assisted dying services will be available through online channels and printed guidance materials from October 2021.

Proactive Release

78 I intend to proactively release this Cabinet paper with the appropriate redactions under the Official Information Act 1982 immediately following Cabinet decisions.

Recommendations

The Minister of Health recommends that the Committee:

- 1 **note** that work to implement the End of Life Choices Act is proceeding well, with all of the required elements to enable assisted dying expected to be in place from 7 November 2021;
- 2 **note** that a range of stakeholders are being engaged in the implementation including advocacy groups, regulatory authorities, unions, professional bodies, palliative care organisations, Māori and disability groups;
- 3 **note** that the End of Life Choice Act is silent on which organisations should provide assisted dying, and that without government action this would be left to individual practitioners, with costs to be met through private fees and access dependent on where there are willing practitioners;
- 4 **agree** that the Government will take steps to ensure that assisted dying services are available to eligible people from 7 November 2021, in line with other health services;

5 **note** that assisted dying will be sought by a small number of people, and that there is likely to be a preference for people to be supported to die at home or another community setting, though this will not be suitable for everyone;

6 **note** that the availability of willing practitioners will be the key factor determining access to assisted dying, and that only a small proportion of practitioners are expected to be willing to provide assisted dying initially;

7 **agree** that the Government will take a national approach to funding and providing for assisted dying services, which will involve:

7.1 allowing any suitable individual practitioner who is willing, to receive funding for providing assisted dying services, on a fee-for-service basis

7.2 ensuring that willing practitioners employed by DHBs are supported to provide assisted dying services

s 9(2)(b)(i)

8 **note** that fee-for-service funding will allow individual practitioners to claim for funding when they complete parts of the assisted dying process and will include an allowance for travel costs;

9 **note** that individual practitioners who provide funded assisted dying services will need to comply with service standards, and will be prohibited from charging additional co-payments, to prevent these from becoming a barrier to access;

10 **note** that funding assisted dying services in this way will maximise the number of practitioners who can provide funded services, allow people to access assisted dying in a range of geographic areas and settings, and reduce cost as a barrier to access;

11 **note** that the level of funding that is provided to individual practitioners for completing parts of the assisted dying process will be determined by the Ministry of Health using independent advice on an appropriate costing methodology;

12 **agree** that there will be an addition to the DHB service coverage schedule to the Crown Funding Agreement to identify assisted dying as part of the range of publicly funded health services, and DHBs will provide assisted dying services using existing baseline funding;

s 9(2)(b)(ii)

- 14 **note** that funding of \$11.86 million was appropriated for 2021/2022 s 9(2)(b)(ii) as part of Budget 2021 for the provision of assisted dying services;
- 15 **agree** that the Ministers of Finance and Health will approve final funding settings for the provision of assisted dying once work has been done on funding levels for practitioners and other costs such as s 9(2)(b)(ii)
- 16 **note** that the implementation of assisted dying is a small component of wider work to improve palliative and end of life care in New Zealand, and that I expect to receive proposals shortly to address recognised sustainability, quality and equity issues with palliative care.

Authorised for lodgement

Hon Andrew Little

Minister of Health

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Appendix A – Approaches considered for providing assisted dying services

The Ministry of Health undertook work to determine what an effective system to provide for assisted dying needs to do, based on what is known about the interests of different groups, the design of systems overseas, and the design principles for the implementation, which include Te Tiriti o Waitangi considerations.

Two high level approaches were identified that the Government could use to provide for assisted dying services in New Zealand.

The first approach would involve supporting any practitioners who are suitably qualified and willing to provide assisted dying, by providing funding for assisted dying services on a fee-for-service basis for individual practitioners, and supporting willing practitioners employed by DHBs to be involved in assisted dying through their existing employment and DHB funding arrangements. This approach is similar to funding arrangements for maternity services. Under this approach the Ministry of Health would be responsible for administering funding for assisted dying services, and have some oversight of provision. This responsibility would then move to Health New Zealand as part of planned health reforms.

This approach has some similarities to the way maternity services are currently funded, allowing people to choose the provider and setting where they receive services, with the costs funded directly by the Ministry.

The second approach would involve making DHBs responsible for ensuring that a level of assisted dying service provision is available. DHBs would be provided with additional population-based funding to provide for assisted dying services, and assisted dying would be added to the Service Coverage Schedule which sets out services that DHBs are required to plan and provide for.

Under this approach, DHBs would be directly responsible for administering funding for assisted dying services, determining the locations and settings where services are provided, whether/how assisted dying services are integrated with other care, and the capacity of services.

This approach reflects the way most health services are currently funded, including other end of life and palliative care services.

A third approach was considered, which would involve the Ministry contracting non-government organisations or private providers to deliver assisted dying services. However, the Ministry does not believe this would be viable. The relatively small scale of demand for assisted dying combined with sensitivities related to assisted dying in the health sector mean that there are unlikely to be organisations that would be willing to enter into such arrangements. There are also some provisions in the Act that could complicate the provision of services by contracted providers¹.

Comparison

¹ These include a provision that prohibits organisations from providing employment or other benefits to staff that are conditional on them providing assisted dying services.

The following table compares the two approaches in terms of supporting accessibility and equity, choice and control, and the wellbeing of those providing assisted dying.

	<p>Approach One - Support any practitioners who are suitably qualified and willing to provide assisted dying, by providing funding for assisted dying services on a fee-for-service basis, and ensure willing practitioners employed by DHBs are supported to provide the service through existing DHB funding (no increase).</p> <p>The Ministry would be responsible for administering fee-for-service funding arrangements and have some oversight of provision</p>	<p>Approach Two – Make DHBs responsible for ensuring that a level of assisted dying service provision is available across New Zealand, and provide additional population-based funding to provide for assisted dying services.</p> <p>DHBs would be responsible for administering funding for assisted dying services and determining where and how services are provided.</p>
<p>What it means for access and equity</p>	<p>Seeks to address access by maximising the number of practitioners who can provide funded services – any suitable practitioner can receive funding for providing services.</p> <p>Potential for people to be able to access service in a range of geographic areas, and settings, though access may be limited if there are areas with no/few willing practitioners.</p> <p>Removes cost as a barrier for all people, whether they receive assisted dying services through public or private health services.</p>	<p>Seeks to address access by seeking to ensure a minimum level of provision across New Zealand through DHBs.</p> <p>Potential for people to be able to access services in a range of geographic areas, but this depends on how DHBs decide to provide for services. Access to services may vary in different areas depending on whether they are provided locally, regionally, or nationally.</p> <p>Potentially removes cost as a barrier for people who receive services from DHBs.</p>
<p>What it means for choice and control</p>	<p>Encourages choice by enabling any suitable practitioners to provide funded services, including those working for smaller providers.</p> <p>People can choose to receive a funded service from any willing practitioner, including their regular</p>	<p>More limited choice as people either need to use funded services provided by DHBs or pay to access services from any non-DHB funded practitioner/provider.</p> <p>Whether or not people can receive a funded service from their regular medical practitioner will depend on whether this</p>

	<p>medical practitioner if that person is willing and able.</p> <p>Choice may be limited if there are few willing practitioners in a particular area.</p> <p>Choice may be influenced by the level of funding that is available – eg, whether funding supports practitioners to travel to deliver services.</p>	<p>practitioner is part of a DHB’s assisted dying service.</p> <p>Choice may be influenced by the level of funding that is available – eg, whether DHB funding supports practitioners to travel to deliver services.</p>
<p>What it means for supporting workforce wellbeing</p>	<p>May reduce pressure on individual practitioners by allowing demand for services to be spread across more people.</p> <p>Provides flexibility for practitioners to make case-by-case decisions about when and who they are willing to provide assisted dying services to (eg, existing patients).</p> <p>May make establishing and maintaining support networks more complex if practitioners are widely spread out or working in remote areas.</p>	<p>Support systems and networks can be developed within DHBs, including potentially using existing structures and processes.</p> <p>The need to support practitioners may encourage DHBs to provide services from one or more central ‘hub’ locations where they can establish communities of willing practitioners, rather than across a range of different areas.</p>
<p>Other potential benefits</p>	<p>Potentially supports organic growth and innovation of assisted dying services, as it creates a level playing field in terms of receiving funding – assisted dying services are funded regardless of the size of an organisation or how many people they provide assisted dying services to.</p> <p>Involves using an existing mechanism and payment systems that are already established within the Ministry.</p>	<p>Potentially allows assisted dying to be connected with the other care that people already receive through DHBs. However, DHBs may want to keep assisted dying provision at arms-length from their other activities given strong views among parts of the communities they serve, and the legal requirement to allow their staff to conscientiously object to being involved.</p>
<p>Other considerations</p>	<p>Organisations that employ practitioners (including DHBs) would need to make</p>	<p>Potential for those who oppose assisted dying to seek to limit any provision through protest. There</p>

	<p>decisions about whether/how they will allow willing staff to participate (eg, by allowing them to conduct assessments as part of their normal practice).</p> <p>A fee-for-service approach to funding may attract criticism that assisted dying is receiving special or more generous treatment compared to palliative care, depending on the nature of funding provided. Palliative care is partly funded by Government with some components (eg, grief and bereavement services) typically funded through charitable donations.</p>	<p>is also some additional risk of legal challenges to planning and funding decisions by DHBs based around the adequacy of community consultation.</p> <p>Implementation by DHBs may be complicated by the relatively limited timeframe before services are required, and how this fits with the timing of their annual planning processes.</p>
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The Ministry did not compare the approaches in terms of how they support safety because safeguards for assisted dying (set out in legislation and through professional requirements) would apply equally under both approaches.

Recommended approach

On balance Approach One was recommended on the basis that it is most likely to result in the successful provision of assisted dying services because it:

- has the greatest potential to support access and choice for people seeking assisted dying services
- provides a high level of flexibility for practitioners who choose to be involved
- will allow the many uncertainties associated with providing assisted dying services, such as unknown levels of demand for services, to be monitored and responded to centrally.

Providing for assisted dying services this way also provides options to revisit and change the approach in future as services become operational and we become more familiar with the complexities of providing assisted dying.

The key issue with both approaches is the potential for gaps in access in areas where there may not be willing practitioners available. This can be addressed by providing support to enable practitioners to travel to deliver services in areas outside their normal catchment.

Appendix B – Summary of safeguards in the End of Life Choice Act and the protections provided by the Health Practitioners Competence Assurance Act 2003 and the Health and Disability Commissioner Act 1994

The following is a summary of the safeguards that are provided within the End of Life Choice Act.

Safeguards to protect those seeking assisted dying

Eligibility criteria

The EOLC Act sets out criteria that must be met in order for a person to qualify for assisted dying. The Act explicitly states that a person cannot be eligible if that person is only suffering from any form of mental disorder or mental illness, or has a disability of any kind or is of advanced age.

Patients must meet all of the following criteria to qualify:

- a. be aged 18 years or over
- b. be a citizen or permanent resident of New Zealand
- c. suffer from a terminal illness that is likely to end their life within 6 months
- d. be in an advanced state of irreversible decline in physical capability
- e. experience unbearable suffering that cannot be relieved in a manner that the person considers tolerable
- f. be able to make an informed decision about assisted dying.

Second opinion

The Act requires that a patient be assessed against the eligibility criteria by two medical practitioners (including one deemed to be 'independent').

Requiring competence to make the decision

The person who is applying must be found competent to make an informed choice about assisted dying by two medical practitioners or a psychiatrist (if one or both of the practitioners cannot make this determination).

Someone is deemed to be competent to make an informed decision if they can:

- a. understand information about the nature of assisted dying that is relevant to the decision (comprehension)
- b. retain that information to the extent necessary to make the decision (recall/memory)
- c. use or weigh that information as part of the process of making the decision (reasoning)
- d. communicate that decision in some way.

Require informed decision making

Someone seeking assisted dying must be provided with information by the attending medical practitioner to enable them to make an informed decision, including:

- a. the prognosis for the person's terminal illness
- b. the irreversible nature of assisted dying and the anticipated impacts of assisted dying
- c. their other options for end-of-life care.

Non-initiation

This requirement means that health practitioners cannot in the course of providing a service initiate any discussion with a person about assisted dying or make any suggestion to the person that the person exercise the option of receiving assisted dying.

Suspected coercion

The attending medical practitioner must 'do their best' to ensure someone seeking assisted dying is doing so free from pressure from any other person, including a requirement to confer with other health practitioners who are in regular contact with the person (with or without their consent) and with members of the person's family (if the person approves). Any actions taken must be recorded.

The attending medical or nurse practitioner must cease all action to assist someone to receive assisted dying (and report this to registrar) if at any time during the process they suspect 'on reasonable grounds' that a person who has expressed the wish to receive assisted dying is not expressing their wish free from pressure from any other person.

Use of advanced directives and decisions by welfare guardians is prohibited

People seeking assisted dying must personally make the decision and have capacity at the time assisted dying is sought.

Regular check-ins to confirm decision

Over the course the person's illness and throughout the application process the practitioner must advise the person that at any time the person may decide not to receive the medication, or to receive the medication at a time on a later date that is not more than 6 months after the date initially chosen for the administration of the medication.

The person has the right to rescind their decision to seek assisted dying at any time, and no further action can be taken if this occurs.

Confirm decision on day medication is provided

The practitioner must confirm with the patient that their decision has not changed, and that they wish to receive the medication so that they can die.

Person signing for an applicant must not benefit from their death

If someone needs to sign the application for assisted dying on behalf of another person (when the person cannot physically write), they must declare that they do not stand to benefit from the person's death.

Immunity from criminal liability

Someone who seeks assisted dying (section 37(3)) is immune from criminal liability.

Use of force to prevent assisted dying is not justified

The justified use of force defence, to prevent suicide or in self-defence, is not justified to prevent someone from seeking assisted dying (section 37(4)).

Offences for practitioners who do not comply with requirements

A medical practitioner, nurse practitioner, or psychiatrist commits an offence if they wilfully fail to comply with any requirement of the EOLC Act. Conviction of an offences carries a prison term of up to three months, or a fine of up to \$10,000 or a combination of both.

There are also offences for practitioners, and other persons who complete, or partly complete forms for others without their consent, or alter or destroy partially completed forms without consent. Conviction of an offences carries a prison term of up to three months, or a fine of up to \$10,000 or a combination of both.

If the Registrar receives a complaint about the appropriateness of the conduct of any health practitioner, they must refer the complaint to:

- a. the Health and Disability Commissioner, if it appears that the complaint alleges that the conduct of the health practitioner is, or appears to be, in breach of the Code of Health and Disability Services Consumers' Rights
- b. the appropriate authority, if it appears that the complaint relates to a health practitioner's competence, fitness to practise, or conduct
- c. the New Zealand Police.

Destruction of prescriptions that are no longer required

2. If an attending medical practitioner, or nurse practitioner holds a prescription and the medication is no longer required, they must immediately destroy the prescription.

Effect of assisted dying on contracts

3. A person who dies as a result of assisted dying is, for the purposes of any life insurance contract, or any other contract taken to have died from the terminal illness they suffered.

Safeguards to protect those providing assisted dying

Conscientious objection

A practitioner is not obliged to assist someone to exercise assisted dying if they have a conscientious objection to providing that assistance to the person – this overrides any legal obligation that might otherwise apply.

Immunity from criminal liability

Practitioners are not liable for aiding and abetting suicide 37(1), or any other liability under the Crimes Act, for the death of someone who seeks assisted dying, whether the death was the result of an action (e.g. administration of medication) or inaction (e.g. not seeking to revive someone who is dying) by that person.

Immunity from civil liability

Practitioners are immune from civil liability if they act in good faith (and believing on reasonable grounds) to assist someone to die, whether the death was the result of an action or inaction by that person.

Safeguards to protect the interests of the general public and the ongoing provision of assisted dying

Annual reporting

The Registrar must provide an annual report to the Minister and House of Representatives on the total number of assisted deaths (including a summary of the methods used), the number of complaints received about any breaches of the EOLC Act and how those complaints were dealt with, and any other matters deemed appropriate.

Restrictions on making public details of assisted dying deaths

Certain details of assisted dying deaths cannot be broadcast, including the method by which medication was administered, the place where the medication was administered, the name of the person who administered the medication or their employer.

Review committee

The committee must consider the reports sent to it and report to the Registrar whether it considers that the information contained in each report shows satisfactory compliance with the requirements of the EOLC Act.

The committee can direct the Registrar to follow up on any information contained in an assisted death report that the Committee considers does not show satisfactory compliance with the requirements of the Act.

Health Practitioners Competence Assurance Act 2003 (HPCAA)

The HPCAA:

- a. establishes responsible authorities for the various professions involved in the health system (e.g. medical council, nursing council, etc). Responsible authorities prescribe scopes of practice for their professions, set standards of competence, prescribe necessary qualifications, register practitioners and issue annual practising certificates.
- b. establishes professional conduct committees that investigate complaints made to responsible authorities. These committees can investigate individual practitioners' competence and conduct, as well as their compliance with the competence and scope requirements set by the responsible authorities.
- c. provides for the Health Practitioners Disciplinary Tribunal (the Tribunal) that hears and determines more serious cases against health practitioners. Professional committees can bring charges against practitioners to be heard by the Tribunal. Additionally, following an investigation by the Health and Disability Commissioner that has demonstrated that there has been a serious breach of the Code of Health and Disability Service Consumers' Rights, the Director of Proceedings may bring charges before the Tribunal.

Responsible authorities and professional conduct committees consider complaints about practitioners received from the Health and Disability Commissioner, employers of practitioners and other practitioners. They do not hear complaints from consumers or complaints made on the consumer's behalf in the first instance as they authorities must first refer any complaints they receive from or on behalf of consumers to the Health and Disability Commissioner for investigation.

At the conclusion of a review of a practitioner's competence, if it has reason to believe a practitioner fails to meet the required standard of competence, a responsible authority must order the practitioner to:

- a. undertake a competence programme
- b. have conditions imposed on their scope of practice
- c. sit an examination or take an assessment
- d. be counselled or assisted, and
- e. if there are reasonable grounds for believing that the health practitioner poses a risk of serious harm to the public by practising below the required standard of competence, or the practitioner fails to satisfy the requirements of a competence programme, the committee may suspend the practitioner until the Tribunal hears the case.

The role of the Health Practitioners' Disciplinary Tribunal

The principal function of the Health Practitioners' Disciplinary Tribunal (Tribunal] is to hear and determine disciplinary charges against health practitioners laid by the Director of Proceedings following an investigation by the Health and Disability Commissioner, or referred to it by a professional conduct committee.

The proceedings before the Tribunal are civil proceedings. The party prosecuting the civil charge before the Tribunal is required to prove it to the civil standard of the balance of probabilities. The Tribunal has stronger powers available to it than the conduct committees and considers more serious misconduct. The Tribunal can make orders when:

- a. the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or
- b. the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred; or
- c. the practitioner has been convicted of an offence that reflects adversely on his or her fitness to practise (these are offences which are subject to a period of 3 months or more, or involve breaches of certain listed statutes which are particularly relevant to practitioner practice, such as the Misuse of Drugs Act, the Burial and Cremation Act and others); or
- d. the practitioner has practised his or her profession while not holding a current practising certificate; or
- e. the practitioner has performed a health service that forms part of a scope of practice of the profession in respect of which he or she is or was registered without being permitted to perform that service by his or her scope of practice; or
- f. the practitioner has failed to observe any conditions included in the practitioner's scope of practice; or
- g. the practitioner has breached an order of the Tribunal.

The Tribunal can make one or more findings of professional or other misconduct – accordingly, a practitioner can be found in breach of one or more of the charges listed above.

Orders that are able to be made are:

- a. an order that the practitioner's registration be cancelled
- b. an order that the practitioner's registration be suspended for a period not exceeding three years
- c. an order that, for a period of up to three years, that the practitioner only practise in accordance with conditions as to employment, supervision, or otherwise specified in the order
- d. an order that the practitioner be censured
- e. an order that the practitioner pay a fine not exceeding \$30,000.00
- f. an order that the practitioner pay part or all of the costs and expenses of any investigation of the Health and Disability Commissioner, any inquiry by a Professional Conduct Committee relating to the subject-matter of the

charge, the prosecution by the Director of Proceedings or the Professional Conduct Committee, and the Tribunal's hearing.

Health and Disability Commissioner Act 1994

The Health And Disability Commissioner (HDC) is a New Zealand Crown entity responsible for promoting and protecting the rights of health and disability services consumers. Some of the key functions of the HDC are to:

- a. act as the initial recipient of complaints from consumers and consumer representatives about health care providers and disability services providers, and to ensure that each complaint is appropriately dealt with
- b. investigate, on complaint or on the Commissioner's own initiative, any action that is or appears to be in breach of the Code of Health and Disability Services Consumers' Rights 1996
- c. refer complaints or investigations on the Commissioner's own initiative to the Director of Proceedings, an officer established under the Health and Disability Commissioner Act for the purpose of deciding whether or not any further action should be taken in respect of any such breach or alleged breach
- d. make recommendations to any appropriate person or authority in relation to the means by which complaints involving alleged breaches of the Code may be resolved and further breaches avoided.

The Commissioner has jurisdiction to receive and investigate complaints in relation to any health service or disability service.

The Code of Health and Disability Services Consumers' Rights (the Code) establishes the rights of consumers, and the obligations and duties of providers to comply with the Code when receiving health and disability services. The Code is a regulation under the Health and Disability Commissioner Act and provides for the following rights:

- a. Right 1 - Right to be treated with respect
- b. Right 2 - Right to freedom from discrimination, coercion, harassment, and exploitation
- c. Right 3 - Right to dignity and independence
- d. Right 4 - Right to services of an appropriate standard
- e. Right 5 - Right to effective communication
- f. Right 6 - Right to be fully informed
- g. Right 7 - Right to make an informed choice and give informed consent
- h. Right 8 - Right to support
- i. Right 9 - Rights in respect of teaching or research
- j. Right 10 - Right to complain.

A provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights and comply with the duties in the Code. The onus is on the provider to prove it took reasonable actions.

The Code provides that "nothing in this Code shall require a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment". Accordingly, the provisions of the End of Life Choice Bill would take precedence over the Code if there was any conflict.

IN CONFIDENCE

Any person may complain orally or in writing to an advocate or to the Commissioner alleging that any action of a health care provider or a disability services provider is or appears to be in breach of the Code. This includes not only consumers, but also their families and other support people, and other third parties such as concerned staff members in a health or disability service.

The Health and Disability Commission (HDC) can investigate after an individual's death in relation to the care provided to that individual up until their death.

There is no limitation period for complaints to the Health and Disability Commissioner

A complaint can be made at any time and often there will be an extended period between when the care is provided and when the harm becomes apparent.

During an investigation, the HDC may consider oral evidence obtained during interviews with witnesses and parties, and documentary evidence such as correspondence, clinical notes, policy and practice manuals, and any other relevant evidence such as labelled medication containers. Where the quality of care is an issue, HDC will obtain independent expert advice from a peer of the provider with knowledge of, and experience in, the matters under investigation.

After an investigation, recommendations may be made to the provider, the appropriate authority (for example, a registration body), the Director-General of Health (the Ministry of Health), or any other person or organisation HDC thinks fit, including professional colleges, district health boards, ACC, and consumer and provider groups.

Recommendations to providers vary from case to case, but may include a written apology to the consumer, undertaking specific training; and implementing and reviewing systems to prevent further breaches of the Code.

In any case where, after deciding to investigate the action of a health care provider or a disability services provider, it appears to the Commissioner that the investigation directly concerns a health practitioner, the Commissioner must promptly give notice of the investigation to the appropriate authority.

The HDC cannot award damages, institute fines or take disciplinary action against practitioners. Where an investigation suggests that there may be concerns about the competence of a registered health practitioner, HDC may recommend to the registration authority (for example, the Medical Council for a doctor) that it consider whether a review of the practitioner's competence is warranted.

In a small number of cases, the Commissioner may refer the matter to the Director of Proceedings, to consider whether to bring disciplinary and/or other proceedings. The Director of Proceedings is a role established under the HDC Act that is independent of the Commissioner.

The Director of Proceedings can issue proceedings against a provider who is a regulated health practitioner by bringing a disciplinary charge in the Health Practitioners Disciplinary Tribunal. The Director of Proceedings may also commence proceedings before the Human Rights Review Tribunal. This would generally be when the provider is not a practitioner regulated under the HPCA Act or relates to a wider entity rather than an individual practitioner.

If a proceeding brought by the Director of Proceedings is successful, the Human Rights Review Tribunal may take any, or a combination of, the following actions:

- a. issue a Declaration that the Code has been breached
- b. order that the provider cease engaging in the offending conduct
- c. order compensatory damages be paid by the provider
- d. order exemplary damages be paid by the provider

IN CONFIDENCE

- e. order that any loss or damage is redressed by the provider
- f. order any other relief as the Tribunal sees fit.

PROACTIVELY RELEASED