Submission: Voluntary Assisted Dying (VAD) in the NT – Opposed - Please prioritise palliative care instead.

Key questions

(1) Do you support making VAD legal in the NT?

Summary: No. VAD demeans human life. Current common law and AMA's Code of Ethics should continue to apply.

I am very concerned to hear that the senate is considering legislation to allow euthanasia in the NT. Indigenous people are against it, and it violates norms held post-WW2 until now.

Under common law, all competent adults can refuse medical treatment. Some people refer to this as passive euthanasia and it has existed since the 1960s at least. The Australian Medical Association's Code of Ethics (1962) explicitly affirms a patient's right to refuse any proposed treatment. It is also permissible to administer (for example) medication for pain, even if administering that may hasten the patient's death.[1]

It is well known that there is a "persistent interest in saving money at the end of life" (NEJM, 24 Feb 1994). Also, there "are unavoidably higher costs in the delivery of health services in regional and remote locations" (WA Health, 2018). Similarly, palliative care has "major capacity and access problems" (RACGP, 28 Nov 2018). In addition, euthanasia "involves the risk of life of vulnerable people being regarded as less worthy" (Guardian, 15 Jul 2019). There are only ten palliative care physicians and 40 palliative care nurses in the NT (AI-generated from AIHW database, 2025). Telehealth will be an option for VAD (NT consultative document, 2025). In other words, there are economic incentives for governments to embrace VAD in place of keeping people alive. Note that a higher proportion of Indigenous people live outside major cities compared to non-Indigenous people (ABS, 2013 in AIHW, 2018).

[1] Australian Law Reform Commission (ALRC) (May 2014), "Informed Consent to Medical Treatment". In Equality, Capacity and Disability in Commonwealth Laws (Discussion Paper 81), Chapter 10, Canberra. Also, Australian Medical Association (1962), "Code of Ethics", Melbourne.

(2) What eligibility criteria should a person need to meet before they can access VAD?

Summary: VAD will make closing the gap even more difficult than it is now.

One risk is that VAD will become widely practised to deal with dementia, for example. Almost 0.5 million Australians are living with dementia (Dept Health, 21 Sep 2021). AIHW (20 Sep 2021) states "many Indigenous Australians perceive the condition [dementia] as a natural part of life and not necessarily a medical problem". However, this is contingent upon "health and aged care services ... transport options ... and ... culturally safe care plans". It is highly unlikely a trend to VAD will be an environment conducive to this. VAD for dementia rose more than ten-fold in the Netherlands, 2009-2017, i.e. in eight years (BBC, 30 Jan 2019). In Belgium, the rise was around 0.5% (2007, averaged) to 3.0% in 2013, i.e. a six-fold in six years (BMC Psychiatry, 23 Jun 2017). Rises in Switzerland are similar (Guardian, 15 Jul 2019). Just over half of Belgian GPs (i.e. >=50%) regard VAD as acceptable for "disorientation, reduced awareness of time, [and] increasingly worse recognition of loved ones", and a study concluded that "Belgian GP[s] [have] an open attitude towards euthanasia for patients with dementia" (BJGP Open, Nov 2017). This means that over time it is likely that many Australians could receive voluntary assisted death for dementia.

(3) How could the NT make sure that an eligible person can access VAD in a safe and effective way, including people living in remote areas, and Aboriginal and Torres Strait Islander people?

Summary: In NT, by comparison with all other States and Territories, VAD delivery will include the most minimalistic checks and supervision. To provide VAD for equality purposes in the NT is a furphy because personnel and budgetary requirements mean VAD will be delivered mostly by telehealth (telephone); VAD will divert funding from palliative care; and the regional, remote and Indigenous status of the majority of Northern Territorians mean VAD will be delivered with the most minimalistic checks and supervision.

Internationally, the "number of patients without terminal illness [who] obtain permission for assisted suicide in Switzerland [is increasing]" (Lancet, 20 Feb 2019). The Lancet article mentions five countries and estimated that "in 2017, more than 13,000 patients died through ... assisted death in countries where these practices are permitted." Statista (in Forbes, 12 Aug 2022) estimates a rise from 13,813 to 21,729 in four countries, 2018 to 2021.

Indigenous people warn that the introduction of VAD may weaken ties to their culture and will lead people not to seek out medical help when it is needed, particularly in remote regions. Authors have noted potential adverse effects since at least 1997 (Lancet, 28 Jun 1997). Euthanasia may also disproportionately affect military veterans (JVS, 29 Jul 2022), women (especially older women), and people with disabilities.

(4) How could the NT monitor the process to ensure VAD is delivered safely and effectively?

Summary: VAD, while "equitable", may be used more frequently in the NT than in most other areas of Australia, compounded by its rural and remote status (which is above average). This means that the "Closing the Gap" initiative may be damaged by "equity" through voluntary assisted dying in the NT. It is not possible to know when VAD will plateau in the NT, but if VAD does not plateau for a decade, up to half of all deaths per annum in the NT could involve VAD.

There are many cultural insensitivities and unaddressed fears about the introduction of VAD amongst First Nations people, but these concerns are either not being heard, or they are being overlooked and underestimated.

Table. AI VAD Projections for Five Years to 2028 (from 2023 Actuals in Calendar Years), Australia

Jurisdiction	Year 1	2020	2021	2022	2023	Years of Operation	CAGR (%)	2028 (Project
Victoria	256	427	646	855	1,097	5	53.4	9,320
Western Australia	–	–	263	356	474	3	34.3	2,069
South Australia	–	–	179	245	328	3	37.9	1,633
Tasmania	–	–	–	78	134	2	35.9	622

AI generated content may not be correct.

CAGR = Compound Annual Growth Rate.

Dashes (–) denote data not available.

Note: The 2028 figure is a projected figure. Projections assume each State's 2023 cases grow at its historic CAGR for five consecutive years. This differs from the 30% growth rate below, where the same growth rate (of 30%) is used for every State. Population and uptake plateau limits mean that the CAGR will slow or plateau eventually (that is, in less than one decade from 2023, i.e. before 2033). Legislative changes may also influence the actual future counts. Excludes States/Territories where VAD not yet operational (i.e. insufficient data exist).

Table. Number of people accessing VAD FY2021-22 to FY2035-36 assuming a +30% baseline rise p.a. (from 2023-24 Actuals in Financial Years), Australia

State/Territory	2021-22	2022-23	2023-24	2025-26	2027-28	2029-30	2031-32	2033-34	2035-36
Vic	407	443	554	936	1,582	2,674	4,519	7,637	12,907
WA	191	255	292	493	834	1,409	2,382	4,025	6,803
Tas	N/A	25	60	101	171	290	489	827	1,398
NSW	N/A	N/A	160	270	457	772	1,305	2,206	3,728
SA	N/A	39	156	264	446	753	1,273	2,151	3,635
Qld	N/A	245	793	1,340	2,265	3,828	6,469	10,932	18,475
ACT (estimate)	N/A	N/A	N/A	35	59	100	169	286	483
NT (estimate)	N/A	N/A	N/A	N/A	65	110	186	314	530
Australia	**598**	**1,007**	**2,015**	**3,405**	**5,755**	**9,726**	**16,437**	**27,778**	**46,946**

Current annual growth rates are used to derive the baseline estimate. Past increases may not be indicative of future progression. Some international growth rates are similar, but at least one country has a growth rate of "only" 5% p.a.

N/A denotes data not available. No data are available for ACT & NT so the figures given are estimates.

Note: The 2035-36 figure is a projected figure. Projections assume each State and Territory's 2023-24 cases grow at 30% p.a. for subsequent years. This differs from the CAGR above, which is based on each individual State's growth rates. Population and uptake plateau limits mean that the growth may slow or plateau eventually (that is, in less than one decade from 2023-24, i.e. before 2033-34). Legislative changes may also influence the actual future counts. The data for States/Territories where VAD is not yet operational (i.e. insufficient data exist) are estimates only. Actuals are unknown for these States/Territories.

It is not possible to know when VAD will plateau in the NT, but the above tables suggest that if VAD does not plateau for a decade, up to half of all deaths per annum in the NT could involve VAD.

Voluntary Assisted Dying was proposed to deal with long covid, which is now considered similar to other infection associated chronic conditions (National Academies Press (USA), 2024). This proposal suggests a possible ramp up of VAD to assist with chronic disease management in the future. NZ's MoH (Dec 2021) has stated that "in some circumstances a person with Covid-19 may be eligible for assisted dying", although it did not explicitly state that this could apply to people with long covid. Long covid is associated with suicidal ideation (QJM, 24 Jan 2021). In Australia's population about 4.1%-20.9% of long covid sufferers might be likely to seek suicide (AIHW, 5 Aug 2022) or assisted suicide, excluding the impact of a long covid diagnosis. The Indigenous rates would likely be higher than this (RRH, 31 Dec 2012).

Cases of ME / CFS treated with voluntary existed dying already occur in the Netherlands (BBC, 29 Jul 2024). This is often carried out in less than five years, which is a common period associated with some relief and stabilisation. There are around 200,000 Australians with ME / CFS and there is a "dearth of specialist primary healthcare professionals for ME/CFS particularly in rural and regional areas [such as the NT]" (BMC Public Health, 2022). The total number of Australians with infection associated chronic conditions may be as high as 6% of the population.[2]

[2] Assuming multiple conditions are the minority.

Mental illness might also be added to the list in the future, and it is already an option in Canada and at least six countries in Europe. This may be corroborated by the data that the highest percentage of all available categories of patients' reasons for VAD in Australia is "Less able to engage in activities making life enjoyable, or concerns about it" (70.9%), which was 1.6x those with "Inadequate pain control, or concerns about it" (44.8%) (Go Gentle, 2024).

One paper concludes "In six of the eight countries where EAS [euthanasia and assisted suicide] is currently legal, mental disorders are accepted as disorders for which EAS may be granted. In four of these countries, EAS in minors with mental disorders is also accepted. ... The majority of patients with personality disorders had tried some form of psychotherapy, but very few had received any of the relevant evidence-based treatments. The decision to grant EAS based on a perception of the patient's illness as being untreatable with no prospect of improvement, could, thus, in many cases fail to meet the due care criteria listed in EAS [euthanasia and assisted suicide] laws. ... there is ample empirical data to show that suicidal tendencies and behaviour can be treated and that they fluctuate rapidly over time. ... Moreover, we assert that this ... neglects the individual's potential for having a life worth living." (Borderline Personal Disord Emot Dysregul, 2020 Jul 30:7:15.)

First Nations Peoples are twice as likely to be psychologically distressed than non-Indigenous Australians. First Nations peoples are more than 2.5 times more likely to die by suicide (Beyond Blue, 2025). About one-quarter of the Northern Territory's residents identify as Aboriginal and/or Torres Strait Islander. Thirteen per cent of Australian Indigenous have a mental health condition (ABS, 1 Jul 2022). Three-quarters of people in the NT live in remote or very remote areas (NT Government, 2025). **This means that demand for voluntary assisted dying, while "equitable", may be significantly greater in the NT than in most other areas of Australia, compounded by their rural and remote statuses (which are above average). This means that the "Closing the Gap" initiative may be further damaged by "equity" through voluntary assisted dying in the NT.**

Additional problems with VAD legislation include the fact that it has been paired in some States with conscientious objection not being feasible, especially amongst trainees (BMJ, 48(8)); most countries have experienced an exponential increase (HEC, 2022); it contradicts the Hippocratic Oath's statement that physicians should not prescribe and plan lethal drug administration; it may disadvantage women under various cultural, economic, legal and/or religious perspectives, including the facts that more long covid cases are female than male (RACGP, 22 Jun 2022), dementia is more common amongst women than men (Harvard, 20 Jan 2022), and sex selection (in abortion) is already permitted in all States and Territories except NSW and SA (MSI, Jun 2022).

Due to the significant risks associated with this bill, I request that you please vote against the bill.

Thank you for your time and consideration in this matter.

Name withheld on request
From: [redacted]
Date: 29 Aug 2025

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NT Government (2025), "Population - Northern Territory Economy". [Based on ABS data. See especially Chart 10.]