LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

15th Assembly

LEGAL AND CONSTITUTIONAL AFFAIRS COMMITTEE

Public Hearing Transcript

10.00 am – 12.00 pm, Friday, 5 September 2025

Litchfield Room, Level 3, Parliament House

Members: Dr Tanzil Rahma MLA, Chair, Member for Fong Lim
Mr Matthew Kerle MLA, Deputy Chair, Member for Blain
Mrs Oly Carlson MLA, Member for Wanguri
Mx Kat McNamara MLA, Member for Nightcliff (via videoconference)
Mr Dheran Young MLA, Member for Daly

Witnesses: ***Australian Medical Association - Northern Territory***
Dr John Zorbas: President

Department of Health
Dr Paul Burgess: Chief Health Officer
Dr Jeremy Chin: Chief Medical Officer
Dr Kane Vellar: Clinical subject matter expert

The committee convened at 10.06 am.

INQUIRY INTO VOLUNTARY ASSISTED DYING
Australian Medical Association NT

Mr CHAIR: On behalf of the committee, I welcome everyone to this public hearing of the committee's inquiry into voluntary assisted dying. Today we are here to talk about issues that may be distressing as they relate to death and dying. We acknowledge that these discussions may bring up difficult emotions, so if anyone feels upset or needs support, we encourage you to take a break. Support services are also available. Their details are listed on our website and have been circulated here at this hearing venue. We thank all the participants and observers in the room for engaging respectfully in this important conversation.

I welcome to the table to give evidence Dr John Zorbas. Thank you very much for coming before the committee. We appreciate you taking the time to speak with us again today on relatively short notice.

I remind you this is a formal hearing—of the proceeding—and the protection of parliamentary privilege and the obligation not to mislead the committee applies. As this is a public hearing, it will be webcast through the Assembly's website and a transcript will also be made available for the use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you can ask the committee to go into closed session, and we will be happy to take your evidence in private if there are matters that you would like to speak to with greater clarity.

Could you please state your name and the capacity in which you are appearing?

Dr ZORBAS: Dr John Zorbas, President of the Australian Medical Association of the Northern Territory.

Mr CHAIR: Thank you, Dr Zorbas, and would you like to proceed to make an opening statement?

Dr ZORBAS: Yes, I will.

I refer the committee to the written submission that the AMA has tendered to the inquiry, which speaks to our main principles and recommendations but also to answer the questions on notice that were presented to me at the first inquiry session. I might quickly just reiterate those principles and recommendations in brief before we go to questions.

Four core principles that we have identified as crucial to a successful VAD legislative framework and program in the Northern Territory include, firstly, the primacy of high-quality palliative care. Investment in VAD must never be at the expense of or compromise investment in high-quality palliative care in the Territory. Nobody, no patient, should ever feel compelled to explore VAD because they are unable to access timely comprehensive and culturally safe palliative care in the Territory.

Secondly, the provision of robust and defensible safeguards—there are safeguards in all medical programs and procedures, but specifically for those who are particularly vulnerable, especially around the voluntary nature of VAD for both patients and practitioners and the provision of legal protection for all practitioners acting lawfully within the provisions.

Thirdly, there is the importance of workforce, support, training and resourcing. A safe and effective service can only be achieved, or is entirely dependent rather, on a medical and healthcare workforce that is appropriately trained and resourced with specific training on counselling, debriefing, capacity assessment and very clear clinical guidelines about the operational nature of the framework so that there is no area for misinterpretation.

Lastly, there should be a model tailored to the Northern Territory. Speaking at the last inquiry, we hope we made clear that a framework that is transposed from a model down south will not suit our needs. While there are elements that might be suitable for us, and we make reference to those in Queensland and Western Australia, simply replicating a model from somewhere else will not serve us, primarily because of our remoteness, our workforce limitations and very specific cultural needs in the Territory.

We have attempted to summarise our recommendations into nine. Again, in brief, for an Act of VAD legislation it is clear that there is community demand for it, and from the AMA's point of view there is a principle of equity of access of healthcare. We are the last remaining jurisdiction without a framework.

To fund palliative care, any funding for a VAD service must be accompanied by a separate protected and significantly increased funding stream for Territory palliative care services. We know that when VAD services are established, we see approximately a 30% rise in demand for palliative care services in that jurisdiction, and thus we should expect an increase in demand for our palliative care service.

Thirdly, we should adopt a centralised hub-and-spoke model so there is a hybrid model that allows us to benefit from elements that can be streamlined and centralised but recognise that there are elements of remote fact-to-face care that will only be delivered if we head out to where the demand is.

Fourthly, we should establish a regional access support scheme. This is simply a support scheme to fund the cost of travel and accommodation for patients. This is not dissimilar to services we already have in the Territory, such as the Patient Assisted Travel Scheme and thus it can probably be adopted with frameworks we already have.

Fifth, we should advocate for federal telehealth reform. We recognise that the Criminal Code prevents the use of telehealth for VAD services. This affects all jurisdictions and thus we will have peers in other jurisdictions to advocate for that change to the Criminal Code at the federal level.

Sixth, we should implement a competency-based practitioner model. Eligibility should be based on a combination of experience and completion of mandatory NT-specific training. The assessment should also require obtaining and documenting confirmation of diagnosis and prognosis from a relevant medical specialist for the diagnosis that the patient is presenting to the VAD service with. In terminal cancer, that would be an oncologist.

Seventh, we should reject mandatory psychiatric assessment. We were asked this question at the last inquiry and took that on notice. We do not believe that the legislation requires a mandatory psychiatric assessment. This is likely a holdover or inertia from the original Rights of the Terminally Ill Act. It is not a condition in other jurisdictions and more importantly we need to focus on capacity assessment rather than psychiatric diagnoses, which is a core skill of all clinicians, but in the case of VAD it needs particular attention.

Eighth, we should mandate pre-implementation codesign. We have spoken to the importance of a culturally safe program, specifically focusing on our remote and Indigenous communities, and partnerships required there over the 18-month period we have suggested for design and implementation.

Lastly, there should be establishment of an independent review board, which is also part of the 2024 report. It is important to have independent oversight of the operation of the Act, including mandatory reports on a quarterly or annual basis to the public on the performance of the VAD service.

Mr CHAIR: Thank you very much, Dr Zorbas. You were extremely efficient in communicating information last time, as you have been this time. We broadly find those recommendations extremely helpful to help guide us.

As with the first time you came and spoke to us, it is clear that the AMA, in principle, wants very much to support VAD services being available in the Northern Territory as a matter of good health practice and equity.

This committee has specific terms of reference. It is not just our obligation to determine in-principle support for VAD legislation but also the practicalities of it in the sense that we have been specifically tasked with evaluating different VAD models from around the country and NT-specific challenges to try to figure out a model that would work in the Northern Territory.

Today, we will dig right into exactly what that might look like because we have been in a chicken-and-egg conundrum of not wanting to prescribe essentially a law that could not be brought into effect, but similarly, lacking the guidance from clinicians and the health service in terms of what might be feasible.

Could you elaborate upon the summary and recommendations to give us an idea of a nuts-and-bolts version of what a VAD service might look like in the Northern Territory? We broadly—I can say on behalf of the committee—appreciate, understand and support these findings. We understand that there will be a need for extra help in palliative care and aged care, and there are other deficiencies in our health system. How could we have a VAD service introduced alongside that which does not compromise those things and does not cost the Earth?

Dr ZORBAS: Specific to infrastructure, staffing, equipment et cetera?

Mr CHAIR: All of the above.

Dr ZORBAS: Are we talking about a centralised service?

Mr CHAIR: It could be. That is up to you to determine.

Dr ZORBAS: That would be my statement. We think a centralised service in a hub-and-spoke arrangement is probably the only feasible setup. The reason for that is a completely centralised service that requires travel to Darwin for everything will have significant costs overrun, and a completely remote and per-case delivery basis dedicated to the patient is also incredibly expensive.

A hub-and-spoke model allows for an element of centralisation regarding the stuff that should be centralised, such as the type of medication that is used, the guidelines as to how those medications should be used across the Territory—NT-wide clinical protocols—and the governance of that system. But the actual delivery of the service—as we have referred to in our written submission—we have said two hubs—one in Darwin and one in Alice Springs. That is based on our current health service, with the five jurisdictions we have with the two larger centres and the two larger delivery services, being Alice Springs Hospital and Royal Darwin Hospital.

The reason for that is the ability to access clinicians and those peer networks for advice on prognosis. You need to be co-located, not physically but within that peer network and having access to your oncologists and palliative care physicians, also pharmacy. It is expensive to fly medications around the Territory and there are also specific laws in the Poisons Act about how those medications are handled. There are some benefits in having some centralised aspect.

Equally, it is incredibly difficult to have these conversations outside of remote communities where people feel safe. Part of our health system relies on us flying practitioners and doctors, nurses—everybody really—out to country and talking to people in places where they are comfortable with their family, where they have the benefit of making that decision.

We estimate—again, these are rough estimates—up to 20 patients in the first year of service. We are not talking huge numbers, thus we see the first 12 months of operation really being more of a trial of the operations and small enough numbers that we can be quite flexible and agile into where the hub ends and where the spokes start.

Mr CHAIR: Dr Zorbas, for 20-odd patients, I am concerned that we are going to end up recommending, by way of a centralised service, something that costs an enormous amount of money and will, potentially, come at the cost of other aspects of the healthcare service. That is the principle of equity that we are now trying to balance.

As a general proposition, the committee has felt that there may be a need for a legislative solution on VAD. The public submission we received from the Department of Health has given us some indicative figures, by way of comparison with the ACT, for any sort of centralised model, suggesting that, at a minimum, a centralised model would require a centralised VAD registry service, a centralised VAD service set-up, the care navigator service and the pharmacy set-up service, in addition to the review board for standalone governance.

The cost window for that at the moment, which we will dig into further with the Health department in the next hours, is somewhere between $1m and $20m. At a time when we are asking questions about why we do not provide maternity services holistically and why we do not have a standalone cardiology or paediatric service, how can we, as a matter of equity, justify for 20 or less people a $1m to $20m service on VAD with a centralised model?

Dr ZORBAS: I cannot speak to the estimates provided by NT Health and, therefore, cannot speak to the veracity of them. What I can say is that it has to be weighed up against the opportunity cost. If the opportunity cost of a—the alternates to a hybrid model are two non-hybrid models which will easily cost more than any form of hybrid model. I think that much is clear and that has been the experience across the other jurisdictions. A hybrid model would be our cheapest option. As to what the total cost is, I cannot really provide any support or refute what NT Health has provided in terms of figures.

Mr CHAIR: Sure, I understand that. What does a model that looks like a community-based model look like to you in practicality? Let me pitch to you a scenario. We have 1,400-odd doctors in the Northern Territory. If we had standalone governance and focused on robust standalone governance in preference to standalone delivery, if you like, could we allow for those 1,400 providers to opt in and out of participating in VAD services, whether as a coordinating practitioner, a consulting practitioner or an administrator?

Dr ZORBAS: If they meet the eligibility criteria we suggested, then yes. As long as the safeguards that we have placed importance on can be met, then yes, any practitioner who meets those eligibility criteria, has completed the mandatory training, is supported appropriately by whatever workforce measures we have in place, would be able to participate in VAD.

Mr CHAIR: If that was the case, the governance of that—at the moment, the Chief Health Officer of the Northern Territory has statutory powers—could the governance and the review board be situated within the Health department, in your opinion, or would that need to be independently located as well? I am asking you as the representative of doctors.

Dr ZORBAS: There is an argument that because VAD is such a final decision that independence is more important here than anywhere else in other areas of medicine that we practice. That is also true of palliative care, and palliative care sits inside NT Health. VAD has, as I am sure you have seen from the submissions you have received, there are moral and ethical arguments around the provision or the lack of provision of VAD services. I am not here to speak to those.

What I will say is that from an AMA point of view, a VAD service should be as independent as possible. If that means it reports directly to the Chief Health Officer rather than the internal structures of NT Health, that is probably our preference; that is not an absolute recommendation. That would be our preference.

Mr CHAIR: I understand that, and again, these are pointed questions and I appreciate you giving us very honest answers. I reiterate that if there is anything that you want to speak about *in camera* you can ask to do so at any point.

I am going to hand over to some of my colleagues now to give them an opportunity to ask a few more questions before I come back to you.

Dr ZORBAS: Could I just add one comment?

Mr CHAIR: Absolutely.

Dr ZORBAS: On the expense figures that have been provided, I wonder if the central aspects have been overestimated. When we pitch a central and like a hub-and-spoke model, really the essential parts of the hub are a senior physician who has oversight of the governance of the program.

Mr CHAIR: And that person is a medical clinician?

Dr ZORBAS: That is a medical clinician and that is someone who …

Mr CHAIR: A palliative care physician?

Dr ZORBAS: Most likely experienced in palliative care, not mandatory.

What we find around the jurisdictions is the doctors who work in this space have a special interest in this area. Sometimes they are palliative care physicians, sometimes they are other clinicians with a diploma in palliative care, sometimes they are not palliative care physicians, but this is their passion, an area they are experts in, and that is where they dedicate their continuing professional development towards, thus they are the best clinicians to run this service. You need that person to exist to make sure the clinical protocols make sense, that they meet the medical board's code of conduct and the provisions of medical care across Australia. That is one person, and not necessarily at one full-time equivalent.

You will also need again a central figure in the nursing space, whether that is a nurse or a nurse practitioner, and a pharmacist. We have also suggested that there is an Aboriginal healthcare practitioner or Aboriginal liaison officer, someone who can represent that cultural care aspect.

That is one hand's worth of people; it is not a lot. I appreciate operationally, to your question about who can participate, but we should absolutely leverage the resources we already have; the staff we already employ in NT Health around the NT. But the central aspect, I suspect, less focus needs to be on what is done at a strategic level within say, Health House, and more on the actual operational nuts and bolts. I think there are probably costs that can be saved there.

Mr CHAIR: I am just going to follow up to that before I hand over. Those four people as it were then, can those four people maintain credibility as a standalone centralised service partitioned from palliative care and the rest of the health system if their FTEs are split up?

Dr ZORBAS: They will require support from the health system in areas that are already synergistic across the health system. What I mean by that is my IT services inside NT Health when I am there as a practitioner are under the control of DCDD. They would need the same access to those other government services that provide multi-agency …

Mr CHAIR: Administrative support aside—which I take your point—my concern is those four people you have identified there, essentially a doctor, a nurse, an Aboriginal health practitioner and a pharmacist, you mentioned; we are in short supply of all of those things as you know better than anyone.

Dr ZORBAS: Yes.

Mr CHAIR: If we were to have four standalone people like that as part of a VAD centralised team, would those four people be reasonably able to do other work or would that contaminate the independence of having a standalone centralised partitioned service?

Dr ZORBAS: If we call it four FTE it probably makes more sense. We can have four full-time equivalent practitioners; that may end up being eight practitioners who work 0.5 across other services. If someone is in a central governance role, I do not think we could support them working inside the VAD service for less than 0.5. If you are a director of a service, you need to be present; it is not a 0.2 or a 0.3 type of job, whereas their clinical work could be split across services that look like fractions of 0.2 or 0.3.

Mr CHAIR: Could the clinical work for those four people be in areas like palliative care or aged care?

Dr ZORBAS: Correct.

Mr CHAIR: It could still do that and you do not think that would compromise integrity or …

Dr ZORBAS: I will explain why. We already have a very thin workforce and we have people who wear lots of hats inside this workforce. Myself as an example, I am trained as an emergency physician. I am dual trained; I am trained as an intensive care specialist. I work across both those services currently inside NT Health. The benefit to that is that a lot of my clinical support or administrative portfolios allow me to serve two bodies at once where the overlap is. For critical care in the emergency department and in the intensive care unit I am able to speak to both. It also means I have the trust of my peers and my colleagues in that service as well.

We have said that these services need to be separate, and what we mean by this is the public-facing side of this service and the infrastructure of the service. In the same way that Clinic 34, which is our clinic for sexually transmitted diseases, is branded separately, looks different, feels different, has different arms of communication and is forward-facing to the patient in that way, gives them comfort in approaching it thinking that it is separate to the emergency department, separate to the hospital, separate to the other clinics and the other doctors I see. That is absolutely important, and the VAD service needs to follow those same principles.

I think it would be unlikely to be able to stand up a service with practitioners who (a) do not work across other areas in NT Health because of the workforce challenges you have alluded to, but (b) peer confidence in the service as well. We need clinicians who have the trust of other clinicians inside NT Health, opinion leaders in our service who are respected but also people here who understand the challenges of delivering healthcare in the Northern Territory. You cannot understand that challenge without working inside the NT.

I see it as a benefit. I see it as entirely feasible. I do not think there is a conflict of interest per se. I think it is unlikely that a patient will see someone with—there is potential overlap in seeing someone for a VAD appointment and then seeing that some practitioner for palliative care. Now we could put a protocol in place or a guideline in place that would prevent that from occurring. That is something we should consider. But the FTE can be split and, moreover, we would suggest that overlap is actually helpful to the service rather than harmful.

Mr CHAIR: Thank you, Dr Zorbas. That is very handy.

I am going to hand over to my colleague now.

Mr YOUNG: I just had one question around the practicalities of implementing VAD, especially around when you talked about the centralised services for potentially Darwin and Alice Springs. We have heard many people—obviously, we have been travelling out to remote communities. How would you see on a practicality level if someone from Borroloola, for example, wanting to go down the line of VAD then takes that option? We have heard many people with palliative care wanting to go back to country and pass away. But if someone had the desire to administer VAD on country, how would you see that in a practical sense? Probably overlaying back to what the Chair was saying to ensuring that there is no overlap with doctors and nurses because of sensitivities in communities.

Dr ZORBAS: Somewhere like Borroloola is a very hard place to reach with our current services. It is not uncommon for people to have to fly back to Royal Darwin Hospital via CareFlight or via charter to receive whatever that service might be. VAD would be in that same bucket. We are not talking about an order of magnitude change to expenditure because we already do it today for people attending, say, a fracture clinic appointment or an oncology appointment or whatever it might be.

We already have incredibly high centralisation of our specialists. Where we have a high demand for a service in a particular area, we fly the specialist to them. We see this especially in services like paediatric cardiology where the cardiology team will fly to a community. We will have an open list, essentially. We try and make bookings, but if someone who needs to be seen rocks up to be seen, they will be seen. We are flexible.

For somebody in Borroloola, because currently it is important legislatively to use telehealth, they would have to be face-to-face consultations. That could either be the patient flying to—for Borroloola, that is Top End, so they would come to Darwin and go through our already existing PAT scheme to make an outpatient appointment with the VAD service, wherever the VAD service might be located. Or the VAD practitioner flies to them if there is justification for flying the service to the community; that is, a high number of people who are using it, or East Arnhem if three potential VAD patients fly to Gove and the practitioner goes to Gove to see them there. That is potentially an option as well.

To answer your question about the delivery of the VAD, death on country is absolutely a critically important part of culturally safe practice. That would require the delivery of the medication and the practitioners who will deliver that medication to Borroloola. That expense or structure, we are talking about a nurse plus/minus a pharmacist flying to the community—again not that different to what we already do with medical charters at the moment. Expensive, but it is an expense we already wear, so it is business as usual for the Territory in our current operations. This is not a new expense. The workload will be a new expense, but the structure will not be.

Mr YOUNG: Just a quick follow-up question around telehealth because we went to a number of communities and some had really good telehealth services; others did not so much. Just to clarify, are you saying a telehealth service probably would not be a way of consultation around VAD generally?

Dr ZORBAS: The trouble with telehealth is that it is a significant resource multiplier. For a jurisdiction like the Territory, it is hugely helpful in terms of minimising expense whilst still being able to deliver safe and quality care. I recognise that telehealth is not for everybody in every situation. I think if a patient who was pursuing VAD did not want to—this is hypothetical because we cannot do it at the moment anyway—use telehealth and wanted to attend face to face, I do not think we could refuse that request for something as important as a decision to enter into VAD.

In a perfect world where telehealth was permitted, the suggestion we have made is that at least one of those two mandatory appointments or assessments for VAD—at least one—would be able to be done by telehealth. Why not both? We still think there is importance in face-to-face assessments, especially around psychosocial elements of

discussion that we have with people to ensure that voluntariness and capacity are there. It would be technically possible to be a completely telehealth service if the legislation permitted it. Our preference would be for at least one face to face. I suspect most patients would prefer two face to face.

Mr YOUNG: That was going to be my next question, around face to face. That is all I have got.

Mrs CARLSON: I have got a follow-up question on the telehealth, just an overall generic question. In some instances where we have been remote, some of the health services have declined over time due to remoteness and staffing issues. I want to confirm that the telehealth in the Northern Territory is actually getting better, more use, or are there still some limitations or is it getting worse? I want to know if it is actually getting better if we do try to go down that path and advocate for it.

Dr ZORBAS: NT Health will be able to provide you with their position. I will say from the doctors' perspective …

Mrs CARLSON: Doctors' point of view, yes.

Dr ZORBAS: … and the feedback we get from our members is that it is deteriorating. That may not necessarily just be infrastructure; in fact, it is usually training and workforce support. Someone who has been in the community for two days is not familiar or has not been trained with how to use the telehealth system, so the cameras might work but if the people attached to them cannot use them, then it is—you know.

The points of failure in telehealth have gotten higher and higher over time. It is definitely more fragmented than it used to be. This will be more fragmented as we move to more NT Health clinics transitioning to ACCHOs rather than being NT Health operated. We see more of a fragmented landscape being an issue.

The AMA's position on IT in healthcare is that we have a fundamental problem with the structure of health IT in the Territory; that is, that almost all decision-making around health IT infrastructure has transitioned to DCDD and there is less and less advocacy in role for the specialists in NT Health. By specialists I mean frontline clinicians—doctors, nurses, allied health. I am not just talking about doctors here. They are not able to inform the projects, are unable direct the projects, and the priorities of NT Health are being outcompeted by the priorities of DCDD. This is not an insult to DCDD; this is simply a reflection of what this fragmentation has done to frontline care.

Mr KERLE: Going back to that scenario you mentioned before where, say, someone in Borroloola would like to access VAD, you were talking about a centralised service. Let us say if they have terminal cancer, they are already travelling using PATS, the patient transport scheme, to come in for specialised care. If we looked at a community model where any doctor or specialist could be accredited or certified to engage in VAD and be the consulting practitioner, would they be able to—say, if the GP who they were normally dealing with and the specialist who they were dealing with as part of their illness, if they were willing to certify as VAD practitioners and assist the person, would they need to consult a centralised service, or would they be able to just use the practitioners they are using to treat their illness?

Dr ZORBAS: Both. What I mean by that is the operational side of things absolutely could be delivered by the local practitioners. If the doctor and nurse are trained, competent, under that centralised framework, then that would be fine. Even the delivery of medication at that point—it becomes cargo rather than moving a patient or a person, so that is significantly cheaper.

However, the safeguards have to be centralised. They would have to operate under centralised protocols that are designed under the governance of the centralised service. I think this is potentially the difference in our position and NT Health's position; we see the central aspect of this as being quite small.

If we have no uptake in the communities from practitioners who are willing and trained to deliver a VAD service, then, yes, it would rely heavily on that centralised service and be very expensive. If we do have uptake, especially as we develop regional hubs—it may be that you are in Groote and there is nobody in Groote but there might be someone in Nhulunbuy. The safeguards, the protocols, the guideline that those practitioners access and the education they receive, the credentialling they undergo—that is the centralised aspect of the service.

The hybrid model allows for both.

Mr KERLE: That is excellent actually. You nailed the answer to my question there. On that one, do you see much overlap between the review board and the centralised oversight that you just talked about there?

Dr ZORBAS: The independence of the review board I think is a really important part of the openness and transparency that we will need for a service like this. Despite VAD being incredibly popular with the people who have elected you, basically, there is still very strong opposition around moral and ethical grounds, so anything we have to do has to be very open and transparent. Everything we do should be, but in this case in particular, we really have to cross our 'T's and dot our 'I's.

I think the independence of that review board is paramount in that respect. I see the VAD service as providing the reports and the review board as being the scrutiny, therefore they probably should be separate.

Mr KERLE: The evidence of the AMA that you are giving is centralised governance and oversight and then a separate review board. Now, if you would indulge me for a second, I have some questions about your opinion on the makeup of the review board. I have been doing some reading recently about the child death review committee, which I assume you are aware of. That is appointed by the minister, but it has some recommendations about the makeup of the committee. I was looking at that as a template of what our review board might look like. Do you have any suggestions on recommendations for the kind of makeup that should be on the review board? Like key roles that should be there?

Dr ZORBAS: Our recommendations are high level, but in terms of key roles it should be a senior medical practitioner with expertise in VAD; a senior nursing practitioner with expertise in VAD; a senior pharmacist with expertise in VAD; a senior Aboriginal healthcare worker or representative of Aboriginal care, especially in the regions; and a senior legal representative with expertise in VAD. That is very high level, and I do not think I would be able to give you more of a drill down. While I am familiar with the child deaths review committee, I do not know the complete membership off the top of my head.

Mr KERLE: That is okay, and it has changed a bit. We have discussed the FTE requirements around the oversight in governance, and we have said that less than 0.5 would probably not really work, but in terms of the review board, would you see that as being something that could be existing people who are brought together at regular intervals to review the material submitted to them rather than a full-time job?

Dr ZORBAS: Yes. It would function similarly to, let us say, the medical board where you have monthly board meetings. There is a body of administrative work behind that supports that, but ultimately it is one day a month where the meeting takes place.

Mr CHAIR: Dr Zorbas, you have been very thorough, as always. We are deliberately going over time, and we appreciate your extra time. I will pitch three short questions to you to be able to answer as best you can.

First of all, as a ratio of expenditure or infrastructure, how much extra palliative care investment do we require if we are to install the VAD service?

Second is could we use practitioners in South Australia and Queensland as consulting physicians, not as coordinating practitioners or administrating practitioners, but as consulting practitioners to be able to verify a diagnosis on a second stage?

Thirdly, physical locations—we have learnt that place matters significantly. We had submissions from places like the Alice Springs Hospital saying we do not want VAD services to be conducted on health premises because we do want people to be scared from coming to our premises. Where would be conduct VAD services in terms of administration? Do we need a purpose facility?

Dr ZORBAS: On question one, the other jurisdictions and experience suggest that we would see roughly a 30% increase in demand on palliative care.

Mr CHAIR: Thirty per cent?

Dr ZORBAS: Thirty per cent. Now that is over—there is an exponential increase in the first three years. While the first year is very easy to manage, it is the second and the third year we see that huge increase in demand. I think it is fair to say that 30% is huge. I would defer to directly liaison with the palliative healthcare physicians, but 30% effectively is the increase in demand, therefore I would expect the resourcing would be around the same.

Mr CHAIR: On the second issue of whether we might be able to rely on expertise elsewhere for a consulting practitioner?

Dr ZORBAS: The answer is yes. For prognoses and confirmation of diagnosis any appropriately trained specialist who also met our eligibility criteria, I think it would be suitable; however, it should be done in concert or at least have some element of peer discussion with a local specialist so that there is an understanding of what services can be delivered here and cannot be delivered here. There are some high-level treatments that we do not have the infrastructure or skill set to deliver in the NT. To make a final decision about VAD I think you need to appreciate all the treatment options you have available to you. So, it is a yes, but there would have to be some peer discussion with our local oncologist.

Mr CHAIR: As a footnote to that question, is it currently the practice that you consult with or gather the expertise of people in other jurisdictions to help with clinical matters in the Northern Territory? Are there any protocols for that?

Dr ZORBAS: Yes.

Mr CHAIR: There are. So we could extend similar protocols or would we need new protocols for that?

Dr ZORBAS: It would be easy to do because it is done at the discretion of the clinician. We do not need overarching protocols necessarily. An example would be cardiothoracics. We do not have cardiothoracic surgeons on a permanent basis in the Northern Territory. However, all our clinicians are equipped to know when we need to consult for a

cardiothoracic opinion, and we would do that on a case-by-case basis. We already do that, and there is no overarching need for a protocol. That would just fall under the code of conduct and current medical practice.

Mr CHAIR: But there is no legislative prohibition working across jurisdictionally?

Dr ZORBAS: No.

Mr CHAIR: Even if it was in relation to VAD?

Dr ZORBAS: I would have to defer to a legal opinion on that …

Mr CHAIR: I think we would need to check that one as well. I think there is a restriction there.

Dr ZORBAS: Whether that is a Commonwealth or a local jurisdiction, I am not sure.

Mr CHAIR: The final one—physical location.

Dr ZORBAS: Separate from our health facilities, that has been consistently and strongly expressed by all members who have reached out to us. In terms of what that physical infrastructure looks like, it needs to be like any other NT Health outpatient clinic-type of set-up, so what would be suitable for a healthcare facility at an outpatient level. That means secure storage and transport of medications. There would be some element of safe and lock-up and security there, and the way administration is set up, the ability to access the Health IT services, that kind of infrastructure. We are not talking about significant medical infrastructure, like oxygen, suction, the required number of GPOs, sterile or clean areas. We do not have to go that extent.

Mr CHAIR: Dr Zorbas, we are running short of time. My colleague Kat McNamara, the Member for Nightcliff, is online. I will pass to her to ask a question.

K McNAMARA: Just a super quick question. Dr Zorbas, I have noticed the AMA NT's submission—really thorough—the point about cultural safety and co-design. I was wondering if there was an example you could point us towards or perhaps briefly mention how—is there other areas of NT medicine, like programs, that have been co-designed in a way that you think is appropriate that you could point us towards as a reference?

Dr ZORBAS: It is a small project, but it is a recent one. That was the ED waiting room redesign project. That was a local, internal to the department, restructure where doctors, nurses and the Aboriginal liaison officers and the office of the Aboriginal liaison officers inside Royal Darwin Hospital redesigned the waiting room and sought culturally appropriate artwork, templates, language, welcome videos to explain the process as you make your way through the emergency department. It is hyperlocal.

I suppose what it speaks to is that we already have frontline clinicians such as our Aboriginal healthcare practitioners and Aboriginal liaison officers who already have these connections in place. I think if we get too high level we are going to get disconnected from what really matters to our patients.

Mr CHAIR: Dr Zorbas, in the interests of time, we are going to wrap up because we have got a short turnaround before we have our next witnesses come to speak with us. It is improbable that we will ask for further written information on the timescales that we are being compelled to work under at the moment.

We thank you for being so generous with your time on short notice and providing us very clear testimony to help us inform our discussions. Thank you, on behalf of the committee, and we look forward to continuing the progress on VAD together.

Dr ZORBAS: Thank you for the chance to appear and thank you for listening to the voice of your doctors.

Mr CHAIR: We will move straight on to the next set of witnesses without taking a break, I think. If everyone wants to make themselves comfortable and stretch their legs for two minutes while we transition.

Department of Health

Mr CHAIR: Good to see you all. Thank you for joining us.

On behalf of the committee, I welcome everybody to this public hearing of the committee's inquiry into voluntary assisted dying. Today we are talking about issues that may be distressing as they relate to death and dying. We acknowledge that these discussions can bring up difficult emotions so we always say to everybody, no matter who they are, if you feel upset or need support and need to take a break, please let us know and we will be happy to do so. We also have support services available both in writing and on our website and circulated in this hearing venue. We thank everybody for taking the time—participants and observers—and respectfully engaging in the important conversations we are having.

I welcome to the table to give evidence to the committee again Dr Paul Burgess, Chief Health Officer; Dr Jeremy Chin, the Chief Medical Officer; and Dr Kane Vellar, clinical subject matter expert. We could add lots of extra titles to you, Dr Vellar which are not listed here.

Thank you for coming before the committee today. We appreciate you taking the time to speak to the committee and look forward to hearing from you. This is a formal proceeding of the committee, and the protections of parliamentary privilege apply, as does the obligation not to mislead the committee.

This public hearing is being webcast through the Assembly's website. A transcript will be made available of the use of the committee and may be put on the committee's website.

If there is anything you would rather not be made public in what you want to say, please let us know and the committee will consider going into a closed session to take your evidence in private. I reiterate that point because we are looking to have a frank conversation with you about how to make VAD work. If, at any time, you feel that you would like to speak with us in confidence then we would be open to having that conversation.

Could you please state your names for the record and the capacity in which you are appearing for the audio.

Dr CHIN: Jeremy Chin, Chief Medical Officer, NT Health.

Dr BURGESS: Paul Burgess, now the Chief Health Officer.

Mr CHAIR: Congratulations.

Dr VELLAR: Kane Vellar, clinical subject matter expert, Department of Health.

Mr CHAIR: Gentlemen, would all or any of you care to make an opening statement? No, we can dispense with that. Let us get straight to the good stuff. We have time, but we also have significant questions. I will begin by, I guess, starting straight into the deep end.

Our concern as a committee is not just to assess whether or not there is in principle support for voluntary assisted dying. As a matter of equity we all believe generally speaking, that there probably is in principle support. Our mandate and remit is also and our directions by terms of reference, are to interrogate models around the country and to look at how it might practically work in the Northern Territory and specific challenges for the Northern Territory.

We have identified a number of those as a committee. We want to have an iterative discussion with you today about how to make this work, noting that last time you were all extremely helpful. Do not take it the wrong way, but we were in a little bit of a chicken-and-egg conundrum of, 'You tell us what the law is, and we will tell you how to implement it', and us saying, 'Tell us what you can implement and then we will try to make sure we can suggest a law that is useful as opposed to prescribe something that may be unrealisable'.

The crux of the issue is this: by everyone's estimation, 20 or less people might access a VAD service based on statistical projections if we were to have a VAD service. We are hundreds of millions of dollars in our capacity deficit in debt in relation to staffing costs on health. There are questions in the community about primary healthcare, maternity, palliative care, now we know, and aged care as well, which we have seen in person in the flesh as a committee.

Your second submission to us in writing, which provides some numbers relevant to the ACT VAD implementation, suggests that to go down the model of putting up a standalone service of some description might cost anywhere between a pretty wide bandwidth of $1m and $20m. I know that those figures that you provided are very high level and indicative of not necessarily reflective of exactly what it would cost us to put a healthcare service in place, but to cite from what you said here, the ACT had an initial budget forecast of $19.2m allocated for the establishment of VAD and recurrent cost from 2024–2025 into 2027–2028. This covered the VAD registry setup, the VAD service setup, the policies, care navigator setup, pharmacy setup and VAD review board.

We would very much like to support a model that will provide equitable access but also realistic and prompt access for Territorians, so today that is what we would like to dig in with you about. The 2024 report we are starting to feel may not have turned its mind to practicalities quite as much as we are being asked to turn our mind to practicalities.

Let me pitch this to you and tell me how this might work. We are now increasingly thinking about standalone governance as a priority rather than a standalone delivery. If we were to use our network of 1,400 doctors across the Northern Territory, how might we have standalone governance to enable those 1,400 practitioners to opt in or out of the coordinating consulting or administrating practitioners?

Dr BURGESS: Thanks, Member for Fong Lim, for that opening statement. There is a lot in there. I think just to go back to one of your earlier points about a possible caseload of 20, that would be people who probably would complete the process with VAD, but there would be many more—and we made that point in our submission too—who consult the service and choose not to go down that pathway but that still requires staff time and consultation and probably several visits to make decisions. That is quite normal with any new service.

In terms of our second written submission, I think what we are trying to assist the committee is to think about what needs to be done in the legislative drafting process, and I think it setting up the authorised environment and the governance—the authorised environment for the safety use of medications and the training credentialing of practitioners, but also importantly, an independent review board that can monitor the statistics of abuse for the VAD service and over time hopefully give guidance about improving the service with relevant input from consumers and practitioners.

Your question regarding practitioners is a good one. My experience interstate, having done VAD training, is often clinicians who already have a role, but see this as important to them personally as providing a service to their patients, will often undertake the training, but it is not all they do.

We will see this, particularly within our general practitioners, many of whom do not work for NT Health, but they work as private businesses, who see this as a duty of care to their community and patients, that they want to be in some ways coordinating or sometimes even participating. That is up to the personal choice of those practitioners. That is quite common interstate where VAD has been implemented. So, I think the number of clinicians might be slightly larger. Not all clinicians will want to do this training. Some will have their personal beliefs and conscientious objections to being involved in this. That is well understood.

I think you were interested in the money story. The key message is there will be significant front-up costs in terms of establishing governance, training, regulatory environments and the safety and the guardrails. That is the same with any new service that gets stood up. The ongoing and recurrent costs will be marginal compared to the set-up costs. In our written submission the $19m-odd from ACT was over the three-to-four year period and then the recurrent cost was $1.6m per annum.

It is clear with our current fiscal position we are probably unable to absorb those costs. There are significant efforts now for budget repair and we hope that will be somewhat successful into the future. Regardless, we are looking at a significant investment to establish both governance and centralised functions of pharmacy, product safety, training, credentialling and supervision of practitioners who participate.

Mr CHAIR: Dr Vellar, do you want to add to that before I dig further?

Dr VELLAR: No, go ahead.

Mr CHAIR: Sorry; I briefly lost my train of thought.

The President of the AMA who has provide testimony to us twice now and in writing as well—I asked him essentially as well, as a ratio of expenditure on infrastructure or otherwise, how much extra investment would be required in palliative care if we were to introduce a VAD service. His estimation was a 30% mark-up.

We are clear, as a committee, from our time out in remote areas, that there is a profound need for extra palliative care help and potentially aged-care help as well. That is not within our remit to necessarily legislate about, but it is within our remit to discuss in our report.

In addition to $20m to set up a service in ACT, plus $1.6m recurrent, we know that every other jurisdiction has also had an exponential rise—I think 'exponential' is fair to say—in demand for palliative care services when you introduce a VAD service. What then does the real cost, in money figures, of putting in a VAD service look like?

Dr VELLAR: From the perspective of palliative care, if we were talking about a 30% increase in running costs that would be a substantial increase overall for budget funding for palliative care. At the moment—I think we went through that last time—some of the medical FTE available for Top End palliative care and Central Australian palliative care, we would foresee that would need to be expanded to at least have additional specialist services and clinical nurse consultant capacity to be able to visit remote communities and be able to provide education services to GPs. It is often a hub-and-spoke model whereby the specialist service provides support to the primary healthcare clinics

We do know that is woefully insufficient at present and does need attention. It has been an issue that, from a personal perspective as well as working in that area that we see an urgent need for that. However, there are always budgetary constraints and conflicting priorities which mean that it is difficult often for everybody to be satisfied with what is only a finite slice of the pie available to fund these services.

Certainly we would expect you would need additional clinical staffing and travel-related costs which would be quite an additional on-cost to NT Health. That would be in the order of potentially $1m to $2.5m if we were to fully service FTE in terms of specialists and nursing staff with those on-costs to the department as well as a travel budget.

Mr CHAIR: Drs Chin, Burgess and Vellar, I reiterate we are not here as bean counters and we are not looking to frustrate the process in any form. What the committee has found is great interest in the idea of a good death, however that might look like. For people in Indigenous communities, to some extent, what we have learnt about is that people are interested in the idea of help and choice to finish up well, particularly on country.

There are significant cost imposts that we have just discussed here and that we are being quite transparent about. From the beginning we are very grateful for the fact that you came in here and said we could only do this with a lot of extra money and a lot of extra people, or at least some extra money and some extra people, to make it work.

We are trying to work out what version of that works best, and a community-based model where we utilise our existing web of providers and do not demand too much of the healthcare system centrally may be our most realistic way forward, notwithstanding that we would love the Rolls-Royce of a standalone set of X number of FTE made up of doctors, nurses, pharmacists and cultural safety officers to be able to provide a fully partitioned service independent of palliative care and the healthcare system.

Help me understand here what a workable model is in terms of FTE and providing a standalone service that has credible separation from the rest of the system.

Dr BURGESS: I think in our written submission there are elements that are useful to be standalone and, particularly, I think a paper has been shared with the committee around the navigator service. We all understand the high turnover of clinicians and practitioners in the Northern Territory, and having a navigator service is really important to help patients who may not be able to navigate that system where there are lots of moving parts and changes in personnel to get through and to coordinate with a central registry of qualified and trained providers who are signed up to do that.

In terms of FTE, I think that for me would be an essential element of a VAD and navigation service. It can really help clients not waste time. Clients are unwell, their families are worried, and we need to give them all the assistance to get through this process with minimal bureaucratic construction as possible. I think that is a core component.

Referring to the other components of the model in the 2024 report, the assessment by medical practitioners, again, I think a realistic model in my perspective as a GP who has an interest in palliative care and also in my patients having a good end-of-life journey, I would be very happy to be at least one of those coordinating practitioners, but not all would be. I think it would be interesting to see what the uptake would be from our clinical staff already in existing clinical roles who have a sense of duty of care for their clients throughout the whole life journey, including end of life.

However, it does not obviate the need that we need this navigation service and the centralised registry of providers so that we can minimise any time delays for sometimes patients who have critical issues and critical illnesses.

Mr CHAIR: Again, Dr Vellar, you brought up some salient points about PATS travel. Dr Burgess, you pointed out that even if there are only 20 people who complete the VAD process, there may be, let us call it hundreds others …

Dr BURGESS: About 100 a year.

Mr CHAIR: About 100 a year who may otherwise be making active inquiries in that space. The demands on PATS are already significant, and we have heard testimony to the effect of people wanting to finish up on country and sometimes not being able to make it back on time, which again is an extra layer of complexity we are adding here. One way that we thought we may be able to work around that is, when you are thinking about consulting practitioners, whether we may be able to use networks of providers in Queensland and South Australia to help us take some of the pressure off the system without incorporating all new FTEs into our set up. How do you guys feel about that?

Dr VELLAR: I guess from that perspective it would need to think about what elements we would need to potentially outsource if that was indeed medical practitioners that would require them to perform or undergo the appropriate training under the NT legislation, which is what is required of each practitioner to their relevant state currently. That would probably be a model that when that was considered previously there were some cultural concerns given that we would potentially have practitioners coming from other jurisdictions without the understanding of remote Indigenous Northern Territory cultural aspects of care.

We felt that it would be important to have practitioners who are locally based or, having had sufficient experience within the NT context, to be part of a proposed panel of medical practitioners who could participate in VAD. That would not necessarily require ongoing FTE, but as sort of a panel whereby you would be requested, as one of a number of practitioners, to potentially participate. A process where that could be managed through an existing medical officers' EBA so that those who wish to participate could come on in a casual capacity to perform the roles required for VAD locally. Then we would be satisfied that they would have the relevant knowledge and experience at the local context. That is one aspect for the medical practitioner side.

There are a couple of other aspects which Paul spoke to which are essentially non-negotiable and essential to any VAD service, as you probably have become aware of, regarding the navigator service with nursing capacity and pharmacy services to ensure appropriate safeguards in the dispensation and administration of medications.

Mr CHAIR: Clearly there are some aspects that we cannot outsource. Clearly, there are some aspects that we cannot rely on the private market, even in primary healthcare, to cover off in the Northern Territory. We are trying to work out how much the Health department can do without overburdening it.

One of the novel aspects of what we are dealing with in the Northern Territory is submissions that clearly say that if this is to happen we do not want it to happen on Health department premises. We have submissions from the Alice

Springs Hospital and their palliative care team specifically making that claim, as have many, many others, so place becomes important as well. Are we adding to our list of infrastructure costs for purpose buildings, facilities or clinics where we can provide VAD services, be they consultation, coordination or, for that matter, administration?

Dr VELLAR: It would no doubt be an additional infrastructure cost, the extent to which that would impact budget would not be insignificant. We would not expect a Rolls Royce department in that respect. As the AMA spoke to, it would just be a standalone facility that would be away from the …

Mr CHAIR: Health department precinct, as it were.

Dr VELLAR: That is right.

Mr CHAIR: Is there a version of this that can be done without us also investing in physical bricks and mortar infrastructure? Can you have a VAD service that only allows VAD to be administered in its final stages in people's homes or in a care facility that allows for it to happen?

Dr VELLAR: Absolutely. I guess it comes back to the premise of VAD and promoting autonomy and choice, and that being about an individual's capacity to choose the time and place, which has always been a central ethical aspect to our deliberations—in 2024, at least—with the expert panel.

In terms of practicality, if that came to pass and it was not possible due to budgetary constraints and practicalities of being able to manage VAD, then I guess that is something that is a reasonable consideration that you will have to deliberate upon.

Mr CHAIR: Before I pass to my colleagues, Dr Burgess I want to hear your thoughts on that as well. If we were to take that argument to its logical extreme, would we then be the first jurisdiction in Australia to allow VAD but not on Health premises?

Dr BURGESS: I want to share an observation from being embedded in the health service in a jurisdiction that did have VAD. The first thing is to understand that 80% of patients who choose the VAD pathway also have palliative care concurrently. If you like, patients see going through the VAD process as having a plan B; if it gets very difficult in palliative care and the end stages of life, they have another option. Up to one-third of people who had both services will pass away from their illness without actually using the VAD substance. It will sit there and be unused and be returned to the pharmacy service.

What I have also observed in some situations is that patients, because of their terminal illness, sometimes end up in a palliative care service. They have the VAD substance and have it administered in that service. I understand some sensitivities have been expressed from Alice Springs. When something is new there is probably some reluctance to have some confusion of roles from the public's perspective about what a palliative care service is there for. Over time, there is inevitable integration as patients go on their care journeys and come into contact with their health system because their symptoms at the end of life can be quite extreme and need hospital management. In a patient-centred view of the world you see, over time, there will be some integration, albeit at the moment we are at the early stages juggling, I guess, sensitivities from the profession then clinical services about the appropriate setting.

Mr CHAIR: To simplify the level of that argument—I take the nuance in what you are saying—but a simplified version of this argument is that people do not want to die in hospital; it is as simple as that—like under VAD. That is the thing we have been hearing over and over. If we are trying to facilitate people being able to choose VAD, could we credibly do so by saying to the Territory, essentially to Territorians, 'That is the thing you can have, but it is not part of the health service so far as you would have it in the hospital'. Dr Chin, do you want to speak to that?

Dr CHIN: Yes. I will also make reference to a number of the submissions in general, in particular the very useful submission from the Alice Springs heads of department and others from palliative care. There is a very strong understanding from subject matter experts and clinicians on the ground and a worry that VAD commencing in health services, in the actual facilities, may have some negative knock-on effects in terms of perceptions et cetera. I do not discount for a moment that they are not real; they are significant concerns.

Having said that, I think it is important to understand also that in other jurisdictions, as VAD is introduced, perceptions and assumptions are unpacked and untangled, and the concepts of death and dying, with increased health literacy and improved communication and understanding, changes and becomes much more nuanced and complex. I think it is challenging from the outset to say that VAD will never happen in a particular type of facility, in an NT Health facility, et cetera.

I completely agree with the concept of coproduction, and in a coproduction approach a particular health facility in conjunction with staff, clinicians and the community would decide whether that would be appropriate for that particular community, so I would not want to assume that any particular community, health service or group of clinicians would never say VAD should not happen in our facility. It may be that some people think that it is appropriate in their community, and it may be that as VAD is introduced, increasing numbers will start to have that conversation at a clinical level with consumers and at an executive level, and that may make it possible and appropriate. It would be difficult and challenging to see how a clinician would be put in a position where they would say, 'I feel comfortable providing VAD,

the community feels comfortable having VAD, and our health service managers feel that it is appropriate to have VAD in the service', yet there would be a prohibition to providing that patient-centred care.

That is not to say a decision should not be made, but there are different models for making those types of decisions about where VAD can happen.

Mr CHAIR: There is an inherent tension there, Dr Chin. A number of our submissions—submission number 179 that you are referring to from the Alice Springs heads makes it explicit that they do not want this to be happening on their premises because, as you are all extremely aware, a lot of people think that going to hospital means you are going there to die as opposed to going to a healing centre. We have a number of other submissions that are smaller, shorter and perhaps less rigorous but every bit as important from everyday Territorians saying, 'I do not want this to happen because I am worried that it will compromise the health system or people seeking care'—that it is the thin edge of the wedge.

There are a lot of thin-edge-of-the-wedge arguments here. Again, we have been asked to think about a VAD model and service that would provide not just equity but is appropriate for the Northern Territory. In the Northern Territory, given the amount of fear or mistrust—whether founded or unfounded—that people have of the health system, would it not be prudent for us to suggest that if a VAD model goes ahead that it is something that happens outside of hospital settings?

Dr BURGESS: I think the objective of legislation is to provide an authorising and regulatory environment. The legislation would be, in my view, ill advised to dictate place and strict dictates around more because what we will see over time is it will evolve. Those are very operational questions and the nuances do change over time as the community becomes more accepting.

For the legislation drafting, we need to be thinking about leaving that or having a tight focus on the enabling environment, authorisation environment, patient and staff safety, medication safety—those issues. I think the bare minimum we have already articulated around a navigation service and an independent board to oversee the operation of VAD.

We will inevitably see evolving models of care as this rolls out. It might be an operational matter to begin with, as I witnessed and tried to explain to you, where we have a preference for VAD at home or VAD on country due to patient preferences. Inevitably there will be individuals who have more complicated journeys. There becomes the nuance, but that is an operational matter, not necessarily a legislation drafting instruction.

Mr CHAIR: That is a reasonable point to make. Dr Chin; sorry.

Dr CHIN: I will give an example of how this could work out to be very theme appropriate in principle, but at the end of the day work out to be quite strange. If, for example, we decide collectively that VAD would not happen on NT Health facilities, but there is a great need from the community and there are the appropriate clinicians and a location for those who felt it was inappropriate or not ideal to take the substance at home, then there could be awkward situations where structures are set up to lease—for example, a house or a location where it would be appropriate. At the end of the day it comes out to the same wash. The money is coming from the same bigger bucket and the clinicians providing the service are the same clinicians providing the service. The consumer is still the same consumer and patient.

I worry that in this particular scenario where we start creating blanket rules that the workarounds we found will end up in a similar position anyway in the medium to long term as perceptions, community consultation, co-production and then health literacy about VAD and its actual place in our community become much broader.

Mr CHAIR: I take on board your concerns. The key point to make here is that this committee has been tasked with testing the curly questions. That is why we are. With no disrespect to any of the bodies of work that have been done previously, they have been largely about garnering in-principle support, support on the basis of principles of equity, thinking about high-level stuff. Now we, as five of the legislators of the Legislative Assembly, have to turn our minds to laws that will be possible and realisable and implementable. Whilst we are obviously not medical practitioners and not in a position to dictate hard and fast things that will frustrate the process, we at least are trying to test those arguments with you. Thank you very much for your candour as well in stating your position.

I am going to stop hogging the microphone and hand over to some of my colleagues. I have plenty more things—you okay, Matt?

Mr KERLE: Hello and welcome again. Thank you for making time for us. I appreciate you coming in.

In your submission—I am going to the review board which is the oversight body—you referred to chapter 6 of the expert report from last year. When I look at chapter 6, it talks about makeup in other states, but it is largely silent on how the board should be constituted. In this place at this time, do you have any specific recommendations on how the review board should be constituted, what specific skills, abilities or statutory roles should be there, given the existing statutory roles and the people who are already in the Health department overseeing our medical system?

Dr VELLAR: With respect to that, it was our view that would be an independent body, so completely separate to NT Health. In terms of what it would look like, potentially a statutory authority where that independent body holds a responsibility to reviewing the practices and maintaining the appropriate compliance with legislation. It would be one that we foresaw at the time—I guess were potentially silent on how that might sit with NT Health, but certainly as a separate body. The roles and responsibilities—essentially similar to other areas—would be made up of a legal member, medical practitioners, community members and appropriate cultural support involved in that as well, which would review the ongoing practices of VAD.

Mr KERLE: You are saying fully independent, but we would need to have medical practitioners on there with experience in VAD. Are you envisaging they would need to be someone from outside the NT because most people with relevant experience would be working for NT Health, wouldn't they?

Dr VELLAR: Not particularly. When each of those statutory boards were established in other jurisdictions there had been no previous experience directly with that. It comes down to subject matter experts within those areas—whether that is a psychiatrist, a palliative care physician, an intensivist or any other relevant interested specialist in terms of medical practitioner. Often that may be an oncologist.

If you review some of the makeup of those boards around Australia, there is wide variety of medical practitioners who are consultant experts in relevant fields.

Dr CHIN: This is a really important question about the independence. The independence is about the composition of the board and its reporting line. A good example is within NT Health we would have a clinical governance committee, and it would report to the health leadership board. It would not be appropriate, for example, to call a VAD review board independent and yet, have it report to the clinical governance committee like a number of other review approaches of committees. Line of reporting is important.

The second thing is about composition. The independence and the robustness of the process is always intention in the NT. It is a small jurisdiction, and we privilege the information provided by people on the ground with knowledge about the communities like the ones you visited. It would seem to me in the best interest of the review board to have access to that specialist knowledge.

In the NT appropriate conflicts of interest registers are appropriate ways to manage that. One of the approaches could be to have NT-based clinicians or NT-based potential future consumer—things like that—on the board providing that in-depth knowledge so that the review board can make those nuances and complex decisions.

Otherwise, if we said that it would be independent in the sense that everybody would feed from another jurisdiction, for example, or would not practice VAD will lose that richness and nuance, which ultimately the review board is there to understand in-depth.

Mr KERLE: I have a follow-up question. I assume you are all aware of the child death review board. I want to draw a parallel between the two bodies we are talking about here.

In VAD we are talking about voluntary assisted dying where someone who has a terminal illness, is suffering intolerably and seeks to relieve their suffering by hastening their end. The child death review board, in my understanding, deals with the loss of life—neonatal and child death.

In that case where we are dealing with someone at the beginning of life who had their whole life ahead of them and there could be potentially systemic problems—medical malpractice, anything—issues that could result in the death of children or babies during various stages of pregnancy, childbirth, newborn.

Are you suggesting that the VAD review board should have a higher level of independence than the child death review board? If that is necessary, can you dig in about why we need that high level of independence when we are dealing with people who are suffering and near the end of life?

Dr BURGESS: Member for Blain, you are right to draw that analogy. You have also alluded to some of the differences where we have not just a death review board; actually the standard practice in our health system is to review all deaths in care, sometimes that is in conjunction with the Coroner, so we are proactively looking for any opportunities to identify either errors or extraneous circumstances that have contributed to those outcomes. You are right; in the case of VAD it is different because it is less likely that we will be concerned about that.

If we can reflect on the functions of a board and the matters they are likely to deal with, it will be complaints. That might be complaints about time or process. It might be also appeals—people who have been here 11 months and not 12 months, but have a short time to live, in the Northern Territory and want to become eligible for VAD and have a strong connection with the Territory. Those would be the functions of the board, really.

The other function is to have a quality assurance or quality control—be sure that the parameters under the legislation, with medication safety and practitioners being accredited and regulated. Oversight of those matters will be critical to the board, as well as monitoring caseload over time. Slightly different functions, I think, in this case.

With that view, the reporting line for the board, consideration could be given if that is directly to the minister, a relevant minister who is overseeing that board, and where that should be best placed. I am sure that is a conversation amongst your legislative colleagues.

Mr CHAIR: Picking up on that comment and the Member for Blain's comment—Dr Chin, I am asking specifically—would it be appropriate for the VAD review board to be chaired and run under the office of the Chief Health Officer? I am asking you, Dr Chin, specifically.

Dr CHIN: That brings a level of independence within NT Health. In its current form and with the current committee compositions, the Chief Medical Officer in NT Health is a Chair of the clinical governance committee within those streams of patient safety. If we want to create a separate process with a level of separation, then nesting that under the CHO provides that level of separation.

The CHO is also already in existence from a statutory perspective. We provide …

Mr CHAIR: That is the reason I asked.

Dr CHIN: … that level of structure.

Mr CHAIR: Yes. The short answer is yes, that would work, potentially.

Dr CHIN: With nesting the service or the board or both?

Mr CHAIR: We are trying to reduce duplication or creation of new services if we have existing ones that might be fit for purpose within the context of the overall demand and the fiscal considerations as well. This is not a bean-counting exercise for me. Given that the CHO already has statutory powers, could the VAD review board essentially be operated under the auspices of the CHO without compromising any of the other principles that we are interested in here?

Dr BURGESS: Yes, it could in …

Mr CHAIR: I will come to you, Dr Burgess. It is not a question of conflict of interest. I am asking because on lines of reporting, you have been clear about your position. As the Chief Medical Officer, I think you have a right to express a position on that.

Dr CHIN: It does. I do not particularly know how Paul or the Chief Health Officer …

Mr CHAIR: We will come to him next.

Dr CHIN: From my perspective, yes, it could.

Mr CHAIR: Dr Burgess.

Dr BURGESS: Thank you for the opportunity to respond.

A survey of other jurisdictions, it has been truly independent. Of course, the Northern Territory reserves the right to chart their own course.

The pros and cons—the pros would be that there always needs to be a CHO under Northern Territory legislation. That is a statutory role that must be always filled, so there is certainty of continuity of that role being existent. The CHO, it is possible to that as an oversight. Perhaps there must be some instructions there about the position of the CHO being perhaps an independent Chair or something like that. That would give comfort to the board that they had the ability to make their decision on the board's composition and the board's merit. The true concept here is that the board is empowered to have that independence and does not have unnecessarily a CHO overriding their decisions necessarily.

Mr CHAIR: Let us try the flipside of that argument then. If you make it a truly independent standalone from NT Health governance set-up, is it reasonable and feasible for the Chair of that board to be a non-medical practitioner?

Dr BURGESS: I think so. I think the composition of boards interstate is they have legal consumers. In the Northern Territory context a First Nations representative would be highly desirable as well. I do not see a need for a Chair of such a board to be a medical person. I think that is a relevant skill set to have on that board, particularly if there are non-medical people present, but I am very used to being in organisational governance situations in medical organisations where the Chair, for example, is the consumer rep.

Mr CHAIR: It just broadens the pool of people potentially in a place with a shallow pool that potentially could run an independent set of oversight, is what we are suggesting.

Dr BURGESS: Yes, absolutely agree.

Mr CHAIR: Notwithstanding that would require statutory powers.

Yes, Dr Chin.

Dr CHIN: I think if we are looking to other examples or exemplars human research ethics is perhaps something worth exploring. All the research that happens on human subjects in NT Health facilities or by NT Health employees goes through the Human Research Ethics Committee. That is a particular committee that is constituted of a number of individuals from pre-prescribed areas. The gravity of what can go wrong and the level of harm that can occur if those processes within the Human Research Ethics Committee are not adhered to is very significant in terms of drug trials, experimental therapies et cetera et cetera, and yet that is significantly and safely nested within NT Health with the appropriate set of checks and balances. It has a level of independence. You are absolutely right to point out that when it is nested with NT Health it can only be afforded a certain degree of independence.

Dr VELLAR: If I may, with respect to the independence one of the considerations around that in terms of the CHO and in terms of other practitioners was independence was really at the forefront so that we could mitigate the issue of conscientious objections. Within, say, a set-up within Department of Health, we would not have to involve any staff, clinical or administrative, to VAD processes, acknowledging that there is such a wide range of views on VAD and protecting those sensitivities. Part of the consideration for that was, 'Let us consider an independent body so that we can ensure that it is a safe environment for all staff'.

Mr CHAIR: We do not want to overly prescribe legislative parameters and constrain ourselves or tangle ourselves in knots, but we are also mindful that if we just kick the can down the road on all operational implementation considerations there is a danger that no Territorian will see VAD anytime soon if they want to access this service. That is the overriding principle here, but I take on board your point.

I am going to pass to my colleague the Member for Nightcliff who is online.

K McNAMARA: It is a shift in topic if that is okay.

Mr CHAIR: Absolutely, yes.

K McNAMARA: I just wanted to ask around cultural safeguards. I just want to get a sense of how currently translators and the use of translators within medical services, how feasible at all, like if someone was to recommend to us you need to have a translator there for every conversation that involved VAD, how does that happen currently within the services and how accessible are translators?

Dr BURGESS: Obviously, the Northern Territory is an incredibly rich, diverse multicultural place with people from all corners of the world, so we do have phone translation services for many cultures available, and they are trained and registered. We also have our Aboriginal interpreter service that we run as well. I am less involved in the running of the hospital system. I think it certainly is the intent to have that available when requested; however, I am aware in the past there have been some gaps in terms of availability of translators at some times.

Mr CHAIR: Does that answer satisfy you?

K McNAMARA: Yes, sure. I am just wanting to get a better idea around some more of the cultural safeguards that perhaps things that we might have missed or things that we might need to still be taking into consideration that perhaps anyone could share.

Dr BURGESS: I can add some more detail. Within Northern Territory Health, our Aboriginal health engagement and workforce division have developed a cultural safety plan and they are in the process of reviewing and refreshing that and looking for implementation and also a quality assurance process as well to shore up the cultural safety, particularly for First Nations having contact with our NT Health system. That is an active area of management, if you like, within NT Health and a high priority for our Aboriginal health engagement and workforce division.

K McNAMARA: In the previous submission that we had from the AMA NT, they spoke about—stressed—the importance of a co-design model. Are you able to share any other examples or ways that you do co-designing with other programs or services?

Dr BURGESS: I draw on my experiences as a remote general practitioner in Arnhem Land and in the Daly region for some time. We work with Aboriginal staff on a daily basis and are in constant communication with our Aboriginal colleagues about how we can do things better and take local advice. We make all efforts to provide services in a way that is impactful but also effective from a cultural safety point of view.

K McNAMARA: Okay, thanks. I was just wondering, because we have been specifically asked as one of the things to look at making sure that something like this VAD was co-designed, if there are any specific examples you could point us towards around maybe other services that have been co-designed?

Dr CHIN: Yes, I will talk in an area that is closer to my subject matter expertise which is maternity and birthing. In Galiwinku the groups there are very, very strong and have a long tradition of safe maternity care, a culturally safe maternity care. That, in partnership with Charles Darwin University and the Molly Wardaguga centre there, have

published a co-production model under the RISE Framework, which is a maternity framework based on four domains that steps through what co-production and culturally safe governance looks like at the highest level. That has been published and referred to in a number of journal articles.

K McNAMARA: Thank you very much.

Mr YOUNG: I just have a question, and I asked the same question to the AMA as well. It is just around the practicalities of administrating the VAD medication. The AMA talked about having a centralised service, whether that sits in Darwin and Alice Springs or both or either/or, but then the practicalities of looking at someone who lives remote—Borroloola, for example—wants to have access to VAD but then wanting to access VAD and pass on country. How would you see that looking in a practicality sense from consultations, through those steps to then administrating the medication, that is also in a culturally safe way of doing it? Would you use local doctors, practitioners, nurses to do those consultations in Borroloola or would you see that as a sensitivity?

Dr VELLAR: I guess coming to your question it does depend on the nature of choice from the participant whether or not they seek out a practitioner administration versus self-administration. Each one of those processes requires an entirely different set of responses to your question.

For example, for a practitioner-based administration, that would require a relevant medical practitioner and clinical nurse consultant to travel to the relevant community with the medication in hand to be able to administer that at a time of the patient's choosing; whereas, with the self-administration method, the medication can be provided to that person and they have an assigned responsible person who assists with ensuring medication is safeguarded. In that context, again, it can be taken at a time and place of their choosing, but what we have in that context is there is medication that is within a community and there are potential issues with, I guess, ensuring that it is monitored and is safe at all times.

What we have seen from previous discussions with communities is the clinic would not be keen to take responsibility for safeguarding that and it may make cause some difficulty in terms of the practicality for administration for self-administration.

Mr YOUNG: Just a follow-up with the self-administration and around a responsible person. That responsible person, potentially could it be a family member or someone completely independent who has no association with the family, or how would that look?

Dr VELLAR: That is right. It would need to be nominated by the person themselves, yes.

Mr YOUNG: Nominated, okay, thank you.

Mr KERLE: I have got some questions about withdrawal from care. When we were travelling out on communities we heard a lot of evidence that the people we were talking to probably were not too interested in using VAD themselves, but there was a lot of discussion about finishing up well on country. The key theme that emerged from that was the ability to withdraw from care.

We heard differing testimony, depending on the community, about how effectively that was able to be done and how much people wanted to engage with it. There was one community where people were commenting that sometimes people died either in the hospital, like the regional hospital, or they died travelling back to community. There was a lot of expression about the importance of, at end of life, having enough time to be able to come home and go back to a suitable place—not the clinic—like their house or somewhere that they appreciated and then all of their family and friends and community members come around and say goodbye. When they pass, there is a number of cultural things that have to happen.

We talked to the palliative care team in Alice Springs Hospital about this withdrawal from treatment idea. They made a comment that it would be something of a cultural shift. This is different. Voluntary assisted dying in the Western sense is taking a substance to hasten death, so it is a positive act; whereas, what we discovered was there is actually—it is happening right now, but there are some barriers in the way of the negative act of withdrawing from treatment. If you are end-stage renal and the dialysis is not really working or end-stage cancer and the pain, you are coming to end of life, what kind of barriers are there now, or can you comment on withdrawal from care and facilitating?

Where were we? Was it Papunya?

The CHAIR: They all blur together; I honestly cannot remember.

Mr KERLE: Sorry; we were in Tennant Creek and we heard evidence that they do return-to-country day trips, so there already seemed to be programs where people are taken home while they are in treatment—obviously, day trips—back to country with the intent of returning to hospital for care. Are there any programs right now that facilitate people withdrawing from treatment and returning home in the knowledge that they would finish up and potentially withdraw from treatment voluntarily?

Dr BURGESS: Just to call on my experience in Maningrida where I have managed several patients in that scenario, people with terminal illnesses, even end-stage renal failure, do get tired of treatment and sometimes elect to withdraw

from care. In that scenario the usual model is that we are working in a shared-care model with our palliative care colleagues and we are working out an end-of-life palliative care plan that can be implemented safely in a community setting. Sometimes that involves us—there are a few technical aspects to it, probably beyond this committee's interest—but certainly easing symptoms and providing the patient with choice to finish up on country is incredibly important and can be a very powerful moment in intergenerational cultural experience. That has been some of the most rewarding experiences as a remote GP facilitating that choice for some of the clients I have had the privilege of caring for.

We have that already as a pathway and I think it is well understood. In remote primary healthcare settings we are very respectful of patient choice for that.

VAD is an interesting option now. I am sure what I have just described is we do not want to see necessarily VAD replacing that. Also, this is part of the reason why we do need to have increased palliative care services. Demographically we have the fastest ageing population in the country. People do have multiple conditions as they age and multiple symptoms, so we will see the need for palliative care also increase. We do not want this to be seen as 'VAD is a good substitute for good end-of-life care' at all.

Mr KERLE: It was very clear that they are very different pathways. You do not see any particular barriers, no legislative barriers? Would there need to be any cultural reform? I am trying to …

Dr VELLAR: From our perspective in palliative care, it is not an uncommon scenario. Frequently we are repatriating people back to country for end of life. One of the challenges we do come up with is being able to efficiently repatriate patients, so it is often dependent on the air services available to be able to do that as hastily as possible, so that is one of the challenges we often have. As a substitute people will come and sit in the hospice in the hope that we can often get them back to country. I know that we are probably more effective at delivering that for our rural and remote patients in the Top End, as opposed to Central Australia where there is less air traffic being able to take people to and from communities of a day, where we have a pretty busy airspace here in the Top End transferring patients around.

Mr CHAIR: I might just sharpen the focus of my colleague's question. Do clinicians require any greater protections in law regarding the withdrawal of care and liability?

Dr BURGESS: No.

Mr CHAIR: Okay. Regarding patient choice, again we have heard a mixed bag of testimony where some people were like we worked very well with the clinical providers to be able to come back onto country at a time of our choosing; sometimes it was a case there were barriers—communication barriers, authorisation barriers and/or just logistical barriers, lack of planes as you said, whatever it might be—to get back and people end up passing away in hospital, rather than being able to come back on country.

Are there any other barriers in relation to people being able to exercise free choice? I am particularly interested in, for example, whether the Mental Health Act is the tool that we have to be able to compel people to be able to stay or go? Is there any interaction in that space?

Dr VELLAR: No.

Mr CHAIR: No, not to your—Dr Burgess you are looking a little quizzical.

Dr BURGESS: I think clearly in the VAD legislation and having a mental health illness is an exclusion. You need to be able to have decision-making capacity and not be suffering an illness that is treatable …

Mr CHAIR: No. To be clear, in the other legislation it is not mutually exclusive, like VAD is not accessible to people who are suffering only a mental health condition, but for people who have a terminal diagnosis but also have a mental healthcare condition it is not prohibitive.

Dr BURGESS: I understand your question now. No, it is not.

Mr CHAIR: Go ahead, Dr Chin.

Dr CHIN: Just very quickly, the concepts of an informed free choice undertaken by someone with the capacity capabilities to undertake a course of treatment, to not undertake a course of treatment or whilst they are undertaking a course of treatment to withdraw from that, are the same principles.

Mr CHAIR: Thank you for clarifying that. That is good to have on the record.

Mr KERLE: Last question on this line. In the report and in our contemplations, we are turning our minds to how the topic may be broached with the patient, of VAD. Can you comment on discussions with patients who are approaching end of life, the option? Is the option to withdraw from care, knowing that it would hasten death but provide more certainty in terms of being able to finish in the way that they would choose, can you comment on how that is discussed with patients?

Dr BURGESS: As a general practitioner it is a conversation I have frequently with my clients in outlining the range of options ahead of them. I think the difference now with VAD being introduced as an additional option is the clear need for clinicians to have done some training about having to present a full range of options, not just one, to clients, but that is a very standard conversation currently happening in remote general practice.

Mr CHAIR: I need to, for the sake of the record, just get this there.

Notwithstanding that service models will evolve, as you indicate in your written submission as we have discussed today, what we are looking at if we have a core centralised service in terms of practical impost in terms of time and resources is something in the order of: an increase of palliative care that the AMA today suggested would be 30%, palliative care potential cost impost extra that we require; plus potentially extra help in aged care, which we have not discussed in great detail, noting that we have seen deficits in aged-care facilities elsewhere; plus the potential for buildings, physical location, to be able to provide VAD services standalone, albeit not building a new hospital; plus at least some FTE being a number between—conversations we have had now—four and let us call it 10 people, but less than 10. Is it fair to say that those are the costs and resource imposts we are looking at to introduce a VAD service in the Northern Territory in the future, notwithstanding that service models may vary?

Dr BURGESS: I think that is not unreasonable. I think the missing component we have not really touched on in that list is the review board …

Mr CHAIR: Yes, sorry; I forgot that one on that list too. It is on my list.

Dr BURGESS: … and the pharmacy service which might be part of your FTE. The pharmacy service would be logically centralised within our hospital network.

Mr CHAIR: Yes. I am sorry; I missed the last line of my little scribbles there which was plus navigator service, plus pharmacy service, plus review board.

Dr Chin did you want to comment on that? Dr Vellar; sorry.

Dr VELLAR: Apologies, there was also an IT budget component which, from the ACT perspective, was approximately $4m, so that would require consideration.

Mr CHAIR: Can you just flesh that out? I am not even clear what that part of it is. Is that just providing centralised administration IT services?

Dr VELLAR: That is right; for the process, for the administering and the coordinating practitioner.

Mr KERLE: I assume there would be an online component. I think the ACT had an online component for tracking the submissions, plus you would have to have like a website that would educate people. That would have been built bespoke, so that $4m would have covered that cost.

Dr VELLAR: I think, importantly, in recent months we have developed pretty good relationships with our interstate counterparts in VAD, particularly in South Australia and the ACT, we have some good contacts who would obviously—there is significant information sharing and that would potentially mitigate some of the initial costs regarding set-up.

Mr CHAIR: In sum we are looking at—I am not going to do the number because the number will become the headline. The number is significantly larger than $1m a year which is the kind of numbers that were loosely bandied about at the genesis of these conversations for us.

Dr BURGESS: I think we hollowed ACT $1.6m per year in terms of operational, but the substantial $19m to $20m cost over the four set-up period. I think Kane is absolutely right. I think the benefits of being the last jurisdiction is we have the benefit maybe to piggyback off developments that have occurred in other jurisdictions.

Mr CHAIR: We procure a licence for $4m of IT is one thing, but just about everything else is not transferable; is that fair to say?

Dr BURGESS: I think that is fair to say, yes.

Mr CHAIR: Everything else requires doing bespoke for the Northern Territory, noting bespoke Northern Territory conditions and concerns, including the tyranny of distance, massive travel costs, patient consultation costs to do things face to face unless and until carriage service conditions change with telehealth.

Dr BURGESS: Correct.

Mr CHAIR: We appreciate your candour in spelling all of that out.

We have a small amount of time left. I still have a small amount of questions, but in the interests of being fair, I did say this would be an iterative process. I am inviting the three of you to ask the panel any questions that you may have that you may want to see clarification on as we go into the last phase of our deliberations.

Dr VELLAR: One thing that has come up from today in terms of discussion around a model that would be delivered in the home or at a person's choosing outside of a Department of Health precinct, I think we would need to consider some of the unintended consequences of that, particularly around practitioner versus self-administration. There would be instances, of course, if a person was approved to have a substance to self-administer, we would not be able to prevent them from taking that substance in a healthcare facility if that was their choosing, they became unwell and decided that was the time they chose to do that. There are some practicality issues that will always be there.

I guess outside of that there may be those who do not have any other family available and would want to have that in a place where they felt safe. For some people, a hospital is a safe place.

I think there are probably some wider considerations that would need to be thought through if there was a limitation on where a person could choose to take a substance, particularly given a lot of the other jurisdictions have made it very clear now, particularly the more recent the addition with VAD in those states, that it can be available at any sort of institution. It is for the patient's autonomy, rather than the conscientious objection.

Mr CHAIR: Dr Burgess or Dr Chin, did you have any questions before I respond?

Mrs CARLSON: Can I just ask one question?

Mr CHAIR: Can I just respond to that question before you ask the question, though, Oly?

I will just respond to that. I am speaking on behalf of the committee, so feel free to correct me and any of my colleagues if you want.

We are not looking to limit that; we are looking to reflect the body of testimony we have got through submissions. There is a strong tendency, not just from laypeople, as I am saying, but from the heads of Alice Springs Hospital, for example, to make that prescription, hence the line of questioning. But certainly we want hospitals to be a safe place. We do not want clinical practitioners in the Health department to be unduly restricted from doing what they need to do.

I pass to my colleague.

Mrs CARLSON: Sorry; I have just come late in the game because I am just trying to work this out.

It is actually to do with cross-border. Obviously, being the Northern Territory and the limitations of our healthcare workers, the vast landscape and the access because of the landscape—more so down the middle and across to Western Australia, South Australia and Queensland, in those remote areas—is there a lot of already cross-border sharing with services now? I think it did come up briefly in our hearings in Alice Springs. I am probably more keen to—as there are already residential requirements in some of the states that already have this, going forward if we are still going to have residential requirements, I need to understand if there is going to be limitations and equity access to those people who are having cross-border medical treatment and things like that.

Dr BURGESS: Thank you, Member for Wanguri; it is a good question. I think we on a day-to-day basis do deal with a lot of cross-border issues, particularly in Central Australia.

Again, going to one of the functions of the appeal board can be if someone identifies or has a strong connection culturally to the Northern Territory and spends some time just over into the WA border, but a lot of the time in Central Australia, that is a very appropriate issue to be canvassed—if they are not fulfilling the time residential requirements—with the appeal board. There are mechanisms in other states where grounds for appeal are significant connections to, for example, the Northern Territory, where that can be taken into consideration.

I think it really goes to what we are saying, some of these centralised processes need to be facilitating this journey and not putting up artificial barriers in this case, where someone strongly identifies with the Northern Territory although they spend time in a Western Australian remote community.

Mr CHAIR: I think the question goes to whether we could employ shared services elsewhere, rather than having to set ours up.

Mr KERLE: For example …

Mr CHAIR: Go ahead; sorry.

Mr KERLE: We are considering if you had the consulting practitioner, be it a specialist in a particular disease that the person is suffering from—obviously we do not have very many of those in the Territory, and a lot of them come in as locums and then they fly-in fly-out—are there any restrictions around if those specialists from South Australia,

Queensland or WA were certified under the NT regime? Could there potentially be recognition if they are already certified in another jurisdiction?

Dr BURGESS: It is a really good question. It is a great one for the legislation drafting, because I think you are right. There will be some uncommon terminal illnesses that we would not have residential specialist capacity for opinion. Really what we are talking about is an opinion about the prognosis or length of time left. That would be something for the legislation consideration about the ability for us to get appropriate expert opinion from another jurisdiction when none exists in the Northern Territory.

Mr CHAIR: Gentlemen, I have lots more questions, but we do not have any time. We need to wrap up. I once again want to thank all of you for making yourselves available to us on short notice and for being so forthright in your answers. It has given us plenty to think about. We will be working in haste as best we can to reflect as much of the information that we have been able to gather. We look forward to working in partnership with you going forward to hopefully progress the issue of voluntary assisted dying in the Northern Territory for the people in the Territory.

Thank you very much again for your time.

The committee concluded.
