Submission to the Northern Territory Legislative Assembly Committee on Voluntary Assisted Dying

Date: 22 August 2025
To: Legal and Constitutional Affairs Committee
Email: LA.VAD@nt.gov.au

I write to provide my submission regarding the proposed Voluntary Assisted Dying (VAD) legislation for the Northern Territory. I thank the Committee for the opportunity to contribute to this important discussion and for the thoroughness of the consultation process.

While I recognise that advocates on all sides of this debate are motivated by genuine compassion and concern for vulnerable people, I respectfully urge the Committee to recommend against the legalisation of VAD in the Northern Territory.

A fundamental concern with this inquiry is that it appears to present Territorians with an inadequate decision tree that does not constitute genuine choice.

The current framework seems to present options as either:

- 'Do nothing and let people die without dignity,' or
- 'Legalise VAD to die with dignity.'

This is a false dichotomy that fails to acknowledge the full spectrum of alternatives available to legislators. Territorians deserve to be presented with genuine options that include robust investment in palliative care, aged care services, mental health support, and addressing the systemic health inequities that drive end-of-life suffering.

I urge the Committee to reframe the decision tree to include more balanced alternatives:

- Option 1: Legalise VAD with various implementation models
- Option 2: Maintain current laws while significantly investing in alternative dignity-preserving options such as:
    - State-of-the-art palliative care services
    - Enhanced aged care and home care options
    - Mental health and psychosocial support services
    - Transport grants for family visits during terminal illness
    - Comprehensive care navigation services for all complex health conditions

Without presenting and seriously developing these alternatives, the Committee risks presenting Territorians with an unfair choice that artificially constrains the debate.

Question 1: Do you support making VAD legal in the NT?

I strongly oppose the legalisation of VAD in the Northern Territory for the following interconnected reasons:

First Nations health must be central to this discussion. Any discussion of healthcare policy in the NT must place First Nations health at its centre, not treat it as a side consideration. First Nations Territorians represent approximately 30% of the NT population, yet account for 46% of deaths and 68% of hospitalisations. The life expectancy gap remains around 15 years, but when considering healthy life expectancy, Indigenous males can expect to live 26 years less of healthy life than non-Indigenous males, and Indigenous females 33 years less than non-Indigenous females.

The introduction of VAD risks reversing decades of hard-won progress in building trust between First Nations communities and healthcare services. During the NT's previous experience with VAD in 1995, First Nations people expressed widespread fear of seeking healthcare due to concerns about being "euthanised" without consent. Given existing communication barriers, with exceedingly few healthcare providers speaking First Nations languages fluently and interpreter services that cannot meet demand, the risk of misinterpreting a request for help as a request for death is unacceptably high.

Legalising VAD in a context where the "Closing the Gap" mission is far from complete represents a fundamental contradiction in policy priorities. While we invest enormous resources in helping the most disadvantaged Territorians live longer and healthier lives, simultaneously creating pathways to deliberately end lives is logically inconsistent and potentially harmful to the communities we seek to serve.

The NT faces finite healthcare resources and significant unmet needs. Evidence from other jurisdictions demonstrates that VAD implementation diverts resources from life-preserving care:

- Between 2012-2019, European countries with assisted suicide increased palliative care provision by only 7.9%, while non-assisted suicide countries increased provision by 25%
- In US states with assisted suicide, hospital palliative care teams increased by only 3.2% compared to 9.4% in non-assisted suicide states
- New South Wales allocated $97.4 million over four years to VAD implementation while cutting $249 million from palliative care in a single year

In the NT context, where remote general practitioners cannot refer patients to diabetes educators, psychologists, dietitians, or exercise physiologists due to workforce shortages, diverting resources to VAD implementation is inequitable. These resources would be better invested in:

- Comprehensive care navigation services for all complex health conditions

- Addressing nursing workforce shortages in remote areas
- Ensuring continuity of GP care in remote communities
- Expanding mental health services
- Improving access to specialist services

Additionally, international evidence demonstrates that VAD laws inevitably expand beyond their original parameters:

- Belgium now permits VAD for children of any age
- Netherlands and Belgium have extended access to those with mental health conditions and dementia
- In Oregon, 54% of people accessing assisted suicide cited "being a burden" as a reason - a percentage that has steadily increased over time

Research consistently shows that VAD does not reduce suicide rates but may increase them, particularly among vulnerable populations:

- Analysis of Victorian data showed increased suicide rates in people over 65 after VAD legalisation
- US research found VAD legalisation associated with a 6.3% increase in total suicides with no decrease in non-assisted suicides
- Studies suggest older women are disproportionately vulnerable to assisted dying where it is legalised

Given the NT's consistently higher suicide rates (14-30 per 100,000) compared to the rest of Australia (10-15 per 100,000), introducing VAD appears counterproductive to public health goals.

Protecting Vulnerable Populations

Any legislation (including that on VAD) is written for everyone, not just privileged individuals in ideal circumstances. **Canadian data shows people of lower socioeconomic status disproportionately request VAD, with some citing lack of social supports rather than medical suffering as their primary motivation.**

In the NT context, with enormous contrasts in socioeconomic circumstances, the risk is that VAD becomes another inequality where society's most vulnerable are subtly encouraged toward death while the privileged retain access to life-preserving care. This would create an unacceptable two-tiered system where socioeconomic status influences whether individuals are encouraged to live or die.

Western civilisation – including our current society – and many other cultures and traditions share the foundational principle of the inherent dignity of human life. This principle holds that human worth is intrinsic and not contingent upon circumstances, abilities, or perceived quality of life. **VAD fundamentally alters this understanding by suggesting that life becomes disposable when it no longer meets certain criteria.**

The concept of "intolerable suffering" is entirely subjective and cannot provide an objective standard for irreversible decisions. Moreover, the power imbalance between healthcare professionals and patients means that even mentioning VAD as an option carries enormous implicit authority that may influence vulnerable individuals.

Rather than crossing this significant legal and ethical boundary, we should focus on addressing the systemic failures that make people feel their only option is death. As Scotland concluded in 2015, there are ways of responding to suffering through increased palliative care and disability support that do not raise concerns about crossing a legal and ethical "Rubicon."

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

This question assumes VAD will be legalised (refer to earlier comments about an unfair decision tree), and is therefore inappropriate. While I oppose VAD legalisation entirely, if the Committee were to proceed despite these concerns, the most restrictive criteria possible would be essential. However, **I emphasise that no eligibility criteria can adequately address the fundamental problems outlined above.**

Even the most restrictive criteria face insurmountable challenges:

- **Medical prognosis is imprecise:** Oregon data shows some people prescribed lethal drugs lived longer than their six-month prognosis
- **Detecting coercion is extremely difficult:** This requires long-term doctor-patient relationships, yet the median duraction of Oregon's doctor-patient relationships was only 10 weeks
- **Mental health assessments cannot guarantee accuracy:** Depression and other conditions may be undiagnosed or inadequately treated
- **Family consultation cannot prevent all abuse:** Elder abuse and "inheritance impatience" are rising concerns that VAD could exacerbate

Any eligibility criteria would need to include extensive safeguards that would be resource-intensive to implement and monitor, further diverting resources from life-preserving care.

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

I believe this question fundamentally misunderstands the risks VAD poses to these populations. Remote areas should be excluded entirely from VAD access. The logistical challenges of safely storing and administering lethal substances in communities with limited medical supervision create unacceptable risks. Moreover, remote communities

often lack the specialist services, interpreter services, and mental health support necessary for adequate safeguarding.

For First Nations communities, the focus should be on improving healthcare access and cultural competency, rather than introducing VAD. **Historical and ongoing evidence suggests that VAD poses particular risks to Indigenous communities:**

- Existing mistrust of healthcare systems would be exacerbated
- Communication barriers increase the risk of misinterpreting patient intentions
- Cultural and spiritual objections to VAD are widespread in First Nations communities
- The significant health disparities mean First Nations Territorians are more likely to face the conditions that might lead to VAD requests

Rather than making VAD accessible to these communities, we should seek to address the underlying inequities that create end-of-life suffering:

- Improving culturally appropriate palliative care services
- Addressing socioeconomic factors contributing to poor health outcomes
- Ensuring adequate interpreter services
- Investing in community-controlled health services
- Addressing the 28% health workforce shortage needed to reflect population disease levels

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

While I maintain that no monitoring system can adequately protect against VAD's inherent risks, any oversight framework would need to include:

- **Diverse representation:** Multiple members with serious reservations about VAD implementation, including faith-based and Indigenous community representatives
- **Comprehensive tracking:** Digital systems ensuring mandatory waiting periods are followed, not just documented retrospectively
- **Full transparency:** Public availability of all statistics, timelines, and misuse instances
- **Protection for conscientious objectors:** Healthcare workers must be protected from employment discrimination based on moral or religious objections

However, it would be better to allocate the resources required for comprehensive monitoring, to expanding life-preserving services that benefit all Territorians.

In 2015, Scotland considered assisted dying legislation but ultimately rejected it, choosing instead to focus on improving palliative care services. Their approach demonstrates that there are viable alternatives to VAD that address end-of-life suffering without the associated risks.

I urge the NT to adopt a similar approach by:

Investing in World-Class Palliative Care

- Developing state-of-the-art palliative care services that could serve as a model for other jurisdictions
- Addressing the acknowledged "misinformation or lack of knowledge about palliative care services" through comprehensive public education
- Ensuring palliative care access extends to all remote communities

Innovative Support Services

- Creating care navigation services for all complex health conditions, not just terminal illnesses
- Establishing transport grants for family visits during serious illness to address isolation and loneliness
- Developing psychosocial support programs that address the emotional and spiritual dimensions of suffering

Addressing Systemic Health Inequities

- Prioritising the closure of health gaps that disproportionately affect First Nations Territorians
- Investing in preventive care to reduce the incidence of life-limiting diseases
- Ensuring adequate healthcare workforce in remote areas

Community Education and Empowerment

- Public education campaigns about palliative care options and end-of-life planning
- Community-controlled health service expansion
- Culturally appropriate end-of-life care models developed in partnership with First Nations communities

As legislators, you have a responsibility to consider the health of all Territorians, particularly the most vulnerable. Laws are made not just for those who advocate strongly for particular positions, but to protect those who may lack the voice or power to advocate for themselves.

The evidence suggests that VAD legalisation may benefit a small number of people while potentially harming a larger number of vulnerable individuals. This trade-off is particularly concerning in the NT context, where:

- Health disparities are stark and persistent
- Healthcare resources are limited
- Remote geography creates unique challenges
- First Nations communities face ongoing health inequities
- Socioeconomic disadvantage is prevalent

Just as the NT Legislature made the bold public health decision to reinstate speed limits on the Stuart Highway in 2016 to protect all road users, I urge similar courage now to protect the most vulnerable Territorians from the unintended consequences of VAD legislation.

A critical concern is whether this consultation process has genuinely captured the voices of those most likely to be affected by VAD legislation. The 2024 VAD report does not provide data on the ethnicity of consultation respondents, despite Indigenous Territorians representing approximately 70% of hospital patients.

Given the power and knowledge imbalances that exist for both First Nations and culturally and linguistically diverse communities, **no consultation should be considered complete until it can demonstrate that opinions have been heard equitably.** The most medically and socially vulnerable Territorians - those least likely to participate in online surveys or email submissions - must have their voices genuinely sought and heard.

I acknowledge that the Committee is in the process of visiting various locations over August – from Alice Springs to Gunbalanya – and the amount of time and effort it takes to orchestrate this. However, referencing my earlier concerns around the false dichotomy created by this set of questions, I am concerned that the questions may steer discussion in these remote sessions in a way that will not result in a full reflection of the views of the various communities attending the sessions.

I appreciate and commend that the Committee is actively undertaking extensive travel across the Territory throughout August, from Alice Springs to Gunbalanya. I appreciate the time and effort required to facilitate engagement in so many diverse locations and hope these sessions go well. However, reflecting on my earlier concerns regarding the limited framework of the consultation questions, I remain apprehensive that this false dichotomy may unintentionally shape the dialogue during remote community sessions, potentially limiting the breadth and authenticity of views expressed. I respectfully urge the Committee to be mindful of this as you conduct consultations, ensuring that all

perspectives (especially those which might not fit neatly within the preset questions) are genuinely heard and reflected in your final report.

My opposition is grounded in my personal Christian faith, which has led me to carefully consider concerns about equity, public health outcomes, resource allocation, and the protection of our most vulnerable citizens, particularly First Nations Territorians who face significant health disparities. These concerns, I believe, transcend any particular religious perspective and should resonate with all who value the inherent dignity and worth of every human life.

I urge the Committee to recommend against VAD legalisation and instead advocate for:

1. **Significant investment in palliative care services** that could make the NT a model for other jurisdictions
2. **Innovative support programs** that address the social, emotional, and spiritual dimensions of end-of-life care
3. **Continued focus on closing health gaps** rather than creating new pathways that may disadvantage vulnerable populations
4. **Genuine community consultation** that ensures the voices of the most vulnerable are heard and respected

The choice before the NT is not between VAD and "doing nothing." The choice is between crossing a significant legal and ethical boundary with its associated risks, or choosing to invest in comprehensive, innovative approaches to end-of-life care that preserve life, dignity, and hope for all Territorians.

The vulnerable members of our society deserve our protection and support, not forms to sign when life becomes difficult. As legislators, you have the opportunity to stand alongside them in solidarity, demonstrating that we deeply value their lives and are committed to helping them through difficult times with dignity, care, and compassion.

I urge you to select an alternative to the illusion of choice presented in this consultation. Choose an option which protects the vulnerable, invests in life-preserving care, and demonstrates that every Territorian's life has inherent value and dignity worth protecting.

Thank you for your consideration of these concerns. I am available to provide further clarification if required.

Yours faithfully,