HOW MANY DEATHS WOULD RESULT
FROM LEGALISED VOLUNTARY ASSISTED DYING (VAD) IN VICTORIA?

Introduction

This Note attempts to estimate how many deaths from Voluntary Assisted Dying (VAD) could be expected to result annually in the State of Victoria if the regime proposed by the Ministerial Advisory Panel (MAP) were to be implemented. It is based on published outturn data from other jurisdictions which have legalised VAD in one form or another. The experience of these latter jurisdictions has been that annual numbers of deaths rise year by year following legalisation. Estimates based on any one year are, therefore, subject to revision in the light of data for subsequent years. The data used in this Note are current data - ie they reflect the latest (2016) published data. They are derived from two jurisdictions - the US State of Oregon and The Netherlands - as these are the jurisdictions with the longest experience of legalised 'assisted dying' and the most published data available.

What is proposed?

The numbers of deaths annually from legalised VAD depend to a large extent on the groups of people who are eligible to apply and on the conditions governing the management of requests. The MAP report proposes that VAD should:

(a) comprise physician-assisted suicide (PAS), where a person is supplied with lethal drugs for self-administration; or physician-administered euthanasia (PAE), where the person is judged to be unable to self-administer lethal drugs and the drugs are administered by a doctor;

(b) be available to persons with advanced, progressive and incurable illness who are considered likely to die within 12 months;

(c) be available to persons who meet the condition at (b) above and are also suffering from mental illness - though mental illness alone should not constitute grounds for approval[1].

Oregon

Oregon's 1997 'Death with Dignity Act' (DWDA) is considerably more restrictive than what the MAP has proposed. It limits VAD to PAS and to persons with a prognosis of life remaining of six (rather than twelve) months, and it excludes persons who are judged to be lacking in capacity, including judgement-impairing depression.

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[1] This appears to be the import of Recommendation 5 of the MAP's Report, which states that "*mental illness does not satisfy the eligibility criteria for access to voluntary assisted dying, nor does mental illness exclude a person from eligibility to access voluntary assisted dying*". It is not clear how this recommendation is reconciled with Recommendation 2, which states that one of the eligibility criteria for VAD is that an applicant has "*decision-making capacity in relation to voluntary assisted dying".*

The Netherlands
The Dutch 2001 'Termination of Life on Request and Assisted Suicide Act' is more widely drawn than both Oregon's law and the MAP proposals. It allows both PAS and PAE and it does not require an applicant to be terminally-ill.

The regime propose by the MAP is a mixture of the two, though its widely-drawn definition of terminal illness, its allowance of PAE in certain circumstances and its approach to concomitant mental illness places it nearer to The Netherlands than to Oregon.

Data
In 2016 the death rate in Oregon from legalised PAS was 37.2 per 10,000 deaths in the State. In 2015 there were 159,052 recorded deaths in Victoria[2]. Oregon's current death rate therefore points to 148 deaths per annum annually in Victoria from PAS alone. However, this figure must be regarded as an under-estimate as the terms proposed by the MAP are considerably wider than those obtaining in Oregon.

It is impossible to know what effect a twelve-month (rather than a six-month) timeframe for prognosis would have. It would bring much larger numbers of people into the catchment area of legalised VAD. Moreover, the proposal that concomitant mental illness should not disqualify an applicant who meets the other criteria for VAD is likely to allow some people through the net who would be excluded in Oregon.

The effect of allowing PAE in certain circumstances would certainly be to increase the numbers, perhaps substantially. In The Netherlands in 2016 1 in 26 of all deaths was the result of either PAS or PAE - mainly the latter. On this basis, and using the 2015 Victoria mortality data as a baseline, Victoria could be looking at 1,535 deaths annually from VAD. On the other hand, the MAP Report does not propose a free choice (as in The Netherlands) between PAS and PAE but that PAE should take place only where self-administration of lethal drugs is not possible. Just how many more deaths the inclusion of PAE would produce would depend on the stringency with which this condition is implemented. It is worth noting, however, that where both PAS and PAE have been legalised (ie The Netherlands and Canada) experience shows that the latter drives out the former.

It is impossible to say with any precision where Victoria would sit, under the MAP's proposals, on a spectrum between Oregon at one end and The Netherlands at the other. The indications suggest it would be nearer the upper rather than the lower end of the scale. It is also necessary to bear in mind that the Oregon and Dutch data used in this Note give the current position. As observed above, the overall trend of deaths in both jurisdictions has been upwards and there are no indications after 20 years (in the case of Oregon) or 15 years (The Netherlands) that a steady state has been reached.

[2] Source: Australian Bureau of Statistics