Palliative Care
New South Wales

NSW Voluntary Assisted Dying Legislative Review
February 2026

Background Information

(as outlined in the official Background Paper provided by NSW Health)

The Voluntary Assisted Dying Act 2022 (NSW) (the Act) commenced on 28 November 2023. Under the Act, the NSW Minister for Health must review the operation and effectiveness of the Act. The Minister must prepare a report based on the review as soon as practicable after the second anniversary of the Act, and after that, at intervals of not more than 5 years. The NSW Ministry of Health will complete the first review and the report on behalf of the Minister.

Scope of this Review

Section 186 of the Act stipulates that a review of the operation and effectiveness of the Act must be conducted and include consideration of the principles of the Act, in particular, the following 2 principles:

- a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in NSW and having regard to the person's culture and language,
- a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and high quality care and treatment, including palliative care and treatment, as a person who lives in a metropolitan region.

The focus of this review is on strengthening the model and frameworks that support voluntary assisted dying in NSW. The review will not examine whether voluntary assisted dying should be precluded. The review focusses on 4 key themes:

1. Patient choice
2. Equitable access, respect and inclusion
3. Safeguards for patients and healthcare workers
4. Service delivery and sustainability

Responding to the Review

Responding to the review was via a survey, with five (5) questions to be answered. Palliative Care NSW surveyed our Members, asking the same 5 questions. Those responses informed the final submission.

Palliative Care NSW Submission
NSW Voluntary Assisted Dying Legislative Review
27 February 2026

Question 1

Regarding the operation of the Voluntary Assisted Dying Act 2022, what has worked well, what has not, and what should be considered for change?

The implementation of the *Voluntary Assisted Dying Act 2022* has marked a significant change in the end-of-life care landscape in New South Wales. From the perspective of Palliative Care NSW (PCNSW) and its members, several aspects of the legislation's operation are working well, while others present clear opportunities for refinement to ensure the system remains safe, compassionate and equitable for patients, families and the workforce.

The establishment and operation of the NSW Voluntary Assisted Dying (VAD) Teams has been a particular strength of the current framework. Members consistently report high levels of professionalism, strong clinical leadership and excellent care coordination across services. The VAD Teams have demonstrated a willingness to engage openly with clinicians and services, to listen to concerns, and to work collaboratively to identify and address emerging challenges. This approach has supported safe implementation of the legislation and helped build confidence across the system during its early years of operation.

At the same time, experience to date highlights several areas where further consideration and change may be required. One key opportunity lies in strengthening understanding of the bereavement and grief needs of families when a person chooses VAD, and ensuring that appropriate, accessible supports are available and aligned to those needs. There is also a clear need to improve communication and continuity of care when individuals who have been approved for VAD move between settings, particularly during transfers into residential aged care. More explicit guidance and "guardrails" are required to ensure staff are aware of a person's VAD status, understand their role, and know how to work effectively with the VAD Team to support both the person and their family. In addition, further resourcing should be considered to support health and aged care staff caring for people who choose VAD, recognising that this work can challenge personal beliefs and have a significant emotional impact.

PCNSW emphasises that sustainable and equitable access to palliative care must remain a core pillar of NSW's end-of-life care system. While VAD is now embedded as an additional end-of-life choice, it must never become a substitute for timely access to high quality palliative care. A genuinely informed end-of-life choice depends on the availability of both. As our members have noted, VAD is not currently accessible to all people, including those living with conditions such as dementia, which require long term, well-resourced palliative and supportive care. It is essential that palliative care services are sufficiently available and resourced to meet the needs of these individuals and their families. Any future legislative or service amendments must therefore be considered alongside, and not separate from, the ongoing need to invest in sustainable palliative care services that support quality, inclusion and dignity at the end of life, while also strengthening safeguards for patients, families and the workforce.

PCNSW supports the continual review of this significant legislation and welcomes the opportunity to contribute to its ongoing refinement. As we have consistently advocated, an individual's decision to explore VAD should never be driven by a lack of access to quality palliative care. The responses in this submission reflect the collective experience and perspectives of PCNSW's broad and diverse membership.

What Has Worked Well

Effective collaboration and coordination

As implementation has matured, collaboration between VAD Teams and palliative care services has strengthened, supported by growing clinical experience and increasing confidence with referral pathways.

"Consultation between VAD teams and Palliative Care teams has improved…

"The local communication between the VAD team and the palliative care team, particularly in the community context has been a real benefit."

Timely and streamlined processes

Referral pathways and assessment processes are generally efficient, with the navigator role consistently identified as a key strength and highly valued by clinicians.

"It has been very streamlined – referral is easy."

"First contact happens in a timely manner."

"Great to have the navigator role."

What Has *Not* Worked Well

Inequitable access to VAD information and referral pathways

Members report ongoing variability in access to VAD information and referral pathways across organisations and care settings. In some cases, patients experience delays or missed opportunities for referral due to uncertainty or reluctance within teams to initiate discussions or referrals, even where eligibility criteria may be met.

"Once referred, no issue. Remains a problem that teams not referring, sometimes waiting for review with pal care in clinic for us to refer."

Low awareness and inconsistent communication across services and the community

Despite increasing system maturity, some confusion persists among patients, clinicians, general practitioners and aged care providers regarding VAD processes, roles and responsibilities. This includes uncertainty around access pathways and post-death requirements.

"Awareness of how to access the Service is low."

"Confusion with GPs around Certification of Death."

Communication challenges are particularly evident in aged care settings, where internal information sharing can be inconsistent. In some cases, staff have been unaware that residents in their care have accessed VAD, leading to uncertainty, distress and moral concern.

"Aged care staff left questioning their care when unaware residents were accessing VAD."

These gaps underscore the need for clearer communication protocols and guardrails, particularly during transitions of care.

Emotional burden on staff and inconsistent support for families

Exposure to VAD in acute and ward-based settings can be emotionally challenging for staff, with limited structured follow up or debriefing support available. Over time, this may contribute to cumulative grief and moral distress.

"More follow up needed to prevent accumulated grief."

Support for families and carers is also inconsistent and often dependent on the availability of social work or palliative care services. Grief and bereavement supports are not adequately resourced and, in many cases, default to palliative care teams even when the patient was not formally under palliative care.

"Family members presenting with moral injury; limited counselling available."

This highlights a significant gap in the current framework, with insufficient recognition of the bereavement and emotional support needs of families and the workforce.

Operational and resourcing gaps

The demand for in-hospital intravenous VAD administration was under forecast. This has placed pressure on inpatient bed capacity, particularly where dedicated space or extended stays are required to support VAD processes safely and respectfully.

"I also believe the number of people wishing to enact IV VAD in hospital was underestimated and has had an impact on inpatient bed availability."

There is also concern that broader system pressures — particularly staffing shortages and bed constraints — may unintentionally influence patient perceptions or decision making, especially in acute and aged care settings.

"I worry that... VAD will become the expected norm while pressures on beds and staff continue to accelerate."

These concerns reinforce the importance of ensuring that VAD operates within a system that is adequately resourced and that safeguards protect patients from real or perceived pressure related to service capacity constraints.

What Should Be Considered for Change

Expand targeted education and public awareness

Targeted education and training should be expanded to improve understanding of VAD processes, roles and responsibilities across the system. This includes further training for general practitioners, hospital clinicians and aged care staff, as well as clearer, more accessible public information about VAD pathways.

A particular focus is needed on culturally and linguistically diverse (CALD) communities, where awareness of VAD and confidence navigating the system may be lower. Tailored, culturally appropriate education materials and engagement strategies will be critical to supporting equitable access to information and informed decision making.

"More information should be readily available."

Strengthen support for staff and families

VAD specific counselling and bereavement support for families and carers should be strengthened and made more consistently available, rather than relying on ad hoc access to palliative care or social work services.

"More follow up and support needed to prevent negative accumulated grief."

Embedding these supports within the VAD framework would strengthen safeguards for both the workforce and families and promote a more sustainable and compassionate system.

Review eligibility and process requirements

Members have identified the need to review eligibility criteria and timeframes, particularly for people living with neurological and other life limiting conditions with longer and less predictable disease trajectories. Current prognosis requirements may unintentionally exclude individuals whose suffering and loss of function are significant but extend beyond existing time limits.

Consideration should be given to extending eligibility timeframes for these conditions or introducing greater flexibility within the assessment process.

“The time limit should be 12 months instead of 6.”

“Often when people are first diagnosed, they talk about fear of not recognising their loved ones, being completely dependent. For some people they express that their wishes are to be able to die at this point, but this makes them ineligible due to their cognitive function.”

Any review of eligibility must be undertaken carefully, with strong safeguards, and in parallel with ensuring access to high-quality, well-resourced palliative care remains available for all people regardless of diagnosis or end-of-life choice.

Question 2

Do you think the NSW voluntary assisted dying legislation, systems, processes and practices support patient choice in relation to voluntary assisted dying in NSW?

Summary of Findings

Feedback from PCNSW members indicates strong overall confidence that the NSW VAD legislation and associated systems support patient choice. Survey results show that 82.76% of respondents believe the current framework supports patient choice, with only 3.45% indicating that it does not, and 13.79% remaining unsure.

Qualitative feedback highlights that once patients successfully enter the VAD pathway, the legislation, systems and processes are experienced as highly supportive of autonomy and informed choice. However, members consistently note that barriers to exercising choice arise most often at the point of initial access, rather than within the VAD system itself. Notably, respondents from regional areas report a more positive perception of patient choice being supported compared to those working in Greater Sydney, suggesting variation in experience across settings.

Where Patient Choice *Is* Well Supported

Strong support for choice once within the VAD system

For patients who access the formal VAD pathway, the legislation and supporting systems are widely perceived as functioning as intended. Members report that processes respect patient autonomy and provide reassurance, even when VAD is ultimately not pursued.

“I think patient autonomy is supported through the process.”

“Wholeheartedly provides patient choice – without VAD choice is removed.”

“Patients found great comfort in having an option even if not utilised.”

These comments reinforce the view that the VAD framework, once engaged, offers clarity, structure and respect for individual decision making.

Where Patient Choice Is *Not* Fully Supported

Gatekeeping at the point of first request

While patient choice is generally well supported once a referral is made, members report that initial access remains inconsistent. Some patients encounter reluctance or gatekeeping at the point of first request, depending on the clinician or service they approach. This misalignment can disproportionately affect people who are already vulnerable or less confident navigating the health system.

"There is still some gatekeeping by clinicians at initial requests."

"Once referred and seen, absolutely… but getting to them is the problem."

These experiences suggest that choice is, in practice, influenced by variability in clinician knowledge, confidence or willingness to engage, rather than by the legislation itself.

Loss of GP support due to values-based conflict

Members raised concern about situations where general practitioners withdraw from a patient's care due to conscientious objection. While the right to conscientious objection is recognised, the resulting loss of an established therapeutic relationship can significantly limit access to choice, particularly in aged care settings where alternative GP access may be limited.

"Where the person's choice to access VAD has not aligned with the GP values… leaving the person without a GP… troubling in aged care."

This underscores the need for clearer pathways to ensure continuity of care when conscientious objection occurs.

Limited awareness among certain population groups

Awareness gaps continue to affect whether patient choice can be meaningfully exercised. Members report lower levels of awareness of VAD within culturally and linguistically diverse (CALD) communities compared with non-CALD populations. Other groups identified as at risk of reduced awareness include older people, socially isolated individuals and residents of aged care facilities.

In these cases, choice may exist in theory but not in practice, due to limited access to information or support to navigate the system.

Exclusion of people with advanced dementia and other neurological conditions

The Act's decision making capacity requirements were identified as a significant limitation for people with advanced dementia and certain neurological conditions. Members note that individuals may express clear wishes earlier in their illness trajectory but are unable to access VAD later due to cognitive decline affecting capacity.

"It definitely does not if you have advanced dementia."

This raises broader questions about how patient choice is understood and supported over time for people with progressive cognitive conditions.

Limited flexibility in hospital scheduling

Operational constraints can reduce a patient's perceived control over the timing and setting of VAD. Members report that limited flexibility in scheduling can undermine the experience of choice, even where eligibility and approval have been established.

"More choice on date and time… to align with patient choice."

Question 3

Do you think the NSW voluntary assisted dying legislation, systems, processes and practices support equitable access, respect and inclusion in relation to voluntary assisted dying in NSW?

Summary of Findings

PCNSW member feedback indicates moderate confidence that the NSW VAD legislation and supporting systems promote equitable access, respect and inclusion. Survey results show that 68.97% of respondents believe the current framework supports equity, respect and inclusion. This perception is stronger among respondents working in regional, rural and remote areas, where 75% reported a positive view.

However, a substantial minority of respondents—13.79% indicating “No” and 17.24% “Unsure”—identified persistent barriers that limit equitable access in practice. These barriers disproportionately affect culturally and linguistically diverse (CALD) communities, people in regional and remote areas seeking clinician assisted VAD, residents of aged care facilities, and people experiencing cognitive decline. Overall, member feedback suggests that while equity and inclusion are supported in principle, real world access remains uneven due to structural, geographic and service level constraints. In particular, access to clinician assisted VAD options is not consistently available across all settings.

Where Equity, Respect and Inclusion Are *Not* Fully Supported

Although most respondents believe equity is supported overall, the 31% who answered “No” or “Unsure” identified several recurring barriers.

CALD and non-English-speaking communities face unmet access needs

Members report that awareness, language access and culturally safe engagement remain significant challenges for CALD communities, particularly where English proficiency and health literacy are limited. These gaps reduce the likelihood that individuals and families are aware of VAD or feel confident navigating the system.

“I work in an area with a highly multicultural/CALD population. I am not confident that the non-English-speaking population has the same access or awareness of VAD.”

This highlights the need for targeted, culturally appropriate education and engagement strategies to support equitable access.

Geographic inequity: regional and remote access limitations for clinician assisted VAD

Respondents identified ongoing geographic inequities, particularly in relation to access to clinician assisted VAD in regional and remote areas. Workforce limitations and uneven resource distribution mean some patients are required to travel significant distances or transfer to larger hospitals to access services.

"Access can be a challenge for some patients in regional and remote areas."

"We have great difficulty getting someone out to our hospital… Clients have had to go to larger main hospital rather than their local."

Aged-Care-Related Barriers and Provider Restriction

Members reported barriers to VAD access within some aged care facilities and inpatient settings that do not support VAD. In these contexts, patients may experience difficulty obtaining information or referrals at the outset. Where VAD is pursued, patients may be required to transfer away from their familiar care environment, despite longstanding relationships with care teams.

Such disruption can be distressing for patients and families and may undermine respect, continuity of care and inclusion at the end of life.

Exclusion of people with advanced dementia and cognitive decline

Legislative requirements relating to decision making capacity were identified as creating inequity for people living with progressive neurological conditions, including dementia. Members noted that individuals may express clear wishes earlier in their illness but are unable to access VAD once cognitive capacity declines.

"They are not able to enact this directive if they lack cognitive capacity."

"Again, access for dementia patients would make it more equitable."

"I fear for those with cognitive changes."

PCNSW notes that supportive and palliative care models currently implemented in some NSW Local Health Districts—particularly those supporting people with non-malignant illness for up to two years—offer an opportunity to better meet the needs of patients currently excluded from accessing VAD. Broader adoption of these models could improve equity, quality of care and support for patients and families regardless of VAD eligibility.

Need for system flexibility in non-participating facilities

Some members identified potential inequity arising in faith based or other nonparticipating facilities where policies restrict onsite VAD assessments. In these settings, patients may experience additional barriers that affect access, dignity and inclusion.

"Access for VAD consults to take place in non-participating facilities would assist in maintaining access, respect and inclusion."

This highlights the importance of system level flexibility to ensure that nonparticipation does not inadvertently create inequitable barriers for patients.

Question 4

Do you think that the safeguards for patients and healthcare workers in relation to voluntary assisted dying in NSW are appropriate?

Summary of Findings

PCNSW member feedback indicates general support for the current safeguard framework, with 72.41% of respondents reporting that safeguards for patients and healthcare workers are appropriate. However, 13.79% of respondents indicated that safeguards are not appropriate, and a further 13.79% were unsure.

While there is broad confidence in the intent and operation of safeguards—particularly once a patient enters the formal VAD pathway—members identified specific areas where safeguards may unintentionally undermine access, place disproportionate pressure on certain staff groups, or fail to adequately protect patients and healthcare workers in complex or high risk situations.

Where Safeguards *Are* Seen as Appropriate

Overall confidence in safeguards and VAD team practice

Respondents who view safeguards positively express strong trust in the professionalism, care and ethical practice of the VAD Teams. Members report that the legislative framework and operational safeguards provide clarity, consistency and protection for patients and staff once the formal pathway is engaged.

"I feel the VAD teams are great, they holistically look after the pt with the caring teams."

"Nursing staff have no need to be involved... they just continue to provide care as normal."

Where Safeguards Are *Not* Perceived as Appropriate

The 27.58% of respondents who answered "No" or "Unsure" identified several areas where safeguards are experienced as insufficient, inconsistently applied, or unintentionally harmful.

Safeguards that may unintentionally restrict appropriate access

Some respondents expressed concern that eligibility criteria and procedural safeguards—particularly those related to prognosis timelines—are overly restrictive and may exclude patients whose circumstances would otherwise warrant consideration.

"Some of the safeguards/criteria may preclude access for patients who would like to choose VAD."

Aged-care providers restricting rights

Members raised concern that safeguards do not always prevent institution level obstruction or restrictive practices, particularly in some aged care settings. In these cases, safeguards intended to protect patients may fail to prevent actions that limit access or compromise patient rights.

"Some aged care providers have used VAD as a means of discharging people... or refusing access to the VAD team."

"Still see some consultants impede or obstruct access to the VAD process."

These experiences highlight a gap between legislative safeguards and their practical enforcement at a service level.

Need for stronger workforce support and psychological safety

Members identified that current safeguards may be insufficient to protect healthcare workers—particularly early career nurses and junior staff—from emotional distress, role confusion or perceived pressure to participate in VAD related care. This is compounded in non-participating settings where communication may be limited, yet VAD related deaths can still occur.

"This area could do with more support, follow up and education."

"Staff who wish to be conscientious objectors are feeling direct and indirect pressure to be involved—particularly junior staff."

Safety concerns relating to medication management and follow-up in community settings

While medication protocols exist, respondents identified gaps in postdelivery follow up, safe storage and monitoring of VAD medications in the community. Prolonged storage of medications without active follow up was raised as a safety concern.

"Approval then med delivery to a home then no follow up by VAD team is not ok... we have had patients with meds in their home for almost 1 year."

Distress in patients declined access to VAD

Members reported that current safeguards do not adequately address the emotional and psychological impact on patients who are found ineligible for VAD. There is limited provision for consistent, compassionate follow up, leaving some patients and families without appropriate support.

“There needs to be consistent follow-up for patients who are declined VAD… this denial… can cause distress—they need ‘bereavement’ support.”

PCNSW notes that supportive care models for chronic and life-limiting illness—currently utilised in some NSW Local Health Districts—may be better placed to support patients and families in these circumstances, particularly where palliative care is not yet required.

Question 5

Do you think the NSW voluntary assisted dying legislation, systems, processes and practices support sustainability and service delivery in NSW?

Summary of Findings

PCNSW member feedback indicates mixed confidence regarding the sustainability of VAD service delivery in NSW. Survey results show that just over half of respondents (51.72%) believe the current legislation and systems support sustainable service delivery. However, 10.34% reported that sustainability is not supported, and a substantial 37.93% were unsure.

This high level of uncertainty reflects widespread concern across the sector about workforce capacity, particularly in regional and remote areas, as well as the emotional and psychological impact on clinicians, limitations in organisational structures, and fragmented connection with palliative care services. Collectively, these factors raise questions about the long-term sustainability of VAD service delivery without further system strengthening.

Workforce sustainability and shortages, particularly in rural and remote areas

Members report that a stable and accessible VAD workforce is not yet assured across NSW. Workforce shortages are most pronounced in rural and remote areas, where recruitment and retention of trained VAD practitioners remain challenging.

“I know there are some issues in rural and regional areas in recruiting VAD practitioners.”

These workforce limitations place pressure on existing clinicians, reduce service availability, and contribute to inequitable access across geographic regions.

Underutilisation of Nurse Practitioners (NPs) and constrained workforce models

Respondents identified that current legislative and practice models may be limiting the system’s ability to build a sustainable workforce. In particular, Nurse Practitioners (NPs) are perceived as underutilised, despite their potential to expand service capacity, especially in nonmetropolitan areas.

“NPs are underutilised and could have a greater role... particularly in regional and remote areas.”

Emotional and professional load on clinicians

Members consistently report that the emotional and professional complexity of VAD related work is not fully recognised or adequately supported. Insufficient attention to workforce wellbeing risks burnout, reduced participation and attrition, undermining sustainability over time. Psychological safety is identified as a challenge across all care settings, including acute, community and aged care environments.

"It is not my experience that the emotional and professional complexity of this work is understood."

"A VAD doctor... stated she was no longer able to sleep well."

Fragmented or absent follow-up support for families

Members identified a lack of structured, ongoing support for families following VAD as a gap that undermines sustainable service delivery. In the absence of dedicated bereavement pathways, responsibility often falls to already stretched pastoral care, social work or palliative care teams.

"Family long-term follow up is an area of concern. Very little is offered."

"There is no bereavement support for families... which is not sustainable."

Without appropriate resourcing and clear responsibility for follow up, these gaps risk compounding workforce strain and negatively impacting family experience.

System fragmentation when VAD and palliative care are not well integrated

NSW VAD reporting indicates that a high proportion of people approved for VAD are also receiving specialist palliative care. This underscores the importance of systems that enable coordinated, high quality care across both VAD and palliative care services. Where communication and integration are poor, patient centred care becomes more difficult to deliver and staff may be unaware of parallel care arrangements.

"A palliative patient may be under VAD and the palliative team is completely unaware."