VOLUNTARY ASSISTED DYING FOR (SOME) RESIDENTS ONLY: HAVE STATES INFRINGED S 117 OF THE *CONSTITUTION*?

Katrine Del Villar* and Amelia Simpson†

All six Australian states have passed laws which now permit (or will, once commenced, permit) voluntary assisted dying ('VAD') in limited circumstances. One controversial feature of all these schemes is that access is restricted to patients who have been resident in the providing state for at least 12 months. We consider the possible justifications for this restricted access and, ultimately, whether it can be reconciled with s 117 of the Australian Constitution, *which proscribes discrimination on the basis of out-of-state residence. We find that while excluding non-residents from VAD schemes may be proportionate to non-discriminatory policy goals, the exclusion of new residents of a state is harder to defend and leaves these laws open to constitutional challenge.*

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* Postdoctoral Research Fellow, Australian Centre for Health Law Research, Faculty of Business and Law, Queensland University of Technology.

† Associate Professor, ANU College of Law, Australian National University. The law as stated in this article is current as at 14 July 2022.

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I Introduction

Voluntary assisted dying ('VAD')[1] is now lawful (in narrowly defined circumstances) in two Australian states — Victoria[2] and Western Australia ('WA').[3]

[1] This term encompasses both *active voluntary euthanasia*, where a medical practitioner performs an action causing the death of a person at the person's request (usually by a lethal injection), as well as *physician-assisted suicide*, where a medical practitioner prescribes a lethal medication which is ingested by the individual unassisted.

[2] The *Voluntary Assisted Dying Act 2017* (Vic) ('*Victorian VAD Act*') was passed in November 2017 and commenced operation on 19 June 2019: see at s 2.

[3] The *Voluntary Assisted Dying Act 2019* (WA) ('*WA VAD Act*') was passed in December 2019 and commenced on 1 July 2021: see at s 2; Kim Beazley, Governor, 'Voluntary Assisted Dying Act 2019 Commencement Proclamation 2021' in Western Australia, *Western Australian Government Gazette*, No 109, 18 June 2021, 2458, 2458.

When laws recently passed in Tasmania,[4] South Australia ('SA'),[5] Queensland[6] and New South Wales ('NSW')[7] commence operation in late 2022–23, it will also become lawful in those states. The legislation passed in all six states restricts access to VAD to people who have been residents of that state for at least 12 months. This is contentious for residents of those four states where VAD is not yet legal, and is particularly problematic for residents of the Australian Capital Territory ('ACT') and Northern Territory ('NT'), as the Commonwealth has removed from their Legislative Assemblies any power to enact VAD legislation.[8]

It is highly likely that residents of other Australian states and the territories will wish to access VAD in those states where it is lawful.[9] Indeed, when VAD was briefly legal in the NT,[10] the first person who sought access was an interstate resident: 66-year-old taxi driver Max Bell, who was suffering terminal stomach cancer, drove himself from his home in Broken Hill to Darwin in April 1996

[4] The *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) ('*Tasmanian EOLC Act*') was passed in March 2021 and will commence by 23 October 2022: see at s 2.

[5] The *Voluntary Assisted Dying Act 2021* (SA) ('*SA VAD Act*') was passed in June 2021 and is expected to commence in early 2023: see at s 2.

[6] The *Voluntary Assisted Dying Act 2021* (Qld) ('*Queensland VAD Act*') was passed in September 2021 and is expected to commence on 1 January 2023: see at s 2.

[7] The *Voluntary Assisted Dying Act 2022* (NSW) ('*NSW VAD Act*') was passed in May 2022 and is expected to commence on 28 November 2023: see at s 2.

[8] In 1995, the NT passed the first law permitting euthanasia in the world: the *Rights of the Terminally Ill Act 1995* (NT). However, this law was overturned by the Commonwealth government in exercise of its constitutional power under s 122 of the *Australian Constitution* to legislate for the territories: *Euthanasia Laws Act 1997* (Cth) schs 1–2, which introduced s 50A into the *Northern Territory (Self-Government) Act 1978* (Cth) and s 23(1A) into the *Australian Capital Territory (Self-Government) Act 1988* (Cth). See also George Zdenkowski, 'The International Covenant on Civil and Political Rights and Euthanasia' (1997) 20(1) *University of New South Wales Law Journal* 170, 177–9. It is possible that this restriction will be removed by the federal government: Josh Butler, 'Albanese Government to Move to Grant Territories Right to Set Own Voluntary Assisted Dying Laws', *The Guardian* (online, 30 July 2022) <https://www.theguardian.com/australia-news/2022/jun/30/albanese-government-to-move-to-grant-territories-right-to-set-own-voluntary-assisted-dying-laws>, archived at <https://perma.cc/XHH8-7GUD>.

[9] In evidence to the South Australian Parliamentary Committee, Dr Roger Hunt, a palliative care consultant, described a patient with advanced ovarian cancer who wished she lived in Victoria so she could have access to VAD: Evidence to Joint Committee on End of Life Choices, Parliament of South Australia, Adelaide, 16 July 2019, 17 (Roger Hunt). In the debate on the Tasmanian legislation, Michael Gaffney referred to a letter received from a resident of NSW requesting that Tasmania's legislation apply to residents of other states: Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 120 (Michael Gaffney).

[10] When assisted dying was briefly legal under the *Rights of the Terminally Ill Act 1995* (NT) s 4.

specifically to avail himself of the law.[11] Residents of the ACT have also indicated frustration at the Territory's inability to pass its own VAD law, and their intention to travel to states where VAD is legal.[12] However, the legislation in those Australian states where VAD is legal expressly restricts access to residents of the state, and excludes residents of other states or territories.

There has been little attention given, to date, to the constitutionality of such attempts to restrict access to VAD to residents of a provider state. In particular, the *Australian Constitution*'s s 117 prohibition of discrimination against out-of-state residents may provide an avenue for challenging state residency requirements that serve as barriers to accessing VAD in Australia. This article explores the potential for s 117 to disrupt state laws limiting access to VAD. After outlining the key features of current VAD legislation, as well as s 117 doctrine, we marry the two to offer an analysis and predictions as to how courts might approach a s 117 challenge in this field.

[11] Max Bell was unable to access VAD in the NT not because he was a NSW resident, but because the laws were new, and doctors were reluctant to be involved, so he was unable to obtain the necessary certification of three doctors that he met the eligibility criteria. He eventually drove back to Broken Hill and died in palliative care: Murray McLaughlin, 'The Road to Nowhere', *Four Corners* (Australian Broadcasting Corporation, 1996).

[12] In 2019, ACT resident Neil O'Riordan illegally assisted his wife Penelope Blume, who was terminally ill with progressive motor neurone disease, to commit suicide. Although there were reasonable prospects of a conviction for assisting suicide — in the ACT, assisting suicide is a crime punishable by a maximum 10 years' imprisonment: *Crimes Act 1900* (ACT) s 17 — based on O'Riordan's full and frank confession to police, the ACT Director of Public Prosecutions exercised his discretion not to prosecute: see Neville Shane Drumgold, Director of Public Prosecutions (ACT), *Police v O* (Statement of Reasons CC2019/3260, 28 June 2019) 2–3 <https://www.dpp.act.gov.au/__data/assets/pdf_file/0007/1382353/Police-v-O-DPP-Statement-of-Reasons.pdf>, archived at <https://perma.cc/7DFL-4BJG>. O'Riordan told reporters that breaking the law to fulfil his wife's wish would have been unnecessary had the *Victorian VAD Act* (n 2) been operational at the time, indicating their intention to travel to Victoria to access VAD, and lack of awareness of the residency requirement: Michael Inman, 'Assisted Suicide Charges Dropped against Canberra Man Who Helped End Wife's Life', *ABC News* (Web Page, 2 July 2019) <https://www.abc.net.au/news/2019-07-02/assisted-suicide-charges-dropped-in-canberra-court/11270040>, archived at <https://perma.cc/N9YQ-57YM>. In 2021, Ruth Wedd shared the story of her husband's 2020 death from cancer, lamenting the lack of VAD legislation in the ACT and asking: 'Do we all have to leave our homes and go interstate to die?': Dan Jervis-Bardy, 'Ruth Wedd Backs ACT's Right to Make Own Euthanasia Laws', *The Canberra Times* (online, 31 July 2021) <https://www.canberratimes.com.au/story/7358284/stephen-made-a-heart-wrenching-request-to-his-wife-of-20-years>.

II VAD Legislation and the Residency Requirement

A *Victoria's VAD Act*

To be eligible to access VAD in Victoria, a person must meet a number of statutory criteria. Most of these relate to the person suffering a terminal illness[13] and making a voluntary, autonomous decision.[14] However, one criterion is that of Victorian residence. Section 9(1)(b) of the *Voluntary Assisted Dying Act 2017* (Vic) ('*Victorian VAD Act*') states that to be eligible to access voluntary assisted dying,

> the person must —
>
> (i) be an Australian citizen or permanent resident; and
>
> (ii) be ordinarily resident in Victoria; and
>
> (iii) at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months.

Strong community support for a residency requirement was expressed at the community consultation forums conducted prior to the introduction of VAD legislation in Victoria.[15] The Bill, as initially introduced, only required a person to be ordinarily resident in Victoria.[16] It was considered that stipulating a minimum 12-month period of residency would increase the administrative burden placed on those requesting VAD, as 'it is unnecessarily onerous to require people who are dying and suffering to collect 12 months of electricity bills, for

[13] A person must be diagnosed with an incurable disease, illness or medical condition that is advanced, progressive, and expected to cause death within six months: *Victorian VAD Act* (n 2) s 9(1)(d). An exception is made if the disease, illness or medical condition is neurodegenerative, in which case death must be expected within 12 months: at s 9(4). The disease, illness or medical condition must also be causing suffering that cannot be relieved in a manner that the person considers tolerable: at s 9(1)(d)(iv). Mental illness or disability alone is not a ground for accessing VAD: at ss 9(2)–(3). However, a person suffering a mental illness or disability who also suffers from a terminal medical condition as described is not precluded from accessing VAD: see Ministerial Advisory Panel on Voluntary Assisted Dying, *Final Report* (Report, July 2017) 80–5 ('*Victorian Panel Report*').

[14] A person must be aged 18 years or over, and must have decision-making capacity in relation to VAD: *Victorian VAD Act* (n 2) ss 9(1)(a), (c). The criteria for a person to be considered to have decision-making capacity are defined in s 4.

[15] *Victorian Panel Report* (n 13) 56.

[16] The introduction print of the Voluntary Assisted Dying Bill 2017 (Vic) did not contain s 9(1)(b)(iii).

example, to demonstrate how long they have lived in Victoria.'[17] However, the lack of a minimum residence requirement was criticised in the parliamentary debate. Indicatively, the Member for Lowan, Emma Kealy, said:

> There is nothing to require that an assessment be done by a practitioner familiar with the patient, and there is no restriction on doctor shopping … The regime is available to any Australian resident willing to rent and live in a flat in Victoria for the few days needed for their assessment and death.[18]

To counter these objections, a minimum 12-month residence requirement was inserted when the VAD Bill was introduced into the Legislative Council.[19]

The residence requirement has already been contentious in Victoria. At least two people have been held to be ineligible for VAD because they were not 'Australian citizen[s] or permanent resident[s]',[20] despite having lived in Australia for decades.[21] However, a more flexible approach was taken to the criterion of 'ordinarily resident in Victoria for at least 12 months'[22] in the case of *NTJ v NTJ* ('*NTJ*').[23] In that case, the Victorian Civil and Administrative Tribunal ('VCAT') determined that a terminally ill man residing in a caravan and absent from Victoria for long periods nevertheless met the Victorian residency

[17] *Victorian Panel Report* (n 13) 57.

[18] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3053 (Emma Kealy).

[19] Amendments and New Clause to Be Proposed in Committee by Gavin Jennings, Voluntary Assisted Dying Bill 2017 (Vic) [3].

[20] *Victorian VAD Act* (n 2) s 9(1)(b)(i).

[21] Julian Bareuther committed suicide after finding he was ineligible for VAD because he had never taken out Australian citizenship: *Finding into the Death of Julian Victor Charles Bareuther* (Coroner's Court of Victoria, COR 2019 5236) [10] (Coroner Byrne). His doctor stated:

> He was an Australian in every sense but a technical one, a previous taxpayer, a current Centrelink recipient, and on the Electoral Roll. Because of this citizenship technicality, he was denied VAD.

Similarly, in *YSB v YSB* [2020] VCAT 1396, a man who was born in the United Kingdom but had lived in Australia for 15 years was denied a VAD permit at the final step of the VAD process, after completing all the eligibility assessments, because he had never formally applied for Australian citizenship or permanent residency: at [2]–[5] (Quigley J). This situation will not arise in New South Wales, Queensland or Tasmania, as the residency requirements in those states include a person who is an Australian citizen or permanent resident, or who has been resident in Australia for at least 3 years: *NSW VAD Act* (n 7) s 16(1)(b)(iii); *Queensland VAD Act* (n 6) s 10(1)(e)(iii); *Tasmanian EOLC Act* (n 4) s 11(1)(a)(iii).

[22] *Victorian VAD Act* (n 2) s 9(1)(b)(iii).

[23] [2020] VCAT 547 ('*NTJ*').

requirement.[24] It stated that residence was 'a matter of fact and degree', which depends on the context and circumstances of a person's life, and that continuous physical presence was not a requirement for 'ordinary residence'.[25] Nor was having a fixed address.[26] Rather, where a person regularly or customarily lives is relevant,[27] as is the person's subjective intention.[28] The patient in this case based himself in Victoria, where his family was,[29] and, despite his frequent absences, was finally determined to satisfy the criterion of being 'ordinarily resident in Victoria', and hence was eligible for VAD.[30]

B *Western Australia's VAD Act*

WA has identical residence requirements to those enacted in Victoria, although the language is streamlined. Section 16(1)(b) of the *Voluntary Assisted Dying Act 2019* (WA) ('*WA VAD Act*') requires that a person requesting access to VAD[31]

> (i) is an Australian citizen or permanent resident; and
>
> (ii) at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months.

As in Victoria,[32] community consultation in WA prior to the introduction of the VAD Bill strongly favoured restricting eligibility for VAD to Australian citizens or permanent residents who were ordinarily resident in WA.[33] However, in WA, community sentiment 'was fairly evenly divided on whether a timeframe should be stipulated and, if one were to be specified, whether it be 6 or 12 months'.[34]

[24] Ibid [83]–[90] (Quigley J), interpreting *Victorian VAD Act* (n 2) s 9(1)(b)(ii).

[25] *NTJ* (n 23) [83] (Quigley J).

[26] Ibid [84].

[27] Ibid [83].

[28] Ibid [88].

[29] Ibid [85], [87].

[30] Ibid [91].

[31] The terms of this provision follow recommendation 3 of the Ministerial Expert Panel on Voluntary Assisted Dying, *Final Report* (Report, 27 June 2019) xii ('*WA Panel Report*').

[32] *Victorian Panel Report* (n 13) 56.

[33] Ibid 19.

[34] Ibid.

Specific concerns were raised that a timeframe might exclude individuals in particular situations, such as:

- Western Australian residents living and working interstate or overseas who return home to be with family after receiving a terminal diagnosis (returning residents);
- persons who have genuinely moved to and established residency in WA, but who are diagnosed with a terminal illness before 12 months have elapsed (new residents); or
- fly-in fly-out workers, who may have more than one legitimate 'ordinary residence'.[35]

Despite these concerns, the Ministerial Expert Panel advising the government on the form of the legislation recommended a 12-month residency requirement, consistently with the approach taken in Victoria.[36] It did not recommend any specific exemptions for new residents, returning residents or fly-in fly-out workers. However, the Panel did recommend that provision be made for

> people to apply to the State Administrative Tribunal for relief from the strict requirements of residency, in exceptional circumstances, on compassionate grounds.[37]

No such flexibility was incorporated into the *WA VAD Act* as enacted.

If the approach taken by VCAT in *NTJ* is applied to the Western Australian law, fly-in fly-out workers should be able to assert residence of the State, as having more than one primary place of residence is permissible. Those who work interstate but reside in WA may also be eligible, although it will depend on the context, the precise nature of the work/residence arrangements, and the subjective intention of the person concerned. However, no protection is provided for new residents of the State: those who have lived in WA for less than 12 months.

C *Tasmania's VAD Act*

The *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* ('*Tasmanian EOLC Act*') requires a person seeking VAD to demonstrate that 'the person has been

[35] Ibid 20.

[36] Ibid.

[37] Ibid.

ordinarily resident in Tasmania for at least 12 continuous months immediately before the person makes the relevant first request'.[38] The different formulation of '12 continuous months' is likely to create problems for people living a fairly nomadic lifestyle, fly-in fly-out workers, and those working away from home. Concern was expressed during debate on this provision as to whether returning former residents of Tasmania (such as adult children working or studying interstate or overseas) would meet the criterion of 'ordinarily resident' in Tasmania.[39]

The reason for stipulating a minimum 12-month residence requirement in the Tasmanian legislation is unclear. Michael Gaffney, the independent Member of the Legislative Council who introduced the legislation, stated that '[w]e took the lead of other states here': that is, the provision was modelled on the requirement in the Victorian and WA VAD laws.[40] One Member of Parliament mentioned the desirability of an 'ongoing relationship with [a patient's] medical team over a lengthy period of time', suggesting that access to VAD should be limited to those currently residing in Tasmania and being treated by Tasmanian doctors.[41]

D *South Australia's VAD Act*

The residence criterion in the *Voluntary Assisted Dying Act 2021* (SA) ('*SA VAD Act*') is practically identical to those in Victoria and WA.[42] The explanatory material contains no specific discussion of the residence requirement: Kyam Maher merely noted that the South Australian Bill is 'a direct translation of the Victorian model'.[43]

38 *Tasmanian EOLC Act* (n 4) s 11(1)(b).

39 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 121–6 (Megan Webb and Leonie Hiscutt).

40 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 120 (Michael Gaffney).

41 Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 123 (Sarah Lovell).

42 *SA VAD Act* (n 5) s 26(1)(b).

43 South Australia, *Parliamentary Debates*, Legislative Council, 2 December 2020, 2350 (Kyam Maher).

E *Queensland's VAD Act*

Queensland's *Voluntary Assisted Dying Act 2021* (Qld) ('*Queensland VAD Act*'), like all other states, requires that a person 'ha[ve] been ordinarily resident in Queensland for at least 12 months' before making a VAD request.[44] It was recommended that this residency requirement follow the format of the Victorian and WA legislation.[45] However, uniquely, the *Queensland VAD Act* also provides that a person may be granted a Queensland residency exemption by the chief executive of the Department of Health.[46] An exemption must be granted where the person 'has a substantial connection to Queensland' and there are 'compassionate grounds' for granting an exemption.[47] Examples given in the Act include residents of border communities who work in Queensland and receive medical treatment in Queensland, and returning residents with family in Queensland.[48] No mention is made of new residents of the State.

The Queensland Law Reform Commission ('QLRC') recognised that the state residence requirement might infringe s 117 of the *Australian Constitution*.[49] It considered that discrimination against out-of-state residents

> might be justified by the need to maintain the integrity of the State's health system and to ensure the availability of voluntary assisted dying services for Queensland residents.[50]

That is, a state residence requirement may be needed — particularly in the 'early stage of implementing a voluntary assisted dying scheme' (when there may be limited numbers of practitioners qualified to assess eligibility and administer medication) — in order to ensure Queensland residents are prioritised in the allocation of limited financial and health resources.[51] However, the QLRC considered there may be less need for a residency requirement when other

[44] *Queensland VAD Act* (n 6) s 10(1)(f)(i).

[45] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary Assisted Dying* (Report No 34, March 2020) 117–18.

[46] *Queensland VAD Act* (n 6) s 10(1)(f)(ii).

[47] Ibid s 12(2).

[48] Ibid. An example in an Act is part of the Act: *Acts Interpretation Act 1954* (Qld) s 14(3).

[49] Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (Report No 79, May 2021) 158 [7.442], 159 [7.448] ('*QLRC Report*').

[50] Ibid 159 [7.448].

[51] Ibid 158 [7.438].

Australian jurisdictions have introduced VAD regimes,[52] and recommended that the need for this requirement be reviewed when the operation of the legislation is reviewed.[53]

F *New South Wales' VAD Act*

The residence criterion in the *Voluntary Assisted Dying Act 2022* (NSW) ('*NSW VAD Act*') is practically identical to those in WA and Queensland: namely, that 'at the time of making a first request, the person ha[ve] been ordinarily resident in New South Wales for a period of at least 12 months'.[54] The explanatory material accompanying the introduction of this law does not specifically mention the purpose of the residence requirement.[55]

G *Residence Requirements in Other Jurisdictions*

In Europe, voluntary euthanasia and assisted dying are lawful in the Netherlands, Belgium, Luxembourg and Spain.[56] Assisting suicide is lawful in Switzerland, provided it is not done for 'selfish motives',[57] as well as in Austria and Germany.[58] Except for Spain, no European jurisdiction maintains an explicit

[52] Ibid 165 [7.498].

[53] Ibid 168 recommendation 7-13.

[54] *NSW VAD Act* (n 7) s 16(1)(c).

[55] See Explanatory Notes, Voluntary Assisted Dying Bill 2021 (NSW).

[56] *Wet Toetsing Levensbeëindiging op Verzoek en Hulp Bij Zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act] (Netherlands) 2001, art 2(1) ('*Netherlands Assisted Suicide Act*'), which is read in conjunction with *Wetboek van Strafrecht* [Criminal Code] (Netherlands) 1881, art 293; *Loi Relative à L'Euthanasie* [Act on Euthanasia] (Belgium) 28 May 2002, s 3; *Legislation Reglementant les Soins Palliatifs Ainsi que L'Euthanasie et L'Assistance au Suicide* [Legislation Regulating Palliative Care and Euthanasia and Assisted Suicide] (Luxembourg) 16 March 2009, art 2; *Ley Orgánica 3/2021, de 24 de Marzo, de Regulación de la Euthanasia* [Organic Law, 3/2021, March 24, for the Regulation of Euthanasia] (Spain) art 4 ('*Spanish Euthanasia Act*').

[57] *Schweizerisches Strafgesetzbuch* [Criminal Code] (Switzerland) 21 December 1937, SR 311, art 115. This exception has been contained in the *Swiss Criminal Code* adopted by referendum in 1938, and in force since 1942: see Olivier Guillod and Aline Schmidt, 'Assisted Suicide under Swiss Law' (2005) 12(1) *European Journal of Health Law* 25, 29–30.

[58] *Gesamte Rechtsvorschrift für Sterbeverfügungsgesetz* [Decree on Death Act] (Austria) BGBl I, 242/2021, § 1(1); Bundesverfassungsgericht [German Constitutional Court], 2 BvR 2347/15, 26 February 2020 reported in (2020) BVerfGE, 25 [202]–[203], 26–7 [208]–[210], 40–1 [278]–[279], 46 [307], [331].

residence requirement in its legislation.[59] Foreign residents commonly travel to Switzerland to access assisted dying services provided by privately run clinics established by organisations such as Dignitas and Exit International, where such acts are prohibited in their home countries. Recently, there have also been reports of considerable numbers of foreign residents, particularly from France, travelling to Belgium to access euthanasia there.[60] This is much less common in the Netherlands and Luxembourg.[61]

By contrast, in Canada[62] and in those jurisdictions in the United States ('US') that permit VAD, a person must be a resident to be able to access VAD, although no minimum residency period is stipulated in the legislation.[63]

[59] In Spain, to be eligible to seek assistance in dying, a person must demonstrate one of three criteria: (a) the person has Spanish nationality, or (b) the person has legal residence in Spain, or (c) the person has a certificate of registration in Spanish territory greater than 12 months: *Spanish Euthanasia Act* (n 56) art 5(1)(a). Under this provision, a Spanish citizen or permanent resident may access euthanasia in Spain even if they have not resided in Spain for the last 12 months.

[60] Cecilia Rodriguez, 'Euthanasia Tourism: Is the EU Encouraging Its Growth?', *Forbes* (Web Page, 17 March 2019) <https://www.forbes.com/sites/ceciliarodriguez/2019/03/17/euthanasia-tourism-is-the-e-u-encouraging-its-growth/?sh=2963cf6229b9>, archived at <https://perma.cc/D3RT-MUGT>; Bruno Waterfield, 'Euthanasia Tourists Flock to Belgian A&Es', *The Times* (online, 19 August 2016) <https://www.thetimes.co.uk/article/euthanasia-tourists-flock-to-belgian-a-e-s-zt9tnljr5>.

[61] The Netherlands Ministry for Foreign Affairs has stated that it would be 'impossible' for a non-resident to access assisted dying, on the basis that a close doctor–patient relationship is needed for the requirements of the legislation to be met: Netherlands Ministry of Foreign Affairs, 'The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in Practice' (Information Sheet, 2010) 17 <http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/03/Netherlands_Ministry_of_Justice_FAQ_Euthanasia_2010.pdf>, archived at <https://perma.cc/KZ8X-D923>. However, there is no requirement in the legislation that a person be a resident, or that there be a longstanding doctor–patient relationship: *Netherlands Assisted Suicide Act* (n 56) art 2.

[62] In Canada, a person must be eligible for health services funded by a government in Canada (that is, a resident or temporary resident) to be able to access medical aid in dying: *Criminal Code*, RSC 1985, c C-46, s 241.2(1)(a). Québec also has a provincial law permitting aid in dying, which was passed prior to the federal government's law: *Act Respecting End-of-Life Care*, RSQ 2014, c S-32.0001, s 26 ('*Québec EOLC Act*'). Eligibility under that law is restricted to a resident or temporary resident of Québec who is registered under the *Health Insurance Act*, RSQ 1985, c A-29: *Québec EOLC Act* (n 62) s 26(1).

[63] In Oregon, to be eligible to request assistance to die under the VAD legislation, a person must be a resident of Oregon: Or Rev Stat § 127.805(1) (1997) ('*Oregon Death with Dignity Act*'). All other US jurisdictions which allow assisted dying similarly require a person to be a resident of that jurisdiction in order to request assistance to die, but do not require a minimum period of residency: *Washington Death with Dignity Act*, Wash Rev Code §§ 70.245.040(1)(b),

In 2021, the first constitutional challenge to an American VAD residency requirement was commenced by a doctor in Portland, Oregon, seeking to assist patients residing a few miles away in Washington State (where VAD is also legal and available to residents).[64] The claim in *Gideonse v Brown* was settled in March 2022, with the Oregonian authorities agreeing not to enforce the residence requirement.[65] This litigation holds an important reminder for Australia — that cross-border issues may persist even if all jurisdictions eventually enact VAD laws.

III Section 117 and the Prohibition on Discrimination

Section 117 of the *Australian Constitution* provides:

> A subject of the Queen, resident in any State, shall not be subject in any other State to any disability or discrimination which would not be equally applicable to him if he were a subject of the Queen resident in such other State.

Significantly, this provision applies only to residents of a state, not residents of the territories.

For the better part of a century, the High Court construed s 117 narrowly. The narrow and formalistic approach to s 117 was well illustrated in the 1973 decision of *Henry v Boehm*, where the High Court rejected a challenge to South Australian rules of court regulating lawyers' admission to practise.[66] The rules provided that lawyers previously admitted in another state or territory must reside in SA for a minimum period before becoming eligible for admission to

70.245.130 (2008) (Washington); *Patient Choice and Control at End of Life Act*, Vt Stat Ann § 5283(5)(E) (2013) (Vermont); *End of Life Option Act*, Cal Health and Safety Code § 443.2(3) (Deering, 2015) (California); *Death with Dignity Act of 2016*, DC Code § 7-661 (2017) (District of Columbia); *End-of-Life Options Act*, Colo Rev Stat § 25-48-103(1) (2016) (Colorado); *Our Care, Our Choice Act 2018*, Haw Rev Stat §§ 327L-2, 327L-13 (2018) (Hawaii); *Medical Aid in Dying for the Terminally Ill Act*, NJ Stat Ann § 26:17-4(a) (West, 2019) (New Jersey); *Maine Death with Dignity Act*, 22 Me Rev Stat Ann § 2140.4 (2019) (Maine); *Elizabeth Whitefield End-of-Life Options Act*, NM Stat § 24-7C-2(A) (2021) (New Mexico).

64 Nicholas Gideonse, 'Complaint for Declaratory and Injunctive Relief', Pleading in *Gideonse v Brown*, DOR3:21-cv-1568, 28 October 2021, 2 [2], 3 [4].

65 'Settlement Agreement and Release of Claims', Settlement in *Gideonse v Brown*, DOR3:21-cv-1568, 28 March 2022, 2.

66 (1973) 128 CLR 482, 489–90 (Barwick CJ, McTiernan J agreeing at 490), 494 (Menzies J), 498 (Gibbs J).

practise there.[67] By a 4:1 majority, the Court found that s 117 was not engaged because the residency requirements were equally applicable to existing residents of SA who had been admitted in another jurisdiction previously.[68]

In its 1989 decision in *Street v Queensland Bar Association* ('*Street*'), the High Court overhauled its approach to s 117, giving the provision a greatly expanded potential operation.[69] Although seven separate judgments were delivered, there was unanimous agreement that the impugned Queensland rule, regulating admission to practise as a barrister, amounted to discrimination on the basis of out-of-state residence.[70] All judgments endorsed two key shifts in the Court's interpretation and application of this constitutional limitation. First, they held that s 117 is concerned not only with the legal form of a given restriction but also the substantive effect that a law has on out-of-state residents.[71] Secondly, they found that the comparison to be drawn, in identifying s 117 discrimination, did not look to the experience of real in-state residents but rather to the experience of a hypothetical comparator — an imagined person sharing all of a claimant's attributes except for their out-of-state residence.[72] Chief Justice Mason accurately summed up the agreed new principle as follows: 's 117 renders a disability or discrimination invalid if the notional fact of residence within the legislating State would effectively remove the disability or discrimination or substantially deprive it of its onerous nature'.[73]

It was conceded in *Street*, in all seven judgments, that s 117 operates subject to limitations that reflect other provisions and implications found in the *Australian Constitution*. A much-ventilated example was that of a person's eligibility to vote in elections for state Parliaments or to vote for Senators to represent a particular state. The four judges who contemplated that scenario agreed that out-of-state residents could not possibly succeed in a s 117 challenge to their exclusion from elections of those kinds.[74] Beyond that example, however, there

[67] Ibid 485–6 (Barwick CJ).

[68] Ibid 489–90 (Barwick CJ, McTiernan J agreeing at 490), 492 (Menzies J), 497–8 (Gibbs J). Justice Stephen dissented on this point: at 507.

[69] (1989) 168 CLR 461 ('*Street*').

[70] Ibid 493–4 (Mason CJ), 519–20 (Brennan J), 531–2 (Deane J), 549–50 (Dawson J), 563–4 (Toohey J), 575 (Gaudron J), 590 (McHugh J).

[71] Ibid 488 (Mason CJ), 506–8 (Brennan J), 526–7 (Deane J), 544–5 (Dawson J), 559 (Toohey J), 568–9 (Gaudron J), 581–2 (McHugh J).

[72] Ibid 486–7 (Mason CJ), 507 (Brennan J), 526–7 (Deane J), 544–5 (Dawson J), 555 (Toohey J), 566–7 (Gaudron J), 582 (McHugh J).

[73] Ibid 489.

[74] Ibid 512–13 (Brennan J), 528 (Deane J), 548 (Dawson J), 570 (Gaudron J).

were a variety of views expressed as to the nature and scope of the limitations upon s 117. Some judgments explained the limitations in federalist terms, viewing them as necessary inferences from the states' status as autonomous political units. For example, Mason CJ stated that

> [t]he preservation of the autonomy of the States demands … the exclusion of out-of-State residents from the enjoyment of rights naturally and exclusively associated with residence in a State …[75]

Alternately, some judgments conceived of the limitations upon s 117 more as a function of the legal concept of discrimination. This was most clearly expressed by Gaudron J, who insisted that s 117 only proscribed different treatment of out-of-state residents where grounded in 'considerations which are irrelevant to the [legislative] object to be attained'.[76] Where, on the other hand, different treatment of out-of-state residents was 'appropriate to a relevant difference', it could not properly be characterised as discrimination and thus would fall outside the scope of the s 117 limitation.[77] Across the spectrum of views on this, however, all judgments seemed to contemplate that the limitations upon s 117's reach, whatever their source and nature, would be marked out in concrete cases with the aid of concepts such as appropriateness, adaptation, balancing and proportionality.[78]

While *Street* is recognised as having instigated the 'new law' of s 117, it is challenging to extract from the seven judgments a lowest common denominator set of principles that could serve as a test when applying the provision. The most authoritative attempt at this task to date was made in the joint majority judgment of Gleeson CJ, Gummow, Kirby and Hayne JJ in *Sweedman v Transport Accident Commission* ('*Sweedman*').[79] Whilst their Honours did not there set out a s 117 'test', they did affirm the two most important planks of the reasoning in *Street*. Specifically, they said: (1) s 117 operates with an 'emphasis upon substance and practical operation';[80] and (2) different treatment of out-of-state residents is beyond the reach of s 117 where 'appropriate and adapted (sometimes described as "proportional") to the attainment of a

[75] Ibid 492.

[76] Ibid 571.

[77] Ibid.

[78] Ibid 492–3 (Mason CJ), 511–14 (Brennan J), 528–9 (Deane J), 548, 550 (Dawson J), 559–60 (Toohey J), 571–3 (Gaudron J), 583–4 (McHugh J).

[79] (2006) 226 CLR 362 ('*Sweedman*').

[80] Ibid 408 [59].

proper objective'.[81] Also relevant to assembling a test for s 117 is the view taken in *Goryl v Greyhound Australia Pty Ltd* ('*Goryl*') that even direct discrimination against out-of-state residents (ie evident in the very terms of an impugned provision) may be vindicated if it served a legitimate policy objective.[82]

In the absence, then, of a single, primary source stating a complete test for the application of s 117, we suggest that the reasoning in *Street*, *Goryl* and *Sweedman* is consistent with the following two-stage test:

> Stage One: Does the impugned law discriminate against out-of-state residents in its practical operation (on an examination of the substance as well as the legal form of the law)? If yes;
>
> Stage Two: Is the treatment of out-of-state residents appropriate and adapted to the attainment of a proper objective?

The second stage involves balancing the nature and extent of the discriminatory treatment of non-residents against the apparent value of the state policy objective being pursued. We expect the methodology of structured proportionality will be adopted by the High Court to perform this balancing analysis, when the Court is given the opportunity.[83] We hold this view for several reasons.

As explained above, the case law on s 117 does not contain a recent, unified expression of how to conduct the required balancing. This significant missing piece within current doctrine leaves it ripe for revision and updating. The methodology of structured proportionality is well positioned to fill the gap. As a means of articulating whether and when constitutional protections should cede to worthy policy objectives, the structured proportionality approach has become firmly established in the High Court's jurisprudence on the implied

[81] Ibid 409–10 [66].

[82] (1994) 179 CLR 463, 479–80 (Deane and Gaudron JJ), 486–7 (Dawson and Toohey JJ), 493 (McHugh J) ('*Goryl*').

[83] The inevitable expansion of structured proportionality has been alluded to extra-curially by Chief Justice Kiefel and advanced more clearly by other commentators: Justice Susan Kiefel, 'Section 92: Markets, Protectionism and Proportionality' (2010) 36(2) *Monash University Law Review* 1, 13–14; Evelyn Douek, 'All Out of Proportion: The Ongoing Disagreement about Structured Proportionality in Australia' (2019) 47(4) *Federal Law Review* 551, 562–3.

freedom of political communication,[84] despite some resistance, most notably from Gageler J and Gordon J.[85]

Further, in *Palmer v Western Australia* ('*Palmer*'), the High Court has very clearly and deliberately installed structured proportionality at the heart of s 92, a constitutional freedom of trade, commerce and movement, which, like s 117, serves a federal–structural purpose within the constitutional design.[86] This is despite the fact that s 92 was already governed by well-settled and clearly articulated balancing principles.

Defending that extension, Kiefel CJ and Keane J insist that structured proportionality is the most 'rational' of the available approaches to the judicial task of balancing and also that,[87] in eschewing habitual deference, it complements the Court's 'proper role … as the guardian of constitutionally protected freedoms'.[88] Justice Edelman prefers it to the balancing tests traditionally employed in Australian constitutional doctrine because, he says, it is more transparent.[89] Tellingly, a majority of the states and territories making submissions in *Palmer* apparently endorsed the extension.[90]

Therefore, currently, two of the three most prominent, well-established Australian constitutional 'freedoms' — the implied freedom of political communication and the s 92 freedom — are governed by a structured proportionality approach to balancing. The third in the troika, s 117, is in need of a clear articulation of principles of balancing, given the variety of formulations expressed in the case law. Having made the leap from the 'representative and responsible government' context (the implied freedom) to the 'federal–structural guarantee' context (s 92), the additional small step required to take structured

[84] The high-water mark so far is seen in *Clubb v Edwards* (2019) 267 CLR 171, 200–2 [70]–[74] (Kiefel CJ, Bell and Keane JJ), 264–9 [266]–[275] (Nettle J), 329–34 [461]–[470] (Edelman J) ('*Clubb*') and also *Comcare v Banerji* (2019) 267 CLR 373, 400–5 [32]–[42] (Kiefel CJ, Bell, Keane and Nettle JJ), 451 [188], 452–8 [192]–[206] (Edelman J). See also Adrienne Stone, 'Proportionality and Its Alternatives' (2020) 48(1) *Federal Law Review* 123, 124.

[85] A careful cataloguing of these statements, which are spread across a number of cases commencing with *McCloy v New South Wales* (2015) 257 CLR 178 ('*McCloy*'), is provided by Stone (n 84) 128–31.

[86] (2021) 388 ALR 180, 195–6 [58]–[62] (Kiefel CJ and Keane J), 247–8 [264]–[265] (Edelman J) ('*Palmer*'). Justice Gageler expressed a different view on this point at 213 [139], 214 [144]–[146], 216 [151], as did Gordon J at 228–9 [198]–[199].

[87] Ibid 194 [55]–[56].

[88] Ibid 195 [59].

[89] Ibid 247–8 [262]–[265].

[90] Ibid 195 [61] (Kiefel CJ and Keane J).

proportionality to s 117 — also a federal–structural guarantee — seems inevitable. If the leading judgment in *Palmer* saw 'no relevant distinction' between the implied freedom and s 92, so far as selecting a balancing methodology goes, then it is hard to imagine any such distinction being conjured for s 117.[91] In view of this inevitability, we have chosen to assess VAD laws using the structured proportionality in preference to rather tediously assessing them against both past and future doctrine, in parallel.

As explained in the leading case of *McCloy v New South Wales* ('*McCloy*'), structured proportionality uses a series of sequential inquiries to determine whether an impugned law is 'suitable … necessary' and 'adequate in its balance.'[92] In Part VI below, we have structured our analysis of the application of s 117 to the residence requirement in the VAD laws around these three sequential inquiries.[93] Then, in the remainder of our article, we will explore how the High Court might approach a s 117 challenge to a residency restriction in a state VAD legislative scheme. We think this is a far-from-academic question, given the determination of some terminally ill Australians, from all parts of the country, to access VAD services and their probable preference for doing so within Australia rather than traveling overseas.[94]

Part IV considers the s 117 threshold question of whether there is discrimination — Stage One of the *Street* test as previously described. We conclude that

[91] Ibid.

[92] *McCloy* (n 85) 195 [2] (French CJ, Kiefel, Bell and Keane JJ).

[93] If, in the alternative, the language of 'appropriate and adapted' were retained as a test for proportionality for the limitation contained in s 117, we do not consider that there would be any real prospect of divergent outcomes.

[94] Worldwide, the main country welcoming non-residents seeking to access VAD is Switzerland. One of the largest providers there, Dignitas, has assisted several Australian clients over the last 20 years: Dignitas, *To Live with Dignity — To Die with Dignity: Accompanied Suicides Per Year and Country of Residence* (Dataset, 2020) 1 <http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2020.pdf>, archived at <https://perma.cc/Y65F-XBG9>. Recent high-profile cases which received considerable media attention include 104-year-old botanist Professor David Goodall, and 54-year-old firefighter Troy Thornton, suffering multiple system atrophy: Charlotte Hamlyn and Lisa McGregor, 'David Goodall's Final Hour: An Appointment with Death', *ABC News* (Web Page, 12 July 2018) <https://www.abc.net.au/news/2018-07-10/david-goodalls-appointment-with-death-and-his-final-hour/9935152>, archived at <https://perma.cc/8W2G-P2Z3>; Tracey Ferrier, 'Australian Firefighter Troy Thornton Dies after Lethal Injection in Swiss Clinic', *The Sydney Morning Herald* (online, 23 February 2019) <https://www.smh.com.au/national/australian-firefighter-troy-thornton-dies-after-lethal-injection-in-swiss-clinic-20190223-p50zr9.html>, archived at <https://perma.cc/E5FT-GVL5>.

all state VAD laws clearly discriminate on their face against residents of other states. The rest of the article explores the Stage Two question of whether there are any legitimate arguments that might justify the discriminatory exclusion of non-residents. Part V identifies a number of possible policy purposes: the need to prevent 'death tourism', which may have financial or healthcare resource implications for a state; and the suggested need for a 'therapeutic relationship' between doctor and patient. In Part VI, we apply the tripartite *McCloy* structured proportionality test to these possible purposes. Ultimately, we conclude that the 12-month residency requirement is not proportionate — or appropriate and adapted — to achieving any of these purposes. Therefore we suggest that limiting VAD to residents who have resided in a state for the previous 12 months cannot be reconciled with s 117 of the *Australian Constitution*.

IV Is There Discrimination on the Ground of Interstate Residence?

As explained in Part III above, a modern s 117 inquiry involves two stages. Stage One asks whether there has been, as a matter of substance, 'discrimination' against an out-of-state resident on the basis of that status. If the answer is 'no', the inquiry stops there and the challenge fails. If the answer is 'yes', the inquiry proceeds to Stage Two, where possible justifications for the discrimination are considered.[95]

There is no question that each of the state VAD laws does discriminate against out-of-state residents. They do so unequivocally as a matter of legal form, as well as substance, in stating that the regulated service may only be accessed by persons 'ordinarily resident in' the relevant state for at least the preceding 12 months.[96] That mirrors the finding in *Goryl*, where the High Court comfortably concluded that a similarly overt prioritising of locals over outsiders was prima facie discriminatory in the sense required at Stage One of the s 117 test.[97] The provision challenged in *Goryl* shares one key feature with the

[95] We have opted not to pursue here an alternative approach to applying s 117, outlined in Gaudron J's judgment in *Street* (n 69) 571–3, that merges the two stages of analysis into one holistic inquiry. See generally Amelia Simpson, 'The High Court's Conception of Discrimination: Origins, Applications, and Implications' (2007) 29(2) *Sydney Law Review* 263, 282–4.

[96] *NSW VAD Act* (n 7) s 16(1)(c); *Queensland VAD Act* (n 6) s 10(1)(f)(i); *SA VAD Act* (n 5) s 26(1)(b)(iii); *Tasmanian EOLC Act* (n 4) s 11(1)(b); *Victorian VAD Act* (n 2) s 9(1)(b)(iii); *WA VAD Act* (n 3) s 16(1)(b)(ii).

[97] *Goryl* (n 82) 474 (Brennan J), 479–80 (Deane and Gaudron JJ), 488 (Dawson and Toohey JJ), 495 (McHugh J).

VAD residency requirements — neither employs (or employed) a proxy characteristic, broadly coextensive with state residence, to achieve the exclusion of out-of-state residents.[98] Rather, the discrimination was evident on the very face of the impugned law, greatly simplifying the judicial task of identifying it.

The easy disposition of the Stage One inquiry still leaves the more complex question posed at Stage Two of the s 117 test, which requires consideration of the possible policy justifications for the prima facie discriminatory treatment. It is to those difficult and nuanced questions that we will now turn.

V Is There a Legitimate Reason for Discrimination?

The Stage Two inquiry as to whether discrimination against out-of-state residents is proportionate to the attainment of a proper objective requires the identification of a legitimate policy purpose for the legislation — where legitimate essentially means any purpose that is not a bare desire to preference residents over outsiders for its own sake.[99] This is an essential preliminary question that determines whether it is even necessary to proceed to the balancing inquiry; without an identified legitimate purpose, one side of the balancing scales is empty, and victory goes by default to the constitutional guarantee.[100]

In relation to VAD residency requirements, there are at least four such potential justifications. The Victorian government has explicitly advanced two: the importance of providing VAD within an ongoing therapeutic relationship;[101] and the prevention of death tourism.[102] Two other possible rationales that were not explicitly stated in the secondary material but which might be inferred are: the financial cost of providing VAD to residents of other states; and the risk of

[98] Section 20 of the *Motor Vehicles Insurance Act 1936* (Qld) capped the damages that could be awarded to out-of-state residents, but not Queensland residents, litigating in Queensland courts: *Goryl* (n 82) 472 (Brennan J).

[99] *Street* (n 69) 511 (Brennan J), 548 (Dawson J).

[100] There have been cases where the Court has come close to finding that there is no legitimate purpose underpinning impugned provisions: see, eg, *Unions NSW v New South Wales* (2013) 252 CLR 530, 557–8 [51]–[52] (French CJ, Hayne, Crennan, Kiefel and Bell JJ); *Castlemaine Tooheys Ltd v South Australia* (1990) 169 CLR 436, 476–7 (Mason CJ, Brennan, Deane, Dawson and Toohey JJ), 479–80 (Gaudron and McHugh JJ).

[101] Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2948 (Jill Hennessy); *Victorian VAD Act* (n 2) s 5(1)(e).

[102] *Victorian Panel Report* (n 13) 56; Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3085 (Tim Pallas).

overwhelming the health services of a state if out-of-state residents can access services that are unavailable in their own jurisdiction.

A *Preventing 'Death Tourism'*

The most commonly advanced justification for imposing a residency requirement on eligibility for VAD is to prevent the phenomenon of 'death tourism', whereby people travel from another jurisdiction to access assisted dying.[103] Switzerland is often cited as the paradigmatic example of this, as there is no residency requirement to access assisted dying in that country.[104] Belgium is also experiencing an influx of non-residents, particularly from France.[105] The Victorian Ministerial Advisory Panel which advised the Victorian government on the form of the *Victorian VAD Act* explicitly stated that one purpose for including a residency requirement was 'to prevent people coming from outside Victoria to obtain assisted dying'.[106] In WA, the prevention of 'so-called "voluntary assisted dying tourism"'[107] was the only reason explicitly advanced for the residency requirement.[108]

While the desire to avoid 'death tourism' from other countries is perhaps understandable, different issues arise in relation to imposing restrictions on

[103] Alexander R Safyan, 'A Call for International Regulation of the Thriving "Industry" of Death Tourism' (2011) 33(2) *Loyola of Los Angeles International and Comparative Law Review* 287, 303–4. See generally Rohith Srinivas, 'Exploring the Potential for American Death Tourism' (2009) 13(1) *Michigan State University Journal of Medicine and Law* 91; Mary Helen Spooner, 'Swiss Irked by Arrival of "Death Tourists"' (2003) 168(5) *Canadian Medical Association Journal* 600. Another name for this phenomenon is 'suicide tourism': see Saskia Gauthier et al, 'Suicide Tourism: A Pilot Study on the Swiss Phenomenon' (2015) 41(8) *Journal of Medical Ethics* 611, 611; Charles Foster, 'Suicide Tourism May Change Attitudes to Assisted Suicide, but Not through the Courts' (2015) 41(8) *Journal of Medical Ethics* 620. The phrase 'suicide tourism' likely stems from a documentary concerning the death in Switzerland of Chicago man Craig Ewert: 'The Suicide Tourist', *Frontline* (Public Broadcasting Service, 2010).

[104] *Victorian Panel Report* (n 13) 56.

[105] See above n 60 and accompanying text.

[106] *Victorian Panel Report* (n 13) 56. See also Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, 9 June 2016) 221.

[107] *WA Panel Report* (n 31) 20, quoting the submission of the Australian Medical Association: 'A process for establishing residency in WA must be clear and specific to proposed voluntary assisted dying legislation to preclude "voluntary assisted dying tourism."'

[108] No further explanation is provided in the Explanatory Memorandum or second reading speech as to why a residency requirement was incorporated: see Explanatory Memorandum, Voluntary Assisted Dying Bill 2019 (WA) 5; Western Australia, *Parliamentary Debates*, Legislative Assembly, 26 September 2019, 3–4 (Stephen Dawson).

residents of other states within a nation. At least until the state border closures imposed as a response to the COVID-19 pandemic, people were accustomed (as is their constitutional right) to free movement between the Australian states and territories.[109] The QLRC expressly acknowledged that '[r]ights are not ordinarily limited to the citizens or residents of a [state]'.[110] As noted earlier, a 12-month residency requirement raises issues for at least four classes of people: people who work in a different state to their ordinary place of residence (including fly-in fly-out workers and residents of border towns); those in rural locations or border towns who regularly travel across state borders to access healthcare in a neighbouring state; 'new residents' who have recently relocated interstate; and those who travel frequently who might not have an 'ordinary place of residence'.[111]

The Victorian Ministerial Advisory Panel acknowledged the 'potential for cross-border issues to arise where residents in New South Wales or South Australia access Victorian healthcare services'.[112] The problems a residency requirement would raise for residents of border communities, particularly along the Murray River dividing Victoria from NSW, were also raised in debate on the *Victorian VAD Act*.[113] However, both the Victorian Ministerial Advisory Panel and Members of Victorian Parliament supported a residency requirement preventing non-Victorian residents (even border-dwellers with a healthcare history in Victoria) from accessing VAD.[114] The underlying policy justification for this inflexibility is unclear.

Due to the remote geography of WA, there was less concern about residents of border towns. However, the Western Australian Ministerial Expert Panel did acknowledge the issues for fly-in fly-out workers, Western Australians working interstate and wishing to return home after receiving a terminal diagnosis, and new residents.[115] And Members of the Tasmanian Parliament also considered the situation of returning former residents.[116]

[109] See *Australian Constitution* s 92.

[110] *QLRC Report* (n 49) 158 [7.441].

[111] Such as BTR in the case of *NTJ* (n 23) [54] (Quigley J).

[112] *Victorian Panel Report* (n 13) 57.

[113] Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3132 (Tim McCurdy).

[114] *Victorian Panel Report* (n 13) 57; Victoria, *Parliamentary Debates*, Legislative Assembly, 17 October 2017, 3132 (Tim McCurdy).

[115] *WA Panel Report* (n 31) 20.

[116] Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 119–22 (Leonie Hiscutt, Michael Gaffney, Megan Webb and Sarah Lovell).

Although the clear rationale for the residency provision appears to be to prevent out-of-state residents from engaging in 'death tourism', a desire to exclude non-residents simply because they are non-residents cannot count as a 'legitimate purpose'.[117] As earlier noted, the High Court's balancing jurisprudence makes clear — consistently across all constitutional limitations on power — that a 'legitimate purpose' must be something other than a purpose of achieving the very thing that a constitutional limitation proscribes.[118] So, in the VAD setting, some other concern must underlie the objection to death tourism for it to constitute a legitimate purpose, potentially protecting the exclusory provision from s 117's operation.

To begin to understand what else — other than bare discrimination — might underpin this objection, we need to imagine what quantifiable problems might flow from 'death tourism'. At the outset, it seems reasonable to rule out a moral underpinning: it would be entirely illogical to accept the moral case for VAD for some Australians, but not others, by reference to place of residence (assuming all are humans of equal worth and dignity etc).

A number of more prosaic considerations may possibly explain why VAD should be restricted to residents within a state. First, the 'death tourism' rationale for a residency requirement might reflect a belief that access for out-of-state residents would place a greater fiscal burden on the VAD-providing state. That possibility will be addressed in Part V(B). Alternately, the concern might be that an influx of out-of-state residents would overwhelm a state's health system and lengthen waiting times for locals. This will be addressed in Part V(C) below. Either of these, depending on the context, may constitute a legitimate reason for discrimination against out-of-state residents, so long as the restrictions are proportionate to this purpose (which will be discussed in Part VI below).

Finally, a more foundational, constitutional, explanation for the 'death tourism' concern may lie in concepts of sovereignty, representative and responsible government and federalism. The Victorian Parliament's legislative power, for example, is expressed as one 'to make laws in and for Victoria', which implies some legitimate focus on the needs and interests of Victorians.[119] Similar formulations of legislative power are found in the constitutions of all other

[117] The QLRC did not find this justification particularly persuasive: *QLRC Report* (n 49) 158 [7.435]–[7.437].

[118] See above Part V.

[119] *Constitution Act 1975* (Vic) s 16.

Australian states.[120] A state's Parliament is chosen by, represents and is responsible to the members of that state's political community. Those mechanisms of representative and responsible government give state lawmakers a depth of insight into the values, needs and preferences of state voters that they generally do not have in respect of people elsewhere in Australia. So, even while state legislative power is conditioned by reference to the restrictions imposed by the *Australian Constitution*, including in s 117, it could be argued that the bonds of representative and responsible government anticipate, and depend upon, each state's Parliament having a primary legislative focus upon the wellbeing of the members of its political community. Accordingly, a particular exclusion of outsiders may be a function of the constitutional nexus between state lawmakers and the state political community, rather than reflecting an illegitimate desire to discriminate against outsiders. The question of how these two conflicting duties — to the state and to the nation — are best reconciled in the VAD context will be deferred to Part VII below.

B *Fiscal Considerations*

Although no state government has explicitly made this argument, it may be suggested that fiscal considerations constitute a 'legitimate purpose' underpinning the residency requirement.[121] Spending on healthcare is primarily a state responsibility, although considerable support is provided through Commonwealth grants.[122] The Commonwealth provides rebates on the cost of consultations with doctors and other health professionals, and subsidises the cost of approved pharmaceuticals through its national Medicare scheme.[123] However, neither the VAD consultations and assessments nor the prescribed VAD lethal medication are eligible for Medicare rebates, meaning they are fully funded by the state concerned.[124] Depending on the costs involved in providing access to

[120] *Constitution Act 1902* (NSW) s 5; *Constitution Act 1867* (Qld) s 2; *Constitution Act 1934* (SA) s 5; *Constitution Act 1889* (WA) s 2(1). The Tasmanian *Constitution Act 1934* (Tas) does not expressly confer a general lawmaking power on the Tasmanian Parliament.

[121] This argument receives support from some comments of the QLRC: *QLRC Report* (n 49) 158 [7.437], 159 [7.448].

[122] Made pursuant to s 96 of the *Australian Constitution*.

[123] Part II of the *Health Insurance Act 1973* (Cth) established the Medicare scheme and was enacted pursuant to s 51(xxiiiA) of the *Australian Constitution*.

[124] Kemal Atlay and Paul Smith, 'Australia's First Euthanasia Doctor Tells His Story of Ending the Lives of Patients', *Australian Doctor* (Web Page, 26 February 2020). But see

VAD, both medically and administratively, it could be contended that it is reasonable for a state to conserve the benefits of a costly program for those whose tax revenues have funded it.

Some of the judgments in *Street* expressly refer to welfare benefits provided by a state as services which could be legitimately restricted to residents of that state, as they are financed by state taxes.[125] This argument is premised on the idea that states are financially independent entities, and their responsibility is to provide assistance to people who are resident within the state.[126] But these comments regarding the financial cost to a state of welfare payments may have limited relevance to the provision of VAD services. Health services have traditionally been provided to all people present within a state, whether resident or not,[127] reflecting the concept of national unity and Australian citizenship which s 117 exists to protect.[128] Indeed, the fact that a no-fault accident compensation scheme was funded primarily by insurance premiums paid by residents within a state was not sufficient to justify the scheme's discrimination against out-of-state residents in *Goryl*.[129]

C *Healthcare Resource Considerations*

Another resource-based argument for restricting access to VAD to residents of the providing state may be the burden on healthcare practitioners and institutions within a state if the services were provided to residents and non-residents alike. Healthcare resources (such as beds within hospitals and care institutions) are limited, and healthcare practitioners are subject to workload pressures and

Department of Health and Aged Care (Cth), *Medicare Benefits Schedule* (Note GN.13.33) General Explanatory Notes.

125 *Street* (n 69) 492 (Mason CJ), 546 (Dawson J).

126 Ibid 492 (Mason CJ).

127 The QLRC cautions against taking such arguments 'too far', however, given that VAD is a medical service available in some states but not others: *QLRC Report* (n 49) 158 [7.439].

128 Daniel Reynolds, 'Defining the Limits of Section 117 of the *Constitution*: The Need for a Theory of the Role of the States' (2021) 44(2) *University of New South Wales Law Journal* 786, 798.

129 *Goryl* (n 82) 479–80 (Deane and Gaudron JJ), 487 (Dawson and Toohey JJ), 496–7 (McHugh J). The High Court in *Sweedman* (n 79) did not consider the significance of the fact that the compulsory motor vehicle insurance scheme was financed by state taxes and compulsory payments by vehicle owners who were residents of the state. Instead, the decision rested on the characterisation of the statute: at 408–9 [59]–[64] (Gleeson CJ, Gummow, Kirby and Hayne JJ). See also Amelia Simpson, '*Sweedman v Transport Accident Commission*: State Residence Discrimination and the High Court's Retreat into Characterisation' (2006) 34(2) *Federal Law Review* 363, 369–72.

other demands on their time.[130] An influx of out-of-state residents seeking to access VAD in those states where it is legal may risk inundating those institutions or individuals involved in providing VAD, compromising the level of care provided to all.[131]

Although this argument has not been explicitly advanced, it is far from theoretical. Providing VAD is a time-intensive occupation. It will add to doctors' and institutions' workload to provide sufficient time to give appropriate support to the patient and their family as they go through the process.[132] The process is administratively and logistically burdensome, with multiple assessments occurring on separate occasions, and a considerable burden of paperwork to be completed.[133] Additional complications arise because of conflict with Commonwealth laws. Because of restrictions imposed by the *Criminal Code Act 1995* (Cth) sch 1 ('*Commonwealth Criminal Code*') on using telehealth to discuss 'suicide',[134] the Victorian government has advised that all VAD consultations must occur in person.[135] Because many patients who are eligible for VAD are too sick to travel, often consultations are conducted at home.[136] In addition, as currently administered in Victoria, most patients are choosing to die at home.[137] This necessarily involves considerable travel time for the medical practitioners

[130] Eswaran Waran and Leeroy William describe a clinical example where difficulty was experienced finding a suitable bed in an institution willing to accept transfer of a patient seeking VAD: Eswaran Waran and Leeroy William, 'Navigating the Complexities of Voluntary Assisted Dying in Palliative Care' (2020) 213(5) *Medical Journal of Australia* 204, 204.

[131] This was expressly recognised by the QLRC: *QLRC Report* (n 49) 158 [7.437].

[132] Rosalind McDougal et al, '"This Is Uncharted Water for All of Us": Challenges Anticipated by Hospital Clinicians when Voluntary Assisted Dying Becomes Legal in Victoria' (2020) 44(3) *Australian Health Review* 399, 403.

[133] Ibid 402.

[134] *Criminal Code Act 1995* (Cth) sch 1 ss 474.29A–474.29B ('*Commonwealth Criminal Code*'). For a detailed analysis of the interaction between these provisions and the *Victorian VAD Act* (n 2) and *WA VAD Act* (n 3), see generally Katrine Del Villar et al, 'Voluntary Assisted Dying and the Legality of Using a Telephone or Internet Service: The Impact of Commonwealth "Carriage Service" Offences' (2021) 47(1) *Monash University Law Review* (forthcoming).

[135] See Department of Health and Human Services (Vic), *Voluntary Assisted Dying: Guidance for Health Practitioners* (Policy Document, July 2019) 4, 74.

[136] Atlay and Smith (n 124).

[137] Ibid.

concerned, as well as VAD Care Navigators[138] and in some cases interpreters,[139] adding to the already significant pressure of their work.

Another resource consideration is the availability of trained practitioners. In all states which have legislated to permit it, VAD cannot be provided unless assessments have been carried out by at least two medical practitioners,[140] both of whom have completed the mandatory VAD training.[141] Doctors are not required to participate in VAD. In SA and Victoria, a doctor with a conscientious objection to VAD may choose not to participate in the process.[142] In Queensland, Tasmania and WA, medical practitioners may choose not to be involved in VAD, either because they conscientiously object or for any other reason.[143] As the QLRC recognised, this limits the number of medical practitioners who may be available and qualified to be involved.[144] If there were an influx of out-of-state residents seeking access to VAD, those medical practitioners involved

[138] VAD Care Navigators are government employees whose job is to provide support and advice to members of the community and the health profession concerning VAD, including referring people wishing to access VAD to willing VAD providers: Department of Health and Human Services (Vic), *Fact Sheet: The Statewide Voluntary Assisted Dying Care Navigator Service* (Policy Document, September 2019).

[139] *NSW VAD Act* (n 7) ss 19(4), 30(4)(j), 41(4)(k), 43(3)(c)(ii), 51(2)(g), 57(4), 58(4), 67(1)(f), 176(2); *Queensland VAD Act* (n 6) ss 37(7), 59(2)(f); *SA VAD Act* (n 5) ss 52(5), 58(5); *Tasmanian EOLC Act* (n 4) s 15(3); *Victorian VAD Act* (n 2) ss 34(5), 40(5); *WA VAD Act* (n 3) ss 29(4)(b)(vi), 40(4)(l), 42(3)(c)(ii), 50(2)(f), 57(4)(f), 60(2)(g), 66(1)(f). In the first year of the operation of the *Victorian VAD Act* (n 2), nine people required an interpreter to attend their appointments: Voluntary Assisted Dying Review Board, *Report of Operations January to June 2020* (Report, August 2020) 8 ('*VAD Review Board Report August 2020*').

[140] In SA and Victoria, these are conducted by the coordinating medical practitioner and consulting medical practitioner: *SA VAD Act* (n 5) ss 34, 43; *Victorian VAD Act* (n 2) ss 16, 25. In NSW, Queensland and WA, assessments are conducted by the coordinating practitioner and consulting practitioner: *NSW VAD Act* (n 7) ss 25, 36; *Queensland VAD Act* (n 6) ss 18, 29; *WA VAD Act* (n 3) ss 24, 35. In Tasmania, the primary medical practitioner makes three separate eligibility assessments and the consulting medical practitioner also assesses the patient's eligibility: *Tasmanian EOLC Act* (n 4) ss 26, 33, 47, 56. If there is doubt as to whether the person's medical condition meets the eligibility criteria, or if there is doubt as to a person's decision-making capacity (for example, due to past or current mental illness), the case must be referred to a specialist for a third opinion: *Queensland VAD Act* (n 6) ss 21, 32; *SA VAD Act* (n 5) ss 36, 45; *Tasmanian EOLC Act* (n 4) ss 25, 32, 46; *Victorian VAD Act* (n 2) ss 18, 27; *WA VAD Act* (n 3) ss 26, 37.

[141] *Queensland VAD Act* (n 6) ss 20, 31; *SA VAD Act* (n 5) ss 35, 44; *Tasmanian EOLC Act* (n 4) s 9(d); *Victorian VAD Act* (n 2) ss 17, 26; *WA VAD Act* (n 3) ss 25, 36, 54(1)(b).

[142] *SA VAD Act* (n 5) s 10; *Victorian VAD Act* (n 2) s 7.

[143] *Queensland VAD Act* (n 6) ss 16(2), 26(3); *Tasmanian EOLC Act* (n 4) ss 20(2), 40(2), 64; *WA VAD Act* (n 3) s 9.

[144] *QLRC Report* (n 49) 158 [7.437]–[7.438].

in providing VAD might be overwhelmed. The need to maintain the integrity of the health system and ensure it functions properly may constitute a legitimate reason for restricting access to VAD to residents of the state.[145]

D *Therapeutic Relationship*

In addition to these practical, resource-focused considerations, another reason has been advanced — at least in Victoria and Tasmania — for the restriction of access to in-state residents. This is the importance of the 'therapeutic relationship' in the decision-making around VAD. In her second reading speech, Victorian Health Minister Jill Hennessy justified the residency requirement, stating:

> This criterion is designed to ensure safety and prevent people coming from outside Victoria to obtain access to voluntary assisted dying, in circumstances where such persons are unlikely to have a therapeutic relationship with a Victorian medical practitioner.[146]

A similar position emerged from the parliamentary debates on the *Tasmanian EOLC Act*.[147]

It is a key feature in most Australian regimes that VAD is provided in the context of a therapeutic relationship where possible. One of the principles guiding decision-making for VAD is that 'a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained'.[148] Other guiding principles reinforce the desirability of making end-of-life decisions within a supportive and ongoing therapeutic relationship.[149] It could be argued that a legitimate reason for restricting access to

[145] Ibid 159 [7.448], 160 [7.452].

[146] Victoria, *Parliamentary Debates*, Legislative Assembly, 21 September 2017, 2948 (Jill Hennessy).

[147] Tasmania, *Parliamentary Debates*, Legislative Council, 13 October 2020, 127 (Sarah Lovell).

[148] *SA VAD Act* (n 5) s 8(1)(e); *Tasmanian EOLC Act* (n 4) s 3(2)(e); *Victorian VAD Act* (n 2) s 5(1)(e); *WA VAD Act* (n 3) s 4(1)(e). No comparable provision exists in the *Queensland VAD Act* (n 6).

[149] For example, the *Victorian VAD Act* (n 2) s 5(1) also states that

> (f) individuals should be encouraged to openly discuss death and dying and an individual's preferences and values should be encouraged and promoted;
>
> (g) individuals should be supported in conversations with the individual's health practitioners, family and carers and community about treatment and care preferences;

VAD to a provider state's own residents is to ensure that VAD occurs within the context of an existing and ongoing therapeutic relationship with a patient's health practitioners, where possible.

E *Summary*

The most commonly stated rationale for including a residency requirement — preventing 'death tourism' — cannot of itself constitute a legitimate reason for discriminating against out-of-state residents. Rather, the real rationale must lie in other, unexpressed, concerns. We have suggested two possibilities. First, an influx of out-of-state residents may place a greater fiscal burden on a state's health system. Secondly, access for out-of-state residents risks overwhelming those medical practitioners and institutions within a state health system who provide VAD services, lengthening waiting times for residents. Unlike an objection to 'death tourism' per se, either of these suggested substantive concerns might constitute a legitimate reason for discrimination against out-of-state residents.

A second reason, advanced in Victoria and Tasmania, to explain the residency requirement — to ensure VAD is provided within the context of a therapeutic relationship — may also constitute a legitimate reason for discrimination, depending on the circumstances. In Part VI, we consider whether the restriction of VAD to people who have been resident in a state for a minimum of 12 months is proportionate to these purposes.

VI Is a 12-Month Residence Requirement Reasonably Necessary to Achieve a Legitimate Object?

In Part V(A), we determined that the desire to protect against 'death tourism' is not a legitimate reason for discrimination. However, we identified two potential legitimate policy rationales that might lie behind it — fiscal considerations and healthcare resource considerations. A separate legitimate policy rationale for restricting access to VAD to residents of a state is to ensure VAD is provided within the context of an ongoing therapeutic relationship.[150]

(h) individuals are entitled to genuine choices regarding their treatment and care.

See also *Queensland VAD Act* (n 6) ss 5(d), (f); *SA VAD Act* (n 5) ss 8(1)(f)–(h); *Tasmanian EOLC Act* (n 4) ss 3(2)(f)–(h); *WA VAD Act* (n 3) ss 4(1)(f)–(h).

150 See above Part V(D).

In this Part, we evaluate whether the 12-month residency requirement is proportionate to any of these three possible policy justifications for discriminating against out-of-state residents. As explained in Part III above, we have adopted the structured proportionality framework for this balancing inquiry, confident that the High Court will take this direction in its s 117 jurisprudence.

In the political communication context, where structured proportionality is most established, a majority of the High Court has explained that to be proportionate to a legitimate policy goal, a law must be:

- suitable — in that it has a rational connection to the purpose of the provision;
- necessary — in that there is no obvious and compelling alternative, reasonably practicable means of achieving the same purpose which has a less restrictive effect; and
- adequate in its balance — which calls for a value judgement balancing the importance of the purpose of the restrictive measure with the extent of the restriction imposed on the freedom.[151]

The element of 'suitability' is widely acknowledged to be the easiest hurdle for an impugned law to clear.[152] All that is required is that the law is rationally related to a suggested policy purpose. The degree and strength of that connection are assessed subsequently through the elements of 'necessity' and 'adequacy of balance'.

The second element — 'necessity' — requires consideration of whether the specific restriction is necessary to achieve the stated objective. At this stage, a court is looking for any 'obvious and compelling' alternative measures that are 'reasonably practicable'.[153] This language is intended to steer courts away from an intrusive insistence on alternatives that would lessen burdens only at the margin.[154] In other constitutional contexts, the High Court has emphasised the importance of comparable legislative schemes operating in other jurisdictions as sources of guidance on the 'necessity' of the specific components of an

151 *McCloy* (n 85) 195 [2] (French CJ, Kiefel, Bell and Keane JJ).

152 See, eg, Stone (n 84) 135.

153 *McCloy* (n 85) 196 [5] (French CJ, Kiefel, Bell and Keane JJ).

154 Ibid 211 [58] (French CJ, Kiefel, Bell and Keane JJ); *Clubb* (n 84) 266 [269], 269 [277] (Nettle J). See also Chief Justice Susan Kiefel, 'Standards of Review in Constitutional Review of Legislation' in Cheryl Saunders and Adrienne Stone (eds), *The Oxford Handbook of the Australian Constitution* (Oxford University Press, 2018) 488, 504.

impugned scheme.[155] Clues as to 'necessity' might also be sought in legislative schemes operating in the defending state in other, potentially comparable, policy contexts (such as abortion or assisted reproduction). Another axis of comparative interest at the 'necessity' stage of proportionality might be the residence requirements tied to access and eligibility in other laws within the state.

The third and final element — 'adequacy of balance' — has proven in the political communication context to be very difficult for challengers to disprove.[156] Assuming that a similarly deferential position would emerge in the s 117 context, an out-of-state resident would need to show 'manifest disproportion' between a residency requirement (and the policy objectives underlying it) and the collateral damage done to excluded non-residents.[157]

In the remainder of this Part we will examine in depth whether the residency requirement in state VAD laws is proportionate to each of the suggested rationales. We will defer to Part VII the question of whether there is, for s 117 purposes, a material difference between the situation of 'new' residents yet to meet the 12-month qualifying period and persons residing outside of the relevant state.

To foreshadow our conclusion, it is doubtful whether a 12-month residency requirement to be eligible to access VAD could be successfully defended against s 117 challenge by recourse to either the fiscal or healthcare resource concerns which nest under the 'death tourism' umbrella. While a bare residency requirement might survive challenge, comparison with other VAD jurisdictions overseas does not point to any need for a 12-month qualifying period. Nor would a state's open-access policies regarding other sensitive health services help in building a case for residency restrictions of any sort. It is also improbable that any residency requirement, even without a qualifying time period, could be justified by reference to the need for a 'therapeutic relationship', given the evidence about the practice of VAD in Victoria to date.

155 *Unions NSW v New South Wales* (2019) 264 CLR 595, 615 [42] (Kiefel CJ, Bell and Keane JJ); *Murphy v Electoral Commissioner* (2016) 261 CLR 28, 63 [70] (Kiefel J); *McCloy* (n 85) 210 [57] (French CJ, Kiefel, Bell and Keane JJ).

156 Since *McCloy* (n 85), the third element seems to have been rebadged as 'adequacy of balance': see, eg, *Clubb* (n 84) 208 [96] (Kiefel CJ, Bell and Keane JJ), 215 [127] (Gageler J), 304 [389] (Gordon J).

157 *Clubb* (n 84) 215 [128] (Gageler J), 345 [501] (Edelman J). See also at 209 [102] (Kiefel CJ, Bell and Keane JJ). An even more stringent standard of 'gross' disproportion was expressed by Nettle J at 275 [292].

A *Fiscal Considerations*

It was noted above that fiscal considerations may be a factor in a state Parliament's concern to avoid death tourism, particularly as VAD consultations and prescribed VAD substances are not subsidised by the Commonwealth's Medicare scheme, but are fully funded by state governments.[158]

1 *Suitability*

The adoption of a 12-month residency requirement is an effective way to ensure that a state government does not bear a material fiscal burden for providing VAD services to out-of-state residents. Hence, it satisfies the initial 'suitability' requirement of proportionality analysis. Unless it could be shown that notional out-of-state patients would not increase the cost of the VAD scheme to the relevant state at all, such a concern is clearly rational.

On its face, and compared with many other state-sponsored services available in the health sector in Australia, the Australian VAD regimes seem like fairly low-cost initiatives. However, they do involve several costs to the state, most of which increase in direct proportion to the number of patients approved for VAD. The main categories of costs are associated with: training and registering participating doctors; consultations and assessments by medical practitioners; dispensing lethal medication; and administering the scheme. Each of these is discussed in more detail below, in order to assess the magnitude of the likely additional expense if access to these schemes were to be extended to out-of-state residents.

The least costly element of providing access to VAD is likely to be the training and accreditation of participating doctors. Victoria's already-operative scheme provides the most meaningful benchmark here. Medical practitioners who choose to participate in VAD must complete mandatory training in all states.[159] In Victoria and WA, this training is conducted online by completion of a series of modules,[160] thus representing a fixed rather than variable cost

[158] See above n 124 and accompanying text.

[159] According to Victorian government information, 511 doctors registered for the mandatory training in the first two years of the scheme's operation: Voluntary Assisted Dying Review Board, *Report of Operations January to June 2021* (Report, August 2021) 4 ('*VAD Review Board Report August 2021*'). Of these, 175 have registered in the VAD Portal.

[160] Voluntary Assisted Dying Review Board, *Report of Operations June to December 2019* (Report, February 2020) 6 ('*VAD Review Board Report February 2020*'); Department of Health (WA), *Western Australian Voluntary Assisted Dying Guidelines* (Policy Document, 2022) 18

to government. Accordingly, any increase in the demand for online training will not place a material financial burden upon a state providing VAD to non-residents.

Another fixed cost of the scheme, which will not be impacted by any out-of-state residents wishing to access VAD, is the cost of oversight of the scheme. In five states, the VAD regime's operation is overseen by a review board,[161] whereas Tasmania will establish a Voluntary Assisted Dying Commission.[162] Many of these review bodies' functions, including reporting to Parliament,[163] community engagement,[164] and the compilation of statistics,[165] are unlikely to be significantly affected by any increase in the number of people accessing VAD from interstate.

There are, however, some direct costs of providing VAD which will increase if out-of-state residents are permitted to access VAD. Probably the most significant cost associated with the schemes would be the cost of consultations with medical practitioners, which are borne by state governments. A minimum of three consultations is required — for the first assessment by the primary or co-ordinating practitioner, the second assessment by a consulting practitioner, and the final request.[166] In some circumstances, additional consultations will also

<https://ww2.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-guidelines.pdf>, archived at <https://perma.cc/W54J-U46S> ('*WA VAD Guidelines*'). In Victoria, it has been reported that the training takes an average of four hours to complete: *VAD Review Board Report February 2020* (n 160) 6.

161 In SA, Queensland and Victoria, this is the Voluntary Assisted Dying Review Board: *SA VAD Act* (n 5) s 107; *Queensland VAD Act* (n 6) s 116; *Victorian VAD Act* (n 2) s 92. In NSW and WA, it is the Voluntary Assisted Dying Board: *NSW VAD Act* (n 7) s 134; *WA VAD Act* (n 3) s 116.

162 *Tasmanian EOLC Act* (n 4) s 110.

163 *SA VAD Act* (n 5) ss 113(1)(c), 120–3; *Tasmanian EOLC Act* (n 4) s 120; *Victorian VAD Act* (n 2) ss 107–12; *WA VAD Act* (n 3) s 155. In NSW and Queensland, the respective boards report to the Minister: *NSW VAD Act* (n 7) s 136(1)(e); *Queensland VAD Act* (n 6) ss 117(1)(f), 134–5.

164 *Queensland VAD Act* (n 6) s 117(1)(i); *SA VAD Act* (n 5) s 113(1)(j); *Victorian VAD Act* (n 2) s 93(1)(j). There is no comparable provision in the *Tasmanian EOLC Act* (n 4) or the *WA VAD Act* (n 3).

165 *NSW VAD Act* (n 7) s 170; *Queensland VAD Act* (n 6) s 134(2); *SA VAD Act* (n 5) s 124; *Tasmanian EOLC Act* (n 4) s 114(1)(g); *Victorian VAD Act* (n 2) s 117; *WA VAD Act* (n 3) s 152.

166 *NSW VAD Act* (n 7) ss 25, 36, 48; *Queensland VAD Act* (n 6) ss 19, 30, 42; *SA VAD Act* (n 5) ss 34, 43, 55; *Victorian VAD Act* (n 2) ss 16, 25, 37; *WA VAD Act* (n 3) ss 24, 35, 47. In Tasmania, there are a minimum of four consultations: the first assessment and second assessment by the primary medical practitioner; a consulting assessment by a consulting medical practitioner; and the final review and decision by the primary medical practitioner: *Tasmanian EOLC Act* (n 4) ss 26, 33, 47, 53.

be necessary.[167] Where the person cannot communicate via speech, or speaks a language other than English, a speech pathologist or interpreter may also be required to be present at these consultations.[168] The Victorian government provides 'patient support package[s]' which pay the cost of the consultation fee, as well as time-based travel fees, to ensure eligible patients are not out of pocket.[169] The WA government has also established the Regional Access Support Scheme, which pays the cost for patients to travel to doctors, or doctors or nurse practitioners (and interpreters, if needed) to travel to patients.[170] Most consultations occur in a patient's home,[171] so travel would be a considerable cost.

Another direct cost of the scheme is the provision of pharmaceutical preparations ('VAD substances') to approved patients. In both Victoria and WA, a single hospital-based pharmacy is the only dispensary approved to prepare and dispense VAD substances,[172] and it must deliver the VAD substances in person, which is a considerable cost. The legislation and regulations do not specify the types or classes of drug that might be dispensed to VAD patients, but Dr Cameron McLaren, an oncologist and VAD practitioner, has stated that the

[167] Where the medical practitioner conducting the assessment is unable to determine that a person suffers from an eligible medical condition, or where the person's capacity is in doubt, it is compulsory in NSW, Queensland, SA, Victoria and WA to seek a specialist opinion: *NSW VAD Act* (n 7) ss 26–7, 37–8; *Queensland VAD Act* (n 6) ss 21, 32; *SA VAD Act* (n 5) ss 36, 45; *Victorian VAD Act* (n 2) ss 18, 27; *WA VAD Act* (n 3) ss 26, 37. In Tasmania, a medical practitioner has discretion to refer a patient to another person for examination before making an eligibility determination: *Tasmanian EOLC Act* (n 4) ss 25, 32, 46. Aside from these legislative requirements, medical practitioners may undertake additional assessments to ensure a patient's request is truly voluntary and not subject to family pressure or coercion: Atlay and Smith (n 124).

[168] See above n 139.

[169] Atlay and Smith (n 124).

[170] *WA VAD Guidelines* (n 160) 76–7.

[171] At least in Victoria: Atlay and Smith (n 124). Comparable data from other states does not yet exist, though it is unlikely to differ significantly.

[172] In Victoria, this is the Statewide Pharmacy Service at the Alfred Hospital in Melbourne: Department of Health and Human Services (Vic), *Voluntary Assisted Dying: Information for People Considering Voluntary Assisted Dying* (Policy Document, August 2019) 28 <https://www.vgls.vic.gov.au/client/en_AU/search/asset/1298948/0>, archived at <https://perma.cc/DK65-B2Y8>. In WA, it is the Statewide Pharmacy Service at a tertiary hospital managed by the North Metropolitan Health Service in Perth: Department of Health (WA), *What Is the Western Australian Voluntary Assisted Dying Statewide Pharmacy Service?* (Fact Sheet, 2021) 1–2 <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Statewide-Pharmacy-Service.pdf>, archived at <https://perma.cc/EBR2-L736>. It is too early to tell what the practice will be in other states.

medications used for self-administration are barbiturates such as pentobarbital.[173] Prescribing costs for these medicines in humans are difficult to find on the public record, no doubt due to the sensitivity of the information. However, reports estimate the cost in the US to be around USD500 per lethal dose where produced by a compounding pharmacy.[174] At present, in Victoria and WA, the prescribed medication is provided to patients by the state without cost,[175] and it is anticipated that this will also occur in other states. Clearly, then, there would be some increased expense for a state if VAD were to be provided to out-of-state residents.

Finally, if interstate residents were permitted to access VAD, this would result in some additional administrative costs for the state. The most significant of these is that four states require every application for VAD to be prospectively approved and a permit issued before a person can lawfully access VAD.[176] In all states, the review body receives forms at every stage during the process and uses

[173] Atlay and Smith (n 124). This accords with international practice, which commonly employs barbiturates such as sodium pentobarbital, sodium thiopental and secobarbital: Owen Dyer, Caroline White and Aser García Rada, 'Assisted Dying: Law and Practice around the World' (2015) 351 *BMJ* h4481:1–3, 1–2. See also Dignitas' publicly available information: Dignitas (n 94). Practitioner administration, where a person is unable to self-administer a medication, uses a mixture of midazolam (a sedative), propofol (an anaesthetic) and rocuronium (a muscle relaxant): Atlay and Smith (n 124). All of these drugs are commonly available and standardly priced.

[174] Sean Riley, 'Navigating the New Era of Assisted Suicide and Execution Drugs' (2017) 4(2) *Journal of Law and the Biosciences* 424, 430; Catherine Offord, 'Accessing Drugs for Medical Aid-in-Dying', *The Scientist* (Web Page, 16 August 2017) <https://www.the-scientist.com/biobusiness/accessing-drugs-for-medical-aid-in-dying-31067>. Interestingly, in a veterinary context, the same class of drugs is inexpensive: Delegates of the Secretary to the Department of Health (Cth), *Interim Decisions and Reasons for Decisions* (2 February 2017) 90.

[175] Department of Health and Human Services (Vic), *What Process Do My Doctor and I Need to Follow: Information for People Considering Voluntary Assisted Dying* (Fact Sheet, August 2019) 10; Department of Health (WA), *Accessing Voluntary Assisted Dying in Western Australia: Frequently Asked Questions* (Fact Sheet, 2021) 5 <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Frequently-Asked-Questions.pdf>, archived at <https://perma.cc/PPH8-CJ42>.

[176] In NSW, the Voluntary Assisted Dying Board issues the 'voluntary assisted dying substance authority': *NSW VAD Act* (n 7) ss 70–2. In SA, the chief executive of the Department administering the *Health Care Act 2008* (SA) issues the permit: *SA VAD Act* (n 5) ss 65–7. In Tasmania, the Voluntary Assisted Dying Commission issues a 'VAD substance authorisation': *Tasmanian EOLC Act* (n 4) ss 66–8. In Victoria, the Secretary of the Department of Health issues a permit to access VAD: *Victorian VAD Act* (n 2) ss 47–9. A permit is not required prior to administration in WA or Queensland.

this information to collate statistics. In Victoria[177] and Queensland,[178] the board also reviews every individual case retrospectively. In both Victoria[179] and WA,[180] the Care Navigator Service has been established to provide support and advice to members of the community and the health profession concerning VAD. A significant influx of out-of-state persons wishing to access VAD may increase the administrative costs of issuing permits, as well as the Care Navigators' and review bodies' operations.

2 *Necessity*

Arguments based on the conservation of a state's public funds for uses beneficial to residents of the state would, we think, be very exposed at the second, 'necessity', stage. One 'obvious and compelling' alternative that would be equally effective to excluding new residents and interstate residents from access to VAD would be to pass on the relevant costs, through a user-pays model. As described above, the costs of consultations with medical practitioners, of providing the VAD substance, and of the administrative handling of permit application and case review would all lend themselves to fairly precise quantification.[181] Recovery of these costs from new or interstate residents seeking to access VAD would minimise the financial burden to the state of their accessing the scheme, and would seem to be a suitable alternative to denying those people access to VAD on the basis of state residence. This provides a solid basis for doubting that the exclusion is 'necessary' on fiscal grounds.

177 Board members review all completed cases each month to determine compliance with the Act: *VAD Review Board Report February 2020* (n 160) 9. The Board's secretariat also makes contact with every VAD patient's nominated contact person 'to seek feedback on the process and ensure any unused medication is returned': at 10.

178 *Queensland VAD Act* (n 6) s 117(1)(b).

179 *VAD Review Board Report August 2021* (n 159) 7. Victoria currently has eight VAD Care Navigators. This number was expanded in response to feedback reflecting the greater than expected interest in VAD among the Victorian community: *VAD Review Board Report August 2020* (n 139) 5.

180 Department of Health (WA), *What Is the Western Australian Voluntary Assisted Dying Statewide Care Navigator Service?* (Fact Sheet, 2021) 1 <https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Voluntary-assisted-dying/Care-Navigator-Service.pdf>, archived at <https://perma.cc/7ABH-CSSF>.

181 This sort of quantification and cost-shifting is already a daily occurrence in state and territory public hospitals all over Australia, when admitting and treating non-Medicare eligible patients who are not Australian citizens or permanent residents (or otherwise eligible).

3 *Adequacy of Balance*

If, as we have suggested, a 12-month residency requirement ought to fail at the 'necessity' stage, the third and final 'adequacy of balance' consideration would not be reached. The arguments at this stage of the analysis would likely look very similar to those at the 'necessity' stage — that is, they would focus on the fact that applying a user-pays approach to new residents and out-of-state residents ought to neutralise whatever fiscal burden might flow from their having access to VAD. Given the availability, and the likely simplicity, of the user-pays cost-recovery solution to the suggested fiscal burden — together with the significant benefit of broader access to the individuals concerned — the 12-month residency requirement can, we think, be characterised as 'manifestly disproportionate'.[182]

Finally, it is worth noting that to impose a cost-recovery charge upon interstate patients accessing VAD in a state of which they were not resident would resolve one s 117 dilemma by creating another. A fee of any sort imposed by a state exclusively upon out-of-state residents is a prima facie breach of the s 117 prohibition on discrimination. However, it must be remembered that in *Street* the High Court made clear that such prima facie, or 'Stage One', discrimination can be redeemed at 'Stage Two', if the differential treatment is proportionate to a non-discriminatory policy objective. On that basis, provided that directing the public revenue of a state for the benefit primarily of residents of that state qualifies as a legitimate policy objective — and there are ample obiter dicta in *Street* suggesting sympathy for this view[183] — then if any fee imposed on interstate residents accessing VAD were calibrated to recover costs, without raising additional revenue, this would not breach s 117.

B *Healthcare Resource Considerations*

Another possible legitimate reason for discriminating against non-residents is that allowing them to travel interstate to access VAD would increase the burden on the provider state's healthcare resources. Although restricting access to VAD to residents of a state would be an effective and rational way to avoid this burden, in our view it is doubtful whether the residence requirement is 'necessary'.

[182] See above n 157.

[183] *Street* (n 69) 492 (Mason CJ), 528–9 (Deane J), 548 (Dawson J), 560 (Toohey J), 572 (Gaudron J). Compare the much stricter approaches taken by Brennan J at 512–13, and McHugh J at 585, to marking out the exceptions to s 117's rule.

1 *Suitability*

Currently, most people accessing VAD in Victoria are choosing to die at home, which minimises the burden placed on hospitals and other care institutions in terms of beds and other resources.[184] However, there is a considerable burden on medical practitioners involved with the provision of VAD. VAD consultations must be conducted in person rather than by telephone or telehealth, because of restrictions in the *Commonwealth Criminal Code*.[185] Many VAD consultations and assessments are conducted in the person's home, because most terminally ill patients are too sick to attend a doctor's clinic.[186] It has been reported that McLaren, one of the pioneering VAD providers in Victoria, once conducted four consultations for one patient, which required four separate home visits within a week.[187] The expectation that doctors undertake such travel greatly increases the workload pressures on participating practitioners.[188]

Further, in Victoria only a small percentage of eligible doctors (15% of oncologists[189] and 1.3% of general practitioners[190]) have registered to provide VAD. As each patient's eligibility for VAD must be assessed by two practitioners,[191] the burden on individual practitioners (particularly in medical

[184] It is estimated that 86% of applicants for VAD reside in a private household, compared to 10% in long-term care or assisted living facilities and 4% in a hospital or health service: *VAD Review Board Report August 2021* (n 159) 10. No data are available from WA as yet.

[185] See above nn 134–5 and accompanying text.

[186] Atlay and Smith (n 124).

[187] Ibid.

[188] Cameron McLaren, 'An Update on VAD: (Almost) A Year in Review', *Dying with Dignity Victoria* (Web Page, 16 June 2020) 2–3 <https://www.dwdv.org.au/an-update-on-vad-almost-a-year-in-review/#:~:text=comprehensive%20article>, archived at <https://perma.cc/NWC9-UMDE>.

[189] Currently in Victoria, 15% of medical oncologists (41 out of 271) have completed the training: *VAD Review Board Report August 2021* (n 159) 6; Medical Board of Australia, *Registration Data Table: December 2020* (Dataset, 10 February 2021) 7 <https://www.medicalboard.gov.au/News/Statistics.aspx>, archived at <https://perma.cc/75UL-PSKB> ('*Medical Registration Data Table: December 2020*').

[190] Of 10,465 registered general practitioners in Victoria, 137 doctors have registered to conduct VAD assessments: *VAD Review Board Report August 2021* (n 159) 6; *Medical Registration Data Table: December 2020* (n 189) 4.

[191] See above nn 140–1 and accompanying text.

specialties such as oncology[192] or neurology[193]) is great. For example, after one year, medical oncologist McLaren reported having been personally involved in 79 cases of VAD.[194] An influx of out-of-state residents seeking to access VAD in those states where it is legal may risk inundating the small number of participating VAD practitioners, resulting in delays for residents of the state and compromising the level of care provided to all.[195]

In view of this, clearly a restriction to exclude non-residents, and arguably newly arrived residents too, has a rational connection to the suggested purpose of safeguarding timely access to VAD for established residents of a state, and protecting healthcare workers in those states from being overloaded with work.

2 *Necessity*

However, as with fiscal considerations, it is doubtful whether the residence restriction as framed is 'necessary' to achieve this purpose. Evidence suggests that the number of interstate residents seeking to access VAD is likely to be small. In the first 12 months of the VAD regime's operation in Victoria, only 124 attributed deaths were recorded.[196] The number of interstate patients could be expected to be even smaller, because of the additional disruption, anxiety and discomfort involved in travelling to Victoria to access VAD while terminally ill. The Swiss VAD provider Dignitas reports that between one and five Australian patients per year travel to Switzerland to end their lives with its assistance.[197] While Switzerland is much further away than another Australian state for potential Australian travellers, the fact remains that only small numbers of interstate residents are likely to travel to those states which currently permit VAD.

Comparison with other jurisdictions internationally does not provide evidence of a significant number of out-of-state applicants overwhelming the healthcare system in a state which provides VAD. The most obvious comparator is the US where, as earlier described, some jurisdictions permit VAD while a

[192] 83% of those who died in Victoria had a form of cancer: *VAD Review Board Report August 2021* (n 159) 14. This puts considerable pressure on those oncologists who have undertaken the training and are willing to participate in VAD.

[193] 7.6% (37 out of 488) of those who died in Victoria had neurological disease, but only 11 neurologists are currently registered to provide VAD in Victoria: *VAD Review Board Report August 2021* (n 159) 6, 11.

[194] McLaren (n 188) 1.

[195] See also *QLRC Report* (n 49) 160 [7.452]–[7.455].

[196] *VAD Review Board Report August 2020* (n 139) 3.

[197] Dignitas reports assisting 37 Australians to die between 1998 and 2020: Dignitas (n 94).

majority have not.[198] In Oregon, the first US jurisdiction to enact VAD legislation, residency is a requirement but no qualifying residency period is stipulated.[199] In a high-profile case, Brittany Maynard — a young woman who was terminally ill with brain cancer — moved to Oregon with her husband in order to access VAD weeks later,[200] and there have likely been other cases that received no publicity. Yet in our research we have encountered no suggestion that the State has been overwhelmed by such cases nor that they have affected long-term residents' access to VAD. Perhaps most tellingly, neither Oregon nor any other US state offering VAD to residents has amended its legislation to instate a qualifying period of residency. The US experience does not provide conclusive proof that a 12-month residency requirement is unnecessary: for instance, there may be much greater demand for VAD among Australians than there has been in the US. However, it does at least suggest that the 12-month requirement may be unnecessarily risk-averse.

Comparison with other laws on sensitive and morally contested healthcare subjects, such as abortion and assisted reproductive technology, is also instructive. Unlike VAD, states which have legislated to provide access to 'late-term' abortions do not restrict these services to residents of their state, but also permit access by residents of other states on equal terms.[201] Victoria was the first state to liberalise access to abortion, and although this policy increased demand, with a steady stream of interstate residents travelling to access the procedure, it was not considered unduly burdensome on the State.[202] On the contrary, it has

198 See above n 63.

199 *Oregon Death with Dignity Act* (n 63) §§ 127.805, 127.880. Oregon's model of assisted dying only includes physician-assisted suicide, and does not permit practitioner administration of VAD: at § 127.815. This legislation also contains fewer procedural steps than the detailed and highly prescriptive models of VAD that have been adopted in Australia.

200 Recalling that time, Brittany Maynard said:

> I had to find new physicians, establish residency in Portland, search for a new home, obtain a new driver's license, change my voter registration and enlist people to take care of our animals, and my husband, Dan, had to take a leave of absence from his job.

Brittany Maynard, 'My Right to Death with Dignity at 29', *CNN* (Web Page, 3 November 2014) <https://edition.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity>, archived at <https://perma.cc/XT2E-95RV>.

201 *Abortion Law Reform Act 2019* (NSW) ss 5–6; *Termination of Pregnancy Act 2018* (Qld) ss 5–6; *Termination of Pregnancy Act 2021* (SA) ss 5–6; *Abortion Law Reform Act 2008* (Vic) ss 4–5.

202 Julia Medew, '"Abortion Tourism" Brings Scores of Women to Victoria for Late Terminations', *The Age* (online, 26 October 2015) <https://www.theage.com.au/national/victoria/abortion-

been reported that doctors from interstate are flown to Victoria to assist in meeting the demand.[203] Another sensitive policy area in which states have opened their doors, on equal terms, to out-of-state residents concerns assisted reproductive technologies.[204]

Finally, comparison with other state laws containing residence requirements is instructive. Victorian and Western Australian laws contain residence requirements to access only a small number of services.[205] Each state maintains only one law, outside the VAD context, which requires a person to have been ordinarily resident in the state for a qualifying period of time.[206] Given that qualifying periods to access services are so rare under state law, it might seem particularly illogical, even cruel, to place such a rare hurdle before a class of people defined by their terminal diagnoses, such that many would likely die before they could qualify.

In summary, restricting access to VAD to those who have been resident in a state for at least 12 months is an effective way to achieve a purpose of preventing strain on the healthcare system, and particularly on those healthcare professionals who agree to participate in providing VAD. However, this restriction may not be 'necessary', given the likely small number of non-residents able to travel interstate while terminally ill to access VAD. Comparison with state abortion and assisted reproduction laws raises questions as to why VAD is restricted to residents of the state, when other morally contentious health services are provided to residents and non-residents alike, despite the additional burden that this places on the healthcare system. Even if a bare residence requirement could be defended as appropriate to the goal of containing the healthcare burden, the 12-month qualifying period may still be deemed excessive (and severable). It represents an exclusionary rule that is highly unusual in state laws, and

tourism-brings-scores-of-women-to-victoria-for-late-terminations-20151026-gkiw6u.html>, archived at <https://perma.cc/NW4G-B8HY>.

203 Ibid.

204 *Assisted Reproductive Treatment Act 2008* (Vic) s 10; *Human Reproductive Technology Act 1991* (WA) s 23.

205 In both states, child adoption: *Adoption Act 1984* (Vic) s 7(1); *Adoption Act 1994* (WA) s 39(1)(c). In Victoria, also legal aid funding: *Legal Aid Act 1978* (Vic) s 24(5); and gun licensing: *Firearms Act 1996* (Vic) ss 17(1)(ab), 20(1)(ab), 23(1)(ab), 27(ab), 29(1)(ab).

206 In Victoria, a person must have been resident in Victoria for at least 12 months to register a change of name of a person born outside Australia and whose birth is not registered in Australia: *Births, Deaths and Marriages Registration Act 1996* (Vic) ss 25(1)(b), 26(1)(b). In WA, a person must have been resident in the State for at least a third of the duration of their de facto relationship to be able to bring proceedings in that State's separate Family Court: *Family Court Act 1997* (WA) s 205X(b)(i).

out of step with residence requirements in other jurisdictions that allow VAD.

3 *Adequacy of Balance*

There is little to say about the third component of the proportionality triad that has not been raised under the head of 'necessity'. The same reasoning that points to the residency requirement (and especially the 12-month qualifying period) being 'unnecessary' also points to its 'manifest disproportionality'.[207] However, were a court to reject the reasons we have offered on the 'necessity' question, it would likely reject those reasons here as well.

C *Therapeutic Relationship*

The importance of the therapeutic relationship is undoubtedly a legitimate policy purpose to be pursued in the context of end-of-life care. However, in a number of respects, it may be doubted whether a 12-month residence requirement is a 'suitable' or 'necessary' method for ensuring that VAD is provided within the context of a therapeutic relationship.

1 *Suitability*

In seeking to establish a 'rational connection' between a 12-month residence requirement and the goal of ensuring that VAD is provided within the context of a therapeutic relationship, two particular problems stand out.

The first concerns the many instances of established, genuine, therapeutic relationships between doctors in one state and residents of other states. This is particularly apparent in border communities such as Albury–Wodonga or Cobram–Barooga, which straddle the Murray River dividing Victoria from NSW. In those communities, a NSW resident may have a longstanding therapeutic relationship with a Victorian doctor but be unable to access VAD based solely on their place of domicile. Identical considerations apply in the case of fly-in fly-out workers, who may have a therapeutic relationship with medical practitioners in both their place of work and their place of ordinary residence. Residents of less populous states and territories, such as Tasmania, the ACT or NT, may also regularly travel to larger states to access the services of medical practitioners who are specialist in their particular medical condition. In all of these contexts, it is hard to argue that there is a 'rational connection' between the

[207] See above n 157.

exclusion of non-residents and the goal of ensuring VAD is provided within the context of a therapeutic relationship.

The second problem in showing the requisite 'rational connection' here flows from the allowances made for doctors not to participate in VAD. Although VAD legislation explicitly aims to provide VAD as part of a holistic service looking at all available treatment options at the end of life and within the context of a therapeutic relationship,[208] no medical practitioner is required to provide VAD. Rather, the legislation permits a practitioner to choose not to participate on conscientious grounds, or for other reasons.[209] Statistics demonstrate that the majority of medical practitioners do not wish to be involved in the provision of VAD.[210] So far in Victoria, only a small percentage of medical practitioners are registered to provide VAD.[211] McLaren has stated that most of his VAD patients are not people with whom he has a long-term treating relationship, but are referrals from other doctors who do not want to participate in VAD.[212] Given that in Victoria — the only Australian jurisdiction where evidence is available about VAD in practice — the majority of patients are not currently receiving VAD within the context of an ongoing therapeutic relationship, it seems irrational to cite the desirability of such a relationship as the reason for excluding out-of-state residents.

2 *Necessity*

The suggestion that non-residents and new residents must be excluded so as to preserve the therapeutic relationship as a cornerstone of VAD falters again at

[208] *SA VAD Act* (n 5) s 8(1)(e); *Tasmanian EOLC Act* (n 4) ss 3(2)(c), (e)–(f); *Victorian VAD Act* (n 2) ss 5(1)(c), (e); *WA VAD Act* (n 3) ss 4(1)(c), (e)–(f). This is not an explicit principle in the *Queensland VAD Act* (n 6).

[209] *Queensland VAD Act* (n 6) s 84(1); *SA VAD Act* (n 5) s 10; *Tasmanian EOLC Act* (n 4) ss 20(2), 40(2), 64; *Victorian VAD Act* (n 2) s 7; *WA VAD Act* (n 3) s 9.

[210] Jodhi Rutherford, Lindy Willmott and Ben P White, 'Physician Attitudes to Voluntary Assisted Dying: A Scoping Review' (2021) *BMJ Supportive & Palliative Care* 11:200–8, 203. This unwillingness to participate in VAD is also present in 'high-impact specialties' (those considered likely receive VAD requests): Marcus Sellars et al, 'Support for and Willingness to Be Involved in Voluntary Assisted Dying: A Multisite, Cross-Sectional Survey Study of Clinicians in Victoria, Australia' (2021) 51(1) *Internal Medicine Journal* 1619, 1625. Before the *Victorian VAD Act* (n 2) commenced, a survey of oncologists found that 20% would be prepared to write a prescription for VAD, and only 14% would be prepared to administer a lethal injection: Christos S Karapetis et al, 'Medical Oncology Group of Australia Position Statement and Membership Survey on Voluntary Assisted Dying' (2018) 48(7) *Internal Medicine Journal* 774, 776–7.

[211] See above nn 189–90 and accompanying text.

[212] McLaren (n 188) 1.

the 'necessity' stage of proportionality review. It is not clear why in-state residency should be used as a proxy for the presence of an ongoing therapeutic relationship (were that the goal) when the latter could be invoked directly as the legislative discrimen. Framed in the language of proportionality analysis, there are a number of 'obvious and compelling' alternative measures that could achieve the policy goal as well, or better, within the overall VAD regime — with a much-reduced impact on out-of-state residents and new residents. A minimalist modification would extend the existing VAD eligibility criteria to encompass established residents plus anyone having an ongoing therapeutic relationship with a medical practitioner within the relevant state.[213] An alternative (preferred in Queensland) would be provision to obtain an exemption where a non-state resident receives medical care in the state.[214] A more extensive rewrite, aligning with the Dutch and Belgian regimes, could remove all reference to residency and require only that a person has a therapeutic relationship with a medical practitioner within the relevant state. Another possibility, which was recommended in WA,[215] would be to allow flexibility in the eligibility criteria — for example, liberty to apply for exemption from the residence requirement in cases of new residents, returning residents, or fly-in fly-out workers,[216] to ameliorate any hardship that rigid application of the provision may cause. Queensland and NSW permit exemptions to the state residence requirement, expressly mentioning border residents and returning residents.[217] They do not, however, consider the status of new residents of the state in detail.[218]

3 *Adequacy of Balance*

Once again, there is little to say at this third proportionality stage. It seems to us very likely that the 'therapeutic relationship' justification for excluding out-of-state and new residents would fail at both the 'suitability' and 'necessity' stages. The considerations would likely be the same in any event, all pointing to the manifest disproportionality of the exclusion.

[213] It would also be possible to specify a minimum period for this therapeutic relationship, but this would risk excluding people like BTR, who returned to Victoria on receiving a terminal diagnosis, and did not have a pre-existing therapeutic relationship with an oncologist in Victoria: *NTJ* (n 23) [56] (Quigley J).

[214] *Queensland VAD Act* (n 6) ss 12(1)(b), (2).

[215] *WA Panel Report* (n 31) 20.

[216] See *Queensland VAD Act* (n 6) ss 12(1)(b), (2).

[217] *NSW VAD Act* (n 7) s 17; *Queensland VAD Act* (n 6) ss 12(1)(b), (2).

[218] *NSW VAD Act* (n 7) s 17; *Queensland VAD Act* (n 6) ss 12(1)(b), (2).

VII Federalism as the Cornerstone of s 117: Implications for VAD

We concluded in Part VI above that none of the context-specific reasons that have been, or could be, given for the exclusion of new and non-residents from accessing VAD in states where it is legal is likely to survive the application of modern constitutional proportionality analysis. Yet as we noted in Part V(A) above, another layer of potential justification exists in the form of constitutional meta-principles of sovereignty and federalism. In this final Part we will consider whether and how these principles might be invoked to attack — or defend — residency-based exclusions from VAD.

In introducing the High Court's modern s 117 jurisprudence earlier in Part III above, we noted that some of the judgments in *Street* explained the exceptions to the limitation's reach by reference to federalism.[219] Since then, the High Court has moved steadily away from the view that individual rights and their protection are among the *Australian Constitution*'s animating purposes.[220] Hence the federal–structural explanation of s 117's purpose would likely dominate High Court reasoning on s 117 today.

Federalism, in all of its incarnations around the world, involves a necessary and inescapable tension between the need for unity of the nation and the need for separateness of the component polities. A number of provisions and doctrines of Australian constitutional law attempt to grapple with this tension, including s 117.[221] The tension at s 117's heart was acknowledged in the judgments in *Street*, despite the variations in thinking as to how it should play out in concrete policy contexts.[222] In simple terms, though, the s 117 prohibition represents the desire for national unity, while the acknowledged need for limits on the prohibition accounts for the countervailing expectation of some ongoing independent sovereignty, or separateness, among the Federation's component parts.

To assume that a national unity objective underpins s 117 unlocks some helpful clues as to how the limitation might apply to the state VAD laws. One of us has argued elsewhere that a national policy consensus around the

[219] *Street* (n 69) 491–2 (Mason CJ), 528 (Deane J), 548 (Dawson J), 559–60 (Toohey J), 583–4 (McHugh J).

[220] See also James Stellios, *Zines's The High Court and the Constitution* (Federation Press, 6th ed, 2015) 656–8.

[221] Other provisions include *Australian Constitution* ss 92, 99, 102, 109, 118, 128.

[222] *Street* (n 69) 492 (Mason CJ), 512–13 (Brennan J), 528 (Deane J), 548 (Dawson J), 559–60 (Toohey J), 570 (Gaudron J), 583–4 (McHugh J).

appropriate means of providing some good or service ought to be persuasive, but not conclusive, evidence of what 'national unity' demands of each jurisdiction in that context.[223] Localism by consensus is, for instance, evident in the pattern whereby states and territories provide public housing only to their own residents. On the other hand, a federal expectation of reciprocal access can be seen in the context of emergency services, including the ability of non-residents to access police assistance or to call an ambulance while traveling within Australia. Equally, the Queensland legal practice rules struck down in *Street* were contrary to a near-unanimous national consensus that barristers should be able to work across state and territory borders.

What, then, are the national unity implications of barring non- and new residents from accessing VAD within a state? On one view, localism in the provision of access to VAD can be viewed as a state's fulfilling its part of the federal bargain, where exclusion of outsiders serves the interests of well-functioning federalism (even if not the personal interests of a particular individual thereby excluded). Given the contentious and emotive nature of VAD, the prevailing federal consensus is, at present, very much one of localism. When viewed within that wider policy landscape, one state's decision to exclude non-residents from access to its VAD scheme seems unlikely to have a corrosive effect upon national unity.[224] On the contrary, other jurisdictions may view it as a provocation to have a VAD-permissive state providing this controversial service to their residents. Unlike the late-term abortions that out-of-state residents are able to obtain, which are offered by and performed in private medical clinics, the VAD service involves the state in a central role as dispenser of the lethal medication. From a more abstract federalism perspective, arguably any constitutional edict that allowed some jurisdictions to avoid engagement with difficult, emotive issues by 'free-riding' on the initiative of others, where those others may be inundated and overburdened as a result, would be unlikely to foster federal goodwill and national unity.

These federalism-based arguments would, we think, assist states to defend their VAD residency requirements against challenges brought by non-residents. However, they do not assist in the case of the exclusion of new residents of less than 12 months' standing, returning former long-term residents, or fly-in fly-out workers. Each of these categories of residents of a state is excluded from accessing services within their home state. On a substance-based

[223] Amelia Simpson, 'The (Limited) Significance of the Individual in Section 117 State Residence Discrimination' (2008) 32(2) *Melbourne University Law Review* 639, 664–5.

[224] Ibid 667.

understanding of s 117, there is a good argument that a qualifying period of residency is actually a type of discrimination on the basis of state of residence, and one which should fall within the purview of s 117's protection. If s 117 is to achieve its objective of promoting national unity, by disincentivising fractious rivalries and provocations, then it is arguably more important to protect new and returning residents from inferior status and entitlements within their home state than it is to extend rights to visitors to a state (as in the case of reciprocal access to health and emergency services).

An interpretation of s 117 that would see it protect newly arrived state residents finds support in the case law. This support can be traced to Griffith CJ in *Davies v Western Australia*, who said that s 117 'must be construed distributively, as applying to any kind of residence which a State may attempt to make a basis of discrimination'.[225] Decades later, that view was endorsed by Stephen J in *Henry v Boehm*,[226] whose dissenting reasons in turn proved so influential upon the Court in *Street*. In *Street*, the distributive understanding of s 117 'residence' was given significant endorsement.[227] In reviewing the majority reasoning in *Henry v Boehm*, several of the *Street* judgments insisted that the former had erred in excluding from s 117's purview instances of one state's imposing a lengthy period of residence 'as a condition of the enjoyment of some advantage or privilege'.[228] That reassessment of *Henry v Boehm* reflects the unanimous commitment, in *Street*, to a substantive conception of discrimination as the conceptual centrepiece of s 117. Given that commitment, it is difficult to imagine the High Court viewing a state's 12-month residency requirement for VAD as anything other than a species or extension of the ban applied to out-of-state residents.

Importantly, incorporating these constitutional considerations does not mean that an out-of-state resident and a new resident of a state must receive the same answer in appealing to s 117. Each of those two notional plaintiffs has a different case to make about the potential damage to national unity from the 12-month residence restriction as applied to them. As has become commonplace in relation to constitutional limitations, the High Court could here read down the impugned restriction to enable its continued operation upon one, but not the other, category of excluded persons. As already explained, and looked

225 (1904) 2 CLR 29, 39.

226 *Henry v Boehm* (n 66) 504.

227 *Street* (n 69) 484–5 (Mason CJ), 516–17 (Brennan J), 543–4 (Dawson J), 586–7 (McHugh J).

228 Ibid 543 (Dawson J). See also at 556 (Toohey J), 587 (McHugh J). See also, less explicitly, at 485, 488–9 (Mason CJ), 517 (Brennan J).

at in isolation, we think that the federalism-reinforcing arguments for allowing a state to exclude residents of other states from accessing VAD are persuasive.

However, we do not consider that continuing to exclude a person from VAD access after they have taken up residence in a state which has legalised VAD is compatible with principles of state sovereignty and federalism. The very idea of 'residence' in a place signifies a commitment that distinguishes it from mere transient presence in that place.[229] This is reflected in the types of documentary evidence which typically demonstrate residence in a state of Australia: a local driver's licence, enrolment to vote in the state, a residential lease or purchase of property within the state.[230] A person who has taken those steps and undertaken those obligations within a new jurisdiction is signalling an intention to become part of the community there. To deny such a person the full range of privileges of residence, on account of their length of residence, sends a message that 'you are not yet one of us — you are still an outsider to us'. That is a very different message to the one conveyed to an out-of-state resident: namely, 'you should ask your own government about VAD (and not free-ride on us)'. The former, we would argue, more closely represents the kind of naked prejudice that could cause deep offence, jeopardising trust and goodwill among component polities within a federal system.

On that basis, a conception of s 117 that anchors the limitation in a federal–structural purpose of advancing national unity could well provide different answers to a non-resident and new resident of a state seeking to access VAD.[231] When the federal–structural foundations of the limitation are kept in focus, a resident of the relevant state of less than 12 months' standing would seem to stand a better chance of activating s 117's protection than would a person with looser ties to the state.

[229] Only Brennan J adverts to this explicitly in *Street* (n 69) 516.

[230] These examples will provide evidence of residence in a state: *Tasmanian EOLC Act* (n 4) s 11(5). See also *Washington Death with Dignity Act* (n 63) § 70.245.130; *Oregon Death with Dignity Act* (n 63) § 127.860.

[231] Other categories of resident that we have discussed in this article, including returning residents and fly-in fly-out residents, are harder to categorise in the abstract. As was foreshadowed in the Victorian case of *NTJ* (n 23) [85], [87] (Quigley J), the individual circumstances of each such person are likely to be significant in working out whether their exclusion threatens the constitutional value of national unity.

VIII Conclusion

This article has explored the vulnerability of VAD residency restrictions to challenge under s 117 of the *Australian Constitution*. We have shown that when proportionality analysis is undertaken by reference to the policy rationales actually given for those restrictions — or by reference to discernible underlying concerns — the case in favour of existing residency-based restrictions is weak. This is true as regards both the exclusion of out-of-state residents and the exclusion of new residents of less than 12 months' standing. It is true whether the suggested policy rationale for exclusion is to discourage 'death tourism', fiscal considerations, healthcare resource considerations, or the preservation of a therapeutic relationship at the heart of VAD provision.

Importantly, though, the position of out-of-state residents and new residents could cleave when the bigger s 117 picture is brought into focus. Since *Street*, the High Court has avoided wading into the complexities of s 117's role in the federal project. There remains much to be worked through and articulated as to how s 117 balances the competing needs for national unity and state separateness and independence. We have suggested in this article that considerations of federalism and state sovereignty might assist states to defend their exclusion of out-of-state residents from access to VAD within their state. Yet the exclusion of new residents does not seem defensible on federalism grounds — on the contrary it seems more likely to fuel the kinds of resentment and suspicion between states that s 117 of the *Australian Constitution* was intended to counter. The position of new residents also negates any suggestion this constitutional problem is a transient one. Even if VAD laws eventually pass in all Australian states and territories, the widespread retention of the 12-month minimum residency requirement would leave many eligibility cracks for new residents, and others, to fall through.

The High Court recently confirmed the relevance of constitutional values to the application of structured proportionality analysis in the political communication context.[232] We are optimistic that that same commitment will eventually emerge in the s 117 context and play a guiding role. The existing, dubious, exclusions from access to VAD would, we think, present the Court with an ideal opportunity to return to the unfinished business of s 117.

[232] *Clubb* (n 84) 205 [85], 209 [102] (Kiefel CJ, Bell and Keane JJ).