Access to voluntary assisted dying in Australia requires fair remuneration for medical practitioners

Medical practitioners are poorly compensated for their time and services in supporting patients through the voluntary assisted dying process

In six Australian states, voluntary assisted dying (VAD) is (or will be) a lawful end-of-life option for terminally ill competent adults. At the time of writing, VAD laws have commenced in Victoria (June 2019), Western Australia (July 2021) and Tasmania (October 2022), with 604 people completing the process in Victoria[1] and 171 people in Western Australia.[2] VAD laws have been passed and are set to commence in Queensland (1 January 2023), South Australia (31 January 2023) and New South Wales (28 November 2023).

VAD in Australia is tightly regulated. A person is only permitted to access VAD if they are deemed eligible by two medical practitioners (coordinating and consulting practitioner), both of whom need to possess certain qualifications and to have completed legislatively mandated training. Owing to the rigorous nature of the process, the time commitment by medical practitioners who support patients through the VAD process is considerable. This is particularly so for the coordinating practitioner who assumes primary responsibility for the patient during the VAD process, which based on ST's experience, typically requires 6–8 hours of commitment, all of which will be unremunerated (unless privately billed).

The obligations of a coordinating practitioner will (or are likely to) include:

- undertaking the mandatory training to assess patient eligibility (which typically takes 6 hours, but can take up to 9 hours);[3]
- travelling to patients (commonly the case as patients are often too ill to leave their homes);
- obtaining prognostic information from other practitioners to support an eligibility assessment;
- completing and uploading the required documentation to the online VAD portal; and
- providing support and information to patients, and their loved ones, throughout the process (and sometimes providing support during the bereavement phase).

Payment structure for voluntary assisted dying services

Medical practitioners perceive that their VAD work is largely unremunerated, despite the significant time commitment involved.[4,5] Currently, there is no dedicated Medicare Benefits Schedule (MBS) item for VAD. The MBS general explanatory notes (GN.13.33) state that "euthanasia and any service directly related to the procedure" will not attract Medicare benefits but note that "services rendered for counselling/assessment about euthanasia will attract benefits".[6] No guidance is given by Medicare about what such services may be and which MBS items may be available for medical practitioners to claim in relation to them. As a result, individual medical practitioners must use their discretion to claim the appropriate MBS item(s), if any, based on the clinical circumstances of the services rendered.

Despite this apparent lack of engagement by Medicare on relevant MBS items, some guidance was offered in the Western Australian VAD parliamentary debates.[7] There it was suggested that MBS items could be claimed in relation to the VAD process despite no dedicated MBS item number being available.[7] It was observed, however, that no MBS item could be claimed for the administration of the VAD substance.[7] The inability to claim for administration is particularly significant in WA, with early data suggesting a much higher proportion of practitioner administration in WA compared with Victoria.[8]

Ultimately, the applicable MBS item number will depend on the duration, location and time of the consultation, and the nature of the disease. For VAD consultations occurring outside the clinical setting (eg, the patient's home), general practitioners may be able to claim MBS items related to general professional attendances (eg, items 24, 37, 47). Other MBS items relating to professional attendances may also be open to GPs in different settings and contexts (eg, private consulting rooms, residential aged care settings, out-of-hours consultations). Moreover, if a practitioner has an established relationship with the patient (which is not always the case in the VAD context), a claim may be made for a telehealth consultation (eg, items 91800, 91801, 91802).[9] However, caution is needed to ensure a telehealth consultation does not breach the Commonwealth Criminal Code.[10]

Fewer options are available for home visits made by other specialist medical practitioners, as the usual MBS items (eg, items 110, 116, 104, 105) only apply in consulting rooms and hospitals. While there may be scope for medical practitioners employed by a health service to provide VAD within the practitioner's existing clinical role,[5] given the labour-intensive nature of VAD work, some of this may need to occur outside work hours and will therefore be unremunerated. For completeness, we note that, depending on the clinical context and nature of the consultation, MBS items relevant to advance care planning generally[11] may also be available.

Outside the Medicare framework, state-based resources may compensate medical practitioners

Casey M Haining[1]
Lindy Willmott[1]
Simon Towler[2]
Ben P White[1]

1 Australian Centre for Health Law Research, Queensland University of Technology, Brisbane, QLD.
2 Department of Health, Government of Western Australia, Perth, WA.

casey.haining@qut.edu.au

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who provide VAD services. In WA, where there is no available local practitioner, a practitioner supporting patients in regional and remote regions may be compensated for their travel expenses and time through the Regional Access Support Scheme.[12] Further, to incentivise the uptake of VAD work in regional and remote areas where there are no VAD providers, the Regional Access Support Scheme funds have, on occasion, been used to remunerate medical practitioners for completing the mandatory training. Funding has also been made available in Victoria[13] to help patients cover the gap for medical practitioners that privately bill and, on occasion, compensate medical practitioners for regional travel. However, such funds are limited and capped per patient.

While it is open for doctors to privately bill their patients for this service,[4,5] medical practitioners have indicated reluctance to do so, expressing the view that this would be insensitive.[5] This is not a universal view, however, as there is evidence of some medical practitioners privately billing their patients,[5] a practice that is likely to become increasingly common as the number of patients seeking VAD grows.

Provision of voluntary assisted dying services should be appropriately remunerated

VAD is a lawful medical service potentially available to a small number of eligible people at the end of life. Its sustainability depends on the availability of trained medical practitioners who are willing to provide that service. Despite suggestions by some that VAD would be provided by health practitioners seeking to profit,[14] early experiences suggest that the provision of VAD will not be financially rewarding. Indeed, the medical workforce is currently receiving limited compensation for their involvement in the process, unless they decide to privately bill. While there is some compensation for regional and remote provision, and some medical practitioners may be able to complete aspects of VAD provision within their ordinary clinical role, this does not cover the full gamut of VAD providers. Indeed, the ability to receive compensation is limited, particularly in cases where a medical practitioner must provide VAD services in a facility they are not employed by, or in the general practice context where there is a reliance on bulkbilling and fee-for-service remuneration. Similarly, many GPs, and other specialists, are operators of small businesses with overheads. It is unreasonable to expect such practitioners to provide services that cause their business and livelihood to suffer.

Early research suggests that some doctors are willing to provide VAD despite the lack of compensation because they feel it is the "right thing to do".[5] Moreover, some are willing to provide outside normal clinical hours.[5] However, VAD providers have expressed concern that the recurrent underpayment may disincentivise them and others from doing this work in the future, because of the demanding workload and difficulties balancing VAD provision with existing clinical roles.[4,5]

Other funding models operate more fairly. In New Zealand, the Ministry of Health introduced an assisted dying service funding model. Under the model, eligible practitioners can claim fixed payments for five modules: application and first opinion of eligibility; independent assessment of eligibility; competency assessment; decision about eligibility (and follow-up); and prescribing and administering the medication.[15] Further payments may be available for additional activities such as obtaining clinical notes, travel allowance, complex cases, and supporting practitioners.[15]

The reluctance of the federal government to provide adequate support for VAD provision, as evidenced by its position to exclude euthanasia from the MBS,[6] is hard to justify given that VAD laws have been enacted in six Australian states. Given the wide community support for VAD, it is reasonable to expect that there would be support for mainstream funding of VAD through Medicare. As each regime is broadly similar, MBS item numbers relevant to the service could be nationally applied.

Because of the limited remuneration available, the provision of VAD services largely relies on the goodwill of medical practitioners to undertake unpaid work. Inadequate remuneration, in addition to being unfair and unethical, is likely to impact the sustainability of the already stretched VAD workforce and hence the ability of patients to access VAD in the future. If the lack of public funding for VAD services results in more medical practitioners privately billing their patients, VAD will be less accessible to a subset of the population.

We support calls for uniform and transparent funding arrangements that ensure medical practitioners are fairly compensated for the medical services they provide,[4] and anticipate the new federal government may be more supportive of such reform. Failure to reform the current funding model is likely to result in an unsustainable medical workforce and an increasing reliance on private billing, which will adversely impact patients' access to this lawful end-of-life option.

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