VADANZ
Voluntary Assisted Dying Australia and New Zealand

# Remuneration Survey of VAD Practitioners

The dominant theme was that VAD should not rely on clinician altruism or patients' ability to pay, and that it must be equitable for all practitioners to access.

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# Executive Summary

Voluntary Assisted Dying Australia and New Zealand (VADANZ) is the peak body for health professionals providing voluntary assisted dying (VAD) care. VAD is now a legal end-of-life choice in New Zealand and every Australian jurisdiction, except the Northern Territory.

Our Australian members consistently raise concerns that VAD care is often not adequately remunerated, with many reporting that they complete significant amounts of unpaid VAD work in the absence of sufficient federal or state provision.

This differs from New Zealand, where medical and nurse practitioners who have completed government assisted dying training may claim on a fee-for-service basis for the provision of assisted dying care. The process is divided into five 'modules', each eligible for a fixed payment, and additional payments may be paid, for example in complex cases or where additional travel is required.

The remuneration shortfall in Australia must be addressed to ensure the sustainability of the country's VAD workforce and services, and ensure continuity amid growing public awareness and uptake.

In 2025, VADANZ surveyed VAD health professionals to understand the current compensation across Australia. This survey found that Australia's approach to VAD remuneration is fragmented and inconsistent. While some states, particularly New South Wales and Western Australia, have developed more workable models with higher levels of satisfaction, practitioners in most jurisdictions report widespread dissatisfaction, unacceptable levels of unpaid care, and doubts about whether they will continue working in VAD long term.

Without urgent reform, Australia risks losing significant numbers of skilled practitioners from the VAD workforce and undermining the ability to deliver this essential area of care.

We need to see dedicated MBS items for VAD care. Alongside this, there is an urgent need to increase funding support for VAD practitioners.

### Our recommendations

- Fee schedules for VAD services occurring outside the hospital setting that cover all aspects of VAD care including travel costs. The NZ funding model is a valuable template.
- Funded hospital roles for practitioners delivering VAD services either as full-time equivalent (FTE) positions or visiting medical officer (VMO) arrangements.
- State guidance on available billing options for VAD.
- A federal update of MBS Explanatory Notes where they limit use of MBS items for VAD (GN.13.33).

# Key Findings

Almost two thirds felt their state's remuneration was inadequate (63%)

More than a quarter of VAD practitioners provide unpaid VAD care (27%)

Around half bill for part of the VAD process through the MBS (47%)

Only a third receive any state government reimbursement for VAD care (32%)

In Victoria 83% of VAD practitioners believed the current payment model for VAD service was inadequate.

South Australia and Tasmania have small VAD workforces and a low number of respondents, however they all reported high levels of dissatisfaction with the existing remuneration arrangements.

NSW was the only state where more respondents believed that their remuneration was adequate (51%) than not (41%).

## Respondents

170 respondents participated in the survey, representing 12% of the national VAD workforce.[1] Among them, 42% were general practitioners (GPs) and 45% were other specialists. The vast majority had more than 11 years' clinical experience.

The survey does not include the Northern Territory or the ACT because there was no VAD legislation in effect in either jurisdiction at the time the survey was conducted.

[1] Correct to 30 June 2024.

# Themes

### Widespread dissatisfaction with current remuneration models

- Almost two-thirds (63%) of respondents deemed their state's remuneration inadequate
- Only 24% reported satisfaction, with half of these coming from NSW
- In Victoria dissatisfaction rates exceeded 80%
- South Australia and Tasmania had low numbers of respondents but with very high dissatisfaction rates (100%).

### Current Medicare Benefits Schedule (MBS) items are not suitable for VAD care

- Practitioners across all jurisdictions reported that current MBS items were unsuitable for the VAD processes and practice
- Essential non-clinical tasks (administration, reporting, portal documentation, coordination, travel, emotional labour) were uncompensated.

### Current remuneration is complex

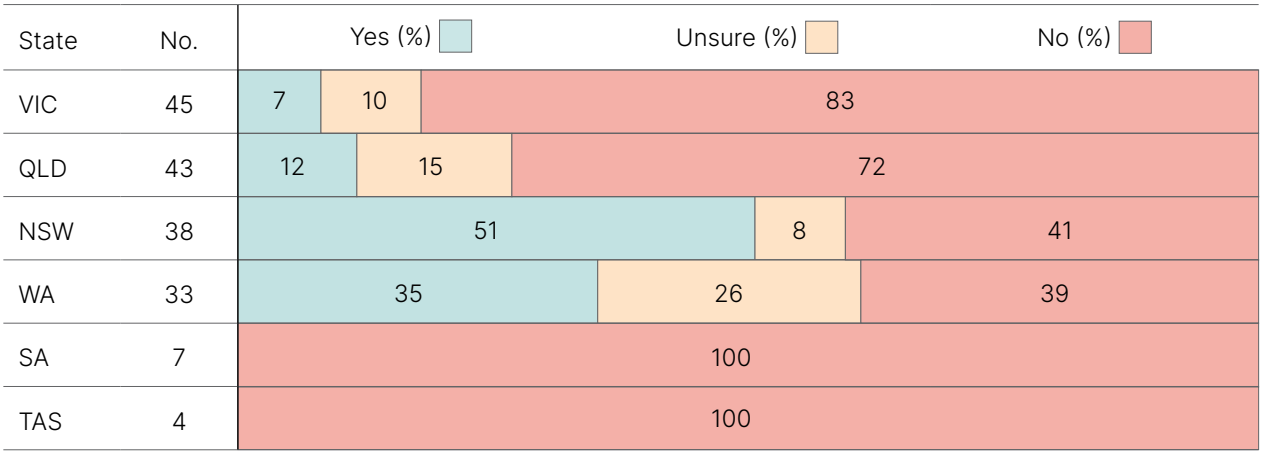
- Current opportunities for payment for VAD work depended on how practitioners were employed, which varied significantly by state (e.g. salaried, self-employed, contracted)
- Salaried doctors found the system more workable, while privately practising GPs and specialists found the system financially unsustainable.

### Need for clarity and consistency

- Many practitioners reported uncertainty about how to bill for VAD care, leading to unpaid or inconsistent remuneration and reports of eventual burnout.

# State Comparison

**Do you believe the current payment model for VAD services in your state is adequate?**




- **Victorian respondents** had the deepest dissatisfaction, with more than half reporting at least partial lack of payment. There were strong calls for dedicated MBS items and state-funded hospital roles.
- **South Australian and Tasmanian** respondents all indicated that the current payment model was inadequate and highlighted their states' reliance on unpaid VAD workforces and a lack of system clarity. These were small sample sizes but the responses consistently reported dissatisfaction.
- **Queensland** respondents were also largely dissatisfied (72%), particularly for rural and community-based doctors facing high travel burdens.
- **Western Australian** respondents had higher satisfaction levels (35%), but were frustrated with under-compensation for travel and after-hours work.
- **New South Wales** respondents were the most positive about remuneration (51% satisfaction) due to government-funded full-time equivalent (FTE) positions and visiting medical officer (VMO) arrangements.

## Implications

- Without reform, practitioner willingness to participate in VAD is at risk, particularly among younger doctors facing financial pressures. This threatens the sustainability of VAD services nationwide.
- Reliance on goodwill and unpaid care risks burnout among experienced and high volume practitioners and ultimately undermines access to VAD.
- Inconsistent funding between jurisdictions creates disparities across Australia, for both patients and their health practitioners.

# Methodology

The intention behind the VAD remuneration survey was to gain a better understanding of how VAD practitioners are being compensated for their services in Australia, and investigate whether the current models are adequate.

The survey was sent to VADANZ members on 16 April 2025. It closed on 17 May 2025 with 146 valid responses. Due to NSW respondents being underrepresented, it was briefly reopened to NSW practitioners. The survey closed on 24 July 2025.

170 practitioners responded to the survey, representing 12% of the registered VAD workforce in Australia as of 30 June 2024. Not all responded to every question, so the total number of responses for a given question may be less than 170.

Practitioners from Victoria, Queensland and New South Wales are all similarly represented with 11%, 11% and 13% of their workforce respectively. Western Australia is over-represented compared to all other locations with 29% of its workforce responding. Tasmania (4%) was particularly underrepresented, even when considering their smaller workforce. While South Australia had relatively few respondents (7 total), so this represents 9% of registered practitioners; a similar proportion to Victoria (11%) and Queensland (11%).

All survey conclusions must keep in mind the relevant workforce that responded. For example, while 1 in 10 practitioners nationally responded, 1 in 3 Western Australian practitioners responded; this means conclusions pertaining to Western Australia are more representative than national conclusions.

# Survey Responses

## Respondents

| Primary Location Summary | | | | |
|---|---|---|---|---|
| **State or Territory** | **Survey Tally** | **Survey %** | **Total registered VAD Practitioners (June 30 2024)** | **% of workforce Responded (June 30 2024)** |
| Victoria | 45 | 26 | 394 | 11 |
| Queensland | 43 | 25 | 381 | 11 |
| New South Wales | 38 | 22 | 296 | 13 |
| Western Australia | 33 | 19 | 114 | 29 |
| South Australia | 7 | 4 | 75 | 9 |
| Tasmania | 4 | 2 | 111 | 4 |
| Total | 170 | 100% | 1,371 | 12 |

## Demographics

- WA is the best represented jurisdiction, with almost 30% of the VAD workforce responding to our survey
- Nationally, the majority of respondents were GPs (42% specialist GPs and 3% general registration) or other medical specialists (45%)
- Of the 76 medical specialists, anaesthetists (18) were most common, alongside oncologists (11), emergency physicians (11) and intensive care specialists (8)

## Deep clinical care experience

Respondents had a wealth of experience to enable insightful and informed feedback:

- 85% of respondents had practised for at least 11 years
- 49% had practised for more than two decades
- 72% of respondents provided VAD regularly
- 22% reported they had participated in VAD before.

## Respondents by Professional Background

| Professional Background | Survey Tally | Survey % |
|---|---|---|
| Specialist | 77 | 45 |
| Specialist General Practitioner | 71 | 42 |
| Nurse or Nurse Practitioner | 7 | 4 |
| Pharmacist | 6 | 4 |
| General Registration | 5 | 3 |
| Other | 4 | 2 |
| Total | 170 | 100 |

## Respondents by Medical Specialty

| Speciality | Survey Tally | Survey % |
|---|---|---|
| Anaesthetist | 18 | 24 |
| Oncologist | 11 | 14 |
| Emergency Physician | 11 | 14 |
| Intensive Care Specialist | 8 | 11 |
| Geriatrician | 6 | 8 |
| Palliative Care Physician | 4 | 5 |
| Respiratory Physician | 3 | 4 |
| Other | 15 | 20 |
| Total | 170 | 100 |

KEY QUESTION 1

# How are you compensated for your work in VAD?

- Almost half (47%) of practitioners reported billing through Medicare
- 32% reported bulk billing
- 15% reported charging a gap fee
- 37% indicated they were receiving a salary that covered VAD duties
- 32% reported receiving payment from the government or some kind of reimbursement
- More than a quarter (27%) reported they were unpaid for VAD work
- Only 7% billed privately.

**How respondents are compensated**

| Compensation Type | Survey Tally | Survey % |
|---|---|---|
| MBS Bulk Bill | 51 | 32 |
| MBS Gap | 24 | 15 |
| Hospital / Employer Salary | 60 | 37 |
| State Government / Reimbursement | 51 | 32 |
| Unpaid | 43 | 27 |
| Private Billing | 11 | 7 |
| Other | 13 | 8 |
| Total Respondents | 161 | N/A |

**Note:** Respondents selected all options that applied so there are more selections than the 162 respondents. The percentage is of respondents that selected a given answer.

When asked to provide information on private billing rates, many respondents indicated that they were highly uncomfortable charging for VAD services. One respondent stated "**It feels like profiting from death and I feel very uncomfortable with this**", a sentiment expressed by many practitioners throughout the survey.

> It feels like profiting from death and I feel very uncomfortable with this.

# Comparison of state VAD remuneration provision

| How respondents are compensated (by State) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Compensation Type** | **Survey Total** | **VIC** | **QLD** | **WA** | **NSW** | **SA** | **TAS** |
| MBS Bulk Bill | 51 (32%) | 23 (55%) | 14 (35%) | 8 (26%) | 0 | 4 (57%) | 2 (50%) |
| MBS Gap | 24 (15%) | 12 (29%) | 5 (13%) | 2 (6%) | 1 (3%) | 2 (29%) | 2 (50%) |
| Hospital / Employer Salary | 60 (37%) | 13 (31%) | 19 (48%) | 11 (35%) | 15 (41%) | 2 (29%) | 0 |
| State Government / Reimbursement | 51 (32%) | 10 (24%) | 4 (10%) | 21 (68%) | 14 (38%) | 2 (29%) | 0 |
| Unpaid | 43 (27%) | 21 (50%) | 10 (25%) | 3 (10%) | 4 (11%) | 5 (71%) | 0 |
| Private Billing | 11 (7%) | 6 (14%) | 1 (3%) | 1 (3%) | 0 | 1 (14%) | 1 (25%) |
| Other | 13 (8%) | 5 (12%) | 2 (5%) | 2 (6%) | 4 (11%) | 0 | 0 |
| Total Respondents | 161 | 42 | 40 | 31 | 37 | 7 | 4 |

**Note:** Percentages are respondents that selected a compensation type from a given state. As respondents selected all that applied, tallies and percentages add up to greater than 100%.

KEY QUESTION 2

# Do you believe the current payment model for VAD services in your state is adequate?

| Respondents' views on adequacy of VAD payment (by state) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Answer** | **Survey Total** | **VIC** | **QLD** | **WA** | **NSW** | **SA** | **TAS** |
| Yes | 38 (24%) | 3 (7%) | 5 (12%) | 11 (35%) | 19 (51%) | 0 | 0 |
| Unsure | 21 (13%) | 4 (10%) | 6 (15%) | 8 (26%) | 3 (8%) | 0 | 0 |
| No | 101 (63%) | 34 (83%) | 29 (72%) | 12 (39%) | 15 (41%) | 7 (100%) | 4 (100%) |
| Total | 161 | 42 | 40 | 31 | 37 | 7 | 4 |

## Victoria

Victorian practitioners overwhelmingly described the current VAD remuneration system as deeply inadequate. This was reflected in the proportion of Victorian respondents that reported being unpaid for VAD work (50%). This was far higher than the survey average (29%), and the results in Queensland (25%), New South Wales (11%) and Western Australia (10%).

Victorian respondents relied heavily on the MBS for remuneration compared to the survey average and were concerned at the lack of dedicated MBS item numbers for VAD. This forced practitioners to rely on generic time-based Medicare billing that does not reflect the complexity or duration of the work.

Even hospital-employed doctors, who do not personally bill patients, stressed that their departments received no dedicated funding for VAD, leading to work being completed after hours or deprioritised against routine duties. These concerns were reflected in Victorian respondents having the highest dissatisfaction rate (84%) amongst all states with their current remuneration system, with 10% being unsure and 7% being satisfied. This is compared to the survey average of 63% being dissatisfied.

> The dominant theme was that VAD should not rely on clinician altruism or patients' ability to pay, and that it must be equitable for all practitioners to access.

### Victorian respondents suggested the following improvements

- Creation of specific MBS item numbers for all stages of the VAD process including; assessments, administrative tasks, death certification, coordination, and home visits
- VAD-specific roles to be built into public hospital staffing models, including properly funded VAD coordinators.

*"**It's a joke.** I do home visits – an essential service for patients who are often desperately unwell. Between preparation for the initial consultation (accessing and reading files, pathology results, imaging results etc), travel time, the initial consultation itself, writing reports, uploading material to the Board's portal, writing a referral to the second practitioner, doing all the same for the second consultation, and then, if the patient requires intravenous practitioner administration, going a third time to actually end their life (a task that not only takes time, but requires expertise, skill, and of course the potential for an emotional toll on me), **a VAD case would take 5-10 hours.***

*For this, if I get a referral from the GP, which is not always the case, **I can bulk bill a 17650 and a 17645 – a total of about $200.***

***My kids earn more in their part-time retail jobs.** If I don't get a referral (e.g. if the request comes directly from the VAD navigators who are generally nurses or social workers), then I can't even bulk bill Medicare, so I do it pro bono."*

> It's a joke.

## Queensland

Queensland respondents reported that the current remuneration for VAD services was inconsistent, often inadequate, and discouraged broader participation from private GPs and specialists. Queensland respondents were slightly more likely to state they were dissatisfied with their model than the survey average (73% compared to 63%). As in Victoria, many noted that Medicare rebates did not cover time spent on essential non-clinical tasks. Respondents said there was no financial support for home visits or private vehicle use, and practitioners emphasised that item numbers were unclear or inapplicable for VAD services.

In salaried positions, some doctors found the system workable, though even then, they reported limitations such as unfunded travel, lack of overtime for after-hours work, and an absence of support for remote travel. This split was notable, as Queensland VAD respondents were the most likely to hold salaried positions (48%) compared to the average of all other states of 37%, potentially reflecting the different funding model for VAD workers in Queensland. Community-based and rural practitioners, in particular, described challenges that made providing VAD care financially unsustainable despite the high need.

### Queensland respondents suggested the following improvements

- Creation of specific MBS item numbers for all stages of the VAD process including; assessments, administrative tasks, death certification, coordination, and home visits
- More state-funded salaried positions, including casual or part-time contracts through hospital and health services, particularly for doctors not currently employed within the public system.

***"It's time consuming, medicolegally delicate, and emotionally stressful."***

*"It is ok for state employed medical officers but, in many cases, the best placed person to provide these services are community primary care doctors.* ***It is ambiguous if and what these services can be billed under****, especially when they are 'referred' services from another doctor. In rural areas it is vastly inadequate as the item number for the time based consultation doesn't cover the hours of travel required. In some instances doctors are away from home for 2-3 days seeing a remote patient, even salaried doctors are not necessarily paid for this impost in their personal time."*

*"The current lack of remuneration other than paltry generic medicare items means VAD services have become largely a matter for health departments…This has largely excluded community doctor involvement. Perhaps this isn't a bad development but* ***it has meant that a practitioner like myself who was keen to be involved is largely excluded."***

> It's time consuming, medicolegally delicate, and emotionally stressful.

## Western Australia

Western Australian respondents were more satisfied with their remuneration model than most. One in three (35%) respondents were satisfied that their funding was adequate, with 26% unsure and 39% dissatisfied. This is notable as Western Australia introduced a fee for service model in July 2024. This approach is the most transparent remuneration model, the full details of which can be viewed here.

While this satisfaction rating is significantly better than many other states, those who were dissatisfied identified a consistent set of limitations. Chief among these were inadequate remuneration for non-clinical time, such as administration, paperwork, coordination, and the emotional toll of care, particularly in urgent or complex cases. Multiple respondents noted that the current system did not appropriately compensate for after-hours work, travel under 50km, or the training and recertification requirements. Some reported that the process of invoicing was so burdensome that they or their peers simply stopped claiming, leading to significant underreporting of work performed.

### WA respondents suggested the following improvements

- Reduce the administrative burden. Suggestions ranged from streamlining or automating invoice processing, more flexible claiming timelines (e.g., fortnightly rather than monthly) and, ideally, integration into the MBS to eliminate separate billing entirely
- Additional travel compensation (at present, claims are only accepted for journeys of 50km+)
- Funding for after-hours care, which is frequently required to meet patient needs.

*"I can get paid much more for my time when working in the public hospital system."*

*"It is emotionally demanding, there is a lot of time spent in bureaucracy.* ***Time spent doing the training … is not remunerated."***

*"Whilst it is a good start, the lack of clarity of how/what to claim (clinical vs non-clinical work) the need to keep really contemporaneous and rigid diary notes, the risk of being seen to be double dipping, and the challenge of having to generate an invoice each month by manually going through every single point of service means I don't do it. Most people I know, unless they are solely offering VAD using this claiming pathway, don't claim either, which means* ***the amount being billed is a gross underestimation of the work being done."***

> ...the amount being billed is a gross underestimation of the work being done.

## New South Wales

Respondents in New South Wales were the most satisfied, with 51% (19) stating the current funding model was adequate, three being unsure and 41% (15) responding it was inadequate. This was more than double the national survey average of 24% of respondents feeling satisfied with their state's funding. Noticeably only one respondent from NSW billed using the MBS, with the majority split between being salaried workers (41%) and receiving state government reimbursements (38%). This was similar to Western Australian respondents who were also more likely to be satisfied with their reimbursement mechanisms.

**NSW respondents suggested the following improvements**

- Dedicated VMO roles and permanent FTE positions within NSW Health to ensure certainty, continuity, and legitimacy of VAD services.
- Creation of specific MBS item numbers for all stages of the VAD process including; assessments, administrative tasks, death certification, coordination, and home visits.
- Ensure staff specialist awards adequately compensate for VAD duties added to regular workloads. Minimum hours per week and flexible arrangements, such as VMO zero-hour contracts, could help balance capacity with demand.
- Suggestions included aligning with New Zealand, where item numbers cover travel and admin time, and allowing Nurse Practitioners to take on greater roles, as in the ACT.

*"Personally it is adequate as the funding is specifically for VAD work. However there are challenges to get specialists to be paid for VAD work that they do within their normal clinical role - ie specialist outpatient, GPs etc."*

*"It is not regular work and sometimes I make myself available but there is no VAD work to do, therefore I lose income (I could have work wise been working in Anaesthetics).* ***No incentive to continue VAD work.****"*

*"Zero hour contract is a theoretical financial risk with regular time set aside for VAD without any surety of work... Minimum weekly hours as part of contract to build certainty. Any hours not used for clinical work could be utilised for education/awareness."*

> No incentive to continue VAD work.

# South Australia

Due to the low number of respondents from South Australia (7) strong conclusions can't be drawn.

However, all 7 respondents expressed clear dissatisfaction with the current remuneration model and 5 out of 7 reported being unpaid for VAD work. Responses highlighted the model's lack of sustainability, particularly for GPs and non-salaried practitioners.

### South Australian respondents suggested the following improvements

- A dedicated state government fee schedule that would apply across all practitioners, including an hourly rate of approximately $450 to cover consultations (whether face-to-face, home visits, video, or phone), travel time (emphasising time lost rather than just kilometres), and the significant administrative tasks like documentation on the VAD portal.
- More state-funded salaried positions, including casual or part-time contracts through hospital and health services, particularly for doctors not employed within the public system
- Creation of specific MBS item numbers for all stages of the VAD process including; assessments, administrative tasks, death certification, coordination, and home visits
- One respondent called for large teaching hospitals to establish salaried VAD roles to support consistent and equitable service delivery.

*"I am a GP. My expenses are $230 for every hour.* ***If I don't charge, I have to pay to see VAD patients****. Time to travel, see patients and do 'paperwork' would require that I pay approximately $2000 per patient. Add the lost income. That equates to approximately $3000 lost per VAD patient. I****t is unreasonable and absurd to get a VAD trained GP Specialist to donate $3000 per VAD patient."***

*"No ability to reimburse any activity apart from adding onto my usual work which is unpaid extra hours. No model to support those not linked to my hospital even though I may be the closest available practitioner. Only way to do this otherwise would be privately but I don't believe this inequity of access should be present."*

*"There need to be MBS specific codes for VAD assessments."*

*"The hospital's funding of permanent salaried staff in our local health network is unique and highly valuable. But it needs to be mirrored across other health networks. It is not fair to patients that their medical care be disparate across health networks. And it is not fair to expect salaried specialists employed by the government to add VAD to their work load without paid time to do that.* ***VAD should be a service within all hospitals with salaried staff.****"*

> If I don't charge, I have to pay to see VAD patients.

# Tasmania

Due to the very low number of responses from Tasmania (4), strong conclusions can't be drawn. Instead of aggregating responses, we have included some reflective quotes below. However, it should be noted that all four respondents were dissatisfied with Tasmania's current remuneration system.

*"The current remuneration system does nothing to encourage my younger colleagues with families/mortgages etc to become a VAD practitioner. I am a specialist GP with over 40yrs experience and basically doing this job because of my very firm views that every patient is entitled to die with dignity. We are very short of medics and I cover a large area."*

*"**Medicare is woefully inadequate and private gaps are out of reach for some people**. Totally ridiculous you can't bill Medicare to attend a death!!"*

*"There is no consistency. Private practitioners develop their own system. I feel embarrassed discussing fees with dying patients. **VAD is legal so there should be Medicare items.**"*

*"**The VAD Commission is funded. The navigation team is funded. The pharmacy team is funded. The medical team is NOT funded.** I would be very happy to be employed or a set fee for each step or a separate properly funded Medicare item number."*

> Medicare is woefully inadequate and private gaps are out of reach for some people.

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