CHAPTER 4

PATIENT SUPPORT AND CROSS BORDER ISSUES

Patient support

> *…I would not see a carer as being a luxury; I would see it as a baseline for negotiating really quite a challenging experience. Most people within the metropolitan area have their carer up there, so it seems fairly discriminatory that we do not provide that and that we do not see that as a baseline for people who come from outside the metropolitan area and who may not have had any familiarity with our freeways and our shopping centres and all of those issues. Then of course there are the other issues of dealing with treatment, with diagnosis; you really do need a carer there...If people do not have a carer there – they are very lonely, they are very isolated, they are in a very alien environment – they spend an enormous amount of money in ringing long distance to get something of that support.*[1]

4.1 An issue raised in all jurisdictions was PATS funding of an escort for patients needing to travel for specialist medical care. All jurisdictions allow an escort for children. For other patients, most jurisdictions (NSW, Queensland, South Australia, Western Australia and the ACT) require the referring GP or specialist to certify that an escort is necessary for medical reasons. In Tasmania an escort is allowed if they are necessary to provide active assistance while travelling or for medical reasons; in the Northern Territory an escort is allowed if they are necessary to assist with patient care and the support services at the place of treatment cannot provide adequate assistance; and in Victoria an escort is allowed if the referring GP or the specialist states that an escort is necessary.

4.2 Witnesses argued that the rules concerning escorts, particularly those in jurisdictions which preclude escorts on grounds other than medical reasons, ignore the very important contribution that escorts make to patient care and well-being. The contribution includes assisting the patient with the practical problems of travelling to a busy, unfamiliar metropolitan area, attending a hospital or specialist appointment and finding accommodation. Even if the patient is familiar with where they are going, their medical condition may make it difficult to access public transport and/or their treatment may leave them debilitated.[2] The Great Southern GP Network commented:

> The major concern we have at the GP network is patients being discharged from the Perth hospitals and sent home unaccompanied by plane often with no support person…There is a real need for the PATS scheme to provide a

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1 *Committee Hansard* 6.8.07, p.16 (Dr P McGrath).

2 See for example, *Submissions* 22, p.2 (Central Australian Division of Primary Health Care Inc); 69, p.5 (HCRRA).

> liaison person who can provide additional care and support to patients travelling alone.[3]

4.3 The assistance of an escort for older patients was highlighted, particularly in the light of hospital admission and discharge practices.[4] The needs of older people are discussed further in chapter 5.

4.4 In addition to assistance with the practical problems of travel, witnesses argued strongly that escorts provide significant psychosocial support for patients which is crucial to positive health outcomes:

> The need for psychosocial and practical support during the time of cancer diagnosis and treatment is a crucial factor affecting an individual's psychological well-being. Patients who must travel long distances to obtain treatment are often faced with the difficult decision to forgo the emotional support of family whilst in the city due to the high costs of travel and accommodation. Lack of this access to this support is a significant risk factor associated with the development of co morbid anxiety and depression.[5]

4.5 Young people are particularly vulnerable. Those over the age limit for automatic allocation of an escort may find it difficult to cope with the treatment regime and being away from friends and family. The Cancer Council of Australia commented:

> Particularly in young people, we are seeing more frequently a need to have psychosocial support to get through the often intensive chemotherapy treatment regimes which have multiple side effects that cause extensive distress. Being able to have someone close by to support them through that, as well as having a multidisciplinary team, is absolutely imperative.[6]

4.6 The needs of other groups of patients were also discussed in evidence. Patients with severe psychological conditions and distress find it difficult to travel without an escort.[7] In the case of patients who must be away from home for long periods because of treatment needs, the lack of an escort can impact severely and increase isolation and loneliness. Indigenous people find it particularly difficult to be isolated their communities for extended periods of time. The needs of Indigenous people are discussed in chapter 5.

4.7 Palliative Care Australia pointed to the special needs of those diagnosed with a terminal illness which it made it a necessity for the presence of an escort:

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3 *Submission* 9, p.1 (Great Southern GP Network).

4 *Submission* 58, pp.5-6 (Aged and Community Services Australia).

5 *Submission* 85, p.1 (Psyco-oncology Collaborative of the Cancer & Palliative Care Network WA); see also *Submission* 101, p.2 (Carers WA).

6 *Committee Hansard* 6.7.07, p.38 (Ms K Thompson, Cancer Council of Australia).

7 *Submission* 156, p.2 (Dr S Thrussell).

> The diagnosis of a terminal illness is a time of extraordinary stress. Requiring a patient receiving treatment to travel without a funded escort is inappropriate, particularly in a palliative situation, where patients experience extreme frailty. PATS arrangements should, as a matter of course, cover the cost of an escort for patients receiving palliative care and include provision for two escorts, particularly in cases of children.[8]

4.8 Another issue raised was the limited options for patients and/or their escort to access assistance to return home for a period of time during an extended treatment regime. This is especially significant when having to relocate for long periods of radiotherapy and for pregnant women who may have to relocate four weeks prior to birthing.[9]

4.9 The Australian Nursing Federation (ANF) argued that the current arrangements around escorts are not patient focused and very few people find that they are eligible for an escort. The schemes do not consider individual patient needs such as the severity of individual conditions, the urgency associated with the episode of care required or the length of time for treatment.[10]

Women and children

4.10 With the closing of many rural obstetric facilities, women are now required to travel to a larger centre to await the birth of their child. If they cannot travel to a centre where they have family members, they may have to stay some weeks in a town with no support. Witnesses commented that this increased expectant mothers' anxiety and distress. Mater Health Services commented:

> In this day and age, when we are promoting two parents being involved in the process of pregnancy and parenting and family, to be removed from your partner at this critical time is quite devastating for some women, and they do not cope all that well. In fact, I have got a number of examples where women will refuse to stay and want to go home, even to the point of putting themselves and the baby at risk because they do not want to stay without some support from a partner or a mother or a family member.[11]

4.11 Maningrida Community Health Centre argued that escorts should be provided for all women having a baby because of the improved outcomes that derive from appropriate support. While this is the case for all women, support is particularly important for Indigenous mothers:

> Improved emotional and psychological coping with the birthing process and fewer interventions have been demonstrated by the presence of a support

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8 *Committee Hansard* 22.6.07, p.23 (Ms F Couchman, Palliative Care Australia)

9 *Submission* 45, p.4 (Australian Rural Nurses and Midwives); see also *Committee Hansard* 5.7.07, p.30 (Ms M Doyle, Ngaanyatjarra Health Service).

10 *Committee Hansard* 22.6.07, p.26 (Ms F Armstrong, ANF).

11 *Committee Hansard* 6.8.07, p.31 (Ms J Petty, Mater Health Services Brisbane).

> person. Such evidence is derived from the mainstream, so one would imagine that that benefit would be magnified when the patient group are women from traditionally-based Aboriginal communities, many of whom barely speak English. The young age of many Aboriginal mothers, combined with limited knowledge and experience of Western systems/hospitals makes for a particularly disempowering experience.[12]

4.12 Associate Professor Sue Kildea provided the following case where the inflexible application of guidelines resulted in a young, first time Indigenous mother being unable to be accompanied by an escort although she was only 16 years of age.

> Carly turned 16 years old a week ago. For most Australian women this would be a time of celebration. For Carly the timing could not have been worse. Carly was due to have her first baby and for this she was being flown into Darwin, the regional centre. Being her first baby she was frightened. She wanted to stay in her community to have her baby but was told she had to go. She wanted her grandmother to come with her, after all her grandmother had been a traditional midwife and had been preparing Carly for this event for months. But the rules of the PATS system meant that Carly was now too old to have a paid escort come with her for her journey. At 38 weeks of pregnancy she would have to wait in Darwin by herself until her baby came. Feeling lonely, surrounded by an unfamiliar environment, people and food Carly was miserable. If her 16th birthday had been a week later she would have had a relative travel with her, be by her side for the birth of her baby and stay to assist her with breastfeeding, travelling back with her when it was time to go home.[13]

4.13 In all jurisdictions escorts are available for children. However, witnesses noted that this was generally restricted to one escort per child. More often than not, the mother travels with the child which places an enormous burden on the mother to be the sole person accompanying the child through the treatment and beyond. Most families wish to be together when a child is seriously ill but must pay for the other parent to travel to the treatment centre. This imposes a further financial burden on the family at a stressful time. Mater Health Services provided the following example:

> A patient from a regional area of Queensland, pregnant with twins, is required to stay in Brisbane from 24 weeks gestation until the birth of her babies who have cardiac abnormalities. She is refused a paid escort on the basis that she is an adult and can look after herself. The family do not have the necessary funds to pay for the escort so the patient is sent on her own. The patient developed complications during her time in Brisbane, and despite written communication from specialists at the Mater, was still refused eligibility for an escort. Upon the birth of the twins who required cardiac surgery and follow-up after discharge, the hospital would only

12 *Submission* 163, p.1 (Maningrida Community Health Centre).

13 *Submission* 147, p.2 (Ass Professor S Kildea).

> provide one escort, even though the PTS guidelines state that each child is entitled to an escort. This placed more financial burden on this family.[14]

4.14 There is also a special need for both parents to be present when a child is admitted to a hospital and is not expected to live. Princess Margaret Hospital, Perth, commented that 'from our point of view, certainly where a child's death is imminent, that is a crucial event that both parents need to be there for'. However, PATS approval is not always given for a second parent to be present.[15]

4.15 Where children have a chronic condition such as diabetes or cystic fibrosis the presence of both parents provides the opportunity for them to receive education on how to care for their child:

> In this world of growing social complexity, quite often we are dealing with blended families and separated parents, so you cannot always rely on one parent being educated and then going home to the biological father of the child and educating him. So sometimes having the flexibility to get the second parent down is crucial for us.[16]

4.16 Princess Margaret Hospital, Perth also pointed to the problem of young mothers (16 years of age or under) who accompany a sick child to the hospital. The Hospital argued that given the young age of these mothers, it is essential that they are escorted by an adult to assist them in making decisions on treatment/consent, navigating the hospital system and dealing with the stress of their child's medical situation. For risk management it is critical in some circumstances to have an adult present. The Hospital has found that some PATS jurisdictions will fund a 'second' escort in these circumstances, and some refuse to assist.[17]

Inconsistencies in the application of escort guidelines

4.17 Witnesses commented on inconsistencies of application of guidelines in relation to escorts. Examples were given of some patients being allowed an escort while others with similar needs were not. This was often very distressing for the patient without the escort.[18]

4.18 One matter raised was the withdrawal of financial support for the escort in some jurisdictions when the patient is admitted to hospital. This was viewed as being particularly harsh as 'the costs to the carer (and patient) do not cease just because the

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14 *Submission* 36, p.1 (Mater Health Services).

15 *Committee Hansard*, 13.7.07, p.48 (Ms J Mace, Princess Margaret Hospital for Children).

16 *Committee Hansard*, 13.7.07, pp.48-49 (Ms J Mace, Princess Margaret Hospital for Children).

17 *Submission* 30, p.2 (Social Work Department – Princess Margaret Hospital); see also *Committee Hansard* 13.7.07, pp.48-49 (Ms J Mace, Princess Margerat Hospital).

18 *Committee Hansard* 22.6.07, p.24 (Ms J Bevan, Kidney Health Australia); 6.7.07, p.31 (Ms K Thompson, Cancer Council of Australia); 6.8.07, pp.4-5 (Dr E Roos, Southern Queensland Rural Division of General Practice).

patient is admitted to hospital, thereby adding to the financial impact and additional costs'.[19]

4.19 The ANF also raised the issue of the rules regarding financial assistance if an escort is only required for travel home. In some jurisdictions, the escort's full journey is not subsidised:

> Other issues include the lack of reimbursement for escorts to assist patients to travel prior to surgery. If people require an escort to travel home with them, the escort is required to pay for their travel away from the community because only the return part of the journey is covered.[20]

4.20 There was also extensive evidence on refusal to fund escorts even though the application may be within the guidelines. Witnesses argued that it is for the doctor to make a decision in the best interests of the patient and it should not be for someone who is not clinically trained to override that decision because of budgetary or other concerns. ARRWAG commented:

> A doctor makes a decision in the best interests of the patient on what they seem to be contributing to their health care, but sometimes there is someone else who has a budget in mind and there are constraints around a program. So that is their prime focus rather than the actual care of the patient. I think that is a very difficult position to put someone in – someone who is not clinically trained, and I know they are not, to override a clinical decision.[21]

4.21 Examples of decisions being changed by another medical practitioner were also provided. In these instances the emotional and financial implications can be severe. The Mallee Division of General Practice provided this case:

> The patient was admitted to hospital and the specialist disagreed that an escort was required. Two days later the patient was sent home via ambulance and his wife, who was 78, was left in Melbourne with no way of getting home. Because the specialist said that it was not a requirement, she was stranded and stuck. That is not an isolated situation. It really needs to be addressed.[22]

Improving access to escorts

4.22 Witnesses called for greater flexibility in the provision of escorts and recognition of the benefits to patient care that an escort can provide. In some particular instances, such as young first-time mothers and patients receiving palliative care, it was considered that the provision of an escort be mandatory.

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19 *Submission* 101, p.2 (Carers WA).

20 *Committee Hansard* 22.6.07, p.26 (Ms F Armstrong, ANF).

21 *Committee Hansard* 6.7.07, p.73 (Dr K Webber, ARRWAG).

22 *Committee Hansard* 6.7.07, p.45 (Mrs M Withers, Mallee Division of General Practice).

4.23 In response, the Western Australian Government commented that while extending travel and accommodation support for escorts may assist in improved health outcomes for patients who may benefit from the presence of such a person due to psychosocial reasons, 'the effective cost of such an initiative would be extremely high'.[23]

4.24 WA Country Health also commented on the need to ensure that the escort who travels with a patient is able to provide assistance and are not themselves in need of support:

> …our experience is that quite often escorts who come down with a patient are not always the best option for that patient. The escorts themselves are often not familiar with the city and do not know their way around hospitals, so they are not really able to help the patient navigate through the hospital system when they are down here. We are told anecdotally that sometimes they do not stay with the patient and can be hard to find when the patient is ready to return home. Often, the escorts themselves are in need of support when they are down here, so it is an additional burden for our health services rather than a support for the patient.
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> …in our experience, it is sometimes difficult to find escorts who are more competent than the patient and who are not equally as intimidated by the whole thing as the patient. In some cases they can be of little value to the patient.[24]

4.25 As a consequence of these concerns, Western Australia has established a 'meet and assist' service for patients travelling to Perth for treatment and needing assistance when they arrive. WA Country Health concluded:

> It is better, in our experience, to be very exquisite about packaging the journey and making sure there are no breaks and vulnerabilities – that everything is really well lined up and the person is cared for, met and assisted all the way through – than it is to simply say, 'An escort will do the job' and have two people who get lost and do not make connections. That is our philosophy.[25]

4.26 The Northern Territory Government responded that there was a great deal of subjectivity in who makes the decisions and how assessments are made about escorts. To overcome these difficulties, some rules had been established but problems still exist:

> We have established some rules there. They are still fairly light. A lot of the escort discussion is about the clinician's assessment of the individual and their need for support when they go to another location. A lot is left to their discretion. One of the problems is that we probably need to be a bit more prescriptive as to what will qualify and what will not. There is a lot of

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23 *Submission* 39, p.4 (WA Government).

24 *Committee Hansard* 13.7.07, p.4 (Ms S Eslick, WA Country Health Services).

25 *Committee Hansard* 13.7.07, p.4 (Mrs C O'Farrell, WA Country Health Services).

> discretion in it. I have some clinicians who give everybody an escort, and I have others who engage with the process a lot more interactively. There are probably others who take a much more hardnosed position on it. There is a lot of variability in there at the moment.[26]

4.27 Queensland Health argued that the introduction of automatic approval for escorts for patients on the basis of their diagnosis would introduce inequity of access as other categories of patients who may have similar health needs could argue that their exclusion is inequitable and lobby for similar access.[27]

4.28 The South Australia Government stated that it recognised the importance of emotional support to assist in achieving good health outcomes. South Australian PATS 'provides assistance to carers who provide support in terms of physical care of the patient as well as support for travel and accommodation for an additional escort to act as an interpreter if needed to assist the patient/family to understand treatment'. Two carers are available where a child requiring medical care is under 17 years of age if the child is seriously ill or both parents are required to make decisions on treatment options. The Government indicated that, from available PATS data, approximately 55 per cent of all claims have an approved escort/s.

4.29 In addition, South Australia has developed a Patient Liaison Nurse network through the Patient Journey Initiative to support country patients and their carers. The Patient Liaison Nurse will be a central point of contact within health units to assist in the transition of care for individuals from country South Australia needing to access health services locally, regionally and within Adelaide.[28]

Conclusion

4.30 The evidence strongly supports the benefits to patients of having support and assistance when they travel for treatment. The Committee considers that patient assisted travel schemes should recognise these benefits through more flexible guidelines in relation to escorts.

Cross-border issues

4.31 Witnesses raised five concerns in relation to cross-jurisdictional travel: variations in subsidy rates and processes; limited cross-state arrangements; determining eligibility for transient residential status; lack of patient choice; and the inability to claim PATS if treatment is required while travelling interstate.

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26 *Committee Hansard* 5.7.07, p.52 (Mr P Campos, DHCS).

27 *Submission* 184, p.7 (Queensland Health).

28 *Submission* 165, pp.11-12 (SA Government).

Differences across the States and Territories

> People are travelling and being subsidised in different ways as they arrive in different major centres. The emphasis on the discrepancy is more that it is not fair to Australians to have people being funded at different levels through a scheme which is basically a Commonwealth scheme but delivered in state and territory parts.[29]

4.32 Witnesses commented that differences across the States and Territories leads to frustration for patients and administrative difficulties for staff. There are differences in the guidelines for escorts, the level of subsidy for travel and accommodation and the ability to access closer, but interstate, treatment centres. The Cancer Council cited this example in relation to access to escorts:

> We are treating three young men for subtissue sarcomas – one is from South Australia, one is from Victoria and one is from New South Wales. They have all been signed off as being eligible for different levels of support through the individuals PATS programs. It has been incredibly distressful for one of the young men – who is 19 years old – who cannot understand why he could not get approval for an escort to come with him while he undergoes treatment. So there are very strong inconsistencies regarding the eligibility for specific kinds of support.[30]

4.33 The Cancer Council also stated that dealing with the administrative processes of different jurisdictions was 'challenging'.[31]

4.34 The Leukaemia Foundation cited difficulties dealing with different schemes:

> You are already aware of the issues of the different schemes crossing borders and what the conditions are. For instance…in New South Wales, for every trip they make up here, they have to pay the first two nights; in Queensland, it is the first four nights annually – so there is a variance there...
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> Then, of course, there is the issue of obtaining approvals. Their process is that the patient has to get up here, and we have to get forms signed by the treating specialist so that we can then fax them down and get approval from their governing district; whereas in Queensland it can be all done by the local hospital or GP prior to travel…
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> Then there is the issue of how long the treatment is going to be, getting the escort approved and the various ways that reviews are done. I have a patient from Darwin at the moment whose application was approved for two months, and now they are asking for a letter from the treating specialist asking how much longer it will be and what treatment is going on before they will extend it past the two months. New South Wales varies on decisions – sometimes they will approve it for the full period and other

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29 *Committee Hansard*, 5.7.07, p.22 (Dr P Beaumont, AMA).

30 *Committee Hansard* 6.7.07, p.31 (Ms K Thompson, Cancer Council of Australia).

31 *Committee Hansard* 6.7.07, p.31 (Ms K Thompson, Cancer Council of Australia).

> times they will ask for reviews, and that review will depend on who is in the chair at the time.[32]

Interstate arrangements

4.35 When patients access interstate facilities, it is not only the differences in the schemes but also the lack of coordination of services and arrangements that cause difficulties. The South Australian Government noted that there were no PATS reciprocal arrangements for interstate patients and their carers at the national/cross border levels for travel and accommodation assistance. Where arrangements are made, they are ad hoc solutions such as individual negotiations between the sending and receiving hospitals on any transfer costs or through charitable organisations providing some financial support where people require it. The only current agreement between States and Territories is for the reimbursement for costs incurred for admitted patient services for residents of another state. The charging arrangement for these cross border admitted patient services is set out under the 2003-08 Australian Health Care Agreement.[33]

4.36 The Northern Territory Government provided information on how admitted patient arrangements are utilised. As there are limited services to treat cranial injuries, major spinal injuries and major burns in the NT, patients may be evacuated to Adelaide, Sydney, Melbourne, Brisbane or Perth. About 3,081 people from the Northern Territory are cared for interstate, with the Territory paying $25 million in 2005-06 to State Governments.[34] Patients from the APY lands and the Western Desert access services in Alice Springs, principally for dialysis. The Northern Territory Government indicated that it is developing a memorandum of understanding with Western Australia on how to enhance access for Kimberley patients to Royal Darwin Hospital, which is closer to them than Perth, to receive care.[35]

4.37 While these arrangements are in place for hospital admissions, the transport and accommodation arrangements remain problematic. The Ngaanyatjarra Health Service commented on moving patients from Western Australia to Alice Springs and then to Adelaide:

> It is really hard when we bring people here [to Alice Springs from WA communities] for an appointment and then they are referred to Adelaide. Who pays? Northern Territory consider they are WA patients, WA consider that it is the Territory referring them, so they are Territory patients. They are stuck in the middle here and it is like a fight.

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32 *Committee Hansard* 6.8.07, p.50 (Mr R Bolton-Wood, Leukaemia Foundation).

33 *Submission* 165, pp.10-11 (South Australian Government).

34 *Committee Hansard* 5.7.07, p. 50 (Mr P Campos, DHCS).

35 *Committee Hansard* 5.7.07, p.51 (Mr P Campos, DHCS).

> …It usually gets resolved with a lot of phone calls and a lot of arguments and somebody gives in. It is never resolved nicely, it is just that somebody gives in.[36]

4.38 A further issue with the lack of coordination of arrangements was raised by the Tasmanian Government. Where patients have to travel interstate for specialist services, the timing of travel was not recognised:

> [T]here appears to be little effort on the part of major mainland specialist centres to allow for the increased travel requirements of Tasmanian patients. For example, Melbourne specialist centres appear to assume that the travel requirements of Tasmanian patients are no more onerous than those of patients living in the outer Melbourne suburbs. As a result, these centres make little attempt to modify arrangements for further treatment to take this into account.
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> Compounding this issue is the reluctance of some specialist units in Melbourne to hand care back to suitably qualified Tasmanian specialists for maintenance therapy, which places additional travel requirements on affected patients.[37]

4.39 The Tasmanian Government went on to argue that metropolitan specialist centres should 'critically evaluate clinical pathways' to better cater for interstate patients.[38]

Patient choice and interstate treatment

4.40 Witnesses were particularly concerned that the PATS guidelines often do not allow for choice of interstate treatment centre. As most PATS guidelines restrict travel to the nearest specialist or treatment centre within the State, patients cannot generally nominate a different city in which to receive treatment. In a case provided to the Committee, a patient from Wentworth NSW did not receive PATS to attend Adelaide (400 km) for treatment for Sleep Apnoea but could if she attended a clinic in Sydney (1200 km).[39]

4.41 Where jurisdictions assist patients who seek treatment across a border, the 'nearest service' guideline generally applies.[40]

4.42 Often patients prefer a different treatment centre as they may have family or friends to offer support:

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36 *Committee Hansard* 5.7.07, p.33 (Ms M Doyle, Ngaanyatjarra Health Service).

37 *Submission* 183, p.5 (Tasmanian Government).

38 *Submission* 183, p.6 (Tasmanian Government).

39 *Submission* 111, p.1 (Mrs K Collinson).

40 *Submission* 165, p.10 (SA Government).

> There are also across-border issues for people living on the Victoria/South Australia border at places such as Dartmoor or Mount Gambier. For example, someone in Dartmoor chose to go to Adelaide for treatment because they had family and a support network there, but they were not eligible for VIPTAS because Melbourne is closer, meaning that they were not travelling to the nearest treatment centre.[41]

4.43 The importance of support was emphasised by Dr Peter Beaumont from the AMA. He noted that 'there are many situations where the social and family issues are of such a significant nature that it is important that the people responsible for administering the scheme need to be able to take that into account'.[42]

4.44 Bosom Buddies also raised the issue of new radiation unit in Darwin and the requirement for Northern Territory patients to go there rather than southern states where they have family support. This is also an issue of patient-choice in terms of accessing the best treatment centre.[43]

PATS and interstate travellers

4.45 A concern raised in several submissions was that patients are not eligible for PATS if they require treatment while travelling interstate. A number of cases of premature birth while parents were interstate were cited. The babies required hospitalisation for several months but the parents received no support and as a result faced severe financial difficulties.[44]

4.46 The problem of residency is particularly difficult for Indigenous people. The Nganampa Health Council explained:

> Our patients are highly transient. They could have family in the Northern Territory, Western Australia or South Australia, and they may live in each of those three areas at various times. We state that our PATS is only for people who are on the APY lands at that time. I understand that in the Northern Territory there is a requirement for a patient to have been a resident of the Northern Territory for, I think, couple of months before they become entitled to PATS. An issue arises, if we have booked an appointment for one of our patients and they have since moved to the Northern Territory and have been there for a couple of weeks, of who is going to pay to get that patient to the appointment. They are no longer on the APY lands, so we would say they are no longer our patient. The Northern Territory government would say: 'They are not actually a resident of the Northern Territory; they have not been here long enough. We are not

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41 *Committee Hansard* 6.7.07, p.52 (Ms R Morton, Western District Health Services); see also *Committee Hansard* 6.7.07, p.71 (Dr K Webber, ARRWAG).

42 *Committee Hansard* 5.7.07, p.24 (Dr P Beaumont, AMA).

43 *Committee Hansard* 5.7.07, p.5 (Mrs L Locke, Bosom Buddies).

44 *Submission* 148, p.3 (The Royal Women's Hospital).

> going to pay for it.' To be honest, I guess we do not have an answer to that. Those situations are generally dealt with on a case-by-case basis.[45]

4.47 The Victorian Government explained that assistance is not provided to visitors or Victorians who are visiting other areas (intra and inter-state) for work or holidays on the basis that travel insurance or Work Cover are the appropriate mechanisms for assistance in these circumstances. However, the Victorian Government did note that there is a review process to cater for Victorians while travelling:

> This process allows that if a patient who is travelling would normally be eligible for VPTAS assistance when at their usual place of residence in Victoria, VPTAS would pay the equivalent of travel from the patient's home to the nearest appropriate treatment location.[46]

4.48 The NT Government commented that there were issues for it to meet the demands of patients from neighbouring States while maintaining health services for its residents. To provide the level of access that is sometimes demanded would require capital investment that is beyond the NT. As a result, the NT has limited some cross border activities and encouraged jurisdictions to refer patients to hospitals in their respective jurisdiction.[47]

Conclusion

4.49 While there was evidence that some patients seeking medical care in another jurisdiction had received PATS assistance, on balance, there appears to be difficulties for patients crossing borders for medical care. The differences in the schemes create administrative difficulties for patients, health service staff and for organisations trying to assist patients in times of crisis. The Cancer Council Australia concluded that:

> Evidence shows that cross-border complications and inconsistencies are contributing to poor usage of the schemes and to patients making decisions about their treatment that lead to inferior outcomes.[48]

4.50 Witnesses called for greater coordination. The Country Women's Association NSW argued that the anomalies created by different criteria and administrative arrangements between states be reviewed, and recommended that this be addressed by a national minimum standard.[49] Other witnesses considered that as it is not uncommon for patients to cross borders for treatment, the Commonwealth should administer PATS to ensure that equitable access to assistance.[50]

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45 *Committee Hansard* 5.7.07, p.78 (Mr D Busuttil, Nganampa Health Council).

46 *Submission* 182, p.5 (Victorian Government).

47 *Submission* 164, pp.7-8 (NT Government).

48 *Submission* 109, p.15 (Cancer Council Australia).

49 *Submission* 5, p.5 (CWA NSW).

50 See for example, *Submission* 12, p.3 (Cancer Voices NSW).

4.51 The Committee considers that there is a great deal of scope to improve coordination of cross-border arrangements. In this regard, the Committee considers that greater coordination in relation to administrative arrangements will provide benefits to both patients and health service staff through decreased paperwork and complexity of procedures.

4.52 Patients should be provided the option to access interstate services if these are the closest or provide the most appropriate care. There should also be flexibility in the schemes to allow patients to access facilities where they may have family or friends able to provide support – in the long-term this may provide cost savings for jurisdictions as there is significant evidence that support assists patient well-being.