# CHAPTER 6

# IMPROVING AND INTEGRATING SERVICES

## The role of charities and not-for-profit organisations

> The role of charities that provide the accommodation and other assistance has increased and whilst there is a so called travel allowance it does not cover many issues that families face.[1]

6.1 Charities and community organisations play a significant role in providing services to patients who must travel for health care. These services include travel assistance, accommodation and general assistance to patients and their families. Some organisations are disease-specific, for example the Leukaemia Foundation and the Cancer Councils, while others assist any patient in need. An Access Economics report commissioned by The Cancer Council NSW found that at least $2.5 million was spent on providing accommodation to people with cancer by non-profit organisations in NSW in 2005.[2] The South Australian Government acknowledged the major role non-profit organisations play in supporting country patients:

> Without this support country patients would find it more difficult to cope with the dislocation and disconnection from the support of family and friends.
>
> Without the accommodation services provided by support organisations, such as the Cancer Society and the Red Cross, the effectiveness of the SA PATS would be significantly curtailed.[3]

6.2 One of the best known medical assistance charities is Ronald McDonald House. There are 12 Ronald McDonald Houses across Australia which accommodates seriously ill children and its activities demonstrate the broad range of assistance that is provided to families.

6.3 Ronald McDonald House Westmead accommodates families from rural NSW, the Northern Territory, Western Australia, Queensland, ACT and overseas as Westmead Children's Hospital offers specialised treatments such as liver transplants. For NSW patients, IPTAAS covers half the cost for each night of accommodation and fundraising is undertaken to cover the other half of the accommodation cost and to cover items which a family may not be able to afford:

> We provide clothing, breakfast cereals, milk, bread and other food items to the families, to reduce their day to day living costs…Many mothers live here all week with a child with cancer while father works at home. They

---

1 *Submission* 38, p.3 (Ronald McDonald House – Westmead).

2 *Submission* 56, p.7 (Cancer Voices Australia).

3 *Submission* 165, p.14 (SA Government).

> need to have that emotional support on the weekends from their partners that we cannot offer. We provide petrol money on an ad hoc basis (only because a family donates for this and it runs out quickly) to families who want to have the emotional support of a partner –average cost for a father to visit Sydney on a weekend is $100.
>
> Many of the cars are not roadworthy, usually not reliable for long distance travel, bald tyres, no registration – all costs to the families. This is for the families who have a car.
>
> If the family has to use public transport it becomes a nightmare for them. We take them to the train or bus station (we have an arrangement with Greyhound where they can travel free of charge) with luggage and wheelchairs, sometimes one suitcase is for the medication and healthcare needs. They somehow manage to travel with sick children to their home town. I know in some cases, particularly for remote indigenous families they opt not to bring their child for treatment because the difficulties seem insurmountable.[4]

6.4 Accommodation and assistance is also provided by many other organisations. The following provides just a very small number of examples of the accommodation services that non-government organisations supply:

- the Leukaemia Foundation of Western Australia provides 14 self-contained units in Perth;
- Australian Red Cross operates 28 accommodation centres throughout Queensland with 1300 clients per month and managed by volunteers;[5] and
- the Australian Heart Lung Transport Association provides a house next to St Vincent's Hospital for up to three families.[6]

6.5 Charities also subsidise travel costs or provide transport and drivers. For example, the Cancer Council NSW provides two cars, driven by volunteers, to transport cancers patients from Foster/Tuncurry and Taree for treatment. The Cancer Council NSW also provides reimbursement for volunteers who drive cancer patients from Gloucester to Taree for treatment – a distance of 84 kms each way.[7] The Cancer Council Tasmania has launched a volunteer-based cancer patient transport system – transport 2 treatment. Many Red Cross branches provide volunteers to assist patients to attend appointments.

6.6 It is not just large organisations which provide assistance. Many examples of the work of small community organisations were provided to the Committee. The Country Women's Association explained the work of one:

---

4 *Submission* 38, p.2 (Ronald McDonald House – Westmead).

5 *Submission* 82, p.1 (Australian Red Cross).

6 *Submission* 122, p.2 (Mr P Hughes).

7 *Submission* 12, p.5 (Cancer Voices NSW).

> In one instance we know of a small country town where the Cancer Patient Assist Society paid between $1200 and $1500 per month for patients travel assistance and $52,000 annually for accommodation. It is not unusual in some rural communities where such organisations are the only means of transport. There is no public transport, families are not living together intergenerationally and if a partner or family friend cannot drive the patient to treatment a voluntary organisation is usually approached for help. That provider of transport and/or accommodation in such cases whether an individual, family or organisation should still be eligible to receive the subsidy.[8]

6.7 Community transport services also provide an invaluable service. For example, Orbost Regional Health Volunteer Transport uses a small band of retired volunteers to provide long distance transport service. The trip to Melbourne takes between 4 ½ and 5 ½ hours one way and can be affected by the health needs of the client being transported, traffic conditions and location of appointment and/or accommodation.[9] Organisations also noted that volunteers are ageing leading to a decrease in the number of drivers.[10]

6.8 Assistance is not restricted to travel and accommodation. The Breast Cancer Association of Queensland indicated that it had provided funding for a 23 year old single mother of three children under school age to access child care so that she could attend chemotherapy and radiation therapy and also have some respite. In another case, the Association provided funding for a patient's car registration to allow her to visit the breast cancer nurse.[11]

6.9 Hospitals also play a significant role in providing financial support to patients. The Mater Hospital for example, provides funds through the Mater Foundation and through donations provided to the Social Work Department. The Social Work Department also relies on community organisations to support patients when they are away from home.[12]

6.10 Witnesses commented that demand for the services provided by charities and not-for-profit organisations is growing. The Leukaemia Foundation provided this overview of its activities in the financial year 2005-06:

> Free transport to 4070 families with 17,598 trips for treatment, covering almost 700,000km in 31 vehicles. This service is provided with generous support from 266 volunteer drivers who committed 24,814 hours to this service for blood cancer patients and their carers/escorts.

---

8 *Submission* 5, p.5 (Social Issues Committee CWA).

9 *Submission* 49, p.2 (Let's Get Connect Gippsland East Transport Connections).

10 *Submission* 69, p.9 (Health Consumers of Rural and Remote Australia).

11 *Submission* 44, p.2 (Queensland Breast Cancer Association).

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

> Free accommodation to 105 families each night in Leukaemia Foundation accommodation and up to approximately 40 families per night in commercial accommodation. Our accommodation service assisted 1149 families with 43,135 nights of accommodation in 05/06 with an average length of stay of 8 months.
>
> 1,357 families were supported with practical assistance valued at almost $400,000 in 05/06. This includes fuel and taxi vouchers to enable patients to access treatment as well as other assistance as needed e.g. food vouchers.
>
> Demand for and usage of our transport and accommodation services increases each year. Demand is expected to increase more rapidly as the Australian population ages and with population drift to coastal and hinterland areas beyond suburbia.[13]

6.11 In part, this growing demand is due to the range of services that are provided, their expertise in the areas of accommodation and welfare support and the lack of expansion of government services in this area. Ronald McDonald House Charities also commented that hospital practices such as early discharge mean that services are coming under pressure as 'children are likely to need intensive follow-up, and need to stay in close proximity to Hospital'. Children who survive serious illness may also be more dependent on specialised equipment, which they need to learn how to use following discharge.[14]

6.12 The NSW Farmers Association noted that charities and non-profit organisations play an important role in light of the 'negligible financial assistance available for accommodation under IPTASS'.[15] Ronald McDonald House Charities also stressed the benefits of their services stating that 'Ronald McDonald Houses can be seen as providing outsourced hospital beds, yet the cost burden has shifted to the Charity'.[16]

6.13 Increasing demand is placing a greater burden on organisation to fund their activities. Inadequate subsidy levels for accommodation and slow reimbursement means that organisations face cash flow pressures and the continual need to fund raise. Ronald McDonald House Charities commented:

> Funding and cash flow are major issues for houses. They cannot afford to have delays in funding for lengthy periods.[17]

6.14 Charities and not-for-profit organisations commented that improved support would make a significant difference to the services that they provide.[18] Ronald McDonald House stated:

---

13 *Submission* 89, p.5 (Leukaemia Foundation).

14 *Submission* 137, p.3 (Ronald McDonald House Charities).

15 *Submission* 166, p.11 (NSW Farmers Association).

16 *Submission* 137, p.3 (Ronald McDonald House Charities).

17 *Committee Hansard* 6.7.07, p.54 (Ms D Dagg, Ronald McDonald House Charities).

> For example, if that cost were to go up by a small $10, that would have a big impact on families. They could claim that little bit more to help them out. A small $10 increase per year would mean about $100,000 extra per house. This was an example for our house, given the number of rooms that we have. That funding is important and vital in keeping our operation open for the families that need our house. Many would have stayed in various places – wards, cars and things – before we came along.[19]

6.15 Witnesses also argued that the provision of government funding for charities to expand their services would be an efficient way of providing services in the face on significant unmet need and increasing demand. Cancer Voices Australia commented that charities and non-government organisations are well placed to increase their role: they have the systems, they have the personnel and they have the trust and respect of cancer patients. Cancer Voices suggested that the Commonwealth 'through one off capital grants for accommodation close to treatment centres could 'fill the void'. The centres would be managed and run by the charities.'[20]

6.16 NCOSS also considered that there is potential for an expanded role of not-for-profit community transport providers. Many of the community transport providers specialise in the provision of non emergency health related transport to health facilities, and utilise drivers who have some expertise in meeting the support needs of people who require this form of transport. NCOSS argued that in some cases there could be opportunities for individuals to use the IPTAAS scheme to cover community transport related costs, or for community transport providers to deal directly with IPTAAS administrators in order to save clients from having to deal with intensive paperwork or high upfront costs. NCOSS concluded:

> …NGO community transport and neighbour aid providers currently face overwhelming demand for services – any proposal to expand the work of the community transport industry would require careful consultation with providers, and adequate resources to cover the costs of operations, administration and vehicles.[21]

### *Conclusion*

6.17 The Committee was overwhelmed by the range and level of services provided by charities and not-for-profit organisation to patients in all jurisdictions. The Committee considers that it is clear that without the provision of services by charities and not-for-profit organisations, government patient assisted travel schemes would be significantly compromised.

---

18 *Submission* 82, p.2 (Australian Red Cross).

19 *Committee Hansard* 6.7.07, p.57 (Ms N Boyd, Ronald McDonald House Charities).

20 *Submission* 56, p.7 (Cancer Voices Australia).

21 *Submission* 59, p.5 (NCOSS).

6.18 However, the Committee was concerned that charities and not-for-profit organisations face both administrative problems and delays in reimbursements of travel and accommodation subsidies.

6.19 The Committee acknowledges that some governments have recognised the service capability and expertise of charities and not-for-profit organisation and work with them to improve services. However, the Committee considers that the role of these organisations could be expanded through partnerships with government to meet the shortfall in services. The Committee believes that not only would patients benefit but also health services.

6.20 The Committee's recommendations in relation to charities and not-for-profit organisations are included in chapter 7.

## Improving communication

### *Awareness, marketing and promotion*

6.21 Where the issue was raised, the Committee almost uniformly received evidence that there was little community awareness of patient travel schemes and that the marketing and promotion of schemes was insufficient.[22] The Australian Rural and Remote Workforce Agencies Group cited a 2005 study *General Practice Hospital Integration: Issues in Rural and Remote Australia* which found that there were significant gaps in public knowledge of the schemes. The study found:

> Many patients involved in this study did not receive practical non-clinical information to assist in the transition of care from the rural to the metropolitan environment. While some hospital staff reported that they provided this type of information through leaflets and through websites, a number of hospitals reported that they were aware that they did not inform their rural patients enough. Patients described the stress of not having appropriate information adding to an already stressful period in their life.[23]

6.22 While a number of witnesses claimed that awareness of PATS was limited, others suggested that GPs were generally aware of the schemes but were reluctant to promote it. Dr Eduard Roos from the Southern Queensland Division of Rural General Practice suggested this was because of the administrative burden:

> There is a wide awareness of the scheme. Doctors do not like paperwork – we get so many requests and forms to fill in – and sometimes they are quite happy not to promote to patients that this is available.[24]

---

22 See for example, *Submissions* 5, 7, 18, 26, 29, 31, 40, 43, 46, 47, 49, 53, 73, 87, 89, 96, 103, 104, 107, 108, 115, 141, 166, 173.

23 *Submission* 136, p.7 (ARRWAG).

24 *Committee Hansard*, 6.8.07, p.6 (Dr E Roos, Southern Queensland Rural Division of General Practice).

6.23 Dr Pam McGrath from Central Queensland University told the Committee that her research revealed reluctance by public hospitals to promote the schemes because of budgetary pressures. Consequently the schemes were not being appropriately accessed by those in need. Her research indicated that strategies are required to increase public knowledge of these schemes.[25] Dr McGrath stated:

> [T]he data in the questionnaires from the travel clerks and superintendents who were giving us feedback said: 'We can't advertise this. We are having trouble coping with it as it is. If we go advertising it, we are going to be inundated.' They were their exact words, written on the form. I would say from my data—and that is all I can speak about—that there is strong evidence, firstly, that it is not well publicised and, secondly, that there is an investment in it not being publicised, because if they did then they would really need the funding, and they are only just coping with the demand as it is.[26]

6.24 This assessment was supported by the Country Women's Association of Australia which stated:

> The present marketing has some problems. There is reluctance to encourage patients to use the scheme and one of the reasons is that the money apparently comes out of the hospital budgets and the doctors may not offer the scheme unless they are asked. The GPs surgery has a poster on display but advice is not always given by doctors or staff probably because the form to be filled in by the doctor requires extra time…[27]

6.25 The National Rural Health Alliance commented that there was a 'perverse incentive because, if the jurisdiction running the scheme does not have enough money for the whole year or for the whole quarter, they are not going to be very keen to promote it'. They suggested 'that more professionals should be encouraging patients to apply and it may be that the application can be…assessed by an agency which is not encumbered by having limited funds'.[28]

6.26 The Denmark Health Service commented in the same vein, that hospitals administering the scheme 'don't want to actively market the scheme…as this will attract more submissions, and put the hospital budget at risk'. GPs were also 'particularly poor in advising clients about PATS and eligibility for PATS, despite information being given to them'. They also noted that the scheme will need to be adequately funded if active marketing occurs.[29]

---

25 *Submission 73*, p.4 (International Program of Psychosocial Health Research, Central Queensland University).

26 *Committee Hansard*, 6.8.07, p. 23 (Dr P McGrath, Central Queensland University).

27 *Submission* 104, p.3 (Country Women's Association of Australia).

28 *Committee Hansard* 22.6.07, p.22 (Mr G Gregory, National Rural Health Alliance).

29 *Submission* 43, p.2 (Denmark Health Service).

6.27 The Association of Independent Retirees (AIR) noted that the issue of marketing and promotion of PATS received the greatest response from their members. AIR members reported it was 'generally poorly done' and that most patients were unaware of the scheme and were not informed about it by their GP. They observed that there was a need for consistent and effective marketing of the scheme to and by all rural GP's who refer patients to distant specialists.[30] The Isolated Children's Parents' Association of NSW recommended 'application forms need to be readily available at doctors' surgeries' and that medical receptionists and secretaries need to be educated about the scheme and be able to help patients complete the form.[31]

6.28 The Australian Medical Association acknowledged that 'a patient's access to PATS is largely dependant on their local GP knowing about the scheme' and their eligibility. The AMA called for more promoting the schemes through the publication of forms, posters, and booklets and distributed widely to all health care practitioners.[32]

### *Conclusion*

6.29 Given the extent of the evidence concerning the marketing of PATS it is clear that the promotion of PATS could be improved. GPs have an important role in ensuring their patients are aware of PATS if they may be eligible. The Committee was particularly concerned that, because of budgetary considerations or additional administrative burdens, health organisations and their personnel were not offering information about PATS to eligible patients. While a publicity campaign may assist public awareness regarding the existence of schemes to patients, it may not address the structural 'perverse incentives' raised by the National Rural Health Alliance. This should be a consideration in Commonwealth, State and Territory discussions regarding PATS.

## Other related health initiatives

### *E-health*

6.30 E-health (or telehealth) refers to healthcare services delivered or supported by electronic processes and communication. E-health can enhance clinical networks and access to timely consultations for patients and health professionals. The Commonwealth, State and Territory governments have invested in e-health and its use, particularly as a diagnostic and teaching tool, is increasing. For example, the Commonwealth Broadband for Health Program provides broadband Internet access to GPs, Aboriginal Community Controlled Health Services (ACCHS), and community pharmacies. In the longer term, e-health is seen as 'taking health care to the patient'

---

30 *Submission* 18, p.5 (Association of Independent Retirees).

31 *Submission* 31, p.6 (Isolated Children's Parents' Association of NSW).

32 *Submission* 47, p.4 (Australian Medical Association).

and as having the potential to reduce the need for patients to seek medical care in distant locations.[33]

6.31 NSW Health has utilised telehealth for some time. It commenced operations in 1996 with 12 pilot projects connecting 16 sites and now has a network to over 257 facilities, which supports 35 clinical services. Telehealth connects patients, carers and health care providers, improving access to quality public health care, particularly in rural and remote parts of NSW. NSW Health stated that telehealth has been used to support a range of assessment and treatment programs and may reduce the need to travel to large towns or cities to receive treatment.[34]

6.32 The South Australian Government noted there 'are opportunities to expand the use of e Health for people living in rural and remote areas without compromising the delivery of safe services'. However they also raised the issue of restrictions on practitioners claiming for client consultations under the Medicare Benefits Schedule.

> There is the potential to reduce the need for patients to travel, particularly for follow-up consultations and post surgery reviews. SA is currently exploring ways to use e Health to improve the transfer of care between high acuity health services in Adelaide and local health care providers in country SA. It is already being employed successfully with video-conference link-ups between the Adelaide Based Rural & Remote Mental Health Service, mental health workers and consumers.
>
> One of the impediments to fully developing e Health is the restrictions on practitioners claiming for client consultations under the Medicare Benefits Schedule. The provision of these IT services to support consulting diagnostic services and client support needs to include voice and image over the internet protocol in addition to telemedicine and satellite access. SA strongly argues that the Australian Government should support this initiative for rural residents.[35]

6.33 This issue was also raised by Queensland Health which encouraged the Commonwealth to urgently consider developing a schedule of MSB payments for use with telehealth consultations for both the specialist service and the referring service.

> There is currently no capacity for specialists (other than psychiatrists) to charge MBS for consultations undertaken through Telehealth. This limitation restricts the potential of Telehealth to offer a wider range of specialist consultations to those living in rural and remote communities. The lack of an MBS payment for the referring service ie general practitioner further limits the use of Telehealth in rural and remote communities as shown by the MBS payment for telepsychiatry consultations where only specialist service is covered.[36]

---

33 *Submission* 157, p.18 (Department of Health and Ageing).

34 *Submission* 188, p.6 (NSW Health).

35 *Submission* 165, pp.13-14 (South Australian Government).

36 *Submission* 184, p.8 (Queensland Health).

6.34 A number of submissions noted that to be effective e-health or telehealth would need to be adequately resourced with equipment, training and marketing to patients and GPs.[37] The Let's GET Connected Gippsland East Transport Project identified e-health as 'one of the most under utilised tools available to rural communities'. They continued:

> Whilst many health agencies and clinics have the technology to provide these services there appears to be a lack of willingness on behalf of specialists and hospitals to utilise these services in order to avoid long distance and often unnecessary travel by the public. It has also been suggested that one of the barriers is how the Medicare benefit is claimed and shared as part of case management.[38]

6.35 The potential for e-health to upskill the primary care workforce was noted by Palliative Care Australia and that 'creating linkages through e-health initiatives such as videoconferencing between local general practitioners and appropriate specialist expertise has the potential to enhance the care provided to patients'. Palliative Care Australia concluded that 'it is appropriate that models of service provision move away from fact-to-face consultation, as long as the care received is of equal quality'.[39]

6.36 The Australian Medical Association considered 'that technology, such as video conferencing, has the capacity to allow patients to access medical services that would otherwise be unavailable' but called for e-health solutions to only be 'delivered with another medical professional, usually the patient's GP, present with the patient'. They also noted that there must continue to be mechanisms through which rural and remote patients can access face-to-face care when required.[40]

6.37 The lack of communications infrastructure in Australia was acknowledged as inhibiting the utilisation of e-health. For example Mr Steve Sant of Rural Doctors Association of Australia stated:

> We think that there are huge opportunities in Telehealth. They are yet to be realised. The recent announcements around increasing broadband access is a good start, but we would need 100 megabits per second to make Telehealth work well in rural communities. That is what you need to have –advanced Telehealth consultations, advanced streaming of things like ultrasound, and that sort of thing, across a broadband network.[41]

6.38 Several submissions noted it would be more convenient if patients could access and lodge PATS applications electronically via a website.[42] The ACT

---

37 For example see *Submission* 43, p.2 (Denmark Health Service).

38 *Submission* 49, p.4 (Let's Get Connected Gippsland East Transport Project).

39 *Committee Hansard* 22.6.07, p.24 (Ms F Couchman, Palliative Care Australia).

40 *Submission* 47, p.9 (AMA).

41 *Committee Hansard*, 22.6.07, pp.21-22 (Mr S Sant, Rural Doctors Association of Australia).

42 For example see *Submission* 30, p.5 (Princess Margaret Hospital); *Submission* 43, p.2 (Denmark Health Service).

Government stated that while there was no reason an electronic system for PATS form lodgement would not work, a 'paper based accompaniment' would need to continue because of the number of patients who do not have access to computers.[43]

6.39 Use of e-health is a developing area in health services. While it can never replace face-to-face specialist care, it has the potential to reduce the need for some rural and remote patients to travel for access to some services. The Committee considers that the Commonwealth, State and Territory governments should continue to support and develop e-health initiatives for the benefit of rural and remote patients.

***Medical Specialist Outreach Assistance Program (MSOAP)***

6.40 MSOAP is a Commonwealth Government funded program that provides for the provision of outreach speciality services. MSOAP encourages medical specialists to visit rural areas by providing funding to cover some of the costs associated with delivering outreach. These include travel, accommodation and consulting room hire costs. It also makes payments to visiting specialists who provide training and professional support to local general practitioners, specialists and, in some cases, other health professionals such as allied health professionals.

6.41 The need for better coordination between MSOAP and PATS was raised in a number of submissions. AMSANT noted that MSOAP was greatly appreciated by remote communities but 'the lack of coordination between them is an endless source of frustration and an inefficient use of the very scarce resources of specialist services'.[44]

6.42 Maningrida Community Health Centre stated that despite good local evidence supporting MSOAP 'in our context outreach remains fractured, disorganised and inequitable'.

> A local general physician has demonstrated a 4 fold cost benefit by seeing people in their home communities over seeing the same people in Alice Springs or Darwin. This has led to an argument that PATS money should be used to support specialist out-reach. Such arguments quickly descend into state and commonwealth gridlock with little gain to the patient.[45]

6.43 There were also suggestions that MSOAP should be extended to provide primary care services in rural and remote areas. The Anyinginyi Health Aboriginal Corporation noted that:

> PATS services are only provided for specialist services (with some exceptions). This seems to be based upon an assumption that GP services

43 *Committee Hansard*, 22.6.07, p.39 (Ms J George, ACT Health).

44 *Submission* 97, p.4 (AMSANT).

45 *Submission* 163, p.2 (Maningrida Community Health Centre).

are readily available in rural and remote areas. The availability of a GP in a remote area is an exception rather than the rule.[46]

6.44 There were also some witnesses and submissions which suggested additional funding should be able to be channelled to specialist outreach services. For example Dr John Preddy, a paediatrician in Wagga Wagga, noted:

> …it is my view that the best way to deliver specialty services to rural patients, if possible, is to 'bring the Mountain to Mohamed' and bring the service to the patients. I believe this is more cost effective and is certainly very supportive to existing local services and in the development of new local services. We have established many outreach clinics locally and feedback from our patients has been extremely positive. Obviously, this will not replace the need for some patients to travel to metropolitan centres for care.[47]

6.45 Mr Paul Quinlivan of Ampilatwatja Health said that in his opinion additional funding would be better used on specialist outreach services.

> My experience having worked in the field for three years in Ampilatwatja and having worked in the Northern Territory in remote communities for 20 years is that if you fly in a specialist – be it a cardiologist or a physician – they go to the community and if a certain Aboriginal person is not there on that day there are always three or four other people who are there. So you are going to get very efficient productivity out of any specialist. Additionally, if you fly a physician into a remote community, you already have all the culturally appropriate processes there in terms of both clinicians and family members. So you get a highly dynamic environment going on, which you cannot reproduce, no matter how much money you invest, when you transport people from the community.[48]

6.46 PATS and MSOAP are opposite sides of the same coin. One assists patients to access specialists, while the other assists specialists to access patients. The Committee considers that better coordination between the schemes and between the levels of government which administer them is necessary. Allowing rural communities some flexibility to utilise PATS funding to bring specialists to them is an option that should also be explored by Commonwealth, State and Territory governments in consultation with other stakeholders.

---

46 *Submission* 160, p.6 (Anyinginyi Health Aboriginal Corporation).

47 *Submission* 16, p.1 (Dr J Preddy).

48 *Committee Hansard*, 5.7.07, p.79 (Mr P Quinlivan, Ampilatwatja Health).