CHAPTER 7

REFORMING PATIENT ASSISTED TRAVEL SCHEMES

> *The prime consideration of the operation of the scheme should be the benefit of the person travelling to access health services. The scheme should be funded and flexible to the level that ensures that isolation and lack of access to health professionals is not the difference between sickness and wellbeing.*[1]

7.1 A vision of improved health outcomes for rural and remote Australians lies at the heart of this inquiry. Better access to health services is fundamental to achieving this vision. In the absence of locally-based services travel assistance to access appropriate services is vital. As such, the Patient Assisted Travel Schemes should be viewed as a necessary, 'core' health service:

> Patient travel and accommodation assistance schemes cannot be seen as discretionary extra services, but as the only means by which people in more remote areas can obtain access to specialist services not available locally. Good patient accommodation and travel systems will never compensate for the absence of face-to-face services. In more remote areas these travel and accommodation schemes are essential services that need to be responsive, affordable, well-promoted and widely available.[2]

7.2 During the course of this inquiry it became evident that considerable changes to the travel schemes are needed. Since the inception of the former Commonwealth scheme, IPTAAS, the environment in which the scheme operates has changed. Diminishing services in rural areas have resulted in a growing need for patient travel. Along with this, we have seen an increased prevalence of chronic disease. This will continue to rise with demographic ageing. On a more positive note, advances in medical technology mean that a broader range of conditions can now be treated – and treated more effectively. Travel assistance is no longer primarily directed at one-off needs to access specialist treatment. More and more, it forms an integral service for people requiring ongoing or block treatment.

7.3 This chapter discusses some potential measures to better meet the demands of a changed environment and remedy flaws in the existing schemes. Such measures include greater national consistency, the introduction of national standards and the expansion of the travel schemes to cover a wider range of treatments. Consideration is given to funding an enhanced and expanded scheme. This chapter also outlines the Committee's conclusions and recommendations for reform.

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1 *Submission* 69, p.5 (Health Consumers of Rural and Remote Australia).

2 *Submission* 55, p.2 (NRHA).

A National Approach

7.4 As discussed in chapter 1, the Commonwealth travel scheme was originally transferred to the States and Territories to enable greater flexibility and local responsiveness. Yet one of the common concerns presented to the Committee was a lack of flexibility in responding to the often complex circumstances of individual patients. It was felt that the guidelines were too rigid, the system 'overly bureaucratic' and decision-making constrained:

> Most of the schemes now in place in the States are under-funded, overly bureaucratic and unfairly restrictive. The schemes appear to be process driven and centred around bureaucratic control and management rather than being patient centred and focused on ensuring that Australians living in rural and remote areas have the same access to treatment services as their city counterparts. For example, the schemes do not appear to take into account factors such individual needs of particular patients, cultural/language issues, socio-economic status, urgency of care, choice of provider or treatment centre, need for support from family, etc.[3]

7.5 At the same time, a number of witnesses argued that guidelines weren't clear enough and that the rules were inconsistently interpreted and applied:

> Evidence indicates that clerks in some jurisdictions use a variety of interpretations of criteria in the guidelines in their decision-making for approval for both patients and their escorts to receive assistance.[4]

7.6 In effect, PATS officers' discretionary decision-making powers were characterised as excessive, resulting in subjectively based decisions and different outcomes for different patients. For example, the Cancer Council WA reported that:

> A major concern for both consumers and PATS clerks is the inconsistencies with the interpretation of the guidelines and discrepancies in the administration of the scheme within and across states. Anecdotal consumer feedback suggested particular PATS clerks make special allowances for certain individuals. For example there have even been instances whereby the same PATS clerk has authorised a payment to a patient which was previously rejected for another person, despite having identical circumstances.[5]

7.7 Along with this, disparate State eligibility criteria and subsidy levels were seen to create an inequitable system for rural and remote Australians.

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3 *Submission* 90, p.2 (Rural Doctors Association of Australia), See also *Committee Hansard*, 5.7.07, p.2 (Mrs L Reilly, Bosom Buddies NT) and *Submission* 30, p.1 (Social Work Department, Princess Margaret Hospital).

4 *Submission* 109, p.14 (Cancer Council Australia). See also *Submission* 158, p.1 (Tom Price Hospital Action Group).

5 *Submission* 46, p.4 (Cancer Council WA).

7.8 The following section looks at the tension between flexibility and consistency and considers the introduction of some form of national standards to create a fairer travel assistance scheme.

National consistency and uniformity

7.9 Many witnesses were supportive of greater national consistency and uniformity, arguing that it would create a fairer system and simplify cross-border arrangements. National inconsistencies were seen to produce an inequitable service. For example, Dr Beaumont from the Australian Medical Association (AMA), told the Committee that:

> 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.[6]

7.10 The NSW Farmers Association stated that it felt 'extremely concerned' by the lack of consistency in the various schemes' eligibility criteria and the administration of the schemes more broadly.[7]

7.11 Reflecting the views of a number of witnesses, the Australian Red Cross commented that consistency would be fairer for consumers:

> A national approach to consistency would foresee equity for all users of our service regardless of which state they reside.[8]

7.12 Witnesses submitted that national consistency would help improve cross-border arrangements. For example, the AMA noted its support for national consistency pointing out that different entitlements created confusion with cross-border travel:

> The AMA supports consistency in the application of the schemes. Currently entitlements differ between the states and questions arise over which jurisdiction is responsible in cases where patients travel across borders for assistance.[9]

7.13 Ms Cahill from ACT Health told the Committee that uniformity would help at an operational level:

> [A]lmost 25 per cent of the number of patients that are admitted in ACT hospitals come from New South Wales. So from our perspective,

6 *Committee Hansard*, 5.7.07, pp 22-23 (Dr P Beaumont, AMA).

7 *Submission* 166, p.4 (NSW Farmers Association).

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

9 *Submission* 47, p.4 (AMA).

> particularly from an operational perspective, it would certainly make some aspects easier if there was uniformity in how arrangements are applied.[10]

7.14 However some witnesses had reservations about the move towards greater national consistency and uniformity. The Australian Rural Nurses and Midwives (ARNM), for example, made the point that uniformity of criteria does not necessarily create equity of outcomes. Differences between and within jurisdictions such as fuel costs, accommodation costs, road quality and so on impact on the ease of access patients have to health services:

> We would like to emphasise that it is a matter of ensuring equitable health outcomes, which is not necessarily facilitated by uniformity of criteria. Uniformity of criteria can create inequity of access (and subsequently poor health outcomes) where geographical patterns vary between states.[11]

7.15 An obvious example is the distance threshold. A nationally standardised threshold of 100 km for example, would fail the equity test when comparing patients travelling 100 km on an unsealed road to patients travelling 100 km on sealed roads.

7.16 Similarly, the Western Australian Government submitted that:

> Differing arrangements and circumstances across jurisdictions (such as fuel and accommodation costs. air fares for commercially marginal routes) suggest that the application of a uniform specified rate would not necessarily result in a more equitable system, or one which meets the diverse needs of rural health consumers.[12]

7.17 The AMA characterised equity in a way that resonated with the above observations, noting that different processes may be needed to produce equal outcomes:

> Equity can be considered as being equal access to services for equal need, equal utilisation of services for equal need and equal quality of care or services for all. Central to this is the recognition that not everyone has the same level of health or capacity to deal with their health problems, and it may therefore be important to deal with people differently in order to work towards equal outcomes.[13]

7.18 While all were open to improving the schemes, State and Territory governments were cautious in their support for greater national consistency and uniformity. For example, the ACT Government stated that it would not support a national scheme if assistance currently provided to ACT residents was in any way undercut:

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10 *Committee Hansard*, 22.6.07, p.40 (Ms M Cahill, ACT Health).

11 *Submission* 45, p.1 (ARNM).

12 *Submission* 39, p.3. See also *Submission* 136, p.6 (ARRWAG).

13 *Submission* 47, p.3 (AMA).

> The ACT would not support a uniform national scheme under which eligibility for assistance toward costs incurred in accessing interstate medical care was reduced for residents of the ACT currently eligible for assistance under the ACT scheme.[14]

7.19 The NT Government expressed in-principle support for greater national consistency but emphasised its budgetary constraints in this regard.[15]

7.20 The Victorian Government argued that current differences across jurisdictions were a reflection of state/territory endeavours to respond to local need. Moves towards greater national consistency should not undermine these local responses:

> While Victoria endorses national consistency of PATS to the extent that this improves equity of access to specialist medical treatment, this needs to be weighed against the particular circumstances and constraints within each jurisdiction. Existing discrepancies reflect jurisdictional attempts to best tailor their PATS to suit the particular geographic, demographic, socioeconomic and health service features within their jurisdictions and to meet the demand that these features create for PATS within available funding.[16]

7.21 The Victorian Government went on to provide an example of well-founded jurisdictional differences:

> In regards to minimum distance for travel reimbursement and air travel eligibility, it is clearly appropriate that these criteria are different across certain jurisdictions, to account for differences in size of jurisdictions, settlement patterns and the locations and numbers of their specialist medical services.[17]

7.22 Likewise, NSW Health commented that national minimum standards for travel schemes need to be 'balanced with the recognition of the geographic, demographic and health system differences between jurisdictions'.[18]

7.23 While the Committee certainly appreciates the argument of local responsiveness in theory, it is not confident that all state/territory scheme differences represent a strategic and considered response to local conditions in practice. For example, the high 200 km eligibility limit imposed on Northern Territory residents makes little sense in a jurisdiction where a relatively high proportion of the population live in communities with unsealed road access, no public transport, and limited flight

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14 *Submission* 150, p.1 (ACT Government).

15 *Submission* 164, p.4 (NT Government).

16 *Submission* 182, p.3 (Victorian Government).

17 *Submission* 182, p.3 (Victorian Government).

18 *Submission* 188, p.23 (NSW Health).

services. The 200 km limit would seem to be a product of history rather than responsive policy.[19]

7.24 The Victorian Government further noted that jurisdictional differences in relation to eligibility may be a reflection of legislative differences across the States and Territories. They provided the following example:

> [T]he cut off age for automatic entitlement to an escort is 18 years in some jurisdictions and 17 in others. This may reflect differences across jurisdictions regarding legal rights of passage such as legal driving age.[20]

Achieving a balance between consistency and flexibility

7.25 Based on the evidence received, it is clear that a balance between consistency and flexibility is required. Witnesses wanted a system that was fair for all consumers. Adopting a uniform approach for some aspects of the scheme was seen as a way to create a fairer system. At the same time it was recognised that other aspects of the scheme would need to be treated differently to reflect jurisdictional differences. Further, flexibility in the assessment of applications to respond to the diverse circumstances of consumers was highlighted.

7.26 Mrs O'Farrell, WA Country Health Service, pointed to the difficulties in establishing a scheme that is both flexible and consistent arguing that, to some extent, the two aims are incompatible:

> We noticed when we read the submissions that there was a lot about inconsistency and a lot about flexibility. We are flexible. We have a delegated arrangement to every region to be able to flex around the guidelines for individual circumstances, and they do because we do not have a generic consumer group here. We have vast differences between regions and distinctly different groups of patients, so there does need to be a lot of flexibility and we do accommodate that. Hence, there is a perception of a lack of consistency. But I do not know how you have both. You cannot have a flexible scheme and then have it be highly consistent. So we kind of keep consistency at a broad level but have a great deal of case by case flexibility to try to match up circumstances for individual families or patients.[21]

7.27 Mr Gregory explained the National Rural Health Alliance's (NRHA) understanding of how uniformity and flexibility could both be applied to create equity, arguing that uniformity was required in some respects and discretion in others:

> [E]quivalence and equity dictate that people in similar circumstances must be treated in an equivalent fashion within all jurisdictions. This is what is meant by greater uniformity when it is listed as one of the key elements of

19 The 200km limit was a feature of the former Commonwealth Scheme, IPTAAS.

20 *Submission* 182, p.4 (Victorian Government).

21 *Committee Hansard*, 13.7.07, p.5 (Mrs C O'Farrell, WA Country Health Service).

> the alliance's position. Currently there are substantial differences between jurisdictions in eligibility criteria, in how the schemes are promoted, in the treatments which are deemed eligible, in the way organ transplant and transplant donors are treated, in the degree of discretion exercised by authorities in respect of the transport used, in terms of payment schedules, in terms of the treatment of carers and escorts, and in terms of appeals. These are all fundamental aspects of the right to supported travel and accommodation that should be set at a high level and should be uniform between the various jurisdictions.
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> Where there should not be uniformity is in respect of the aspects of the scheme determined by distance alone. Travel times and costs are significantly different in Tasmania compared with Western Australia, for example. There needs to be discretion about transport arrangements. Arbitrary standards such as 30 hours on a train or 15 hours in a car may well be detrimental to a patient's health and should be weighed against the higher cost of an airfare. In these sorts of cases evaluation on a case-by-case basis would clearly be sensible.[22]

A case for national standards

> The absence of national minimum standards and a national framework has, over 20 years, led to an inequitable, fragmented, and inefficiently administered collection of schemes operating in isolation within jurisdictions.[23]

7.28 There was extensive support from a broad range of witnesses for the introduction of national standards as a means of creating a more equitable and efficient system.[24] As discussed in chapter 3, a number of witnesses felt that access to specialist services should not be compromised by state idiosyncrasies. National standards were seen as a way of gaining greater national consistency and, in turn, a fairer system.

7.29 Health Consumers of Rural and Remote Australia argued that minimum standards would form a clear point of reference for the assessment of PATS applications and would enable a flexible response:

> The key to improved operation of the PATS scheme is flexibility. Because personal circumstances can present the most complex challenges for administrators, it can be difficult to assess accurately within the rules and regulations, the entitlement for people under PATS schemes. Minimum standards would act to level out the eligibility of individuals for assistance under these schemes, making the implementation of the provisions

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22 *Committee Hansard*, 22.6.07, p.2 (Mr G Gregory, NRHA).

23 *Submission* 109, p.2 (Cancer Council Australia).

24 See for example, *Submissions* 12, p.1 (Cancer Voices NSW), 137, p. 11 (Ronald McDonald House Charities) and 55, p.10 (NRHA).

> streamlined and hassle-free, thus improving the access to and affordability of health care services to people from rural and remote areas.[25]

7.30 The Australian Rural and Remote Workforce Agencies Group (ARRWAG) focused on the issue of health outcomes in their support of minimum 'access' standards:

> A critical question to ask is "what health outcomes should we expect from an assisted travel scheme?" In this regard, it may be important to develop minimum standards of *access* as a baseline in terms of key health services.[26]

7.31 The Social Issues Committee of the Country Women's Association of NSW highlighted uniform eligibility criteria in their support for national standards:

> We believe that this is a national issue and there should be national consistency and uniformity across all jurisdictions particularly with relation to eligibility. The level and forms of assistance provided may need to be modified depending upon the areas and availability of various forms of transport, but the eligibility should be uniform.[27]

7.32 The Rural Doctors Association of Australia (RDAA) indicated a longstanding commitment to the introduction of national standards in calling for the establishment of a Rural Health Obligation covering health service access:

> The RDAA has been for some time calling on the Federal Government to put in place a Rural Health Obligation that…establishes minimum health service standards that rural Australians can expect with regard to access to health services.[28]

7.33 Not all witnesses were confident that national standards could easily be introduced. The WA Government, for example, argued that national uniformity would need to underlie national standards, which in turn would impact on local flexibility and responsiveness:

> The success of any initiative to provide for national minimum standards would be contingent upon nationally measurable criteria. This would be difficult to achieve without consistency and uniformity of schemes cross Australia. The remoteness of Western Australia's rural population, and the transport difficulties associated with access to certain regions would need to be given consideration in terms of the development of any national standards for rural patient access to specialist health services. In particular, the logistical issues associated with the culturally appropriate transportation of small numbers of people across large distances to various treatment

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25 *Submission* 69, p.6 (Health Consumers of Rural and Remote Australia).

26 *Submission* 136, p.6 (ARRWAG).

27 *Submission* 5, p.2 (Country Women's Association of NSW).

28 *Submission* 90, p.6 (RDAA).

> centres requires flexibility and a strong knowledge of patient needs, local conditions, and available transport options.[29]

7.34 NSW Health noted that the difference in service delivery between the jurisdictions has been recognised under the Council of Australian Governments (COAG) initiative *Better Health Access for Rural and Remote Australians*: 'while there is a national approach in relation to priority areas for action, actual implementation will be negotiated on a bilateral basis'. This is in recognition that a 'one size fits all' approach is not appropriate. NSW Health concluded that 'it may be appropriate to consider state-based approaches taking into consideration other initiatives to improve access to services'.[30]

7.35 While the introduction of some form of national standards was, in the main, supported, the Committee received little evidence on the type of standards that should be developed (prescriptive or outcomes-based) or suggestions as to specific standards.

7.36 However, the peak body for cancer support and advocacy groups in NSW, Cancer Voices NSW, in their support of the introduction of 'uniform minimum standards' did highlight the following broad areas for consideration: choice of treating specialist, fuel and vehicle rebate, claim forms and process, increased level of accommodation reimbursement with regular CPI adjustments, eligibility for PATS by clinical trial participants and consistent eligibility criteria and administrative arrangements.[31]

Monitoring and reporting

> There is a need for…better data collection and public reporting of scheme performance, including against carefully designed key performance criteria, that cover measures of safety, quality and efficiency. In few other areas of health care is such a simple 'gate-keeping' arrangement applied in the provision of necessary health care services.[32]

7.37 Evidence provided on the issue of monitoring and reporting indicated an absence of robust performance monitoring or quality improvement frameworks across the country. The Committee notes that the States and Territories currently provide a progress report against the *Healthy Horizons* Framework to the National Rural Health Policy Sub-Committee.[33] This includes details of programs that aim to facilitate access to health services. However, this reporting is at a very broad, descriptive level and gives no indication of the success of each program.

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29 *Submission* 39, p.3 (WA Government).

30 *Submission* 188, p.23 (NSW Health).

31 *Submission* 12, pp1-3 (Cancer Voices NSW). See also, *Submissions* 14 and 18.

32 *Submission* 55, p.3 (NRHA).

33 The National Rural Health Policy Sub-Committee provides advice to AHMAC on rural and remote health policy issues. The Sub-Committee is responsible for overseeing progress against the goals of the *Healthy Horizons* Framework.

7.38 In its submission the Department of Health and Ageing noted that the States and Territories are required to ensure access to public health services under the Australian Health Care Agreements (AHCAs). The Department conceded that this requirement could be better monitored:

> More information is needed from the states and territories to find out how this obligation is being met. Greater accountability and the ability to measure the performance of the states and territories in ensuring access to public hospital services by people living in different regions could be considered by the Australian Government in developing the next AHCAs.[34]

7.39 The NRHA highlighted the importance of monitoring the schemes to enable continuous quality improvement:

> Whilst national minimum standards will bring improved consistency to the schemes' operation, operational monitoring, annual reporting and fair and reasonable benchmarking will promote continuous improvement. Flexible and responsive scheme arrangements, and best practice, are a reasonable expectation.[35]

7.40 The NRHA isolated the relevant areas that could be usefully benchmarked:

> Differences between States and Territories with regard to population demography, health status and health service distribution; population densities and geographic size mean that performance comparisons in terms of total allocations and per capita cost will be of limited value. However the rate of adverse events, eligibility criteria and some aspects of utilisation should be directly comparable. Benchmarking performance should be achievable on relevant measures.[36]

7.41 The Committee notes that, as outlined in chapter 1, reviews of the travel schemes have recently been undertaken in several jurisdictions and improvements have been made as a result of these reviews. While such reviews are commendable, they form a poor proxy for the quality assurance that a well-developed, robust monitoring system can provide.

Who should administer a national approach?

7.42 While, on balance, there was considerable support for some degree of national coordination and consistency, only a handful of witnesses recommended transferring administration of the travel schemes back to the Commonwealth. The Country Women's Association of NSW, for example, highlighted the issue of cross-border travel in their recommendation that the scheme be administered at the Commonwealth level.[37]

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34 *Submission* 157, p.16 (DoHA).

35 *Submission* 55, p.10 (NRHA).

36 *Submission* 55, p.4 (NRHA).

37 *Submission* 5, p.5 (Country Women's Association of NSW).

7.43 Mr Sant from the Rural Doctors Association of Australia (RDAA) saw the Medicare system as the appropriate avenue through which to administer the scheme:

> We would argue that the great bulk of services provided under the patient assistance schemes are MBS funded services, so why would you not bundle it back into the Commonwealth? For all its sins, Medicare, through its offices, can administer things quite well. You could do it fairly simply. You could have a form like the Veterans' Affairs form. I do not see any reason why this should not be addressed as part of the Australian healthcare agreements, brought back to the Commonwealth and administered through a Commonwealth program.[38]

7.44 Similarly, the Cancer Council Australia argued that a 'robust national framework' is required and suggested this be 'administered through Medicare (e.g. funded through the Extended Safety Net)'.[39]

Expanding PATS

7.45 There was considerable support for the expansion of PATS to cover a broader range of treatments. Many witnesses recommended that PATS include all items listed on the Medicare Benefits Schedule – Enhanced Primary Care.[40]

Ante-natal and post-natal care

7.46 As discussed in chapter 5, a number of witnesses highlighted ante-natal and post-natal care as a priority area for PATS expansion. Several witnesses pointed to the closure of maternity and birthing services across the Country. For example the NRHA stated:

> A specific matter of concern relates to access to maternity and birthing services for rural people. Some 130 birthing services in country areas have been closed in the last decade. This has the effects, inter alia, of increasing the travel and financial burden on rural families and may even adversely influence decisions about having children or remaining in country Australia. An extended patient assistance scheme would reduce the financial burden on those mothers and families required to relocate temporarily to close proximity of the birthing service some weeks prior to the anticipated birth.[41]

7.47 Ms Stratigos from RDAA recommended that inclusion of obstetric and infant care should take precedence in an expanded travel scheme:

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38 *Committee Hansard*, 22.6.07, p.10 (Mr S Sant, RDAA).

39 *Submission* 109, p.2 (Cancer Council Australia).

40 See for example, *Submissions* 47, p.2 (AMA); 57, p.5 (Health Consumers' Council WA) and 136 (ARRWAG).

41 *Submission* 55, p.2 (NRHA).

> I would like to say that we could begin at the beginning and there would be fairly defined parameters. We could begin this wider approach to the scheme by ensuring that assistance for pregnant women and mothers of infants of up to a year are supported with transport and accommodation to access the normal support services that mothers and babies have in urban Australia. That would be a start.[42]

Allied health services and dental care

7.48 A major concern for those living in rural and remote areas is access to allied health services and dental care. In many jurisdictions, PATS does not cover travel to access these services. As a result, there was significant support for the extension of PATS to cover allied health services and dental care.[43]

7.49 The Committee was particularly concerned to hear that allied health and dental care services that form an integral part of treatment – for example, oral and dental care in managing rheumatic heart disease – are not covered by the majority of schemes. As the NRHA pointed out, the travel schemes are not designed for:

> whole-of-health-care necessities, such as coordinated care, for example where oral and dental health care are integral components of health enhancement, as occurs in managing heart valve damage in rheumatic heart disease.[44]

7.50 The Queensland Government is an exception to this:

> Queensland PTSS is the only scheme that has a provision for the use of allied health services where these are provided as an essential component of services for eg physiotherapy following orthopaedic surgery, psychological assessment in preparation for psychiatric treatment.[45]

7.51 Dental care was one area of particular concern given that 'poor dental health has been shown to greatly increase systemic infections and retard return to health after illness'.[46] Poor dental health in rural, regional and remote areas is, in part, a result of the lack of fluoridation and poor access to dental services.

7.52 Many submissions noted that dental services are very restricted in rural areas and specialist dental services all but non-existent. Witnesses commented that the

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42 *Committee Hansard*, 22.6.07, p.16 (Ms S Stratigos, RDAA).

43 See for example, *Submissions* 6, p.2 (Frontier Services); 1, p.1 (Miss J Andrew, Marree Health Service), 103, p.6 (Qld Rural Women's Network) and 159, p.2 (Australian General Practice Network).

44 *Submission* 55, p.3 (NRHA).

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

46 *Submission* 1, p.1 (Miss J Andrew).

problem is compounded in some rural areas because dental practices have 'closed books', forcing patients to travel further for routine and emergency dental treatment.[47]

7.53 In the area around Charleville in Queensland there is currently one public dentist servicing an area of 233,020 km and a population of around 9,046 people.[48] In NSW, a survey of Country Women's Association (CWA) branches provided the following findings:

> 44 branches reported travelling more than 50 km to access the school dental service e.g. Bourke and district residents have to travel 400 km to a school dental service in Dubbo. Seventy branches reported travelling more than 50 km to use a private dentist and 78 reported they travel 50 km or more to use the government dental clinic.[49]

7.54 The Tullawon Health Service cited the case of one of its Indigenous patients who had to attend Port Augusta for dental surgery following a tongue malignancy. Because dental work is not covered by PATS, the patient was not eligible for accommodation and had to sleep in the Accident and Emergency Department of the Port Augusta hospital.[50] In the Northern Territory, the Kakadu Health Service commented that, as there were no dental services in its region, it assisted clients to travel to attend dental services in Darwin. However, in the main this was only for emergency treatment.[51]

7.55 Access to other allied health services is similarly difficult and does not attract support through PATS. The Isolated Children's Parents' Association of NSW commented that families often travel many hours to access speech pathology and other services for their special needs children.[52] Other services not covered include counselling or related services such as occupational therapy for people with epilepsy;[53] access to Parkinsons Disorder Clinics providing multidisciplinary support; and access to community mental health services.[54]

Screening services

7.56 Of particular concern was the lack of PATS for rural women who need to travel to visit mobile breast screen programs. In NSW for example, travel to visit the

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47 *Submission* 34, p.2 (Hay Shire Council).

48 *Submissions* 6, p.2 (Frontier Services); 25, p.3 (Southern Queensland Rural Division of General Practice).

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

50 *Submission* 83, p.2 (Tullawon Health Service).

51 *Submission* 94, p.2 (Kakadu Health Service).

52 *Submission* 31, p.5 (Isolated Children's Parents' Association of NSW).

53 *Submission* 78, p.2 (Epilepsy Foundation of Victoria).

54 *Submission* 127, p.1 (Child &Adolescent Mental Health Services Rural & Remote Network).

mobile service fails to attract a PATS benefit because the service is not provided in a 'designated building'.[55]

7.57 In the Northern Territory, Bosom Buddies noted that there are only limited windows of opportunity for rural women to access Breast Screen services. While there is a full-time service in Darwin, screening in Alice Springs takes place in three, three-week blocks annually, Tennant Creek has one week of screening per year and there are periodic visits in Katherine and Nhulunbuy. Bosom Buddies also noted that mammogram units cannot travel off the bitumen road, so it is necessary for women to travel many hundred of kilometres on dirt roads to access screening. In some cases, this is a three day trip.[56]

7.58 The CWA NSW commented that the current situation is 'bizarre' as funds are being spent on urging women to have regular breast screening but they are then denied the financial assistance to do so. Ironically, 'if they fail to be screened, develop breast cancer, then they are eligible!'[57]

Primary medical care

7.59 While PATS is available for travel to specialist appointments, a number of witnesses commented on the costs of accessing general practitioner care for those in rural and remote areas. As workforce difficulties rise and single practitioners move to less remote centres, patients are increasingly faced with travelling greater distances to access primary medical care.[58]

7.60 Along with this, the importance of primary care in early intervention and prevention was highlighted. With an ageing population and, correspondingly, an expected future increase in chronic disease statistics, early intervention and prevention were presented as critical.[59]

Procedural and specialised services undertaken by GPs

7.61 The RDAA commented that assistance should not be restricted to specialist treatment arguing that travel assistance schemes should cover procedural and specialised services undertaken by GPs:

> The requirement that assistance only be available to receive specialist treatment does not reflect the situation in rural and remote Australia where procedural general practitioners (e.g. GP surgeons, GP obstetricians, GP anaesthetists, etc) undertake much of the work that is done by their

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55 *Submission* 5, p.3 (Social Issues Committee, CWA NSW).

56 *Submission* 8, p.4 (Bosom Buddies NT).

57 *Submission* 5, p.3 (Social Issues Committee, CWA NSW).

58 See for example, *Submissions* 61, p.2 (Shire of Sandstone, WA); 47, p.7 (AMA); 31, p.4 (ICPA-NSW).

59 See for example, *Submissions* 47, pp 7-8 (AMA); 90, Additional Information, p.7 (RDAA).

> specialist counterparts in large centres. Subsidies should also be available to travel to see GPs who provide procedural and other ‘specialised’ services.[60]

7.62 Similarly, Women's Health Tasmania called for PATS to include procedural services undertaken by GPs. Their focus was on terminations for women from rural and remote areas. Women's Health Tasmania pointed out that first-trimester terminations are generally performed by GPs with specialised training. However, there is a limited number of GPs trained in this area nationally and none in Tasmania specifically. Further, terminations undertaken after the first trimester, which are performed by specialists, do not attract PATS assistance unless there are 'foetal abnormalities'.[61]

7.63 Marie Stopes International – a sexual and reproductive health care organisation with seven centres in Australia – also raised concerns around the issue of terminations. It was noted that, in keeping with State laws, the organisation provides termination services up to nineteen weeks and six days. Ideally, however, terminations are performed at less than twelve weeks. Marie Stopes International argued that women seeking terminations should be eligible for PATS assistance – particularly as the lack of financial support sometimes led to delays in seeking terminations:

> We do, however, see some women presenting at a later gestation and often this delay has been caused by the need to save up funds to pay for related travel and accommodation to our centres. These travel costs particularly impact on disadvantaged young women, teenagers and women who are sole parents.[62]

Clinical trials

7.64 Rural patients have very little opportunity to access clinical trials. Costs of participation in clinical trials are perceived by some governments to be the responsibility of the institution conducting the trial. As a result, patients outside metropolitan areas are ineligible for PATS.[63] However, the Committee heard that clinical trials frequently do not cover travel-related costs. Witnesses argued strongly that rural and remote patients should be supported to take part in clinical trials (particularly publicly funded trials) as cancer patients, for example, enlisted in clinical trails have been found to have better outcomes.[64]

7.65 This was echoed by the Cancer Council Australia which submitted that:

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60 *Submission* 90, p.3 (RDAA).

61 *Submission* 162, p.1 (Women's Health Tasmania).

62 *Submission* 19, p.1 (Marie Stopes International); see also *Submission* 84, (Pregnancy Advisory-Centre – Central Northern Adelaide Health Service).

63 *Submission* 12, p.3 (Cancer Voices NSW).

64 *Submission* 105, p.3. (Cancer Council Victoria).

> Cancer clinical trials deliver a range of benefits to participating patients. For example, patients trialling successful new modalities are at the cutting edge of new treatment technology, while patients on a trials control arm also benefit from the rigorous standards of care and monitoring applied in a trial. Patients also report a sense of heightened care quality from their experience of a trial's disciplined and structured environment.[65]

7.66 Cancer Voices NSW commented that it believed that 'participation in clinical trials should be encouraged by Government, not discouraged – in both the interests of individual cancer patients and the public good'.[66]

7.67 Professor Currow from Cancer Australia told the Committee that: 'There is no doubt that, if we can take into account improving access to quality clinical trials, we will have done a very substantial good'.[67] However, he did note that in a limited number of cases 'physical proximity' to the centre where the trial was being conducted would be important for the patient's safety.[68]

7.68 The Department of Health and Ageing also noted the importance of clinical trials:

> Patient participation in cancer clinical trials is increasingly important because of new technologies and treatments becoming available. Patient participation is being actively sought and promoted by governments and health care professionals because of the benefits to the patient irrespective of the trial outcome and to many subsequent patients. Many patients have to travel to be able to participate in trials.[69]

7.69 The Committee was concerned to hear about this apparent anomaly in the various PATS eligibility guidelines. It presented yet another example of the many disadvantages that Australians living in rural and remote Australia face in accessing health care.

Other services

7.70 There is currently no consideration given to the impact on family, business or property. Frontier Services argued that property owners who are self-employed could greatly benefit by the provision of a caretaker subsidy.[70] Other witnesses noted that additional child care is required when parents travel for medical reasons.[71]

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65 *Submission* 109, p.8 (Cancer Council Australia).

66 *Submission* 12, p.3 (Cancer Voices NSW).

67 *Committee Hansard*, 22.6.07, p.49 (Professor D Currow, Cancer Australia).

68 *Committee Hansard*, 22.6.07, p.49 (Professor D Currow, Cancer Australia).

69 *Submission* 157, p.8 (Department of Health and Ageing).

70 *Submission* 6, p.2 (Frontier Services).

71 *Submission* 154, p.3 (Ms Callabro-Rowse). See also *Submissions* 44, p.2 (The Breast Cancer Association of Qld) and 60a, p.71 (GlaxoSmithKline).

7.71 The South Australian Government recommended that the Australian Government establish a 'Living Away from Home Allowance', which families needing to travel for treatment for an 'extended period' could access.[72]

An expanded scheme – government responses

7.72 State and Territory Governments submitted that they had, in various ways, expanded the scheme coverage in their respective states.

7.73 The SA Government reported that since 1987 it has 'relaxed' the 'medical specialist service criterion' to address some specific issues for rural residents. This includes:

- Women who deliver with the nearest General Practitioner Obstetrician in attendance
- Dental work that is part of an oncology treatment plan provided the referral is by a medical specialist
- Children who have been referred to the Women's & Children's Hospital for assessment and/or treatment by any member of the Child Protection Team.[73]

7.74 The Western Australian Government noted that under its scheme assistance is provided for the fitting of artificial limbs and, in exceptional circumstances, for certain dental health treatments.[74] In Queensland, there is a provision for the use of allied health services where these are provided as an essential component of treatment.[75]

7.75 The Victorian Government reported that it is 'continuing to work towards improving access to allied health services for rural Victorians' but it was doing this through increasing services in large regional centres and other programs.[76]

7.76 NSW Health noted that oral health procedures performed under general anaesthetic are eligible for assistance and stated that there may be 'merit' in including a 'broader range of dental procedures' under the scheme.[77]

Concerns about cost

7.77 Some State and Territory Governments gave in-principle support for further expansion of the schemes. However, concerns were raised about the cost. For example, NSW Health stated: 'extension of the scheme to treatments that are not

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

73 *Submission* 165, p.9 (SA Government).

74 *Submission* 39, p.5 (WA Government).

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

76 *Submission* 182, p.9 (Victorian Government).

77 *Submission* 188, p.24 (NSW Health).

currently covered under the scheme would pose a considerable cost impost for the states'.[78]

7.78 Similarly, the WA Government commented that extending the Scheme to all items listed on the Medicare Benefits Schedule would entail extremely high costs. Furthermore, it was argued that extension of the scheme for second opinions 'would potentially jeopardise the viability of the provision of specialist medical services in regional and remote areas, as patients may bypass their regionally based specialist or service'. The WA Government concluded that:

> should the patient wishes to seek a second opinion then, as for all health consumers, this is the prerogative of the patient and the patient may reasonably be expected to bear the cost associated with the exercise of this choice.[79]

7.79 While providing for allied health treatments that form part of an integrated care plan, Queensland health argued that further expansion would not be viable: 'broadening the PTSS to include access to all allied health services would impact significantly on the sustainability of the scheme'.[80]

7.80 The Tasmanian Government stated: 'within the current funding arrangement, it is not possible to expand the scope of PTAS services'.[81]

7.81 The Northern Territory Government submitted that it 'would support a change to the business rules, such as extending the availability of PATS via the Medicare Benefits Schedule (MBS), to dental services to improve health outcomes particularly for Indigenous people'. However, it was noted that it would be difficult for the Northern Territory Government to contribute additional resources to PATS.[82]

Funding

> Funding for patient assisted travel is almost certainly insufficient at the individual patient and scheme level. Better financing and administration of the schemes could be brokered with the re-negotiation of the Australian Health Care Agreements.[83]

7.82 The dominant perspective of witnesses was that the travel schemes were insufficiently funded across the States and Territories. Research conducted in Queensland, for example, revealed that hospital administrators thought the

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78 *Submission* 188, p.24 (NSW Health).

79 *Submission* 39, p.5 (WA Government).

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

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

82 *Submission* 164, p.5 (NT Government).

83 *Submission* 55, p.8 (NRHA).

Queensland travel scheme was under-funded.[84] Similarly, the NRHA stated that: 'The schemes are almost certainly under-funded at both the patient and service levels'.[85]

7.83 Within this context of insufficient funding State/Territory Governments reported the increasing demand for travel assistance, which outstripped available resources. The SA Government submitted that PATS has grown on an average of 12 per cent per annum while Commonwealth funding through the AHCAs has increased by just under five per cent per annum. The SA Government argued that this level of indexation is 'inadequate' and should be redressed.[86]

7.84 As discussed in chapter 3, under-funding translated into insufficient subsidy rates and, in some areas at least, a budget-focused rather than patient-focused system. Recent changes to various state schemes – the increase in Queensland's mileage subsidy from 10 cents per kilometre to 15 cents, the lowering of the distance threshold in NSW from 200 to 100 kms and the introduction of a 'safety net' in Western Australia were acknowledged by witnesses. However, the changes were seen to fall considerably short of what could be viewed as adequate.

7.85 Several witnesses argued that under-funding was compounded by the fact that funds were not specifically allocated for PATS within hospital budgets. It was explained that this put pressure on those having to manage hospital budgets. For example, Dr Pam McGrath from the International Program of Psychosocial Health Research, Central Queensland University, told the Committee that in her research:

> …the data from the medical superintendent would say that their problem is the difficulty of juggling competing interests over a fund of money when they have other significant hospital expenses.[87]

7.86 Dr McGrath concluded that a discrete budget item for PATS would be beneficial:

> One of the strong recommendations that we have is that the money is specifically targeted for it so that you remove that sense of 'if we take it from them, we give it to them', which I think sets up a very inappropriate conflict of interest.[88]

7.87 Similarly, Mrs O'Farrell, CEO of WA Country Health Service stated:

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84 *Submission* 73, p.5 (International Program of Psychosocial Health Research, Central Queensland University).

85 *Submission* 55, p. 3 (NRHA). See also for example *Submissions* 6, p. 1 (Frontier Services); 65, p.1 (AMA Tasmania); and 109, p.2 (The Cancer Council Australia).

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

87 *Committee Hansard*, 6.8.07, p.13 (Dr P McGrath, Central Queensland University).

88 *Committee Hansard*, 6.8.07, p.13 (Dr P McGrath, Central Queensland University). See also *Submission* 189, p.2 (Childhood Cancer Support Inc.).

> This is the rub here: there is no budget for PATS. We are allocated a budget, I allocate a budget to regions, they allocate budgets to the health care units and PATS has to be paid for within that budget. It may be very helpful in the future if we could have a stand-alone line item budget for PATS based on a more generous application of the scheme and based on what PATS cost and indexed annually. We would love that. My proposition to you is that that would be a great way to go, because as long as PATS money is integrated with hospital budget money, there is no saving to a hospital if a patient has to be sent on PATS to Perth. We have to pay for PATS and pay for hospitals, so there is always a tension between PATS and the operation of budgets.[89]

7.88 Other witnesses looked to the Commonwealth for additional funding. As noted earlier, witnesses identified Medicare as an appropriate avenue. The NRHA stated:

> The Medicare safety net could be expanded to cover travel for eligible treatments, courses of care or diagnostic tests for rural people.[90]

7.89 The NRHA identified the Department of Health and Ageing's Rural Health Strategy as another possible source:

> It is recognised that the existing schemes operate at the State and Territory levels. However capacity building, benchmarking and system development to achieve a nationally consistent framework could have a Commonwealth funding co-contribution provided through the Australian Government Department of Health and Ageing's Rural Health Strategy.[91]

7.90 The Cancer Council Australia suggested an 'inter-jurisdictional funding pool' administered through Medicare or a 'national funding agreement involving all jurisdictions and negotiated through the Australian Health Care Agreements'.[92]

Private health insurance

> The Health Consumers' Council is of the view that private health insurance should provide financial assistance for travel and accommodation for country people.[93]

7.91 Witnesses argued that private health insurance should offer financial assistance for treatment related travel costs.[94]

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89 *Committee Hansard*, 13.7.07, p.8 (Mrs C O'Farrell, WA Country Health Service).

90 *Submission* 55, p.7 (NRHA).

91 *Submission* 55, p.7 (NRHA).

92 *Submission* 109, p.2 (Cancer Council Australia).

93 *Submission* 57, p.4 (Health Consumers' Council WA).

94 See for example, *Submission* 55, p.7 (NRHA).

7.92 As discussed in chapter 1, approximately half of all private health insurers do provide some form of cover for health-related travel costs. Information provided by the Department of Health and Ageing indicates that cover varies from one insurer to the next with basic benefits offering restricted cover with limits of $200 per person per year.[95] The Committee notes that basic cover would be insufficient for patients requiring block or ongoing treatment.

7.93 The Queensland Government argued that the Commonwealth Government should amend legislation so that all private health insurers include cover for travel costs:

> The Queensland Government is calling on the Commonwealth Government to reform the private health insurance legislation to ensure patient transport costs are included in private hospital insurance products by all private health insurance companies.[96]

7.94 Similarly, the ACT Government saw a 'greater role' for private health insurers in providing financial assistance for health-related travel and accommodation expenses.[97]

7.95 The NRHA supported financial assistance for travel and accommodation as an insurance product but expressed concern about the transfer of cost to individuals. Mr Gregory from the NRHA, told the Committee that:

> Our proposal is just that given the greater flexibility that has now recently been made available to insurance companies for the products they provide we see no reason why this should not be a new product. In other words, because the legislative change – I think it was legislated recently—has enabled private health insurance companies to cover a wider range of things, we think it might usefully cover necessary transport and accommodation. This is not our first order response because, again, it transfers the risk or the cost to private individuals.[98]

7.96 Mr Sant from RDAA was also concerned about transferring the cost to individuals – particularly for financially disadvantaged individuals:

> The people who can most afford private health insurance are probably those who can most afford to meet the costs of transport. It is the disadvantaged part of our community that cannot afford the private health insurance that will be doubly disadvantaged by relying on private health insurance.[99]

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95 *Submission* 157, Additional Information, p.1 (Department of Health and Ageing).

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

97 *Submission* 150, p.2 (ACT Government).

98 *Committee Hansard*, 22.6.07, p.18 (Mr G Gregory, NRHA).

99 *Committee Hansard*, 22.6.07, p.18 (Mr S Sant, RDAA).

7.97 Given the above reservations, the Committee emphasises that private health insurance cover should be encouraged as a supplementary – and not alternative – source of finance. This would enable the targeting of (limited) government funds to those most in need.

A path to reform

7.98 The Patient Assisted Travel Schemes provide important – and in many cases, vital – travel support to Australians living in regional, rural and remote areas who need to access specialist medical services. A number of witnesses expressed their appreciation for the assistance available through PATS. However, it was clear from the evidence received that improvement and increased funding of the Patient Assisted Travel Schemes is urgently needed.

7.99 Reform of the travel schemes is timely. The imminent re-negotiation of the Australian Health Care Agreements (AHCAs) and the review of the *Healthy Horizons* framework provide ideal vehicles for the State, Territory and Commonwealth Governments to jointly consider patient access in a systematic and integrated way.

7.100 The Committee considers that there is ample evidence that a greater commitment to patient travel schemes will not only improve health outcomes for people living in rural, regional and remote areas but will also ease the healthcare burden in the longer term. While there were calls for increased commitment to improving services *in situ*, it is evident that there are factors which mean that this cannot be the only solution considered: the move to centralisation of services; more advanced medical technology; workforce shortages; safety and efficiency concerns; and improved patient outcomes for those accessing multidisciplinary teams means that patients will have to travel to access services.

7.101 In order to travel, patients need assistance with costs. The assistance scheme, either because of the complexity of the application process, inconsistency of provision or insufficient funding, should not in itself create a barrier or disincentive to access medical care.

7.102 The Committee welcomes the State and Territory Governments' commitment to improving outcomes for patient travel. The Committee considers it is imperative that all governments work together to produce a travel assistance approach that can meet both current and future demands. This approach will require a joint commitment to, and plan of action for, improved outcomes. The Committee believes that the AHCAs provide the appropriate mechanism through which to reform patient assisted travel schemes and, consequently, enhance rural and remote patient access to health care.

Recommendation 1

7.103 That the next Australian Health Care Agreement recognise the fundamental importance of patient assisted travel schemes and include:

- **a clear commitment to improvement of services;**
- **a clear allocation of funding for the schemes;**
- **a clear articulation of the services and supports that people using transport schemes can access; and**
- **a commitment to regular monitoring of access and service provision.**

7.104 The Committee recognises that each jurisdiction has its own geographic, demographic and health system differences and, therefore, believes that administration of the schemes should remain with the States and Territories. However, the evidence received by the Committee indicates that there is need for an overarching national framework to improve patient access to services. Greater national consistency through the introduction of national standards would add value to the travel schemes for the following reasons:

- it would facilitate development of reciprocal arrangements between States and Territories;
- it would encourage patient-focused travel assistance schemes;
- it would give greater certainty to consumers on the nature and quality of the service they can expect to receive;
- it would provide clearer guidance to PATS officers in assessing and processing claims; and
- it would promote greater equity of access to services for all Australians living in regional, rural and remote areas.

7.105 However, the Committee recognises the concerns raised about a move towards national consistency, that is, that uniformity of criteria does not necessarily lead to equity in outcomes; and that national consistency could undermine the capacity for local responsiveness and reduce flexibility.

7.106 On this basis, the Committee concurs with the view that governments should seek to achieve national consistency in the 'health outcomes' of consumers. Uniformity of criteria should only be introduced if it facilitates such a result. The Committee notes that recent trends in the development of human service standards focus on the outcome to be achieved, rather than prescribing the process taken to achieve an outcome. Such an approach recognises that there may be more than one way of achieving an outcome and enables a tailored service delivery response that accommodates jurisdictional differences. At the same time, there may be core features of a service that are relevant to all jurisdictions and national standards capturing these features will contribute to improved consumer outcomes. As a result, the Committee also supports the introduction of a subset of baseline, minimum standards.

7.107 Witnesses identified a range of technical and administrative anomalies that create barriers to patient access to health services: complex application processes, eligibility inconsistencies, inadequate patient support, inadequate appeals processes, treatment coverage, inconsistencies and insufficient review of subsidy levels. The Committee considers that the development of national standards – and a review of the schemes more broadly – provide an opportunity to address these issues.

Recommendation 2

7.108 That as a matter of urgency, the Australian Health Ministers' Advisory Council establish a taskforce comprised of government, consumer and practitioner representatives to develop a set of national standards for patient assisted travel schemes that ensure equity of access to medical services for people living in rural, regional and remote Australia.

7.109 That, in establishing national standards, the taskforce:

- **identify relevant legislative, geographic, demographic and health service variables of the States and Territories impacting on access;**
- **identify barriers to access including costs of travel and accommodation, restrictions on escort eligibility and access to transport;**
- **assess the impact of co-payments;**
- **identify mechanisms to improve access for patients travelling between jurisdictions;**
- **identify, as a matter of priority, core, minimum standards that are relevant to all jurisdictions particularly in relation to eligibility criteria and subsidy levels; and**
- **give consideration to the development of optimal, outcomes-based standards that support consistent, quality outcomes for consumers, whilst enabling different State/Territory approaches that are responsive to local need.**

7.110 Development of the national standards should include (but not be limited by) consideration of the following areas:

- **patient escorts including approval for:**
  - **psycho-social support;**
  - **approval for more than one caregiver to accompany a child; and**
  - **approval for a caregiver to accompany a pregnant woman.**
- **eligibility:**
  - **identify a means other than the distance threshold to determine eligibility that takes into account a broader range of factors such as public transport access and road conditions; and**

  - **referral on the basis of the nearest appropriate specialists where an appointment can be secured within a clinically acceptable timeframe.**

- **appeals processes.**

7.111 The Committee considers that the improvement of patient assisted travel schemes is vitally important and improvements should be implemented as a matter of priority.

Recommendation 3

7.112 That the taskforce report to the Australian Health Ministers' Advisory Council expeditiously so that national standards can be formulated and instituted within twelve months of tabling of the Committee's report.

7.113 The Committee notes with concern the numerous complaints regarding inconsistency in the interpretation and application of PATS guidelines. In order to meet the diverse and complex needs of applicants, it is important that PATS officers have discretionary powers. Assurance that assessments are objective, fair and patient-focussed would be assisted through a robust performance monitoring system.

Recommendation 4

7.114 That the taskforce develop a performance monitoring framework, which enables ongoing assessment of State/Territory travel schemes against the national standards and relevant goals set out in the (revised) *Healthy Horizons* Framework, and facilitates continuous quality improvement.

Recommendation 5

7.115 That the Australian Health Ministers' Advisory Council establish a mechanism to monitor performance, identify areas for improvement and review the standards as required.

7.116 On the basis of the considerable evidence submitted to the Committee on the administrative complexity of the schemes (discussed in chapter 3), the Committee strongly encourages streamlining of existing arrangements.

Recommendation 6

7.117 That the taskforce review existing administrative arrangements to make them less complex, including development of a simplified generic application form; consideration of an on-line application process; and revision of the authorisation processes.

7.118 Current subsidy levels for travel and accommodation are clearly insufficient in all States and Territories and have not kept pace with rising living costs. Once patient contributions are factored in, negligible reimbursement amounts, combined with the complexity of the application process, can provide a disincentive to apply for

assistance. In turn, the lack of adequate travel assistance can provide a disincentive to seek appropriate treatment in a timely manner.

7.119 The Committee recognises that the travel schemes are subsidy schemes and that full reimbursement would be prohibitively expensive on the public purse. However, the Committee strongly believes that the subsidy levels should better recompense people disadvantaged by their residential status and should reflect current associated costs, such as petrol and private accommodation. A more generous scheme will provide an incentive for people to seek early treatment.

7.120 At the same time, the Committee appreciates that public funds are not unlimited and for this reason believes that consideration should be given to prioritising those most disadvantaged. The Committee is particularly concerned that health card holders, the 'working poor' and asset-rich but cash poor residents are inadequately supported by the current schemes. Encouraging private health insurance take-up by those who can afford it, through inclusion of travel assistance in health insurance products, would free-up funds for those most in need.

Recommendation 7

7.121 That the Australian Health Ministers' Advisory Council determine transport and accommodation subsidy rates that better reflect a reasonable proportion of actual travel costs and encourage people to access treatment early.

Recommendation 8

7.122 That the taskforce identify appropriate mechanisms against which to review subsidy levels on a regular basis to keep pace with changes in living costs.

Recommendation 9

7.123 That all States and Territories adopt a pre-payment system, whether by vouchers, tickets or advance bookings, for patients experiencing financial difficulty with the initial outlay.

Recommendation 10

7.124 That the Commonwealth Government initiate negotiations with the private health insurance sector to encourage insurers to offer products that include transport and accommodation assistance.

Recommendation 11

7.125 That State and Territory Governments develop memoranda of understanding that underpin clear, workable reciprocal arrangements for cross-border travel.

7.126 The Committee recognises that historically, the travel schemes were designed to assist patients to access specialist services. However, in view of the broader decline of health services in rural and remote areas and the difficulties in attracting GPs and other primary health care workers to these areas, the Committee strongly believes that

the schemes should be expanded to cover all MBS items, including primary care. The Committee recognises this will have significant funding implications in the immediate term. Nevertheless, inaction in this regard will, the Committee concludes, result in enormous costs to the health system in the longer term. Expanding the schemes' coverage is consistent with the focus on health promotion and disease prevention in COAG's 2006 National Reform Agenda[100] and the goals of the *Healthy Horizons* Framework.

Recommendation 12

7.127 That State and Territory Governments expand travel schemes to cover items on the Medical Benefits Schedule – Enhanced Primary Care and live organ donor transplants (with assistance to the donor and recipient) and access to clinical trials.

7.128 Consumer and practitioner knowledge and understanding of the scheme was variable. If access to health services for rural and remote Australians is to be improved, better promotion of the schemes is paramount.

Recommendation 13

7.129 That the taskforce develop a marketing and communication strategy that targets consumers and health practitioners. Consideration should be given to the role of the Divisions of General Practice in educating GPs about the scheme.

7.130 The lack of appropriate, affordable accommodation for people accessing outpatient specialist care across the country was emphasised in the evidence. Accommodation in tourist centres was particularly limited. Charities play a critical role in providing suitable accommodation for the chronically ill. However, demand outstrips supply.

Recommendation 14

7.131 That appropriate, on-site (or nearby) accommodation facilities be incorporated into the planning and design of new hospitals/treatment centres.

Recommendation 15

7.132 That State and Territory Governments work proactively with charities and not-for-profit organisations to provide affordable patient accommodation and services. This should include:

- **developing administrative arrangements that facilitate organisations' access to PATS funding;**
- **establishing memoranda of understanding with charitable organisations, which set out commitments to quality service delivery; and**

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100 COAG, *Council of Australian Governments Communique – 10.2.06*, (accessed 4.9.07).

- **developing partnerships with the non-government sector to provide suitable patient accommodation.**

7.133 As discussed in chapter 5, health access issues for Indigenous Australians are of particular concern to the Committee. Many Indigenous Australians live in remote areas without ready access to primary, allied or specialist health services. In addition, Indigenous peoples face considerable social and economic disadvantage leading, in part, to poorer health outcomes and a shorter life expectancy than non-Indigenous Australians. Further, cultural factors – for example, community-based consent – and language barriers bring particular challenges to health care access.

7.134 The Committee believes that improved access to health services for Aboriginal and Torres Strait Islander peoples can be achieved through programs targeted at overcoming the barriers that Indigenous patients face. The Committee considers that such programs should include a greater availability of escorts, enhanced access to appropriate accommodation, improved links with communities and Aboriginal health workers and improved coordination of transport and health services. The improvements in coordination must take place both within communities and at treatment centres and address the specific problems of Indigenous patients moving interstate for treatment.

7.135 Increased patient liaison and coordination of services is crucial to ensuring that there are arrangements in place so that Indigenous patients move from their communities to health facilities and back again in a seamless and appropriate manner. The Committee received considerable evidence that programs with a high level of coordination have been very successful in decreasing the number of 'no shows' at medical appointments, improving management of travel arrangements, improving health outcomes for Indigenous patients and ensuring cultural safety. These programs included the pilot Remote Area Liaison Nurse service in South Australia which has now been expanded to a step up/step down program in Adelaide. The Committee believes that such programs could serve as a best practice model for other jurisdictions. While these programs require intensive administrative support, the Committee considers that the benefits far outweigh the costs.

Recommendation 16

7.136 That State and Territory Governments, in consultation with Indigenous representatives and Indigenous Health Services, identify and adopt best practice standards and develop programs to improve Indigenous patients' access to medical services by:

- **ensuring continuity of care for Indigenous patients by establishing liaison services and improving coordination in, and between, remote communities and treatment centres;**
- **accommodating the cultural and language needs of Indigenous patients from remote communities, particularly in respect to the provision of escorts and translators; and**
- **expanding access to appropriate accommodation services.**

7.137 In establishing these best practice standards and programs government and Indigenous representatives should:

- **identify and build on existing examples of good practice by health services in Indigenous communities and State and Territory programs; and**
- **establish clear governance and administrative arrangements for the delivery of programs, including consideration of the most appropriate bodies to provide day-to-day administration of services (for example, a government body or community-managed Aboriginal and Torres Strait Islander health services).**

Senator Gary Humphries
Chair

September 2007