

18th May 2007.

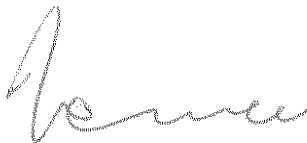
The Secretary
Senate Community Affairs Committee
P O Box 6100
Parliament House
CANBERRA ACT 2600

Dear Sir/Madam,

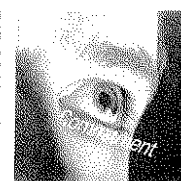
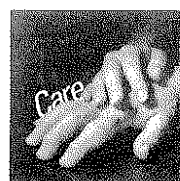
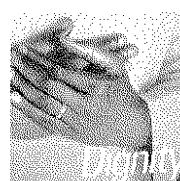
Re: Inquiry into the Operation and Effectiveness of Patient Assisted Travel Schemes [PATS]

Thank you for the opportunity to provide comment to the inquiry. I attach a submission prepared by the clinical staff of the Mater Public and Private Hospitals in Brisbane for your consideration.

Yours sincerely,



Dr. John O'Donnell
Chief Executive Officer.



SENATE COMMITTEE INQUIRY INTO PATIENT ASSISTED TRAVEL SCHEMES (AHA)

SUBMISSION BY MATER HEALTH SERVICES

Terms of Reference

- a) **The need for greater national consistency and uniformity of Patient Assisted Travel Schemes across jurisdictions, especially the procedures used to determine eligibility for travel schemes covering patients, their carers, escorts and families: the level and forms of assistance provided and reciprocal arrangements for interstate patients and their carers.**

Mater Health Services gains referrals for patients from a variety of rural and regional areas in Queensland and northern New South Wales. Many inconsistencies occur both within Queensland itself and with other States in determining who is eligible for the Patient Assisted Travel Schemes, the level of support that is provided and how payments for assistance are processed. Health districts interpret and determine eligibility for financial support differently. Patients who are referred from New South Wales to the Mater Hospital (because they are unable to receive the care they need from their local facilities/hospitals and live less than 100 kilometres) are not considered eligible. However, they often have the ongoing costs of transport and/or petrol as well as accommodation if they need ongoing treatment at a tertiary referral hospital.

A recent review of the New South Wales system that reduced the limit of 200 kilometres to 100 kilometres was a welcome relief for those patients who became eligible. However, in the process of this change, the overall amount paid for accommodation was decreased from \$33 per person per night to \$46 for two people, a reduction of \$20 overall which can be significant for longer stay patient. The amount of money provided for patients per night does not always cover costs and in a metropolitan area it is increasingly difficult to find accommodation for \$30 per night. It often excludes private providers entering the market needed for these patients. Overall, the forms and process to claim assistance are complicated and vary from State to State. This is often too complicated for the patient and/or guardian to complete before arrival for treatment and adds to the stress of the situation. Many rural hospitals require PTS approval to be signed off by their Superintendents. Access to Superintendents can be limited and this creates a delay of up to a week or more, as Superintendents are shared between regions. Inconsistencies also occur when considering eligibility for escorts and often the needs of the patient are not taken into account with a purely medical focus, rather than a holistic model of health which includes the psycho-social/emotional well being of the patient.

For example:

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

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2. Patient transferred from Cunnamulla area to the Mater Children's after a car accident in which one child died and one was seriously injured. The injured child was required to stay in Brisbane for three months for surgery and follow-up treatment. Parents paid for accommodation up-front as they were not informed of the PTS scheme until some time after the event. The father lost his job because he was required to support his remaining family while they were in Brisbane. Upon the child's recovery the family moved to another State and began the process of applying for reimbursements of costs through PTS. The initial accident occurred on January 2006. In May 2007 the family contacted the Mater to ascertain if the Patient Transit Officer could assist them in finalising their application as they had had no success with this, even though they had completed all the forms and complied with every request made by the Superintendent of the home hospital. They have also contacted the Health Rights Commission and were told to contact the Ombudsman for Health, all to no avail. On investigation, it appears that the specialist in Brisbane did not sign the correct box provided on the form D1; consequently this family have endured delays in payment of their entitlements.

b) The need for national minimum standards to improve flexibility for rural patient access to specialist health services throughout Australia:

Given the need to gain access to expertise in any particular field of health, patients may need to travel interstate to gain their care. The complexity of systems and differences in procedures for eligibility can prevent or deter patients from gaining the care they need if they are deemed not eligible for financial assistance.

c) The extent to which local and cross-border issues are compromising the effectiveness of existing Patient Assisted Travel Schemes in Australia, in terms of patient and health system outcomes.

In Queensland, there is a requirement that patients live more than 50 kilometres from the nearest treating hospital to which they are referred. In many cases this ruling presents significant financial disadvantage to families who live within the 50 k zone, particularly when there is a requirement for long-term inpatient or outpatient care. For example, if a baby is born at 24 weeks gestation, the parent needs to be close to the infant on a daily/regular basis, but the family is not entitled to either accommodation assistance close to the treating hospital, transport costs or for children or adults who have chronic conditions where regular outpatient appointment are required to sustain health. A more holistic view of the family's needs to be taken in consideration when assessing eligibility for financial assistance. Often in such cases, other welfare, social work or voluntary services/funds need to be provided by the treating hospital to enable patients and families to maintain the health care needed.

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- d) The current level of utilisation of schemes and identification of mechanisms to ensure that schemes are effectively marketed to all eligible patients and monitored to inform continuous improvement.**

The referring health district does not always have a recognised person to provide information or to make decisions about eligibility of patients who need to be referred to a different health facility. This can result in budgetary issues conflicting with the needs of patients where funds are not allocated/quarantined to enable patients to be referred to an appropriate facility with appropriate financial support. It is suggested that there needs to be a recognised contact/contacts within Queensland Health who can advocate for patient needs, make decisions about budgetary issues for the scheme and oversee consistent interpretation of guidelines. Where there is not a recognised person, confusion and lack of knowledge can result in delays in decision-making, inappropriate denial for eligibility and inappropriate processing of paperwork.

The referring facility should be able to automatically provide information to the patient about the scheme, determine eligibility and process the paperwork before referring to another facility. Instead, on many occasions patients are not aware of the scheme and therefore eligibility needs to be determined by the facility where the patient has been referred. This causes unnecessary distress to patients and increased workload for the facility the patient is attending. A review needs to be undertaken to ensure uniformity and the most appropriate way to process applications for eligibility.

- e) Variations in patient's outcomes between metropolitan and rural, regional and remote patients and the extent to which improved travel and accommodation support would reduce these inequalities.**

See (d) above.

- f) The benefit to patients in having access to a specialist who has the support of a multidisciplinary team and the option to seek a second opinion.**

Patients may need health care other than what can be provided by a medical specialist. Allied Health professionals are often an integral part of any treating health care team. In essence, Allied Health may be the only staff member/s that needs to assess and treat a patient after the treating doctor has determined need. In rural and remote areas, there may not be access to the required Allied Health personnel, eg. Audiology, Dietetics, Speech Therapy, Physiotherapy, Occupational Therapy, Psychology, Social Work etc or Dental. Ensuring that Referring doctors in rural/remote areas have the capacity to refer directly to Allied Health in an appropriate facility, instead of having to refer to another treating doctor would ensure that patients did not have to see two different doctors where it was not necessary and fast-track the referral to the proposed treating Allied Health personnel. However, this would mean a change in who signed off on the paperwork as the Treating Specialist, with the Allied Health personnel signing off rather than a medical specialist.

- g) The relationship between initiatives in E Health and Patient Assisted Travel Schemes;**

E Health initiatives enhance access for certain patients but will not necessarily address the health care needs of those who require face-to-face consultations from treating specialists.

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- h) **The feasibility and desirability of extending patient assisted travel schemes to all treatments listed on the Medicare Benefits Schedule – Enhanced Primary Care items such as allied health and dental treatment and fitting of artificial limbs.**

See (f) above

- i) **The role of charity and non-profit organisations in the provision of travel and accommodation assistance to patients.**

See (c) above.

The current scheme does not recognise the needs of patients beyond travel and accommodation expenses. Families often have a number of other issues that impact on them because of the need to be away from their own home. This is especially the case when a parent has a sick child, but needs to be present at a hospital facility and there are other children who have to be cared for by another family member or child care facility. Families continue to have the expenses of maintaining a family home and the extra expenses of being in another environment without access to the normal cooking facilities, shopping, and capacity to access facilities outside of the hospital environment. The Mater Hospital plays a significant role in providing financial support through the Mater Foundation and through donations provided to the Social Work Department who also rely on other community organisations to support patients when they are away from home. Recognition of these extra expenses could also be addressed by a one-off payment to support families who have extended periods away from home.