



Mr Elton Humphery  
Committee Secretary  
Community Affairs Committee  
Department of the Senate  
PO Box 6100  
Parliament House  
Canberra ACT 2600

Dear Mr Humphery

Australian Rural Nurses and Midwives (ARNM) is the peak professional body representing rural nurses and midwives. The aim of our association is to promote quality health care to rural communities through excellence in nursing and midwifery

Nurses in rural practice are very aware of the challenges that exist in the Patient Assistance Travel Schemes (PATS); the inequities for rural consumers and the relative inaccessibility of the scheme due often to the inefficient and inflexible processes embedded in administrative processes.

Access to a scheme that supports the travel and accommodation needs of rural consumers needs to be intrinsic to the health system, not viewed as a bonus for rural consumers. The ever increasing limited access to specialist services (which are also often minimum health services), results in great inequities between rural and urban dwellers.

A significant amount of time is spent by rural nurses orchestrating patient access to health services away from their place of residence. Patient advocacy and support is a part of the nursing role which is not generally acknowledged.

The key concerns of our members that are addressed in this submission relate to:

1. Administration of the PATS
2. Equity of access and health care outcomes
3. Specific areas of care and specific groups
4. The metro and rural divide
5. Risk management and quality improvement

The administration of PATS requires significant improvement and development. This is in reference to the most basic factors of the design of the forms, authorisation processes and financial arrangements relating to reimbursement and block treatments. Financial support for escorts/carers is also essential to promote the psychosocial wellbeing of patients.

Equity is addressed throughout the document in relation to payment structures, escorts, interstate and cross border issues. 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.



There are specific issues around particular groups as exemplified through birthing services, cancer services and the chronic disease groups. This also warrants consideration for ATSI people as well as other CALD groups.

The Metro and Rural divide issue relates to access with well documented decreasing levels of services in rural areas which demands that rural people access metropolitan services. This differs in more populated states, which may have regional services, to less populated states (eg Western Australia and South Australia) where specialist services are primarily located in the capital city.

There is a need to address the general lack of understanding by metro clinics of the implications of timing of appointments and the impact this has on patients, their families and the cost of travel and unnecessary accommodation. A more informed approach at this end of the process could enable better use of resources such as PATS.

The transport issues in rural areas are well known with many rural towns have no frequent public transport. For a variety of reasons, it cannot be assumed that travel via private vehicle is an option for many patients. Charitable and volunteer agencies are limited in rural areas and often lack the driver resources required to meet demand.

Further, a well supported PATS will enable better use of transport services provided by Ambulance and aero medical services (eg RFDS), which are often used inappropriately merely because there is no other option.

The risk management around the scheme needs to ensure that the patient journey is safe and that the mode of transport selected is based on best practice. This should not be impeded by a lack of finance and reduced access to appropriate transport. Performance monitoring will ensure improvements made in the best interest of the rural consumers.

Whilst there are many aspects related to this important topic, we would like to reaffirm that patients requiring health care are generally under significant personal stress with limited personal control over the path their journey is taking them and their input to decisions. The need to travel away from homes and communities, along with the financial impact, add significantly to the burden of illness for rural people.

In order to minimise the impact on individuals and families, the processes to facilitate this travel should function as seamlessly as possible and contribute positively to providing optimal care for rural consumers of health care.

We thank you for the opportunity to contribute to this very important inquiry and look forward to the opportunity to having further input, and would be very happy to expand upon any of the issues identified in our submission.

Yours sincerely



Ms Geri Malone  
Executive Director

22 May 2007

## Terms of reference

The operation and effectiveness of Patient Assisted Travel Schemes including:

- 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 inter-state patients and their carers;

### **Equity vs Uniformity:**

It is apparent from our feedback from different States that there is marked disparity between the states - specifically around procedures and eligibility for this scheme. However whilst there needs to be consistency in the approach to the criteria, issues of escorts and inclusion of medical services, care has to be exercised in ensuring that the scheme is equitable as opposed to uniform.

There are considerable differences between states with regard to the geographical spread of services. Remoteness factor cannot only be measured by geographical location or distance; regional health services for example are in much greater numbers in rural New South Wales, Victoria and Queensland as opposed to Western Australia and South Australia. As such specialist services in these states are only available in the capital cities.

We would advocate for equity of access as opposed to uniformity of criteria.

### **The forms:**

are often the first thing commented upon when seeking feedback on the schemes, from both consumers and health professionals. All states have their own versions; some have been revamped over recent times but our feedback indicates they are only "marginally better".

*"The forms are complex and cumbersome for both patients and medical staff - they are incredibly bureaucratic, about four pages long and need to be completed for each trip away - these need to be reviewed with a view to simplifying the forms and the process eg by enabling individuals to put in one claim for a series of treatments"*

*Rural Director of Nursing*

### **Authorisation:**

of the form is an issue with each state having varying processes and restrictions. Authorisation by a medical officer creates limitations for consumers accessing the scheme.

*As stated by a Rural Director of Nursing "filling out PATS forms is a nightmare no matter how much training is offered. This issue would be the most time consuming factor of managing the process, as in order to assist the clients to what they are entitled to we have to frequently ring/return forms for clarification. GP and the specialist are no better at this and in fact often leave it to nursing staff".*

An alternative model in South Australia allows a rural liaison nurse in a major metropolitan hospital to authorise the forms. Rural and remote nurses are well placed to authorise forms, as they have a depth of knowledge of the rural situation and the patient's situation. Often a specialist or junior medical officer has no ongoing relationship with the patient and therefore diminished insight into the patient's social circumstances.

GP' s in rural communities are also often well placed to understand the rural perspective as well as the patient's situation, but the completion of such complex forms is a poor use of their valuable and limited time.

**Expenses to patients and families:**

As already identified, the complexity of the process is often a barrier for consumers accessing the scheme. This is compounded by the necessity for payment at completion of a visit. Whilst this may not always create hardship for single visits, it does result in individuals being considerably out of pocket where block treatments are required e.g. for radiotherapy.

It is of concern that associated costs of treatment may impact on a patient's decision to seek therapy. It is therefore preferable that where these costs are significant, up front payments are made available to the patient.

The rates of reimbursement are also well below the gazetted rates for government department employees and politicians.

Personal income levels are lower for rural people compared to their urban peers. Costs for a course of treatment and care borne over a period of time by a rural patient are significant.

*"The other problem is that you are not supposed to start the travel until you get approval to claim. Obviously this can be a bit silly at times. If you have done the travel I think you should be able to claim whether it is before or after."*

*Rural Nurse*

**Escorts:**

is a particularly cumbersome and inequitable situation across the schemes. The needs of Indigenous people, for example are not met in the current configuration of the scheme, particularly where long term hospitalisation is necessary.

For example, Northern Territory Aboriginal and Torres Strait Islander (ATSI) children requiring high level burns treatment have to travel to Adelaide, as there is nothing available in the Northern Territory. There is no allowance for interchange of escorts, or the increase in the number of escorts over a prolonged period of time. The social and cultural isolation of these patients is profound and exacerbated during long term hospitalisation. Older ATSI patients are equally impacted when they are forced to relocate thousands of kilometres away without family support.

The distress to individuals who have to leave their families for long term care applies to non- Indigenous groups as well - particularly the younger and older age groups who rely on families for care and support in day to day situations.

The schemes also limit the option for patients and/or their escort to return home for a period of time during an extended treatment regime. This is especially significant when having to relocate for long periods of radiotherapy and for pregnant women who may have to relocate 4 weeks prior to birthing for example.

**Interstate patients:**

inconsistency and incredible complexity is apparent for patients who find themselves being treated in a state other than their home base e.g. requiring care due to sudden onset or accidental injury when on holidays. The scheme could better support carers or escorts to travel to the patient to provide vital psychosocial support that is important to well being and recovery.

**b) the need for national minimum standards to improve flexibility for rural patient access to specialist health services throughout Australia.**

Determining national minimum standards should bring about consistency to the scheme around issues of eligibility, types of services covered, escorts and payment equity. The challenge is to allow for flexibility to accommodate the diversity that exists, specifically around block payments for extended periods of treatment.

An effective monitoring system is essential to ensure continuous improvement

**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.**

This is difficult to quantify. However anecdotal feedback indicates that cross border issues cause great contention in terms of eligibility. Whilst in some instances, specific State agreements have been entered into, it seems that this creates administrative confusion.

One of the major cross border issues is the requirement for patients to travel extensive distances to access services in their own state, when the same service may be geographically closer in another state. The latter is obviously far less expensive and involves less time away from home. Examples of this are where patients in Kimberley have to travel to Perth, and patients in the top end of South Australia have to access Adelaide instead of Alice Springs.

This situation often impacts on Indigenous populations where the cultural impact of travelling to such unknown areas is significant. Care closer to home is much more appropriate.

**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 anecdotal evidence as already referred to is that the complexity of the administrative processes in itself is a deterrent to claiming the payment.

In addition the scheme is not well marketed, and the actual process of applying is not well supported. The scheme needs to provide access to supports (eg social workers; IPTAAS support staff) to assist patients with completion of forms.

More effective marketing of the scheme is warranted, which needs to go hand in hand with supportive structures.

Quality process that enable monitoring and evaluation are also required. These will enable a greater understanding of the demographic profile of people who apply for funding; as well as those who do not apply, and may be 'falling between the gaps'.

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

It is well known that the health status of people living in rural and remote areas is inferior to that of the urban population. The tyranny of distance contributes to delayed diagnosis, reduced access to appropriate specialist services and incontinuity of services and follow up.

As already indicated, rural and remote areas have reduced access to specialist services and in some instances, local access to a GP, allied health services, dentistry and specific health prevention initiatives. Therefore, the capacity to travel to such services is essential to the health outcome of rural patients.

Cancer services and chronic disease care are good examples where on going management and coordinated care from a variety of agencies are not uncommon. Birthing services are another example, where higher numbers of women in rural areas have to access maternity health services in a location away from their home. This includes antenatal care, birthing and post natal care.

Where the financial and social cost of this relocation is substantial, it does influence the regularity with which they attend which is particularly significant for antenatal care that impacts on well being of both mother and baby. Whilst the appropriate allocation of money is not the total answer, and more user friendly process will increase the likelihood of mothers accessing the services.

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.**

ARNM supports the principle of equity of access to health care services across rural and urban environments. The reality is that there is reduced access to specialists and multidisciplinary teams in rural Australia.

The notion of patients having a right to a second opinion is challenged where the means of travelling to obtain this is not available. This is clearly inequitable.

A fair and equitable PATS scheme will enable better access to essential multidisciplinary health services and second opinions for rural patients.

g) **the relationship between initiatives in e Health and Patient Assisted Travel Schemes.**

It has well acknowledged in many forums that there are huge advances to be made in terms of infrastructure development and health service reform before e health initiatives have capacity to positively impact rural and remote communities.

There is little doubt that there is a need for further development of this aspect. However at the current time there is huge inequity in access and appropriateness of this avenue for rural people.

**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.**

Access to primary services is very limited for rural consumers and in some instances denied thus there is a requirement to extend the benefits outside of specialist services.

Patients in rural communities have to travel for services ranging from radiological services, allied health such as physiotherapy, speech therapists and dentistry. There is abundant evidence identifying the demonstrated benefits such services for prevention of illness as well as treatment. It is crucial that these types of services be part of the scheme.

In the current rural health environment, varying models of care are continuously being implemented to improve access and quality of care to patients. This needs to be matched with a flexible and responsive PATS structure to ensure support across a range of care models. This includes midwifery services, emerging nurse practitioner services and nurse led specialty clinics that are evolving in answer to the over burdened specialist clinics.

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

The role of charity and not for profit organisations is significant in this area, along with initiatives undertaken by many regional/rural hospitals who have implemented their own systems of provision of transport for non urgent appointments, often utilising a pool of volunteers from their communities.

These initiatives are to be applauded. Rural communities often fall back on their own resources to narrow the gap of inequity in services that exist. Examples of this are through volunteer ambulance services and Country Fire Services.

However there is a dearth of volunteer drivers and the same people are called upon time and time again in their communities. Therefore, they should be able to get Government support in providing these services. However as one respondent highlighted: *“Volunteer drivers are either older than the clients or simply do not exist - probably the result of all of us working to a ripe old age!!”*

This is an essential role in rural communities. However, inconsistency of these services across rural communities is problematic and would need to be careful exploration in relationship to existing PATS.