



06/80

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Department of the Senate  
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Dear Mr Humphery

Please find attached the AMA's submission on the operation and effectiveness of Patient Assisted Travel Schemes.

The AMA strongly supports the travel schemes. The AMA is however, concerned about a number of deficiencies in the current schemes that reduce the assessability of people living in rural, regional, and remote areas of Australia to the same level of health care as those people living in metropolitan areas.

Thank you for providing the AMA with the opportunity to contribute to the inquiry.

Yours sincerely

A handwritten signature in black ink that reads "Warwick Hough". The signature is written in a cursive style with a large, looping flourish at the end of the name.

Warwick Hough  
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24 May 2007

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**AMA**

**Submission to**  
**Senate Community Affairs Committee**  
**Patient Assisted Travel Schemes**

**May 2007**

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## **BACKGROUND**

Every state and territory health department in Australia has a scheme in place to enable patients to access treatment not available at local level. The Patient Assisted Schemes, commonly referred to as PATS, are designed to assist patients through the form of a subsidy towards the cost of travel to a specialist, and accommodation costs associated with that journey.

The AMA strongly supports the travel schemes. The AMA is, however, concerned about the operation and effectiveness of the current schemes which have a number of deficiencies that reduce the assessability of people living in rural, regional and remote areas of Australia to the same level of health care as those people living in metropolitan areas.

This paper is not intended to be an exhaustive portrayal of the problems associated with current PATS. Rather, it is intended to outline the main problems of concern held by the AMA in relation to the schemes and outline the AMA's view in relation to the terms of reference of the inquiry.

## **RECOMMENDATIONS**

1. That the goal of this review should be to make recommendations that achieve greater uniformity and consistency across jurisdictions to allow all people in rural, regional, and remote areas to have the same access to health care as those in metropolitan areas.
2. Increased marketing and promotion of the schemes in all jurisdictions to boost awareness of the schemes to patients and health care practitioners.
3. Improved travel and accommodation support to reduce the inequalities in patient outcomes.
4. Improve PATS access and experience for Aboriginal and Torres Strait Islander patients.
5. Improved/Reduction in the administration of the schemes through the adoption by all states of a pre-payment system (vouchers, tickets or advance bookings) and a reduction in the amount of paperwork required to be filled out (such as one form covering all episodes of care).
6. Transport and accommodation assistance for all treatments listed on the Medicare Benefits Schedule – Enhanced Primary Care items such as allied health and dental treatment and fitting of artificial limbs.
7. Patient access to a specialist who has the support of a multidisciplinary team and the option for patients to seek a second opinion.
8. Development of a system that incorporates both e-Health and PATS.

9. Greater recognition as a means of increasing support, for the role of charity and non-profit organisations in the provision of travel and accommodation assistance to patients.

## **DETAILED COMMENTS**

### National Consistency and Uniformity Based on Equity of Access

The Australian healthcare system is based on the principle that all Australians are able to have the same equity of access to the same level of health care regardless of where they live. In its recently adopted *Position Statement on Public Health, 2006* the AMA has embraced the fundamental basis of public health activities as seeking to achieve equity in health 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.

The Australian Medical Association believes that service funding and development should as much as possible be based on evidence and cost effectiveness data. If a service is evidence based, cost effective, and available to the population, the government must plan to ensure it is accessible to all, irrespective of where they live. Unfortunately, many services are not available in rural and remote areas so patients have to travel to access the services.

Unfortunately, the current PATS is geographically limited and it is inaccessible for patients who live in communities that are within the geographical radius but are often isolated. PATS is often a barrier to members of these communities receiving specialist care.

Access hurdles to PATS are one of the reasons rural morbidity and mortality falls behind that of the rest of Australia. Many patients are left in situations where they are not eligible for PATS because the service is “provided” locally. However, in many cases there are long waiting times for the “local” service and patients often have no choice but to pay for the cost of travelling interstate. Neither does PATS recognise that the closest available centre is not necessarily the most appropriate for the individual patient.

A table detailing the various patient assisted travel schemes is provided at Attachment A to this submission. The table highlights the fact that PATS is only available for necessary travel and in most states the benefits barely covers the cost of petrol. In addition, the reimbursement amount for accommodation is woefully inadequate and leaves patients with large out of pocket expenses.<sup>1</sup>

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<sup>1</sup> Costs can vary widely depending on where the patient stays. As an example, in NSW the reimbursement rate for motel accommodation is \$33 per night. This is unreasonable given the average commercial rate in Sydney for three star accommodation is a minimum \$150 per night.

The AMA strongly believes there are a large number of initiatives that should be implemented by governments to increase the medical workforce in regional and remote areas. However, patients must not be denied access to care while these solutions are being determined. Nationally standardised travel and accommodation schemes will allow patients to seek care that is not currently readily available in their community.

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. Entitlements should be reviewed and increased so that they reflect the real costs of travel and reasonable accommodation.

### Increased Marketing and Promotion

AMA discussions with health care professionals have highlighted that a patient's access to PATS is largely dependant on their local GP knowing about the scheme and their patient's eligibility for it. More work needs to be done on promoting the schemes through the publication of forms, posters, and booklets and distributed widely to all health care practitioners.

The AMA supports greater marketing of the scheme to ensure that all eligible patients are aware of the availability of the scheme.

### Variations in Patient Outcomes - Improved Travel and Accommodation Support

A social gradient of health runs across society with the most profound differences in health being seen between the most and least disadvantaged. Key contributors to this gradient are the social determinants of health which are the social and environmental conditions in which people work and live. They include such factors as income, education and housing. Therefore variations in patient outcomes due to access and travel issues will be compounded for those further down the social gradient experiencing by negative impacts of the social determinants. Health labour workforce statistics demonstrate that regional and remote parts of Australia are significantly underserved in terms of health care compared to their metropolitan based colleagues. The 34% of Australians who live in regional and rural areas tend to have lower levels of access to health services.<sup>2</sup>

However, it is in terms of access to specialist care that patients in rural, regional and remote areas are particularly disadvantaged. The average number of full time equivalent specialists per 100,000 patients working in major cities in Australia stands at 119. In addition, there are an average of 48 specialists-in-training in these locations. In inner regional areas these numbers drop to 55 and 13 respectively. In outer regional areas they are 33 and 9. In remote areas they are 19 and 3 and in very remote areas the numbers drop to 5 and zero.<sup>3</sup>

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<sup>2</sup> AIHW: Strong et al. 1998. "Health in Rural and Remote Australia". AIHW cat. no. PHE6. Canberra.

<sup>3</sup> Medical Labour Force 2006. Australian Institute of Health and Welfare. December 2006.

People from regional areas tend to report similar levels of chronic and complex conditions as their counterparts in major cities. However, they are 1.2 times as likely to report a recent injury and at least 1.12 times as likely to report a long-term condition due to injury. Dental health problems and communicable diseases are significantly more prevalent in regional and remote areas. Rates of disability are higher in these areas, as is the number of days of reduced activity because of illness. Life expectancy drops with remoteness. People from regional and remote areas have higher rates of foetal and neonatal deaths.<sup>4</sup>

The leading causes of the higher death rates experienced in regional and remote areas are circulatory diseases (42% of the 'excess' deaths), injury (24%), respiratory disease (10%) and cancers (10%).<sup>5</sup>

A driving factor behind these poorer health outcomes is the difficulty people in regional and remote areas face in accessing specialist and primary health care. Isolation and lack of services make it complicated for these patients to receive preventive services and manage chronic diseases. Consumers needing to travel long distances to access services can face considerable disruption and personal financial cost. Providing travel assistance to these patients can be an integral element in improving access to essential health services and in obtaining positive health outcomes.

An effective travel and accommodation support program would not only assist these patients in accessing care, but encourage them to seek care earlier. The travel schemes should support on-going care as required, based on a doctor's clinical decision, and not limit patient services based on pre-determined budgetary restraints.

It should also allow patients to travel to a more distant specialist if the waiting list for the closest available specialist exceeds clinically acceptable time frames.<sup>6</sup>

Provision should also be made for private patients to have access to PATS. In the Northern Territory, subsidised travel interstate for treatment not available at local centres is only available via application to the NT PATS by a public hospital specialist. This discriminates against private patients who have decided to obtain their care outside the public hospital system, saving that system the cost of their care.

### Indigenous Australians

ABS statistics show that 895 indigenous communities are located 100 kilometres or more from the nearest hospital with 547 communities being located greater than 250 kilometres from the nearest hospital.

While most of these communities are located in the Northern Territory (381 communities are located 250 kilometres away), there are also significant numbers in

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<sup>4</sup> "Rural, Regional and Remote Health: Indicators of Health". Australian Institute of Health and Welfare. May 2005.

<sup>5</sup> Ibid

<sup>6</sup> "Transport and Accommodation Assistance for Health Patients from Rural and Remote Areas Position Paper". National Rural Health Alliance. October 2005.

Western Australia (133 communities located between 100k and 249km from the nearest hospital), Queensland, and South Australia.<sup>7</sup>

Patient assisted travels schemes are vital if indigenous Australians in rural and remote areas are able to access specialist health care. However, the schemes fall short of the standards of assistance expected as they do not meet the needs of indigenous patients and they are not flexible enough to consider their individual and cultural needs. Of particular concern is the rigid criteria applied under the schemes for provision of an escort with the patient.

Official escorts should be permitted for any indigenous patient who is from, or who originates from a remote rural community irrespective of age, English language skills or medical condition and irrespective of whether or not the patient has a medical escort accompanying them in transit. This is necessary for the cultural security and support for people mostly unfamiliar with regional hospitals or large cities outside their own immediate area, and for this group of people who are rarely on their own in daily life and who come from a background of common/consensus decision-making processes.

Currently, the varying schemes pay for one escort which in itself is an issue, particularly in cases of paediatrics where one carer, usually the mother, is allowed to accompany the child interstate. This causes major problems for indigenous patients where the mothers are often very young themselves, do not speak good English and are going to a large hospital and city where there are few indigenous people around to provide assistance. In these cases it would be more appropriate to send to two escorts such as mum and dad or mum and grandma.

Discussion with AMA doctors working in rural areas with a high proportion of indigenous patients have noted that the restriction on more than one escort impacts on the willingness of patients to undergo treatment. The AMA is aware of cases of indigenous patients refusing elective travel to large centres unless a relative or friend accompanies them. Usually PATS will not pay for a person to accompany them unless they are a minor or have a specific medical need for an escort. This is one of the main reasons indigenous women have refused interstate radiotherapy treatment for breast cancer.

The restriction on escort numbers is particularly concerning in cases of indigenous patients suffering from a terminal illness. Attitudes to death and death rituals vary in communities and in many indigenous communities; dying patients are surrounded by immediate and extended family members. The restriction on the number of escorts means that indigenous patients dying from a terminal illness are sent to hospital without the support of family members.

The restriction on the number of escorts is also a particular problem in relation to antenatal women who live in indigenous communities. They are often required to travel large distances for care and be away from family support for four to six weeks

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<sup>7</sup> Derived from the "Community Housing and Infrastructure Needs Survey", produced by ABS on behalf of ATSIC Canberra 1999.

to have a baby as there is no provision in PATS for family support or attendance for these women.

In addition, the low economic background of the majority of indigenous Australians means that many patients are unable to access the schemes and those who do face economic hardship because full reimbursement is not provided.

### Improved Administration

AMA is aware of problems with the administration of PATS. Repeated trips to the one treating specialist /clinic require additional paperwork every trip, both from the GP and the specialist to support the PATS documentation requirement. The process is time consuming for health workers as an inordinate amount of time is spent chasing PATS forms, getting signatures and organising transfers. . This is also the case for NGO staff who can spend time completing paper work that could otherwise be spent supporting patients through lengthy and difficult treatment such as chemotherapy.

Adoption of a pre-payment system using vouchers, tickets or advance bookings in addition to reimbursement, would improve the administration and effectiveness of the scheme.

The AMA recommends significant streamlining of PATS documentation for both patients and clinicians.

### Inclusion of all PATS Treatments to the MBS

Patients living outside metropolitan areas often have limited access to primary health care, often having to travel a significant distance to visit both a general practice and other allied health providers.

Evidence suggests there is an inverse relationship between access to primary health care and pharmaceuticals, funded through the MBS and PBS, and use of in-hospital care, especially with increasing remoteness.

*“International studies show that the strength of a country’s primary care system is associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases. This relationship is significant after controlling for determinants of population health at the macro-level (GDP per capita, total physicians per one thousand population, percentage of elderly) and micro-level (average number of ambulatory care visits, per capita income, alcohol and tobacco consumption). Furthermore, increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending.”<sup>8</sup>*

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<sup>8</sup>“What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?” WHO Regional Office for Europe’s Health Evidence Network (HEN) January 2004

Australia's ageing population, the increasing prevalence of chronic disease, and the already demonstrated poorer health expectations for rural and remote populations, makes it even more vital to ensure all Australians have access to strong primary care services.

Remote patients are disadvantaged by the non-coverage of dental, psychology or other allied health areas. When a patient is seen in an outreach clinic and requires a service in town, this is not covered under the schemes. In addition, the limitation on PATS for services such as dentistry creates a barrier to accessing services appropriately such as rheumatic heart disease patients requiring dental review.

Discussion with Alice Springs paediatricians indicates the importance of PATS being available for all allied health services. This recognises that generalist practitioners may not be able to provide patients with access to allied health service.

The AMA endorses the recommendation of the National Rural Health Alliance that:

*“Transport and accommodation assistance for all treatments listed on the Medicare Benefits Schedule should be covered, not just treatment by medical specialists. This would include those treatments covered by Enhanced Primary Care MBS items, such as allied health and dental treatment and should also cover artificial limb fitting.”<sup>9</sup>*

#### Patient Access to a Multidisciplinary Team

Australians living in regional and remote areas deserve access to the same level and quality of health care as any other patient. This includes being able to seek a second opinion when warranted. The Australian health system is centred on the principle of patient choice, and all Australians should have the same health care choices available to them. Costs of travel and accommodation must not be a barrier to these patients seeking clinically appropriate health care. The patient assisted travel schemes must not restrict patient access to a second opinion.

Intervention studies have demonstrated the advantages to chronically ill patients of care by a team. Chronic illnesses are often complex and multisystem. The most effective management of these illnesses require a doctor as the central provider with input from other relevant members of a multidisciplinary team.

Governments around Australia have recognised the need to address the growing prevalence of chronic disease in this country. In 2005, the Australian Health Ministers' Conference (AHMC) released a National Chronic Disease Strategy.

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<sup>9</sup> “Transport and Accommodation Assistance for Health Patients from Rural and Remote Areas” Position Paper. National Rural Health Alliance. October 2005.

A key direction of that strategy calls for: “Develop funding and organisational structures that support multidisciplinary care, care planning, coordination and review.”<sup>10</sup>

It also recommends: “Improve access for all Australians to the range of services needed for chronic disease prevention and care, particularly for Aboriginal and Torres Strait Islander peoples, rural and remote communities and other under serviced population groups.”<sup>11</sup>

The AHMC recognised that state and territory governments have instituted transport schemes to assist rural and remote residents access specialist services, but concluded that greater support is needed for patients who need to travel to obtain treatment, as well as their families and carers.

Unfortunately, access to a multidisciplinary team is increasingly difficult for patients in rural areas. Just as numbers of specialists are declining, there is also limited access to allied health providers such as physiotherapists and psychologists.

The AMA believes access to the entire multidisciplinary team should be facilitated by a program such as PATS.

### E-Health and PATS

Advances in information technology will impact on the delivery of care in these rural and remote areas. The AMA is currently in discussion with the Government on mechanisms that would support, encourage and enhance the use of e-Health in service delivery around Australia.

The AMA is of the view that technology, such as video conferencing, has the capacity to allow patients to access medical services that would otherwise be unavailable. However, to ensure best quality care and reduce the potential for risk, the AMA is calling for this care to only be delivered with another medical professional, usually the patient’s GP, present with the patient at the time of the ‘e-consult’.

In order to ensure take-up of e-Health initiatives, medical practitioners must be financially supported in installing and operating appropriate technology. The AMA believes the Federal Government must set standards on the type of technology that would be approved for these services.

While e-Health will assist in the delivery of services, this type of consultation does not replace care where the doctor considers a face-to-face consultation is necessary in order to provide the best care for the patient and in compliance with quality and safety standards for patient care.

Therefore, there must continue to be mechanisms through which rural and remote patients can access face-to-face care when required.

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<sup>10</sup> National Chronic Disease Strategy. Australian Health Ministers’ Conference. 2005

<sup>11</sup> National Chronic Disease Strategy. Australian Health Ministers’ Conference. 2005

The AMA recommends that PATS arrangements should take into account developments in E Health and that PATS be expanded to assist E Health initiatives that can help in the effective delivery of care.

### The Role of Charity and Non-profit Organisations

The AMA acknowledges that charity and non-profit organisations play an important role in the provision of travel and accommodation assistance to patients. Central Australian patients rely significantly on financial support from non-profit organisations such as Angelflight and The Butterfly Connection.

However, it is important to note that in some cases there are problems with the provision of accommodation through charities. AMA is aware of cases of racial discrimination in relation to indigenous antenatal women being housed at a church-based charitable accommodation.

### **CONCLUSION**

Patient assisted travel schemes are an important part of the Australian healthcare system. They are critical in supporting Australians living in rural and remote areas of the country when they need to access healthcare in larger centers.

However, the high cost of travel and accommodation for these families when they need to access medical treatment away from home is prohibitive. Patients often have to travel a significant distance before they become eligible for assistance and the payments made under the schemes for transport and accommodation only cover a small proportion of the actual costs incurred by the patients.

The AMA supports the inquiry into PATS as a step towards reducing the inequalities in health care between rural and metropolitan patients

**PATIENT ASSISTED TRAVEL SCHEMES – STATE/TERRITORY COMPARISONS**

	<b>Eligibility</b>	<b>Accommodation Subsidy</b>	<b>Travel Subsidy</b>	<b>Personal Contribution</b>
<b><u>VIC (VPTAS)</u></b>	Eligible if need to travel more than 100km one-way or on average 500km for a minimum of five consecutive weeks.	Commercial accommodation - maximum of \$30 per night.	14 cents per km (car).	If no concession card – must pay first \$100 from total benefits each treatment year.
<b>NSW (IPTAA)</b>	Eligible if need to travel more than 200km one-way.	Commercial accommodation - maximum of \$33 per night.  Private – only available to concession card holders - \$30 per week.	12.7 cents per km (car).	If no concession card – must pay \$40 per person deducted from total benefits paid under the scheme.  \$20 if concession card.
<b>QLD</b>	Eligible if need to travel more than 50km one way	Commercial accommodation - maximum of \$30 per night.  Private - \$10 per night.  If required to drive more than 600km or eight hours – one nights accommodation can be subsidised.	10 cents per km (car).	Unless concession card – required to contribute first four nights of accommodation per financial year.

	<b>Eligibility</b>	<b>Accommodation Subsidy</b>	<b>Travel Subsidy</b>	<b>Personal Contribution</b>
<b>WA</b>	<p>Non-chronic condition – eligible if need to travel more than 100km one way</p> <p>Chronic condition – eligible if need to travel between 70 – 100 km one way.</p>	<p>Commercial accommodation - maximum of \$35 per night – reimbursed upon receipt.</p> <p>Private - \$10 per night.</p> <p>Rental or leased – maximum of \$140 per week</p>	13 cents per km. If travel more than 4 times per year and more than 100 km away – 15 cents per km (car)	If no concession card – must pay maximum of first \$50 of each trip for first four trips.
<b>SA</b>	Eligible if need to travel more than 100km one way	<p>Commercial accommodation - maximum of \$30 per night.</p> <p>Private – no reimbursement.</p>	16 cents per km (car)	\$30 subtracted from the eligible benefit.
<b>TAS</b>	Eligible if need to travel more than 75km one way	Commercial accommodation - maximum of \$30 per night.	13 cents per km (car).	<p>If no concession card – must pay \$75 towards cost of each return journey to a maximum of \$300 in one financial year.</p> <p>\$20 if concession card to a maximum of \$120 in one financial year.</p>

	<b>Eligibility</b>	<b>Accommodation Subsidy</b>	<b>Travel Subsidy</b>	<b>Personal Contribution</b>
<b>NT</b>	Eligible if need to travel more than 200km one way	Commercial accommodation - maximum of \$30 per night. Private – \$10 per night.	15 cents per km (car)	Nil
<b>ACT (IPTAS)</b>	Eligible if patient has a current referral for a service not available in the ACT.	Commercial accommodation - maximum of \$30 per night per patient and \$20 per night per escort. Private or hospital accommodation – \$10 per night per person.	Travel by car CBR – SYD – CBR - \$40. Other cities greater reimbursement. Travel by coach or train - \$40 per adult and \$20 per child.	Nil