



**SUBMISSION TO THE SENATE COMMITTEE INQUIRY  
INTO OPERATION AND EFFECTIVENESS OF PATIENT  
ASSISTED TRAVEL SCHEMES (PATS)**

**FROM**

**AGED AND COMMUNITY SERVICES AUSTRALIA**

## **The ACSA Federation**

Aged and Community Services Australia (ACSA) is the national peak body for not for profit aged care providers. ACSA seeks to ensure the continuing development of a vibrant and responsive industry with the flexibility to meet the changing needs of Australians requiring residential and community care.

ACSA is the national office for the ACSA Federation. The six State and Territory Associations that make up the ACSA Federation represent over 1,200 organisations. Our members provide services to over half a million older people, people with disabilities and their carers through over 4,000 aged care homes, community care outlets and retirement villages throughout Australia. It is estimated that over 300,000 people work in aged care. The residential care sector alone is the ninth largest employing industry in Australia employing 1.3% of the workforce. Our industry is made up of a broad range of providers from small residential facilities in rural and regional Australia managed by a voluntary Board, to sophisticated multi million dollar operations.

In September 2005 ACSA and the National Rural Health Alliance (NRHA) launched a joint policy paper, "*Older People and Aged Care in Rural, Regional and Remote Australia.*" One of the three priority areas identified for urgent action was transport. In particular this policy statement recommended that:

- All State and Territory Governments should commit to a consistent approach to an improved and well resourced Isolated Patients' Travel and Accommodation Assistance Scheme with:
  - sufficient funds to guarantee access to the program for those who qualify;
  - uniform reimbursement rates for travel and accommodation for the patient and their escort; and
  - the flexibility at the local level to provide support on an individual basis.
- The schemes should be widely publicised and promoted in a range of user friendly formats.

ACSA supports the work previously undertaken by the NRHA and the recommendations contained in its report "*Transport and Accommodation for Health Patients for Rural and Remote Areas*" 2005. Therefore ACSA supports fully the Senate Community Affairs Committee Inquiry and we look forward to the Committee's final report.

Our submission focuses on Terms of Reference (a) and (c) and provides general commentary on the specific PATS issues of relevance to aged care.

## **PATS and Aged Care**

The quality of older people's health is inextricably linked to their capacity to get transport to health services. In rural and remote Australia, and for aged people in particular, transport is a health issue and an equity issue. State Health Departments provide varying degrees of financial assistance for rural and remote older Australians who must travel large distances to access specialised medical and hospital services,

through the Patient Assisted Travel Scheme (or its equivalent). In most cases, PATS schemes provide partial coverage only of travel and necessary accommodation costs.

As the population ages, more people from rural and remote areas will require assessment and/or treatment at distant primary health and specialist facilities (especially given the loss of many local health services, and the move towards reduced length of stay which, for older people, is associated with increased episodes of care). Travel assistance schemes will become even more important in reducing barriers to accessing health care. However, there is considerable concern about aspects of these schemes:

- **Treatments that do not require hospital admission**

ACSA has received reports of a number of cases in the Northern Territory where lack of transport for older people is causing concern and in some cases resulting in poorer health outcomes for individuals. For example, a senior Indigenous woman who requires dialysis treatment in Alice Springs is ineligible to receive funding under PATS because the treatment does not require her admission to hospital. The cost of travelling a 500km round trip and the time taken for the trip on a bus ultimately acts as a disincentive and this individual eventually stopped attending the hospital. This resulted in her admission to and long stay in an acute hospital bed.

- **Non Emergency Medical Appointments**

Another example concerns older people in a residential care service requiring transport to attend medical appointments 500 kilometres away. If the medical appointment is not considered an emergency, there is no air service available, and again, if the resident does not require admission to hospital, no PATS funding. Transport of older people to attend medical appointments requires residential care facility staff members to accompany the individual, wheelchair accessible transport and an overnight stay to access the medical care in some instances. The residential care provider bears the cost, despite receiving no funding to do so.

- **Access for older people in residential aged care**

Members have reported that PATS funded transport may be travelling to a regional centre with a number of people to see medical specialists. The bus may go straight past the residential facility and may have capacity to take the resident but guidelines do not allow this sharing of resources. Instead the residential facility needs to make the same trip with the resident in a separate vehicle.

These are just a couple of examples that illustrate unnecessary obstacles facing older people and their service providers in rural, regional and remote areas.

## **Specific Comments on Inquiry Terms of Reference**

As noted in the Terms of Reference, each state has its own set of PATS regulations, and many of the administrative arrangements are complex, anomalous and inconsistent, deterring people from seeking assistance.

### **Term of Reference (a)**

Some of the systemic anomalies and prohibitive factors that the inquiry should address include:

- PATS funds transport to specialist services once a patient has been referred to that specialist by a local GP. In rural and remote Australia, substantial travel may already be required to access that 'local' GP and such travel is not covered by PATS, but should be. Assisted access to primary health care is cost efficient in so far as it limits the decline into acute health crises that arise when patients put off seeking preventative and early intervention care.
- The distance to a service considered as 'local' differs between states/territories. Distances within which a PATS subsidy is inapplicable vary from 50km in Queensland to 200 km in the NT (dialysis patients in the NT have a lower threshold of 80kms) and in NSW (where the threshold is lowered for financially disadvantaged patients, those with chronic medical conditions and 'frequent travellers'). This should be standardised to facilitate ease of understanding by beneficiaries and professionals of program eligibility.
- Assistance is only available for patients for travel from their permanent residence. Patients are not covered if they need medical treatment when they are away from home; nor is it available for travel between medical sites. Flexibility for this should be built into the system.
- Eligibility depends on patients not being eligible for assistance from any other source, such as Veterans Affairs, third party or private health insurance. For aged patients, this creates a layer of administrative complexity that may cause them to delay or defer seeking treatment.
- In most cases clients must be referred by a GP. Nurses can not refer in Tasmania and the NT even in remote communities, and in WA remote area nurses must fax to a GP to approve the referral. Allied health professionals may only refer under limited circumstances. All accredited health practitioners should be authorised to assist eligible clients to complete the forms for assistance with the forms to be forwarded to a GP for them to authorise. In remote communities where a nurse or nurse practitioner is the sole local primary care provider, they should be able to make independent referrals.
- In general, referral must be to the nearest specialist. Some states, but not all, allow some flexibility if the nearest specialist cannot see the patient within a 'clinically acceptable timeframe' due to extended waiting lists. This option should be available nationally.
- Treatment for general dentistry (except in South Australia where dentistry requiring a general anaesthetic and hospital admission is allowable) and from psychologists, physiotherapists, speech therapists and other allied health professional is generally not covered. Queensland alone allows some flexibility when allied health services are recommended as an essential component of care. In all other states, travel to allied health is not covered even when treatment (for depression, for example) could dramatically improve or stabilise the patient. These strictures unnecessarily limit treatments that have major impact on patient health and wellbeing. PATS should be extended to cover travel to all treatments considered essential by accredited health professionals.
- Assistance for travel for artificial limb fitting is not covered in SA, Victoria or NSW, and upgrade fittings are not covered in Queensland, because the treatment is not listed under the MBS because a technician fits the limb rather than a medical specialist. As these procedures are related to medical outcomes they should be included.

### **Term of Reference (c)**

There is also a lack of uniformity in PATS funding arrangements for patients who need to cross State/Territory borders to access specialist services.

- While the NT, Tasmania, the ACT and NSW enable cross-border travel when this is required to access the nearest specialist, other states do not cover interstate travel. This lack of uniformity needs to be addressed to recognise that there are communities of interest that straddle state/territory borders. Specialist located on one side of the border naturally intend their service catchment to encompass the whole of that recognised community and will have standard referral protocols with health care services in that community and its hinterland. Transport routes are also likely to service the natural (cross-border) community; travelling beyond the community hinterland may well make accessing transport more difficult. Requiring PATS patients to travel to more distant specialist (or primary) services may be an inefficient use of limited resources as well as inconvenient for patients. Cross-border travel should therefore be uniformly allowable under PATS where this facilitates access to the most appropriate health care provider.

### **Mode of Transport**

The type of travel for which patients are eligible for subsidy is closely prescribed. In most schemes, cost coverage or reimbursement is based on the cheapest means of transport, i.e. bus or train. Patients and their escort/carer may be required to travel up to 30 hours by train or up to 15 hours by car before being eligible for air fare coverage rates. Travel is reimbursed at a set rate per return journey rather than an actual cost of travel rate, leaving those who need to travel frequently, eg for chronic disease management, or those without resources, facing affordability issues. The ability to waive these limits to finance air travel on a case by case basis when a patient's welfare will otherwise be detrimentally affected is a discretionary power in most states, but should be written into guidelines. In general, taxis to and from airports are not covered when public transport is available, leaving aged and infirm patients to negotiate public transport links and timetables. This is not desirable and the scheme should be amended to cover such costs as required to take account of the ease of the journey for aged patients. Lack of ease of access to health services is recognised as a disincentive to patient attendance at essential health care, especially for aged patients.

Fuel subsidies differ from 10c/km in Tasmania and Queensland to 16c/km in South Australia and should be standardised, taking account of remote area surcharges.

### **Patient Escorts**

The eligibility of patient escorts for PATS is limited to those who are required for the physical support only of the patient except in the case of minors. If an adult is to be accompanied, the medical need has to be proven by a statement from the treating practitioner. Emotional support is only an eligible requisite in Queensland and South Australia.

For aged Australians, reducing limitations on PATS support for patient escorts is critical. Early discharge from hospitals, attendance at outpatients and day treatment at

doctors' surgeries means that older people must travel more frequently for health care, often under circumstances where they require support while travelling. Overnight accommodation is covered in all states and territories if the return journey to receive specialist treatment cannot be made in one day, but the criteria for eligibility are inordinately harsh, eg accommodation is covered if the patient needs to drive more than 650 km *one way*. The number of nights covered is limited.

These funding arrangements gives no consideration to the fact that same day procedures require consumers to attend hospital early in the morning, creating enormous difficulties for those travelling long distances, and similar problems are caused by discharge late in the day and/or at short notice. The immediacy of discharge from regional hospitals under pressure to maximise bed occupancy rates has seen cases where transport arrangements have had to be hurried, and convalescent aged patients have been stranded at night. Expenses such as meals are not covered by any state scheme. Aged patients who have to travel long distances to access treatment may be particularly vulnerable and stressed by these circumstances and may decline to seek subsequent or follow-up treatment.

ACSA understands that that there are some innovative transport programs in various states that have demonstrated how the PATS funds can be used more creatively to better meet the needs of the target group.

### **Indigenous Australians**

All of these issues are exacerbated for older Indigenous Australians living in rural and remote locations. Overall, Indigenous people living in rural and remote Australia have lower income and are less likely than others to have their own transport. Most remote communities have no access to public transport, so patients from such areas have considerable barriers to accessing the 'mainstream' health system. They also experience more cultural difficulties when interacting with that system.

For many reasons, then, it is appropriate that additional assistance be given to Indigenous people in remote communities, such as reduction in the required distance for travel when there is no public transport, and 'topping-up' of assistance payments when they have no resources to add to the subsidy received. The lack of additional assistance, cultural reasons such as inability to travel at certain times, communication and literacy issues, and lack of understanding of the system, all significantly contribute to Indigenous patients' non-attendance for care and treatment.

Most jurisdictions have specific programs to assist Indigenous people from outer rural and remote areas who need to travel to access specialist health care, but patients and providers are often not aware of these. For Indigenous patients in the NT and SA, for example, travel and accommodation are arranged in advance by specific units, and at the hospital to which the patient is referred there are Aboriginal Liaison Officers who can help with paperwork, if necessary, and may pass on the relevant forms to the administrator of the scheme. In NSW, Aboriginal health organisations may transport eligible Indigenous patients to specialist appointments in major centres, and can claim travel and accommodation assistance directly on behalf of their clients. Such initiatives are to be applauded and should be adopted by all states and territories, along with promotions to enhance program and eligibility awareness.

## **Recommendations for the Effective Operation of PATS for Older People**

1. In general, no older person in rural or remote Australia should be unable to access appropriate treatment because of the cost of transport.
2. PATS schemes in all states and territories should have greater national uniformity of administration and uniform principles of eligibility so that there is consistency across the country to allow all people in rural and remote areas to have the same equity of access to health services, as those in cities. It is important to ensure that flexibility exists to allow innovative approaches to operate in response to local conditions.
3. There is a need to extend the PATS scheme to cover travel to health care at the primary and preventative end of the health care spectrum for aged patients including allied health and dental care. PATS should provide people from remote and rural areas with reasonable reimbursement for accessing all services that are not available in their own communities.
4. In remote communities where a nurse or nurse practitioner is the sole local primary care provider, they should be able to make PATS referrals without reference to a GP.
5. Administrators and Patient Assistance staff should be able to exercise discretion and flexibility about transport arrangements. Limits such as 30 hours on a train or 15 hours in a car may be detrimental to the patient's health.
6. The possibility for carers to escort patients not just for physical support, should apply in all states, once it is approved by the patient's GP.
7. Assistance should be extended for all patients for whom specialist care is not available locally, not only those patients travelling to and from their permanent residence. In particular, eligibility should be extended to cover patients domiciled in aged care facilities.
8. There should be allowance for patients to visit a more distant specialist if the waiting list for the closest available provider exceeds clinically acceptable time frames. This is a particularly positive aspect of the scheme in some states, which should become standard in all jurisdictions.
9. The schemes should be widely publicised and promoted in a range of user friendly formats.
10. Discussions should take place at the Council of Australian Governments as a matter of urgency, with consideration given to how transport to health care services for older Australians will be resourced in the 2008 Australian Health Care Agreements.

## **References**

National Aged Care Alliance *Transport and Access to Health Care Services for Older Australians* (Position Paper) May 2007.

National Rural Health Alliance Inc. *Transport and Accommodation Assistance for Health Patients from Rural and Remote Areas* (Position Paper) October 2005.

National Rural Health Alliance Inc. and Aged and Community Services Australia *Older People and Aged Care in Rural, Regional and Remote Australia* (National Policy Position) September 2005.