CHAPTER 1

INTRODUCTION

Terms of Reference

1.1 On 28 March 2007 the Senate, on the motion of Senator Adams, referred the following matter to the Community Affairs Committee for inquiry and report by 20 September 2007:

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;

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

(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;

(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;

(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;

(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;

(g) the relationship between initiatives in e Health and Patient Assisted Travel Schemes;

(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; and

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

Conduct of the inquiry

1.2 The inquiry was advertised in *The Australian*, several regional papers and through the Internet. The Committee invited submissions from Commonwealth, State and Territory Governments, Patient Assisted Travel Scheme (PATS) coordinators and other interested organisations and individuals.

1.3 The Committee received 190 public and four confidential submissions. All State and Territory Governments and the Commonwealth Government provided submissions. A list of individuals and organisations that made public submissions to the inquiry together with other information authorised for publication is at Appendix 1.

1.4 The Committee held six days of public hearings in Canberra, Alice Springs, Melbourne, Perth, Launceston and Brisbane. While in Alice Springs, the Committee undertook discussions and inspections at the Alice Springs Base Hospital, Central Australian Aboriginal Congress, and the Western Desert Dialysis Unit. Witnesses who gave evidence at the hearings are listed in Appendix 2.

Background to the inquiry

The Broader Context – Australia's health care system

1.5 Australia has a complex health care system with all levels of government playing a role in the funding and/or provision of health services. The system is financed by a mix of public (government) and private (individuals, private health insurers, injury compensation bodies) funds.

1.6 In 2003-04 an estimated total of $78.6 billion (9.7 per cent as a proportion of Gross Domestic Product) was spent on health as follows:

- Commonwealth Government – estimated $35.7b (45.5 per cent);
- State/Territory and Local Governments – estimated $17.7b (22.6 per cent); and
- Private sector – estimated $25.1b (32 per cent).[1]

Commonwealth Government

1.7 The Commonwealth Government plays a principal role in the provision of universal access to medical, pharmaceutical and hospital services through the Medicare arrangements. This includes the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS) and the Australian Health Care Agreements (AHCAs).

1 AIHW, *Health Expenditure Australia 2003-04*, September 2005, pp.18-19.

1.8 Under the MBS, the Commonwealth subsidises patient costs for medical services provided on a fee-for-service basis. These services include medical consultations, surgical procedures, diagnostic services, and a range of preventative health checks and allied health services. The PBS subsidises the cost of pharmaceuticals for all Medicare-eligible people. The Government contributes to the funding of public hospitals through the AHCAs. The AHCAs are five-year bilateral agreements between the Commonwealth and the States/Territories, which set out the Commonwealth Government's financial commitment and the conditions and obligations of the States and Territories underpinning the provision of free public hospital services.[2] The current agreements will expire on 30 June 2008.

1.9 The Commonwealth Government is also involved in the supply and distribution of the medical workforce,[3] and provides the bulk of funding for high-level residential care and health research.[4]

State, Territory and Local Governments

1.10 State and Territory Governments are principally responsible for the provision of public hospital infrastructure and services, community health services, mental health programs, patient transport and population health programs.[5] Local Governments also contribute to the delivery of health programs.

Private sector

1.11 The private sector plays a significant role in the delivery of primary, specialist and allied health care. Services are provided by general practitioners, specialists, pharmacists, dentists and a range of other allied health professionals. In general, services are provided on a fee-for-service basis with financial assistance provided through Medicare.

1.12 Private hospitals complement the public hospital system. There are also private health insurers who offer a range of health insurance products.[6]

1.13 The non-government (not-for-profit) sector also holds an important place within Australia's health care system. Community organisations, research and educational bodies, consumer and support groups and professional bodies provide health services, which ease the 'burden' on the government sector.[7]

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2 *Submission* 157, pp.5-6 (DoHA).

3 *Submission* 157, p.6 (DoHA).

4 AIHW, *Health Expenditure Australia 2003-04*, September 2005, p.2.

5 *Submission* 157, p.6 (DoHA).

6 *Submission* 157, pp.6-7 (DoHA).

7 Senate Community Affairs References Committee, *The Cancer Journey: informing choice*, June 2005, p.17.

Health care and travel assistance

> Effective health care depends on access to that care, but the sheer size of Australia precludes easy physical contact between patients living in rural and remote areas and medical specialists, the majority of whom are in urban centres.[8]

1.14 While Australia has a relatively sophisticated public and private health care system, for some people geographic isolation inhibits their access to specialist health care. Out of a total population of just over 21 million,[9] approximately 34 per cent of Australians reside in regional, rural and remote areas with limited specialist health services.[10]

1.15 To improve patient access all States and Territories have established a Patient Assisted Travel Scheme (PATS). The schemes provide assistance – in the form of travel and accommodation subsidies – to patients for whom specialist medical care is not locally available.

1.16 The State-based schemes replaced the Isolated Patients Travel and Accommodation Scheme (IPTAAS), which was centrally administered by the Commonwealth Government.

Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)

1.17 The Commonwealth Government established IPTAAS on 1 October 1978. The scheme provided financial assistance to persons living in rural and remote areas who had to travel long distances (more than 200 kilometres) to obtain specialist medical treatment and oral surgery.[11]

1.18 In June 1985 a working party comprised of Commonwealth, State and Territory officials was established to review the scheme and related patient transport issues. It was agreed that responsibility for the administration of the scheme should be transferred to the States and Territories.[12] The then Minister for Health, the Hon. Neal Blewett announced that IPTAAS would be abolished from 1 January 1987 with funding provided directly to the States and Territories through special revenue (financial) assistance grants. It was stated that the Commonwealth would provide

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8 *Submission* 55, Attachment 1, p.6 (NRHA).

9 ABS, *Population clock* (accessed 13 September 2007).

10 *Submission* 90, p.1 (RDAA).

11 Senate Community Affairs Committee, *Breaking the silence: a national voice for gynaecological cancers*, October 2006, p.87; see also *Submission* 157, p.7 (DoHA).

12 Mr Robert L. Chynoweth, member for Dunkley, *House of Representatives Hansard*, 7 October 1986, p.1587.

funding of $21.8m (indexed) per year to the States and the Northern Territory.[13] This was an increase of 26 per cent of Commonwealth benefits paid in 1985-86.[14]

1.19 Dr Blewett explained that IPTAAS had been the subject of criticism from a number of sources including State and Federal members of Parliament, consumer advocacy groups, individuals, social worker associations, the Commonwealth Ombudsman and the Administrative Appeals Tribunal. The principal concern was that the Commonwealth Government lacked the requisite local knowledge and delivery mechanisms to respond flexibly to the needs of different geographical communities. Dr Blewett concluded that the States and Territories would be able to administer the scheme more effectively:

> [T]he Commonwealth is poorly placed to administer any scheme of this nature, having no suitable delivery and processing mechanism outside the capital cities and at best only a second-hand knowledge of available services. On the other hand, State hospital and welfare delivery networks are well established and some already provide cash advances to the needy in anticipation of IPTAAS benefits. Accordingly, the States and Territories are well placed to develop and administer more flexible and effective measures for those in need.[15]

1.20 The State-managed schemes became known generally as the Patient Assisted Travel Schemes (PATS), with different titles adopted across the States and Territories.

PATS funding

1.21 In 1999, the States and Territories surrendered the Financial Assistance Grants in return for the Goods and Services Tax (GST) revenue stream.[16]

1.22 As noted above, funding is granted to all States and Territories for the provision of free public hospital services through the AHCAs. The Department of Health and Ageing pointed out that under the AHCAs, the States and Territories must ensure that people have equal access to public hospital care regardless of their geographic location. Therefore, while funds are not specifically earmarked for patient transport, PATS is one obvious mechanism to achieve equal patient access.[17]

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13 As noted by the Department of Health and Ageing, the transfer of the travel scheme predated self government in the ACT. *Submission* 157, p.7 (DoHA).

14 The Hon. Neal Blewett, MP, Minister for Health, 'Budget Information 1986-87', *Press release 147*, 19 August 1986 and *House of Representatives Hansard*, 17 September 1986, p.847.

15 The Hon. Neal Blewett, MP, Minister for Health, *House of Representatives Hansard*, 17 September 1986, p.847.

16 *Submission* 157, p.7 (DoHA).

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

Other forms of patient travel assistance

1.23 The *Private Health Insurance Act 2007* regulates private health insurance benefits including patient travel and accommodation. Roughly half of all private health insurers provide some form of travel and accommodation cover for their members who must travel a specified minimum distance to receive health care. Benefits vary across insurers, with a basic benefit offering $30-$40 for travel, $30-40 for accommodation and a limit of $200 per person per year.[18]

1.24 Transport services are one of a range of services provided through the joint Commonwealth and State/Territory Government program, Home and Community Care (HACC). The HACC program supports frail elderly Australians and people with a disability and their carers to maintain independent living. Transport is provided for attendance at medical appointments along with other activities such as shopping and social outings.[19]

1.25 A number of not-for-profit organisations – including volunteer organisations – provide free or subsidised transport to medical appointments. Further, there are various (but limited) accommodation facilities, which house patients undergoing specialist treatment. This is discussed in chapter 6.

Current arrangements – Patient assisted travel schemes (PATS)

Case Study

The PATS system…is administered locally with States and Territories having different rules, for example: if Carly had lived in Cape York Queensland she would have had an escort paid for by the PATS system if she was an Aboriginal or Torres Strait Islander woman, not if she was a non-Indigenous Australian. In remote NSW Carly would have had to pay the bus fares up front claiming back a proportion if she was able to prove financial hardship, an escort would probably not have been approved. In the Kimberley in Western Australia a trip home could have entailed a 12 hour overnight bus trip where Carly was too frightened to sleep in case she dropped her baby. In the Northern Territory she may have had an escort paid for if the remote staff had pushed hard enough and if she had had a sympathetic medical officer to approve it; though this often depends on the PATS budget at the time and the amount of pressure being applied to decrease it.

Source: Submission 147 p.2 (Associate Professor Sue Kildea).

1.26 The health departments in each State and Territory oversee their respective schemes. As noted above, the schemes assist patients to access planned (non-emergency) clinical care that is not available locally. With a few exceptions, the schemes cover patients accessing treatment from medical specialists only; allied

18 *Submission* 157, Attachment B, p.1 (DoHA).

19 *Submission* 157, Attachment B, p.1 (DoHA).

health care is excluded. Assistance involves a contribution towards the travel and accommodation costs of the patient and, in some circumstances, the patient's escort. The schemes are expressly subsidy schemes. They are not designed to cover the full cost of transport and accommodation or other costs incurred such as meals and incidental expenses.[20]

1.27 To be broadly eligible for travel assistance patients must be residents of the jurisdiction in which they are making an application and must not be entitled to other sources of financial assistance such as the Department of Veterans' Affairs' travel assistance or other compensation schemes.

1.28 Whilst the schemes have some basic features in common, travel assistance arrangements vary across the States and Territories with different eligibility criteria, subsidy levels, requirements for patient contributions and areas of medical care covered.

1.29 An overview of the travel schemes on a State-by-State basis is provided below, along with a brief outline of relevant demographic and geographic characteristics. A table of major features of each scheme is included.

New South Wales - demographic and geographic characteristics

1.30 The population of NSW is just over six and half million. Over 25 per cent of the population live outside of the major centres of Sydney, Newcastle and Wollongong.[21] The percentage of Indigenous Australians residing in NSW is 2.1 per cent.[22]

New South Wales – travel scheme overview

1.31 NSW retained the Commonwealth title for its travel scheme – IPTAAS – until 2006 when the scheme was integrated with other transport schemes under the program *Transport for Health*. The policy provides a framework for all non-emergency health-related transport services – including patient assisted travel. Under *Transport for Health*, the various transport services have been integrated into one multifaceted program, which is delivered through six Transport for Health units within the four NSW rural Area Health Services.[23]

1.32 NSW Health noted that *Transport for Health* has the aim of improving patient access to health services by:

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20 *Submission* 55, Attachment 1, p.6 (NRHA).

21 *Submission* 188, p.3 (NSW Health).

22 ABS, *2006 Census QuickStats*, www.censusdata.abs.gov.au (accessed 2 August 2007).

23 NSW Department of Health, *Transport for Health Policy 2006-2011*, August 2006, p.1; see also *Submission* 188, p.7 (NSW Health).

- responding to the health transport needs of patients in a consistent, strategic and efficient manner;
- developing and maintaining working partnerships with transport providers and stakeholders; and
- recognising the role and importance of health transport in service planning and delivery within the NSW Health system.[24]

1.33 On 1 July 2006, two changes to the scheme took effect: the vehicle allowance was increased to fifteen cents per kilometre and the distance eligibility threshold was reduced from 200km to 100km (one way).[25]

1.34 In 2006-7, the total budget for the *Transport for Health* program was $15.9 million. In the previous year, just under $8.2 million in IPTAAS benefits was paid out for 40,082 claims. The average benefit paid per claim was $141.[26]

Australian Capital Territory - demographic and geographic characteristics

1.35 The ACT's population is 324,034. Of this total, 323,056 reside in Canberra with the remainder in relatively close proximity to the city. Indigenous peoples comprise 1.2 percent of the ACT population.[27]

Australian Capital Territory – travel scheme overview

1.36 The ACT operates an Interstate Patient Travel Assistance Scheme (IPTAS). All permanent ACT residents are eligible for the scheme as the ACT does not impose distance criteria. ACT residents are eligible for assistance toward travel and accommodation costs incurred irrespective of whether they hold concession cards.

1.37 In 2007-08 the ACT expects 1,800 claims for travel and accommodation assistance totalling an estimated $625,000. A recent review of the scheme resulted in an increase in reimbursement amounts as well as putting in place mechanisms for regular review of the amounts reimbursed under the scheme.[28]

Northern Territory - demographic and geographic characteristics

1.38 The Northern Territory's population is just under 200,000[29] and is widely dispersed over a vast area. The NT encompasses 17.5 per cent of Australia's total land mass. Close to 60 per cent of people in the NT live in the major urban areas of

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24 *Submission* 188, p.8 (NSW Health).

25 *Submission* 188, p.11 (NSW Health).

26 *Submission* 188, pp.18-20 (NSW Health).

27 ABS, *2006 Census QuickStats*, www.censusdata.abs.gov.au (accessed 2 August 2007).

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

29 ABS, *2006 Census QuickStats*, www.censusdata.abs.gov.au (accessed 2 August 2007).

Darwin, Palmerston and Alice Springs. The remaining 40 per cent reside in regional towns, Indigenous communities and pastoral properties.[30]

1.39 A total of 29 per cent of the NT population are Indigenous Australians, far exceeding all other States and the ACT on a percentage basis. Approximately 70 per cent of Indigenous peoples in the NT reside outside of the major urban centres, with a number living on remote communities. As a result, they have limited access to public or private health services.[31]

1.40 Overall, people that live in the NT are the youngest Australians, with a median age of 31 years compared with the national average of 37 years. The median age of Indigenous people in the NT is lower than non-Indigenous people. This is a function of a higher birth rate, having children at an earlier age and the shorter life expectancy of Indigenous people.

1.41 The NT Government noted that the NT has the highest burden of fatal disease and injury in Australia. Cardiovascular disease, mental disorders, cancers, unintentional injury and chronic respiratory disease are the principal contributing conditions. A significant proportion of the Indigenous population live with one or more chronic illnesses such as cardiovascular, diabetes, renal and respiratory diseases.[32]

Northern Territory – travel scheme overview

1.42 In the NT, the scheme is known as the Patient Assistance Travel Scheme (PATS) and sits within a broader travel assistance program – the Patient Travel Scheme (PTS), which also includes Inter-hospital Transfer and Medical Evacuation. PATS is funded by the NT Government at $6 million per year. The scheme is administered through the NT Hospital Network, which includes five public hospitals – two in central Australia and three in the top end. Each of the five hospitals has a PATS officer.

1.43 The scheme is promoted to patients through the NT Government website, posters, brochures, health boards and the patient-GP interface. The scheme is monitored through 'specific patient travel data collection and reporting'.[33]

1.44 The travel scheme was last reviewed in the NT in 2004. A separate review of the staff training manual was recently completed.[34]

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30 *Submission* 164, p.3 (NT Government).

31 *Submission* 164, p.3 (NT Government).

32 *Submission* 164, p.3 (NT Government).

33 *Submission* 164, pp 2-3 & 9 (NT Government).

34 *Committee Hansard*, 5.7.07, p.48 (Dr L Firth, NT Government).

Queensland - demographic and geographic characteristics

1.45 Queensland's population is close to four million. Of this four million, 3.3 per cent are Indigenous Australians.[35] The south-east corner of the State and the larger regional coastal centres are densely populated with close to two-thirds of the Queensland population. In contrast, large tracts of the state are very sparsely populated.[36]

1.46 Queensland Health identified three demographic factors that present challenges to the delivery of health care in Queensland: an ageing and growing population, a decentralised population and a diverse population. Queensland is currently experiencing the highest rate of population growth in Australia, with an expected increase from four million to 5.6 million within 20 years. It is projected that the bulk of this growth will be concentrated in the older age groups.[37]

1.47 As with the general Queensland population, the health workforce is unevenly distributed across the state, with a concentration of workers in the south-east. Areas with a low population density struggle to attract health professionals or have sufficient 'throughput of patients' to maintain workforce skills. Queensland has the second lowest number of health professionals on a per capita basis.[38]

1.48 Queensland Health noted that within the state's population there are significant differences in health status and life expectancy. Consistent with the country more broadly, disadvantaged population groups such as Aboriginal and Torres Strait Islander peoples and those experiencing socio-economic disadvantage have higher rates of ill-health and death.

Queensland – travel scheme overview

1.49 In Queensland, the scheme is known as the Patient Travel Subsidy Scheme (PTSS). It is broadly administered by Queensland Health with the day-to-day running of the scheme undertaken by public hospitals.

1.50 Queensland Health recently reviewed the scheme and, as a result, is making the following changes:

- redesigning and streamlining the application forms;
- updating PTSS brochures and information sheets;
- reworking the administration guidelines to improve consistency of interpretation; and

35 ABS, *2006 Census QuickStats*, www.censusdata.abs.gov.au (accessed 2 August 2007).

36 *Submission* 184, p.2 (Queensland Health).

37 *Submission* 184, p.2 (Queensland Health).

38 *Submission* 184, p.3 (Queensland Health).

- raising the mileage subsidy from 10 cents to 15 cents per kilometre (already implemented).[39]

South Australia - demographic and geographic characteristics

1.51 South Australia's population is just over 1.5 million with some 429,000 living in rural areas. Of this number, 1.7 per cent are Indigenous Australians.[40]

1.52 The SA Government pointed to the remoteness of many communities and the large number of small towns in South Australia. This presents significant challenges. The general lack of resident country specialists creates a high reliance on access to transport to the city for specialist medical services. On any given day there are about 550 country inpatients in metropolitan hospitals receiving treatment and care.[41]

South Australia – travel scheme overview

1.53 In broad terms, PATS in South Australia provides for treatment by the nearest registered specialist for patients residing more than 100kms from the treatment centre.

1.54 In some communities different models of administration have been applied to enable better management and support, particularly for remote communities. An example is the Nganampa Health Council, an Aboriginal Community Controlled Organisation located in the APY Lands, where people travel both to the Northern Territory and to Adelaide or other South Australian regional centres depending on their health needs and cultural linkages. To facilitate service delivery, funding from PATS has been cashed out to Nganampa Health Council to enable them to manage their own PATS service for their clients.

1.55 At the time of transfer of the IPTAAS scheme from the Commonwealth Government to the States and Territories, SA's PATS funding in 1987-88 was $1.8 million. For 2006-07, it is projected that actual expenditure on PATS will be around $6.95 million for an estimated 41,600 claims. The average cost per claim is estimated at $167.06.

1.56 In 2006 PATS was included in a review under the *Patient Journey Initiative.* In response, the SA Government has announced the establishment of an overarching support program – the *Transport and Patient Support Program*.

1.57 A key component of this program is enhanced transport support, which includes a Health Bus Network. The key elements of the proposed Health Bus Network are:

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39 *Submission* 184, pp.3-4 (Queensland Health).

40 ABS, *2006 Census QuickStats*, www.censusdata.abs.gov.au (accessed 2 August 2007).

41 *Submission* 165, p.4 (SA Government).

- a door-to-door service incorporating expanded Community Passenger Networks and a significant number of identified contracted Health Bus routes;
- a nominal vehicle allowance proposed for those choosing to take a private vehicle;
- additional air travel (Medical Specialist Services Only if approved) and provision for special circumstances;
- assistance for the metropolitan component of the journey could be enhanced by two new patient support programs, a 'Meet & Assist' service and the provision of two 'Transit Lounges' through NGO's; and
- support for accommodation costs will remain only for specialist medical services.

To complement the transport system, additional patient support could be provided in partnership with Non Government Organisations (NGO's). A trial of the Health Bus Network will be implemented in one country region and pending a satisfactory evaluation, will be rolled out across country SA.[42]

Tasmania - demographic and geographic characteristics

1.58 The total population of Tasmania is approximately 489,000 with 16,900 (3.5 per cent) Indigenous Australians.[43]

1.59 As Tasmania has a relatively low population, a range of specialist services are not available intrastate. In the 2005-06 financial year, roughly $1.6 million was spent on interstate travel with only $800,000 spent on intrastate travel.[44]

Tasmania – travel scheme overview

1.60 The Acute Health Services Group in the Department of Health and Human Services (DHHS) funds the Patient Travel Assistance Scheme (PTAS) in Tasmania. Financial assistance is provided for both intra- and inter-state travel to access eligible specialist services.[45]

1.61 The three major hospitals in the state each have a PTAS travel coordinator, who assess patient eligibility and, in the case of interstate travel, assist with transport and accommodation bookings.[46] The PTAS Review Committee – comprised of the

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42 *Submission* 165, pp.7-8 (SA Government).

43 ABS, *Population Distribution, Aboriginal and Torres Strait Islander Australians* 2006, Cat. No. 4705.0, p.5.

44 *Committee Hansard*, 23.7.07, p.4 (Dr P Renshaw, Launceston General Hospital).

45 *Submission* 183, p.3 (Tasmanian Government).

46 DHHS, 'Patient Travel Assistance Scheme (PTAS)', interstate and intrastate information sheets, www.dhhs.tas.gov.au/services (accessed 14 August 2007).

PTAS travel coordinators and medical authorisers – is responsible for reviewing and monitoring the travel scheme as well as serving as an appeals mechanism.[47]

Victoria - demographic and geographic characteristics

1.62 Victoria has close to five million residents. Victoria has a relatively low number of Indigenous residents – 0.6 per cent Victoria's population.

Victoria – travel scheme overview

1.63 In Victoria, the travel scheme is known as the Victorian Patient Transport Assistance Scheme (VPTAS). In the last five years, the number of recipients of VPTAS payments has increased by 64 per cent, with VPTAS real expenditure (above CPI increases) increasing by an average of 8.7 per cent per annum. Projected VPTAS expenditure for the 2006-2007 financial year is nearly $6 million. In 2005-06, approximately 34,000 VPTAS claims were paid to nearly 12,000 recipients.[48]

1.64 In 2001 changes to VPTAS were introduced:

- car travel subsidy increased from 11 to 13 cents per kilometre, with reviews recommended every two years, based on local operating costs as determined by the Royal Automobile Club Victoria (the rate was subsequently lifted to 14 cents);
- the patient and escort travel contribution was abolished for concession cardholders;
- the patient and escort travel contribution for non-concession cardholders was reduced to a maximum of $100 in a treatment year; and
- accommodation assistance was made available for the first night for patients and escorts.[49]

1.65 Reviews of VPTAS policy and guidelines were conducted in 2001, 2004 and 2006. A review of VPTAS claims processing was also undertaken in 2006 leading to increased administrative efficiency and consistency.[50]

1.66 The Victorian Government stated that VPTAS plays an important role in assisting equitable access to specialist medical services for those most in need by reducing the cost of travelling to appointments. However, it stated that it is 'also working to improve patient access to the right care in the best setting, as close to home as possible'.[51]

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47 *Submission* 183, p.4 (Tasmanian Government).

48 *Submission* 182, pp.2,5 (Victorian Government).

49 *Submission* 182, p.8 (Victorian Government).

50 *Submission* 182, p.6 (Victorian Government).

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

Western Australia - demographic and geographic characteristics

1.67 Western Australia has a population of just under two million. Three per cent of the population are Indigenous Australians.[52] The WA Government explained that:

> The WA Country Health Service (WACHS) is the single biggest Area Health Service in Western Australia, and the largest country health system in Australia. It services an area of some 2.55 million square kilometres with a combined regional population of 454,000 people (almost a quarter of the State's population), including 44,900 Aboriginal people (around 10% of the State's total rural population).[53]

WA – travel scheme overview

1.68 The WA Government stated that PATS 'provides a safety net to enable patients to gain access to the nearest appropriate medical specialist'. In the 12 months ending 31 March 2006, the scheme assisted a total of 51,089 trips at a cost of $13.9 million. The majority of trips were made by private vehicle; however the largest item of expenditure was for air fares – over $6.4 million. Some $2.7 million was paid for accommodation costs. Over 41,000 trips were made to Perth with a small number interstate (275).[54]

1.69 The WA Government indicated that the scheme is reviewed regularly and improvements made to administrative practices on an on-going basis, subject to budget constraints. Following reviews in 2002 and 2005, the scheme was amended to:

- provide a safety net for patients who regularly travel between 70-100 km (one way) to access specialist medical services;
- improve awareness of the scheme among health professionals and potential recipients;
- provide assistance to patients in advance of travel for the booking and payment of transport and accommodation, and for the purchase of fuel; and
- increase the subsidy rate for frequent travellers (those with chronic conditions) and for group travel from remote communities.[55]

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52 ABS, *2006 Census QuickStats*, www.censusdata.abs.gov.au (accessed 2 August 2007).

53 *Submission* 39, p.1 (WA Government).

54 *Submission* 39, p.2 (WA Government).

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

Table 1.1: Summary of PATS in Australia

	Eligibility requirements	Nearest specialist	Travel assistance	Accommodation assistance	Patient contributions	Escorts
NSW	Patient must: - be a permanent resident of NSW or Norfolk Island; - reside more than 100 km (one way) from nearest treating specialist; - referred by medical practitioner to specialist, by optometrist, by dental practitioner to specialist for oral surgery or orthodontics for cleft lip and palate	Referred to nearest specialist; includes nearest appropriate interstate specialist; exceptions made in certain circumstances. Referrals initiated by nearest specialist for a 2nd opinion or referral to another specialist also accepted; interstate referral if treatment not available in NSW	Assistance provided for rail or bus at economy rates Fuel subsidy of 15c/km for private car or hire car Air travel available if valid medical reason put forward by GP or treating specialist and prior approval received Partial reimbursement of relevant taxi and public transport cost	Payable if: - referring practitioner certifies in-transit accommodation required for medical need; - transport schedules require overnight stay; - treatment as outpatient. Commercial: $33 per night (single); or $46 per night (double) Private: $30 per week after 1st week for pensioners or Health Care Card holders	$40 ($20 for pensioner or Health Care Card holders) personal contribution deducted from the total benefits paid per claim	Medical practitioner or treating specialist certifies that escort medically necessary to accompany patient and/or remain during treatment; or patient under age of 17 years
Qld	Patient must: - be a permanent resident; - service being sought not within 50 kms of nearest public hospital; - referred by medical practitioner, in remote areas by a remote area nurse, by dental services or by an ophthalmologist	Referred to closest service of its type; some exceptions including travel to a more distant service if support of family and friends available	Assistance provided at the cost of the least expensive form of public transport from the town of local hospital to the transport terminal of the town the patient is travelling to Fuel subsidy of 15c/km for private car calculated from post office nearest to local hospitals to post office nearest to medical facility being attended	Available for minimum period required to be away for medical reasons; one nights accommodation if travelling more than 600 kms or 8 hours Commercial: $30 per night per person for concession card holders Private: $10 per night per person for concession card holders Non-concession card holders pay first 4 nights each financial year	Nil	If hospital medical officer decides it is medically necessary or patient under 17 years of age

	Eligibility requirements	Nearest specialist	Travel assistance	Accommodation assistance	Patient contributions	Escorts
Vic	Patient must: - be a permanent resident in a DHS designated rural region or reside on Mornington Peninsula; - travel more than 100 km (one way) from place of residence or travel an average of 500 kms per week in a block of at least 5 weeks; - have a current referral by GP to the nearest approved medical specialist; by optometrist; by dental practitioner to nearest oral surgeon, orthodontist for cleft lip and palate; by breast screening service; by approved rural and remote area nurse; by psychologist to nearest psychiatrist	Referred to nearest approved specialist; includes specialists visiting rural and remote areas Nearest specialist can be bypassed if referring practitioner decides treatment is urgent	Assistance provided for most direct means of public transport at economy or concession rate Fuel subsidy of 14c/km for private car Air travel available if living more than 350 kms (one way) from nearest approved specialist Taxi fares reimbursed only when no other means of transport to travel from residence to nearest public transport or from public transport to nearest specialist	Payable if specialist states that it is necessary to be accommodated close to or at treatment location Commercial: Up to $30 per night each for patient and escort (if approved) for a maximum of 120 nights in a treatment year Private: Not eligible	First $100 deducted from travel each treatment year for non-concession card holders	Referring practitioner and treating specialist state escort appropriate and responsible for patient's needs; or patient under 18 years of age
ACT	Patient must: - be a permanent resident - referred by medical practitioner; by optometrist to ophthalmologist; by dental practitioner to specialist for surgery or orthodontics for cleft lip and palate	Referred to nearest treating specialist; exemptions where specialist service not available at nearest specialist including urgency of referral; referral from specialist to more distant specialist	Coach or rail cost of return economy ticket Fuel subsidy of 16c/km (from 1 July 2007) Air fares if certified by specialist	Commercial: $35 per night Private: $10 per night	Nil	Referring medical practitioner or treating specialist certifies escort necessary based primarily on medical or medically related need or patient under 17 years of age

	Eligibility requirements	Nearest specialist	Travel assistance	Accommodation assistance	Patient contributions	Escorts
WA	Patient must - be permanent resident; - travel more than 100 km (one way) from the nearest treating specialist - travel more than 70kms (one way) to access treatment for a chronic medical condition	Referred to nearest specialist Referral to another specialist only if regional service is unable to make appointment in a clinically acceptable time frame	Assistance provided at economy rate for bus or train Air travel only if required by medical condition or journey by road over 16 hrs Fuel subsidy of 13c/km for private car or 15/km for frequent travellers (more than 4 times per year) May be eligible for fuel voucher, taxi voucher or shuttle bus tickets	Available if forward and return journeys cannot be completed in 1 day; for stop-over if travelling by car more than 750 kms (one way); transport schedules do not permit return on day of discharge Commercial: Up to $35 per night. Private: $10 per night Max of $140 per week if patient enters into domestic rental agreement Non-concession card holders pay first 3 nights accommodation	Non-concession card holders pay first $50 for a maximum of 4 trips in 12 month period	Referring practitioner specifies escort required for physical well-being of patient or well-being of patient due to an effect of treatment to be received; or patient under 18 years
Tas	Patient must: - be a permanent resident - live more than 75 km (one way) by shortest practical route to access nearest appropriate specialist - resident of King Island and Furneaux Islands and have to leave island to access eligible specialist medical service - referred by medical specialist, oral/maxillofacial surgeon or rural GP	Referred to nearest specialist; interstate referrals only if treatment not available in Tasmania	Assistance provided at economy bus travel from patient's residence Fuel subsidy of 13c/km for private car Air fare for King & Furneaux Island residents or for travel interstate	Commercial: up to $30 per night for each approved person Private: not applicable Non-concession card holders pay first 2 nights	Card holders: $15 per trip; maximum contribution $120 per fiscal year Non card holders: $75 per trip; maximum contribution $300 per fiscal year	If referring specialist certifies escort necessary to provide active assistance while travelling or for specific medical reasons relating to treatment or patient aged under 18 years

	Eligibility requirements	Nearest specialist	Travel assistance	Accommodation assistance	Patient contributions	Escorts
SA	Patient must: - be a permanent resident of a rural region - travel more than 100 km (one way) to nearest medical specialist	Referred to nearest registered specialist; travel to interstate allowed through referring teaching hospital if treatment not available in SA	Assistance provided at economy rate for bus/ferry/train Fuel subsidy of 16c/km for private car Air travel only where medically endorsed	Commercial: up to $30 per night for patient and approved escort No reimbursement on 1st night for non-concession card holders Private: Not applicable	Patient contribution of $30 deducted from total travel benefits: means tested exemption for genuine hardship	Need for escort medically endorsed or person under 17 years
NT	Patient must: - be a permanent resident - live more than 200 km from nearest specialist service or interstate service if service not available in NT; exceptions for dialysis patients and aged and disabled patients	Referred to closest resident or visiting eligible service or nearest appropriate interstate specialist if service not available in NT	Assistance provided at the cost of an economy return bus trip from the bus depot closest to the patient's residence Air for Alice Springs/Darwin and interstate or medically necessary or no alternate means of transport Fuel subsidy of 15c/km for private car	Available if forward and return journey cannot be completed in one day, for follow-up treatment, or travel schedules do not permit immediate return Commercial: Up to $30 per night per person Private: $10 per night per person	Nil	If necessary to assist with patient care and support services at place of treatment cannot provide adequate assistance or patient under 16 years; mentally or physically disabled

Source: Submissions 150, (ACT Government); 164 (NT Government); 182 (Victorian Government); 183 (Tasmanian Government); 188 (NSW Health) and guides to patient assisted travel schemes published by each jurisdiction.

The call to improve the operation of Patient Assisted Travel Schemes

1.70 The lack of uniformity across jurisdictions and, consequently, the perceived lack of consumer equity form the basis of criticism of PATS. Along with this, concerns have been expressed in relation to cross-jurisdictional portability, subsidy levels, community awareness of the schemes and the scope of treatments covered under the schemes.

1.71 The need to improve the operation and effectiveness of PATS has been identified in several parliamentary and non-government reports.

Parliamentary inquiries

1.72 Three recent Senate inquiries have produced recommendations to comprehensively improve the operation of the travel schemes:[56] the inquiry into public hospital funding (2000), the inquiry into services and treatment options for persons with cancer (2005), and the inquiry into gynaecological cancer in Australia (2006). The most recent inquiry report – *Breaking the Silence: a national voice for gynaecological cancers* – recommended that:

> [T]he Council of Australian Governments, as a matter of urgency, improve the current patient travel assistance arrangements in order to:
>
> - establish equity and standardisation of benefits;
> - ensure portability of benefits across jurisdictions; and
> - increase the level benefits to better reflect the real costs of travel and accommodation.[57]

1.73 This echoes an earlier House of Representatives Committee report, which recommended that:

> the Department of Health and Aged Care work with state and territory governments to review patient assistance travel schemes, particularly in relation to eligibility criteria, escorts, return travel, cross-border issues, pre-

56 In addition, two inquiry reports include recommendations that aim to improve travel assistance for specific consumer groups. The Senate Community Affairs Committee recommended that 'the importance of access to appropriate transport and Patient Assisted Travel Schemes for people with disabilities be reflected in the terms of the next CSTDA', *Funding and operation of the Commonwealth State/Territory Disability Agreement*, February 2007, p.98. The (former) Senate Community Affairs References Committee recommended that: 'the Commonwealth Government work with State governments to assist Aboriginal and Torres Strait Islander women who have to give birth outside their communities by funding an accompanying family member, with funding provided through their patient transfer assistance schemes.', *Rocking the Cradle – A Report into Childbirth Procedures*, December 1999, p.15.

57 Senate Community Affairs Committee, *Breaking the silence: a national voice for gynaecological cancers*, October 2006, p.100.

> payment and access to allied health, dental and other non-medical services.[58]

1.74 Despite these appeals for reform, the Commonwealth Government has declined to take action on the basis that the schemes are the responsibility of the States and Territories. For example, the Government's response to the recommendation from the gynaecological cancer inquiry (cited above) calling for COAG to improve the schemes stated:

> Implementation of this recommendation is the responsibility of the state and territory governments. On 1 January 1987, responsibility for the provision of the Isolated Patient Travel and Accommodation Assistance Scheme (IPTAAS) - with funding - was transferred from the Commonwealth Government to the states and territories.
>
> States and territories are best placed to develop and administer flexible and effective measures for those in need, having regard to their own distribution of specialist services and the specific needs of their rural population.[59]

Other reports

1.75 The call to reform the travel schemes was also highlighted in the 2003 Radiation Oncology Jurisdictional Implementation Group (ROJIG) report.[60] The intergovernmental ROJIG was established by the Commonwealth and State/Territory Health Ministers to respond to a 2002 radiation oncology inquiry (the Baume inquiry) and provide advice on measures for improvement. The ROJIG final report was endorsed on 28 November 2003 at the Australian Health Ministers' Conference (AHMC) in Sydney. Alongside four other actions the Health Ministers agreed to:

> State and territory strategies to raise awareness of Patient Travel Assistance Schemes that are available to radiotherapy patients and consideration of a range of principles produced by ROJIG, which will help patients to access those schemes.[61]

1.76 In 2003, a report on cancer care was jointly prepared by the Clinical Oncological Society of Australia, the Cancer Council of Australia and the National

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58 House of Representatives Standing Committee on Primary Industries and Regional Services, *Time Running Out: Shaping Regional Australia's Future*, February 2000, p.326.

59 The Commonwealth Government, *Response to the Committee's Report - Breaking the Silence: a national voice for gynaecological cancers*, February 2007, http://www.aph.gov.au/Senate/committee/clac_ctte/gynaecological_cancer/gov-resp.pdf (accessed 15 May 2007).

60 Radiation Oncology Jurisdictional Implementation Group Final Report, September 2003.

61 Australian Health Ministers' Conference Joint Communique, 'Australian Health Ministers Announce Radiotherapy Plans', *Press release*, 28 November 2003.

Cancer Control Initiative.[62] It recommended that a national review of access issues be undertaken, 'including an investigation into problems with travel'.[63]

1.77 Similarly, the National Rural Health Alliance (NRHA) has called for a review of all State and Territory schemes with a view to achieving consistency across jurisdictions. Additionally, the NRHA has made a number of recommendations to improve or remedy other problems within the schemes.[64]

Outline of the report

1.78 The Committee received much evidence identifying problems in the schemes with many witnesses providing examples of their personal experiences. The Committee has used these to identify a number of issues common to all the schemes rather than assessing the schemes on a State-by-State basis. In this way, the Committee has been able to highlight the areas where major improvements can be made and to make recommendations which it considers will improve access to medical service for the many Australians living outside metropolitan areas.

1.79 Chapter 2 of the report provides a brief overview of health service delivery in regional, rural and remote Australia. Chapter 3 addresses the impact of the design and administration of PATS across all jurisdictions while chapter 4 discusses the provision of escorts and cross-border issues. Chapter 5 discusses the impact of PATS on particular groups including Indigenous Australians. Chapter 6 examines the role of charities and non-government organisations and the means of improving and integrating services. The Committee's discussion on reforming PATS, conclusions and recommendations are contained in chapter 7.

Acknowledgements

1.80 While in Alice Springs the Committee undertook an number of inspections and would like to thank Ms Maxine Chaseling, Branch Manager, Mrs Deanna Habib and Mr Matthew Strangeways from the Central Australian Aboriginal Congress; Ms Vicki Taylor, General Manager, and staff of the Alice Springs Base Hospital; Ms Sarah Brown of the Western Desert Dialysis Unit; Ms Sabina Knight, Senior Lecturer, Nursing and Remote Health Practice and Mr Tristan Ray from CAYLUS.

1.81 The Committee also expresses its appreciation to the individuals and organisations that made submissions to the Committee or gave evidence to the inquiry

62 Clinical Oncological Society of Australia, Cancer Council Australia and the National Cancer Control Initiative, *Optimising Cancer Care in Australia*, February 2003.

63 Clinical Oncological Society of Australia, Cancer Council Australia and the National Cancer Control Initiative, *Optimising Cancer Care in Australia*, February 2003, p.xvii.

64 *Submission* 55, Attachment 1, (NRHA).