Patient Assisted Travel Schemes: are they actually assisting rural Australians?

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Abstract

This paper reviews the State and Territory-based Patient Assisted Travel Schemes, taking into consideration the experiences of individual health providers and patients. We highlight current issues that interfere with access to the schemes and contribute to an unfair distribution of health care services amongst Australians.

We argue that to ensure equitable provision of medical services to patients from rural and remote regions, it is necessary to harmonise the current eligibility criteria and to provide uniform levels of financial support across jurisdictions. Furthermore, all States and Territories must adequately promote the Patient Assisted Travel Schemes and simplify the application processes to facilitate accessibility.

Introduction

Patient Assisted Travel Schemes (PATS) aim to provide equitable access to essential healthcare services for the 30% of Australians living in regional, rural and remote areas (1). Specifically, travel and accommodation subsidies are provided for non-metropolitan residents to access specialist health services that are not available within their local area (2). Given the limited provision of specialist medical services in rural and remote regions of Australia and the increasing prevalence of chronic diseases, it is paramount that PATS function effectively (3). To this end, in 2007, the Federal Senate launched an inquiry into the effectiveness of PATS (2). Whilst there have been various reviews of the different State and Territory-based schemes, it has been nine years since a nationwide systematic critique has been undertaken (4,5,6). This paper reviews the current State and Territory-based schemes, highlighting the issues associated with the variability of provision of services as supported by examples given by patients and providers. We recommend that for Australia to realise equitable accessibility to healthcare services, it is necessary to align eligibility criteria across States and Territories and to update the level of financial assistance to reflect actual costs. Furthermore, PATS must be adequately promoted, and a nationwide uniform and simplified application process should be developed to ensure ease of scheme accessibility.

Methods

Data presented in this paper describe a point in time analysis of the PATS system in Australia, and a literature review of the known issues pertaining to these schemes. The search strategy for this paper included searching PubMed, the Australian Institute of Health and Welfare database, the Australian Bureau of Statistics database and Hansard publications. Only English language papers were included in the search. Broad search terms included the following: Patient Assisted Travel Schemes, Government review, Policy, Issues and Recommendations.

Background

The Evolution of the Current Patient Assisted Travel Schemes. In the 40 years since the first scheme commenced, there have been several variations in authority and funding between State and Commonwealth Governments (2). The antecedent of PATS was the Isolated Patients Travel and Accommodation Scheme (IPTAAS), established by the Commonwealth Government on 1 October 1978 under the *National Health Act 1973* (2). The purpose of this scheme was to enable access to specialist medical care for those living more than 200 km from the closest practitioner by providing financial assistance to offset the cost of transport (2).

Following a review of the scheme in 1985, Commonwealth, State and Territory governments agreed that the responsibility for the scheme should be transferred from the Federal government to the realm of States and Territories to better address the different needs of local communities (2,5). In 1987 the Commonwealth IPTAAS was abolished and the current form of PATS commenced. Since 1999, in return for GST funding streams, each State or Territory has funded its PATS from within its own budget (2).

Current State and Territory-based Schemes. The State and Territory-based schemes share several common elements (7-14). The schemes are designed to provide partial financial support of travel and accommodation expenses for attending eligible specialist health services when they are not available within a certain distance of the patient's residential address. Travel assistance is usually based on the most economical form of transport, with patients reimbursed for attending the nearest specialist, regardless of preference or state borders. All schemes allow the patient to travel with an escort.

Eligibility criteria and the level of travel and accommodation subsidies differ across jurisdictions (Tables 1, 2, 3, 4). Although the reasons for variability have not been clearly articulated in published guidelines, differences in funding allocation is likely to be the predominant factor. This results in several issues. Firstly, from a patient perspective there is no apparent reason why eligible services and financial support vary depending on the area of residence. Secondly, differences in paperwork and regulations introduce an additional level of complexity both for healthcare providers and patients alike when interstate patient care is required.

Current issues with State and Territory-based Patient Assisted Travel Schemes

Issue 1: Non-uniform Principles of Eligibility

Distance. Eligibility criteria for distance vary among States and Territories and do not always offer a cumulative distance subsidy. This is particularly relevant for patients with chronic diseases such as renal replacement therapy who travel repeatedly (Table 1). The greatest disparity occurs between two neighbouring jurisdictions, Queensland (QLD) and the Northern Territory (NT), which have minimum one-way travel distance of 50 km and 200 km respectively (7,12). Only New South Wales (NSW), Victoria (VIC) and the NT provide a weekly cumulative distance criterion (8,10,12).

Table 1 Eligibility Criteria: Distance

State/Territory	Eligibility distance	
	One way (km)	Cumulative (km/week)
NSW	100	200
VIC	100	500
QLD	50	-
SA	100	-
WA	100	-
TAS	75	-
NT	200	400
ACT	-	-
Average	104	

Eligible Medical Services. There is lack of uniformity with respect to the health services that are eligible within PATS (see Table 2). For example, while fertility treatments are eligible in NSW, South Australia (SA), the NT and the Australian Capital Territory (ACT), they are not covered within the scheme for Tasmanian (TAS) residents and are not even mentioned in the guidelines for VIC, QLD and Western Australia (WA), thus contributing to inequality and confusion (7-14). Similar variability occurs for other health services such as health screening programs and specialist consultation for second opinions. The following story demonstrates the impact these services can have to individuals.

> In one case at Broken Hill, a female patient was traumatised by the care she received during pregnancy, which ultimately resulted in a stillbirth. She wished for a second specialist opinion with regard to her required ongoing care but as there was already a specialist in town (the one involved with her care during the pregnancy), she was ineligible for transport assistance to see an alternative consultant. (private conversation between a health care provider and S. Bachman. March 2016)

Table 2 Eligible Services Across States and Territories

State/ Territory	Eligible services							
	Specialist	Fertility	Clinical trials	Health screening programs	Special dentistry	General dentistry	Allied health services	Second opinion
NSW								
VIC								
QLD								
SA								
WA								
TAS								
NT								
ACT								

Green: eligible service
Red: non eligible service
Yellow: service available only in special circumstances
White: not addressed within State or Territory guidelines

Allied Health and Dental Services. Allied health and dental services are not available on many PATS schemes, or are eligible only under special circumstances (Table 2). Recognising the importance of these services both in prevention and management of many conditions, parliamentary inquiries have previously recommended their inclusion in PATS funding (5). States and Territories have been reluctant to expand eligible services given the scheme is already expensive. However, this short-term cost needs to be balanced with long-term gain. For example, in people with diabetes mellitus, regular access to podiatric care has the potential to prevent or delay amputations, thus reducing morbidity and expenditures over the longer-term. However, podiatry services are not included in any scheme, which has been noted to be a major issue in remote WA and NT, particularly within the Indigenous population (15). Expanding allied health availability for conditions such as these has potential to increase the cost efficiency of healthcare delivery and improve outcomes.

Escort Eligibility. All states and territories have provision for patient escorts, including automatic provision for children. However, many shortfalls have been highlighted by various reviews, particularly with respect to the Indigenous population. The SA, NT and WA reviews found that those from remote communities were particularly disadvantaged by limits on escorts, due to cultural and language differences which make negotiating health care difficult (5,6,8). For example, in the NT, pregnant women from remote communities are transferred to tertiary hospitals at 38 weeks gestation (6). However, there is no escort or accommodation provision for the woman's other children unless they are below the age of two (12).

> One Aboriginal mother from Yuendumu recounted that when she was transferred to Alice Springs at 36 weeks gestation, none of her three children were covered by PATS and had to remain in the community without seeing their mother for four weeks. While the children had care, being forced to leave her children for such a long period of time without any visits was challenging (private conversation between anonymous patient and R. Irwin. Yuendumu, NT; August 2015).

Issue 2: Non-uniform and Inappropriate Travel and Accommodation Benefits

Travel and Accommodation Reimbursements. Many differences in travel benefits exist between States and Territories. The per-kilometre subsidy for private vehicle travel differs between schemes (Table 3). Moreover, there is no reimbursement for taxi fares in QLD, TAS and ACT (7,9,11), while other states provide a contribution towards taxi expenses. Finally, five out of the eight states only cover intrastate travel assistance, except for NSW, the schemes do not cover travel related to emergency admissions (7-14).

Table 3 Travel Benefits

State/Territory	Travel benefits			
	Private vehicle (cc/km)	Public transport (cc/km)	Air travel	Taxi
NSW	22	Economy Rate	Medical reasons	20 dollars/visit
VIC	20	Economy Rate	> 350 km	Reimbursement
QLD	30	Economy Rate	Economy Rate	-
SA	21	Economy Rate	Medical reasons	Reimbursement
WA	16	Economy Rate	if > 16 hours by car	Exceptional Circumstances
TAS	21	Economy Rate	Economy Rate	-
NT	20	Economy Rate	Economy Rate	Reimbursement
ACT	38	Economy Rate	Medical reasons	-
Average	24			

There is overwhelming consensus across all the states that financial reimbursement for accommodation is inadequate to cover the costs of healthcare for rural and regional Australians (5,6,8). There are also significant discrepancies between the schemes in terms of reimbursement (Table 4). In NSW, patients are reimbursed $43 per night for single room accommodation, a subsidy last increased in 2005 (16). This fails to meet the Senate recommendation to regularly update subsidies to reflect changes in living costs (2). Similar findings came from the WA parliamentary inquiry and the NT review of PATS for accommodation (4,6). The WA review noted that insufficient subsidies contribute to patients sleeping rough near treatment centres in Perth (4). Similar problems are evident in other states (5,6,8).

Table 4 Accommodation Benefits

State/Territory	Accommodation benefits	
	Commercial (dollar/night)	Private (dollar/night)
NSW	43	20
VIC	41	-
QLD	60	10
SA	40	-
WA	60	20
TAS	66	-
NT	60	20
ACT	41.74	12.76
Average	51	

These shortfalls are particularly relevant if we consider that people living in rural and remote areas have lower average income, with 51% of households having disposable incomes in the lowest 2 quintiles, as opposed to 38% in capital cities (17). Hence, patients using PATS are less likely to be able to meet unexpected additional costs.

Flexibility with Transport Options. Current schemes do not make optimal use of air transport. Air travel reimbursements are provided if medically required or beyond a set travel distance. However, we consider these minimum distance requirements to be excessive. For example, the WA scheme only allows for air travel if surface travel would take more than 16 hours one-way (14). Additionally, flights may be cheaper than the combined cost of surface travel and necessary accommodation. For example, with regards to travel from Broken Hill to Adelaide, a healthcare provider described a common patient experience:

> Buses from Adelaide run 3 times per week but only when there are enough passengers to make the trip. Specialist appointments frequently do not match the bus schedule. This means that patients may need to claim reimbursement for several days accommodation before they are able to return home (Bachman S., oral communication, March 2016).

Allowing flexibility to book air travel in these cases would not only save money, but also allow more time with family, decreased travel time and reduced time spent away from home, all substantial considerations for sick patients.

Issue 3: Lack of Promotion and Complexity of the Application Process

Awareness of PATS. Different states have different approaches to information dissemination regarding the transport scheme, with varying degrees of success. In WA, PATS program managers and regional coordinators have clearly defined roles and responsibilities including communication and marketing of PATS to all relevant stakeholders (4). However, a South Australian review reported that medical professionals lack knowledge on the application processes pertaining to PATS (5). A healthcare provider from Broken Hill, NSW described his experience of the system:

> Our rural hospital is often serviced by locums who do not necessarily know the requirements for PATS reimbursement. They are frequently unaware of visiting local specialist services and refer to the nearest specialist base—but these visits are ineligible for reimbursement since a visiting service exists. Furthermore, emergency department referrals are frequently made without consideration for PATS reimbursements (Bachman S., oral communication, March 2016).

The National Rural Health Alliance (NRHA) Position Paper argues for greater promotion of PATS schemes to ensure all eligible patients are aware of the financial assistance available for accommodation and travel to medical specialist appointments (18). We agree, and consider this a high-priority issue.

*Simplified and Streamlined Documentation***.** A South Australian review concluded that both practitioners and patients found PATS challenging to negotiate (5). Clients most likely to need transport assistance are those from lower income families, who are also more likely to have poor literacy skills and require assistance to obtain reimbursement (19). Creating a streamlined and easily accessible system would allow increased utilisation of PATS, contributing to better health outcomes for rural Australians.

Return Home following Emergency Transport. Emergency transportation to major centres for treatment is funded by emergency services, while return transport and follow-up care are reimbursed through PATS. A nationwide uniform, simplified and better-known system would expedite organisation of transportation back home and would reduce the pressure on people who are facing an already stressful situation. This is particularly true when patients must travel interstate. A healthcare worker from Broken Hill described her experience:

> Our health care service spends significant administration time organising transport back to Broken Hill and obtaining all of the necessary paperwork from our patients. Transportation home for these types of events should be simplified and streamlined since the patients will not have had time to organise anything in advance (Bachman S., oral communication, March 2016).

Recommendations

Achieving truly equitable access to quality healthcare for all people across Australia should be the goal of our governments. In the long term this goal can be achieved by improving two different services:

- Improve local medical services where possible
- Improve the Patient Assisted Travel Schemes

This position paper and the following recommendations focus on the second point but we acknowledge that substantial improvements to the Patient Assisted Travel Schemes must be important, but not exclusive, way to improve health care provision in rural and remote Australia.

Recommendation 1. Simplification and Nationwide Uniformity

It is recommended that the eligibility criteria and the benefits of the PATS be reviewed with the objective of developing common principles under which the states and territories can operate the scheme. This has two main goals: first, to achieve equitable access to the scheme regardless of the state or territory of residence. Second, to provide the basis for developing a uniform and simplified set of guidelines with the aim to facilitate promotion (Recommendation 2), improve accessibility to the scheme, and facilitate provision of the scheme when interstate travel is required.

Eligibility Criteria

- A nationwide uniform set of eligible services should be established. An agreement should be reached with respect to services that are currently eligible only in some states or territories (e.g. fertility treatments, health screening programs, dentistry, and seeking second medical opinion). It is also recommended that non-eligible services be clearly indicated thus removing the risk of confusion.

- A nationwide uniform eligibility distance should be indicated both for one-way visit and cumulative distance in case of regular travels (e.g. dialysis, chemotherapy). A weekly and a monthly cumulative distance threshold should be established.

Transport and Accommodation Benefits

- Nationwide uniform transport benefits should be set. Private vehicle subsidies should be calculated based on the total running cost of a medium-sized car, including fuel, tyres and maintenance. Commercial transportation should be fully refunded based on the economy rate. Air transportation should be easily accessible.

- A revision of the accommodation benefits is highly recommended:

  – Establish a reasonable accommodation expense based on current commercial accommodation costs.

  – Establish additional ways to reduce the patients' financial burden (e.g. the ability to write off accommodation expenses incurred in accessing medical care against their income for tax purposes).

  – Provide pre-paid vouchers to patients who cannot afford to pay for accommodation.

Recommendation 2. Promotion and Accessibility

It is recommended that the PATS are promoted nationwide to increase the awareness of the program among health professionals and clients. To facilitate this process, it is recommended the schemes continue to be governed by individual states and territories under the current funding arrangements but implement nationally consistent guidelines and initiatives where appropriate, including:

- Nationwide uniform name and logo.

- Nationwide uniform guidelines booklet.

- Appropriate promotion to target audiences.

- Publications of brochures, booklets, forms and posters to be distributed to health care facilities in rural and remote centres.

It is recommended that the accessibility to the PATS is improved via:

- Nationwide unique Internet portal.
- Nationwide uniform application forms.

Conclusion

The primary aim of this paper was to review the State and Territory-based Patient Assisted Travel Schemes. The experiences of individual healthcare providers and patients demonstrate that there are multiple current issues that interfere with patient access to healthcare services. Whilst previous papers have offered valid recommendations for the various schemes, these solutions are often too broad and expensive to be realised. This paper advocates for the implementation of two recommendations, which could help optimise the effectiveness of the Patient Assisted Travel Schemes. Firstly, we propose that current eligibility criteria are simplified and standardised across States and Territories. Secondly, we recommend nationwide standardisation of PATS branding, application forms and materials to ease promotion and education of both patients and clinicians. The implementation of these recommendations has the potential to ensure Australians have more equitable access to health care.

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Presenter

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