



Fact Sheet 10

Patient Assisted Travel Schemes

MAY 2009

Patient assisted travel schemes (PATS) make a major contribution to the ability of rural people to access more specialised health services that are not available locally. Several aspects of the PATS are currently the subject of government review.

Background

The Commonwealth Government established the Isolated Patients' Travel and Accommodation Assistance Scheme (IPTAAS) almost 30 years ago to provide financial assistance to people who needed to travel more than 200km to obtain specialist medical treatment and oral surgery.

In 1987 the responsibility for IPTAAS passed to the States and Territories because it was thought they would be better able to administer the scheme. At the time it was felt that the Federal Government "lacked the requisite local knowledge and delivery mechanisms to respond flexibly to the needs of different geographical communities".

Commonwealth funding continued through Special Revenue Assistance Grants. The State-run schemes were commonly referred to as Patient Assisted Travel Schemes (PATS) although official titles varied between States. In 1999 the States and Territories relinquished those direct Assistance Grants in return for a revenue stream provided through the Goods and Services Tax.

The present

Although funds are no longer earmarked specifically for patient transport, Commonwealth funding provides for free public hospital services through the Australian Health Care Agreements (AHCAs). Under these agreements the States are required to "ensure that people have equal access to public hospital care regardless of their geographic location".

Given the size of Australia this is a daunting task – the provision of complex and specialist services to people in rural and remote areas is subject to real economic constraint. In reality, it is unlikely that all those living in rural and remote communities will ever have, or can expect to have, the same level of access to all health services as those living in metropolitan areas. What they do expect, and are entitled to, is access to a health care system that does not ignore or discriminate against them because of where they live.

So the practical question is about the degree to which people who live in the bush are entitled to assistance in accessing the same medical services available to those in metropolitan areas. PATS have an important role to play in achieving this. While government budgetary constraints must be taken into account in any deliberations, whatever the cost of PATS it is likely to be significantly less than the cost of providing local specialist health services throughout rural and remote Australia.

Although PATS systems and payment rates vary between States, there is general agreement that all are deficient in one way or another. Current principal areas of concern include the following.



PHOTO: STEVE LOVEGROVE

The level of reimbursement for travel and accommodation.

At present, the average fuel subsidy paid by the States to patients who must travel to access medical care is about 15 cents per kilometre. Despite the fact that PATS are designed as a subsidy and not a full reimbursement, 15 cents is seen as grossly inadequate given the cost of fuel and the fact the patient is using their own vehicle. The table below shows the deductions currently allowed for business travel by the Australian Taxation Office (ATO).

Deduction per Kilometre	Engine Size
58 cents	1.6 litre
69 cents	Up to 2.6 litre
70 cents	Larger than 2.6 litre

In other words, the ATO currently assesses the cost of travel by private car to be between 58 and 70 cents per kilometre – four to five times the current subsidy under PATS.

There is also a deal of variation between the States when it comes to the accommodation subsidies paid under PATS. In most cases the subsidy is between \$30 and \$35 per night. In Western Australia, which recently announced an overhaul of the system, the subsidy has been raised to \$60 a night for any person travelling alone and \$75 a night for anyone travelling with an approved escort or carer.

In itself, falling ill can impose a substantial financial burden, but for those living in rural and remote areas the costs are greater when travel and accommodation expenses are taken into account. In some cases these costs can prove prohibitive and cause patients to decline treatment.

Lack of uniformity

A key reason the States were given control of PATS was because of the perceived flexibility they would have in meeting the needs of local communities. While this may be true, the lack of uniformity inherent in a fragmented system is now seen to cause inequitable outcomes for consumers from different regions. For example, differences have developed in the amount of subsidy provided, eligibility criteria, which treatments qualify for support and the actual form of transport to be used. In addition, administrative problems can arise when it is necessary for patients to cross State borders for treatment, not only for the patient but also for health service staff and organisations that try to assist.

The current view is that State boundaries should not become obstacles to accessing medical care and that patients should have access to interstate care, if appropriate, or if they have friends and family there to support them. In effect, the pendulum appears to have swung back to a point where there are now calls for the Commonwealth to again take a greater role in the administration of PATS or set basic guidelines to which the States must adhere.



Escorts and carers

The question of whether an escort or carer should be subsidised to accompany a patient poses difficulties for policy makers and managers. Should there, for example, be a set of national eligibility criteria or is it preferable to deal with the issue on a case by case basis and, if so, who is best placed to make the decision?

There is a current lack of uniformity as rules relating to escorts vary between States. Some allow for a GP or specialist to specify if an escort is necessary, while others insist escorts are allowed only if the patient requires active assistance. However, to preclude escorts solely on the basis of whether or not they are needed to provide tangible care, ignores the vital contribution escorts can make to the overall wellbeing and safety of the patient.

All States allow an escort for children, but it is often the case that adult patients may be travelling to a large city with which they are unfamiliar. They may need to find accommodation, their treatment may leave them incapacitated, or their condition may be such that they are unable to properly care for themselves after treatment. 'Meet and greet' support for Indigenous people visiting a major city from remote areas (as is now available in Western Australia) is likely to be particularly helpful.

Publicity and paperwork

It is doubtful that any State currently allocates enough money in their health budget to adequately fund PATS. One of the major criticisms levelled at the current system is that people who are entitled to use it are not informed of its existence as a matter of course. Even if a patient is made aware of the available assistance, the amount and complexity of paperwork and red tape involved can be seen as excessive, both for the patient and medical practitioner. In such cases they act as a disincentive to claiming reimbursement.

The future

Two major reviews are currently underway. In 2007 a Senate Inquiry made 16 recommendations on how to improve PATS. These are being examined by a Health Policy Priorities Principal Committee which is due to report to the Australian Health Ministers' Advisory Council. In 2008 the National Health and Hospitals Reform Commission produced an Interim Report which included:

"There is a need for a patient travel and accommodation assistance scheme with nationally consistent guidelines and user-friendly submission processes. This scheme should be funded at a level that takes account of the 'real' costs to families, and have regard to a safety net for frequent users of specialist services."

It is possible these reviews will lead to significant changes to PATS in the near future by including a wider range of effective health interventions. Preventive medicine, antenatal care and child health services are not covered by the current schemes. Not only would such changes improve the access rural people have to services, it would also help keep people healthy and out of hospitals. A range of e-health initiatives could well make the administration of PATS much simpler.

PATS is just one important aspect of providing equitable access to health care to people in rural and remote Australia. In the future improvements to Medical Specialist Outreach Assistance Programs, advances in telehealth services and the establishment of multi-disciplinary clinics might all play complementary roles.

If and when it becomes necessary for a patient to receive treatment at a facility that is only available in a metropolitan centre, that person has the right to expect a system that will:

- subsidise a realistic proportion of their costs, perhaps means-tested so that people on low incomes receive full support;
- not discriminate because of where they live;
- allow reasonable funding when it is necessary for an escort to accompany them; and
- be readily accessible and easy to navigate.