Position Paper

Transport and accommodation assistance for health patients from rural and remote areas

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This Position Paper represents the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies.

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Transport and accommodation assistance for health patients from rural and remote areas

Background

One of the Key Recommendations endorsed at the 8th National Rural Health Conference in Alice Springs in March 2005 was:

> There should be an immediate national review of the State schemes that assist patient and carer transport and accommodation. The purpose would be to introduce a uniform approach which provides people from remote and rural areas with reasonable reimbursement for accessing services that are not available in their own communities.[1]

The various schemes are detailed and compared in the attached appendices, and a number of policy issues and recommendations arise from this comparison.

The Vision of *Healthy Horizons: Outlook 2003–2007* is that "People in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities". It then goes on to say that this will be achieved when:

- there is improvement in the health of rural, regional and remote Australians when compared with other Australians;
- people in rural, regional and remote Australia have access to appropriate levels of health care; and
- areas of high need in rural, regional and remote Australia have access to adequate resources.[2]

This Vision anticipates that people living in rural, regional and remote areas of Australia will have equity of access to the same levels of health care as those who live in metropolitan areas. While in principle Medicare provides low cost in-patient treatment for everyone, such services are not always provided in rural and remote areas, so patients have to travel. Being able to physically get to the required treatment is an essential component of equitable access. Unfortunately the hidden cost-shift to these patients means that patients with limited funds often choose not to travel, and this reality contributes significantly to the higher mortality rates in rural and remote areas.

There are two issues—the physical infrastructure, (ie the state of the roads, the poor availability and timetables of public transport), and the cost factor of fares, petrol and accommodation. It has long been accepted by the state and territory governments that if people in rural and remote areas cannot travel to treatment and

care because they do not have their own car, or the distance is too far to drive, or the cost to travel is prohibitive, assistance should be provided for transport and accommodation expenses. The inadequate government budgets, the disparities between the various jurisdictions and the areas that are excluded from the various schemes, constitute barriers to national attainment of the Vision of *Healthy Horizons*.

The current state and territory schemes

Australia has a well-established public and private health care system, and levels of technology to rival any developed country. 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.

To combat this problem, every state and territory health department in Australia has a scheme in place to assist patients to access care not available at their local treatment centre. Assistance takes the form of a financial contribution towards travel and accommodation costs associated with attending such a centre, usually for an appointment with a medical specialist. The various schemes are designed for planned clinical care; they do not cover emergency admissions, except for NSW where transfer for emergency admission is covered. All the schemes are designed primarily to cover intrastate travel, although some, such as those of the NT, Tasmania and even the ACT on occasions, operate interstate schemes for procedures not performed in the state. In NSW state boundaries are not relevant in considering a patient's eligibility, as patients seeking assistance are required to attend the nearest specialist, regardless of the state. All the schemes acknowledge that the reimbursement programs do not aim to cover all costs incurred, and expenses such as meals are not covered by any scheme.

There are several general similarities between the schemes concerning eligibility and operation. Travel assistance is always based on the most economical form of transport, although allowance is made for cases of 'medical necessity', and an alternative form of transport is considered in such cases. All schemes have provision for an escort to accompany a patient if required.

There are also some important differences between the schemes, which affect their impact on patients' access to treatment, and it is recommended that some of these anomalies be addressed by moving to greater national uniformity, especially in administration.

Support for Indigenous Australians

Overall, Indigenous people living in rural and remote Australia have lower income and are less likely than others to have their own transport. In addition, 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, 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 and other reasons, such as inability to travel at certain times, lack of communication and 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 often they are not aware of these. If they are to receive treatment as an out-patient, arrangements are usually made for them to stay at a hostel, where some additional support is given in a culturally appropriate environment. 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 they should be adopted by all states and territories.

Promotion of the schemes

Promotion of the transport and accommodation schemes is crucial, yet often it seems that patients' access depends on their local GP knowing about the possibility of assistance and the patient's eligibility for it.

In most states, it seems that some patients only find out about the scheme after they have arrived in the larger centre for specialist treatment. Although most remote area nurses and GPs know about the scheme, in areas where there is a high turnover of staff, especially with short-term and locum positions at the local hospital, problems may arise. Where information and promotion are concerned, pharmacists do not appear to be targeted in any jurisdiction, although they are a very important health care contact in many small towns.

In Victoria, for example, work on promotion of the scheme will be undertaken later in 2005, including education sessions for the Divisions of General Practice and the social work departments of health services. Currently, access to the scheme often depends on the knowledge of staff members seen by the patient. In NT hospitals there is a Patient Services Manager responsible for the day-to-day running of the scheme. In addition, they hold workshops to let everyone involved know about the scheme and the relevant steps they need to follow, and are in the process of setting up a comprehensive training schedule to educate all PATS users (at hospitals, remote clinics and non-government organisations) including a 'roadshow' to increase knowledge of the scheme.[3]

Reliable statistics are not readily available on the number of patients who cannot access follow-up care at a distant location because of a lack of funds to do so, but

anecdotal evidence suggests it is a major issue. What is known is that patients from rural and remote areas die from illnesses because of lack of treatment at a greater rate than patients who live in metropolitan areas.

Recommendations

1. It is recommended that the **Patients' Travel and Accommodation Assistance schemes in all states and territories be reviewed with the objective of integrating 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.

2. **Promotion of all schemes should be encouraged** through the publication of brochures, booklets, forms and posters, and promotional material should be in a user-friendly format and distributed widely to a range of health care practitioners.

Eligibility

3. **All health care practitioners,** such as Remote Area Nurses, and allied health professionals, eg dentists, physios and psychologists, **should be alert to ensure that eligible patients complete the forms** for assistance. The forms would then be forwarded to the referring GP for them to authorise.

4. **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. This could be limited to the initial phase—the first transfer would often be by ambulance to the nearest facility. However, subsequent transport for patients who then need to be referred to a distant specialist for treatment, should also be covered. After this phase, patients would normally be referred for ongoing treatment close to the patient's home.

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

6. **Assistance should be available for organ transplant donors.** Transplant donors are not eligible for support in some schemes. Sometimes this is provided by the operating hospital, but there can be limitations with regard to interstate travel for donors. Patients requiring financial assistance to travel to receive an organ are covered by all the schemes, but not always for travel interstate, which is becoming more common.

7. **Allowance for patients to visit a more distant specialist** if the waiting list for the closest available exceeds clinically acceptable time frames. This is a

particularly positive aspect of the scheme in some states, which should become standard for all. It is very important that local specialists always be the first point of referral, but workforce shortages have meant waiting lists in some areas have blown out beyond reasonable levels.

Transport

8. ***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, and should be weighed up against the higher cost of an airfare. While this is happening within most schemes, the authority for it should be written into state and territory guidelines, allowing administrators to evaluate claims on a case-by-case basis, and not allow patients to be stranded late at night.

Scheme administration

9. **Reimbursement rates for travel and accommodation**, for both patient and escort, should be such that they uniformly cover all applicable costs.

10. **All states should adopt a pre-payment system, whether by vouchers, tickets or advance bookings, for patients experiencing financial difficulty with the initial outlay.**

11. **There should be provision to fill-out one form for a complete set of treatment, or for chronic illness**. However, payments would be made only one treatment at a time, either before or after the event in the normal manner. This long-term support should be approved for six months at a time, subject to medical reviews for extensions as needed

12. **In general, no patient should be unable to access treatment because of the cost to them.** No patient, whether concession cardholders or not, but particularly those on low incomes, should be liable for considerable expense to access treatment. There should be no cost difference between them and metropolitan patients attending that service.

13. **It should be ensured that detailed information about the schemes is as widely available as possible.** This would cover general practice staff as well as GPs, nurses, social workers etc. It is important to extend the knowledge base among professionals likely to come into contact with suitable patients and to have a member of staff at small hospitals dedicated to ensuring seamless patient care between rural and metropolitan treatment centres.

14. **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. The requirement for escorts to accompany patients only when physical assistance is required represents a very limited view of patients' needs. However, tighter criteria should be imposed on escorts to ensure that the main focus is on providing assistance for patients.

15. **Information about the appeals process** should be included in all literature about the schemes.

Funding

16. All states and territories should **budget to commit sufficient funds** to be able to deliver the assistance detailed above to all eligible patients, so that no one is excluded because of lack of funding or merely because a particular quarter's budget has been expended. The cost of access should be factored in as an integral component of providing the service, eg when a radiotherapy unit is built, travel and accommodation for rural people should be part of the overall funding allocation.

Emergency travel

17. **Ambulance travel** is not covered by the Patients' Assistance schemes, and is a very serious issue that is not being addressed. A strong case could be mounted to have **emergency ambulance transport covered under Medicare** for everyone across the country regardless of where they live, or where they are when they need this assistance.

Appendix 1 Eligibility

Assistance under each of the schemes is only available for patients to travel to and from their permanent residence. Patients who need medical treatment when they are away from their home are not covered. Patients must be referred to the nearest possible centre where the necessary treatment, usually specialist, is available. Assistance also depends on patients not being eligible for assistance from any other source, such as the Department of Veterans' Affairs or third party insurance, or from any private scheme. In Queensland, if patients are likely to receive damages, they may apply for cover only if subsequent payment can be made directly to Queensland Health. Specialist treatment for injury or illness incurred during business or recreational travel is not covered under any of the schemes. Assistance only applies if the patient is travelling from their permanent residence.[4]

Referral

In most cases, patients must be referred to the schemes by a GP. Dentists may refer patients for dental surgery but not general dentistry, and optometrists may refer patients to ophthalmologists, except in Tasmania. Psychiatrists may refer to the scheme in NT. In most states, only medical specialists, not GPs, may refer patients for interstate treatment. When a GP is not available in remote areas of Queensland and SA, a remote area nurse can refer patients to the scheme. This is rare in SA, however, as most areas are covered by the Royal Flying Doctor Service (RFDS). In WA, where there is no GP the nurse will complete the form and have it signed by a doctor, by way of faxing, but may not refer patients directly. In NT and Tasmania, nurses may not refer patients, even in remote communities.

Choice of specialist

In general, assistance is only provided to the nearest specialist. If a closer service opens, most schemes require patients to change specialist but allow some flexibility. In WA, patients must change unless there is a medical reason not to do so. In Queensland, SA and Tasmania, consideration is given to allow patients one additional visit to their specialist while arranging the transfer. In NSW and Victoria, patients with a history with a specific specialist would usually be allowed to continue with them, if recommended by their GP. NT guidelines state that patients must use the 'nearest available service'.

If there is a long waiting list for the nearest specialist, some states operate a flexible system. If the nearest specialist cannot see the patient within a 'clinically acceptable timeframe', or certification by the specialist themselves exempts the 'nearest specialist' rule, patients may receive assistance to visit a specialist further away[5] after supporting documentation is provided. In Queensland, assistance may also be given for a patient to visit a more distant centre if they have family support there.

Exclusions

Medical specialties that are not covered under the schemes do not vary significantly and are generally limited to those covered by the Medicare Benefits Schedule (MBS). In all areas, treatment must be from a medical specialist rather than an allied health professional, so treatment from psychologists, physiotherapists, speech therapists and others is not covered. General dental treatment, such as tooth extraction, is not covered by any scheme. In SA, however, children and disabled people who receive dental treatment requiring a general anaesthetic at the Women and Children's Hospital are covered—the only reported exception to this exclusion.

In the Queensland guidelines, however, there is some allowance for coverage of "Health services provided as an essential component of services (eg physiotherapy following orthopaedic surgery, psychological assessment in preparation for psychiatric treatment)".[6] In all other states, for example the parents of a child with speech difficulties are not eligible for assistance to access a therapist, when a relatively short treatment period could dramatically improve their capabilities. Likewise, short-term treatment by a psychologist may have positive effects for depressed individuals. While depression and suicide levels are significantly higher in rural and remote areas compared to metropolitan locations[7,8], access to a psychologist is lower, and exacerbated by the exclusion of psychology from the Schedule.

It may be decided that some specific areas should continue to be excluded, such as plastic/reconstructive surgery (unless covered by MBS), laser eye surgery and clinical trials.

Experimental procedures are not generally covered but, in SA, if active treatment is involved, the scheme may consider funding transport and accommodation on a case-by-case basis.[9] In Queensland, if a patient is approved to attend a specialist service under normal eligibility conditions and then agrees to take part in a clinical trial at the same time as normal treatment, payment under the scheme is still possible. This is at the discretion of the Medical Supervisor or delegated officer. In most cases, the centre undertaking the experimental procedures is expected to cover the costs of transport if they wish to include a country patient in the study.

Assistance for travel for artificial limb fitting is not covered in SA, Victoria or NSW (unless it is part of an approved surgical treatment regime in NSW). The reason is that the treatment is not listed under the MBS (a technician fits the limb rather than a medical specialist). In Queensland, if eligible, the patient would receive assistance for travel for the initial amputation, which could involve fitting of the limb and possibly follow-up treatment, but if a person needed to 'upgrade' an artificial limb or required adjustments to the limb, assistance would not be given. Fitting is covered in WA, Tasmania and NT.

There is provision for assistance for prospective mothers to access obstetric care under most schemes. NT is the only jurisdiction that spells out clearly the services to which she is entitled in information available to patients. In the NT, a pregnant woman otherwise eligible for assistance:

> … is eligible for a maximum of three antenatal visits to a specialist obstetrician; or public hospital antenatal clinic, in addition to confinement, where antenatal care can be provided locally at an accessible health care centre by a registered midwife, resident or visiting medical practitioner. Where there is no locally accessible registered midwife or visiting medical officer, a woman may receive assistance for a maximum of 10 routine antenatal visits.[10]

Obstetric care is covered, including for non high risk cases, in WA, SA, Queensland, Tasmania and Victoria, but with some restrictions. In NSW, only care by a specialist obstetrician is covered by the scheme. Patients receiving IVF treatment are not covered in Tasmania, and in Queensland, IVF is covered but an escort subsidy is only paid for the first treatment. Payment for the escort for subsequent treatments is at the discretion of the District Manager or the recommendation of the Medical Superintendent. In NT, patients receiving IVF and other reproductive treatment intrastate are eligible for assistance for three interstate trips per year. Following one live birth, assistance ceases. There is no automatic entitlement for the partner to travel as an escort, except when it is a requirement of the program. IVF is covered by the NSW, WA, Victoria and SA schemes.

In some schemes, transplant donors are not always eligible for support, although patients requiring financial assistance to travel to receive an organ are covered by all the schemes. In WA, where a country resident is a suitable transplant donor and travels to the metropolitan area, reimbursement for travel costs and other expenses are met by the specialist service co-ordinating the transplant. The Royal Perth hospital, for example, has a fund available to cover such costs. In exceptional circumstances, where no other assistance is available, the donor could be eligible for the same assistance as if they were the patient's escort. In Queensland, travel and accommodation costs relating to the donor are also the responsibility of the treating hospital.

In SA, both recipient and donor may receive assistance. A kidney donor, for example, from anywhere in Australia over 100 km away may receive funding to travel to SA as long as the recipient is resident in SA. The scheme also covers patients to travel interstate to receive a donated organ. Likewise, in Tasmania, Victoria and NSW, both recipient and donor may be funded if the recipient is eligible under the schemes. Provided that the recipient is a resident, a donor from anywhere in Australia will receive accommodation assistance in addition to travel assistance in Tasmania and NSW. In NT, an organ recipient receives assistance to travel to the referring state and accommodation will be paid for up to 3 months to allow the patient to stay nearby and be readily available should an organ become available. When news of a suitable donor arrives, an escort will be subsidised to join the patient. The question of support for an organ donor has not arisen in the NT to date.

Appendix 2 Transport

Distance threshold

Distances required before assistance is given vary between 50 km and 200 km. All distances are measured one-way—in Queensland it is 50 km, in Tasmania 75 km, WA, SA and Victoria 100 km, and NSW and NT 200 km from patient's home, or their home town to the nearest treatment centre.

A degree of flexibility is allowed in some states—in WA, individuals requiring dialysis or cancer treatment receive assistance if they live more than 70 km from the treatment centre;[11] in the NT, dialysis patients have a lower threshold of approximately 80 km. In NSW, financially disadvantaged patients, those with a chronic medical condition, those who must travel often and some others, may be eligible for assistance for travel if they live less than the 200 km, under the Transport for Health program.

Transport

In most schemes, travel assistance or reimbursement is based on the cheapest means of transport, usually economy train or bus fare, but some allow 'medical necessity' to dictate when a more expensive means of travel is needed, such as air travel. In the NT, travel between Alice Springs and Darwin, and interstate travel is usually by air. Prior approval is needed before air travel will be considered, except in certain circumstances. In WA, air travel is automatically covered if the journey is greater than 16 hours (one-way), and in Victoria, assistance for air travel is available if approved by a specialist, and the journey exceeds 350 km one-way. In most cases interstate travel, if required, is assumed to be by air. In NSW for patients living close to the border, the nearest specialist may be located interstate, but they would not be eligible for air transport.

In ACT, reimbursement is made at a set rate, depending on the location of the specialist. Return fare to Sydney is reimbursed at $40 per adult and $20 per child. Travel by car is reimbursed at $40 per return journey. Travel to Melbourne is reimbursed at $100; travel to Adelaide and Brisbane is reimbursed at a rate of $150.

Costs to and from the transport terminal and hospital are covered in certain circumstances, in some regions. In WA, taxi vouchers may be given when a patient cannot walk or where there is no public transport. Taxis are covered in Victoria when a patient has no other means of transport available from home to the nearest public transport terminal. In NSW, patients may be subsidised for taxi fares/public transport costs to and from their residence to the local terminal, to and from the treatment centre, and to and from their accommodation.[12] In rare cases taxis are available to patients in NT. In general, taxis are not generally covered elsewhere.

A fuel subsidy is available in all states for travel by private car. The rate varies from 10 cents/km (Tasmania, Queensland) to 16 cents/km. The measurement of distance is not uniform—in one state (Qld), it is between post offices, in another (WA), it is between nearest towns. In NSW the distance is measured from the patient's residence, which must be at least 200 km from the nearest specialist service, and that state has migrated to a global positioning system (GPS) to calculate distance using the most direct road network.

Table 1 Summary

State	Minimum distance	Air travel allowed	Fuel subsidy
New South Wales	200 km	If approved medical necessity only	12c/km
Victoria	100 km	>350 km	14c/km
Queensland	50 km	If approved medical necessity only	10c/km
Western Australia	100 km	>16 hours	13c/km
South Australia	100 km	If approved medical necessity only	16c/km
Tasmania	75 km	Interstate	10c/km
Australian Capital Territory	Interstate	If approved medical necessity only	Set rate
Northern Territory	200 km	If approved medical necessity only	15c/km

Escorts

Financial assistance for escorts is permitted automatically if the patient is aged less than 16 years and in some circumstances up to 18 years (in NT), 17 (in NSW, ACT, Queensland[13] and SA) and 18 (in Victoria, WA and Tasmania). Two escorts may be considered in NSW, NT, ACT, Tasmania and Victoria in exceptional circumstances, if medically supported.[14]

If an adult is to be accompanied and will require financial assistance to do so, all states require that the necessity for this be proven, usually through a statement by the referring or treating practitioner or Hospital Medical Officer. Necessity is not a concrete factor, however, and its definition varies between states. Only NT spells out clearly in the information available online the cases in which an escort should be funded and this includes eligible IVF patients. In NSW, the need for an escort is based on medical, or medically related, necessity alone, which is defined in their *Guidelines for Medical Practitioners and Specialists*. In Tasmania, an escort will be funded only if the patient needs physical assistance. In contrast, in SA, the need for an escort may be based on medical, practical or psychological needs. Similarly, in Queensland, an escort may be approved to provide emotional support.

In some states it is not necessary for an escort to physically accompany a patient during travel to receive assistance, for example where an escort cannot accompany the patient travelling by ambulance or RFDS, or where there is no seating available, they may be funded separately. If a patient's condition deteriorates, an escort may be assisted to travel to be with the patient. In the event of a patient dying while away from home, all states provide some assistance for the escort to travel to the hospital, but the rate varies, and not all provide for a return journey. Repatriation of the body is covered only in some cases. Figures for rate of approval of escorts were not available for all states, but in general are for about half of all trips approved.

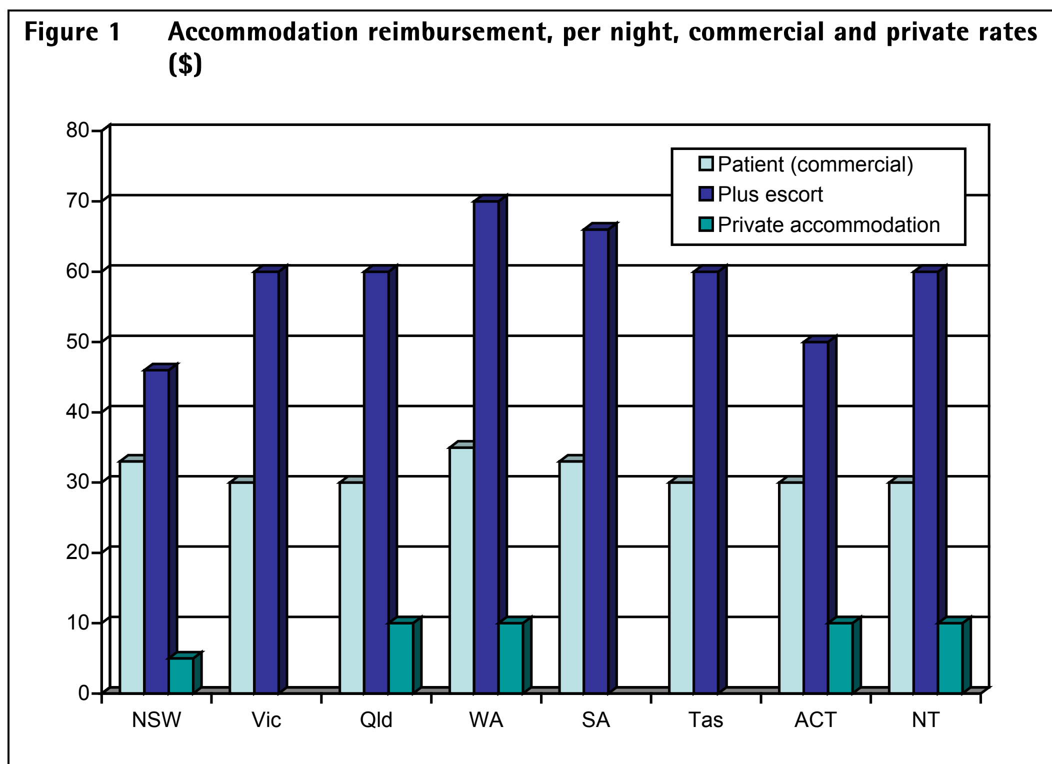
Appendix 3 Accommodation

For all schemes, in-patient accommodation costs must be met by the patient, but an accommodation allowance is granted for patients receiving outpatient treatment, if the return journey to receive specialist treatment cannot be made in one day, eg if patients need to drive on average 650 km one way. Costs of *en route* accommodation are covered in NSW in cases of 'genuine medical need' or in NT if a patient must drive more than 8 hours to the hospital.

Accommodation assistance rates vary (see Figure 1). In some areas and circumstances, a room allowance is calculated, in others, the rate is calculated per person. In NSW up to $33.00 per night per single room and $46.00 per night per double room is reimbursed. In all other states, it is $30–35.00 per night, for both the patient and the escort, excluding ACT, where the escort can claim an extra $20.00.

Some states are stricter than others regarding payment for private accommodation. No private accommodation allowance is given in Victoria, Tasmania or SA. In NSW, for pensioners and Health Care Card holders, a private accommodation allowance of $35.00 per week (or pro rata) is payable after the first week. In Queensland, ACT, NT and WA, up to $10.00 per night is provided. No receipt is required except in the ACT, where a letter from the host is needed to prove that payment was made.

Figure 1 Accommodation reimbursement, per night, commercial and private rates ($)



In all schemes, assistance is available from the first night's accommodation for concession cardholders. Non-concession cardholders are treated the same as

cardholders in NT, but in all other states they are expected to make a contribution—in SA, for the first night, in Tasmania for two nights, and in Qld and WA, for the first four nights in each year. Time limits vary for patients requiring long-term outpatient treatment. WA patients may claim assistance for up to 6 months' accommodation at up to $140.00 per week, however, some patients undergoing chemotherapy or dialysis have been known to receive assistance for periods in excess of this. The limit of 120 days in Victoria can be extended if medically approved. There is no cut-off point for patients in SA, (where the accommodation provider is paid directly in such cases for patient and escort), Queensland, NSW, NT and Tasmania, provided the patient is still technically resident in their country area.

Appendix 4 Scheme administration

Reimbursement versus pre-payment

Patients' transport and accommodation assistant schemes fall into two basic types: those in which patients are reimbursed for out-of-pocket expenses after they return (NSW, Victoria, SA and Tasmania, intrastate travel) and those in which travel, accommodation and other costs may be paid in advance (Qld, WA, NT, ACT and Tasmania, interstate travel), usually by administration staff booking tickets and accommodation for patients before they leave for their appointment.

In Qld, WA and Tasmania, country hospitals or health services administer the scheme, and the preferred option is for them to book, or at least assist with accommodation and travel for the patient in advance, particularly where there is a need to co-ordinate multiple appointments. In the other states, the schemes are administered through the Health Departments. In NT, local Patient Travel Clerks book tickets and accommodation. Accommodation arrangements are usually made at hostels for Indigenous patients and escorts, in which case the hostel is paid directly. Patients who choose to stay elsewhere are reimbursed after travel. Only one-way tickets are issued, with the return travel ticket being issued on completion of hospital treatment or date of last specialist appointment. This arrangement is in place to prevent people returning home before their treatment is finished and to save cancellations and rebooking when treatment takes longer than expected.

Although a reimbursement scheme is in place in SA, where patients are 'having trouble coping', accommodation may be booked for them. In such cases, the bill is sent directly to the scheme administrator. This is similar to NSW, where patients/guardians with a concession card, and all patients with treatment longer than 28 days may have their accommodation bulkbilled.

In Qld and the NT the doctor applies for the subsidy, whereas in other states the patient must apply, with the doctor's approval. In most areas, application approval prior to travel is needed in order for a claim to be considered. In Qld the application in most circumstances, must be approved by the local Medical Superintendent before they attend the specialist appointment. In WA, approval from the local hospital is needed before departure, except in emergencies it may be given over the telephone. In NT, the guidelines require applications to be lodged at least 7 days before intrastate travel, and 21 days for rural patients (14 for patients in major centres) before interstate travel, but there is considerable flexibility. Retrospective claims are possible. In SA approval must also be sought before travel, and in NSW prior approval is needed for air travel only. Most states cover a series of trips for the same medical condition with block treatment subsidies, which have the benefit of requiring only one referral for several trips, and reduce paperwork for scheme administrators, specialists and GPs. In NSW, the payments may be made for accommodation exceeding 8 days.[15] In Victoria they are available for treatment of five weeks or more, but assistance only covers travel.

There are slightly different rules in each state regarding the cancellation of trips. If a specialist cancels the appointment, a second trip will be funded and, in NSW, if the patient travelled to the specialist prior to cancellation, this trip is also covered. In some states, if a patient misses an appointment through their own fault, they may not receive funding for a second trip and may have to repay the costs. In NT this would only apply to constant 'no show' patients.

Claims and reimbursement

Claims for reimbursement schemes must be lodged by the patient within 6 months of travel in NSW, ACT and Victoria, within 4 months in Tasmania (reimbursement is for intrastate travel only, most interstate payments are made directly) and within 3 months in SA, with a separate form required for each return trip, unless block payments are being made. In WA, claims must be made within 8 weeks of the consultation. In Queensland, the claim forms should be lodged before travel but a patient can lodge a retrospective claim once, within 12 months of travel. In NT, when patients have opted to arrange their own accommodation or travel and so reimbursement is required, patients must return their form within 2 weeks of travel.

Original receipts and tickets for petrol, bus, train and air fares must be provided with the claims form. For reimbursement schemes, accounts showing who was accommodated along with the dates of stay and rates per night must be provided. Credit card sales vouchers and cash receipts alone are not acceptable under any scheme. Reimbursement is made, in WA within a maximum of 8 weeks, after return of the form signed by the specialist. In SA and Victoria, it's within 10 working days, and about the same in Tasmania. Where NT patients have sought reimbursement, they can expect payment within one month. Payment is made in NSW within 45 days of receipt of the claim.[16]

Personal contributions

Personal contribution rates vary across the country, but most states require a fairly substantial contribution from patients who do not hold concession cards. The figure decreases per trip if repeat or long-term treatment is needed. These personal contributions are deducted from any claim lodged under the reimbursement schemes.

In NSW, the personal contribution is $20 for pensioners or Health Care Card holders, and $40 for others and applies for each claim. Children who are patients are exempt, but their escorts must contribute. If escorts incur expenses separate to the patient (eg if they stayed in a separate room or in a hotel while the patient was in hospital, unless the patient is aged less than 17) they must make a personal contribution.

In Victoria, no personal contribution is required from concession cardholders, but other patients have the first $100 deducted from their travel payment each treatment year, even if only one trip is made. Once the $100 threshold is reached,

full payment will be made at the specified rates. This means that effectively no financial assistance is given initially. Escorts do not have to make the personal contribution. Escorting parents of eligible children must make a personal contribution.

In Queensland, no personal contribution is required from concession cardholders or their escorts, and non-concession cardholders are only required to pay the first four nights' accommodation. In WA, no personal contribution is required from concession cardholders or their escorts, but non-concession cardholders have $50.00 deducted for each trip (not from each person) for a maximum of four trips each 12-month period. Children are also subject to this charge, which is calculated for a family, unless the parents or the child hold a Health Care or Pensioner Card. In SA, concession cardholders, or those in financial hardship, are exempt from contribution or the cost of the first night's accommodation. For others, $30.00 personal contribution towards travel must be made, by both adults and children, in addition to the first night's accommodation costs.

In Tasmania, for both intra- and interstate travel, concession cardholders are required to pay $15 towards each return journey, and non-cardholders must pay $75. In any year, the maximum that a cardholder must pay is $120. For non-cardholders, this figure is $300. The contribution is not reduced for children. There is a maximum limit of $2000 per patient per year travel and accommodation costs. NT is the only jurisdiction that does not require a personal contribution or payment of any accommodation costs by concession cardholders or not. All NT applications receive the same level of assistance.

Table 2 Personal contributions

State/territory	Contribution		Concession cardholders	Accommodation costs
	Per trip	Per treatment year		
New South Wales	$40 adult $20 child	n/a	$20 per trip	nil
Victoria	n/a	$100	nil	nil
Queensland	nil	nil	nil	1st 4 nights for non-cardholders
Western Australia	$50 (maximum of 4 trips)	n/a	nil	1st 3 nights for non-cardholders
South Australia	$30	n/a	Means-tested exemption	1st night for non-cardholders
Tasmania	$75	Up to $300 per year for non-cardholders Up to $120 per year for cardholders	$15 per trip	1st 2 nights for non pensioners
Australian Capital Territory	nil	nil	nil	nil
Northern Territory	nil	nil	nil	nil

Cases of financial hardship

In cases of severe financial hardship, most states will arrange for travel and accommodation to be paid in advance. In WA, airfares are pre-paid in any case and there is the capacity to pre-pay other expenses—fuel vouchers may be given and earlier reimbursement is possible. Likewise, in SA, accommodation and travel may be paid in advance in cases of financial hardship. This is means tested. Such patients are also exempt from making a personal contribution. In Tasmania, extra assistance is possible, judged on a case-by-case basis. Airfares and other travel arrangements may be prepaid in NSW, and a lower distance threshold may be used for severely impoverished patients. Advance payment for fuel is also possible. In Victoria the hospital may arrange travel and accommodation in special circumstances. In Qld and NT, most travel and accommodation is booked and paid in advance automatically.

Appeals

When patients wish to complain about the level of reimbursement received, or if they have experienced a problem with another aspect of the administration, they can appeal. The procedure is set out in the literature given to patients in Qld, WA, Tasmania and NT. In Victoria, in the guidelines and in the letter advising of the outcome of their claim, clients are told that they can request a review in writing within three months. A review of the claims system is under way in SA and the new form will contain Appeals information. NSW and the ACT do not describe their Appeals procedures in the literature, however, ineligible patients are advised of their right to have their claim reviewed.

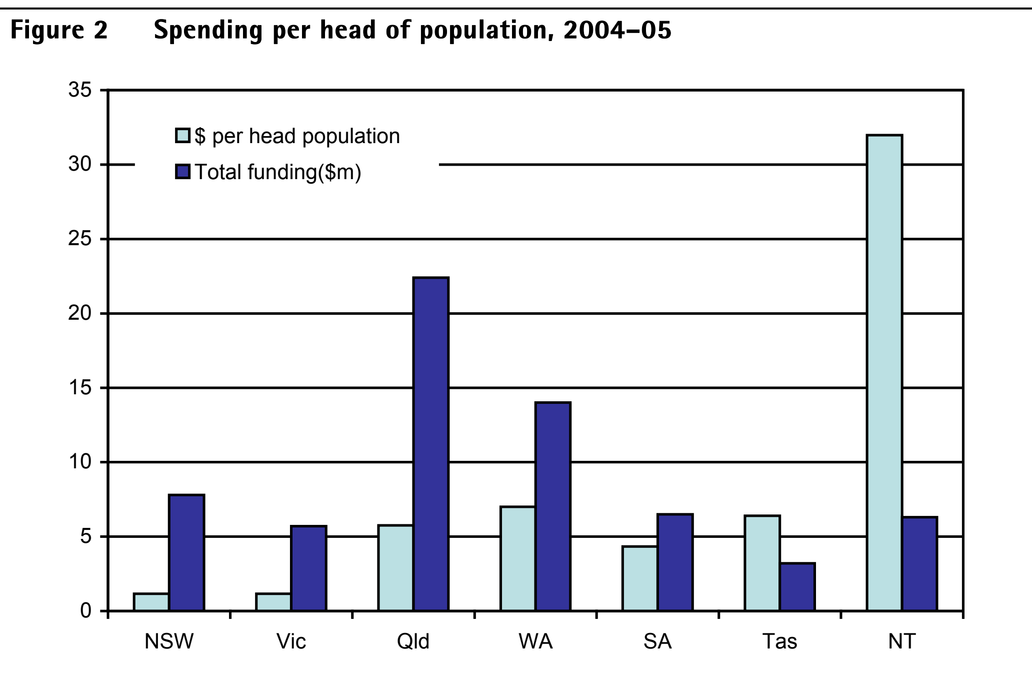
Funding

All schemes are funded by the individual state and territory governments. WA spends $14 million per annum, funding around 44 000 trips. This represents $318 per trip. The average payment per case ranges widely, from almost $1000 for Kimberley residents down to $20 for Peel residents, with 27% of the population eligible to receive assistance. SA spends approximately $6.5 million per annum, and the projected number of claims for 2005 is 36 000, representing an average of $180 per case. In Tasmania, the budget for both the inter- and intrastate assistance schemes for 2005–06 totals $3.2 million, representing some $484 per claim overall.

Funding for the scheme in NSW totals $7.8 million per annum. In 2003–04, 29 610 trips were funded, representing an average of $263 per trip. Funding in Victoria is approximately $5.7 million per annum. This assists approximately 25 000 trips, at an average of $228 per trip, however there is no limit set, and all eligible claims are paid. In Queensland, expenditure for the 2004–05 period was $22 428 743. Information on the number of claims is not held centrally as all details of claims are kept by the different Districts, but spending per head of population can be seen in Figure 2, below. In NT, the relatively few hospitals and consequent great need for patients to be transported intra- and interstate for

specialist treatment means that the Health Department's Budget is often exceeded, but all applications for assistance by eligible patients are met.

Figure 2 Spending per head of population, 2004–05



Changes in claim patterns

Requests for assistance under all schemes have increased in recent years, most dramatically in WA and SA, (by approximately 70% in SA since 2000). In WA, changes to the operation of the scheme, including decreasing the threshold distance from 200 to 100 km and inclusion of a 'safety net' of 70–100 km for renal and oncology patients, increased the number of claims significantly. This second change made some 50 000 additional people in the Peel region eligible for some type of assistance.

Significant increases have also been seen in Tasmania (an increase of 17% in the South in the last 2 years) and the NT. Suggested explanations include the ageing population, changing referral patterns, increased complexity of medical care, greater awareness of the schemes, and reduced availability of some specialist areas, such as obstetrics, at a local level.

Appendix 5 Emergency travel

Many patients who require transfer for specialist medical treatment may need it in an emergency. Costs associated with inter-hospital transfers, emergency travel by ambulance, air ambulance or any other form of emergency transport are not covered by any of the Patient Assistance travel schemes detailed above, or by Medicare (although subsides are possible). Return travel to home, following emergency admission is covered by all the schemes. However, interstate travel is not covered, which often means that patients are stranded with no mechanism to pay for their repatriation to a hospital near their home.

Ambulance services

Demand for ambulance services has increased in recent years, by 9.5% between 2001–02 and 2003–04 in the overall rate of responses across Australia. In 2003–04, the total cost of the primary ambulance service organisations was $1166 million. Total government funding increased by 5.8% on average between 1999–2000 and 2003–04, while charges paid directly by users totalled $266 million. The average cost nationwide to the individual patient for an emergency ambulance was $433.03. While many patients are covered by private schemes and ambulance subscriptions, this does not apply to everyone. Sometimes it is the most vulnerable—in some areas, concession cardholders are not covered for free ambulance services—and those without insurance are left open to large bills to cover emergency transportation.

New South Wales

- In NSW, Pensioners, Veterans' Affairs and Health Care Card holders and School/Group subscribers do not have to pay ambulance fees, but other individuals must obtain cover through a private health fund, otherwise they are required to pay if they use the service. The Independent Pricing and Regulatory Tribunal is currently undertaking a review. The fee is based on the distance travelled. The first 16 km, or part thereof, is charged at $165. Each additional kilometre, or part thereof, is charged at a rate of $4.23 per km, provided that the total fee does not exceed $3894.

Victoria

- In Victoria, ambulance fees are covered for those who subscribe to a voluntary scheme. Service is provided by three organisations which service three distinct geographical areas. The Metropolitan Ambulance Service is also responsible for the provision of air ambulance services throughout the state. Free ambulance services are available for a similar group of concession cardholders as in NSW.

Queensland

- The Queensland Ambulance Service is a division within the Department of Emergency Services. A community based funding model was introduced in 2003 that levies almost all residents through an add-on to retail electricity bills of $22.49 per quarter. This was introduced in an attempt to spread the cost of providing ambulance services across the community, and has almost eliminated the need to bill patients after the travel.[17] Queensland still has some hospital based ambulance services.

Western Australia

- All emergency ambulance services in WA are provided by St John Ambulance, which is an incorporated not-for-profit organisation funded by the state government. Private health cover is required in WA to cover ambulance charges. Health Care, Pharmaceutical or Pensioner Benefit Card holders are not eligible for free services but, from 1 July 2005, all aged pensioners in WA will have access to ambulance services free of charge, and over-65s will receive a 50% rebate on the cost of emergency and non-emergency ambulance transport. Country ambulance cover is separate from metropolitan cover and does not include all areas.

South Australia

- Residents of SA need to take out private health insurance that includes ambulance cover, or purchase ambulance cover separately. The cost of an emergency ambulance for a patient without ambulance cover in SA is approximately $670. The ambulance service is provided by the South Australian Ambulance Service (SAAS).

Tasmania

- In Tasmania, the Tasmanian Ambulance Service, which is a division of the Department of Health and Human Services, is the major provider of ambulance services. The Department's Community and Rural Health Division manages the ambulance services in Queenstown and Scottsdale which are attached to rural health facilities, and Tasmanian Ambulance Service provides staff training and vehicles. In Oatlands, there is a tripartite arrangement between Tasmania, local government and the Community and Rural Health Division.

Australian Capital Territory

- Residents of ACT, need to take out private health insurance that includes ambulance cover, or purchase it separately. Centrelink concession cardholders are exempt from payment, although those with only a Seniors Health Care Card are liable.

Northern Territory

- In NT, the ambulance service is provided by St John Ambulance, which receives Government funding to provide all inter-hospital transfers and

medical evacuations at no cost to patients. Residents of NT must take out private health insurance to cover routine ambulance travel. Pensioner concession cardholders (including DVA) are eligible for free ambulance transport. St John Ambulance also operate a subscription scheme, where NT residents can insure.

This brief overview of emergency transport shows the disparity between jurisdictions. Overall, it appears that groups who are less likely to have private health insurance and who may include more patients likely to require emergency treatment, may be faced with a hefty bill if they require emergency transport to hospital. The exclusion of concession cardholders in some states from free emergency transport is surprising and inequitable.

Notes

1 *Communique and Key Recommendations* from the 8th National Rural Health Conference, Alice Springs, March 2005.

2 *Healthy Horizons: Outlook 2003–2007. A Framework for Improving the Health of Rural, Regional and Remote Australians*, Australian Health Ministers and the NRHA, Canberra, 2003.

3 Email from Amanda Webber, 23 June 2005.

4 Therefore, if patients are on holiday/business and need to travel (within the state, interstate or overseas) they are not eligible for assistance.

5 A clinical decision is needed from one of the four Directors of Medical Service in such a case.

6 Patient Travel and Subsidy Scheme. Information for patients and their carers. Available at: <http://www.health.qld.gov.au/services/community/ptss/www11399doc.pdf>.

7 Quine et al. Rural Remote Health. Health and access issues among Australian adolescents: a rural-urban comparison. 2003;3:245.

8 Caldwell et al. Suicide and mental health in rural, remote and metropolitan areas in Australia. Med J Aust. 2004;181 (Suppl): S10–4.

9 It is more likely that the interstate system would be involved in funding such treatment.

10 Patient Travel Scheme, Special Rulings. Available at <http://www.nt.gov.au/health/hospital_svs/pats/special.pdf>.

11 Such patients receive a flat rate of $20 per return trip.

12 The cost of in-transit public transport and taxi fares are subsided at the following rates: one visit/consultation, up to $20; short-term visit (2–7 days), $40; medium-term visit (8–14 days), $80; long-term visit (15 days or more), $160.

13 As long as the child is a dependent.

14 An example might be if a newborn baby was seriously ill. Both parents would be granted assistance to accompany the child for treatment.

15 The claimant must pay the first two nights' accommodation before bulk-billing is permitted.

16 GST is not reimbursed in NSW. Where the GST is not identifiable, one eleventh is deducted as the GST portion of the total cost. It is not clear whether a similar situation exists in other states.

17 Teething problems have been reported with this scheme, as the property is essentially charged rather than the individual. This disadvantages owners of more than one property and advantages cases where many people live at the same address.