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CASE STUDIES IN PATIENTS’ TRAVEL:

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JODIE ALTSCHWAGER: Thanks, John. Firstly, I would like to thank the National Rural Health Alliance and the health consumers of rural and remote Australia for inviting me here today. As John said, I do work in the Royal Adelaide Hospital, which is a nasty city hospital which has about 190 country patients on average in it, so hence that’s why we have a rural liaison nurse, in case some of you are confused as to why a city nurse should be standing out here in front of you.

I’ve been the creative manipulator of the inflexible PATS schemes for many years now, having working in a hospital that has the pleasure of frequently using about five of the different schemes. These are the South Australian, the Victorian, the Northern Territory, the occasional WA resident, and my favourite, being really sarcastic there, the IPTAS scheme in New South Wales. I can quote the rules of every scheme in my sleep. I’ve heard all the rhetoric on how this new form that we’re developing for this scheme is actually going to change everything. I don’t know if any of you have seen the new Victorian form which came across my desk last week. I didn’t think the old one was that bad, so I’m not sure what quite inspired the new changes, but I would suggest they were perhaps not consumer-related. I have some copies here perhaps you could pass around while I’m talking, and if any of you think you can your writing in the boxes, you’re doing better than me.

I sign hundreds of South Australian PATS forms a year and assist in the completion of many of the other state forms, sometimes in a very creative manner, to get the best deal for the patient, but usually always quite legally. Within South

Australia I encourage the rural based healthcare providers and consumers to take a lead role in the promotion of the schemes, and as a city-based nurse I am continually frustrated at the lack of knowledge by people as they come into the hospitals of these schemes, and it takes city-based people often to educate people and assist them with the scheme. I'm aware of the time restrictions, so my case studies are pretty general, but they're going to be quick to keep John happy.

This one is one that will always stick with me. This man is an Aboriginal man from Gove. He came down to Adelaide on a commercial flight. His wife wasn't approved as an escort. He had a significant head and neck tumour. He had an emergency tracheostomy in his initial panendoscopy investigation where something went wrong that shouldn't have early in his investigations and he ended up with a tracheostomy. I was asked to see him once he had a tracheostomy by one of his friends who was concerned that his wife wasn't approved as an escort. When contacting patient travel in the Northern Territory, they stated he wasn't approved an escort because he could speak and understand English quite well. There was no consideration for his significant diagnosis or the fact that he had a tracheostomy.

Luckily for this man, he had a very good friend who was in the medical profession who paid for his wife's flight and provided accommodation for her at their house in Adelaide. They would bring her into town when they were bringing the kids to school and when they started work, and then take her home at the end the day. The patient proceeded to have his extensive head and neck surgery, a PEG tube inserted for nutrition, and discharged from hospital into an Aboriginal hostel for six weeks of radiotherapy.

He needed his wife with him to assist with his PEG tubes and his permanent tracheostomy. He would not have managed at discharge from the Royal Adelaide without his wife's assistance and it wasn't until probably halfway through his radiotherapy that his approval for an escort was granted, after much negotiation and many hours of work, which was very disappointing. It was approved and she did get her flight home, as did he, and their ongoing accommodation from that point of approval, but no historical reimbursement, and their friend paid a lot of the bills for the accommodation and we supported them as much as we could.

This is a classic story which is repeated several times. In the recent Health Consumers newsletter you will see two other case scenarios which have come from the Royal Adelaide. It takes a lot of negotiation to assist these patients. There is no consistency in the approval of escorts from the Northern Territory really. I've seen cases come down where I can't understand how this person had their wife approved as an escort, when this bloke couldn't. It's disturbing. I'll just leave it at that, because I could go on.

This next example is a bloke that I saw on Monday this week. He's a 50 year old man. He's quite capable. He's a professional man who was transferred from a local regional hospital with an extensive laceration to his hand. He was transferred by the Royal Flying Doctor. He underwent plastic surgery and

significant tendon repair to the hand. I was contacted by the ward on Monday to assist him in arranging his transport home as he had no idea how he was going to get home. Now, this bloke lived in New South Wales, went to a regional hospital in Victoria and came to the nearest specialist which was in South Australia. So travelled across three states to get here, and he was not aware of the PATS scheme.

This is what he got. He was a New South Wales resident who could access the Isolated Patients Scheme. He self-funded a trip on his credit card. Now, he's a bit of a strange person because he actually had a credit card with him so that was really good and he had the funds because he was a professional and could work. He was not eligible for the flight reimbursement that he had. He chose to fly, and I would have too, but he would only be medically allowed to travel by road because he didn't have an injury that was significant enough to warrant air approval, which he would have to get before he flew. So he would be reimbursed 12.7 cents per kilometre one way back to Broken Hill. We could have been creative if his wife was here and approved an escort on the basis that he was post-acute with pain issues and couldn't drive. She wouldn't have got any flight reimbursement though.

Chasing of the medical staff to complete the form is a constant battle. I had to ring the Mildura Base Hospital, get the referring doctors to fill the form in, get them to fax it to me, get our doctors to fill the form in and then give it to the patient. The patient would not have put in a claim if he had had to chase the forms himself. They're quite daunting, the IPTAS forms. So he was out of pocket at least \$150, and like I said, without my assistance I doubt he would have bothered with a claim.

If he was from Northern Territory, he probably wouldn't have been too bad. He certainly wouldn't have had an escort because his injury wasn't significant enough. He would have had a commercial flight home booked and paid for by the Regional Patient Travel. Of course, if he had had this accident in Alice Springs or Darwin or Gove or Tennant Creek, follow up in Adelaide in two weeks' time would not have been approved. He would have had to stay down in Adelaide for two weeks in some commercial accommodation or with friends and then fly home if he wished to have that follow up. Even if there wasn't that follow up in the Northern Territory, he does need to be seen in two weeks because he had significant tendon injury, so he probably would have had to stay down in Adelaide, because the timeframes for the turnaround flights would have been too close. So knowing him, he probably would have refused to have follow up in Adelaide and just gone home anyway.

If he was a Victorian, well, I'd have to help him fill out the form. I still would have had to chase the forms from the hospitals and get our medical staff to complete them as well because I'm not allowed to sign the specialist section for any of the other schemes except the South Australian scheme, even after much negotiation. He would have to pay the first \$100 of his travel as he wasn't on a Healthcare card and then for the subsequent trip he could probably get his mileage

back, but a lot of people are deterred because what's the point? On the first trip you're going to get your money back anyway.

Escort would have been approved if his wife had come over, so her accommodation could have been covered. The flight would have been covered. We would have manipulated the system to allow him to fly, and he could put several trips on one form, which was always a bonus with the Victorian scheme. His outpatient follow up then could have been put on the same form, but he would have had to wait some time before he got some reimbursement.

If he was a South Australian, he probably would have done okay. I could have filled his form in in five minutes flat and he wouldn't worry about it and I'd probably submit it for him as well. He'd get full reimbursement for his flight and any escorts and if he didn't have the funds to pay for it, we would have paid for it and we would have been reimbursed from the PATS scheme for him. There would be no need for the referring section of the form to be completed because he came from another hospital RFDS, and I would just write "RFDS transfer" and they accept that. No other scheme is accepting that that I use on a regular basis except the South Australian scheme. And he wouldn't have been out of pocket for anything at all. There would be no patient contribution because he came in an emergency.

So as you can see from these very brief studies, there's a lot of rules and inequalities across the schemes. It's a very medically-based model. It's archaic and complex, a lot of the forms. Nothing has changed in the whole concept behind the scheme for several years now. You need two medical officers to sign a form. You can go to theatre with less. I mean, it's ridiculous, the amount of specialty approval or medical staff approval that you need on these forms, and I think that's a significant change that should occur. The complexity of the forms is a deterrent and I think that they may be like that on purpose because it's certainly saves your PATS budget because it deters people from actually filling them in.

So the forms definitely need to be simplified and I think perhaps a national approach is a good way to tackle it, but I think you'll get quicker wins on a state approach and going really hard at your state offices, and that's how I've been able to get some gains with the South Australian PATS scheme, is just drilling and drilling and drilling and giving a case summary and ringing them all the time every day and saying, "What else am I supposed to do with this patient?", and then they sort of succumb slowly over a period of 10 years. Thank you.

JOHN WAKERMAN: Thanks, Jodie. It is worth saying PATS is a state responsibility and we were very strongly remind of that yesterday.