DEPARTMENT OF **HEALTH**

Review of the Patient Assistance Travel Scheme

July 2013

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1. Introduction

The Northern Territory Patient Assistance Travel Scheme (PATS) promotes equity of access to specialist services for permanent residents of the Northern Territory. The scheme provides a financial subsidy to cover a portion of the 'out of pocket' expenses incurred when residents need to travel long distances to access specialist services; however the scheme cannot address all circumstances or situations and is not intended to fully fund travel.

All jurisdictions in Australia operate some form of travel assistance scheme and the schemes are governed by some shared principles:

- Providing financial assistance for people to travel between their principal residence and the nearest available specialist service.
- Governed by guidelines which outline patient eligibility and entitlements under the scheme.
- Specifying the specialist health services that qualify for support under the scheme.
- All schemes provide a partial subsidy only. It has never been within the scope or intention of any jurisdictional scheme to fully fund the travel and accommodation expenses for patients attending specialist services.

The Northern Territory scheme was last reviewed in 2008. There has been a view expressed that the subsidy levels do not reflect the increased cost of travel since 2008 and have fallen behind the subsidy levels of other jurisdictions.

A commitment was made by the Northern Territory Government in 2012 to a full review of PATS. Funding was provided to perform the review and an additional $7.5 million per annum was allocated to fund the implementation of recommendations from the review.

The review was undertaken between April and June 2013 in consultation with Department of Health staff, community groups and external health organisations and was informed by a Terms of Reference.

The specific objectives of the review were to:

1. Compare the level of PATS subsidy to programs nationwide.
2. Investigate and recommend priority increased eligibility and/or entitlements which can be delivered within the additional available budget.
3. Investigate and recommend options for reducing costs, including equity testing.
4. Review the current PATS guidelines in comparison to other jurisdictions and make recommendations that would bring the Northern Territory PATS into line with the majority of the jurisdictions.
5. Identify efficiencies in the administration of PATS, including client feedback on the streamlining of administration.

The scope of the review was confined to the operation of the scheme and the experience of users of the scheme; the foundation principles did not form part of the review.

2. Executive summary

The Northern Territory has one of the most geographically dispersed populations in Australia and an extremely low population density (approximately 0.17 persons per square kilometre). This presents many challenges in the delivery of specialist health services to its residents and PATS exists to assist Northern Territory residents in accessing these services.

The review of PATS did not include consideration of patient travel as a whole (for example, retrievals, evacuation or inter-hospital transfers) even though they were raised often and it was apparent that for most people there is no distinction between the various categories of patient travel. These other categories of patient travel are only discussed in the review where their operation impacts on PATS.

The number of PATS applications in the Northern Territory has grown each year and the reasons for this are varied. The aim of the review was to identify ways to constrain current and future demand along with increasing entitlements and eligibility and improving the patient experience. It was also the intention of the review to bring the scheme into alignment with other jurisdictions where possible and appropriate.

In comparing the Northern Territory scheme with that of other jurisdictions it was found to compare quite favourably, as those jurisdictions with an apparent higher level of subsidy or expanded eligibility, also operate some form of co-payment scheme (with the exception of WA).

One of the first issues examined was eligibility for the scheme and recommendations have been made to make access to the scheme more equitable and to bring the scheme into line with other jurisdictions. These include:

- introducing provisions for frequent 'block' treatment so that patients who reside under the 200km limit, but have to travel to a specialist service regularly for treatment, can access financial assistance.

Another area examined was the level of subsidy available and recommendations have been made to increase these to recognise current market conditions and to bring them into line with, or in some cases ahead of, other jurisdictions. It is recommended that:

- the commercial accommodation subsidy be raised from $35 to $60 per night per person;
- the private accommodation subsidy be raised from $10 to $20 per night per person;
- an absolute limit of 12 months be introduced for claiming accommodation subsidies;
- following the death of a patient, accommodation of two nights be made available to an accompanying escort;
- the ground transport subsidy be increased from $40 to $50 per trip and extend it to all intrastate travel (currently only available for interstate travel); and
- the fuel subsidy be increased from 15c/km to 20c/km.

One area of concern raised in the review was that of the role and suitability of escorts for patients. The requirement for, and behaviour of, some escorts continues to be an issue of concern for many people involved in the scheme. Some recommendations have been made around automatic approvals for escorts but further work needs to be done on the issue on eligibility and suitability of escorts; however this will require further consultation with stakeholders to ensure the right balance is achieved.

Some areas of administration were identified for improvement during the review and these will be addressed in conjunction with the introduction of the new electronic Travel Management System (TMS) which is currently being implemented across the Northern Territory. Previously PATS was administered via a paper based system which connected with a rudimentary computer program. The data available from the old system is therefore thought to be unreliable and in some cases not collected (for example people deemed ineligible).

Another area identified for improvement was the current guidelines. The inconsistent nature of the current guidelines creates confusion and leads to out of policy use (both intentional and unintentional) and it is recommended that they be rewritten to provide clarity and support decision making. A recommendation has also been that following full implementation of the TMS and the release of the new guidelines that audits be made of the program to ensure appropriate usage of the scheme.

In terms of eligible services, it is the intention of PATS to provide access to a number of specialist services. In some cases it also provides access to non-specialist services under a set of special rulings. Representations were made during the review for eligibility to be extended to incorporate non specialist services. However, access to many non specialist services are already provided by other programs in the Northern Territory Department of Health and it was felt that including additional services to PATS at this time would be potentially costly and change the basic principle of the scheme that it is for specialist services only.

Changes have been recommended however to the definition of the nearest specialist service as it was found during the review that the current guidelines are inflexible and do not take into account issues such as continuity of care or the benefits of family support in a patient's treatment and recovery.

In terms of reducing costs, equity testing was examined but found not to offer significant enough reductions to warrant introduction.

As fares and aircraft charters are the single component of PATS that is 100% funded, and responsible for 78.13% of total PATS expenditure, the only truly effective way to reduce expenditure under PATS is to reduce the need to travel. One of the most effective ways this can be achieved is by the delivery of specialist consultations through Telehealth facilities where appropriate. The provision of care via Telehealth services is a program that is gaining prominence in the Northern Territory, with opportunity for wider use.

To this end the establishment of a program has been recommended which would evaluate whether establishing Telehealth as an option of first choice (before visiting specialist services or travel) is viable and effective. If this connection was established Telehealth should be identified in the guidelines as the first option for treatment and review, before requiring a patient to travel to a tertiary facility.

3. Summary of Recommendations

Recommendation 1 Provision be made for fuel subsidy financial assistance for patients travelling a cumulative distance of 400kms or more per week for oncology and renal services. 15

Recommendation 2 The commercial accommodation subsidy is raised from $35 per night, per person to $60 per night, per person.

Recommendation 3 Increase the private accommodation subsidy from $10 to $20 per night, per person. 19

Recommendation 4 Introduce an absolute time limit of 12 months on accommodation subsidies. 20

Recommendation 5 Increase the ground transport subsidy amount to $50 per return trip.

Recommendation 6 Expand eligibility for the ground transport subsidy to include intrastate travel. 22

Recommendation 7 Increase the fuel subsidy level from 15c/km to 20c/km. 23

Recommendation 8 Cap the per vehicle claim to no more than the total cost of fuel for the trip. 24

Recommendation 9 Allow approval for children under the age of two years to accompany their mothers and for an escort to be automatically approved to assist the mother and child. 26

Recommendation 10 Allow automatic approval of an escort for a child under the age of 18 years 27

Recommendation 11 Allow automatic approval as escorts for both parents when their child is under the age of 18 years and travelling for treatment of a life threatening condition. 27

Recommendation 12 That where one escort has been approved, but has failed to perform the roles and responsibilities of an escort and another escort is requested, financial assistance under PATS for the replacement escort is not provided and must be funded by private means. Exceptions to this policy must be escalated to a Tier 2 Executive. 28

Recommendation 13 Upon the death of a patient, an escort be deemed eligible for two nights of accommodation in order to make repatriation and own travel arrangements. 33

Recommendation 14 Develop an updatable register of decisions capturing out of policy travel request outcomes 34

Recommendation 15 Adopt a hybrid model allowing clients to book own travel and claim reimbursement at the appropriate subsidy level defined in the guidelines and to extend the claim period from 28 days to three months. 36

Recommendation 16 A comprehensive audit and reduction in the number of authorised approvers to ensure that the approval process is managed efficiently and consistently and in policy. 36

Recommendation 17 Audit all PATS approvals over six month period and to identify and analyse those approvals which are outside the guidelines. 37

Recommendation 18 PATS guidelines to be re-written in clear unambiguous language, and made available to all stakeholders as a priority, incorporating the accepted recommendations. 37

Recommendation 19 Establish a Telehealth Pilot over an operational period of 12 months, including stakeholder education, community programs, primary health support and an evaluation of outcomes and funded from the PATS budget. 42

4. The Northern Territory Patient Assistance Travel Scheme

The Northern Territory PATS has been in operation since the late 1980s and prior to that was operated by the Commonwealth government as the *Isolated Patients Travel and Accommodation Assistance Scheme*.

Over the years there has been an increase in usage of the program in the Northern Territory, *see Table 1 – Number of travel requisitions*. The reasons for demand growth are multifaceted and include population increase, an ageing population, the burden of chronic disease, the increase in remote services, more advanced diagnostic services and increased level of referrals. A greater awareness of PATS among service providers and the community also drives increased use. It is noted that there is some concern about the reliability of retrospective data held.

Although it is expected that growth in the use of PATS will continue, a more efficient use of the program is certainly possible, and areas where savings can be made have been identified in the report.

Table 1 – Number of travel requisitions

Financial Year	Interstate	Intrastate	Total	% Increase or Decrease
08/09	2,368	15,460	17,828	-
09/10	2,540	16,849	19,389	8.76
10/11	2,707	17,482	20,189	4.13
11/12	2,775	17,689	20,464	1.36
12/13 (to End April 2013)	2,430	17,916	20,346	Year incomplete

The majority of expenditure is for commercial fares (60.17% of the total). This includes bus and aircraft journeys. Accommodation is the second highest expense (19.2% of the total). The current subsidy of $35 per night is paid towards the patient's accommodation and an approved escort, if applicable. Any additional expense for accommodation is the responsibility of the patient and escort. A lower subsidy of $10 per night is paid if the patient and escort stay in private accommodation.

Aircraft charters (to transport patients from communities to regional centres) is 17.96% of the total. A kilometre allowance can be claimed for private vehicle travel expenses at the rate of 15c/km. These claims are a small component of the funding (2.11%). Combining commercial fares and aircraft charters shows that fully subsidised travel (i.e. 100% covered by PATS program) accounts for 78.13% of total PATS expenditure.

5. Comparison of jurisdictional schemes, eligibility and subsidies

Each jurisdiction in Australia operates a travel subsidy scheme for patients and the schemes share common principles:

- Providing financial assistance for people to travel between their principal residence and the nearest available specialist service.
- Governed by guidelines which outline patient eligibility and entitlements under the scheme.
- Specifying the specialist health services that qualify for support under the scheme.
- All schemes provide a partial subsidy only. It has never been within the scope or intention of any jurisdictional scheme to fully fund the travel and accommodation expenses for patients attending specialist services.

In the Northern Territory, to qualify for PATS and receive subsidised travel and accommodation under the program the patient must meet all of the following criteria:

- be a permanent resident of the Northern Territory(with their usual residence in the Northern Territory);
- need to travel a minimum distance of 200km to obtain essential specialist medical treatment;
- be eligible for Medicare;
- be utilising an eligible service; and
- travelling to the nearest available service.

In the Northern Territory the current subsidies are:

- commercial accommodation at $35 per night;
- private accommodation at $10 per night;
- private vehicle travel reimbursement at 15 cents per kilometre;
- bus and commercial air travel subsidised in full at the most economic and appropriate fare available; and
- ground travel at $40 per return journey for interstate travel only.

In each jurisdiction there are differences in the level of subsidy available and the eligibility requirements for access. This section compares the eligibility requirements and subsidies in each jurisdiction to those of the Northern Territory PATS. Recommendations are based on comparative analysis of the comparable programs and current market conditions.

The cost modelling associated with the recommendations are based on best possible estimates given the demand driven nature of the scheme.

Exclusions common to all jurisdictions

A general principle across the jurisdictions is that patient travel subsidies are only provided when there is no other source of external funding available to the patient. Such exclusions are necessary to prevent 'double dipping'.

All jurisdictions, including the Northern Territory, exclude patients who are eligible for assistance through other funding arrangements such as Veterans Affairs, Motor Vehicle Accident Insurance and Workers Compensation. NSW requires all patients to declare that they are not eligible for reimbursement from any other source; including private health insurance and SA require that a patient with private health insurance must claim the maximum benefit available from the private health fund first, if applicable.

Residency requirements

Almost all jurisdictions require patients to be an Australian citizen who is a permanent resident of the jurisdiction and eligible for Medicare. The exception is the ACT which also provides cover for asylum seekers. WA specifically excludes FIFO workers who do not reside permanently in the state. Queensland is the only jurisdiction that provides coverage for visiting Australian residents, effectively covering 'grey nomads' travelling through the state.

The Northern Territory is the only jurisdiction to impose an initial residency qualifying period for access to PATS. The guidelines state that:

- The qualifying period is six months and the client must continue to reside in the Northern Territory for a minimum of 6 months of each year.
- The qualifying period can be reduced to three months by providing evidence of residency.

Even though this provision is out of step with most other jurisdictions, given the highly transient nature of the Northern Territory population it is recommended that this provision be retained.

Distance eligibility

All schemes have eligibility criteria defining the minimum distance the patient needs to travel to reach their nearest specialist medical service before being eligible for a subsidy (see Table 2 Distance eligibility criteria by jurisdiction).

Table 2 Distance eligibility criteria by jurisdiction

Jurisdiction	Minimum Distance	Method of Calculation
NT	200 kilometres one way	Distance by road from town of residence to town of treatment; or from home address to town of treatment if patient resides outside town boundaries.
NSW	100 kilometres one way or 200 kilometres cumulatively per week	Whereis.com / NRMA / Global Positioning System (GPS)
VIC	100 kilometres one way or 500 kilometres per week on average for five consecutive weeks (block treatment)	Google Maps: Patients residence to specialist service
QLD	The service is located 50 kilometres or greater from nearest public hospital.	For reimbursement when using private vehicle: calculated from the Post Office closest to patient's home to Post Office closest to medical specialist. Otherwise, transport costs covered from transport terminal in the town of patient's local public hospital to the transport terminal in the town or city to which the patient is travelling.
WA	100 kilometres one way 70 kilometres one way, for renal and oncology services	Distance Book – Main Roads WA
SA	100 kilometres one way	GPS calculations Postcode of patient's residence to Post Office nearest specialist service
TAS	75 kilometres one way, 50 kilometres one way, for renal and oncology services	Each health service has distance listing for their local areas by road, town distances.
ACT	N/A (Subsidy provided for interstate travel)	N/A

The most common minimum one way travel criterion is 100km, with Queensland set at 50km and Tasmania 75km. In the Northern Territory the minimum distance criterion is a distance of 200km distance one way.

Given the heavy demand on the PATS, and the large geography of the Northern Territory, it is recommended that the distance remain benchmarked at 200 kilometres.

Frequent (block) treatment

When a patient needs to travel frequently for treatment, even when they do not meet the minimum travel distance requirement, the total amount of travel undertaken can create an impost. Some jurisdictions cover frequent travel expenses under 'block treatment' provisions designed to cover those patients who do not meet the minimum distance requirement, but are undertaking treatment that requires frequent journeys over a short period of time. The cumulative distance is then taken into consideration to enable a claim for a fuel subsidy. Four jurisdictions (refer *Table 3 Cover for block treatment – jurisdictions and criteria*) provide block treatment arrangements covering oncology and renal patients.

Table 3 Cover for block treatment – jurisdictions and criteria

Jurisdiction	Distance Criteria
VIC	500 kilometres per week on average for five consecutive weeks
NSW	200 kilometres in one week
TAS	50 kilometres one way for renal and oncology services
WA	70 kilometres one way for renal and oncology services

For example; someone living in Batchelor (which is under 100kms from Royal Darwin Hospital) travelling each day for cancer treatment at the Alan Walker Cancer Care Centre could accumulate approximately 1400km in a week depending on their treatment regime.

Renal patients may also benefit; for example there are currently 14 renal patients in Santa Teresa who dialyse in Alice Springs (81 kilometres from Alice Springs) and they would be eligible for this subsidy if block treatment coverage was introduced.

It is not anticipated that there will be a high level of usage of this additional entitlement but it will provide support for those people who have to travel several times a week for treatment.

Recommendation 2
Provision be made for fuel subsidy financial assistance for patients travelling a cumulative distance of 400kms or more per week for oncology and renal services.

6. Travel subsidy amounts

It is important to re-emphasise that all patient travel schemes in Australia are funded on a subsidy basis only. No jurisdiction covers all costs incurred by the patient when they attend a specialist service.

Adding complexity to the comparison is the level of co-payment required by some jurisdictions. A co-payment means that the apparent 'headline rate' of subsidy may be less generous than a lower subsidy level once the co-payment is factored in. In this section we have reviewed the various subsidies to determine how the Northern Territory compares when these variables are taken into account.

All jurisdictions provide subsidies for accommodation and a fuel allowance for private vehicle travel. The fuel allowances are all quite low and are not intended to cover wear and tear or depreciation on the vehicle, only a portion of the cost of fuel on a cents per kilometre basis. Some schemes provide support for ground transport, which is the incidental travel between a transport hub and accommodation, and between accommodation and the specialist service.

The modes of travel subsidised under the various programs also vary and are determined by necessity in each jurisdiction. For example in the ACT, air travel is only approved in the most serious cases. In the Northern Territory a much higher use of air transport is a necessity, given the distances travelled, the sparse population and the prevalence of remote and extremely remote communities. As demographics are the main determining factor for the modes of travel permitted in each jurisdiction, they have not been compared. Focus has instead been placed on accommodation, fuel subsidies and the provision of incidental ground transport.

Accommodation subsidies

Accommodation subsidies vary between jurisdictions *(see Table 4 Accommodation subsidies compared to Northern Territory).* Overall, the Northern Territory rate of $35 per night per person (up to $70 per night with an approved escort) compares quite favourably with other jurisdictions, with the exception of WA.

Jurisdictions with a headline rate of subsidy higher than the Northern Territory also include some form of co-payment *(see Table 5 Patient co-payment by jurisdiction).* The co-payments can negate the headline rate advantage in these jurisdictions for the occasional user.

Table 4 Accommodation subsidies compared to Northern Territory

Jurisdiction	Accommodation Subsidy	Comparison to Northern Territory
NT	Commercial: $35 per night per person Maximum is $70 per night where an escort is approved. Private: $10 per night. Maximum $20 per night where an escort is approved	
NSW	Co-payment required. Commercial: Single $43 per night; Double $60 per night with approved escort. Private: $20 per night	Single is $8 more than the NT. Double is $10 less than the NT. Private is $10 more than NT
VIC	Co-payment required. Commercial: $35 per night plus GST for each patient and escort (if approved). No private accommodation subsidy	$3.50 more than Northern Territory as the GST inclusive payment is $38.50.
QLD	Co-payment required. Commercial: $60 per night. Private: $10 per night.	Commercial rate $25 more than NT. Private is same as NT.
WA	Commercial: $60 per night single ($75 per night for patient and approved escort). Private: $20 per person per night.	Commercial single rate $25 per night more than NT for a single; $5 more for patient and escort. Private is $10 per night more than NT.
SA	Co-payment required. Commercial: $30 per person, per night; $60 maximum with two escorts.	Single is $5 less per night than NT. Double is $10 less per night than the NT.
TAS	Commercial: $46 per person per night for intrastate; $64 per person per night for interstate. No private accommodation subsidy is provided	Commercial rate is $11 more for a single and $29 more for a double. NT private accommodation rate is $10 per night more.
ACT	Commercial: $36.90 per night for patient and/or escort Private: $11.28 per patient and/or escort	Commercial rate is $1.90 more for a single and $3.80 more for a double, compared to the NT Private is $1.28 more per night than NT.

Table 5 Patient co-payment by jurisdiction

State / Territory	Co-payment requirement
NT	No co-payment required.
QLD	First four nights accommodation paid by the patient in each financial year, unless a Pensioner Concession or Health Care card holder
NSW	$40 co-payment from the patient for each return journey unless a Pensioner Concession or Health Care card holder ($40 paid once for weekly treatments) $40 waived once patients subsidy reaches $1,000 over a 12 month period.
WA	No co-payment required
SA	$30 for each travel claim
VIC	$100 co-payment every 12 months, unless a Pensioner Concession or Health Care card holder.
TAS	$15 per trip for Pensioner Concession or Health Care card holder, capped at $120 per annum. $75 per trip for non-concession patients, capped at $300 per annum
ACT	No co-payment

Example:

Queensland provides a subsidy of $60 per night, per person for commercial accommodation, but the client and escort (if applicable) are required to contribute the first four nights of accommodation per financial year. The Northern Territory contributes a lower amount of $35 per night, but the contribution is payable to both client and escort from the first night. If a person was to claim for seven nights of accommodation in a financial year under the Queensland scheme they would be reimbursed $180.00, while under the Northern Territory scheme they would receive $245.00.

Note: this contribution is not required if the client holds a Health Care Card, a Pensioner Concession Card or a Commonwealth Seniors Card, or is a dependent children under 17 years of age. For lengthy treatment episodes or chronic conditions requiring frequent travel the Queensland scheme would provide a higher rate of subsidy.

During the consultation process the low rate of subsidy was raised many times and most people spoken to noted that unless accommodation could be found in a hostel the travelling patient was significantly out of pocket. Hostel accommodation is also in very short supply and there has been a contraction in the number of hostel beds over time as

the subsidy level has not kept pace with increased costs. The private sector has withdrawn from the market and the remaining hostels are government funded.

In some cases where accommodation cannot be found in a hostel PATS staff will authorise the payment of the full cost at a commercial facility, hotel or motel, as the patient has indicated they will not travel otherwise. An increase in the payments to hostels that would result from an increase in subsidy may lead to an improvement in the supply of this type of accommodation through private enterprise, although this is not guaranteed. If supply does increase over time the additional hostel beds could reduce the 'out of policy' approval of commercial hotel/motel accommodation, with reduced costs to the scheme.

Commercial hotel/motel accommodation rates in the Northern Territory are increasing rapidly due to market conditions and the availability of suitable accommodation is also limited, particularly in regional centres. An increase in the commercial accommodation subsidy will provide a greater degree of equity to the patients who are contributing to accommodation costs, reducing the financial impact on these patients.

Not all patients stay in commercial accommodation, with some patients choosing to stay with family or friends. Private accommodation is currently subsidised at a rate of $10 per night for both the patient and one approved escort if applicable. The subsidy is paid to the patient, not to the private individual providing the accommodation. Private accommodation subsidies are not paid at all in Victoria and Tasmania, and substantially higher subsidies are paid in WA and NSW compared to the Northern Territory.

It is recommended that to recognise the change in market conditions since 2008 and the rising cost of commercial accommodation the accommodation rate be increased to $60 per person per night from the first night. And that the subsidy rate for private accommodation is raised to $20 per person per night.

Recommendation 3
The commercial accommodation subsidy is raised from $35 per night, per person to $60 per night, per person.

Recommendation 4
Increase the private accommodation subsidy from $10 to $20 per night, per person.

Accommodation subsidy period

The Northern Territory and four other jurisdictions place time limits on the provision of accommodation subsidies (refer Table 6 Accommodation subsidy periods compared to the Northern Territory)

Table 6 Accommodation subsidy periods compared to Northern Territory

Jurisdiction	Subsidy period
NT	Two weeks initial period, can be extended for up to eight weeks. Additional extension up to six months maximum of continuous accommodation.
NSW	No time limit indicated
VIC	No time limit indicated
QLD	Reviewed monthly
WA	Not greater than six months for a single trip, patients staying longer than month encouraged to seek rental accommodation
SA	Ongoing subsidies no longer than three months in a twelve month period
TAS	Time limit not specified but patient's staying longer than the minimum time needed must pay for any additional accommodation and the difference in airfares if applicable
ACT	No time limit indicated

The current PATS guidelines provide for a subsidy of two weeks which can be extended to eight weeks when recommended by the practitioner and approved. This can be further extended to a maximum of six months in certain circumstances. In practice however additional extensions are made as the six month limit is defined as 'continuous accommodation'. Patients may remain interstate between treatments and claim the accommodation subsidy when undergoing a treatment episode. This means that they are not receiving a 'continuous' subsidy in excess of six months but are being subsidised for intermittent periods in excess of two years, and not living in the Territory during that time.

This raises the issue of when a patient should be deemed to have relocated and no longer a resident of the Northern Territory. An absolute 12 month time limit would give the patient ample time to plan and make suitable arrangements for relocation and it is recommended that this introduced for the accommodation subsidy.

Recommendation 5
Introduce an absolute time limit of 12 months on accommodation subsidies.

Ground transport

Incidental ground transport was an issue raised often in the review due to the lack of suitable public transport in many areas. Current guidelines provide a subsidy for patients approved for interstate travel of $40 subsidy per return journey for ground transport, to use at their discretion. This is for use only once they reach their interstate destination, and not in the Northern Territory. Feedback from the public, clinicians and support staff indicated that this the lack of support for ground travel was an issue for intrastate travel as well.

In Central Australia examples were given of patients arriving at Alice Springs airport and having to walk back to Alice Springs. There is no regular public transport available; taxis and airport shuttles are available but are unaffordable for many patients. In some instances the Aboriginal Liaison Office (which has a vehicle available) has been sent out to look for patients who have not made it back into the hospital. This increases risk for the patient both clinically and from a road safety point of view, and raises significant duty of care concerns and risk exposure for the department.

In Darwin the Top End Patient Transport service (TEPTS) transports patients to and from their accommodation and/or the airport to Royal Darwin Hospital for treatment. There is no cost to the patient and it is funded from Royal Darwin's budget. The service runs from Monday – Friday 6am to 10pm. On weekends there is a limited service for renal patients only, but no service runs on public holidays and the service does not operate past Berrimah. This service was designed to provide access from accommodation to appointments, and on this basis does not provide a service out of hours.

Other jurisdictions cover forms of ground transport in certain circumstances but there is no uniformity *(see Table 7 Ground transport subsidies by jurisdiction).* NSW has the most generous subsidies for ground transport (up to $160 per return journey varying by length of stay), with some other jurisdictions covering taxis only if no other form of transport is available. The variation in amounts and eligibility criteria makes it difficult to perform a direct comparison that would align the Northern Territory with the majority of jurisdictions.

Table 7 Ground transport subsidies by jurisdiction

Jurisdiction	Subsidy
NT	$40 ground transport per interstate trip; none for intrastate; payable automatically, no receipts are required
QLD	Specifically excluded at destination.
NSW	Ranges from $20 for one day trip to $160 for 15 days or more
WA	Will cover taxi if no other form of transport available
SA	Will cover taxi if no other form of transport available
VIC	Will cover taxi if no other form of transport available
TAS	Only if most economical form of transport
ACT	Not covered

Given it was raised as a real concern during the review, it is recommended that the subsidy for ground transport be increased to $50 per trip and extended to all intrastate as well as interstate travel and where appropriate the subsidy to be provided in the form of taxi vouchers to ensure its use for the intended purpose. It may also be possible to negotiate contract rates with appropriate service providers to reduce rates charged and control expenditure directly.

A ground subsidy provided to all patients would position the Northern Territory ahead of most other jurisdictions, and also address a need raised many times in the review.

This extension of subsidy would be on a per patient basis only. Escorts, if travelling separately would not be entitled for a ground transport allowance. In other words, the subsidy would be $50 per return trip regardless of whether or not the patient was accompanied by an escort.

Recommendation 6
Increase the ground transport subsidy amount to $50 per return trip.

Recommendation 7
Expand eligibility for the ground transport subsidy to include intrastate travel.

Fuel subsidy

Fuel subsidies in all jurisdictions are low and are in most cases contribute a portion of the cost of fuel that would be incurred by the travelling patient. None of the jurisdictions compensate for wear and tear or depreciation of the vehicle.

In the Northern Territory, patients who travel by private vehicle to an appointment can claim a reimbursement for fuel expenses at the rate of 15 cents per kilometre travelled. The distance is calculated from home to the specialist medical centre. The Northern Territory is the only jurisdiction that increases the subsidy based on the number of patients travelling in the one vehicle. If more than one patient (excluding escorts) travels in a vehicle the fuel subsidy can be claimed for each patient, up to a maximum of three patients. This equates to a maximum reimbursement of 45 cents per kilometre.

Table 8 outlines fuel subsidy by jurisdiction. It should be noted that fuels costs are volatile and are higher in the Northern Territory than in other jurisdictions, the most recent data indicating that the regional average price in the Territory is approximately 14% higher than the national regional median.

Table 8 Fuel subsidy levels by jurisdiction

Jurisdiction	Rate (c/km)	Comparison to Northern Territory
NT	15	-
QLD	30	15c more than Northern Territory
NSW	19	4c more than Northern Territory
WA	16	1c more than Northern Territory
SA	16	1c more than Northern Territory
VIC	17	2c more than Northern Territory
TAS	19	4c more than Northern Territory
ACT	Up to a maximum of $104.53 per trip	

The outlier in this comparison is Queensland which has a 30c/km headline rate, double the Northern Territory. However Queensland's subsidy is measured not from the patient's residence to the nearest specialist service, but from the post office nearest the patient's local hospital to the GPO or post office in the city where the patient receives treatment. This could work to the patient's advantage in some circumstances, where they live in-between the two points, or to their disadvantage if they live outside the origin point and have to travel through.

Claims for fuel do not comprise a significant component of PATS budget (2.11% of the total). The estimated increase in cost has been factored into the recommendation.

It is recommended that the Northern Territory recognise the rising costs of fuel and raise the reimbursement rate to 20c per km travelled, which will make the Northern Territory subsidy higher than all other jurisdictions with the exception of Queensland.

Recommendation 8
Increase the fuel subsidy level from 15c/km to 20c/km

Number of Patients per Vehicle

The kilometre subsidy is available for private vehicle travel and for local communities who transport patients to a health care facility. Owners can claim the kilometre subsidy on a per patient basis when more than one patient is travelling in the same vehicle. The fuel subsidy does not apply to commercial services, only private and community vehicles.

Currently the maximum claim allowed is for three patients in one vehicle – i.e. 45c/km in total. Representations were made that the maximum number of patients claimable in the vehicle should be removed so that communities could claim for each person on the bus. However, this could lead to claims being made for expenses above the total cost of the trip. It is not recommended that this maximum number of patients claimable per trip be increased and it is further recommended that the per vehicle claim does not exceed the total cost of fuel for the trip.

Recommendation 9
Cap the per vehicle claim to no more than the total cost of fuel for the trip.

7. Escorts

All schemes in Australia include provision for the patient to be accompanied on their travel by an escort in certain circumstances (*see Table 9 Eligibility for escort – comparison by jurisdiction*). Escorts in all jurisdictions must be 18 years of age or older, and able to assist the patient during their journey and while undergoing treatment. No jurisdiction provides for emotional support alone.

Table 9 Eligibility for escort – comparison by jurisdiction

Jurisdiction	Eligibility for an Escort
NT	Automatic under 16; provision for up to 18 years of age given clinical or social conditions. Patients travelling interstate for intensive therapies or surgery, or IVF Frail or chronically ill; ambulatory issues; significant physical, intellectual, behaviour or emotional disabilities; where escort required to allow informed decision making or consent; language and cultural barriers.
QLD	Automatic under 17 or under sedation or requiring oxygen Patient cannot care for themselves, or escort is required to participate in treatment or rehabilitation.
NSW	Automatic under 17 Escort has to travel with patient; not covered for separate travel Must be deemed necessary by medical practitioner
WA	Patient is a child or is under the care of a principle carer Home dialysis patients receiving training Escort is required to make decisions on behalf of the patient Referring practitioner deems it necessary
SA	Automatic under aged 17 and under Escort has to travel with patient; not covered for separate travel Deemed necessary by medical practitioner Other indications; physical impairment, carer, involved in medical treatment, support for person with mental illness or escort would be involved in major medical decisions; cultural reasons As an alternative to air travel, for example mental illness, psychosis, or visual or hearing impairment
VIC	Automatic under 18 Escort has to travel with patient; not covered for separate travel Deemed necessary by medical practitioner Indications for family to travel under certain circumstances; e.g. genetic testing
TAS	No escort as a default, unless a child under 17 Other patient is a organ transplant donor or recipient; requires assistance when travelling or being treated; high risk life threatening condition; serious morbidity
ACT	Automatic under 17 Escort must remain with the patient Cognitive impairment; carer, radiotherapy, person is required as part of the treatment, including decision making, non English speaking, visual or hearing impairment

In the Northern Territory if the patient is less than 16 years old an escort is automatically approved, with an escort approved for a patient up to the age of 18, depending on clinical and social circumstances.

There is also an automatic approval if the patient is travelling interstate for surgery or other intensive therapies and for IVF for eligible patients (where the escort is the partner and also required to attend for assessment or participate in the treatment procedure).

Generally jurisdictions leave the eligibility for escorts to the discretion of the requesting physician or approver based on their understanding of the patient's needs. It is recommended that this practice should continue with some amended provisions and some further work to be performed on the suitability and eligibility of escorts.

Dependent children

Concerns were raised in the review regarding women who are travelling into regional centres for treatment and/or maternity services and who have dependent children. Clinicians and community groups remarked that women often do not want to leave their young child behind when they travel, particularly if they do not have access to suitable child care arrangements at home. In some cases, to circumvent the restriction, the child has been approved as an escort, even though they are less than 18 years of age and obviously unable to perform the duties of an escort.

This is particularly the case for women who are required to travel to a regional centre for obstetric confinement and have a dependent child. Current practice recommends that expectant mothers residing in remote or rural areas travel to a hospital providing obstetric services at 38 weeks. Travel to the regional centre is eligible for travel assistance for the expectant mother, but no provision is made for dependent children.

No jurisdiction specifically mentions dependent children or escorts for expectant mothers, but to address this issue it is recommended that a dependent child under the age of two be permitted to travel with its mother if she is attending a regional centre for treatment or maternity services and that in these cases there is also automatic approval for an escort who must be able to provide the necessary additional care and support for the child and the mother.

Any older or additional dependent children should be assessed for eligibility to travel on a case by case basis, depending on available child care options. This would remain at the discretion of the PATS approver.

Recommendation 10
Approval for children under the age of two years to accompany their mothers and for an escort to be automatically approved to assist the mother and child.

Escorts for children undergoing treatment

The Northern Territory is also the only jurisdiction to limit the automatic approval of escorts to children under the age of 16 (with the possibility of 18 years in certain social or clinical

situations). The majority of jurisdictions allow escorts for patients up to the age of 17, with Victoria an age limit of 18 years.

Some people raised this issue as they felt the age of 16 was too low and that in reality most children were allowed an escort up to the age of 18. It is recommended that the age limit for an automatic approval of an escort be raised to 18 years. This also accords with the requirement that to act as an escort a person must be 18 years or older. It is consistent in principle to state that a child under 18 years of age, who cannot *act as an escort* under the guidelines, may also be eligible for an escort if the circumstances require it. Not all children above 16 years of age may need or desire an escort, but in the cases where they do, it should be approved.

Recommendation 11
Allow automatic approval of an escort for patient who is a child under the age of 18 years.

Life threatening situations

Other jurisdictions allow two escorts for a child under 17 if the condition is life threatening. Currently the Northern Territory makes no explicit provision of an additional escort in these circumstances. It is most probable that both parents would need to accompany their child in a life threatening situation, and it should be recognised that this requires additional support. It is recommended that the Northern Territory recognise the special needs of a child and its parents as a family unit in these cases. For consistency with Recommendation 11 it is recommended that an age limit of 18 years would be appropriate in these circumstances.

Recommendation 12
Allow automatic approval for both parents to be escorts, when the patient is their child and under the age of 18 years and travelling for treatment of a life threatening condition.

Suitability of Escorts to provide support to Patients

It is clear that the role performed by an escort can be extremely beneficial to the patient and improve their health outcome and it is equally important for escorts to understand their role and agree to meet their responsibilities towards the patient.

Problems involving the selection and suitability of escorts and their performance in the role were raised at every meeting during the review consultations.

There were several instances related where escorts accompany the patient to regional centres and interstate and then leave the patient and do not return. There are also cases where more than one escort is requested per treatment episode. Some offices fund this extra escort and some request payment from the family, or a combination of both, depending on the circumstances.

People consulted during the review felt that the guidelines make it possible for “just about anyone” to get an escort and that they are often put under pressure to approve an escort out of policy. PATS staff and approvers often stated that they felt ‘blackmailed’ into allowing an escort when they believed an escort was not necessary.

During consultations, an example was given of a patient refusing to board a pre-booked charter flight to attend an appointment unless an escort was allowed. This demand was made during the boarding process, with the health centre staff contacting the PATS office and asking for instant approval of the escort.

The issue of escort suitability generally is a difficult one to address in a broad sense as each situation is dependent on a person's circumstances and the approvers assessment of the situation. However, there is sufficient concern about this issue that a redevelopment of the guidelines will include a review of the risk assessment tool that is provided to PATS requestors, staff and approvers and guidelines should include an education component dealing with the issues of escorts and what alternatives might be available.

As an interim step and to limit the cost to PATS it is recommended that where an escort fails to undertake their role, the replacement escort should not be funded by PATS. It should be the patient or family's responsibility to replace the escort with a more suitable person under these circumstances. If a case is to be made for an exception to this ruling then it must be escalated to a Tier 2 Executive for approval.

Further work will be performed on the suitability and eligibility of escorts in consultation with stakeholders so that the best and most appropriate balance is struck.

Recommendation 13
That where one escort has been approved, but has failed to perform the roles and responsibilities of an escort and another escort is requested, financial assistance under PATS for the replacement escort is not provided and must be funded by private means. Exceptions to this policy must be escalated to a Tier 2 Executive.

8. Eligible specialist medical services

PATS provides Northern Territory residents with assistance to access specialist services, it is not intended to cover access to all health services; although there have been some Special Rulings (see Section 9) that have provided access to non-specialist services under certain conditions.

Eligible specialist services under the guidelines are currently defined as those services:

- funded by a Northern Territory public hospital;
- provided by a medical specialist; and
- defined by an item in the Commonwealth Medicare Benefits Schedule.

Specialties that the Northern Territory deems eligible for PATS are those recognised by the National specialist Qualification Advisory Committee of Australia. (*see Appendix B: List of accepted* specialties)

During the review treatment for diabetes was raised as a possible inclusion. It is at the moment specifically excluded, except where the referring service provider is a medical specialist, consistent with the intent of PATS. This and other exclusions will be clarified during the redevelopment of the guidelines, with the intention of removing any ambiguity or inconsistencies.

At present it is recommended that the present list of accepted specialities is retained, consistent with the intent of PATS for access to specialist services.

9. Special Rulings

Special Rulings applicable to PATS guidelines have been made, extending access to PATS for certain health services that are not considered specialist services. The Special Rulings are addressed below, only where they have been raised in the context of the review.

Allied health

Allied Health services may be approved under the current guidelines if intensive treatment is required before or after specialist medical or surgical treatment. Under these circumstances patients can receive assistance to access allied health treatment under PATS for an initial period of seven days, and up to a total of 21 days in certain circumstances. There is also allowance for one further visit, if required, after the patient has returned home. Allied Health services are not supported under PATS in any other circumstances.

Representations were made during the review that Allied Health should be included under the scheme. No jurisdiction supports Allied Health in isolation under their scheme, although some, like the Northern Territory, provide them in conjunction with the eligible specialist services included in their schemes.

The addition of stand-alone Allied Health services would be counter to the basic principle, that it is for access to specialist services, and add considerable additional expense to PATS program. It is not recommended that any change to the Allied Health special ruling be made.

IVF

Under the current Northern Territory guidelines, patients receiving IVF treatment and other assisted reproductive treatments are eligible for PATS assistance subject to the following criteria:

- Medically diagnosed infertility; male and/or female factor
- The female partner is below the age of 43
- Eligibility will cease following the first successful live birth

There is no automatic entitlement for an escort unless it is a requirement of the programme; i.e. the partner is required to participate in the treatment.

Intrastate travel is approved for all IVF and other assisted reproductive treatments, but interstate travel is only approved for a maximum of three trips per year for the purpose of ‘pre implantation genetic diagnosis’.

IVF was raised several times in the review, especially around the need to clarify whether PATS funding is intended to be available only for cases of childless couples or couples with children who can no longer conceive for various reasons. This is further complicated by situations where a person may have had children in the past with a different partner, and now, in a new relationship, the couple is infertile. It was stated that the guidelines are ambiguous and too open ended.

Issues were also raised about the age limit applied for the female partner, as some women now use donor eggs – a relatively new technology. The age limit of 43 years was seen as arbitrary and outdated.

Approvers felt the guidelines did not give them enough information about government policy in this area, leading to inconsistencies in decisions. One physician received a PATS request for a woman who had three children and wanted a fourth, but was unable to conceive naturally anymore. The woman wanted to access IVF for the fourth child. Theoretically the woman was eligible under the current guidelines as no distinction is made for a couple with children previously conceived naturally. The request was declined in this instance but the physician believed that the guidelines should provide a basis that would support decision making is this area.

Most jurisdictions, including the Northern Territory, cover specialist treatments for infertility that are listed under the Medicare Benefits Schedule. With regards to reproductive technology the Northern Territory also covers some forms of non-specialist Assisted Reproductive Technology (ART). Medicare does not provide a rebate for a single woman or a woman in a same-sex relationship who is not medically infertile. Only Tasmania specifically excludes IVF in their guidelines.

The Northern Territory has historically followed the South Australian legislation on reproductive technology. There is currently a Bill before the South Australian parliament on ART and if the legislation is passed, ART would be opened to all parties, regardless of infertility status, thereby including single women and same sex couples. The passage of the legislation is slow and at the time of the review it was not known when, or if, it would be passed, although it is possible it will be progressed sometime in the July-September period. This was also identified by parties as a ‘grey’ area in the Northern Territory as it required a subjective judgement as to whether the woman was infertile and examples were given of same sex couples being approved for PATS interstate (e.g. WA) as the referring physician considered them infertile, whereas another physician would not have approved the assistance.

It is recommended that once the outcome of the SA legislation is known that further policy work is undertaken into eligibility for ART and that during the redevelopment of the guidelines some clarity is provided as to the eligibility of patients for IVF in the interim.

Mammography screening

At present women attending for non-symptomatic screening in the Northern Territory are not eligible for PATS assistance; however PATS subsidies are available for women who, after screening, have been recalled for assessment of an abnormality. Women who detect an abnormality through self examination and receive a referral to a specialist service from their primary health care provider are also eligible for PATS.

Only two other jurisdictions specifically refer to non-symptomatic breast screening in their guidelines or information resources.

- WA covers breast screening if not available within an acceptable period locally.
- NSW excludes breast screening from travel subsidies.

Representations were made from health professionals and community groups that non-symptomatic breast screening should also receive travel subsidies under PATS. However, opening PATS up to non-symptomatic screening would be against the access to specialist services principle of PATS and would be out of alignment with other jurisdictions.

Also, non-symptomatic screening is provided by breastscreenNT and breastscreenNT have entered into an agreement with the Commonwealth government to expand services. Staff are currently procuring equipment and a 4WD, and barring unforeseen logistical problems, this will service twenty Territory Growth Towns on a two year cycle. The expansion of services to remote communities where participation is currently low or non-existent provides a unique opportunity to attract women to the breast screen service, particularly indigenous women. breastscreenNT believes this will ultimately have a big impact on participation rates.

With the development of the mobile screening service it is not recommended that PATS be expanded to include non-symptomatic screening services.

Dental

Representations were also made during the review that general dental treatment should be eligible for PATS subsidy. Specialist dental treatment is already covered under PATS as are, by exception rulings, dental services requiring co-treatment by a medical practitioner (e.g. general anaesthetic) or required dental treatment in preparation for a medical procedure (e.g. cardiac surgery).

No other jurisdiction, with the exception of Victoria, covers general dental treatment under a travel subsidy program. Victoria deems dental treatment for children, by a practitioner based at the Royal Children's Hospital, as eligible for PATS. Opening PATS to general dental treatment would increase costs by an unquantifiable amount, and be inconsistent with the primary principle that PATS is designed to support access to specialist services.

For these reasons it is not recommended that general dental treatment be made eligible for PATS subsidies.

Deceased patients

Under the current Northern Territory guidelines, in the event that a patient dies during treatment, the cost of repatriation of a deceased person is covered by use of a government contractor. In practice the repatriation of an escort who accompanied the deceased patient is also provided for, although this is not explicitly stated in the guidelines. Any accommodation subsidy for the escort ceases immediately upon the death of the patient and no allowance is made for the escort to remain in order to make suitable arrangements for the return of the deceased.

Other jurisdictions have various guidelines in this area but it is recommended that when a patient accompanied by an escort dies during treatment, there be provision for the escort to receive the accommodation subsidy for up to two additional nights to assist during a difficult time. This will enable the repatriation of the deceased person to be appropriately arranged.

Recommendation 14
Upon the death of a patient, an escort be deemed eligible for two nights of accommodation in order to make repatriation and own travel arrangements.

Choice of specialist and second opinion

Financial assistance for travel to a specialist of the patients own choice (unless the specialist is located at the nearest appropriate specialist service and incurs no extra cost) or to enable a patient to obtain a second opinion is not supported by the Northern Territory PATS program, nor any other jurisdiction.

It is recommended that the status quo be retained in both these areas.

10. Administration of the Patient Assistance Travel Scheme

Register of decisions

A frequent comment from approvers, PATS staff and primary health care providers throughout the networks, was that decisions were often made in isolation, with insufficient access to resources or peer support that could provide a context for current decisions based on previous decisions.

A register, focussed on decisions that have been made for 'out of policy' travel requests, will provide much needed support for future decision making. This is particularly important where travel approval is not granted as it allows a precedent based approach which will be more acceptable to patients and primary health care providers, rather than decisions appearing to be 'at the whim' of an individual approver.

Recommendation 15
Develop an updatable register of decisions capturing out of policy travel request outcomes

Streamlined administration: Benefits of the Travel Management System

Administration of PATS is currently undergoing change through the implementation of the electronic Travel Management System (TMS). The TMS will provide online access, for referring practitioners, PATS clerical staff and authorised approvers, to a centralised system with patient management features that have previously not been available in an integrated environment. The TMS draws data from CareSys and the Outpatient Booking System (JCCB) reducing double entry of data and consolidating information related to the patient travel arrangements. At the time of writing the TMS is being rolled out across the five public hospitals.

A key feature of the TMS is the inclusion of embedded PATS Guidelines which automate the approval of PATS applications where the travel request is within policy, which is the majority of cases.

When a travel request does not meet one of the relevant guidelines the request is automatically referred to the delegated approver and the approver is notified by email of the pending request. When fully implemented the system will reduce the turnaround time for routine approvals and also reduce the approvers' workload, as they are only required to approve requests by exception.

Once the TMS rollout is complete and the management reports have been developed there will be a significant improvement in reporting capability. Detailed analysis of the costs associated with patient journeys will be possible, broken down by mode of transport, type of accommodation, number and cost of no-shows and detailed reporting of the cost of escorts accompanying the patient. It will also be possible to report on PATS travel applications that have not been approved.

The TMS ensures consistency of data entry and categorisation of travel episodes with controls over the content of fields in the database. This will provide consistency of reporting across the networks. The department will continue to monitor the TMS rollout and ensure appropriate reports are developed to provide relevant and timely information to management teams.

Reimbursement options

Assisted travel programs in other jurisdictions are generally reimbursement models, where the client is responsible for making their own travel arrangements and then claiming the subsidy at the completion of the travel episode. The time to process the travel claim varies. Prepaid bookings will usually be made on behalf of clients where financial hardship can be demonstrated.

Currently the Northern Territory PATS defaults to PATS travel clerks making the travel arrangements on behalf of the client, unless specifically requested not to, with the patient responsible for the difference in accommodation costs where applicable. This means that for patients who wish to make their own arrangements it is more difficult than necessary. It also creates conflict between the patient and PATS office when the patient is unhappy with the arrangements made on their behalf.

To be eligible for support under PATS all travel must be approved prior to the travel episode. There is provision for one retrospective PATS claim where a patient was not aware of the program before they travelled. The patient has 14 days to lodge this ‘one off’ application, which is subject to the usual approval process.

Patients who prefer to make their own travel and accommodation arrangements and then claim the appropriate reimbursement should be allowed to do so. The patient should also be able to lodge retrospective claims, subject to approval of the claim under the usual guidelines. To facilitate this process new guidelines and patient information would be developed to encourage patients to use the reimbursement option when it is suitable to their needs.

We recommend that a hybrid model would be more appropriate, similar to other jurisdictions, and that the claim period be extended to three months (from 28 days) to allow for patients to gather their reimbursement paperwork and approvals in a timely fashion.

The amount of reimbursement for claims will be limited to the most economic relevant mode of travel and lowest available fare. Accommodation subsidies would also be at the standard accommodation subsidy rate. The hybrid reimbursement model allows patients the flexibility to choose travel arrangements that suit their individual requirements and to choose accommodation that is more appropriate to their needs.

Appropriate information materials will be made readily available to facilitate the reimbursement process, including the requirement to provide receipts and other documentation including referring practitioner and consulting specialist, and to ensure that the client understands the subsidy level that is applicable to their travel. This will provide the opportunity to further emphasise that PATS is a subsidy program, and not a full cost recovery scheme. A public education program and the availability online of the new guidelines should reduce the number of misunderstandings and unrealistic expectations about what the PAT scheme is designed to provide.

It will also be recommended that the patient obtain approval for their PATS subsidy prior to booking travel and accommodation. This will provide the opportunity for the patient to make appropriate decisions; however prior approval would not be mandatory. Information materials will explain that where the patient submits a claim after the travel has been completed, and where prior approval has not been sought or given, any reimbursement will require PATS approval and this cannot be guaranteed. In other words, submitting a claim after travel will not provide a mechanism to circumvent the approval process; normal eligibility criteria and subsidy levels will apply.

For clients who choose to use the prepaid option there would be no change in the current system.

Recommendation 16
Adopt a hybrid model allowing clients to book own travel and claim reimbursement at the appropriate subsidy level defined in the guidelines and to extend the claim period from 28 days to three months.

Consolidation of authorised approvers

During our consultations it was evident that the number of authorised approvers should be reviewed. As the manual system is phased out and the workload for approvers is significantly reduced there will be less demand and less need for ‘backup’ approvers.

The list of approvers has grown over time and it has become more difficult to ensure that all approvers have a thorough understanding of the subsidy only nature of PATS and a detailed understanding of the guidelines. This leads to inconsistency in application of the guidelines across the network and out of policy approvals, which is a cause of confusion and discontent among the patient population.

Particularly in small communities patients become aware of other PATS applications that they view as the same or similar to their own. It is a source of frustration when another patient’s subsidy has been approved when their own was declined.

A reduction in ‘out of policy’ approvals will also reduce the cost to PATS budget overall.

Recommendation 17
A comprehensive audit and reduction in the number of authorised approvers to ensure that the approval process is managed efficiently and consistently and in policy.

Effective use of PATS and TMS integration

With the reporting capabilities that will be available under the TMS it is recommended that regular audits of PATS be conducted. This will enable the Department to identify usage patterns and trends, track costs on an active basis and manage emerging areas of concern in a timely fashion. This will in turn drive efficiency and improve the patient experience over time.

Of particular relevance will be the opportunity to provide insight into the ‘out of policy’ approvals. approvers have the authority to override the automatic system where appropriate so that travel requests that do not strictly meet the embedded guidelines can

be appropriately managed. An audit of all approvals and in particular out of policy approvals will enable the Department to evolve the guidelines in a proactive manner to ensure consistent and appropriate application of the program in the most equitable manner. This is particularly relevant within the first six months of the new TMS coming fully online as it will facilitate any adjustments that may need to be made to the embedded guidelines.

Recommendation 18
Audit all PATS approvals over six month period and to identify and analyse those approvals which are outside the guidelines.

PATS guidelines

There was consistent feedback that PATS guidelines in their current form could be improved upon. This includes:

- Lack of internal consistency and contradictions
- Difficulty in understanding and interpreting the guidelines
- Guidelines in 26 separate policy documents
- Unavailability of the full guidelines outside the Department of Health intranet
- Lack of information available to patients, escorts, GPs and other external health professionals
- Imprecise language making a loose interpretation of the guidelines prevalent

The reviewers found numerous examples of out of policy approvals during the review process, and it is believed that some of this is caused by confusion as well as the opportunistic use of loopholes in the guidelines to sidestep the intent of the scheme. Concise, clear and publicly available guidelines will facilitate improved governance of the scheme and also support PATS staff and approvers to make in policy decisions.

With the review recommendations in mind there will need to be a thorough revision of the guidelines. The revised guidelines must then be made widely available so that all users of the program, patients, escorts, PATS staff, practitioners at all levels, service providers and non-government organisations have access to the information most relevant to them.

Once the guidelines are in place a communication plan will be developed to inform stakeholders of the changes and provide an opportunity to clarify any areas of concern or confusion.

Recommendation 19
PATS guidelines to be re-written in clear unambiguous language, and made available to all stakeholders as a priority, incorporating the accepted recommendations.

11. Equity testing

The Northern Territory, Western Australia and ACT are the only jurisdictions that do not have any form of equity testing or co-payments attached to their travel schemes. All other states have a level of co-payment that is either reduced or waived if the patient is the holder of a Health Care Card, Pensioner Concession Card or Seniors Card (*Table 5 Patient co-payment by jurisdiction).*

WA and Queensland provide a more direct comparison to the Northern Territory due to their geographic size, remote populations and indigenous health priorities. In WA there is no equity test and in Queensland it is waived completely for concession card holders.

If the Northern Territory were to introduce a level of co-payment for non concession card holders similar to Queensland, and factoring in the proposed increased subsidies, the outcome for an infrequent user, who does not hold a concession card, would be less advantageous than the subsidies currently in place.

It would be problematic to introduce equity testing, given the high level of awareness of PATS benefits across the entire population and the policy initiative to provide subsidy for access to medical specialist services. Introducing improved subsidies while at the same time limiting the benefits received by non-concession card holders could be poorly received and would be creating two systems. This is not the intent of PATS program, which has to stated aim to provide equity of access to specialist services for all Territorians and given that most patients do not receive full reimbursement for their expenses they are in effect already contributing.

Added to this consideration is the additional complexity equity testing would introduce to the administration of the program, with the patient mix resulting in a minimal saving overall. A greater focus on clarifying the PATS guidelines, reducing out of policy use and promoting Telehealth will be a more equitable way of reducing costs to the scheme.

We do not recommend the introduction of equity testing in determining PATS eligibility or co-payments due to the complexity and negative outcomes for many patients who now have access to the scheme.

12. Reducing Scheme Costs and Improving Patient Experience

Adoption of Telehealth as the first option

While the PATS program is a subsidy scheme, one component of it is fully covered and that is fares. Commercial fares and airflight charters account for 78.13% of expenditure in the PATS budget and to achieve any meaningful reduction in scheme costs you need to eliminate and/or reduce the need to travel.

Telehealth is a system that is slowly gaining prominence in NT Health circles but it still requires some imbedding before its full benefit can be realised and to improve the situation integration is required between the booking systems for Telehealth, specialist outreach and outpatient appointments, and also a commitment for Telehealth consultations to be provided on a regular basis by the hospital services.

Telehealth facilities in the first instance allow patients in remote areas to consult with specialists in major centres via a remote video conference facility. At the most basic level this innovation utilises computer desktop video conferencing software to deliver over 50 Telehealth enabled sites in the Northern Territory. Where a fibre connection is available more advanced systems provide high definition video capabilities, including cameras in the treatment room controlled by the advising specialist.

In many instances Telehealth enables the consultation to be held in the patient’s community with family in attendance if desired. If the facilities are not available in their immediate community there may still be a requirement for the patient to travel to the nearest Telehealth facility, but the distance, time and expense of travel could be reduced. For example Borroloola has Telehealth facilities; so patients from communities surrounding Borroloola may be able to travel there rather than having to fly by charter to Katherine.

In considering the ways in which PATS costs could be reduced and the patient experience improved it became evident that adopting Telehealth as a first option will be the most effective way of doing this. However, support is required to ensure the continued growth of Telehealth services which in turn will drive benefits for patients and clinicians and deliver savings in PATS expenditure. Community and service provider education, in-community support, information dissemination and ongoing assessment of Telehealth services are recommended.

To provide a better picture of the potential of Telehealth, one area that was consistently identified as an unnecessary impost on the PATS budget (patient reviews) and one new initiative (rapid assessment clinics) are examined in detail below.

Patient Reviews

During our consultations with practitioners the efficacy of follow up reviews being conducted by a local resident physician, and supported by Telehealth, was raised often. There was agreement that at present the Telehealth infrastructure is not being utilised to the optimal degree.

For example, patients who have had surgery are frequently returned to the specialist medical facility where the procedure was performed for a post-operative review. This is often not

necessary; the reviews can be done locally via Telehealth with the specialist in attendance if required. One physician in Katherine estimated that 40-50% of his patients were reviews that could have been performed via Telehealth facilities.

Requiring a patient to undertake travel for follow up appointments of this kind imposes an unnecessary cost on the system and is at considerable inconvenience to the patient.

Example

A Doctor in Katherine related the example of a patient travelling from Borroloola to Katherine by road for what turned out to be a 10 minute review consultation. In his opinion this should have conducted as a Telehealth consultation .The journey is around 650km one way and takes approximately 8 hours. In this instance the patient was extremely unhappy about the amount of travel required for such a short consultation. The travel is also at considerable cost to PATS. It was the Doctors further view that this would have increased the likelihood of the patient refusing to attend future appointments, and if considered in a wider context, unnecessary travel for short review consultations would lead to increases in 'no shows' and DNAs across the scheme.

Rapid Assessment Clinics

Another example of Telehealth in action was provided by a clinician at Katherine Hospital.

He identified that initial assessments performed via Telehealth facilities could benefit people in rural and remote communities by providing timely and easy access to specialist services and at the same time reducing the burden of travel and cost to PATS.

A trial is commencing at Kalkarindji this year for a three month period. The intention is for the clinician to spend one hour a day speaking with patients and staff at Kalkarindji via Telehealth facilities and performing assessments. At the end of the trial the results will be assessed and evaluated.

It is believed that if the use of Telehealth facilities in indigenous communities can be grown significantly this will have positive health benefits for the patient, and help reduce 'no show's as the patient will be able to attend the consultation in their local community with support from family during the session. If further treatment is then found to be required, the use of Telehealth will enable the practitioner to discuss the need for travel with the patient and family, increasing the patient's understanding of their condition and improving the rate of attendance.

The only costs of the trial were the installation of Telehealth infrastructure in the clinician's office and the time allocation for administration staff.

The identified benefits of the rapid assessment clinics are:

- reduced patient travel requirements;
- reduced unnecessary admissions to Katherine Hospital;
- rapid access to specialist input;
- reduced specialist Outpatient (General Medicine) waitlist; and
- Medicare incentive payments.

The results of this trial will further inform the coordination work which will be undertaken following the PATS review.

Telehealth Pilot

Supporting growth in awareness and uptake of Telehealth would have positive and measurable impacts on the patient experience; decreasing unnecessary travel and at the same time reducing expenditure for travel and accommodation under the PATS program. This development work needs to be undertaken at the community and practitioner level in conjunction with related services.

There is considerable support within Central Australia for Telehealth with a number of ‘practitioner champions’ working across Alice Springs and Tennant Creek hospitals.

A common theme was that Telehealth needed some ‘runs on the board’ before it would become a pathway embedded in everyday practice. There is a role for the Department to play, in its role as System Manager, in accelerating the adoption of Telehealth and ensuring it reaches its full potential.

Therefore it is recommended that the concept of reducing PATS expenditure by actively promoting the use of Telehealth be supported with the establishment of a pilot program.

The aim of the Telehealth Pilot will be to increase the adoption of Telehealth through raised awareness and utilisation of the program at a community and clinical level.

The initial establishment period and scoping of the Telehealth Pilot would be supported from existing administrative resources within the department over a six month period. This can begin immediately. However, determining the success of this program will be dependent on the full implementation of the TMS, so the operational phase would be timed to commence upon completion of the rollout. TMS will ensure that the data captured during the program period will be accurate and complete, enabling meaningful evaluation and reporting.

At the end of the operational period a review will be undertaken to ascertain the success of the program in increasing the utilisation of Telehealth, improving patient experience and outcomes and reducing the dependence on PATS.

If successful, Telehealth considered as the option of first choice for people wishing to access PATS.

In summary, a greater use of Telehealth will provide:
- an improved service to remote communities, *in the community;*
- an improved patient experience;
- in-community consultations that are Medicare eligible and receive bonus payments; and
- and is expected to reduce the need for PATS.

Recommendation 20
Establish a Telehealth Pilot over an operational period of 12 months, including stakeholder education, community programs, primary health support and an evaluation of outcomes and funded from the PATS budget.

13. Further Work

The review of PATS and discussions with stakeholders and service providers revealed a number of 'pressure points' in the system which need to be considered further, with work undertaken to improve systems and processes. There was a degree of consistency in the issues raised across the networks and a willingness to work towards additional reform. The new TMS will provide ready access to timely and consistent data that will facilitate this and provide an evidence base to continue the change process.

'No Shows' and DNAs

Significant expense is incurred in payments for pre-paid travel and accommodation which is subsequently lost when the patient does not travel. These events are recorded as a 'no show'. In other cases the patient may travel but then fail to attend the appointment – this is recorded as a 'Did Not Attend' or DNA.

When the patient notifies the PATS office of their cancellation sufficiently in advance there is an opportunity to recover some of the cost of pre-booked fares and accommodation. However, more commonly no notification is provided, which can lead to full loss of a commercial airfare, accommodation penalties or charter flight costs, which could have been avoided. Over the course of a year there are significant financial losses to the system from both 'no show's and DNA's.

In addition to the financial cost, 'no shows and DNA's also place a significant additional burden on PATS staff, service providers in the community and clinical staff in the major centres. 'No show's and DNA's also potentially decrease the efficiency of outpatient clinics, although staff manage the expected 'no show' component by backfilling appointments where possible and overbooking the clinics in the first instance. However there is still the loss of opportunity for another patient on the wait list to access the service.

During consultations there were significant differences in what regions estimated their 'no show' rates to be with one region estimating 70% and another 25-33%. However, the data shows that the latter figure is closer to reality.

Discussion during the review suggested some strategies that would assist in reducing 'no show's and DNA's. These are discussed below. A thorough review of the suggested strategies will be undertaken to determine the efficacy of these approaches and what can reasonably be expected to improve this metric – there would need to be a positive return on investment for focus in this area of concern to be sustainable.

Sufficient notice

A common concern from communities was that there was often insufficient notice of a patient appointment and the need to travel. Sometimes only a days notice may be provided which, given the travel times involved for some patients, was impractical.

A community clinic reported:

> *"When we find out about the travel details less than 24 hours before the flight... If there are any issues (like an escort wasn't booked or some other detail) then it is too late to make any changes. Changes have to be made with more than 24 hours notice... if we are given less than 24 hours notice about the travel details, then it can't be changed. Then PATS wastes heaps of money."*

Appropriate mode of travel and communication

Some patients are reluctant to fly, but are willing to travel by land, even if this is a long journey. The local primary health care staff are in a better position to assess what a patient's most appropriate form of travel is and for that knowledge to be taken into consideration by PATS offices.

A community clinic reported

> *A 38 year old woman presented with severe anaemia and other medical problems.*
>
> *We knew that the woman was too scared to fly on a plane and scared to go to Darwin on her own. But we knew that PATS wouldn't approve an escort. So she and her husband booked and paid for the bus on the day that we expected her to travel. We had requested travel by bus on PATS form. PATS request form sent on 15th Jan and then again on 30th January. Was marked "please book bus".*
>
> *RN rang PATS office today to find out what the travel plans are. Office said that she is booked on a plane on Monday. RN said that patient's husband has already booked the Bohdi bus for Sunday and can't the PATS office change the booking. PATS office said no.*
>
> *We knew that the woman was going to refuse to fly on the plane, but PATS office refused to change it to the bus. And in the end – yes, the woman didn't travel. PATS then wasted the money on the flight and arranged for the bus.*

Informing patients

Patients may not have been informed about the reason for travel, or have been on the wait list for a long period and have simply forgotten why they need to see a specialist. They may find out at the last minute that they will be away overnight and have not made the necessary arrangements for child care, or have no money for incidentals. In other instances patients have previously travelled long distances from extremely remote communities to attend follow-up appointments that only take a few minutes. This leads to frustration and a refusal to attend future appointments.

14. Appendices

Appendix A: Terms of reference
Review of patient assistance travel scheme

Overall Aim

Undertake a review of the Patient Assistance Travel Scheme (PATS). This review should consider ways to increase client satisfaction, reduce the administrative burden of the scheme and manage current and future demand on PATS.

Background

The Northern Territory Patient Assisted Travel Scheme (PATS) exists to promote equity of access to specialist services for Northern Territory residents. Assistance is provided for people to travel between their principal residence and the nearest available specialist service. The scheme is governed by the Medical services Act (2011) and the Patient Assistance Travel Scheme (PATS) Guidelines. The Scheme is designed as a subsidy rather than a full cost recovery scheme.

The Guidelines were last updated in July 2008 when eligibility criteria were enhanced to include:

- an escort for every patient travelling interstate for surgery or intensive therapies e.g. radiation therapies, non surgical cancer treatments, cardiology and neurosurgery
- a ground transport allowance of $40 per return trip for patients who are required to travel interstate for treatment;
- an increase to the commercial accommodation rate from $33 a night to $35 a night;
- an increase to the Private Vehicle allowance to allow a claim of 15 cents per kilometre per patient for up to three patients travelling together

Access to assistance under PATS program is currently driven by a paper-based triplicate form. Travel episodes are recorded in the Patient Travel System (PTS), developed in 1994, which acts as a retrospective record keeper of business processes rather than a travel facilitator and business support system. The PTS has not kept pace with internal and external business and clinical environment changes.

Specific Objectives

Compare the level of PATS subsidy to programs nationwide.

Investigate and recommend priority increased eligibility and/or entitlements which can be delivered within the additional available budget.

Investigate and recommend options for reduced costs including equity testing.

Department of Health is a Smoke Free Workplace

Review the current PATS guidelines against other jurisdictions and make recommendations to bring the Northern Territory in line with the majority.

Implement the Travel Management System to provide for an electronic booking and travel environment.

Identify any efficiencies in the administration of PATS, including client feedback on streamlining of administration.

In Scope

- Take account of additional $7.5 million per annum funding provided as part of mini-budget decisions.
- Feedback from clients in relation the operations of the scheme, including their experience of the administration of the scheme.

Out of Scope

- Changes to the TMS, as currently scheduled for go-live on 21 March 2013.
- Change of goal of scheme, to provide assistance for people to travel between their principal residence and the nearest available specialist service.

Responsible Director

The primary point of contact for the consultant will be the A/Director, Policy and services Development.

The Executive Sponsor is the Executive Director Strategy and Reform.

Deliverables

Indicative timelines for the review are:

- A final report will be completed by the end of May 2013.
- Recommendations will be implemented by the end of July 2013.

Appendix B: List of accepted specialties

The National specialist Qualification Advisory Committee of Australia (Recommended Medical Specialties and Qualifications, No 24 — May 1997) identifies the following as a list of accepted specialties (including sectional specialties):

Anaesthesia **Dermatology** **Diagnostic Radiology** Diagnostic Ultrasound Nuclear Medicine	**Obstetrics and Gynaecology** Gynaecological Oncology Maternal — Foetal Medicine Obstetric and Gynaecological Ultrasound Reproductive Endocrinology and Infertility Urogynaecology
Emergency Medicine Intensive Care	**Occupational Medicine**
Internal Medicine General Medicine Cardiology Clinical Genetics Clinical Haematology Clinical Immunology and Allergy Clinical Pharmacology Endocrinology Gastroenterology Geriatrics Infectious Diseases Intensive Care Medical Oncology Neurology Nuclear Medicine Paediatric Medicine Renal Medicine Rheumatology Thoracic Medicine	**Ophthalmology** **Otorhinolaryngology (ENT)** **Pathology** Haematology Immunology **Psychiatry** **Radiation Oncology**
Ophthalmology	**Rehabilitation Medicine**
Surgery General Surgery Cardio-thoracic Surgery Neurosurgery Orthopaedic Surgery Otolaryngology Paediatric Surgery Plastic and Reconstructive Surgery Urology	

Appendix C - Consultation

The following people and organisations were consulted during the review period:

Department of Health

Lesley Kemmis – A/Director System Planning and Development
Jeffery Gaden – Manager System Wide Hospital Services
Joy McLaughlin – Senior Grants Policy Officer
Jo Wright – Director, Activity Based Funding
Kirstie Annesley – Project Officer, Activity Based Funding
Judith Hutchings – Finance Service Manager
Suzy Poppe – Senior Nurse Renal Advisor
Dorothy Brown – Renal Services Development Officer
Gemma Lawrie – Change Manager, Travel Management System (TMS)
Julie Mitchell – System Administrator TMS
Sharon Sykes -A/ED Central Australia Hospital Network Hospital
Winton Barnes - Director of Medical Services
Kimberley Hitchens - PATS Manager
Anne Griffin - PATS Office
Mark Friend - A/Director Corporate Services
Megan Halliday - Head of Obstetrics and Gynaecology
Phyllis Hanna – Liaison Officer
Melissa Brown – A/Nursing Director Critical Care, Peri operative Services & Patient Flow
Sam Arthbuthnot – Outpatient Manager
Rose Fahy – Consultant Paediatrician
Larissa Ellis – Senior Social Worker
Neil Pomfret – Manager Aboriginal Support Services Unit
Karen Harris – Director Rehabilitation & Allied Services
Michelle McGuirk – Telehealth Manager, Northern Territory
Christine Dennis – Executive Director, Top End Hospital Network
Governance Group: John Edwards, Dr Nadarajah Kangaharan, Denby Kitchener, Roma Smyth, Jenny O'Shaughnessy, Maureen Brittin, Jo Seiler, Dr Sara Watson, Jeff Thomson, Dr Garrett Hunter, Dr Charles Kilburn, Fiona Roche, Adam Walding, Brian Spain, Dr Marcus Ilton
Margie Rajak – Manager, Indigenous Support, Patient Travel, Accommodation and Transport Services
Jemma Redding – A/Business Manager
Jeff Thomson – Director of Finance, Top End Hospital Network
Angela Brannelly – General Manager
Kelvin Billinghurst – Director Medical Services
Simon Quilty – Physician
Madeleine Morris – Patient Services Manager
Hugh Heggie – Senior Rural Medical Administrator
Sam Goodwin – A/Director Medical Services (and as practitioner at ASH)
Wayne Marshall – A/General Manager/Director of Nursing
Peter Chilcott – Director of Medical Services

External Organisations

AMSANT – Liz Moore
NTML – Kath McFarlane
Kidney Health Australia:
NTCOSS
Bosom Buddies – Lesley Reilly
Alice Springs Seniors Coordinating Committee
Alice Springs Town Council
Desktop review of ministerials and feedback from individuals,
External groups and from public meetings held by Central Australia Governing Council