



Department of **Health**  
Government of **Western Australia**

# **PATS REVIEW REPORT**

**Monday 11 March 2002**

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## **SECTION 1 - EXECUTIVE SUMMARY**

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The Patient Assisted Travel Scheme (PATS) provides assistance for country patients to attend specialist medical appointments. The scheme was established in 1987 as a replacement to the Commonwealth Isolated Patient's Travel and Accommodation Scheme.

PATS is administered by rural Health Services through country hospitals and has an annual expenditure of approximately \$10 million.

The social, medical and financial context in which the scheme operates has changed since its inception, and there is a need to refocus the scheme to take account of the current operating environment. Changes in the availability of visiting specialist services, advances in technology and community expectations have all impacted on the scheme.

The Minister for Health commissioned this review by the Western Australia Department of Health (the department) to focus on a number of specific concerns that have been raised by the community. Prior to the 2001 election, the Government committed to:

- Increase funding to PATS by an additional \$4 million over the next four years.
- Change the boundary to ensure PATS is available to patients living in towns closer to Perth, such as Pinjarra and Mandurah.
- Review the scheme to include issues relating to the adequacy of its funding and the way it is administered in order to foster a more flexible approach in the application of its guidelines.

### **MAIN FINDINGS**

The main findings of the review are outlined below:

#### **Expenditure**

There is a high growth in PATS expenditure due to rising costs of air travel and increased demand for assistance. There is only limited potential to reduce expenditure through more tightly focussing the scheme. The main way to reduce the rise in expenditure is through reducing the need for patient travel.

The capacity of regional centres to provide access to specialist consultations and treatments needs to be enhanced. When referral to a metropolitan teaching hospital is required, diagnostic and follow-up work should be carried out locally where possible.

## **Focus**

The focus of the scheme should be to give priority to those who are most in need of assistance. That is people who live furthest away, those on a low income, and those with the need to make frequent trips to specialist appointments.

## **Administration**

The administration of the scheme can be simplified and streamlined. This has the potential to reduce administrative costs whilst improving customer service. One option for achieving this is by centralising, or regionalising some aspects of PATS administration.

## **Information**

There is a strong need to improve the information available to the community regarding PATS. This includes providing education and awareness raising with General Practitioners, Health Service staff and metropolitan hospital staff as well as ensuring that the general public are well informed.

## **Scope**

The current scope of the scheme has broad support, but an expansion to include some areas of highly specialised allied health services would be desirable if funding permits.

There are also some inconsistencies and anomalies in the guidelines that should be addressed.

## **Cultural Appropriateness**

The specific needs of Aboriginal people from remote communities are noted, and some recommendations made for better meeting these needs. This includes the high cost of travel to and from remote communities, the need for good coordination of travel arrangements, and the issues faced by people who do not speak fluent English or who are unaccustomed to the city.

## **Planning, Monitoring and Evaluation**

Data collection and policy and procedures for program planning, monitoring and evaluation need to be further developed.

## **Outcomes of the Review**

The review has made a number of recommendations that aim to address the above issues. The revised scheme will be introduced on 1 July 2002 and will:

- Streamline the administration of the scheme to provide greater consistency of decisions, reliable data and simpler processing of claims;

- Address anomalies in the guidelines and ensure that assistance is provided to those most in need;
- Improve access to the scheme through the introduction of a “safety net”<sup>1</sup> and greater awareness of the scheme;
- Examine the PATS budget allocation to Health Services so that Health Services are better able to meet the demand for PATS from within their budget allocation;
- Make better use of existing resident and visiting specialist services as well as General Practitioner proceduralists;
- Explore a range of options to reduce the need to travel for specialist appointments;
- Provide assistance to General Practitioners and patients when required to coordinate specialist appointments and travel arrangements;
- Improve communication between country and metropolitan health services to ensure that patient travel and accommodation needs are better coordinated.

## SUMMARY OF RECOMMENDATIONS

### *It is recommended that:*

1. **A project is undertaken to explore patient procedures in hospital specialist outpatient clinics and work with rural GPs to identify alternative options for country patients. Details of this proposal are provided in Appendix 3.**
2. **The application and approval process be streamlined in the following ways:**
  - **working with GPs and metropolitan hospital staff to educate them about the PATS guidelines and approval process;**
  - **simplification of form layout to ensure greater completion; and**
  - **simplification of the process for obtaining block approvals for specified courses of treatment.**

**Cost: Within budget**

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<sup>1</sup> People who live just inside the 100km distance boundary and are experiencing financial difficulty because of the need to make frequent trips to a specialist would become eligible for PATS assistance after having made a predetermined number of trips.

**3. In the implementation of a new organisation structure for country health services, consideration be given to:**

- centralising or regionalising aspects of the administration of PATS including approving claims, data entry and the payment of accounts; and
- providing a central (and/or regional) referral point/s for making decisions that fall outside of the guidelines.

***Cost: Within budget***

**4. Measures are taken to ensure good knowledge of the scheme, including both the guidelines and application procedures. This may include:**

- providing more detailed written information to the community;
- providing relevant information and ongoing education to GPs and others involved in administering the scheme;
- ongoing promotion of the scheme to ensure that the community is aware of the scheme and what it covers;
- making the guidelines available on the Department of Health web site; and
- awareness of the ability to make retrospective claims in exceptional circumstances.

***Cost: \$20,000 initial one-off cost to produce promotional materials and to provide training.***

**5. Inconsistencies in the application of PATS be addressed through greater clarity in the guidelines, specifying the types of circumstance that constitute 'exceptional circumstance' and focussing on the purpose or intent of the scheme.**

***Cost: Neutral***

**6.**

- the admission and discharge of country patients in metropolitan hospitals is made easier for the patient through improved communication between metropolitan and rural health services and by ensuring the provision of adequate information to the patient and their escort; and
- in particular, it is recommended that:

- country patients are not discharged from metropolitan hospitals without a coordinated plan to ensure their return home; and
- after-hours discharges of country patients are avoided unless plans for the patient's return journey are pre-arranged by the discharge planning coordinator.

**Cost: Neutral**

7. Further research be undertaken to identify the extent of and reasons for patients failing to travel on a pre-paid journey. As a general principle, if a journey needs to be re-booked, the patient should be asked to pay for the journey and then reclaim the cost after attending the appointment unless there are exceptional circumstances.

**Cost: Neutral**

*(See also recommendation 17 regarding transport within the city).*

8. Procedures for ongoing monitoring and regular evaluation of the scheme be developed and implemented.

**Cost: Within budget**

9. Subject to funding becoming available, the scope of PATS is expanded to include some highly specialised allied health assessments/treatments from specified agencies such as pressure garment assessment and complex alternative communication assessment (a complete list of services is to be developed in consultation with allied health specialists).

**Implementation: To be reviewed in 12 months**

**Estimated cost: Dependent upon services to be included.**

10. Transport to a GP Proceduralist for a specialist procedure, for example obstetrics, is covered by PATS (excluding standard GP consultations and minor procedures).

**Implementation: 1 July 2002**

**Estimated cost: Neutral**

11. PATS accommodation assistance is provided for a maximum of six months and that suitable long term accommodation options are explored for renal patients who need to relocate in order to access dialysis treatment.

*Implementation: 1 July 2002*

*Cost: Neutral*

12. Consideration be given to extending the 'safety net' concept to dialysis and oncology patients across the State.

*Implementation: 1 July 2002*

*Cost: Approximately \$30,000 (in addition to the estimated \$60,000 for Peel Health Service)*

13. Subject to funding being available, patients who are transferred from a public to a private hospital are eligible for PATS for their return journey home so long as the PATS criterion of 'nearest available specialist service' is met.

*Implementation: To be reviewed in 12 months*

*Estimated cost: \$30,000*

14. The PATS fuel and accommodation subsidy rates remain unchanged. However, the high cost of group transport, for example, from a remote community to the nearest town is acknowledged. It is therefore recommended that for journeys that include a group of 2 or more PATS eligible patients/escorts in a minibus or similar group transporter owned by a community or organisation, the fuel subsidy be increased to 25c per kilometre is payable to the relevant organisation rather than the patients.

*Implementation: 1 July 2002*

*Cost: Approximately \$10,000 p.a.*

15. An accommodation subsidy is provided to people driving more than 750 km one way to assist them to break their journey.

*Implementation: 1 July 2002*

*Cost: Approximately \$10,000 p.a.*

- 16. The current patient contribution rates remain unchanged. That is:**
- **no patient contribution is required for concession card holders; and**
  - **for non-concession cardholders, the current patient contribution of up to \$50 per trip and an accommodation allowance only after the first 3 nights for the first 4 trips apply.**
- 17. For people holding a concession card and flying to Perth, transport is provided between the city destination (motel or hospital) and the airport terminal using the cheapest appropriate form of transport.**

***Cost: Up to \$50,000***

## SECTION 2 - INTRODUCTION

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### REVIEW REPORT

The review report is presented in 5 sections:

<b>Section 1</b>	Executive Summary.
<b>Section 2</b>	The background and conduct of the review together with an overview of PATS utilisation and expenditure.
<b>Section 3</b>	Proposals for changes to the administration of the scheme and the rationale for those proposals.
<b>Section 4</b>	Proposals for changes to PATS policy including the scope and eligibility criteria.
<b>Section 5</b>	A brief conclusion to the report.
<b>Appendices</b>	Supporting information, including a summary of the internal review.

### BACKGROUND

PATS was transferred from the Commonwealth to the States in 1987. The guidelines established by the Commonwealth have been largely retained in the Western Australian PATS scheme, however, the levels of support provided have been increased and the distance criteria has changed from the initial 200 kms.

A comprehensive review of PATS was undertaken in 1995 following devolution of the administration of the scheme to rural health services. At this time a number of changes were introduced to the guidelines including setting new patient contribution rates and fuel subsidy rates and extending the distance criteria which was reduced to 50kms around 1987 and subsequently extended to 100 kms in 1995.

The PATS guidelines were revised again in 1999 and further minor policy changes were made at this time.

## NEED FOR A REVIEW

PATS attracts significant community attention with the majority of concerns related to the scope of services covered, eligibility criteria for assistance and kilometre rate paid when driving a private vehicle.

Prior to the 2001 State election, the Government made a commitment to review and enhance PATS.

Listed below are some of the issues identified by the Department of Health to be addressed by the review:

- there are regular public representations seeking extension of the scheme to cover allied health, dental treatment, and chronic disease sufferers within the 100 km limit;
- PATS expenditure is increasing year by year. For example in 1996/97 it was \$6.8 million. The expenditure for 2000/01 was \$9.6 million;
- most health services exceeded their nominal PATS budget for the last few financial years;
- there have been many requests from the public and Parliamentarians to increase the kilometre rate because of increasing fuel prices; and
- there are many queries and comments from the community in relation to the administrative arrangements of the scheme and poor knowledge of the scheme across the community and health sector.

## SCOPE OF THE REVIEW

The scope of the review includes:

- an examination of the policy and procedures by which patients access PATS funding;
- the implementation of those policies and procedures;
- the amount of funding that patients are entitled to;
- barriers that have been identified to patients' access to the scheme;
- comparisons with other States in regards to the eligibility criteria, scope and rates paid; and
- the administration and management of the scheme.

## **CONDUCT OF THE REVIEW**

An internal review was carried out over a six week time period and reported to the Minister in May 2001. The internal review identified a number of concerns regarding the scheme, including areas where further analysis was needed. The internal review also proposed a broad range of recommendations for addressing areas of concern and enhancing PATS.

A discussion paper was prepared and widely distributed throughout the community. The discussion paper provided an overview of the internal review and presented a number of options for the future of the scheme. A feedback sheet was included to assist people to respond.

A copy of the discussion paper is provided in Appendix 1.

Community consultations were held in a number of locations throughout the rural area focussing on the options detailed in the discussion paper. In addition a call for written submissions was made through an advertisement in the West Australian newspaper.

A total of eleven community forums were held in rural locations across Western Australia during October and November 2001 attracting a total of 174 participants.

In addition, 134 completed feedback sheets and 44 written submissions were received.

A summary of the consultations is provided in Appendix 2.

## **POLICY AND FUNDING CONTEXT**

### **Focus**

The PATS scheme has always focussed on those in most need rather than providing equal assistance to everyone. This is achieved through the patient contribution policy. The review highlighted the need to strengthen this focus, and examined a number of ways to better focus the scheme.

### **Cost**

One of the concerns addressed by this review is the rising cost of PATS. These costs are set to continue to rise with increasing airfares, policy changes such as the recent Qantas decision to discontinue discounted children's airfares and the collapse of Ansett. For example, the combined effect of these changes has led to a 30% rise in the costs of air travel for PATS patients in the Northwest.

Costs to patients themselves are also rising as fuel and accommodation subsidies have not consistently kept pace with rising costs particularly in the

Northwest of the State. It is also acknowledged that the scheme does not meet all of the costs associated with accessing specialist services. There are a variety of other costs that are not covered by the scheme including meals, child care, time off from work etc. All patients irrespective of whether they live in the country or a regional or metropolitan centre may incur these costs. PATS provides a subsidy towards those costs that are over and above those incurred by patients residing in the metropolitan area.

As payments represent a subsidy towards the travel and accommodation costs only, a recurring issue is how to address the needs for patients and escorts who undertake their journey with no money.

**Access**

Consistent with the Commonwealth-State Health Care Agreement, PATS provides assistance to access the nearest medical specialist. PATS does not provide a choice of specialist.

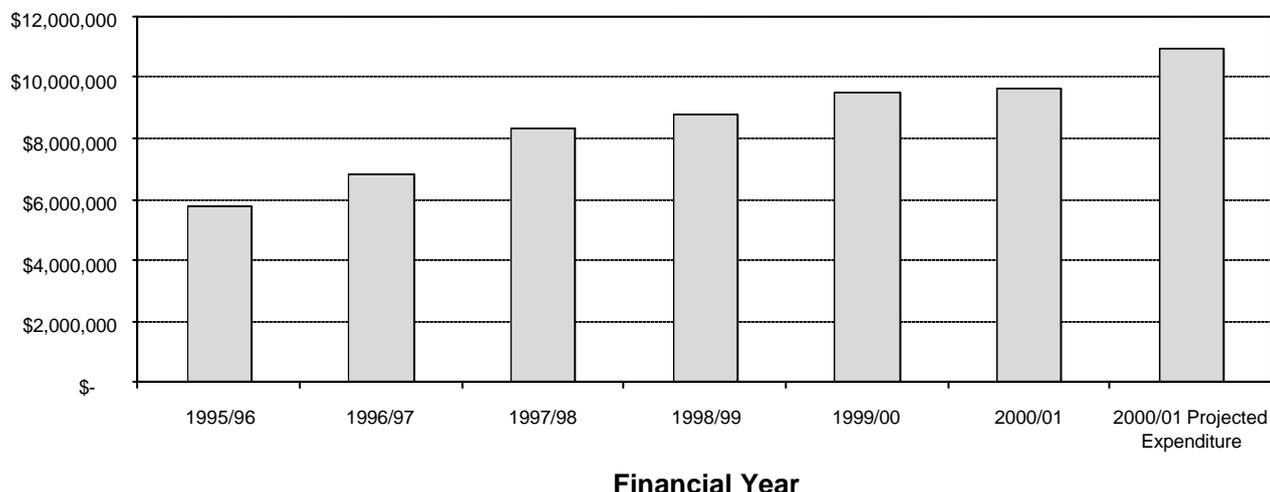
The Government is committed to increase the availability of specialist services in rural areas and both State and Federal Governments have committed funds to achieve this. In addition, innovative models such as Telehealth have the potential to enhance access to specialist services for people living in rural areas.

It is recognised that there will always be a number of highly specialised services or complex procedures that will only ever be available in the metropolitan area or large regional centres. PATS will continue to have an important role in enhancing access to these services.

**PATS EXPENDITURE AND UTILISATION**

The approximate expenditure of PATS over the last six years is shown in the Figure 2.1 below:

**Figure 2.1: Chart of the Growth in PATS Expenditure 1995/6 to 2000/1**



The average growth in PATS spending over the last 6 years is approximately 10.7% per annum. The expenditure for the last two years was relatively stable at approximately \$10 million. This is approximately \$1 million over the nominal budget allocation (\$8.6 million for 2000/01).

Projections of additional funding requirements have been based on the average annual growth in PATS expenditure from 1995/96 to 2000/01. This rate of growth suggests that additional annual funding of \$1 million (additional to the previous year's expenditure) will be required in 2001/02 to meet growth in demand for PATS under the existing guidelines. Increased annual funding will be required in each year, with an annual increase in funding of \$1.4 million being required by 2004/05.

The projected expenditure for 2001/02 is \$11 million based on expenditure at 30 December 2001.

### **Utilisation**

The average annual growth in PATS trips over the last 6 years is 3.8% with the number of PATS trips funded in 2000/01 being approximately 35,000.

#### ***Escort***

Of the 35,000 trips, 34% or 12,000 trips involved an escort either because the patient was under 18 years of age, or because of medical necessity. The cost of escorts was approximately \$1.7 million.

#### ***Concession Status***

In forty five per cent (43%) of trips (15,200 trips) made in 2000/01 patients were non-concession card holders and paid a patient contribution of \$50 providing a total income of over \$700,000.

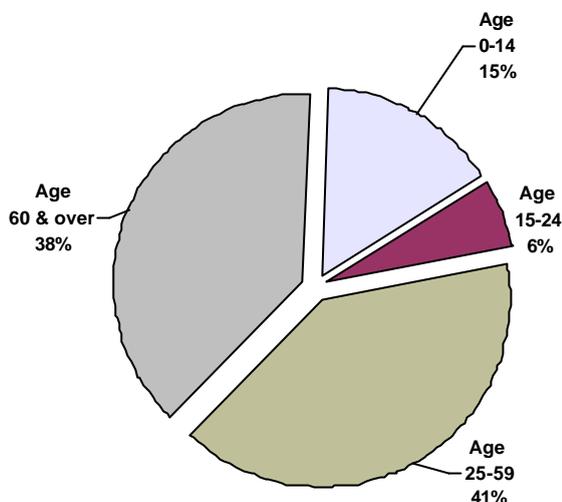
Of the 19,800 trips made by concession card holders, 53% were made by health care card holders, 32% by aged care pension card holders, 15% by disability concession card holders and 9% by people of a carers or sole parent pension.

#### ***Exceptional Rulings***

In 2000/01 General Managers used their discretionary powers in two per cent (2.3%) of cases where hardship could be demonstrated (796 trips) to approve trips that did not fully meet the PATS guidelines, including 610 retrospective applications.

### Age Breakdown

The age breakdown of people who accessed PATS in 2000/01 is as follows:



### Type of Transport

The type of transport used and growth each year across the previous three years are shown below:

Type of travel	98/99	%	99/00	%	2000/01	%	Average Annual % Growth
Public (surface)	2,646	10	2,854	9	2,406	7	-5%
Air	5,277	20	6,445	20	6,435	18	10%
Private Car	18,601	69	22,165	70	24,656	71	15%
Unknown	410	1	294	1	1,522	4	
<b>TOTAL</b>	<b>26,934</b>	<b>100</b>	<b>31,758</b>	<b>100</b>	<b>35,019</b>	<b>100</b>	

The proportion of travel by public transport has dropped from 10% to just over 7% whilst the proportion of private car travel has risen from 70% to just under 74%. The proportion of air travel has remained steady at 19 - 20%.

### ***Destination***

The majority (73%) of referrals are to specialists in the metropolitan area, 17% are to regional centres and 1% are interstate (Darwin or Alice Springs) as shown below.

#### **DESTINATION OF PATS PATIENTS 2000/01**

<b>Destination</b>	<b>Number of Trips</b>	<b>Percentage of Trips</b>
Metropolitan Area	25,559	73%
Regional Centre	5,928	17%
Interstate	230	.6%
Unknown	3,302	9.4%
<b>Total</b>	<b>35,019</b>	<b>100%</b>

### ***Patient Status***

Over eighty four percent (84.5%) of referrals in 2000/01 were for outpatient appointments and slightly over 15% of referrals were admitted as in-patients.

### ***Frequency of Trips***

Approximately 35% of trips were one-off trips, and 46% of trips were repeat trips made at intervals less frequently than once per month. Ten percent (10%) of trips are repeat trips made at intervals more frequently than once per month, the frequency of the remaining 9% of trips is not known.

***Type of Speciality***

The most common types of specialist accessed through PATS are shown below:

**PATS referrals by 7 most common types of specialty 2000/01**

<b>Specialty</b>	<b>Number</b>	<b>%</b>	<b>Cost</b>
General surgery	8,188	23	2,777,000
Internal medicine	7,863	22	1,650,000
Ophthalmology	2,716	8	527,000
Radiation oncology	2,449	7	751,000
Diagnostic radiology	1,927	5	322,000
Obstetrics/ gynaecology	1,875	5	594,000
ENT	1,288	4	361,000
<b>TOTAL</b>	<b>26,306</b>	<b>74</b>	<b>6,982,000</b>

These specialty areas account for 74% of all PATS trips, and 73% of the 2000/01 expenditure.

## **SECTION 3 - PROPOSED CHANGES TO PATS ADMINISTRATION**

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PATS is administered and managed by rural Health Services, with the Royal Street office of the department being responsible for budget allocation and overall policy development.

The review has considered a number of issues that need to be addressed in relation to the administration of the scheme. These include the following:

- **Managing Expenditure**

Health Services are responsible for managing the PATS budget but have limited direct control over the expenditure because approvals are based on clinical need.

- **Processing Claims**

The application and approval process is cumbersome and there is poor compliance with the process.

- **Public Awareness**

There is poor knowledge of the scheme amongst the community and within the health sector.

- **Consistency of Decisions**

There is inconsistency in the application of the scheme across health services.

- **Coordination of Patient Travel**

Whilst it is preferable that most patients make their own travel arrangements, there is the need to coordinate travel arrangements for some people, particularly people living in remote communities.

- **Planning, Monitoring and Evaluation**

Processes for monitoring and evaluating the scheme need further development.

These issues are discussed below and recommendations to address the issues are made where appropriate.

## MANAGING EXPENDITURE

PATS expenditure is growing at an average rate of 10.7% (calculated over the last 6 years). This increase is due to a number of factors including increased demand, increased proportion of people using air travel and increasing costs of air and bus travel, and a reduction in the use of surface (coach and rail) travel. Considerable extra funds would be required to maintain this level of growth in expenditure.

There is limited potential to reduce expenditure through tightening the guidelines and changing the eligibility criteria. Significant reductions in the growth of expenditure can only be made by reducing the need for patient travel.

Anecdotal information obtained during the PATS review suggests that many people are referred to Perth for follow-up appointments that in some cases could be carried out by the patient's own General Practitioner (GP). Patients have reported that they sometimes travel hundreds of kilometres for a follow-up appointment of less than one-minute duration, for consultations such as a check to see if the wound has healed, or for a standard monthly review.

In other cases, patients are requested to check in at the outpatient clinic at 8am on the morning of their appointment. In most cases this necessitates travelling the day before the appointment and staying overnight in Perth.

In addition to the cost to PATS, this travel can be highly disruptive and expensive for patients themselves. The consultative forums held during the review found that patients would be very supportive of any initiatives to reduce the need to travel or to reduce the length of stay.

There is a need to explore whether the needs of country patients for outpatient appointments at teaching hospitals can be better met. This could be either through more flexible timing of appointments to fit in with transport and travel arrangements, or to reduce the need to travel, especially for follow-up appointments.

### 1. *It is recommended that:*

**A project is undertaken to explore patient procedures in hospital specialist outpatient clinics and work with rural GPs to identify alternative options for country patients. Details of this proposal are provided in Appendix 3.**

## PROCESSING CLAIMS

PATS is administered by rural Health Services through local hospitals. General Practitioners generally provide a referral for PATS assistance along with the referral to a specialist. The completed PATS application form is taken or sent to the PATS Clerk at the local hospital for processing and approval. There are approximately 90 full time or part-time PATS Clerks based in rural hospitals throughout the State adding up to the equivalent of approximately 17 full time positions. Other staff involved in the administration of the scheme includes Finance Managers, Health Service Managers/ Directors of Nursing and General Managers.

Options for simplifying the administration of the scheme, making it more customer focussed and reducing administrative costs have been explored, including centralising or regionalising some aspects of the administration of the scheme.

Fifty five percent (73) of respondents to the Discussion Paper feedback sheet indicated support for centralised coordination of the service, whilst 38% (52) of respondents did not support the proposal. The remaining 7% of respondents did not answer this question. Those in favour commented that centralisation would provide more consistency and expertise in the application of the scheme. Those not in favour noted the need for personal contact and local knowledge. Many people commented that the referring doctor rather than the PATS agency should determine which specialist the patient sees.

A suggested model for the coordination of PATS administration that addresses the issues raised is outlined in Appendix 4.

A survey of PATS Clerks<sup>2</sup> in rural hospitals carried out during the review found that:

- there is poor compliance with the completion of the yellow PATS application form. This results in PATS Clerks spending unnecessary time following up details with GPs, and can result in the patients themselves filling in the details;
- there is a need for much greater information about PATS to be available in the community - especially for GPs, patients and teaching hospital staff;
- clarification and consistency in the application of the guidelines is needed in a number of areas including referral to the nearest specialist, inter hospital transfers, issuing tax vouchers and block approvals;
- there was support for centralised decision making for PATS applications that fall outside of the guidelines, in order to provide greater consistency across health services; and

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<sup>2</sup> Survey of PATS Clerks, November 2001. Details available from Country Services

- there needs to be greater awareness of the specialist services that are available within rural areas, and the waiting list for each specialist.

Similarly a meeting of metropolitan hospital administrative staff in November 2001<sup>3</sup> reported that:

- some GPs do not inform patients of the PATS scheme. As a result, metropolitan hospital staff have to try to arrange for retrospective approvals of PATS after the patient arrives in the city; and
- clearer guidelines and consistency in the interpretation of guidelines would assist tertiary hospital staff in assessing patient's eligibility for PATS.

**2. *It is recommended that:***

**The application and approval process be streamlined in the following ways:**

- **working with GPs and metropolitan hospital staff to educate them about the PATS guidelines and approval process;**
- **simplification of form layout to ensure greater completion; and**
- **simplification of the process for obtaining block approvals for specified courses of treatment.**

***Cost: Within budget***

**3. *It is recommended that:***

**In the implementation of the new structure for country health services, consideration be given to:**

- **centralising or regionalising aspects of the administration of PATS including approving claims, data entry and the payment of accounts; and**
- **providing a central (or regional) referral point/s for making decisions that fall outside of the guidelines.**

***Cost: Within budget***

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<sup>3</sup> Meeting held on Tuesday 13 November 2001. Details available from Country Services

## PUBLIC AWARENESS

The lack of knowledge of the scheme was highlighted in the internal review of PATS and has been reinforced by feedback obtained through the community consultations. Lack of knowledge of the scheme results in people who need assistance not receiving it, and in unrealistic expectations from the community on the level of assistance that the scheme can provide. Thirteen percent (13%, 17 people) of survey respondents provided additional comment on the need for more promotion and user friendly written information.

It is believed that a greater understanding of the scheme amongst General Practitioners, together with a redesign of the application form, will help address current issues of incomplete applications (see above).

### 4. *It is recommended that:*

**Measures are taken to ensure good knowledge of the scheme, including both the guidelines and application procedures. This may include:**

- **providing more detailed written information to the community;**
- **providing relevant information and ongoing education to GPs and others involved in administering the scheme;**
- **ongoing promotion of the scheme to ensure that the community is aware of the scheme and what it covers;**
- **making the guidelines available on the Department of Health web site; and**
- **awareness of the ability to make retrospective claims in exceptional circumstances.**

***Cost: \$20,000 initial one-off cost to produce promotional materials and some training.***

## CONSISTENCY OF DECISIONS

An issue that has been frequently raised throughout the review is a lack of consistency in interpretation of the guidelines and in determining exceptional circumstances.

Health Services aim to be internally consistent in the implementation of the scheme, however, there are no mechanisms in place to ensure consistency across Health Services.

### ***Escorts Whilst the Patient is in Hospital***

The PATS guidelines need to be clarified in relation to escorts for patients who are hospitalised, particularly in cases where the patient is critically ill or a young child. This should include consideration of the Boarder Policy.

#### **5. *It is recommended that:***

**Inconsistencies in the application of PATS be addressed through greater clarity in the guidelines, specifying the types of circumstance that constitute 'exceptional circumstance' and focussing on the purpose or intent of the scheme.**

**Cost: Neutral**

## **COORDINATION OF TRAVEL**

In general patients are responsible for making their own travel arrangements, however, when patients are flying, the health service normally arranges and pays for the flight. When patients are travelling from a remote community, the PATS Clerk liaises with other relevant health providers and the community to ensure that the journey is coordinated. This arrangement generally works well although issues can arise when patients are discharged from metropolitan hospitals outside of normal hours. Concerns have been raised that a number of people who come from the country for medical treatment do not return home immediately and become homeless in Perth. Patients and escorts can also arrive in the metropolitan area ill prepared for the visit or unsure how to get to the specialist appointment. Better coordination amongst health service agencies, clarification on the role of escorts and greater information to the patient is needed. This issue was also raised in the State Homelessness Task Force Report.

Issues can arise when patients fail to show for a non-refundable pre-paid journey. On some occasions Health Services have booked and paid for a journey a number of times for the same appointment.

#### **6. *It is recommended that:***

- **the admission and discharge of country patients in metropolitan hospitals is made easier for the patient through improved communication between metropolitan and rural health services and by ensuring the provision of adequate information to the patient and their escort; and**
- **in particular, it is recommended that:**

- country patients are not discharged from metropolitan hospitals without a coordinated plan to ensure their return home; and
- after-hours discharges of country patients are avoided unless plans for the patient's return journey are pre-arranged by the discharge planning coordinator.

**Cost: Neutral**

**7. It is recommended that:**

Further research be undertaken to identify the extent of and reasons for patients failing to travel on a pre-paid journey. As a general principle, if a journey needs to be re-booked, the patient should be asked to pay for the journey and then reclaim the cost after attending the appointment unless there are exceptional circumstances.

**Cost: Neutral**

*(See also recommendation 17 regarding transport within the city).*

## **PLANNING, MONITORING AND EVALUATION**

There are inconsistencies and gaps in the recording of PATS information across Health Services and this has resulted in poor quality of data on PATS usage and expenditure. It is difficult to provide an analysis of trends, or use data for planning purposes with the present data returns.

It is essential that good quality data be provided and collated on a regular basis and in a consistent manner in order for planning, ongoing monitoring and periodic evaluations of the scheme. Issues regarding the collection and collation of data are detailed by the internal review and should be addressed by the recommendation to coordinate the administration of PATS.

Attention also needs to be given to the types of information that are collected. Performance measures need to be developed to monitor and evaluate the scheme against set criteria in regard to access, equity, efficiency, effectiveness and quality.

Good quality information is essential for identifying trends and issues and planning future priorities and directions for the scheme. Planning for PATS needs to be undertaken on a regional basis and done in conjunction with planning for rural specialist services.

**8. *It is recommended that:***

**Procedures for ongoing monitoring and regular evaluation of the scheme be developed and implemented.**

***Cost: Within budget***

## **SECTION 4 - PROPOSED CHANGES TO PATS POLICY AND GUIDELINES**

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The PATS Guidelines prescribe the scope of the scheme, the assistance provided and the eligibility criteria. There are regular public representations to extend the scope of the scheme to cover allied health, dental treatment and other health services not available locally. There are also calls for the eligibility criteria to be extended by changing the distance boundary, and for the levels of subsidy provided to be increased.

These issues have been considered in the review and formed part of the focus of the public consultations.

The costs of any proposals to expand the scope of PATS, the eligibility criteria and the levels of subsidy paid have to be met from within the budget allocation. The additional \$1 million per annum has been fully absorbed by the increase in costs of airfares following the collapse of Ansett. Any expansions to the scope of the scheme are therefore subject to the identification of sufficient funds. However, it is proposed that some recommendations that address current anomalies in the scheme and have a low budget implication are implemented immediately.

The following recommendations reflect the priorities identified in the review and address some current anomalies within the program.

### **SCOPE**

Whilst given extra resources, many people would like to see an expansion to the scope of PATS, most people consulted in the review agreed that the current scope and eligibility criteria are about right. For example, fifty percent (67) of completed feedback sheets indicated support for the current eligibility criteria and scope of services. Twenty eight percent (37 people) of respondents felt that PATS should cover a broader range of services for a more limited target group, the remaining 22% did not respond.

#### **Dental and Allied Health**

PATS does not cover referrals to allied health specialists. The department is exploring ways to increase access to allied health services in rural areas, however there will continue to be a demand for some highly specialised allied health services that can only be accessed from Perth. This is the subject of some community concern, particularly for people with a disability.

Submissions from a number of organisations including the Cerebral Palsy Association of Western Australia, and several allied health groups supported the expansion of PATS to cover specific highly specialised allied health services, and this is recommended.

Similarly, there has been a call to expand PATS to cover some specialised dental and orthodontic services. Submissions on this issue were received from several dental associations and dentists as well as PATS clients. The current arrangements provide for country patients to access emergency and urgent specialist dental treatment under a general anaesthetic. No expansion of PATS is recommended in this area.

### **Other Services and Treatments**

At present, PATS does not cover specialist work undertaken by a GP, for example, minor surgery or obstetrics. It is believed that better use would be made of services provided by GP Proceduralists in regional centres if PATS were available for these services (subject to the distance boundary and other PATS eligibility criteria).

Similarly, PATS is not available to people who need to travel more than 100kms to obtain specific services that are an essential component of the specialist treatment but are not performed by a specialist, for example, x-rays. In most instances it is possible to arrange for these diagnostic services to coincide with the specialist visit and therefore no change to PATS is recommended.

#### **9. *It is recommended that:***

**Subject to funding becoming available, the scope of PATS is expanded to include some highly specialised allied health assessments/treatments from specified agencies such as pressure garment assessment and complex alternative communication assessment (a complete list of services is to be developed in consultation with allied health specialists).**

***Implementation: To be reviewed in 12 months***

***Estimated cost: Dependent upon services to be included.***

#### **10. *It is recommended that:***

**Transport to a GP Proceduralist for a specialist procedure, for example obstetrics, is covered by PATS (excluding standard GP consultations and minor procedures).**

***Implementation: 1 July 2002***

***Estimated cost: Neutral***

## Renal Dialysis

There are a number of renal dialysis patients from the country who are required to remain in Perth long term for renal dialysis. Many of these patients are at end stage renal failure and are not expected to return home. Up to thirty renal patients, mostly from the Kimberley reside at the Elizabeth Hanson Autumn Centre in Maylands. The cost of accommodation and board is met through a PATS accommodation subsidy of \$35 per night.

Whilst this is outside of the scope of the scheme, it is acknowledged that these people are highly disadvantaged and vulnerable and the PATS accommodation subsidy should not be withdrawn unless alternative options for supporting this group are identified.

The establishment of a renal dialysis satellite service in Broome in 2002 should go some way to alleviating this problem. However, renal failure is a growing issue and some continuation of long term accommodation for renal patients in Perth may be unavoidable.

### **11. *It is recommended that:***

**PATS accommodation assistance is provided for a maximum of six months and that suitable long term accommodation options are explored for renal patients who need to relocate in order to access dialysis treatment.**

***Implementation:* 1 July 2002**

***Cost:* Neutral**

## **ELIGIBILITY CRITERIA**

### Boundary/Safety Net

The review considered a proposal to restore the PATS distance criterion to the pre-1995 criterion of 50kms from the nearest treatment centre. This option was considered to be costly and was not supported by the community in the consultations. The community feedback suggests that priority should be given to those who live furthest away from the treatment centre. However, there was widespread support for the concept of a 'safety net' or buffer zone.

Under this concept, people who live just inside the 100km distance boundary and are experiencing financial difficulty because of the need to make frequent trips to a specialist would become eligible for PATS assistance after having made a predetermined number of trips. This concept is to be introduced in the Peel Health Service from February 2002.

**12. It is recommended that:**

**Consideration be given to extending the 'safety net' concept to dialysis and oncology patients across the State.**

**Implementation: 1 July 2002**

**Cost: Approximately \$30,000 (in addition to the estimated \$60,000 for Peel Health Service)**

### **Inter Hospital Transfer to Private Hospital**

Under the current guidelines, patients who are transferred from a public hospital to a private hospital are not eligible for PATS for their return journey home. There have been a number of representations regarding this issue arguing that this discourages people from using private health care and unfairly discriminates against private health patients. This is also considered to be inconsistent with the PATS policy regarding outpatient consultations where no distinction is made between public and private patients. There is a benefit to the public health system in that the cost of treating these patients is covered through private health insurance or other means.

**13. It is recommended that:**

**Subject to funding being available, patients who are transferred from a public to a private hospital are eligible for PATS for their return journey home so long as the PATS criterion of 'nearest available specialist service' is met.**

**Implementation: To be reviewed in 12 months**

**Estimated cost: \$30,000**

## **BENEFITS AND CONTRIBUTIONS**

### **Subsidy Rates**

The current PATS fuel subsidy rate is 13 cents per kilometre. Many people have expressed the view that this rate is inadequate, particularly in the more remote areas where fuel costs are highest. Many people compared the PATS fuel subsidy with employee vehicle reimbursement rates which are set at a much higher level as they take into account all of the costs of keeping a vehicle on the road. Information from the RAC<sup>4</sup> on car running costs indicate that the fuel costs for a car up to 4 years of age range from approximately 8 to 13 cents per kilometre. Costs for a four wheel drive are approximately 15 cents per kilometre (calculated on fuel costs of 93.5 cents per litre).

<sup>4</sup> RAC Web site 'Car Running Costs'.

Similarly, there has been a call to review the accommodation subsidy rate of \$35 per night. Whilst it is possible to find accommodation around this price in the city, low cost accommodation options are not always available in other regional centres.

The current subsidy rates compare well to the rates provided in other States and Territories (see Appendix 5)

Several submissions to the review requested that consideration be given to the distances that people are expected to drive in one day, particularly when they have accompanying children or an illness that requires them to make frequent breaks from driving.

**14. It is recommended that:**

**The PATS fuel and accommodation subsidy rates remain unchanged. However, the high cost of group transport, for example, from a remote community to the nearest town is acknowledged. It is therefore recommended that for journeys that include a group of 2 or more PATS eligible patients/escorts in a minibus or similar group transporter owned by a community or organisation, the fuel subsidy be increased to 25c per kilometre payable to the relevant organisation rather than the patients.**

**Implementation: 1 July 2002**

**Cost: Approximately \$10,000 p.a.**

**15. It is recommended that:**

**An accommodation subsidy is provided to people driving more than 750 km one way to assist them to break their journey.**

**Implementation: 1 July 2002**

**Cost: Approximately \$10,000 p.a.**

### **Patient Contribution**

Feedback from the consultation forums indicates that in the context of limited resources, the community supports focussing PATS assistance to those who are most in need. "Most in need" was defined as those people who are most financially disadvantaged by having to travel due to low income, the need for frequent trips or the long distance they are required to travel.

Twenty nine percent (39) of people supported a rise in patient contribution, and 66% (89) did not support this. The main reasons given for not supporting this were that many non-concession cardholders are on a low income. The

often considerable additional costs of having a sick person in the family were also noted.

Fifty eight percent (77) of those surveyed agreed that priority for PATS assistance should be given to people who have to make frequent visits to a specialist. Thirty four percent (46) disagreed.

Feedback from Health Services and community forums indicated that the introduction of a means test would be difficult to apply in a fair and consistent manner, difficult to administer and would not raise significant revenue without creating hardship.

**16. *It is recommended that:***

**The current patient contribution rates remain unchanged. That is:**

- **no patient contribution is required for concession card holders; and**
- **for non-concession cardholders, the current patient contribution of up to \$50 per trip and an accommodation allowance only after the first 3 nights for the first 4 trips apply.**

**Transport Within The City**

Community feedback indicates that policy in regard to the issuing of taxi vouchers is viewed as inadequate and inconsistent. Currently patients are only eligible for a taxi fare on the grounds of medical necessity or because of language or cultural reasons. Application of this policy is inconsistent across Health Services and the number of people leaving metropolitan hospitals without the taxi fare back to the airport is a significant issue for hospital welfare staff. Knowledge of alternative transport to/from the airport such as the private shuttle service is poor. The problems experienced by Aboriginal people in managing travel under PATS has been noted in the State Homelessness Task Force Report.

**17. *It is recommended that:***

**For people holding a concession card, transport is provided between the city destination (motel or hospital) and the airport terminal using the cheapest appropriate form of transport.**

***Cost: Up to \$50,000***

## SECTION 5 - CONCLUSION

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This review of PATS was initiated by the Minister for Health in response to concerns from the community, in particular, concerns regarding the scope, eligibility criteria and level of benefits paid under the scheme. The department has also raised a number of concerns in relation to PATS including minimum control over PATS expenditure, current over expenditure and community demand for expansions to the scheme.

An internal review was initially undertaken by the Department of Health and reported to the Minister in May 2001.

Following the internal review, a discussion paper was prepared and formed a framework for consultations with the rural community.

This report reflects the finding of the internal review and feedback from the community.

The report concludes that access to specialist services for country residents can be improved through enhancing PATS in a number of ways including:

- developing strategies to minimise the need to travel for specialist services;
- simplifying and streamlining the administration of PATS;
- reducing some anomalies within the guidelines;
- increasing community knowledge of the scheme;
- focussing the scheme on those people with highest needs; and
- improving mechanisms for planning, monitoring and evaluation.

A set of recommendations has been proposed to achieve these improvements. The extension of PATS assistance to Peel is effective from February 2002. Most other recommendations will be implemented from 1 July 2002, however, recommendations involving an expansion to the scope of the scheme will be delayed until sufficient funds are available.

Implementation will involve revising the PATS Guidelines, developing promotional materials and an information program for GPs, health services and the community and working with health professionals to address specific issues highlighted in the review.

# APPENDIX 1 - DISCUSSION PAPER

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## BACKGROUND

The purpose of this discussion paper is to stimulate discussion and community debate on the future directions of the Patient Assisted Travel Scheme (PATS).

PATS provides assistance to country residents who are required to travel more than 100 kms in order to attend specialist appointments. The scheme is administered through the network of country hospitals, in accordance with set guidelines.

The PATS scheme is highly valued by rural Western Australians and there is an ongoing demand to extend the scope of PATS to cover additional specialist services, and to increase the levels of assistance provided.

Prior to the election, the government committed to:

- increase funding to PATS by an additional \$4 million over the next four years;
- change the boundary to ensure PATS is available to patients living in towns closer to Perth, such as Pinjarra and Mandurah; and
- review the scheme to include issues relating to the adequacy of its funding and the way it is administered in order to foster a more flexible approach in the application of its guidelines.

The Department of Health has recently reviewed PATS and has proposed a number of ways in which the scheme can be enhanced within the current budget (including the additional funding of \$4 million).

This discussion paper has been developed in order to take these proposals to the community for response. The experience and views of those people who use PATS as patients and family members, together with health service providers are essential to the future development of the program.

There are two ways of providing your response to this discussion paper:

- you can attend a community forum; and
- you can make a written submission about the paper.

Details of how to participate in a forum, or how to make a submission are provided at the end of this paper.

## INTERNAL REVIEW

The Department of Health recently reviewed the PATS scheme. The review was initiated in response to community concern regarding the scope of the scheme. Concerns include:

- the 100 km boundary;
- exclusion of allied health, dental care and visits to critically ill patients from the scope of the scheme; and
- the level of benefits paid.

The Review Steering Committee consulted with a broad range of agencies including hospitals, PATS clerks, social workers and Aboriginal Medical Services to gather information on the issues for both patients and those who administer and manage the scheme.

### Review Findings

The main findings of the review are as follows:

- PATS expenditure is growing at a high rate and significant additional resources will be required to maintain the current scheme. The review proposes a number of options to control expenditure on the scheme whilst ensuring that those who are most in need of assistance are receiving help. Options that could be considered include:
  - introduce means testing;
  - raising the contribution rate; and
  - introducing safeguards for people living between 100 and 50 km of the nearest treatment centre who need to make frequent trips for specialist treatment.
- Any across the board increase in the fuel subsidy or significant change in boundary will greatly impact upon the PATS expenditure.
- There is poor knowledge of the guidelines amongst the community and some General Practitioners. This has led to confusion and unrealistic expectations about the assistance that can be provided. Together with a lack of alternative options, this has led to the scheme being regarded as a 'catch all' for any type of health related travel.
- The scheme does not have the flexibility to meet all of the requirements of people with specific needs. For example:
  - people from remote communities need specific assistance with coordinating travel and accommodation arrangements;

- as PATS is intended to provide a subsidy only, this can be a problem for people with no money;
  - there can be cultural security issues for Aboriginal people and people who do not speak English;
  - PATS is not designed to meet the needs of people who are in Perth for long term treatment (renal dialysis); and
  - people with disabilities need to have access to a specific range of services that are not all covered by PATS.
- Access to the scheme can be simplified and made easier by changes to the way in which the scheme is administered.
  - The introduction of additional specialist services into country areas and the exploration of alternatives such as telemedicine and video conferencing may reduce the demand for PATS in the longer term.

### **Recommendations**

Some of the key recommendations in the review include:

- Exploring options for reducing growth in PATS expenditure by refocussing the scheme on those who are most in need of assistance;
- Addressing issues of access to allied health and dental services through increasing services to country areas rather than expanding the scope of PATS;
- Reviewing the administration of the scheme and clarifying the guidelines;
- Considering alternative options for providing support to people who live within 50 km and 100 km of a specialist service;
- Giving consideration to an increase in fuel subsidy for people living in remote locations;
- Reviewing the needs of people in Perth for long-term renal dialysis with the aim of meeting those needs through a program specifically designed for their needs; and
- Undertaking more work to clarify the roles and responsibilities of relevant agencies in ensuring that transport services and PATS assistance provided to Aboriginal people and people from remote locations are appropriate and well coordinated.

## KEY ISSUES

The review has highlighted a number of issues and possible directions that need to be considered in order to enhance the level of assistance provided through the scheme as described below. Where appropriate, key questions are posed as a prompt for people who wish to respond to the paper.

### Targeting the Scheme

**Question:**

***What is the best way of targeting PATS to those people who are most in need of assistance?***

The current PATS expenditure is approximately \$10 million per year (2000/01). Assistance is provided for approximately 32,000 trips per year.

An additional \$1 million per year applied across the scheme will have marginal impact in fundamentally extending access or the eligibility criteria. For example, it is estimated that the cost of increasing the fuel subsidy would be approximately \$400,000 for each 1 cent per kilometre (c/km) increase.

At present all people who live more than 100 km from the nearest treatment centre are eligible to apply for PATS irrespective of their income. At the same time people living 90 km from the treatment centre may be experiencing real hardship, yet do not qualify.

More effective targeting of the scheme can help ensure that assistance is going to those who are most in need. There are a number of ways in which this can be done.

#### ***Means Testing***

A means tested scheme would help ensure that assistance is provided according to people's capacity to pay, irrespective of whether they are a concession cardholder. With a means tested scheme, the patient contribution and distance boundary criteria could be removed. People would be paid a subsidy towards the cost of travel - the level of subsidy paid would depend upon the family income. Families whose income was on or around the pension rate would receive the maximum subsidy (this could be 100%).

There are two ways of providing a subsidy:

- a percentage of the actual cost of travel; or
- a set amount.

The challenge of implementing means testing would be to find a simple and fair way to establish it without creating complex red tape. It would need to be very simple and clear and as non-intrusive as possible on the family. It is important to the success of the scheme that it is not burdensome to administer and that the community is able to simply and accurately assess how much they are eligible to receive.

An advantage of a scheme based on income is that the distance boundary could be removed. People's eligibility for assistance would depend upon their level of income rather than where they lived.

### ***Patient Contribution***

***Question:***

***Would the introduction of a safety net for people who are experiencing hardship because of the need for multiple trips be a more effective way of assisting the community than changing the boundary for everyone?***

***What is an appropriate level of patient contribution?***

The current patient contribution rate for non-concession cardholders is \$50 per trip up to a maximum of \$200 per financial year. A raise in the per trip or per annum contribution rate would lead to a reduction in PATS claims from non-concession card holders living relatively close to the treatment centre. This would provide a greater pool of funds to assist people living further away or on a concession.

### ***Safety Net***

Some people have a chronic medical condition that requires multiple or frequent trips for specialist treatment. Under the current PATS guidelines some of these people do not qualify for PATS because they live just inside the 100 km boundary, however the costs of multiple trips may be causing hardship.

The introduction of a 'safety net' would provide assistance to those people who live inside the current boundary who are experiencing hardship. For example, people could become eligible for PATS assistance once the cost of travel related to their treatment had exceeded a certain amount for the year.

## Providing a Better Customer Focus

**Question:**

***What are the options for a centralised coordination and referral centre to enhance the service provided to patients requiring specialist appointments?***

Many of the complaints received about PATS are about a lack of flexibility or people having difficulty in following the process for successfully making a claim.

There can also be a lack of coordination across the full range of the patient's medical needs, for example a patient may travel to Perth for a specialist appointment one week, and then make a second trip for a routine check up a few weeks later.

Some doctors may be routinely referring patients for specialist appointments in Perth without being aware of other possible options such as services available in the regional hospital or the use of videoconferencing. This can lead to unnecessary travel and time away from family and work for the patient, and also unnecessary expense for PATS.

Rather than being viewed solely as a travel subsidy scheme, PATS could be remodelled to provide a more complete service. For example, a doctor could refer a patient to PATS rather than to a specific specialist, stating the type of treatment or speciality required, and degree of urgency. PATS staff would then explore the full range of suitable services available together with any other related health needs of the patient. A service could then be arranged that was tailored to the needs of the patient taking account of the options available. At present the onus is on the doctor to keep up to date with the best referral options. A PATS coordinating unit could assist with packaging the best arrangements for each patient based on appropriate clinical justification.

A call centre such as Health Direct could assist patients with information about PATS and also other ways of accessing assistance such as the Veterans Affairs Gold Card.

## Dental and Allied Health

**Question:**

***Should PATS fund a broader range of services for a smaller eligible population, or should the range of services be restricted and the scheme be made available to a broader number of people?***

There is a shortage of dental and allied health services in some rural areas. Some people may have to travel considerable distances or wait for a long period of time in order to access dental or allied health services.

It is acknowledged that there is inequity in access to dental and allied health services for people living in rural areas. However, the way to address this issue is to increase the provision of services in country areas, rather than to assist people to travel out of their area to access services.

The Centre for Rural and Remote Oral Health is working to improve access to dental services in rural Western Australia. The Department of Health has committed an additional \$2.4 million to improve access for people in rural and remote communities, and the Government has committed an extra \$1 million to further increase these services.

An additional \$4 million has been committed to increase allied health services in rural areas.

Dental and allied health services provided in rural Western Australia are being reviewed to ensure that services are placed in areas of highest demand.

The cost of extending PATS to cover dental and allied health services would be enormous and would need to be made at the expense of limiting those people who are eligible for PATS assistance.

There will always be people requiring highly specialised dental and allied health services that can only be provided in Perth. Currently these services are outside of the scope of PATS, however, if a patient has received PATS assistance to travel to Perth for a medical specialist appointment, additional accommodation subsidy can be provided to extend the stay for related non-medical specialist appointments.

## **CURRENT PATS POLICY**

The policy and procedures by which PATS operates is set out in detailed guidelines. These are summarised below.

### **Patient Eligibility**

In order to be eligible, the patient must:

- be a permanent resident of rural Western Australia;
- be a non-admitted patient. ie commencing their journey as an outpatient;
- be travelling intrastate. Interstate is covered by a separate Interstate scheme coordinated through the Office of the Chief Medical Officer; and
- not be covered for travel by another scheme, for example, Veteran's Affairs or Worker's Compensation.

### **Scope**

PATS applies for patients needing to access essential specialist medical services that are not available locally from a resident or visiting specialist medical practitioner.

#### ***Recognised Specialists***

A recognised specialist is either:

- recognised as a specialist for Medicare benefits purposes; or
- a hospital/health service employed specialist.

#### ***Eligible Services***

Services that are eligible under PATS include:

- services covered by an item in the Commonwealth Medicare Benefits Schedule Book;
- specialist services involved in the fitting of an artificial limb or artificial eye; and
- dental treatment covered by an item in the Commonwealth Medicare Benefits for the treatment of a cleft lip and cleft palate.

## **Nearest Specialist**

Patients claiming PATS must be referred to the nearest appropriate specialist. The nearest specialist includes the nearest resident or visiting specialist service.

PATS funding does not provide for a choice of specialist.

The referring doctor must give a valid medical reason if the patient is referred to other than the closest appropriate specialist.

## **Escorts**

PATS funding for an escort will be approved when:

- the eligible patient is under 18 years of age; or
- the referring practitioner certifies that an escort is necessary for the medical well-being of the patient, taking account of special circumstances such as disability and culture; and
- the escort is over 18 years of age.

Assistance is restricted to one escort per patient.

## **Patient Contribution**

Patients who hold a Health Care or Pension Concession Card are not required to make any contribution.

Patients who do not hold a Concession Card are required to contribute \$50.00 per return journey for each of the first 4 trips in a financial year. No patient contribution is required for subsequent trips.

## **Mode of Travel**

### ***Surface Travel***

Travel costs for patients are based on economy surface travel (bus or train), or use of private motor vehicle at 13 cents per kilometre.

Taxi and local bus fares are generally not provided unless warranted because of the patient's medical condition or for cultural issues.

### ***Air Travel***

Air travel is only funded in the following circumstances:

- a regular scheduled air service between the point of departure and point of arrival exists;

- travel to the nearest specialist involves a bus trip greater than 16 hours, and
- other modes of surface travel (eg private car) are not feasible.

In exceptional circumstances, the General Manager can approve air travel. These are generally if the patient requires air travel because of medical risk or personal care needs.

### **100 km Distance Criterion**

In order to be eligible for PATS, the patient must travel a minimum of 100 km (one way) to the nearest specialist. Distance is calculated using the Distance Book Edition 8, published by Mains Roads WA.

### **Mileage Allowance**

The mileage allowance paid for use of a private vehicle is 13 c/km. The initial mileage rate set when the scheme was first transferred to the State in 1989 was 15 c/km. This was reduced to 10 c/km in 1995 and increased to 13c/km in 1999. Whilst this allowance has not kept pace with rising fuel costs, it still compares favourably with other states as shown in the following table.

### **Accommodation**

Assistance with the costs of accommodation is provided to the patient and/or the escort when:

- the forward / return journey cannot be reasonably completed in one day;
- the specialist certifies that the patient needs to stay overnight for follow-up treatment; and
- the specialist certifies that the escort needs to remain with the patient for medical reasons.

If the patient has a Concession Card, assistance is provided for all nights. If the patient does not have a Concession card, assistance is provided for all nights in excess of the first three nights for each journey. If the patient has travelled four times in a financial year, all further accommodation assistance is payable from the first night for that financial year.

The General Manager must approve periods of accommodation in excess of 10 days. Lengths of stay up to one month can be approved. If patients are required to stay for extended periods, the option of leasing or renting accommodation should be explored. Rental assistance up to \$140.00 per week may be provided. This is a single payment and does not vary with an escort.

## **APPENDIX 2 - SUMMARY OF COMMUNITY CONSULTATIONS**

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The internal review of PATS identified a number of options for the future of the scheme. Before making any decisions on these options, the Minister requested that consultations take place with the community.

A discussion paper was prepared to provide an overview of PATS and of the internal review and to focus community feedback on the main issues under consideration. A feedback sheet was included in the discussion paper to make it easier for people to provide feedback and to assist with the collation of responses.

The consultation process included public forums, written submissions and a number of individual interviews and group meetings.

### **PUBLIC FORUMS**

Forums were held during October and November in the following locations:

- Albany
- Collie
- Derby
- Esperance
- Geraldton
- Kalgoorlie
- Karratha
- Mandurah
- Newman
- Tom Price
- Wagin

A total of 174 people attended the above community forums.

Forums were hosted by the local Member for Parliament and comprised of a short presentation about PATS and the internal review followed by discussion and feedback on the issues and options identified in the discussion paper.

In addition to providing feedback on the discussion paper, the forums provided valuable information on the issues faced by PATS clients in different locations, together with useful suggestions for enhancing the scheme.

## **WRITTEN SUBMISSIONS**

A call for written submissions was made through an advertisement in the West Australian on Saturday 29 September 2001.

In all, 178 submissions were received including 134 completed feedback sheets and 44 written submissions. The feedback sheets were completed anonymously. Written submissions were made by a wide range of respondents including health agencies and individual practitioners, metropolitan and rural hospitals, Members of Parliament, and 14 PATS clients. A list of agencies that responded is included at the end of this Appendix.

## **COMMUNITY FEEDBACK**

Feedback obtained through forums and written submissions was largely consistent. Feedback is summarised as follows:

### **Means Testing**

Respondents were generally opposed to the introduction of means testing as it would be difficult to administer, and may not take account of the high costs of living in the country and the considerable additional costs faced by some families accessing PATS.

Most people did not believe that concession cardholders should be asked to make a contribution, or that the patient contribution rate should rise. However, those who did, felt that the contribution rate should vary according to income.

### **Boundary/Safety Net**

Most people felt that priority should be given to people who have to travel furthest, and they did not support a reduction in the 100km boundary. However, there was limited support to the idea of a safety net for those who live just within the boundary and have a chronic condition.

### **Coordinated Administration**

The majority of respondents supported the concept of centralised administration of PATS. Support was particularly high in the forums where staff from Country Services were available to explain how the concept might work. However, many people believed that the referring doctor should retain the responsibility for identifying the most appropriate specialist. Comments also noted the need for a 'human face' for patients to liaise with. Support for this option was particularly high from metropolitan hospital staff who perceived that centralised coordination would provide greater consistency in decisions.

## **Scope and Eligibility Criteria**

Whilst access to dental and allied health services continues to be a problem, particularly for people with a disability, 50% of respondents were in support of retaining the existing scope and eligibility criteria for PATS. Of the remaining, 28% favoured expanding the scope but restricting the eligibility criteria and 7% favoured restricting the scope and expanding the eligibility criteria, 15 % did not respond to this question. The general consensus at the forums was that the scope is about right.

## **Level of Support Provided**

Whilst the level of fuel and accommodation subsidies were raised as an issue, most people at the forums acknowledged the high cost of increasing these subsidies and agreed that it would be more beneficial to focus additional assistance on those in greater need.

Many people felt that fuel subsidy should vary with distance (and consequently with fuel prices). The high fuel consumption of four wheel drive vehicles for group transport from remote communities was a particular concern.

Another concern that was frequently raised was the requirement to travel by road for distances of between 4 and 16 hours rather than be funded to fly. Long road journeys can be very uncomfortable for sick people and usually require overnight accommodation that involves disruption and additional expense for families. In addition, the length of journey that can reasonably be made in one day needs to be considered, and where necessary, an accommodation subsidy paid.

## **Other Comments**

A great number of additional comments and suggestions were made. These comments have been noted and will be acted upon where possible. Some of the main comments are noted below:

- strong need for greater information, promotion and education of the scheme;
- patients should not have to go back to the doctor for a new PATS application for follow-up;
- the need to increase the number and frequency of visiting specialist services in the country;
- general Practitioners often do not know where the nearest relevant specialist is;
- more follow-up work could be carried out locally by GPs;

- there is a need for assistance with coordinating multiple appointments, particularly for children with a disability;
- outpatient clinics need to take account of the travel time for country patients;
- a register of cheap accommodation options would be useful, also PATS may be able to negotiate discount accommodation rates for clients;
- PATS should cover referrals to GP obstetricians;
- PATS should cover x-rays, blood transfusions and ultrasound;
- PATS should allow for continuity of care with the same specialist, even if a closer specialist becomes available;
- pregnant women from remote areas need accommodation assistance 2-4 weeks prior to delivery;
- the need of some patients for emotional support be recognised by approving assistance for a carer, particularly for oncology patients and for complications in childbirth;
- policy in regard to escorts for sick children and the terminally ill needs to be clarified; and
- payments to PATS clients needs to be made in a timely manner, electronic funds transfer should be used where possible.

### **Feedback Sheet Responses**

The collated responses to the questions on the feedback sheet are as follows:

Question	YES		NO	
	Number	%	Number	%
1.1 Do you support introducing some kind of means testing for PATS?	42	31.3	90	67.2
1.2 Should concession cardholders make a patient contribution?	40	29.8	91	67.9
1.3 Do you support a rise in the patient contribution rate of \$50 per trip?	39	29.1	89	66.4
1.4 Do you support a rise in the patient contribution limit from \$200 per annum?	32	23.9	96	71.6

Question	YES		NO	
	Number	%	Number	%
1.5 Should priority for PATS assistance be given to people who have to make frequent visits to a specialist?	77	57.5	46	34.3
2.1 Do you support the introduction of a 'safety net' to assist people experiencing financial hardship who live inside the 100km boundary?	85	64.4	42	31.3
2.2 Is a 'safety net' a better way of targeting PATS funding than changing the boundary for everyone?	73	54.5	43	32.1
3.1 Would you be in favour of a centralised service to coordinate specialist appointments, transport, accommodation and hospital admissions?	73	54.5	52	38.1
4.0 <u>Scope and Eligibility Criteria</u>  Should PATS:  (a) fund a broader range of services but restrict who can apply; or  (b) restrict the range of services and make the scheme available to a broader number of people; or  (c) maintain the current eligibility criteria and scope of services?	Number		%	
	37		27.6	
	9		6.7	
	67		50	

### List of Written Submissions

In addition to the 134 anonymous feedback sheets written submissions were received from the following agencies:

Australian Dental Association  
Cancer Foundation of WA  
Capel/Dardanup HACC Service  
Cardiologist

Carers WA  
Cerebral Palsy Association  
Denmark District Health Service Board  
General Practise Division of Western Australia  
GP, Carnarvon  
GP, Tom Price  
Gumala Aboriginal Corporation  
King Edward Memorial Hospital / Princess Margaret Hospital, Fremantle  
Hospital Social Work Departments  
Kununurra Wyndham Dental Clinic  
Member for Burrup  
Member for Murray-Wellington  
Member for Vasse  
Metropolitan Allied Health Council  
Moora Multi-Purpose Service  
Newman Health Service  
PATS Clerks from 2 Health Services  
PATS client  
PATS client, Balingup  
PATS client, Busselton  
PATS clients, Carnarvon (4)  
PATS client, Geraldton  
PATS client, Jurien bay  
PATS client, Kalgoorlie  
PATS client, Kalgoorlie  
PATS client, Mount Barker  
PATS client, Narrogin  
PATS client, Paraburdoo  
PATS client, Yalgoo  
PATS clients, Boulder  
Peel South West Division of General Practice  
Rural and Remote Allied Health  
Services for Australian Rural and Remote Allied Health Inc.  
Social Work Department, Fremantle Hospital  
Tom Price Medical Centre  
WA Advisory Committee on Hepatitis C  
WA Substance Abusers Association  
Wirraka Maya Health Service

# APPENDIX 3 - PROPOSAL TO EXPLORE THE POSSIBILITY OF TRANSFERRING SOME OUTPATIENT APPOINTMENTS TO RURAL GENERAL PRACTITIONERS

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## PROPOSAL

It is proposed to undertake a small project to work with tertiary hospital staff and rural General Practitioner's to explore the ways in which outpatient appointments for country patients are processed. Where possible, alternative options will be identified which are more cost effective and less disruptive for the patient, for example, greater use of telemedicine and/or GP follow-up.

The types of speciality for which people were most often referred for PATS assistance in 1999/2000 were as follows:

Orthopaedics	13%
Ophthalmology	10%
Paediatrics	10%
Internal medicine	9%
Neurology	8%
Oncology	7%

In the first instance, it is proposed to work with outpatient clinics for these six specialities plus general surgery to see if any reduction in the need for patient travel can be achieved.

### Outpatient Referrals

In addition to carrying out a procedure, specialists within teaching hospitals are paid a set fee for carrying out three related outpatient tasks. These include:

- initial assessment;
- chart review; and
- follow-up.

### ***Initial Assessment***

The initial assessment may be streamlined and shortened by following the Clinical Prioritisation Assessment Criteria (CPAC). CPAC requires the referring General Practitioner to ensure that an appropriate range of diagnostic tests is carried out prior to the specialist referral. In most

cases these tests can be carried out locally. Use of CPAC may reduce unnecessary referrals or reduce the time a patient needs to spend at the treatment centre in having tests and waiting for test results.

CPAC protocols are currently being piloted in Fremantle. The CPAC process involves the completion of a referral form by the GP. It may be possible to combine this form with the PATS referral form.

### ***Chart Review***

The chart review is important as this is the point at which the specialist determines the necessity for follow-up. The chart review is often carried out following a procedure and whilst the patient is still an inpatient, or may not require the presence of the patient.

### ***Follow-up***

Following a procedure, patients are often routinely referred to outpatient clinics for a follow-up appointment without consideration of where the patient lives or the expense in attending an appointment.

For country patients, alternatives such as the use of Telehealth, and training GPs to carry out routine follow-up appointments could be explored. Patients may only need to return to the treatment centre in complex cases or where there are complications. It may be possible to pay GPs a management fee for undertaking this work.

### ***Advantages***

The potential advantages of this approach include:

- enhanced skills for country based GPs;
- the development of increased trust between GPs and metropolitan based specialists;
- reducing the need to travel for patients; and
- cost savings for PATS and for outpatient clinics.

### **Stakeholders**

The major stakeholders for this project include:

- Chief Medical Officer;
- Teaching hospital Medical Directors;
- Health Workforce and Reform;

- North West and South West Medical Directors;
- WA Centre for Rural and Remote Medicine;
- General Practice Division of Western Australia;
- Rural Doctor's Association;
- Aboriginal Medical Service General Practitioners; and
- Telehealth

### **Purpose**

The purpose of the project is to achieve more equitable access to specialist treatment for country residents.

### **Outcomes**

The anticipated outcomes of this project include:

- increased flexibility in outpatient procedures to take account of the patient's travel arrangements;
- the development of a shared approach to outpatient work between specialists and rural general practitioners;
- increased skills in rural general practitioners;
- greater cooperation between tertiary hospital specialists and rural GPs;
- a reduction in the number of patients travelling to the metropolitan area for follow up appointments; and
- more streamlined assessment visits through the use of CPAC protocols.

### **Tasks**

The project will involve the following tasks:

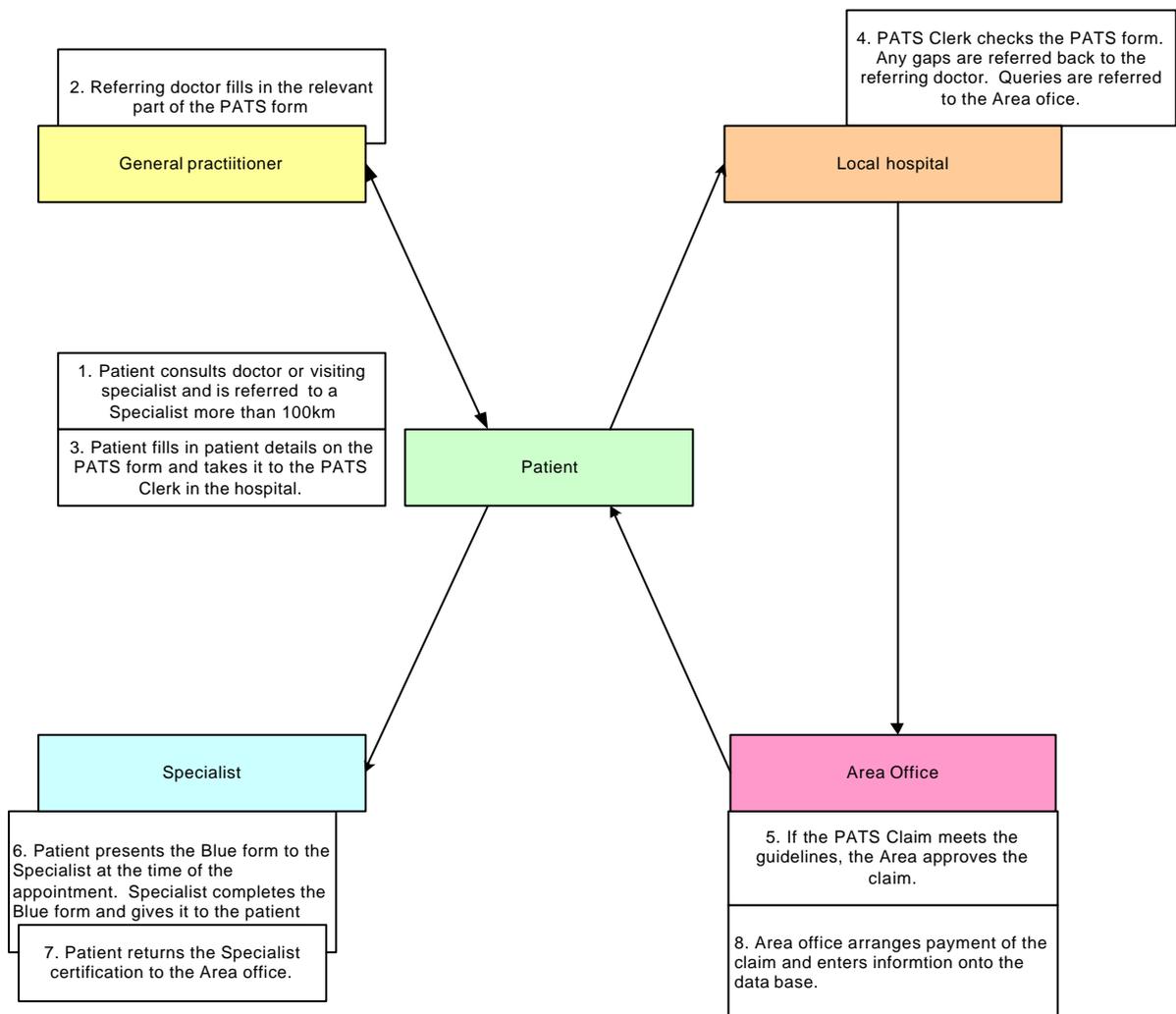
1. analysis of tertiary hospital outpatient data to identify referral patterns for country residents including type of specialty, home location, reason for appointment, and outcome of appointments;
2. together with Hospital Medical Directors, examine the outpatient processes and identify ways in which increased flexibility can be introduced to better meet the needs of country residents;
3. engage key stakeholders in discussion of options for the increased involvement of rural GPs in follow-up appointments;

4. identify the training requirements of GPs to undertake this work;
5. identify the resources available in rural areas for shared patient care, including Telehealth and pathology services; and
6. prepare a costed proposal for how increased numbers of routine patient tests and follow up work can be carried out without the patient being required to travel to the metropolitan area.

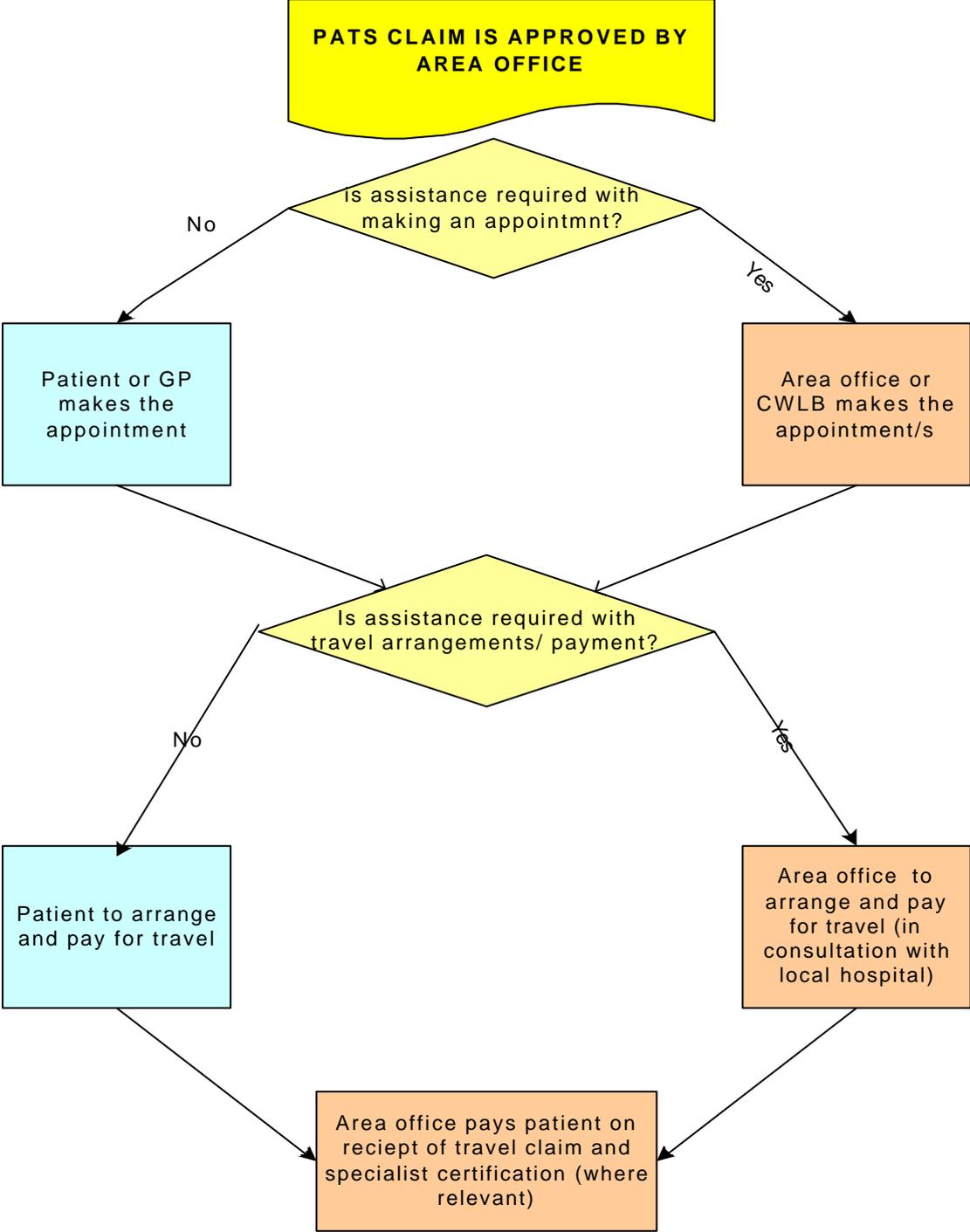
# APPENDIX 4 - PROPOSAL TO COORDINATE THE ADMINISTRATION OF PATS

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## PROCESS FOR PATIENTS MAKING PATS CLAIMS UNDER AN AREA MODEL



**COORDINATING PATIENT APPOINTMENTS AND TRAVEL UNDER AN AREA MODEL**



## **APPENDIX 5 - COMPARISON OF PATS ENTITLEMENTS ACROSS AUSTRALIA**

<b>SCHEME</b>	<b>FUEL SUBSIDY RATE AND DISTANCE CRITERIA</b>	<b>APPROXIMATE EXPENDITURE 1999-2000</b>
Australian Capital Territory Interstate Patient Travel Assistance Scheme (IPTAS)	No fuel subsidy. Standard rate of \$40 to Sydney, \$100 to Melbourne and \$150 to Brisbane & Adelaide if travelling by bus or coach. Economy Airfare if required to fly. No personal contribution or mileage criteria.	<b>\$0.2M</b>
New South Wales Isolated Patients' Travel and Accommodation Assistance Scheme (IPTAAS)	Fuel subsidy is 12.7c/km, with eligibility distance criteria of 200 km one way, and a personal contribution of \$20 for pensioners (\$40 for non pensioners)	<b>\$7.5M</b>
Northern Territory Movement of Patients Scheme (MOPS) – includes old Patient Assistance Scheme (PATS) + inter-hospital transfers + medical evacuations	Fuel subsidy is 15c/km, with eligibility distance criteria of 200km. There is no personal contribution.	<b>\$14M</b>
Queensland Patient Travel Subsidy Scheme (PTSS)	Fuel subsidy is 10 c/km, with eligibility distance criteria of with a distance criteria of 50km from the nearest hospital to the treatment centre, and no personal contribution.	<b>\$15.7M</b>
South Australia Patient Assistance Transport Scheme (PATS)	Fuel subsidy is 10c/km with eligibility distance criteria of 100 km and a personal contribution of \$30 on every trip.  (If travelling over 100 km for regular treatment eg chemotherapy, mileage may be accumulated over a month so as to not financially disadvantage patients eg: 4 trips of 110 km could incur only 1 personal contribution of \$30 )	<b>\$2.6M</b>
Tasmania Patient Travel Assistance Scheme (PTAS)	Fuel subsidy is 10 c/km with eligibility distance criteria of 75 km. and a personal contribution of \$15 for concession card holders and \$75 for non concession card holders.	<b>\$2M</b>

<b>SCHEME</b>	<b>FUEL SUBSIDY RATE AND DISTANCE CRITERIA</b>	<b>APPROXIMATE EXPENDITURE 1999-2000</b>
Victoria Patient Transport Assistance Scheme (VPTAS)	Fuel subsidy is 11 c/km, with eligibility distance criteria of 100 km. and a personal contribution of \$20 for the first 7 trips per treatment year for concession card holders and \$40 for non concession card holders.	<b>\$2.5M</b>
Western Australia Patients Assisted Travel Scheme (PATS)	Fuel subsidy is 13 c/km, with eligibility distance criteria of 100 km. Non concession card holders pay the first \$50 for a maximum of 4 trips.	<b>\$8M</b>
Department of Veterans' Affairs Repatriation Transport Scheme.	Fuel subsidy 22 c/km. Minimum of 3 km round trip. 5 visits per claim form. Must be claimed within 3 months of trip being carried out. Gold Card Holders for any medical trip and White Card Holders for accepted service related disability trips only.	<b>Not known</b>