

Cost and policy issues of patient assisted travel

Jeff Wearne¹

¹Health Consumers of Rural and Remote Australia

Jeff Wearne has a degree in Economics from the ANU, is currently the Executive Officer of the Health Consumers of Rural and Remote Australia and is on the Executive of the Australian Health Care Reform Alliance. Previously he worked as an economic researcher for the Commonwealth Government and has owned and run several small businesses. Since joining HCRRA just over three years ago his cold economic logic has been replaced with some degree of human compassion.

It's easy for lobbyists—they have the luxury of being able to take a narrow view of the world. They see a particular situation which they perceive to be unjust or inequitable and have the exquisite freedom of demanding that governments act, usually by allocating more money, to rectify what they see as a clearly an appalling state of affairs.

To some extent, they have tunnel vision. No need for them to lie awake at night agonising over the question of whether their particular cause is more worthy than the next.

The Australian Government raises money primarily through taking a slice of the income earned and spent by companies and individuals. It is a finite amount—not a bottomless bucket. They have to decide the best way to spend that money with a cacophony of competing priorities ringing in their ears. We need to remember there are opportunity costs to every spending decision they make.

For example, should more money be spent on improving the health outcomes of people living in rural and remote Australia or should more be done to provide housing for homeless people?

Lobbyists have a simple answer to this type of thorny question. We need to either increase taxes or divert spending from other (presumably less deserving) sectors of the economy.

I say all this to provide a backdrop to examining Governments' support of Patient Assisted Travel Schemes (PATS).

For many years now, the Health Consumers of Rural and Remote Australia (HCRRA) has been advocating strongly for improvements to be made to these schemes.

It has been a major focus for our organisation simply because whenever we talk to residents living in rural and remote areas about their health care issues, it is almost inevitable that they will mention the inadequacies of their particular PATS.

However, given competing demands for government assistance, the question is whether the situation is so dire that Governments should divert funds from other worthwhile causes, even other rural health programs, to provide increased funding for PATS.

It should be remembered that travel subsidies for rural patients have not always existed. It was not until 1978 that the Commonwealth Government first established the Isolated Patients Travel and Assistance Scheme (IPTAAS). The scheme was designed to provide financial assistance to those living in rural and remote areas who had to travel long distances to obtain specialist medical treatment.

It sounded like such a good, simple idea but it was plagued with problems from the outset until finally, in 1985, Commonwealth, State and Territory officials met and agreed that, because there had been so much criticism, especially from patients and consumer advocacy groups, responsibility for the administration of the scheme should be transferred to the States and Territories.

The feeling was that the Commonwealth Government lacked the local knowledge and systems to respond flexibly or appropriately to the needs of different local communities.

Even though IPTAAS was abolished in 1987, the Commonwealth continued to fund the new schemes, now run by the States, through the provision of indexed special financial assistance grants. In 1999, these grants were discontinued and replaced by the general revenue generated by the Goods and Services Tax.

In other words, the States took total control of the schemes with no checks and balances to guarantee they were funded sufficiently.

Despite this current situation where no specific funds are allocated to PATS, under the Australian Health Care Agreements the Commonwealth has charged the States with ensuring people have equal access to public hospital care regardless of their geographic location. In reality, just like access to other medical services, that goal has not been achieved and honestly, if we are to be realistic, it probably never will.

However, that does not mean we should give up striving to achieve it and PATS obviously have an important role to play in doing this.

But why, given we have now had over 30 years to get them right, are the current systems still seen as being so inadequate? Rural and remote consumers have been advocating for improvements to the state run PATS for years without seeing any real results.

Albert Einstein once famously said that 'The definition of insanity is doing the same thing over and over again and expecting different results'. This definition should probably alarm those of us who have been advocating for improvements being made to PATS given that we continue to press for the same changes despite being rejected time and time again.

It is not as if the problems which beleaguer the schemes are not well known or are in dispute. They include:

- the complexity of the paperwork and application process which acts as a disincentive for both patients and doctors to actively engage with the schemes,
- the inconsistency in the interpretation of PATS guidelines across jurisdictions and questions surrounding the eligibility of carers to accompany a patient
- the distance threshold for determining eligibility resulting in inequity of access to health care,
- referral constraints requiring patients to see the nearest specialist rather than the most appropriate specialist and finally,
- the level of subsidy provided for travel and accommodation.

This last grievance is probably the most common and merits closer examination. Is the level of assistance given to patients through PATS inadequate in terms of compensating them for the costs they incurred when accessing treatment?

Although it varies somewhat between States, patients can currently claim a refund of between 15 and 19 cents per kilometre travelled provided they live more than a prescribed distance from the medical care they require. This remuneration is generally seen as insufficient for two reasons.

The first is that Australian Taxation Office currently allows a deduction of around 60 cents per kilometre for business travel—around 4 times the subsidy paid under PATS. However, this is not really a valid comparison. The PATS reimbursement is a tax free direct assistance payment as opposed to a deduction, made for tax purposes, of a legitimate cost incurred in earning income.

The second reason that the PATS subsidy is seen as inadequate is that while the refund is only 15–19 cents a kilometre, the price of fuel is currently around \$1.30 a litre. However this argument is also questionable.

In fact a reimbursement of between \$15 and \$19 per 100 kilometres travelled is actually quite reasonable. The Royal Automobile Club of Victoria recently estimated the total running cost of a medium sized car, including fuel, tyres and maintenance, to only be, on average, around 19 cents per kilometre—an amount roughly equivalent to the PATS subsidy.

The reimbursement for accommodation and other expenses associated with travel are not so realistic. Apart from Western Australia and Tasmania who refund a relatively generous \$60 and \$45 a night respectively, the rebate in other States varies from \$30 to \$35 per night. This subsidy equates to less than twenty per cent of what could be considered as reasonable accommodation expenses. In addition, little if any reimbursement is currently made to cover ancillary expenditure such as parking fees, intra city travel costs etc.

It should be remembered these figures can be misleading in terms of the real level of support offered by the various states because they do not take into account the fact that, to obtain a PATS subsidy, patients are required to contribute a certain amount towards the cost of their travel and this personal contribution varies markedly between states.

In Tasmania, for example, patients contribute \$75 per trip. In NSW, it is \$40 per trip while in Victoria the rate is \$100 per year, irrespective of the number of journeys undertaken.

In Queensland, many patients are required to pay the first four nights of accommodation per financial year, in Western Australia it is the first 3 nights and so on.

In some cases this personal contribution will mean it is simply not worthwhile for the patient to apply for assistance. In others, the personal contribution may significantly lessen the amount received under an ostensibly higher level of subsidy.

This lack of uniformity between the state systems makes it difficult to ascertain the extent to which patients are actually subsidised by their State Governments and has led to procedural problems when patients need to cross State boundaries for treatment. As a consequence, there have recently been calls for the Commonwealth to step in and establish common parameters under which the States would operate their schemes but progress in this area has been slow at best.

It seems then that we are at an impasse.

After thirty years of inquiries, haggling, lobbying and advocating, the Commonwealth has basically passed the buck to the states.

The States, for whatever reason, are apparently unwilling to either streamline or increase funding to the schemes, and consumers are claiming the schemes are inadequate.

How can we possibly move forward?

The answer may lie in changing the way we think about PATS.

We should first acknowledge that PATS should really be the last, least preferred option for those seeking medical care.

Late last year, a 6000 signature petition was presented to the Queensland State parliament asking that improvements be made to that State's PATS. The Government was unmoved saying that improving medical services available in regional areas was actually a far better option than increasing the PATS allowance.

They cited, as an example, recent expenditure on providing a new oncology service in Cairns which will mean that around 300 people a year will no longer have to travel at all to access the service and others would have travel a much shorter distance.

Their point is a valid one. We should not lose sight of the fact that, wherever feasible, providing a service locally is the best solution to improving the access for regional patients.

That being said, a realistic level of PATS funding should be available to those who are forced to travel and who cannot afford to meet the associated costs, but, given the limited funds available, we need to ask ourselves if the schemes should be universal, and, in effect, used to support those residents who can actually afford to meet travel and accommodation expenses out of their own pocket.

In essence, shouldn't travel assistance be seen as a social security issue rather than being regarded by State Governments as an inconvenient and inappropriate drain on their health budgets? After all, surely Centrelink

would be better resourced to operate an efficient payment system rather than a small state health bureaucracy.

As a general premise, health funding would be better used to provide more health services where they are needed, not in subsidising patients to travel to locations where the services already exist.

There will be those who say that it is inequitable that rural and remote residents who can afford to pay for travel and accommodation should be asked to do so given that people living in urban areas do not incur the same costs. This is a dubious argument.

There are costs and benefits to living in the bush just as there are to living in the city. Some urban dwellers may have easier access to medical care but they also face long commutes to work, higher housing costs, high levels of pollution etc. In addition, there are social determinants which limit access to health care in urban communities which may be just as restrictive as the distance from medical facilities.

There is clearly a role for Governments to play in terms of providing a safety net for those who need assistance to access health care. No one would argue that we abandon those, whether they live in the city or in the bush, who are in genuine need, but, given the current level of dissatisfaction with PATS and the stalemate we appear to have reached in terms of making improvements to the schemes, it may be time to seek alternatives which could act to ease the cost pressures they face and allow funds to be better directed.

Governments could, for example, encourage or subsidise rural and remote residents to insure themselves against the travel expenses incurred to access medical care in the same way, and for many of the same reasons, they currently subsidise private health insurance. Individuals could be given the opportunity to protect themselves against unanticipated travel costs in exactly the same way as they do for other large or unexpected outlays associated with living in the bush. Crop and livestock insurance is commonplace, so why not insure that travel and accommodation expenses would also be covered in case of accidents or illness in the family?

If such a plan were to be introduced, the savings flowing from the subsequent reduction in PATS payments could be used to first, subsidise insurers who offered the coverage thus making such cover more affordable; secondly to increase PATS assistance to those in genuine financial need or thirdly to increase funds available to community organisations to run their own transport systems and provide patient and carer accommodation.

Another alternative would be to introduce a rural travel safety net along the lines of, or as part of, the current Medicare safety net whereby once a patient had passed a pre determined expense threshold, the Commonwealth, through Medicare, would pay a percentage of any costs over and above that prescribed threshold.

Another possible alternative to take pressure off PATS would be to simply allow eligible rural and remote residents to write off travel and accommodation expenses incurred in accessing medical care against their income for tax purposes just like they would any other legitimate expense. There is certain logic to this in that given the lack of medical services in the regions, travelling to access them could almost be seen as a justifiable cost of living and doing business in rural areas.

One advantage of such a system would be that it would be easy to administer:

- patients would simply retain their receipts and claim a deduction when completing their tax return
- the compliance burden currently faced by both patients and health professionals would be significantly reduced
- using the Taxation Department would surely be a much more efficient means of processing any rebates involved.

So there you have just a few possible alternatives to the current PATS. While further work would be required to ascertain whether any of them are actually feasible, we do know that the current system of drawing money from state health budgets to directly subsidise patient travel has not worked well.

After thirty years of banging our heads against a wall, trying and failing to make PATS function effectively, it is perhaps time that we realised that they should be treated more as a social security rather than a health issue and that we need to examine alternatives which would not consign rural and remote patients to the role of second class citizens dependant on government handouts but which instead, provided them with strategies which empowered them to be self reliant.

