REPORT
REVIEW OF THE TASMANIAN PATIENT TRAVEL ASSISTANCE SCHEME

February 2022

KPH
knowledge into practice

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Executive summary and recommendations

The purpose of patient travel assistance schemes, since inception in the 1980s, is to address the health outcomes gap between those who have ready geographical access to healthcare and those who do not.

The Patient Travel Assistance Scheme (PTAS) provides financial subsidies to eligible Tasmanian residents who are required to travel long distances to access specialised clinical services.

In recent years PTAS activity and claim costs have increased substantially. The scheme has also received an increased number of complaints, with particular concerns regarding ambiguity and inconsistency in the application of the scheme, and barriers to equitable access, especially for residents of very remote areas of Tasmania.

In response to these issues and others, this review was commissioned.

The tasks of the review were to:

- Review the suitability of the scheme.
- Review the PTAS Ministerial Policy and make recommendations towards a revised PTAS policy.
- Review and revise key PTAS operational documents including: the Operational Protocol, the Application Form, and communication resources for patients and referring medical practitioners.

The review was informed by:

- Review of existing PTAS documentation.
- Review of relevant historical documents.
- An environmental scan of patient travel assistance schemes in other Australian jurisdictions.
- Analysis of PTAS performance data.
- Review of public consultation findings.
- Extensive consultation with staff and stakeholders.

This report provides the findings and recommendations of the review of the PTAS scheme. The revised documents developed as part of this review are provided as attachments to this report.

Governance

PTAS is governed by the PTAS Ministerial Policy. The policy is currently in a process of review as it requires updating. In particular, the policy no longer:

- reflects contemporary models of care;
- addresses the broader aims and purpose of the scheme; or
- effectively delegates responsibility for the implementation of the Policy.

Findings from this review indicate that strategic policy direction for PTAS is lacking and there is a general reluctance by Departmental stakeholders to provide leadership and governance of the scheme. This has resulted in an over-reliance on operational drivers for PTAS decision-making. Recommendations 1-5 specifically address deficits in the current PTAS Ministerial Policy that require consideration as part of the PTAS policy review, currently in process in parallel to this review.

Recommendation 1: That the PTAS policy articulates the full intent of the scheme. In particular, the role of the scheme in preferentially supporting access to Tasmanian services, as close to home as possible, and directing assistance towards those most affected by travel and travel related costs, in a manner that provides value for money.

Recommendation 2: That the following principles be included in the PTAS policy to guide decision making by the Tasmanian Health Service (THS) when operationalising the policy.

1. **Equity of access** - PTAS supports equitable access to specialised clinical services for Tasmanians.
2. **Transparency of process** - Information about PTAS and the process by which the scheme is administered is accessible to the public and subject to review.
3. **Consistency of application** - The scheme is administered fairly, based on consistent application of the PTAS Operational Protocol.
4. **Patient-centred decision making** - Decisions regarding the application and administration of PTAS is informed by a patient-centred approach that aligns with safety and quality principles.
5. **Sustainable use of resources** - PTAS promotes the efficient use of public resources through support for access to specialised clinical services that are as close to home as possible, by providing financial assistance in a manner that promotes value for money, and by contributing data and information towards clinical service strategy and development.

Recommendation 3: That the PTAS policy include updated language to more accurately reflect the services and service providers that meet PTAS eligibility criteria. Specifically, that reference to ‘specialist medical services’ is changed to ‘specialised clinical services,’ and providers of these services, are described as ‘approved clinical providers’ rather than medical specialists.

Recommendation 4: That the purpose of targeting PTAS support is accurately described in the draft PTAS policy.

Recommendation 5: That the PTAS policy articulates the delegation of responsibilities by the Secretary including:

- Identification and nomination of a Departmental **policy custodian** with the clinical expertise required to provide clear clinical policy direction and oversight to the PTAS Advisory Committee (noting Recommendation 7 in this report to strengthen the role, and broaden the remit of this committee (forthwith described as the PTAS Advisory and Approvals Committee [PTAS AAC]), and the positional power to respond strategically to data and advice from the PTAS AAC that may inform statewide clinical service planning and clinical workforce planning.

- Nomination of a THS **business owner** that provides administrative and financial governance of PTAS and the service unit that operationalises the scheme, can maintain and further strengthen the statewide business model for the scheme, and has the positional power to ensure that the scheme: adheres to financial policy; maintains administrative efficiency and clarity whilst maintaining a patient-service focus; and is responsive to clinical advice (policy and operational), to ensure the scheme is governed in accordance with the intent and principles of the PTAS policy.

- Inclusion of the role and function of the **PTAS AAC** as the statewide, collective, decision-making and advisory group that maintains and applies the PTAS Operational Protocol, monitors PTAS performance at the operational level, responds to exception ruling requests, appeals and complaints, and provides strategic advice to the Health Executive, via the Departmental policy custodian and the THS business owner.

The PTAS Policy is operationalised through the PTAS Operational Protocol. The current Operational Protocol lacks clarity and is a source of ambiguity and inconsistency in the application of the scheme. It has been revised, as part of this review (see Attachment 1), to improve clarity and consistency of application of the scheme in accordance with the PTAS policy intent and principles for decision-making.

Recommendation 6: That the revised PTAS Operational Protocol is implemented to facilitate improved clarity and consistency in operationalisation of the PTAS policy.

Clinical governance of PTAS is currently provided at the operational level by five Medical Authorisers located across the State, operating largely independently of each other. In order to improve the consistency of clinical decisions across the state, and facilitate collaborative governance between the clinical and administrative functions of the scheme at the operational level, the review recommends the current PTAS Advisory Committee is strengthened and expanded be become the PTAS Advisory and Approval Committee.

Recommendation 7: That the role and remit of the PTAS AAC is strengthened and expanded, such that:

a. The Committee provide collective decision making for exceptional ruling requests, outcome appeals and complaints as outlined in the revised PTAS Operational Protocol.

b. The Committee meet at least monthly to ensure timely determination of exceptional ruling requests, outcome appeals and unresolved complaints.

c. The Committee review the performance of the scheme in accordance with the performance monitoring schedule described in the revised Operational Protocol and provide a report with advice to the Health Executive (through the policy custodian and business owner) at least annually.

d. Membership of the Committee includes: policy custodian and business owner representation; social work representation to support effective decision-making

for applications with complex socio-economic factors, and consumer representation.

e. The role of the Chair is expanded in line with the role and responsibility outline provided in the revised PTAS Operational Protocol.

f. The appointment of the Chair is limited to practising Medical Authoriser members (in recognition of the clinical expertise required for this role), and the position is appointed by the policy custodian in consultation with the business owner.

g. The Committee title and Terms of Reference is updated to reflect the revised role and remit of the Committee as described in this report.

Comparison of PTAS with other patient travel assistance schemes

PTAS shares a number of similarities with other jurisdictional patient travel assistance schemes, which is to be expected as all schemes originate from a Commonwealth program, the responsibility for which was later transferred to the states and territories.

Despite these core similarities there is significant variation across jurisdictional schemes as each state and territory has modified their particular scheme to some extent.

Key features identified in other schemes that align with the intent and principles of the PTAS policy have been modified and included in the revised Operational Protocol, in consultation with staff and stakeholders. Although elements of innovation were identified in the documents of other jurisdictions, on the whole, scheme administration remains administratively burdensome and process driven across all jurisdictions.

The financial support offered by PTAS is equal to, or in some instances more generous than other jurisdictions. The patient contribution requirements of PTAS are the most onerous in the country.

Performance monitoring

Whilst the PTAS Operational Protocol describes a suite of performance monitoring measures, PTAS staff only collect and report on a sub-set of these measures. Due to the limitation of the current performance monitoring schedule, additional analysis was performed using data from the Department of Health.

Key findings of the analysis include:

- Total PTAS costs are rising faster than total PTAS claims.
- Paediatrics, oncology and cardiology specialities are the highest contributors to PTAS claim costs.
- The scheme is successfully targeted towards low-income Tasmanians with 80% of PTAS patients being cardholders, compared with 23% of the Tasmanian population more broadly.
- Removing patient contributions for cardholders (concession and pension) would have a small impact on PTAS costs ($370,000 per annum).

- Cardholders are more likely to be reimbursed to access Tasmanian services, whereas non-cardholders are more likely to be reimbursed to access Victorian services.
- The rate of use of mainland public hospital services is much higher for residents of the North West Region (Royal Children's Hospital Melbourne, other Victorian public hospitals) and Northern Region (other Victorian public hospitals) than for residents of Southern Tasmania, which strongly suggests excess interstate referrals when these services are available in Tasmania. If a standardised referral rate based on the Southern Region was adopted, with the excess referrals made to the Royal Hobart Hospital (RHH) instead of interstate, estimated annual savings of more than $766,732 per annum could be realised.
- In addition, savings of $766,371 per annum could be achieved if referrals to private Victorian specialists were re-directed to Tasmanian private specialists.
- For King Island residents the average PTAS cost for interstate travel is significantly less than the average PTAS travel cost for intrastate travel.

Recommendation 8: That in recognition of the high cost of oncology-related PTAS applications, a statewide Specialist Medical Authoriser position is established for the assessment of PTAS applications for interstate travel to oncology services. [Noting Specialist Medical Authorisers positions are already in place for paediatrics and cardiology].

Recommendation 9: That PTAS eligibility rules are strengthened, as per the revised Operational Protocol, to prevent referrals to interstate services for services that are available in Tasmania. As such, PTAS subsidies are not payable for travel to access interstate services if they are available in Tasmania (with the exception of residents of King Island and the Furneaux Group Islands [see Recommendation 28]) and PTAS subsidies are not payable for private interstate services, regardless of applicant place of residence. We also recommend that rates of referral to interstate services are monitored by the PTAS AAC as described in the performance monitoring schedule detailed in the revised Operational Protocol.

Recommendation 10: That the PTAS performance monitoring schedule is strengthened by removal of redundant measures, inclusion of service efficiency and quality measures, increased clarity of reporting frequency, and allocation of responsibilities for collecting, reviewing, and responding to PTAS performance data; as detailed in the revised Operational Protocol.

PTAS Service provision

The PTAS service was originally managed as three separate regionalised units. In recent years the regional services were amalgamated into a single statewide service within the Health Information Management Services (HIMS) portfolio. The amalgamation has established clear points of accountability for the administrative functions of the service. However, there is scope to increase the consistency of the service, further leverage administrative systems, and enhance customer service.

Recommendation 11: That PTAS continues to operate as a statewide service and that systems and processes are further aligned to improve consistency of service

arrangements and scheme application, in accordance with the revised Operational Protocol.

Recommendation 12: That the revised PTAS Application Form (provided at Attachment 2) is implemented in 2022 and that development of an online PTAS Application smart-form (or equivalent) is progressed, in collaboration with eHealth and ICT Services (or another area as nominated by Chief Information Officer), for implementation in 2024.

Recommendation 13: That nominees of the PTAS business owner and Chief Information Officer are engaged to develop a business case, in consultation with PTAS staff, to enhance the functionality of the PTAS database TOMS and facilitate integration with other information systems of relevance to the processing of PTAS applications and claims (including Finance One, CM9 and iPM).

Recommendation 14: That a nominee of the PTAS business owner document and present the data integration needs of PTAS for inclusion and consideration in the development of the Health ICT Plan 2020-2030.

Recommendation 15: That all PTAS offices encourage electronic submission of paper-based applications by patients, and designated collection centres, to reduce delays due to mail delivery, improve records of submission, allow for flexible allocation of workload across offices, and assist in preparing applicants toward a future online form (see Recommendation 12).

Recommendation 16: That after-hours service arrangements are strengthened through development of a formal handover arrangement between PTAS offices and the local After-Hours Nurse Manager group at each acute public hospital in Tasmania that includes:

- Provision of information on the booking arrangements for all active interstate patients.
- Access to an emergency phone number for a member of PTAS staff (statewide) for urgent issues that cannot be resolved by the After-Hours Nurse Manager.

We also recommend that After-Hours Nurse Managers, in recognition of their important role in maintaining PTAS continuity after hours, receive regular training support on relevant PTAS processes and requirements to maintain a strong understanding of the scheme.

Recommendation 17: That the PTAS Manager implement the customer service standards described in the revised Operational Protocol and monitor service efficiency and patient satisfaction in accordance with the indicators described in the performance monitoring framework, also described in the revised Operational Protocol.

Recommendation 18: That PTAS staff receive regular customer service training in areas such as empathetic communication, culturally sensitive communication, and conflict resolution.

Key external service providers

Subsidised accommodation providers

The PTAS Operational Protocol (current and revised) recommends that patients who require access to commercial accommodation consider staying in subsidised accommodation. These accommodation services are largely owned and operated by charitable organisations that specifically cater for those who need to travel to access clinical services.

Subsidised accommodation providers are highly valued by recipients of PTAS. They provide affordable accommodation, assist with navigating PTAS operational rules, facilitate access to other services and supports in their local area, provide emotional support to users of the scheme, and can provide additional financial support in cases of significant hardship.

PTAS is reliant on subsidised accommodation providers to provide accommodation for those who are most financially disadvantaged, as this assists in maintaining accommodation subsidy rates at a sustainable level. Subsidised accommodation providers are also an important source of information about PTAS for patients.

Accommodation providers have identified that relationships with PTAS have weakened in recent years. Opportunity exists to better recognise the value of subsidised accommodation providers and strengthen the relationship between PTAS administrative staff and subsidised accommodation providers into the future.

Recommendation 19: That PTAS management work towards strengthening the relationship between the PTAS service and subsidised accommodation providers by:

- Promoting subsidised accommodation providers on the PTAS website, by updating the content in the Accommodation Handbooks (South and North-West), developing similar content for the North, and creating a statewide resource that is accessible by staff and patients.
- Encouraging additional accommodation providers to engage with the scheme, particularly in areas such and Burnie and Devonport-Latrobe.
- Improving communication with subsidised accommodation providers, particularly regarding substantial changes to the scheme as a result of this review and changes into the future.

Repatriation service providers

PTAS provides financial assistance towards repatriation of the deceased when a PTAS-eligible patient dies in a treatment facility.

The THS is reliant on a small group of private funeral director services for repatriation services. Repatriation service costs are highly variable, even across the same or similar services.

Recommendation 20: That PTAS management work with Tasmanian funeral directors, through the Tasmanian Branch of the Australian Funeral Directors Association, to develop a standardised costing arrangement for PTAS eligible patients.

Recommendation 21: That in lieu of any formal arrangement between PTAS and Tasmanian Funeral Directors (see Recommendation 20) that revised subsidy caps for repatriation of the deceased are implemented (as described in the reviewed Operational Protocol) to more clearly differentiate maximum subsidy rates permitted for a) repatriation within mainland Tasmania and b) repatriation from interstate or to the remote islands of Tasmania.

Addressing socio-economic barriers to access

PTAS provides financial assistance that is targeted towards those who are most affected by high travel costs, and have greatest need for financial assistance.

The targeting of PTAS assistance to low-income Tasmanians is effective, with 80% of PTAS recipients being concession or pension card-holders.

Low-income patients are particularly susceptible to financial barriers to access of specialised clinical services, particularly when required to travel long distances and wait for extended periods of time to receive subsidy reimbursement (currently 6-8 weeks).

Opportunity exists to further tailor PTAS arrangements to reduce sources of hardship for low-income Tasmanians by:

- Abolishing co-contributions for low-income patients.
- Increasing up-front payment of subsidies.
- Indexing rates of subsidy.
- Providing timely reimbursement of PTAS claims.
- Implementing pathways to respond to patients experiencing transport disadvantage and other forms of socio-economic hardship.

Recommendation 22: That co-contributions are abolished for holders of approved means-tested concession cards as described in the revised Operational Protocol.

Recommendation 23: That co-contributions continue to be applied to non-concession card holders at the capped rate described in the revised Operational Protocol.

Recommendation 24: That upfront payment of eligible subsidies is increased by: improving patient awareness that air, ferry and accommodation bookings can be made by PTAS staff (as described in new and revised PTAS materials at Attachments 3, 4 and 5); and by providing taxi vouchers in advance of travel for eligible applicants, as described in the revised Operational Protocol.

Recommendation: 25 That PTAS subsidy rates are indexed, as documented in Appendix A of the revised Operational Protocol, in recognition of the increased cost of living since the rates were last reviewed in July 2014, and that rates are subject to indexation review every three years to ensure subsidy levels maintain currency.

Recommendation: 26 That PTAS applications and claims are processed by PTAS staff in accordance with the time frames documented in the revised PTAS Operational Protocol, in order to provide applicants with clarity of processing times and to reduce out-of-pocket wait times for reimbursement.

Recommendation: 27 That in addition to recommendation 7d, social workers are formally engaged in PTAS application approval processes, through a process of referral, when patients are identified as experiencing transport disadvantage and their needs cannot be sufficiently addressed by PTAS subsidies alone.

Recognising and responding to remoteness

Residents of King Island and the Furneaux Group Islands (FG Islands) experience some of the most significant barriers to health care access due to geographical remoteness.

The Australian Bureau of Statistics determines remoteness based on access to services using the Accessibility and Remoteness Index of Australia (ARIA+). Classification 5 – very remote, describes the most remote areas of Australia. King Island and the FG Islands are the only geographical areas within Tasmania that are classified at level 5.

King Island and the FG Islands are also uniquely located in the Bass Strait, between the main island of Tasmania and the State of Victoria. For King Island residents average PTAS costs for interstate travel is significantly less than PTAS travel costs for intrastate travel, due to higher levels of family support in Victoria.

PTAS is a key enabler of clinical service access for residents of King Island and the FG Islands. It is important to address the specific health access needs of very remote populations whilst retaining the overall principles of equity and consistency of the scheme for the broader Tasmanian population.

Recommendation 28: That eligibility criteria for PTAS subsidy are modified for residents of King Island and the Furneaux Group Islands (as described in the revised Operational Protocol). These modifications recognise the unique health care access needs of very remote island communities, and the practicalities associated with off-island travel.

It is recommended that:

- Equitable eligibility criteria are applied for residents of King Island and the FG Islands.
- There is a broadening of the nearest eligible service exemption to all residents of King Island and the FG Islands regardless of private health insurance status.
- There is an extension of the travel subsidy support to facilitate access to allied health and preventative health services at least annually for adults, and twice yearly for children.

Enhancing communication

Awareness of PTAS among the general public is low. The scheme is reliant on health care workers, particularly referring general practitioners, specialist medical practitioners, and hospital healthcare workers to assist in identifying eligible patients and informing them of PTAS. Despite this reliance, PTAS does not have a clear communication strategy for this important stakeholder group.

Recommendation 29: That PTAS management engage with Primary Health Tasmania to design and implement an effective communication strategy between the PTAS service and referring general practitioners and medical specialists, to support improved

awareness of the scheme and to increase information sharing as the scheme changes over time.

Responses from consultation with the public, and review of PTAS issue registers demonstrate that, for those that are aware of PTAS, there is a lack of clarity about the intent of the scheme. In addition, inconsistent application of the operational protocol in the past has driven variation in public expectation of PTAS support, particularly in the North West of Tasmania.

It is essential that public messaging about PTAS reinforce the intent and principles of the PTAS policy, as this maintains consistency of messaging and supports ongoing expectation management of the scheme.

Recommendation 30: That prior to implementing the recommendations of this review, the PTAS business owner commissions development of a resource (in addition to the consumer awareness brochure developed as part of this review) to clarify the intent and boundaries of PTAS and directly address misunderstandings about the scheme. A short visual communication tool such as a video clip could be used to assist with disseminating this message to the public through the PTAS website and amongst stakeholders more broadly.

Potential applicants are directed to the PTAS website for information about the scheme, however, the information provided on the website is not patient-friendly.

Recommendation 31: That the content of the PTAS website is revised for accuracy, improved clarity of messaging, and enhanced accessibility for members of the public. We also recommend that the Patient Guidelines document (Attachment 3) and patient awareness brochure (Attachment 5), developed as part of this review, are submitted to an appropriate consumer forum for feedback, and once finalised, are made available in hardcopy and electronic versions.

There is currently a lack of clarity regarding who is responsible for notifying patients that their applications (or claims) have been approved or declined. Further, there are no clear timeframes for notification.

Recommendation 32: That patients are notified of the outcome of the application or claim assessment in writing, and in a timely manner, in accordance with the processes for approval described in the revised Operational Protocol, and as detailed in the process flow charts in the PTAS User Guide (Attachment 6).

Communication with patients whose applications or claims have been declined should be handled with particular care. Current letters of notification of non-approval are not satisfactory and are contributing to patient dissatisfaction with PTAS decisions.

Recommendation 33: That the content of letters of notification for applications and claims that are not approved include, at a minimum:

- Clear reasoning as to the specific reason why the application was not approved
- Opportunity to resubmit with more information (if relevant)
- Advice on how to contact the PTAS office for more information
- Information on how to appeal a PTAS decision.

In addition, we recommend copies of letters of application non-approval are also provided to referring doctors for their information.

Responding to appeals and complaints

The scheme does not have a robust appeals and complaints management process. As such, some patients who feel aggrieved by PTAS decisions raise their issues through various channels including executive members of the Department of Health, parliamentarians, and the media.

Recommendation 34: That a robust process of appeal is implemented for PTAS in accordance with the revised Operational Protocol, to ensure consistency and fairness in decision making and to provide applicants with an avenue to respond to decision outcomes. Further, we recommend record keeping and review of appeals data occurs in accordance with the revised PTAS performance monitoring schedule, to support improved decision making and inform future revisions of the Operational Protocol.

Recommendation 35: That aggregate patient complaint data is analysed and reported to the PTAS AAC at least biannually, for the purpose of continuous quality improvement, in accordance with the requirement of the performance monitoring schedule documented in the revised Operational Protocol.

Towards implementation

Whilst the resourcing of PTAS operational staff, and the implementation of the revised scheme is not within the remit of this review, the following suggestions are made for consideration by the THS, with the aim of facilitating successful implementation of the recommendations of this review, and implementing the resources developed as part of this review (Attachments 1-6):

1. That resourcing support for successful implementation of the revised operational protocol and to action the additional recommendations in this report is considered. Failure to allocate sufficient resources to facilitate implementation will risk achievement of the intended outcomes of this review.
2. That prior to transition to the revised arrangements a comprehensive communication plan is developed that provides targeted communication with key stakeholders, and where appropriate, provides an opportunity for two-way communication between the THS and PTAS stakeholders. The communication strategy should include the following groups as a minimum:

    a. PTAS staff
    b. Members of the PTAS Advisory and Appeals Committee
    c. Relevant THS healthcare workers: including after-hours nurse managers, social workers, clinical service providers and associated educator staff, reception staff particularly in areas such as ambulatory care, emergency care, paediatrics, oncology, and cardiology
    d. External healthcare workers: including general practitioners, private specialists and their support staff
    e. Service providers: including subsidised accommodation providers, and funeral service directors

f. Key patient support groups and representative agencies
g. Local government representatives
h. Regular or current applicants of the scheme
i. Members of the general public, as part of an overarching public awareness strategy.

3. That PTAS staff and Medical Advisors receive training on the changes to PTAS eligibility criteria, financial rules and rates, and PTAS related processes relevant to their roles, with the aim of ensuring consistency of implementation of the revised Operational Framework.
4. That PTAS staff roles and responsibilities as described in the revised Operational Protocol and detailed in the PTAS User Guide are reflected in the Statement of Duties for relevant positions, recognising that some roles may require reclassification review as a result.
5. That where possible PTAS staff identify patients or patient groups who will be affected by specific changes in the revised protocol, and with advice and approval from the PTAS AAC, action specific communication and transition strategies to compassionately assist these patients with change. This may include:
    a. Providing a transitional period – where existing applicants are approved for a period of time using former rules (up to 12 months) but made aware that this will change for future applications.
    b. A grandfathering arrangement for specific patient types or groups for which established health care access patterns will be difficult to change and risk a lack of health care continuity.
    c. Offering exceptional ruling opportunities to those who have received subsidies based on the previous rules and believe their arrangement should be retained for clinical reasons.

1. Background to this project

1.1 Context

PTAS provides financial subsidies to eligible Tasmanian residents who are required to travel long distances to access specialised clinical services.

The aim of PTAS is to improve equity of access to specialised services for those who cannot access these services close to home.

PTAS is governed by the Department of Health (DoH) through the PTAS Ministerial Policy and applied by the Tasmanian Health Service (THS) through the subordinate PTAS Operational Protocol. The current Ministerial Policy and Operational Protocol were established in 2013 have not been substantially reviewed since.

The State Manager Health Information Management Services (HIMS) has managerial responsibility for the scheme under a single statewide governance model. Prior to this PTAS was managed regionally. Clinical governance is provided by five Medical Authorisers, who are also core members of the PTAS Advisory Committee. The PTAS Advisory Committee is tasked with monitoring and providing advice on PTAS.

In recent years PTAS activity and claim costs have increased substantially. The annual cost of PTAS assistance claims in the financial year prior to the COVID-19 global pandemic was almost $9.4M.

The scheme has also received an increased number of complaints and queries in recent years. It is understood many of these complaints stem from a perception that the scheme is not consistently applied and does not adequately support equitable access for those in very remote areas of Tasmania.

In response to these issues the Business Improvement and Reform Unit commissioned a statewide review of the PTAS by KP Health.

The overarching aims of the review were to enhance client satisfaction, strengthen PTAS controls, and improve staff satisfaction.

The tasks of the review were to:

1. Review the existing PTAS Ministerial Policy and make recommendations towards a revised PTAS Policy.
2. Review the following documents, and draft revised versions:
   - PTAS Operational Protocol
   - PTAS Application Form
   - PTAS Communication resources for patients and referring medical practitioners.
3. Develop a draft PTAS User Manual for use by staff.
4. Review performance against the current monitoring and performance measures, including timeliness of claim processing.
5. Review the suitability of the following aspects of the scheme and provide recommendations as appropriate:

- application and claim processing times
- service delivery modes and locations
- administrative processes and systems
- governance arrangements
- monitoring and performance measures, including reporting arrangements
- external service providers
- appeal, complaints and feedback processes.

1.2 Review Methods

The review was informed by the following:

- **Review of existing PTAS documentation** - including policy, protocol, website content, consumer information, registers of decision, registers of issues, PTAS Review Committee Terms of Reference and meeting minutes, and example correspondence.
- **Review of relevant historical documentation** - including previous governance arrangements, historical PTAS reviews and audit reports.
- **Consultation with staff and stakeholders**. We undertook extensive statewide consultation with PTAS staff, health care professionals, executive staff, organisational stakeholders, private service providers and their representatives. A list of stakeholders consulted is available at Appendix A. We also undertook a site visit to King Island to meet with local government, healthcare providers, and members of the public to understand the unique service access issues of remote island communities of Tasmania. We also viewed relevant submissions to the Legislative Council Rural Health Services Inquiry, and met with the Chair of the Inquiry.
- **Analysis of PTAS performance data -** provided by the Department of Health (see Section 5 and Appendix B).
- An **environmental scan** of patient travel assistance schemes in other Australian jurisdictions and comparative analysis with PTAS (see Section 4 and Appendix C).
- **Review of public consultation findings** - The Department of Health hosted a four-week public consultation to support the PTAS review. The consultation questions were developed by KP Health and the Department invited feedback from the public, through the Departmental web-page, and specifically from applicants of the scheme by invitation. In total 242 responses were received and reviewed.

2. Recognising the place of PTAS in clinical service delivery

The purpose of jurisdictional patient travel assistance schemes, since inception in the 1980s, is to address the health outcomes gap between those who have ready geographical access to healthcare and those who do not. In seeking to achieve this, patient travel assistance schemes are an important enabler of safe and sustainable clinical service delivery.

Tasmania is a small jurisdiction by both land mass and population size. This contributes to a reliance on interstate services in some clinical specialties. The Victorian health system is particularly important to the delivery of health care for some Tasmanians.

For these reasons the *One State, One Health System, Better Outcomes* reforms of the Tasmanian Government, first described in 2015, rightly recognises that Tasmanian clinical services are best provided as part of a single statewide system and that interstate service arrangements in some clinical disciplines are maintained.

A single Tasmanian statewide health system is intended to provide safe and sustainable clinical service delivery as close to home as possible through a network of clinical services distributed across the State. Each service has a clear role (as described in the Tasmanian Role Delineation Framework) and a defined clinical service profile. Ensuring health services deliver against their defined role requires effective clinical governance.

PTAS is an enabler of patient access to the statewide service system. If integrated with systems for clinical service delivery and governed appropriately, PTAS could facilitate the flow of patients through the clinical services network in a way that supports better access to care, whilst also facilitating sustainable service delivery. Conversely, PTAS can undermine the service delivery network if not well integrated with the clinical service system.

Findings from this review indicate Departmental oversight of the scheme is lacking. There is a general reluctance by Departmental stakeholders to provide leadership and governance of the scheme or to provide strategic policy direction for PTAS. Despite significant investment in the *One State, One Health System, Better Outcomes* reform agenda, towards a single statewide health system, the movement of patients between health settings is perceived as an ‘ancillary’ and administrative function of the health service that requires fiscal management through the application of restrictive and bureaucratic controls. Processes for collaboration between PTAS administrative and clinical staff are unwieldy and result in PTAS administrative functions and clinical decision making at times being mis-aligned.

Models of care for clinical services have evolved since the Ministerial policy for PTAS was introduced in 2013. However, performance data detailed later in this report show that PTAS policy has not been updated to reflect these changes. As a result, PTAS service delivery is at times out-of-step or contrary to the broader clinical service delivery aims of the Department.

In the absence of a clear Departmental policy direction, PTAS has developed an over-reliance on operational drivers. Operational managers, with administrative and/or financial expertise, have sought to navigate the application of an aged PTAS policy from

within their own operational remit and limited positional power, and in doing so have found implementing any broad change to the scheme difficult to achieve.

Moving forward PTAS requires clear governance arrangements, as determined by the Secretary, in a new PTAS Policy with key clinical, administrative, and financial governance responsibilities assigned to relevant members of the Health Executive. Operational governance also requires strengthening through a collaborative governance arrangement that reports to the Health Executive through members with delegated responsibilities. This would strategically position PTAS to:

- Be an enabler of statewide clinical service delivery (e.g., support patient access to a statewide waiting list and align patient flows with the Tasmanian clinical service profile.
- Inform regional and statewide clinical service planning.
- Reduce the financial impact of travel for patients, and the administrative burden of the scheme.
- Move PTAS beyond a basic reimbursement model for assistance, and towards upfront tailored assistance packages for patients required to travel.

Until effective governance arrangements are established, PTAS will remain limited in strategic value, disconnected from the broader clinical vision for the Tasmanian Health Service, difficult to co-ordinate and administer, and generally unresponsive to change.

With this understanding, and within the remit of the scope of this review, governance recommendations within this report are aimed towards:

- Identifying the key actions required to establish strategic governance, and further strengthen operational governance of the scheme.
- Improving service delivery for enhanced patient satisfaction, staff satisfaction and administrative efficiency.
- Improving communication with stakeholders and users of the scheme, to clarify the intent of PTAS and assist with navigating the scheme.
- Increasing the responsiveness of PTAS to facilitate access to specialised clinical services, particularly for Tasmanians experiencing socio-economic and geographical access barriers.
- Enhancing the performance of the PTAS scheme within the current operational boundaries and positioning the scheme to adapt in response to future initiatives facilitated once appropriate executive governance arrangements are in place.

The supporting materials provided in addition to this review have been developed to assist in the operationalisation of the review findings. The revision and development of these materials have included a focus on:

- Clarifying the intent of the PTAS policy (once updated), and the principles that underpin operationalisation of the Policy.
- Supporting consistent PTAS decision-making.
- Aligning the strategic intent of PTAS with health services safety and quality.
- Enhancing comprehension and navigation of the scheme.
- Streamlining administrative processes.

3. Governance

PTAS is currently governed by the Department of Health through the PTAS Ministerial Policy. The PTAS Ministerial Policy is operationalised by the THS through the PTAS Operational Protocol.

The PTAS statewide service is managed as part of Health Information Management Services (HIMS), which forms part of the Business Improvement and Reform (BIR) Unit, reporting to the Deputy Secretary Policy, Purchasing, Performance and Reform.

Clinical governance is provided by five Medical Authorisers, who are also core members of the PTAS Advisory Committee.

3.1 PTAS Policy

The current PTAS Ministerial Policy was issued in 2013 in accordance with the *Tasmanian Health Organisations Act 2011*. It outlines the purpose and policy objectives of the scheme and delegates implementation of PTAS to the Tasmanian Health Organisations (now the Tasmanian Health Service):[1] and monitoring of policy compliance to the Department of Health and Human Services (now the Department of Health).

Subsequent issue of the *Tasmanian Health Service Act 2018*, changed the mechanism by which the Minister sets broad policy expectation from Ministerial Policy to a Ministerial Charter. Nevertheless, the PTAS Ministerial Policy remains in effect due to a Direction to the Tasmanian Health Service by the Secretary, Department of Health and Human Services that includes a 'grandfathering arrangement.'[2] This arrangement firstly recognises all Ministerial Policies applying to the THS prior to implementation of the *Tasmanian Health Service Act 2018*, until such time as they are varied or revoked, and secondly applies the Ministerial policy as a direction of the Secretary to the THS in accordance with the powers afforded the Secretary in Section 22 of the *Tasmanian Health Service Act 2018.*

As such the current PTAS Ministerial Policy remains in place until replaced by a policy issued by the Secretary, Department of Health. A draft PTAS policy for consideration by the Secretary is currently in the process of development.

3.2 PTAS Policy update

This section provides recommendations for the development of a Department of Health PTAS Policy that includes:

- updating the stated purpose of PTAS in line with contemporary clinical service models
- clarifying the intent of PTAS

[1] The three Tasmanian Health Organisations were later amalgamated into one Tasmanian Health Service in accordance with the Tasmanian Health Service Order 2015.

[2] See Secretary Department of Health and Human Services, Directions to the Tasmanian Health Service 29 June 2018.

- identifying the principles of PTAS
- clarifying the purpose of the targeted financial assistance approach
- delegating responsibilities.

Updating the purpose

The PTAS Ministerial Policy describes the aim of PTAS as '*to ensure equity of access for Tasmanian residents to specialist medical services by assisting eligible patients with the transport and accommodation costs associated with the accessing of specialist medical services*'

Since release of the Ministerial Policy the manner in which specialised health services are delivered has changed. Due to current and projected gaps between specialist medical workforce availability and demand for health services, the THS continues to transition towards sustainable health workforce models that include multidisciplinary skill sharing and extended scope of practice roles for the clinical workforce.[3] As such, specialised services, that meeting the intent of the PTAS policy are increasingly being provided by, or supported by, a wider clinical workforce than that of 'medical specialists.'

We recommend that the draft PTAS Policy include updated language to more accurately reflect the services and service providers that meet PTAS eligibility criteria. Specifically, we recommend that references to 'specialist medical services' is changed to 'specialised clinical services' and providers of these services, if referenced in the policy, are described as 'approved clinical providers' rather than medical specialists.

Clarifying the intent of the scheme

Opportunity exists to more clearly articulate the intent of PTAS. The current policy wording recognises the role of the scheme in promoting equity of access, but fails to describe other key elements that contribute the overall intent of the scheme.

We recommend the policy articulates the full intent of the scheme more clearly. In particular the policy should articulate the role of the scheme in preferentially supporting access to Tasmanian services, as close to home as possible, and directing assistance towards those most affected by travel and travel related costs, in a manner that provides value for money.

An example statement of intent is provided for consideration.

'The Patient Travel Assistance Scheme facilitates equity of access to specialised clinical services for Tasmanian residents by providing financial assistance towards travel and accommodation costs, in a manner that supports:

- *access to quality specialised clinical services as close to home as possible;*
- *a reduction in travel related costs for those most affected; and*
- *a sustainable Tasmanian health system.'*

[3] Health Workforce 2040 Strategy. Health Workforce Planning Unit, Department of Health Tasmania, 2020.

Identifying the principles of the scheme

Redrafting of the Policy also provides an opportunity to articulate the policy principles that underpin the PTAS scheme and its application by the THS. Some principles are already explicit in the policy wording (such as equity of access) but others are currently implicit or silent.

We recommend the following principles be included in the PTAS policy to guide decision making by the THS when operationalising the policy.

1. **Equity of access** - PTAS supports equitable access to specialised clinical services for Tasmanians.
2. **Transparency of process** - Information about PTAS, and the process by which the scheme is administered is accessible to the public and subject to review.
3. **Consistency of application** - The scheme is administered fairly, based on consistent application of the PTAS Operational Protocol.
4. **Patient-centred decision making** - Decisions regarding the application and administration of the PTAS scheme is informed by a patient-centred approach that aligns with safety and quality principles.
5. **Sustainable use of resources** - PTAS promotes the efficient use of public resources through support for access to specialised clinical services that are as close to home as possible, by providing financial assistance in a manner that promotes value for money, and by contributing data and information towards clinical service strategy and development.

Clarifying the purpose of PTAS targeting

The PTAS Ministerial Policy currently describes targeting of the scheme towards *'Tasmanians who have to travel long distances to access medical [clinical] services and face high travel costs as a result.'* The purpose and mechanism of targeting the scheme is described as follows… '*To maximise the benefit of PTAS to the greatest number of Tasmanians the scheme is targeted towards those most in need. This is achieved through eligibility criteria and tiered co-contributions.'*

This description is not an accurate description. The intended effect of the targeting of the scheme is to specifically support those Tasmanians who are most financially affected by high travel costs to access eligible clinical services, rather than *'maximising the benefit of PTAS to the greatest number of Tasmanians.'* We recommend the purpose of targeting PTAS is more accurately described in the draft PTAS policy.

Delegating responsibilities

Since the original issue of the PTAS Ministerial Policy there has also been a number of organisational restructures, the last of which occurred in March 2020. Through these successive restructures the delegation of PTAS responsibilities has become unclear.

PTAS governance describes the systems and strategies necessary to ensure PTAS operates in a manner that is clinically appropriate, fiscally prudent and administratively efficient and effective.

The PTAS policy should describe how responsibility for implementation is delegated within the current organisational structure. We recommend that delegation of responsibilities by the Secretary include the following:

- Identification and nomination of a Departmental **policy custodian** with the clinical expertise required to provide clear clinical policy direction and oversight to the PTAS Advisory Committee noting the recommendations in this report to strengthen the role, and broaden the remit of this committee (forthwith described as the PTAS Advisory and Approvals Committee [PTAS AAC]). The Departmental policy custodian must also possess the positional power required to respond strategically to data and advice from the PTAS AAC that may inform statewide clinical service planning and clinical workforce planning.
- Nomination of a THS **business owner** that provides administrative and financial governance of PTAS and the service unit that operationalises the scheme. It is important that the business owner possesses a broad remit to maintain and further strengthen the statewide business model for the scheme, and the positional power to ensure that the scheme: adheres to financial policy; maintains administrative efficiency and clarity whilst maintaining a patient-service focus; and is responsive to clinical advice (policy and operational), to ensure the scheme is governed in accordance with the intent and principles of the PTAS policy.
- Inclusion of the role and function of the **PTAS AAC** as the statewide, collective, decision-making and advisory group that maintains and applies the PTAS Operational Protocol, monitors PTAS performance at the operational level, responds to exception ruling requests, appeals and complaints, and provides strategic advice.[4] The policy should describe the accountability of the PTAS AAC to the Secretary via the Departmental policy custodian and the THS business owner.

3.3 PTAS Operational Protocol update

The PTAS Operational Protocol describes how PTAS is operationalised and administered by the THS. The Operational Protocol describes the:

- criteria by which eligibility for the scheme is determined
- the financial assistance rules and rates that are applied for those who are eligible for the scheme
- application, approval, booking and claiming processes of the scheme
- processes by which applicant appeals, complaints and feedback are considered
- roles and responsibilities of parties engaged with the scheme
- standards by which the performance of the scheme is measured.

The Operational Protocol has not received substantial review since 2013. It has been broadly recognised that the Operational Protocol requires a comprehensive update to facilitate improved application, efficiency, effectiveness and accountability of the scheme.

[4] See sections 3.4 and 3.5 for further information and recommendations for the strengthening the role, and broadening the remit of the PTAS AAC.

A comprehensive update of the PTAS Operational Protocol has been undertaken as part of this review. A draft of the updated protocol is provided as an attachment to this report (Attachment 1). A full description of the key changes to the protocol, and the reasoning for each change is provided at Appendix D of this report.

We recommend that the revised PTAS Operational Protocol is implemented to facilitate improved clarity and consistency in operationalisation of the PTAS policy.

3.4 The PTAS Advisory Committee

The PTAS Advisory Committee, in accordance with the Committee Terms of Reference, monitors, reviews, and provides advice on the application of the PTAS Ministerial Policy.

The Committee's core membership includes the Medical Advisors, PTAS Co-ordinators, PTAS Manager, the State-wide Manager of Health Information Management Services (HIMS) and a representative of the Department of Health - currently the Manager, Strategy and Projects of Clinical Quality, Regulation and Accreditation. The Committee is chaired by the Medical Advisor – North.

The Committee meets approximately biannually. Review of committee minutes provided for the past three meetings (from December 2019 to May 2021), indicate:

- Medical Authoriser engagement with the committee is generally low
- PTAS is still largely operating as three regionalised services rather than a single statewide service
- meetings have a focus on information sharing rather than collective decision making
- many of the actions agreed by the committee are not followed up or followed through in a timely manner
- the accountability and reporting arrangements of the Committee are unclear
- the Committee does not have a consumer representative (although the Terms of Reference does allow for a consumer representative).

Despite these issues, the Committee does provide a collective forum that includes both clinical and administrative experts, that are operationally engaged with PTAS, from all three regions of the state. Therefore, through information sharing it does informally support some consistency of decision making.

The Committee also provides a link between the THS operationalisation of the Ministerial Policy and the Department, with an employee of Department of Health with policy expertise included in the membership, although no formal representation or reporting arrangements exist between the Committee and the Department.

Opportunity exists to further formalise and strengthen the role of the Committee in order to:

- Strengthen clinical governance at the operational level.
- Provide a single forum that represents the clinical, financial and administrative governance interests that the scheme requires.
- Cement transition of the scheme from a regionalised model to a state-wide model.

- Increase consistency of application of the scheme through collective decision-making for exceptional approval rulings, outcome appeals and unresolved complaints.
- Improve accountability for the scheme through clear delegation of responsibility.
- Leverage the data and advice from operationalisation of the scheme to inform clinical service planning and strategic workforce development.

Opportunity also exists to broaden the membership of the Committee in order to:

- Ensure the membership has the requisite skill-set to make effective decisions when applying PTAS in complex patient situations (clinical, financial and social).
- Ensure the policy custodian and business owner are appropriately represented.

3.5 The PTAS Advice and Approvals Committee

In order to realise the opportunities identified it is recommended the role and remit of the PTAS AAC is strengthened and expanded, such that:

- The Committee provide collective decision making for exceptional ruling requests, outcome appeals and complaints as outlined in the revised PTAS Operational Protocol.
- The Committee meet at least monthly to ensure timely determination of exceptional ruling requests, outcome appeals and unresolved complaints.
- The Committee review the performance of the scheme in accordance with the performance monitoring schedule described in the revised Operational Protocol and provide a report with advice to the Health Executive (through the policy custodian and business owner) at least annually.
- Membership of the Committee includes: policy custodian and business owner representation; social work representation to support effective decision-making for applications with complex socio-economic factors, and consumer representation.
- The role of the Chair is expanded in line with the role and responsibility outline provided in the revised PTAS Operational Protocol.
- The appointment of the Chair is limited to practising Medical Authoriser members (in recognition of the clinical expertise required for this role), and the position is appointed by the policy custodian in consultation with the business owner.
- The Committee title and Terms of Reference is updated to reflect to revised role and remit of the Committee as described in this report.

While operational resourcing is not included in the scope of this review, it is strongly suggested that the PTAS Advice and Approvals Committee receives adequate administrative support commensurate with the revised role, responsibilities and remit of the group.

4. Comparison with other patient travel assistance schemes

We compared the current PTAS Operational Protocol with similar documents from other jurisdictional patient travel assistance schemes across Australia. This section provides a brief overview of the findings. Detailed comparison tables are provided at Appendix C.

4.1 Scheme features

All jurisdictional patient travel assistance schemes were originally derived from a Commonwealth program that was later transferred to the States and Territories. As such, all programs have retained core features that include:

- eligibility for specialised clinical services only
- eligibility based upon a minimum distance from usual residence to an approved specialist clinical service
- subsidised travel and accommodation for patients and eligible escorts.

Outside of these core features there is significant variation across jurisdictional schemes as each state and territory has modified their particular scheme according to specific contextual drivers.

A number of features present within other jurisdictional schemes have been identified as being useful for inclusion, with modification for the Tasmanian context, in the revised PTAS Operational Protocol. A full list of changes and the reasoning for change is provided at Appendix D.

Examples of key features identified from other schemes that have influenced revision of the Operational Protocol include:

- Reducing barriers to access the scheme – by allowing alternative forms of proof of residence other than electoral roll, and describing a simple access pathway for homeless patients.
- Improving transparency of the scheme – by using plain language in scheme documentation, providing unambiguous information about eligibility criteria and financial assistance rules, and using publicly available calculation tools for distance, and taxi fares.
- Balancing consistency and flexibility – with processes for non-precedent forming case-based decisions, and by describing specific exclusion criteria for the nearest eligible service for waitlist management and other clinical reasons.
- Streamlining the approval process – through the use of clear automatic approval criteria for eligible services, escorts, and accommodation.
- Time-limited support – through the use of review processes at set time frames (usually 3 months).

Whilst there are elements of innovation in the documents of other jurisdictions, overall scheme administration across the country remains administratively burdensome with detailed program rules and a largely reimbursement-based subsidy model. Patient-centred approaches are present in some schemes, but in general schemes remain very process driven. In addition, schemes appear to be slow adopters of technology, with

detailed paper-based application forms continuing to be the main method by which applicants engage with the schemes across the country.

4.2 Financial support

Tasmania is the only jurisdiction that requires concession card holders to provide a financial contribution toward their travel subsidy.

Tasmania and Victoria are the only jurisdictions that require a patient contribution for travel related costs for non-card holders. The Victorian scheme caps the patient contribution at $100 per year. Whereas the Tasmanian contribution is capped at $330 per annum, making it the most financially onerous in the country for patient contributions.

Patient contributions towards accommodation for non-card holders are only required in Tasmania, Queensland and South Australia. The Queensland scheme requires patient payment of the first four nights, Tasmanian the first two nights, and South Australia the first night.

Whilst PTAS has the highest patient contribution requirements of all jurisdictions, the rates of subsidy provided by PTAS, compared to the other jurisdictions is generous.

In comparison with other jurisdictions PTAS provides:

- the median level of subsidy for private patient travel;
- the most generous subsidy for accommodation for patient and escort;
- the same level of subsidy for bus travel as all other jurisdictions except for ACT;
- substantial subsidy for repatriation of deceased patients, where only Western Australia and the Northern Territory fully repatriate home and the other jurisdictions only provide the pre-confirmed amount for the patient's previously expected return journey.

Further detail is provided in Table 1 on the following page.

Table 1: Financial support and subsidies comparison by jurisdiction

State	Private travel	Other transport	Accommodation	Deceased client
TAS	21c / km	Most economic and clinically appropriate	$66 p/n in Tasmania; $87 p/n interstate. Non cardholders pay first two nights	Up to a maximum of $1500
ACT	25c / km to Brisbane; 38c / km to Sydney	Coach $90 to Sydney up to $390 to Brisbane	$50 p/n; $100 p/n with escort	Not specified
NSW	22c / km	Full reimbursement less GST	Base rate for one night at $43, increasing with length of stay and accommodation type up to $120 p/n for more than 15 days	At approved return journey rate
NT	20c / km for up to three clients, to a maximum of 60c	Lowest available fare	$60 p/n for commercial; $20 p/n for private	Base cost of repatriation
QLD	30c /km	Most economical method, with variations allowed	$60 / night. Non-card holders must pay for first 4 nights	At approved return journey rate
SA	16c / km	Based on standard fare	For card holders and children first two nights pre-authorised at $40 / night. Non-card holders also pre-authorised but must pay first.	At approved return journey rate
VIC	21c / km	Full economy fare train, bus, plane	$49.50 incl GST p/n	At approved return journey rate
WA	16c / km	Economy fare	$60 p/n, $75 with escort	Base cost of repatriation

5. Performance monitoring and analysis

5.1 PTAS reporting

PTAS performance measures are currently listed in the PTAS Operational Protocol. The Operational Protocol identifies the PTAS business unit as the area responsible for monitoring the performance of the scheme with the purpose of ensuring a patient-focussed and efficient service.

There are 17 performance measures identified as the minimum performance monitoring set for PTAS. PTAS staff are tasked with providing a statewide data set to the Department of Health for collation and reporting through the For Your Information (FYI) business intelligence tool.

The measures include:

- Cost and activity data breakdowns by: specialty, procedure, location of treatment (inter-state, intra-state, remote island of Tasmania) patient, escort, concession status travel, and accommodation.
- Claim rates.
- Number of claims refused with estimated costs.
- Number of referrals by specialist.
- Number of patient complaints.
- Service planning data sets.

PTAS Offices do not report data against the full performance monitoring suite described in the Operational Protocol. Instead, the PTAS Manager provides a monthly data set that describes:

- the number of claims, number of trips and associated costs by application collection depot (in the North West), areas of residence (in the North) and clinical area (Medical, surgical or Women's and Children's) in the South.
- the number of flights and associated costs for interstate travel, King Island travel, Flinders Island travel, and THS staff travel.

This data set is provided to the Department of Health. PTAS staff are unaware of how the data is used and who, if anyone, reviews the data.

5.2 Data analysis

Where data are available, we have analysed PTAS performance against the PTAS performance measures described in the Operational Protocol. This analysis is provided at Appendix B.

Due to the limited nature of this data set we have also undertaken some additional analysis, using the available data set, historic data sets from a previous PTAS review and other publicly available metrics to more clearly identify trends in scheme access, costs and allocation.

We compared PTAS utilisation in the four years to 2014-15 with more recent utilisation in 2018-19 and 2019-20 (2018-2020), acknowledging the impacts of mainland travel restrictions associated with the COVID-19 pandemic is a limitation with this analysis.

Overview

In 2018-2020, there were 40,329 Tasmanians who accessed benefits from PTAS. The scheme paid a total of $17 million over the two years, with patients contributing $700,000 per year on average.

Patients often need multiple visits to health services each year and in 2018-20, PTAS recorded 1.9 claims per patient.

Consistent with the scheme's intent to support access to care for people who live outside the immediate geographical catchment of health services, rates of access to PTAS were highest in North West Tasmania. However, the average payments per patient are twice as high in the South as elsewhere. This is attributed to a high proportion and high costs of interstate referrals, described further below.

Table 2: PTAS patients per 1,000 population, and payment costs, 2018-20

Location	2018-19 Patients per 1,000 population	2019-20 Patients per 1,000 population	2018-20 Average payment / patient
Northern	42	39	$398
North West	114	96	$313
Southern	10	8	$980
Tasmania	41	35	$421

*

Total PTAS costs are rising faster than the number of PTAS claims

The total cost of all PTAS claims is increasing over time, from $5.14 million in 2010-11 to $7.62 million in 2019-20 (a 48% increase).

Cost is increasing at a faster rate than the number of patients seeking assistance; there were 30,848 patients who received support in 2010-11 compared with 36,226 patients in 2019-20 (a 17% increase).

The rapid increase in costs of the scheme is important to policymakers, who ensure the sustainability of all public sector services.

Paediatrics, oncology and cardiology specialities are the highest contributors to PTAS claim costs

The top three specialties by PTAS claim costs are paediatrics, oncology and cardiology, across all three regions of Tasmania.

Table 3: Top 10 total cost of claims by specialty, 2018-2020

Southern Office Specialty	Southern Office Total claims	Northern Office Specialty	Northern Office Total claims	Burnie Office Specialty	Burnie Office Total claims	Devonport Office Specialty	Devonport Office Total claims
Paediatric	$1,713,414	Paediatric	$624,135	Paediatric	561,396	Paediatric	$547,921
Oncology	$612,201	Oncology	$572,824	Cardiac	408,539	Oncology	$402,850
Cardiac	$479,252	Cardiac	$302,112	Oncology	278,264	Cardiac	$197,772
Haematology	$394,096	Neurology	$260,013	Neurosurgical	172,704	Neurosurgical	$140,695
Hepatology	$140,564	Haematology	$254,417	Orthopaedic	130,782	Orthopaedic	$108,201
Ophthalmic	$132,118	Cardiothoracic	$147,928	Neurology	120,150	Renal	$102,399
Nephrology	$126,521	Obstetric	$145,494	Respiratory	114,215	Neurology	$90,518
Orthopaedic	$112,450	Orthopaedic	$127,159	G/E	110,255	Transplant	$87,089
Neurology	$108,530	Renal	$122,955	Urology	108,171	G/E	$86,897
ENT	$99,657	Neurosurgical	$118,918	Ophthalmic	106,741	Cardiothoracic	$66,526

PTAS applications for interstate paediatric treatment, and cardiology treatment are reviewed by statewide Specialist Medical Authorisers, with high level specialist experience in their respective fields. We recommend a similar arrangement for interstate oncology applications.

Removing out of pocket costs for cardholders would have a small impact on PTAS costs

PTAS records whether patients are pensioners or health care cardholders. Cardholders pay a smaller co-payment for travel assistance than non-cardholders. An estimated 23% of Tasmania's population are cardholders, whereas 80% of PTAS patients are cardholders. This indicates that the scheme is targeted of the scheme towards low-income Tasmanians.

Tasmania's population experiences high levels of socio-economic disadvantage. Pensioners are among the poorest people in Tasmania. Yet, Tasmania almost uniquely requires patient contributions from both cardholders and non-cardholders, with an annual cap of $132 for cardholders and $330 for non-cardholders. Of the other jurisdictions, only Victoria requires any patient contribution which has an annual cap of $100 for non-cardholders only.

In Tasmania there were 32,307 cardholders who accessed PTAS in 2018-20. Their total reimbursements received were $6 million each year and their co-payments amounted to a total of $370,000 each year over the two years.

The total impacts to the scheme of removing the co-payment for pensioners and health care cardholders, at approximately $370,000 annually, are small and represent only 4% of the total cost of the scheme.

Reducing interstate travel would have a large impact on PTAS costs

The intent of the PTAS policy and protocol is to support travel to access Tasmanian services where these are available. On average, 61% of total PTAS costs are incurred for interstate referrals, with $3 million on interstate airfares and $2 million on mainland accommodation.

Interstate costs comprised $10.4 million of total PTAS costs in 2018-2020, compared with $6.57 million for intrastate PTAS costs. The claimed amount for interstate travel is up to 11 times higher than claims to access services within Tasmania.

Table 4: PTAS claims, treatment location, 2010-11 to 2019-20

Year	Interstate Cost ($,000)	Interstate Claims	Interstate Cost / Claim	Within Tasmania Cost ($,000)	Within Tasmania Claims	Within Tasmania Cost / Claim	All Cost ($,000)	All Claims	All Cost / Claim
2010-11	$2,997	3,588	$835	$2,166	27,255	$79	$5,136	30,843	$167
2014-15	$4,470	4,912	$910	$2,655	30,818	$86	$7,125	35,730	$199
2018-19	$5,941	5,569	$1,067	$3,446	35,162	$98	$9,387	40,731	$230
2019-20	$4,495	4,098	$1,097	$3,127	32,128	$97	$7,622	36,226	$210

The rate of interstate referrals, to both private specialists and public hospitals, varies substantially between regions (with adjustments for the Bass Strait Islands) even though the population mix requiring these specialist services should be very similar. The rates vary from a high of 12.3 / 1000 population in the North West (excluding King Island) to 9.3 in the North (excluding FGI) to 6.4 in the South.

At a public hospital referral destination level there appear to be excess levels of referral from the North West to the Royal Children's Hospital Melbourne (3.6 / 1000 compared with 1.5 / 1000 from the South) and mainland public hospitals (7.1 / 1000) and from the North to other mainland public hospitals (5.6 / 1000) compared with the South (3.3 / 1000).

Table 5 models the nett savings if the excess proportion of referrals were made to RHH from the North and North West regions rather than to the mainland, to achieve a statewide standard mainland referral rate. The estimated annual savings are more than $760,000 per annum.

Table 5: Estimated savings of standardising mainland referral rates

Referral destination	Current annual referrals	Adjusted annual referred	New RHH referrals	Nett PTAS saving
NW region to RCHM	399	177	222	$194,180
NW region to other mainland public hospitals	796	370	426	$338,905
Northern region to other mainland public hospitals	819	482	336	$233,638
Total	**2014**	**1029**	**984**	**$766,723**

Variations in the use of mainland services by PTAS recipients is also associated with cardholder status. Cardholders are more likely to receive subsidies to access Tasmanian health services whereas non-cardholders are more likely to receive subsidies for accessing Victorian health services.

Table 6: Referral destination, cardholder status, 2018-20

Referral destination	Cardholders N	Cardholders %	Non-Cardholders N	Non-Cardholders%
Tasmanian public hospitals	16,716	52%	2,700	34%
Royal Children's Hospital Melbourne	1,333	4%	736	9%

Referral destination	Cardholders N	Cardholders %	Non-Cardholders N	Non-Cardholders%
Other Melbourne public hospitals	3,146	10%	1,903	24%
Tasmanian private specialists	9,767	30%	1,641	20%
Victorian private specialists	1,153	4%	915	11%

Of total PTAS subsidy costs, 11% are for referrals to mainland private specialists; a further 12% of reimbursements is for Tasmanian private specialists, with 61% of reimbursement for residents of the North West and 35% from the Northern region. Estimated savings of redirecting Victorian private specialist referrals to Tasmanian private specialists is also more than $760,000 per annum.

Table 7: Redirection of excess interstate private specialist services

Annual average 2018-20	Nett travel reimbursements $8,504,176	Net change
Redirection to Tasmanian private specialists from Victorian private specialists	$7,737,805	Saving of $766,371

We recommend that PTAS eligibility rules are strengthened, as per the revised Operational Protocol, to prevent referrals to interstate private services for services that are available in Tasmania. As such, PTAS subsidies are not payable for travel to access interstate services if they are available in Tasmania (with the exception of residents of King Island and the Furneaux Group Islands [see Recommendation 28]), and PTAS subsidies are not payable for private interstate services, irrespective of applicant place of residence. We also recommend that rates of referral to interstate services are monitored by the PTAS AAC as described in the performance monitoring schedule detailed in the revised Operational Protocol.

There is a special case in support of interstate travel from the Bass Strait Islands

Residents of King Island and the Furneaux Group Islands experience unique geographical challenges accessing health care. They are also the only two Local Government Areas in Tasmania that are wholly reliant on air travel to access health care on the Tasmanian mainland or mainland Australia.

In 2018-20, there were 765 per 1,000 residents of Furneaux Group (FG) Islands and 693 per 1,000 residents of King Island who claimed PTAS support. The average payment per patient was $488 for FG Islands and $709 for King Island.

In comparison, only 40 per 1,000 residents of Northern Tasmania and 105 per 1,000 residents of North West Tasmania accessed PTAS in 2018-2020. This reflects the relative geographical isolation of both islands, the limited range of health services available on each island and the impacts of reliance on air travel to access health care.

In 2018-20 there were 459 patients referred interstate from King Island and 71 referred interstate from FG Islands. This represents 5% of all interstate referrals. For King Island

residents the average total cost for interstate patients is $593 compared with $804 for intrastate patients, supporting consultation findings that the patients have support networks in Melbourne and that travel costs to Victoria are actually cheaper overall for King Island residents. For FG Islands, interstate referrals incur an average total cost of $637 compared with $518 for intrastate referrals.

Interstate travel by residents of the Bass Strait islands is discussed further in Section 9.

5.3 Improved performance monitoring

The current performance monitoring schedule is difficult to report against as a significant number of the measures are unable to be easily collected from existing databases.

The schedule is also very heavily skewed towards the reporting of activity and financial data. The schedule has an absence of service efficiency indicators, and the only quality indicator present within the schedule is not reported on currently.

For the measures that are collected, it is unclear where the information is reported, beyond the FYI business intelligence tool, and how frequently it should be reported.

PTAS performance data are important for:

- ensuring that the scheme is operating in accordance with the PTAS policy intent and principles
- informing quality improvement decisions specific to the administration and application of the scheme
- informing strategic planning for statewide clinical service development and workforce development.

The performance monitoring schedule documented in the Operational Protocol has been revised to improve the clarity and utility of PTAS performance monitoring information.

The revised performance monitoring schedule includes:

- Removal of service planning information indicators that are too labour intensive to collect.
- Addition of a small number of service efficiency indicators to monitor the timeliness of the scheme in accordance with timeframes for service delivery described in the revised Operational Protocol.
- Addition of a small number of quality indicators to target monitoring efforts towards areas of inconsistency and complaint.
- Identification of timeframes for reporting by measure.
- Identification of those responsible for reporting and receiving performance monitoring data.

In recognition of the importance of PTAS as an enabler of clinical service delivery, the schedule also requires that the PTAS AAC produce an annual report for tabling at a meeting of the Departmental Executive. The report is to provide, at a minimum, performance of PTAS against the performance monitoring schedule, and strategic advice to inform ongoing clinical service planning and clinical workforce planning activities.

We recommend that the PTAS performance monitoring schedule is strengthened by removal of redundant measures, inclusion of service efficiency and quality measures, increased clarity of reporting frequency, and allocation of responsibilities for collecting, reviewing, and responding to PTAS performance data; as detailed in the revised Operational Protocol.

6. PTAS service provision

The PTAS service was originally managed as three separate regionalised units. In recent years the regional services were amalgamated into a single statewide service within the HIMS portfolio with the aim of improving the consistency and accountability of the service, and leveraging administrative systems and expertise from the HIMS portfolio. [5]

The PTAS statewide service model consists of staffed local offices within the three regions (Hobart, Launceston, Burnie and Devonport) with overarching statewide management provided by the PTAS Manager (statewide) reporting to the Statewide Manager HIMS.

The amalgamation has established clear points of accountability for the service, with the Statewide Manager HIMS and PTAS Manager. However, there is scope to increase the consistency of the service, further leverage administrative systems, and enhance customer service.

6.1 Statewide service consistency

Stakeholder consultation and review of the issues and complaints register indicate that consistency in application of the scheme remains a challenge for the service. Factors affecting statewide consistency include:

- Regional variation in application of the scheme prior to statewide amalgamation, creating different levels of consumer expectation of the scheme across the state.
- Ambiguity within the Operational Protocol resulting in varied interpretation and application of the scheme currently across the PTAS offices.
- A lack of training and support materials for staff.
- A continuation of regionally-based (siloed) service arrangements and decision-making processes.
- No clear process to distinguish between precedent-forming decisions and non-precedent forming decisions.
- Insufficient mechanisms of appeal and complaint resulting in aggressive lobbying practices by a small number of applicants, and the development of inequitable 'special arrangements' for specific individuals and people groups.

Opportunity exists to further strengthen statewide consistency of the PTAS through:

- Standardisation of service arrangements across the four staffed PTAS offices including hours of operation, timeliness of service provision, and implementation of the service standards described in the revised Operational Protocol
- Implementation of the revised Operational Protocol to:
    - Improve consistency of application and interpretation of the scheme in accordance with the intent and principles of the PTAS Policy.
    - Action a collaborative (statewide) decision making pathway for exceptional rulings, appeals and unresolved complaints.

[5] See recommendations of the PTAS Review Stage 2 – Report to Business Owners (2016)

    - Clearly distinguish when decisions form precedent or not (using the exceptional ruling process).
    - Strengthen the role of the PTAS AAC in providing collective clinical governance for the scheme and supporting standardisation of Medical Authoriser approaches to decision making (see Section 3).
- Implementation of the PTAS User Guide (Attachment 6) to assist with staff training and support consistent application of the Operational Protocol.
- Improved public messaging about PTAS and the intent of the scheme to strengthen consumer understanding and manage expectation (see Section 10).

We recommend the PTAS continues to operate as a statewide service and that systems and processes are further aligned to improve consistency of service arrangements and scheme application, in accordance with the revised Operational Protocol.

6.2 Leveraging and integrating administrative systems

The PTAS Application Form

When asked 'what opportunities exist to improve the scheme' the highest public consultation response was 'simplification of the PTAS application and claims process and paperwork.' This response also ranked second highest in response to the questions 'In what ways could the scheme be delivered differently to ensure support is provided to those with most need?' and 'what improvement [to the scheme] would you like to see addressed first?'

The detail of the responses provided indicate that consumers value:

- A more flexible and streamlined approach to the application and claims process - this has been addressed where possible in the revised Operational Protocol.
- Improved design and layout of the PTAS Application Form, a revised application form is provided at Attachment 2.
- More information about how to complete the PTAS Application Form, particularly for first-time applicants. This has been addressed with the development of Patient Guidelines resource provided at Attachment 3.
- Processes that reduce the need for applicants to provide information that is already available within information systems of the THS.
- An online application and claims pathway.

Submission of the PTAS Application Form is required for obtaining approval for PTAS subsidy and claiming PTAS subsidies. The revised PTAS Application form is a three-part paper-based form that requires documentation and signature from the patient (Section 1), referring medical practitioner (Section 2) and the treating clinician or their Authorised Officer (Section 3).

Whilst some improvements have been included, as part of this review, to streamline the application and claims process for PTAS, improve the appearance the paper-based form, and assist applicants to complete the form; opportunity exists to further streamline the application and claiming process through the use of technology.

The PTAS referral (Section 2), provided by the medical practitioner could be developed as an electronic referral. Some general practitioners have already developed their own

electronically generated PTAS referral documents for ease of use and improved record keeping. Transition to an electronic referral form could improve the timeliness of PTAS referral forms, and assist with the accuracy of forms through the use of prompts and drop-down menus. Development of such a form would also align with the aims of the current Tasmanian eReferral project conducted by Primary Health Tasmania in collaboration with the Tasmanian Health Service and Department of Health.

Population uptake of electronic data gathering systems such as on-line smart form technology and application software has increased in recent years. Opportunity exists to develop an on-line, multi-user PTAS Application Form that is integrated with the THS information patient management database iPM and the DoH finance management system Finance One.

An on-line PTAS application form could provide the following advantages:

- Increase accuracy and quality of data provided (through the use of mandatory fields, drop-down selection menus, and auto-population of integrated fields).
- Reduced need for applicants to provide information already held on file by the THS.
- Ability to provide advice on completing the form at the time of population, through the use of help function or embedded information tailored to the user type (referring medical practitioner, patient or clinical service provider).
- Eliminate double handling of data by PTAS staff.
- Eliminate need for spreadsheet recording of application submission dates and progress milestones.
- Eliminate the requirement for paper scanning and archiving processes.
- Reduction in processing and patient notification times.
- Improved record keeping and data management.
- Increase audit protections for financial data.
- Increase patient privacy and security of clinical data.

Development of an online PTAS Application form would require expertise and support from eHealth and Information and Communication Technology (ICT) services (or similar) to assist with development of a business case, and consultation with finance to support a budget submission to fund the project development and roll-out.

We recommend that the revised PTAS Application Form (Attachment 2) is implemented in 2022 and that development of an online PTAS Application smart-form (or equivalent) is progressed, in collaboration with eHealth and ICT Services (or another area as nominated by Chief Information Officer), for implementation in 2024.

PTAS administrative processes

PTAS staff use a number of administrative systems to track, process, pay, and archive PTAS applications. These systems are not integrated and require re-keying of information into multiple systems for each application.

The following outlines the administrative process that staff undertake for an ‘average’ PTAS application after it has received a preliminary check for completeness and accuracy.

1. Manually enter 'headline data' about the application into an excel spreadsheet to establish the date of submission and document any issues that require the applicant's attention prior to processing the application.
2. Document any verbal communication with applicants using a manually populated spreadsheet.
3. Notify the applicant of non-approval (if applicable) using manually generated templated letter.
4. Scan or deliver applications to the PTAS Manager for onforwarding to Medical Authorisers.
   For approved applications
5. Manually calculate financial assistance entitlements, inclusive of co-contribution deductions.
6. Submit for verification of approval and calculations from a second member of staff.
7. Book flights (if required) in consultation with patient using a manually generated form that is emailed to the third-party travel provider.
8. Book accommodation (if required) in consultation with patient using provider booking process (by email or phone).
9. Manually record bookings in an excel spreadsheet.
10. Manually enter all required data into the TOMS database including costing.
11. Generate purchase orders (if required) using Finance One.
12. Manually enter batching/payment data into Finance One.
13. Scan paper-based application and supporting document form for archiving using CM9 software. Scanning process requires setting up a patient folder and scanning separate parts of the form and supporting documents to different sub-folders.

Staff are required to manually re-key the same or similar data multiple times for each approved application (steps 1, 7, 10, 11) because of an absence of integration between the systems needed to process PTAS applications and claims.

Staff also keep multiple excel spreadsheets (steps 1, 2, 10) in addition to the information stored in the three core databases (TOMS, Finance One and CM9).

TOMS

The TOMS database was implemented by PTAS in January 2021. Prior to this implementation, PTAS used an access database developed and maintained by staff. This database became unstable over time, and implementation of TOMS was necessary. Staff agree that the TOMS database is a significant improvement from the previous database. However, there are efficiencies in processing applications that could be achieved if the TOMS database had additional functionality and interoperability.

Key elements that could improve administrative efficiency include:

- A tracking function for applications, including timestamping and reporting on application processing progress.
- Support for electronic entry of applications and upload of supporting documentation.
- Electronic transmission of applications for approval by a Medical Authoriser.
- In-built calculation tools and accuracy checking functions.

- Integrated functionality with iPM for access to patient details and verifying clinical service attendance.
- Integrated functionality with CM9 for accessing scanned records.
- Integrated functionality with Finance One for the generation of purchase orders, invoices, and for payment of claims.

We understand that some of these functions are possible through the current version of TOMS in use by PTAS (such as the finance functions) and some other functions may be possible with enhancement of the TOMS functionality.

We recommend that nominees of the PTAS business owner and Chief Information Officer are engaged to develop a business case, in consultation with PTAS staff to enhance the functionality of the PTAS database TOMS, and facilitate integration with other information systems of relevance to the processing of PTAS applications and claims (including Finance One, CM9 and iPM).

Leveraging the information in the patient record

PTAS is a small but integral part of the THS. A significant amount of PTAS activity pertains to the movement of patients between the acute public hospitals of Tasmania, and yet, PTAS staff do not access the patient record to verify patient details, identify referral information, or determine when a patient has accessed a public health service in Tasmania. Instead, patients are required to provide this detail every time they submit an application form, or claim for an occasion of service (which must be documented and signed off by the treating clinician).

It is clear from patient feedback that patients expect PTAS staff to use the data already stored by the THS, and do not understand why they are being asked to provide this information in addition to information already provided.

PTAS is located within the HIMS portfolio, and as such is uniquely placed to consider how information flows from the patient record could be captured and integrated within PTAS workflows to reduce the application burden on patients, and reduce the need for clinical service providers to complete administrative tasks on Section 3 of the PTAS Application Form. For example, the PTAS form requires patients to receive a specialist's signature confirming a consultation took place, when HIMS could confirm that a consultation took place, at least within the THS, (without breaching patient confidentiality) from the THS electronic systems. Remembering to obtain the specialist’s signature, whilst also focussing on the clinical purpose of the consultation, and obtaining the signature if the patient forgets in the consultation, is a significant source of stress to PTAS users.

Clearly, movement towards improved integration in this space will require careful consideration, from a patient privacy perspective. The use of access filters and rules may assist in facilitating access to specific areas within the record of greater administrative relevance. In addition, access to the patient record will not assist in identifying relevant data for patients who attend services outside of the public health system.

Nevertheless, patients expect that PTAS work towards more seamless data integration with the wider Tasmanian public health system. Whilst this may take time to achieve it is important that steps are taken in this direction.

The Department of Health is currently developing a Health ICT Plan 2020-2030, that incudes electronic medical records, a new patient information system, and other electronic tools. It is important that the data integration needs of PTAS are included in the consultation for this strategy.

We recommend that a nominee of the PTAS business owner document and present the data integration needs of PTAS for inclusion and consideration in the development of the Health ICT Plan 2020-2030.

6.3 Service accessibility

Staffed PTAS offices are located in Hobart, Launceston, Devonport and Burnie. PTAS advice can also be obtained from designated community health centres and district hospitals located in North-West Tasmania.[6]

PTAS staff need to maintain a detailed working knowledge of the clinical services, accommodation, and transport providers available in their local area and in areas to which patients from their region are travelling. As such PTAS operates using localised service delivery hubs connected through a statewide administrative arrangement.

Patients are able to access local PTAS advice by phone, email, and in-person. Patients and other stakeholders report good access to staff (Patient Service Officers) by phone during business hours.

The dominant method of application delivery varies across the State, as reported by staff:

- The Devonport office receives high volumes of in-person presentations, this is facilitated by its co-location in a community health services centre that is centrally located within the city.
- The Burnie office receives high volumes by mail, particularly as applications collected at the designated community centres and district hospitals are forwarded in batches by mail to the Burnie office for processing.
- The Launceston office receives approximately equal volumes of applications by email and mail, as they have actively promoted emailing of applications.
- The Hobart office receives most applications by email.

There are advantages to encouraging patients to submit their applications electronically, where they are able to do so. Electronic submission of applications reduces the time taken for the application to be received (compared to mail), allows timely two-way communication between the applicant and PTAS staff using email, provides a time-stamped record of when the application was received and any subsequent advice given, and prepares patients towards a future electronic application process as described earlier (see Recommendation 12).

[6] Devonport Community and Health Service Centre, Rosebery Community Health Centre, King Island Hospital and Health Centre, West Coast District Hospital, Smithton District Hospital.

Similarly, applications collected by designated community health centres and district hospitals should be scanned to the PTAS office in Burnie to reduce delays caused by mail delivery.

The current location of offices appears to support local access and provide a sufficient local presence to facilitate the scheme. Opportunity exists to improve flexibility of workload management between the offices according to demand and staffing availability. Currently offices operate within very defined regional boundaries, to the point that applications submitted to an office outside of the applicant's region are returned to patients for resubmission to the 'correct' regional office.

While there is merit in having local offices to administer the scheme locally, there is also value in recognising the role of the 'network' of offices in administering the scheme statewide. There is opportunity to increase the flexibility of workflows between the offices during times of surge demand or when staffing levels are low in specific offices. This may include diverting calls between offices,[7] and processing electronically submitted claims from an office other than the local office.

In the longer term there would be value in implementing a single statewide phone and email contact for members of the public seeking to access PTAS. This would simplify contact messaging on the website and brochures, and enable triage of incoming PTAS communication to the correct office.

We recommend that all PTAS offices encourage electronic submission of paper-based applications by patients and designated collection centres to reduce delays due to mail delivery, improve records of submission, allow for flexible allocation of workload across offices, and assist in preparing applicants toward a future online form as described at recommendation 12).

6.4 After-hours service provision

PTAS office operating hours vary across the regions but in general are within regular business hours. PTAS offices do not provide an after-hours service.

In the event of an after-hours booking issue patients with flight bookings made by PTAS staff are able to contact the emergency travel assistance number provided on the front page of their travel booking information. This 24-hour help-desk is provided by the contracted travel provider used by PTAS for all flight bookings.

After-hours flight bookings for escorts of patients requiring urgent transfer can be made on an urgent-needs basis by rostered After-Hours Nurse Managers at the acute public hospitals. Although this arrangement can be difficult as nurse managers are not familiar with PTAS processes and requirements. As such, they are mostly unable to advise patients and their family of the extent to which their bookings will be reimbursed by PTAS, which can be a source of stress for patients with limited financial means. Further,

[7] Noting that this already occurs between the Burnie and Devonport offices

as the booking process is unfamiliar, After-Hours Nurse Managers are required to be 'off the floor' for long periods of time as they navigate booking arrangements.

PTAS eligible patients who are discharged from interstate hospitals after hours cannot access the PTAS office to arrange urgent return flights home. In these situations, some patients call their referring hospital in Tasmania for advice, others make their own arrangements incurring the full cost of the travel upfront, others 'make do' until the office is available.

Ideally, in recognition of the 24/7 nature of interstate travel and specialised healthcare, PTAS would provide an on-call service to all PTAS-eligible patients that would manage urgent bookings and provide urgent booking related advice. However, due to the small staff size of the unit such arrangement would not be sustainable.

Therefore, as a minimum we recommend that a formal after-hours handover arrangement is developed between the PTAS offices and the local After-Hours Nurse Manager group at each acute public hospital in Tasmania that includes:

- provision of information on the booking arrangements for all active interstate patients; and
- access to an emergency phone number for a member of PTAS staff (statewide) for urgent issues that cannot be resolved by the After-Hours Nurse Manager.

We also recommend that After-Hours Nurse Managers, in recognition of their important role in maintaining PTAS continuity after hours, receive regular training support on relevant PTAS processes and requirements to maintain a strong understanding of the scheme.

6.5 Enhancing customer service

Public consultation identified that the majority of patients who have accessed PTAS report a positive experience.

Table 8: Public consultation - experience of PTAS

What is your experience of PTAS?

Positive	**Neutral**	**Negative**	**N/A**
163	**40**	**35**	**4**
67%	**17%**	**14%**	**2%**

A number of respondents described PTAS staff as friendly, helpful and efficient. Some respondents (14%) described their experience of PTAS as negative. Most negative comments were directed towards the rules and requirements of the scheme, or a lack of consistency in applying the scheme but a small sub-group of responses described staff communication approaches as lacking in compassion or empathy. This theme was also identified by other stakeholders with a number noting a change in the 'tone' of staff administering the scheme in recent years.

PTAS staff are required to apply the scheme within the Operational Protocol and according to financial probity requirements. In 2018, an internal audit of PTAS (North)

identified a number of areas in which the scheme was not accurately administered and did not have sufficient financial controls. The auditors made a number of recommendations to improve the financial rigor of the scheme, including increased accuracy of calculations, applications of financial delegation limits, and implementation of fraud prevention strategies.

Since release of the audit report there has been a concerted effort to increase controls. Stakeholder feedback indicates that patients and stakeholders have perceived this shift but have not understood the drivers behind the change.

PTAS staff are tasked with balancing application of the scheme within policy, protocol and financial controls whilst providing a patient-focussed service. PTAS staff often communicate with patients and their carers/guardian soon after they have received unsettling news of a medical diagnosis, and need to travel as a result. Some patients have complex clinical, financial and social issues that are further compounded by the need to travel to access specialised medical services.

PTAS staff report that they do not receive customer service training, despite having an important customer service role. Opportunity exists to improve the capacity of staff to communicate effectively with PTAS applicants by providing regular training in areas such as empathetic communication skills, culturally sensitive communication, and conflict resolutions strategies.

We recommend that PTAS implement the customer service standards described in the revised Operational Protocol and monitor service efficiency and patient satisfaction in accordance with the indicators described in the performance monitoring framework, also described in the revised Operational Protocol.

We also recommend that staff receive regular customer service training in areas such as empathetic and culturally sensitive communication, and conflict resolution.

Staff also require clear escalation and referral pathways when communicating with patients that have exceptional needs and require support beyond the capacity of administrative staff to provide. This issue is specifically addressed in Section 8 of this report.

7. Key external service providers

7.1 Subsidised accommodation providers

Patients and approved escorts eligible for PTAS accommodation assistance can choose where to stay. The PTAS Operational Protocol (current and revised) recommends that patients seeking to access commercial accommodation consider staying in subsidised accommodation. Subsidised or low-cost accommodation is available through a small group of providers in Tasmania that specifically cater for those who need to travel to access clinical services. These accommodation services are largely owned and operated by charitable organisations. They use differing business models, 'no-cost' providers do not collect funds from guests but do collect the accommodation subsidy rate from PTAS for PTAS-eligible guests. Low-cost accommodation providers charge a fee per night but allow PTAS-eligible guests to pay only the gap between the PTAS subsidy rate on receipt of a PTAS purchase order.

PTAS also interacts with subsidised accommodation providers located interstate as required.

While it may not be formally recognised, there is a mutually beneficial relationship between PTAS and the subsidised accommodation providers. Providers are aware they have a level of financial reliance on the PTAS scheme, and timely payment of PTAS subsidies to maintain their business models. Conversely, PTAS is reliant on subsidised accommodation providers for providing accommodation for those who are most financially disadvantaged, and this assists in maintaining PTAS accommodation subsidy rates at a sustainable level.

Feedback from stakeholders indicates that subsidised accommodation providers are highly valued by recipients of PTAS, particularly by those who are required to travel frequently and those requiring accommodation for long periods of time.

Subsidised accommodation providers also have a very good understanding of the PTAS eligibility criteria and financial assistance rules, and are often a source of advice, support and even advocacy for patients experiencing difficulty in navigating the scheme.

Service providers interviewed for this review described the majority of their guests as concession cardholders and reported high rates of financial hardship. Most providers described occasions in which they distribute supplementary assistance to selected guests experiencing extreme hardship due to travel related costs. Examples of assistance include fuel cards and taxi vouchers. Providers also provide compassionate support from time to time to those who are declined PTAS accommodation subsidy (before or after the service event).

Providers identified a number of ways that PTAS could be improved to reduce the financial impact of high travel related costs on patients, including:

- Improving public awareness of the scheme - providers estimate that approximately half of all first-time guests are unaware of PTAS (see Section 10).
- Improved clarity and consistency of PTAS eligibility criteria and financial assistance rules – to provide patients with more certainty about the out-of-pocket

expenses they will incur personally as a result of travel (see revised Operational Protocol).
- Faster approval times – so that patients can make arrangements in a timely manner (see Section 8).
- Faster reimbursement times - to minimise 'out-of-pocket' periods that can cause financial stress or hardship (see Section 8).
- More assistance to complete the application form (see Patient Guidelines at Attachment 3).

Subsidised accommodation providers also have very regular contact with PTAS staff. Some providers identified differences in 'office culture' between the three regions and suggested that staff could benefit from additional training in customer service, and compassionate communication.

Further, some providers described a perceived decline in the working relationship between their organisation and PTAS staff due to a change in 'management style'. As described earlier in Section 6, this perception may be due to a failure on behalf of the THS to adequately communicate with key stakeholders about changes to the structure and administration of PTAS that occurred after the 2016 PTAS Stage 2 Review.

We recommend that PTAS management work towards strengthening the relationship between the PTAS service unit and subsidised accommodation providers by:

- Promoting subsidised accommodation providers on the PTAS website, by updating the content in the Accommodation Handbooks (South and North-West), developing similar content for the North, and creating a statewide resource that is accessible by staff and patients.
- Encouraging additional accommodation providers to engage with the scheme – particularly in areas such and Burnie and Devonport-Latrobe.
- Improving communication with subsidised accommodation providers, particularly regarding substantial changes to the scheme as a result of this review (see also Section 12).

7.2 Repatriation services

If a patient is eligible for a PTAS subsidy, or has been transferred between hospitals, and dies at the treatment facility, PTAS assistance is available towards meeting the cost of returning the deceased home.

Repatriation of the deceased is managed by private funeral home services. There are currently 8 Funeral Director companies in Tasmania. All are members of the Tasmanian branch of the Australian Funeral Directors Association (AFDA).

Relatives of the deceased make arrangements directly with their choice of funeral service and PTAS provides reimbursement of costs incurred by the next-of-kin up to a maximum of $1,500.

A record of repatriation costs over the period of a few months indicates that repatriation fees are highly variable, even for the same or similar distances travelled. Average ground

travel expenses for transfer between Hobart and Launceston range between $350 to $700.

Previously, the Coroner's transport service would transport the deceased from Hobart to Launceston, but as coronial services are being consolidated to Hobart this no longer occurs.

Costs associated with interstate transfers and repatriation of the deceased back to King Island or the Furneaux Group Islands range between $1200 and $2,200. More complex repatriation requirements such as embalming due to delays in releasing the body for transport (such as the need for quarantine periods since the COVID-19 pandemic) can further increase costs.

Concerns about the variation in costs associated with repatriation services have been raised by senior managers. Some feel that repatriation service providers may be tailoring their prices to increase revenue. On the other hand, the PTAS Advisory Committee have recently discussed streamlining administration of the PTAS subsidy to provide an upfront lump sum payment to funeral directors for the provision of services.

The THS is reliant on a small group of private funeral director services for the repatriation of the deceased. In order to standardise PTAS repatriation costs and minimise administration burden PTAS management can choose to:

1. work with the Tasmania branch of the AFDA to develop and agreed costing arrangement for PTAS eligible patients; or
2. provide clear subsidy limits that recognise the variation in costs between:
    - ground travel only repatriation within Tasmania; and
    - air and ground travel for interstate repatriation and repatriation of the deceased to King Island or the Furneaux Group Islands.

We recommend that PTAS management work with Tasmanian Funeral Directors, through the Tasmanian Branch of the AFDA, to develop a standardised costing arrangement for PTAS eligible patients.

We also recommend in lieu of any formal arrangement between PTAS and Tasmanian Funeral directors services that revised subsidy caps for repatriation of the deceased are implemented (as described in the revised Operational Protocol) to more clearly differentiate maximum subsidy rates permitted for a) repatriation within mainland Tasmania and b) repatriation from interstate or to the remote islands of Tasmania.

8. Addressing socio-economic barriers to access

PTAS provides financial assistance that is targeted towards those who are most affected by high travel costs, and have greatest need for financial assistance. The intent of the PTAS Policy is to reduce financial barriers to accessing specialised clinical care.

PTAS applicants were asked through public consultation how well PTAS supports those who need it most? Two thirds of applicants provided responses indicating they believe that PTAS provides suitable support. One third believe PTAS does not provide suitable or sufficient support for those who need it most.

Table 9: Public consultation - how PTAS supports those who need it most

How well do you think PTAS supports those who need it most?

Provides suitable support	**Does not provide suitable support**	**Provides some/partial support**	**Unsure**
169	32	26	2
67%	17%	14%	2%

When asked 'in what ways could the Scheme be delivered differently to ensure support is provided to those with most need?' key response themes included reducing out-of-pocket expenses by increasing up-front payments, minimising gaps between actual costs and subsidies, and improving timely reimbursement.

8.1 Reducing out-of-pocket expenses

Abolishing patient co-contributions for individuals with low income

PTAS requires concession cardholders to provide a co-contribution when accessing financial subsidy. No other jurisdictional patient travel assistance scheme requires concession cardholders to provide a co-contribution. Means-tested concession cards identify individuals with low income as determined by the Australian Government.

Persons with low income (verified as those holding a means-tested concession card issued by the Australian Government) should not be required to provide a PTAS co-contribution.

The financial impact of abolishing co-contributions for concession holders, as described in Section 5, is $370,000 per year, representing 4% of the annual PTAS subsidy costs. This cost could be fully offset by savings resulting from re-direction of excess interstate referrals to Tasmanian services, also identified in the analysis in Section 5.

We recommend that co-contributions are abolished for holders of approved means-tested concession cards as described in the revised Operational Protocol.

We also recommend that co-contributions continue to be applied to non-concession cardholders at the capped rate described in the revised Operational Protocol.

Increased opportunities for upfront payment of eligible subsidies

PTAS approved applicants can request PTAS staff make air transport, ferry transport and accommodation bookings on their behalf. When bookings are made by staff, patients do not incur the full cost of the travel but rather are only required to pay any gap between the cost of travel and the PTAS subsidy amount.

If patients choose to make their own travel arrangements, they are required to pay the full upfront cost of travel and seek reimbursement from PTAS.

The revised Operational Protocol, PTAS Patient Guideline and PTAS User Guide (all attached) recognise that patients may choose to make their own bookings, but also emphasise that high-cost travel bookings (air, ferry and interstate accommodation) should be booked by PTAS, as this reduces up-front travel costs to patients.

Currently, PTAS approved patients are required to pay up-front for transport costs associated with private vehicle travel and taxi travel. Once patients have incurred these costs, they can claim the PTAS subsidy.

Stakeholders provided clear feedback that upfront taxi costs can be a source of financial hardship for patients. Further, the current Operational Protocol does not clearly define when taxi travel is PTAS eligible and at what rate the reimbursement is provided. This can result in patients incurring taxi costs that are subsequently not eligible for reimbursement, adding to issues of hardship.

The revised Operational Protocol clearly describes when taxi travel is permitted and the rates at which taxi travel is reimbursed. The reimbursement is provided as a taxi allowance which can be issued as a voucher at the time of application approval (normally prior to travel) to reduce out-of-pocket costs associated with taxi travel. The allowance can also be paid after travel for those who claim for travel expenses retrospectively.

There is a small group of PTAS eligible patients for which upfront petrol costs are a source of hardship. While the revised Operational Protocol continues to support reimbursement of private vehicle transport costs after the cost has been incurred, it does allow for alternative arrangements in the event of hardship (see Section 8.5)

We recommend that upfront payment of eligible subsidies is increased by: improving patient awareness that air, ferry and accommodation bookings can be made by PTAS staff (as described in new and revised PTAS materials at Attachments 1, 3 and 4); and by providing taxi vouchers in advance of travel for eligible applicants, as described in the revised Operational Protocol.

8.2 Revision of subsidy rates

PTAS rates of subsidy have not been revised since July 2014. The ‘All Group CPI’ measured by the Australian Bureau of Statistics increased in Hobart by 14.9% between September 2014 and September 2021. The increase in Melbourne for the same period was 13.2%.

We identified the weighted indexation rate for PTAS costs from 2014 to 2021 at 7.56% based on average CPI increases in Tasmania for intrastate subsidies, and average CPI increases in Melbourne for interstate subsidies.

Revised travel and accommodation subsidy rates are provided in Table 10.

Table 10: Travel and accommodation subsidy rates

Subsidy type	Subsidy amount
Private vehicle subsidy	$0.24 per km
Accommodation subsidy (Tasmania)	$76 per night
Accommodation subsidy (interstate)	$98 per night

In recognition that PTAS patient contribution rates are more onerous than similar schemes in other jurisdictions, contribution rates have not been indexed.

Table 11: Co-contribution rates

Subsidy type	Co-contribution amount
Travel subsidy	Patients contribute the first $83 towards the cost of each patient return journey. Patient contributions are capped at $330 per financial year.
Accommodation subsidy	The patient and approved escorts meet the total cost of the first two nights' accommodation per travel journey.

The financial impact of the revised subsidy rates described in Table 10 is $637,000 per annum. This figure is based on the average travel reimbursements (2018-20), less patient contributions (by non-cardholders only) with a whole PTAS weighted indexation rate of 7.56% applied, which includes indexation of reimbursements for private vehicle and accommodation subsidies, but not air or sea travel. To ensure PTAS subsidy rates continue to align with rising costs of living, they should be subject to indexation review every three years, based on changes in All Group CPI.

The cost of indexation can be fully offset by savings identified from redirecting excess interstate travel to Tasmanian specialists (as described earlier in Section 5).

Reimbursement cost impact of proposed PTAS changes

To support the objectives of the scheme of supporting access to specialist clinical services for financially disadvantaged Tasmanians and geographically challenged communities and sustaining and developing Tasmanian clinical services it is proposed that:

- The cardholder patient contribution be discontinued.
- PTAS subsidies are not provided to attend private clinical services interstate.
- A standard statewide target, based on RHH rates for referrals to mainland public hospitals is established.
- Private road travel and accommodation is indexed at 14% (equivalent to 7.56% for all PTAS reimbursements) to cover the period since last indexation in 2014.

- Private road travel and accommodation is indexed every three years at the aggregate CPI change for Hobart.

Table 12 shows the projected impact of these changes.

Table 12: Projected PTAS costs with change to reimbursements

Annual average 2018-20	Nett travel reimbursements $8,504,176	Net change
Redirection to Tasmanian private specialists from Victorian private specialists	$7,737,805	Saving of $766,371
Achieve standardised rate of referral to Victorian public hospitals	$6,971,982	Saving of $766,723
Cease cardholder contributions	$7,353,959	Cost of $382,877
Indexation at each 1%		Cost of $84,280
Average indexation weighted at 7.56%	$7,991,164	Cost of $637,205
Projected annual cost using baseline of average of 2018-20	$7,991,164	Saving $513,012

By redirecting PTAS support for interstate travel back to Tasmanian services over $1.5M could be saved annually. This amount represents the difference in costs between interstate and intrastate referrals. These savings could be used to fully offset costs associated with abolishing concession card holder contributions ($383,000), and indexing the subsidy rates ($637,000) resulting in an overall saving to PTAS of $0.5M per annum.

We recommend that PTAS subsidy rates are indexed, as documented in Appendix A of the revised Operational Protocol, in recognition of the increasing cost of living since the rates were last reviewed in July 2014. We also recommend that rates are subject to indexation review every three years, to ensure subsidy levels maintain currency.

8.3 Promoting subsidised accommodation providers

There is a small group of accommodation service providers in Tasmania that specifically cater for those who need to travel to access clinical services and provide accommodation, close to major hospitals, at significantly reduced rates compared to other accommodation providers (see Section 7).

PTAS staff and PTAS documents encourage the use of subsidised accommodation as a way to reduce ‘gap’ costs between actual accommodation costs and PTAS subsidy rates.

Opportunity exists to increase patient awareness of subsidised accommodation options through improved promotion of subsidised accommodation providers on the PTAS website (see Recommendation 19).

8.4 Timely reimbursement with clear remittance advice

The current PTAS Operational Protocol does not describe the timeframes in which application approvals and claims should be processed. Further, performance monitoring measures do not include key performance indicators relating to timeliness of service provision.

The current average wait time for payment of PTAS subsidies is 6-8 weeks after successful lodgement of a claim. Claim wait times have been impacted more recently due to challenges with PTAS staff turnover and subsequent recruitment process delays, and travel co-ordination complications associated with the COVID-19 pandemic. Applicants, staff and stakeholders all agree that processing times are currently too long.

Delays in processing application approvals and subsequent claims results in delay in payments to patients, and increases the time that patients are out-of-pocket for travel-related costs. Delays in reimbursement can be a source of financial stress for patients, particularly those who are required to travel frequently or travel long distances. Staff often field calls from applicants who are seeking information about when their claims will be paid.

Timely processing of claims requires an efficient approval and claiming process and clear guidance on acceptable time frames for each step.

The revised Operational Protocol describes the time frames within which applications are assessed, processed and claims for reimbursement are paid (Attachment 1).

It requires that patient claims for approved travel are paid within 20 working days of lodgement of a completed claim (PTAS Application Form Section 3) and required receipts.

Applicants are informed of these time frames in the newly developed Patient Guidelines.

The performance monitoring schedule documented in the revised Operational Protocol provides key performance indicators for the timeliness of service delivery, in line with these requirements, and forms part of the performance monitoring suite for PTAS.

Applicants are informed of these time frames in the newly developed Patient Guidelines.

We recommend that PTAS applications and claims are processed by PTAS staff in accordance with the time frames documented in the revised PTAS Operational Protocol, in order to provide applicants with clarity of processing times and to reduce out-of-pocket wait times for reimbursement.

Currently, PTAS subsidies are paid as a single sum and the components of the payment amount (for example flight, accommodation and road travel) are not itemised in the remittance advice provided by PTAS staff using the Finance One system. Further, the remittance advice provided does not include a claim reference. This can be problematic for patients who frequently claim PTAS subsidies as they experience difficulties in reconciling their payment amounts with their claims. We suggest that the PTAS Manager work with PTAS staff to develop an approach to improve the remittance advice provided to patients through the Finance One system, particularly for those patients with a high frequency of claims.

8.5 Responding to socio-economic hardship

Current PTAS financial assistance approaches do not have sufficient flexibility to adequately address, or respond to, individuals who are experiencing complex socio-economic issues associated with transport disadvantage or hardship more broadly. Further, PTAS staff are administratively trained and not equipped to navigate application of PTAS beyond the pathways described in the Operational Protocol.

Social workers are equipped with the specific skill-set required for identifying the right support for individuals experiencing complex socio-economic issues, and can, if necessary, connect patients with support and services beyond those which are offered by PTAS.

Social workers, particularly those working in the acute public hospital sector, already support patients informally to navigate access to PTAS, and will, at times, advocate for patients when they feel PTAS outcomes have not met the needs of specific individuals.

PTAS decision making for patients with complex socio-economic needs, requires more formalised input from social workers. The revised Operational Protocol describes two key pathways in which social work expertise and support is formally introduced to the PTAS decision making process.

Firstly, in response to patients who are believed to be experiencing transport disadvantage, and secondly in response to complex socio-economic issues that warrant referral of an application to the PTAS Advisory and Approval Committee.

Social work consults for transport disadvantage

Transport disadvantage describes a lack of access to transport. An individual can experience transport disadvantage due to financial, social, geographical, or health-related reasons.

Examples of factors that in combination can contribute to persons experiencing transport disadvantage include:

- insufficient income to own or run a car
- residing in a geographical area with low or no access to public transport
- physical, cognitive, immunological, or behavioural issues that prevent individuals from accessing public transport services
- lack of social support (for example, an individual may own a car but be unable to identify someone else to drive them after a procedure).

From time-to-time, PTAS subsidies do not adequately support those experiencing transport disadvantage. These patients require additional or alternative support mechanisms that are beyond that offered through PTAS.

Patients experiencing significant transport disadvantage should be considered on a case-by-case basis, in consultation with a social worker, to identify additional travel options (such as community transport services) or support options (such as fuel cards or taxi allowances) that are suitable for their individual situation. This arrangement is described in the revised Operational Protocol.

We recommend that social workers are formally engaged in PTAS application approval processes, through a process of referral, when patients are experiencing transport disadvantage and their needs cannot be sufficiently addressed by PTAS subsidies alone.

Social work involvement in PTAS collective decision making

As described in Section 3, this review recommends strengthening the role and broadening the remit of the PTAS Advisory Committee, as described in the revised Operational Protocol (see Recommendation 7). This recommendation also includes expansion of the current membership of the Committee to include social work representation. Social work representation is important for broadening the skill-set of the Committee when considering patient-specific socio-economic issues of relevance to exceptional ruling requests, appeals and complaints. Social work input is also required to strengthen the committee's role in ensuring PTAS operates in accordance with the principles of the PTAS policy, and in particular, the principle of patient-centredness.

9. Recognising and responding to remoteness

Residents of King Island and the Furneaux Group Islands (FG Islands) experience some of the most significant barriers to healthcare access due to geographical remoteness.

The Australian Bureau of Statistics determines remoteness based on access to services using the Accessibility and Remoteness Index of Australia (ARIA+). This scale classifies geographical remoteness on a scale of 1 to 5. Classification 5 – very remote, describes the most remote areas of Australia. King Island and the FG Islands are the only geographical areas within Tasmania that are classified at level 5.[8]

King Island and the FG Islands are also uniquely located in the Bass Strait, between the main island of Tasmania and the State of Victoria.

The population residing on King Island and some of the FG Islands (not all islands are populated) is small (approximately 2000 people in total). This population has access to some generalised healthcare services located on the more populated islands, and some visiting primary care services. However, residents have very limited access to allied health services and no access to specialised clinical services. As such, they are required to leave their island of residence to access these services.

PTAS is an important enabler of clinical service access for residents of King Island and the FG Islands. Residents of the FG Islands largely travel to Launceston to access specialised clinical services. This is because the Launceston General Hospital (LGH) is the closest acute public hospital for these residents. The LGH is broadly a Level 5 facility, providing a range of specialised services as described in the Tasmanian Role Delineation Framework (TRDF). Further, residents of the FGI largely have family and support linkages in Northern Tasmania, and flight times between Flinders Island (the most populated island of the FG Islands) and Launceston are short at approximately 35 minutes one-way.

Travel patterns for King Island residents are more variable. The closest acute public hospital service for King Island residents is the North West Regional Hospital (NWRH). The NWRH is broadly a Level 4/3 facility, as described by the TRDF.[9] It provides some specialist services but not the range of specialist services provided at the LGH, as such residents of King Island may fly to Burnie (Wynyard) or Launceston to access the same services as residents of the FG Islands. King Island is located almost exactly between the mainland island of Tasmania and the State of Victoria. Flights times to either destination are roughly the same. King Island residents may have family and support linkages in either Tasmania or Victoria.

Whilst both King Island and the Furneaux Group islands are classified as ‘very remote’, and all residents require air travel to access specialise clinical services, there has been some inequity in the application of PTAS to residents of King Island compared to residents of the FG Islands. ‘Special’ arrangements for King Island residents, have been

[8] https://www.abs.gov.au/websitedbs/d3310114.nsf/home/remoteness+structure

[9] The Mersey Community Hospital (MCH) is located approximately 50km east of the NWRH, it is broadly a Level 3 facility.

in place for a number of years. These arrangements appear to have arisen due to lobbying by individuals to facilitate PTAS subsidy for:

- choice of service, rather than nearest eligible service
- travel to Victoria for residents with private health insurance only
- ground travel costs not currently covered by PTAS (such as uncapped taxi reimbursement)
- access to non-specialised services not available on King Island
- additional accommodation allowances beyond current PTAS levels to facilitate access to other services (health-related or otherwise).

These arrangements, regardless of their validity, must be addressed as they have resulted in a preferencing of King Island residents over the residents of the FG Islands.

9.1 Recognising the needs of very remote populations

Stakeholder and community member feedback from Flinders Island (representing the FG Islands) and King Island was largely positive. KP Health met with key representatives from each island, and undertook a 3-day site visit on King Island, meeting more than thirty members of the community in formal meetings, and many others through informal consultation settings such as local businesses and places of public gathering. Responses indicate that the scheme is valued by people residing on the island, but there are opportunities to improve the scheme to further reduce access barriers to healthcare for populations in the most remote areas of Tasmania.

Key issues of concern for representatives of this population group, were largely similar to those raised by residents of the main island of Tasmania. However, there were some issues specific to the remote island context, these are highlighted in bold below.

Key issues raised include:

- Out-of-pocket costs due to taxi travel associated with flights - the need for up-front subsidised taxi travel for patients (and their escorts) travelling from the airport to their place of treatment (or accommodation if arriving prior to the day of treatment) and return.
- **No PTAS support available for a return trip home during an extended course of treatment (such as cancer treatment lasting 6 or more weeks at a time).**
- Need to simplify and modernise the application process.
- A lack of after-hours support for when travel arrangements change.

Feedback specifically from the King Island community included the need for:

- Quicker refunds to minimise out-of-pocket pressures.
- **Access to services located in Victoria if treatment there is quicker (due to reduced waitlists) and easier (particularly when family support is based in Victoria).**
- **Support for access to preventative healthcare not readily available on the islands (such as dental).**

- More flexibility in determining accommodation needs in light of flight schedules, and pre-medication requirements (such as bowel preparations), and post-surgical recovery requirements.
- Ability for residents to make their own flight bookings interstate.
- Patient choice of clinical service provider and location.
- **Choice of airline for clinical reasons (particularly for patients with orthopaedic issues).**
- Increased information about PTAS and subsidised accommodation options.
- **More visiting healthcare providers – to reduce the need for travel.**
- Review of subsidy rates.
- A better decision-review and complaints process.

Feedback from populations that have a strong reliance on the PTAS and are required to use the scheme frequently, such as residents of King Island and the FG Islands is of particular value, as it provides information specific to the remote context and provides information about the scheme more broadly that may not be identified through feedback from patients who use the scheme more sporadically or have access to additional travel support options.

9.2 Addressing the specific needs of very remote populations

It is important to address the specific access needs of very remote populations whilst retaining the overall principles of equity and consistency of the scheme for the broader Tasmanian population.

For this reason, issues identified that have broad application to the Tasmanian population have been addressed in the body of the revised Operational Protocol so that, where possible, eligibility criteria and financial assistance rules are the same for all Tasmanian residents, promoting consistency, equity and ease of administration.

For a small number of issues that are very specific to the King Island and FG Island population, a specific sub-group of modified eligibility criteria for residents of King Island and the FG Islands have been developed. For reasons of equity these modified eligibility criteria apply equally to all residents of King Island or the FG Islands.

Many of these eligibility criteria align closely with current practices (on one or more of the islands) and have been revised for clarity and equity. These include:

- additional maternity support, including subsidies for off-island confinement periods and obstetric care
- provision of additional travel support to return home during extended treatment periods.

More significant changes include:

- a broadening of the nearest eligible service exemption – from privately insured residents only to all residents regardless of private health insurance status.
- introduction of travel subsidy support for access to allied health and preventative health services.

9.3 Nearest eligible service exemption

Currently residents of King Island with private health insurance are eligible for PTAS subsidies to specialised clinical services in Victoria or Tasmania, whereas those without are not eligible. Residents of the FG Islands are not eligible, regardless of private health insurance status. This special arrangement creates inequities in a publicly-funded program based on island of residence and private health insurance status.

The purpose of the nearest eligible service criteria is to support patients to access appropriate services that are close to home. This reduces unnecessary travel and supports the sustainability of the Tasmanian health system network.

For practical reasons and equity, island residents should be permitted to travel to eligible services located in either Tasmania or Victoria, as:

- Island residents are required to fly to access specialised services regardless of destination, as there are no specialised clinical services on island.
- The distance between Tasmania and King Island is approximately equal, and it is often more cost effective to fly to Victoria from King Island.
- Patient support networks can be located on either island and patient support networks are particularly important for populations groups that require longer stays away from home (such as during maternity confinement, post-surgical recovery, active rehabilitation, oncology and dialysis treatment).
- The design of aircraft used for travel to Victoria is more appropriate for patients with specific orthopaedic needs.
- Historical arrangements mean that patients (particularly those residing on King Island) have established relationships with clinical providers based in Victoria.

Allowing residents of the islands to travel to services located in either Tasmania or Victoria (noting interstate private clinical services are not eligible services) is expected to have a minimal effect on the sustainability of the Tasmanian heath service due to the very small population residing on the islands.

Allowing residents of the islands to travel to services located in either Tasmania or Victoria is also expected to have a minimal effect on the cost of the scheme. As identified in the data analysis provided at Section 5, for King Island residents the average total PTAS subsidy per journey is significantly less for interstate travel ($593) compared with intrastate travel ($804) For Flinders Island, interstate travel is only somewhat more expensive that intrastate travel with an average total PTAS subsidy of $637 for interstate travel compared with $518 for intrastate travel.

9.4 Support for access to allied health and preventative health services

Residents of King Island and the FG Islands experience unique challenges to accessing allied health services and some preventative health services. Access to these services on island is very limited. There are few services located on the islands and the small number of visiting services can have long waiting lists and high out-of-pocket costs.

Residents require support for, at least, annual access to allied health services such as optometry, dental, podiatry, diabetes education and psychology. Further periodic access

to preventative health services not routinely available on the island such as skin checks and dental services. Whilst these services are not eligible clinical services for the purposes of PTAS more broadly, there is clearly an opportunity to assist island residents with access to these services by providing additional accommodation support (up to 48 hours) to enable patients to access these services before or after a PTAS approved journey.

For those residents that have not left the island on PTAS approved travel for 12 months or more (6 months or more for children aged 14 years and younger) a specific, time-limited journey for access to allied health and preventative health services should be supported to enable appropriate access to supportive health care and assist towards reducing the prevalence and acuity of future presentations.

We recommend that eligibility criteria for PTAS subsidy are modified for residents of King Island and the FG Islands (as described in the revised Operational Protocol). These modifications recognise the unique health care access needs of very remote island communities, and the practicalities associated with off-island travel.

It is recommended that:

- Equitable eligibility criteria are applied for residents of King Island and the FG Islands.
- There is a broadening of the nearest eligible service exemption to all residents of King Island and the FG Islands regardless of private health insurance status.
- There is an extension of the travel subsidy support to facilitate access to allied health and preventative health services at least annually for adults, and twice yearly for children.

10. Enhancing communication

10.1 Improving awareness of the scheme

Awareness of PTAS among the general public is low. Information about PTAS is publicly available on the PTAS website and within the Tasmanian Government Concessions Guide. However, patients with no previous experience of PTAS are usually unaware of the scheme until informed by a healthcare provider (at the point of referral, or at the point of specialised service provision) or by ad-hoc communication from others who are aware of the service (such as family or friends).

As such, there is a strong reliance on health care workers, particularly referring general practitioners, specialist medical practitioners, and hospital healthcare workers to assist in identifying eligible patients and informing them of PTAS. Despite this reliance, the PTAS service does not have a clear communication strategy for this important stakeholder group.

A pro-active communication approach with healthcare providers is required, with resources that support them to easily promote the scheme to those who have greatest need of it, as part of their usual interaction with patients. If healthcare providers are not confident regarding the intent, process, and value of the scheme they will be more reluctant to speak to their patients about it.

Further, if key healthcare providers, such as referring general practitioners and medical specialists, are not kept informed of changes to the scheme, particularly those that affect their patients, confidence and support for the scheme will be eroded.

A patient awareness brochure (see Attachment 5) has been developed as part of this review to assist healthcare providers to introduce PTAS to patients that may benefit from PTAS support.

We recommend that PTAS management engage with Primary Health Tasmania to design and implement an effective communication strategy between the PTAS service and referring general practitioners and medical specialists, to support improved awareness of the scheme and to increase information sharing as the scheme changes over time.

10.2 Clarifying the intent of PTAS in public documents

Responses from consultation with the public, and review of the PTAS issue register demonstrate that, for those that are aware of PTAS, there is a lack of clarity about the intent of the scheme.

In particular, some applicants are not aware that PTAS:

- Provides a subsidy only – and is not a full cost attribution scheme.
- Provides a subsidy for specific transport and accommodation costs only - and does not subsidise other costs that may be incurred during travel such as meals, parking, and excess baggage.
- Provides subsidies to the nearest eligible service – not the patient's choice of service.

- Supports the sustainability of the Tasmanian health system – and as such, does not subsidise access to interstate health services, except where eligible services are not available in Tasmania.

It is essential that public messaging about PTAS consistently reinforces the intent of the policy, as this maintains consistency of messaging and supports ongoing expectation management of the scheme.

Inconsistent application of the Operational Protocol in the past has driven variation in public expectation of PTAS support, particularly in the North West of Tasmania. Later attempts to 'rein-in' the scheme has been met with strong resistance from some applicants. This situation has potentially been exacerbated by a lack of pro-active communication with applicants about the intent and boundaries of the scheme.

Prior to implementing the changes recommended in this review, it will be important to communicate the policy intent of PTAS in a way that is easily understood by members of the public and other stakeholders more broadly.

The patient travel scheme in the Northern Territory uses a brief cartoon video to educate members of the public (and other stakeholders) about the intent of their scheme. The cartoon uses a relaxed conversational delivery to communicate the aim and intent of the scheme. It also establishes the boundaries of the scheme by directly raising and responding to common misunderstandings. A visual communication tool, as part of a co-ordinated communication package regarding PTAS, could assist in re-educating the public and stakeholders about the intent of PTAS. It could be made available through the PTAS web page, and be provided to general practitioners for use in waiting rooms and in patient waiting areas of the hospital (such as outpatient clinics and emergency departments).

We recommend development of a resource (in addition to the consumer awareness brochure developed as part of this review) to clarify the intent and boundaries of PTAS and directly address misunderstandings about the scheme. We suggest that a short visual communication tool such as a video clip that could be used to assist with disseminating this message to the public through the PTAS website and amongst stakeholders more broadly.

10.3 Improving communication with patients

Communication to support the application process

Potential applicants are directed to the PTAS website for information about the scheme, to access the application form, and for information about accommodation options in Tasmania. However, the information provided on the website is not current or patient-friendly. While some documents may be intended for a patient audience (such as the brochures and 'frequently asked questions' document) the actual content of these documents does not effectively support patients to navigate the scheme.

The patient communication documents currently in use on the PTAS website have been revised, as part of this review, to include content that aligns with the revised Operational Protocol and improves accessibility and utility for patients.

The patient information brochures and frequently asked questions documents have been replaced with a patient awareness brochure and Patient Guidelines document. The patient awareness brochure is a high-level communication tool designed to introduce PTAS to those who are unfamiliar with it. The Patient Guidelines document is designed to explain the eligibility and process requirements of the scheme and its financial assistance provisions.

These documents have been drafted with support from plain language experts with a focus on:

- Clarity of purpose.
- Ease of comprehension.
- Reduced duplication.
- Simplified messaging.
- Improved visual appeal.

The PTAS Application Form has also been revised to align with the revised Operational Protocol and to improve: clarity of process, ease of use, and enhance data collection.

We recommend the content of the PTAS website is revised for improved clarity of messaging and enhanced accessibility for members of the public. We also recommend that the Patient Guidelines document (Attachment 3) and patient awareness brochure (Attachment 5) are submitted to an appropriate consumer forum for feedback, and once finalised are made available in hardcopy and electronic versions.

Notification of assessment

There is currently no clear process by which patients are notified that their applications (or claims) have been approved or declined. As application approvals can be made by various staff according to the nature of the application (for example simple interstate applications are approved by Patient Support Officers whereas complex interstate applications are approved by Medical Authorisers). It is important that a process is documented to identify who is responsible for notifying the patient of the assessment outcome and how they are notified. Further, there are no clear timeframes stipulating the timeframes for notification. All applicants should receive notification of the outcome of their application or claim assessment in writing within a specific time period.

The revised Operational Protocol articulates who is responsible for patient notification at each step in the approval process and the time frames for processing and notification. This information is further reinforced in the process flow diagrams provided in the Staff User Guide.

Notification of non-approval

Communication with patients whose applications or claims have been declined should be handled with particular care. We reviewed a sample of letters provided to patients that were not approved for PTAS subsidy and note that:

- The reason for application non-approval was unclear - patients were directed to a section heading reference in the PTAS Operational Protocol and not provided with any specific information on the protocol content or why their application did not meet the protocol requirements.

- In some instances, patients were referred back to their referring specialist for information, rather than a PTAS staff member.
- Patients were not provided with any avenue for appeal.

It is essential that notification of a declined application or claim is accompanied with sufficient reasoning, specific to the context of the application. It is not satisfactory to refer patients to another source to interpret for themselves. Letters of non-approval must include an opportunity for applicants to discuss the outcome with a member of PTAS staff and include information about how an application can be resubmitted if it meets the requirements for an exceptional approval ruling or can be appealed.

A selection of carefully written templated letters may be appropriate for notification of less complex applications that are clearly outside of PTAS eligibility criteria. These letters should provide clear information about the overarching intent of PTAS and the specific eligibility criteria that has not been satisfied.

For example, for patients seeking PTAS subsidy to attend a specialist in Hobart when the nearest eligible specialist is in their home city of Launceston, the letter should describe a PTAS policy intent statement such as

PTAS supports access to specialised healthcare services as close to home as possible. As such PTAS subsidies are available to the nearest eligible clinical service. As the nearest eligible service for your requirements is located in Launceston which is within 75km from your home, your application does not qualify for PTAS assistance.

If you believe that your application may qualify for an exceptional ruling, for specific medical reasons, please resubmit your application with any additional supporting information to your local PTAS Office. For more detail regarding the exceptional ruling process and criteria see the attached PTAS Guideline for Patients or contact the PTAS office on the number listed at the top of this letter.

For information on how to lodge an application for appeal of this decision please visit the PTAS website (insert link) or contact your PTAS office for advice on how to lodge an appeal.

More complex application decisions that required consideration by a Medical Authoriser or communication between the Medical Authoriser and the referring doctor, require a more nuanced and carefully developed letter of notification. It is essential that these letters are compiled with input from the Medical Authoriser, and address the specific details of the application that are not eligible. A copy of the letter should also be provided to the patient and their referring doctor.

We recommend that patients are notified of the outcome of the application or claim assessment in writing, and in a timely manner, in accordance with the processes for approval described in the reviser Operational Protocol and as detailed in the process flow charts in the PTAS User Guide.

We also recommend that the content of letters of notification for applications and claims that are not approved include, at a minimum:

- Clear reasoning as to the specific reason why the application was not approved

- Opportunity to resubmit with more information (if relevant)
- Advice on how to contact the PTAS office for more information
- Information on how to appeal a PTAS decision.

In addition, we recommend copies of letters of application non-approval are also provided to referring doctors for their information.

11. Responding to appeals and complaints

In recent years PTAS has been the subject of an increasing level of patient complaints. The scheme does not have a robust appeals and complaints management process. As such, some patients who feel aggrieved by PTAS decisions raise their issues with executive staff, their local member of parliament, or with local media.

Responses to ministerial correspondence or media reports are further complicated as PTAS does not have a collective decision-making approach for complex application requests (see Recommendation 7). As such responses to ministerial correspondence or media scrutiny have been described at times as 'reactionary', sometimes resulting in occasions of over-ruling of Medical Authoriser decisions and issue of 'special' arrangements for some applicants. These responses, whilst not the norm, appear to be driven by a desire to avoid further political or media pressure, rather than based on the intent and purpose of the scheme.

11.1 Strengthening the appeal process

All PTAS applicants have the right to appeal the outcome of their PTAS application for approval or their claim for reimbursement. Unfortunately, applicants have not been made aware of this fact. Recommendation 32 requires that all patients with declined applications are provided with information on how to appeal a PTAS decision.

The process of appeal is an important mechanism to ensure PTAS is applied in accordance with the intent and principles of the scheme. Failure to provide a robust system of appeal undermines patient, stakeholder and political trust in the scheme. The current PTAS appeals process, as documented in the Operational Protocol, is not appropriate:

- It is outdated and no longer reflects the governance arrangement of the scheme.
- It does not clearly differentiate between an appeal and a complaint.
- If requires applicants to lodge their appeal to the same decision-makers involved in the original assessment (either PTAS Co-ordinator in the first instance or Medical Authoriser in the second instance).
- The escalation pathway describes up to six different parties that the patient may escalate their appeal through:
    - PTAS co-ordinator
    - Regional Medical Authoriser
    - PTAS Operational (Advisory) Committee via the Medical Authoriser
    - The THS CEO (for urgent or unresolved issues, position title no longer correct)
    - The Office of the Health Complaints Commissioner
    - The Deputy Secretary, System Purchasing and Performance (for policy issues, position no longer exists)
- Provides no detail about how to submit an appeal.
- Does not describe the process by, or timeframe within which, appeals are considered.

- Does not provide any information about how the appellant is notified of the outcome.

A new PTAS appeals process has been developed as part of this review (see the revised Operational Protocol). It provides a single point of appeal lodgement, independent review of PTAS decisions, an escalation pathway for collective decision making through the PTAS AAC (where required), and clear time frames for assessment and notification.

Information about appeals and appeal outcomes are an important source of information, as such, appeal data should be recorded and reported. The revised appeal process includes tabling of PTAS appeal outcomes at the PTAS AAC for ratification and ongoing approval consideration, and reporting of appeals trend data to inform ongoing PTAS performance monitoring and review.

We recommend that a robust process of appeal is implemented for PTAS in accordance with the revised Operational Protocol, to ensure consistency and fairness in decision making and to provide applicants with an avenue to respond to decision outcomes. Further, we recommend that record keeping and review of appeals data is maintained and used to support improved decision making and inform future revisions of the Operational Protocol

Patient compliments, complaints and feedback

Patients are to be encouraged to lodge their compliments, complaints or feedback with their local PTAS office or via the 'compliments, complaints and feedback' process co-ordinated by the Quality and Patient Safety Service (QPSS).

Complaints lodged with QPSS staff are captured in the consumer sub-section of the agency-wide Safety Reporting and Learning System (SRLS), and then assigned to the Statewide Manager HIMS and the Statewide Manager PTAS for action.

PTAS staff are in the process of being trained to upload patient complaint data, received directly to the PTAS offices, using SRLS. This will facilitate the collection of all complaint data into a single database for ease and completeness of reporting.

PTAS complaint data, as yet, has not been compiled or analysed for quality improvement purposes. Once SRLS training is complete and reporting processes are established, regular trend analysis should be introduced to assist with identifying emerging barriers to access and inform quality improvement activities.

To support continuous quality improvement, we recommend that aggregate patient complaint data is analysed and reported to the PTAS AAC at least annually, in accordance with the requirement of the performance monitoring schedule documented in the revised Operational Protocol.

12. Towards implementation

Successful transition to the revised Operational Protocol and accompanying resources will require a comprehensive communication strategy to provide stakeholders, including members of the public, with awareness of the scheme and key changes to current arrangements.

A clear and compassionate process of change management is also required for specific patients who will be affected by the change.

Whilst the resourcing of PTAS operational staff, and the implementation of the revised scheme is not within the remit of this review, we make the following suggestions for consideration by the THS.

Resourcing

Successful implementation of the recommendations of this review and the revised Operational Protocol will require resourcing support. Failure to allocate resources to support these aims will risk achievement of the intended outcomes of this review being: enhanced client satisfaction, strengthened PTAS controls and enhanced staff satisfaction.

When determining revisions to the Operational Protocol consideration has been made to the impacts on clinical quality and safety, administrative efficiency and appropriate financial controls. Where possible decisions have been made to decrease patient impacts through improved patient-centredness, decrease administrative impact through the streamlining of processes, and reduce the impact on clinicians through judicious use of this resource. Despite these aims, there will be necessary trade-offs that may directly impact resourcing requirements and the THS should consider these impacts as part of a pre-implementation transition plan.

We recommend that PTAS staff roles and responsibilities as described in the revised Operational Protocol and detailed in the PTAS User Guide are reflected in the Statement of Duties for relevant positions, and note that some roles may require classification review as a result.

Communication

Prior to transition to the revised arrangements, the THS should develop a comprehensive communication plan that provides targeted communication with key stakeholders, and where appropriate, provides an opportunity for two-way communication between the THS and PTAS stakeholders. The communication strategy should include the following groups as a minimum

- PTAS staff
- members of the PTAS Advisory and Appeals Committee
- relevant THS healthcare workers: including after-hours nurse managers, social workers, clinical service providers and associated educator staff, reception staff particularly in areas such as ambulatory care, emergency care, paediatrics, oncology, and cardiology

- external healthcare workers: including general practitioners, private specialists and their support staff
- service providers: including subsidised accommodation providers, and funeral service directors.
- key patient support groups and representative agencies
- local government representatives
- regular or current applicants of the scheme
- members of the general public, as part of an overarching public awareness strategy.

To ensure consistency of implementation PTAS administrative staff, and clinical decision makers will require effective training to support them to understand the changes to PTAS eligibility criteria, financial rules and rates, and PTAS related processes. This training should also include support to clearly communicate changes to the scheme when responding to requests for information or advice from patients and other key stakeholders.

Proactively identifying and responding to patients directly affected by change

Patients who are regular PTAS applicants, or are currently approved for PTAS subsidies, and will be affected by the revision of the scheme require special consideration and notification.

We recommend that where possible PTAS staff identify patients or patient groups who will be affected by specific changes in the revised protocol, and suggest the PTAS AAC endorse specific communication and transition strategies to compassionately assist these patients with change. This may include:

- Providing a transitional period – where existing applicants are approved for a period of time using former rules (up to 12 months) but made aware that it will change for future applications.
- A grandfathering arrangement for specific patient types or groups for which established health care access patterns will be difficult to change and risk a lack of health care continuity (for example PTAS applicants who have received a PTAS subsidy to access the same clinical service provider for 5+ years).
- Offering exceptional ruling opportunities to those who have received subsidies based on the previous rules and believe their arrangement should be retained for clinical reasons.

It is important that the revised Operational Protocol is implemented slowly and compassionately to facilitate acceptance of the revised scheme long-term and to ensure the revisions do not result in people experiencing unnecessary barriers to service access, which would be counter to the intent of the scheme and the principles that underpin it. It is also important to communicate with these patients early about the changes, the impact on their situation, and the available transition options to prevent unnecessary distress for existing patients and those in their support network.

Appendix A: Stakeholders consulted

We wish to acknowledge the following stakeholders who participated in consultation meetings as part of the PTAS review.

Stakeholder	Description
PTAS Staff	PTAS Manager PTAS Co-Ordinators PTAS Service Officers
Staff of the THS/Department of Health	Social Work Managers, RHH, LGH, NWRH/MCH After-hours Nurse Managers, RHH, LGH, NWRH/MCH Medical Authorisers, North, South, North-West, Statewide Statewide Manager, Health Information Management Services Director, Strategy and Projects, Business Improvement and Reform Executive Director, Business Improvement and Reform Nursing Director, Quality and Patient Safety, Clinical Quality Regulation and Accreditation Director, Finance and Procurement Manager, Service Development, Clinical Quality Regulation and Accreditation Deputy Secretary, Clinical Quality, Regulation and Accreditation Director of Nursing, King Island Hospital and Community Health Centre
Other stakeholders	Chair, King Island Hospital and Health Centre Community Reference Group King Island residents (34) Mayor, King Island Council General Manager, King Island Council Mayor, Flinders Island Council Director of Nursing, Flinders Island Multipurpose Centre General Practitioners, Ochre Health King Island General Practitioners, Ochre Health Flinders Island Manager, Marillac House Manager, Ronald McDonald House Manager, John Opie House Manager, Argyle Accommodation Executive Officer, Spurr Wing Chair, Rural Health Services Inquiry President, Tasmanian Division, Australian Funeral Directors Association

We also wish to acknowledge the 242 members of the public that responded to the PTAS public consultation issued by the Department of Health. Responses to this consultation process were considered as part of this review.

We also wish to acknowledge those who made submissions to the Legislative Council Rural Health Services Inquiry, submissions relevant to PTAS were also considered as part of this review.

Appendix B: Performance against monitoring framework

This analysis provides available data against the PTAS Monitoring and Performance Measures framework, described in the PTAS Operational Protocol.

The data analysed here were provided by the Department of Health for the 2018-19 and 2019-20 financial years. Health care and interstate travel were substantially impacted the second six months of the 2019-20 year by pandemic related restrictions. Consequently, PTAS expenditure in 2019-20 reversed historical trends of increasing utilisation. The analysis presented here, is according to the context, in distinct years, or as an average of the two years with a view to smoothing out the effect of the disruption in use.

The data provided includes the number of patients who access PTAS, the number of claims made by patients, the number of escort claims and the cost of accommodation for eligible patients and escorts. Data were not available for analysis regarding: applications that were refused and their associated estimated claim amounts. Detailed data for performance planning 'lists' were also not available.

Measure 1: Number and cost of PTAS claims

Table 13 identifies the change in PTAS utilisation from 2018-19 to 2019-20, where there was a 14% reduction in the number of patients and a 11% reduction in claims. This reduction is due to pandemic related restrictions on travel and does not reflect the growth trend for utilisation and cost of the scheme prior to the pandemic.

Table 13: Number and cost of PTAS claims by year

Year	All Cost ($,000)	All Claims	All Cost / Claim
2018-19	$9,387	40,731	$230
2019-20	$7,622	36,226	$210

The total cost of PTAS claims by specialty (Table 14) identifies considerable consistency in the specialties represented in the referrals handled from each of the main offices with paediatrics, cardiology and oncology featuring in the top three for total claims at each of RHH, LGH, NWRH and Devonport and then neurosurgery and orthopaedics at both North West region sites. The differences in referred specialties between regions appear to mainly relate to diagnostics, radiology and anaesthesia, which presumably relates to pain management.

Table 14: Referral specialties, total claims and number of visits, 2018-2020

Hobart Office Specialty	Hobart Office Total claims	Hobart Office Number visits	Launceston Office Specialty	Launceston Office Total claims	Launceston Office Number visits	Burnie Office Specialty	Burnie Office Total claims	Burnie Office Number visits	Devonport Office Specialty	Devonport Office Total claims	Devonport Office Number visits
Paediatric	$1,713,414	985	Paediatric	$624,135	862	Paediatric	$446,523	685	Paediatric	$547,921	772
Oncology	$612,201	889	Oncology	$572,824	1,101	Cardiac	$340,241	1,267	Oncology	$402,850	799
Cardiac	$479,252	483	Cardiac	$302,112	757	Oncology	$157,668	278	Cardiac	$197,772	1,129
Haematology	$394,096	150	Neurology	$260,013	848	Neurosurgical	$140,282	471	Neurosurgical	$140,695	493
Hepatology	$140,564	108	Haematology	$254,417	355	Orthopaedic	$101,663	222	Orthopaedic	$108,201	327
Ophthalmic	$132,118	253	Cardiothoracic	$147,928	203	Neurology	$96,162	417	Renal	$102,399	390
Nephrology	$126,521	68	Obstetric	$145,494	128	Respiratory	$90,511	479	Neurology	$90,518	403
Orthopaedic	$112,450	157	Orthopaedic	$127,159	420	G/E	$83,427	261	Transplant	$87,089	62
Neurology	$108,530	144	Renal	$122,955	220	Urology	$79,314	514	G/E	$86,897	382
ENT	$99,657	151	Neurosurgical	$118,918	366	Ophthalmic	$75,648	246	Cardiothoracic	$66,526	103
Cardiothoracic	$91,880	42	Gen Surgical	$116,445	247	Gen Surgical	$70,968	326	ENT	$59,899	181
Transplant	$88,785	51	G/E	$105,738	362	ENT	$69,085	189	Obstetric	$57,264	73
Renal	$86,181	60	Radiology	$102,201	1,187	Plastic	$52,375	302	Diagnostic	$44,770	460
Urology	$85,663	93	Respiratory	$94,599	335	Obstetric	$49,238	59	Ophthalmic	$41,999	171
G/E	$68,213	102	Ophthalmic	$94,595	648	Haematology	$47,186	130	Respiratory	$40,709	539
Neurosurgical	$62,499	66	ENT	$90,765	237	Anaesthesia	$43,522	144	Anaesthesia	$39,552	164
Gen Medical	$61,297	141	Nephrology	$81,334	104	Anaesthesia	46,633	173	Rheumatology	$35,026	353
Gen Surgical	$60,358	81	Hepatology	$80,309	76	Radiology	45,438	386	Haematology	$33,453	171
Spinal	$58,497	33	Transplant	$56,875	53	Colorectal	44,514	170	Plastic	$32,561	202
Obstetric	$53,507	24	Plastic	$51,804	165	Cardiothoracic	42,822	77	Gynaecology	$31,113	139

*Data for cost per procedure not provided

Measure 4: Number and costs of interstate patient claims

Over 30% of all PTAS claim costs relate to interstate travel by patients. Accommodation costs account for 27% of this amount.

Table 15: Interstate patient claims, 2018-2020

Patient cohort	Total	Accommodation component	Less Patient Contribution	Total payments
Interstate patient (N=9,667)	$2,825,605	$713,000	$179,618	$2,645,987

Measure 5: Number and costs of interstate escort claims

Another 30% of PTAS claim costs relate to interstate travel by patient escorts. For escorts interstate travel accommodation costs account for almost half of all costs (47%).

Table 16: Interstate escort claims, 2018-2020

Patient cohort	Total	Accommodation component	Less Patient Contribution	Total payments
Interstate escort (N=7,681)	$2,571,882	$1.2m	NA	$2,571,882

Measure 6: Number and costs of intrastate patient claims

Intrastate claims by patients constitute 29% of all PTAS costs. Accommodation costs account for 45% of this amount.

Table 17: Intrastate patient claims, 2018-2020

Patient cohort	Total	Accommodation component	Less Patient Contribution	Total payments
Intrastate patient (N=67,290)	$2,972,548	$381,000	$524,607	$2,447,941

Measure 7: Number and costs of intrastate escort claims

Intrastate claims for patient escorts constitute 10% of all PTAS costs. Accommodation costs account for 73% of this amount.

Table 18: Intrastate escort claims, 2018-2020

Patient cohort	Total	Accommodation component	Less Patient Contribution	Total payments
Interstate escort (N=9,778)	$838,366	$608,000	NA	$838,366

Measure 8: Number and costs of patients claims from the Bass Strait Islands

A significantly higher proportion of King Island residents receive PTAS reimbursement for interstate travel compared with residents of the Furneaux Group Islands. This is not unexpected as the current Operational Protocol exempts privately insured residents of King Island from the nearest eligible clinical service rule, allowing travel to Victoria for this specific cohort.

Table 19: Number and costs of claims, Bass Strait Islands

Location	Interstate patients Patients	Intrastate patients Patients	Interstate proportion
Flinders Is	71	1,419	0.05
King Is	459	1,758	0.21
Tasmania	**9,514**	**30,826**	**0.24**

Table 20 shows the referred specialties from the Bass Strait Islands with the highest costs associated with referrals for radiology from Flinders Island Group and diagnostics from King Island. There were higher rates of referrals from King Island for paediatrics and obstetrics.

Table 20: Costs by specialty, Bass Strait Islands, 2018-2020

Flinders Island Specialty	Flinders Island Total claims	Flinders Island Number visits	King Island Specialty	King Island Total claims	King Island Number visits
Radiology	$131,087	310	Diagnostic	$214,115	424
Cardiac	$76,747	157	Paediatric	$156,678	191
Orthopaedic	$60,496	127	Cardiac	$142,838	207
Oncology	$54,879	79	Oncology	$127,989	106
G/E	$48,647	102	Ophthalmic	$106,395	155
Ophthalmic	$43,866	92	Orthopaedic	$106,046	169
Urology	$41,003	76	Gen Surgical	$99,726	132
Respiratory	$25,130	56	G/E	$72,761	114
Gen Surgical	$23,324	50	Obstetric	$66,560	64
Gynaecology	$22,923	56	Respiratory	$54,000	58
ENT	$21,521	40	Urology	$52,379	71
Diagnostic	$17,357	41	Plastic	$43,956	55
Gen Medical	$16,717	36	Haematology	$39,091	42
Cardiothoracic	$15,685	22	Gen Medical	$38,464	55
Paediatrics	$11,782	20	Radiology	$18,445	38

Flinders Island Specialty	Flinders Island Total claims	Flinders Island Number visits	King Island Specialty	King Island Total claims	King Island Number visits
Obstetric	$10,954	14	Gynaecology	$28,011	48
Plastic	$14,296	27	ENT	$18,918	28
Haematology	$2,306	5	Cardiothoracic	$3,968	3

Measure 9: Costs of reduced contribution for health and pension card holders

PTAS patients identified as Health Care Card holders and Pensioners are described in this analysis as Cardholders, who are subject to smaller patient contributions and more generous accommodation payments. The rest of PTAS patients are classified as non-cardholders or abbreviated to 'No Card'. About 80% of PTAS patients are cardholders, while they constitute about 23% of the population

In 2018-19 and 2019-20 patient contributions averaged just over $700k per annum. The average payment was two thirds higher for non-cardholders compared with cardholders, with the patient contribution from non-cardholders representing 13% of their average payment, compared with 6% for cardholders.

Table 21: Payments and patient contribution, concession status, average of 2018-19 to 2019-20

Concession status	Number patients 2018/19 & 2019/20	Number patients 1 year average	Payments 1 year average	Patient contrib. 1 year average	Average payment	Average patient contrib.	Contribution as % of total payment
Card	32,307	16,154	$6,010,103	$369,993	$372	$23	6%
No Card	8,022	4,011	$2,488,711	$334,232	$620	$83	13%
Total	40,329	20,165	$8,498,814	$704,225	$421	$35	8%

Appendix C: Comparative analysis of other schemes

An environmental scan of patient travel assistance schemes in other Australian jurisdictions was performed to provide a comparative analysis with PTAS. The findings of this analysis were used to inform the revision of the PTAS Operational Protocol.

Jurisdictional comparison

Variations in other jurisdictions
Eligibility In general, primary requirements are permanent resident or eligible for Medicare; and also includes: **ACT** - asylum seeker; participating in clinical trial done by eligible medical practitioner. **SA** - permanent South Australian resident, who is enrolled in Medicare and receives treatment claimable through Medicare and travels more than 100km from place of residence to appointment or treatment. **WA** - humanitarian visa holder (subclass 200-204), or eligible for Reciprocal Health Care Agreement Medicare card, more than 100km one way. **QLD** - a student living at a QLD boarding school or university campus, more than 50 km one way from the public hospital / facility closest to their permanent address and be unable to use Telehealth. **NSW** - dual resident who regularly lives in more than one location, such as two homes or a student who is attending boarding school, eligibility based on the location a patient travels from at the time of their appointment. An itinerant worker, has no fixed place of employment and stays in accommodation at their temporary job location, will meet the residency criteria if they are travelling to their appointment from a temporary job location in NSW. A patient with no fixed address will meet the residency criteria if they travel to treatment from a location within NSW. Distance requirements are 100km one way, or 200km in a week. **Victoria** – distance requirements are 100km one way, or 500km in a week. **NT** - need to travel more than 200 km one way or more than 400km cumulativelyin one week (to attend eligible renal and oncology services) to be eligible. The distance is calculated as follows: when residing within town boundaries the distance by road between the home town andthe town or city where treatment is provided; when residing outside a town's recognised boundaries, the distance by road between thepatient's usual residential address and the town of treatment. Minimum distance restrictions do not apply for eligible patients repatriated following an evacuation, retrieval or inter-hospital transfer.
Private patients **SA** - claims will be accepted from clients who have claimed benefits from their private health fund towards travel and accommodation costs provided: the benefit paid by the fund is less than the applicable PATS rate (in such instances, clients will be paid the difference between the benefit paid and the PATS rate); and the client has already claimed the maximum benefit available from the fund. **NT** - Patients who have PHI may access assistance if their referral is to the nearest approved specialist service in the Northern Territory; or a Northern Territory resident specialist has determined that the service is not available in the Northern Territory and has referred the patient interstate. If the patient chooses to travel to a destination for treatment that is not their nearest approved specialist service, they are not eligible for PATS. **WA** – makes no distinction between public and privately insured patients.
Not eligible

ACT - travelling for medical treatment needed while interstate; travelling to seek a second opinion; travelling to receive medical care from a health professional of patient choice when that type of care is available in the ACT either publicly or privately. **NT** - a Fly-in-Fly-out (FIFO) contractor whose permanent residence is not in the NorthernTerritory; are a Medicare Reciprocal Rights Card holder. **SA** - an overseas resident visiting South Australia is not eligible even if they have a Medicare card under a reciprocal health card arrangement. Holiday accommodations are not considered to be permanent residences. Clients who are on holidays or visiting family and friend's interstate or within the state are not eligible for subsidy. **QLD** - travelling on holidays or business and live in another state, this includes fly-in fly-out or temporary workers who are not permanent Queensland residents. **NSW** - patient who stays in a holiday home, regardless of the length of stay, or a patient who relocates during treatment, including to remain on a pre-transplant waiting list, is not considered a dual resident.
Proof of eligibility **ACT / NSW** - registration on the electoral roll, a current driver's licence, or utility accounts or rental receipts showing usual residence. **SA** - residency is determined using a client's principal place of residence (their home), as per their enrolment on the South Australian electoral roll. Documentation including driver's licence, proof of age card, utility bills or concession cards may be requested to confirm the client's permanent residence. **WA** - place of residence is address on the electoral roll, however other documents including driver's license, health care card, or a gas, water or electricity bill may be used as proof of residency if required. If a resident for a limited time, lease or mortgage documents may be used to prove residency.
Closest service **ACT** - must be referred for treatment to the place closest to the ACT where medical care is available from permanent residence, regardless of which state or territory the health service is in. May approve travel to a health service that is not the closest to the ACT if: urgent treatment is needed and the nearest health service unable to provide; the nearest health service refers for a second opinion; the nearest health service has a waiting list and the referrer advises that delaying treatment would likely result in emergency admission or adversely affect patient's health; no escort available and family support available at a more distant health service which would result in better health outcome. **Victoria** - the person's GP is expected to provide a referral to the closest specialist available. If they choose to travel to a different specialist, the subsidies will be worked out as if they were seeing the closest specialist. Uses Google Maps, get directions. Referrals interstate require confirmation from that specialist that service not available in Victoria. **SA** - if there is a visiting medical specialist and the client is unable to be seen locally within a clinically acceptable timeframe, the client will be supported to travel to the visiting medical specialist's primary rooms. The client's GP must provide a valid medical reason to refer to a medical service other than the nearest provider. Special interest in a particular area of specialty or bypassing waiting lists for non-urgent treatment are not considered legitimate reasons to bypass a closer specialist. Referrals to an alternative medical service (not the nearest) are required to meet one of the following criteria for the claim to be valid: the timeframe to be seen locally is clinically unacceptable (in which case the client may be paid subsidies for up to 12 months). The client's clinical risks cannot be managed in a regional South Australian health facility. The client cannot be treated in South Australia (these referrals are only accepted from a SA Health tertiary health site). If a client has been visiting a particular medical specialist and a similar service has since been established closer to the client's home, the client will be advised of the availability of a closer service and that they will no longer be eligible for PATS subsidies if they choose to continue travelling past their nearest specialist when the next claim is lodged.

NSW - a patient may be eligible if the referrer certifies that travel to a more distant health service is necessary for one of the following reasons: a patient needs urgent treatment and the nearest health service is not available; the nearest health service cannot provide the treatment the patient needs; the nearest health service refers a patient for a second opinion; the nearest health service has a waiting list and the referrer certifies that delaying treatment would likely result in emergency admission or have an adverse effect on the patient; a patient needs multi-disciplinary care that is not available at the nearest health service; a patient is unable to pay to access the nearest health service; a patient is not accompanied by an escort and the referrer can demonstrate that the family support available at the more distant health service will provide a clinical advantage to the patient. A visiting or outreach service available in the patients nearest public or private hospital is considered the nearest health service. A patient may be eligible to travel to a more distant location for treatment if the outreach or visiting service is unable to access equipment required for treatment at the nearest location.

QLD - is not the closest if: an emergency: the patient received emergency transportation to the service; historical approval: the patient has previously been approved for financial assistance and a closer service is subsequently available. In this instance, the patient can receive a subsidy for one further visit to the originally approved specialist. The patient may choose to continue to see the original specialist, however, the patient will only be subsidised for travel to the closest service as pernormal eligibility criteria.

WA – Assistance is provided to the nearest available eligible specialist medical service or telehealth service that meets the clinical timeframe specified by the referring or treating doctor. Assistance is provided to the closest private or public medical specialist services. Does not differentiate between public or private specialists. PATS also does not differentiate between face-to-face consultations and telehealth consultations. This means that if the nearest appropriate medical specialist appointment is available by telehealth, will be assisted to attend that appointment if the appointment is more than 100 kilometres away.

Practicality: transport to the closest specialist service is not available or it is more cost effective to refer patients to another specialist. Clinical reason: there is a valid clinical reason to attend. This may include timeliness of treatment at the nearest location.

System-wide strategy: the patient has been selected for a system-wide strategy, such as a wait-list reduction program.

NT - telehealth facilities are available in more than 50 locations in the Northern Territory. Where possible and clinically appropriate, consideration should be given to conducting the appointment via telehealth rather than requiring the patient to travel. Only after attending a Northern Territory based specialist and it is determined the treatment for the medical condition is not available in the Northern Territory or not available within a clinically appropriate timeframe, the patient may be referred interstate for treatment.

Services covered

Victoria - receiving specialist medical treatment from a medical practitioner registered with Medicare Australia and recognised as a specialist in a particular specialty under the Health Insurance Act 1973 (Cwlth) as per Schedule 4 of the Health Insurance Regulations 1975; also approved are: hyperbaric treatment; lymphoedema treatment at the Lymphoedema Clinic, Mercy Hospital, Melbourne, paediatric dental services by a registered dental practitioner at RCH, Monash, W&CH Adelaide.

NSW - Oral surgery is an eligible dental service if it is performed by an eligible dental practitioner in an operating theatre and the patient is under general anaesthesia. Oral and maxillofacial surgery provided by an eligible medical or dental practitioner is an eligible dental service. Dental services provided to patients certified with a cleft lip or palate are eligible. An allied health clinic will be considered highly specialised if the service provided: includes an advance scope of practice by the allied health clinician; is not available outside a few major centres/locations; is generally provided in a public tertiary hospital; is endorsed by a medical practitioner to be provided at a clinic (or a specified clinic location); is part of a regime of care supervised by a medical practitioner; and is provided face to face.

QLD - be unable to use Telehealth to access the required service; and

be referred for specialist health services which are necessary for the health of the patient. Eligible patients who are accessing allied health services as an essential component of their treatment plan, and have been referred by a specialist, are eligible for a subsidy if allother eligibility criteria are met. Allied health services include audiology, clinical psychology, nutrition/dietetics, occupational therapy, orthotics/prosthetics, physiotherapy, podiatry, psychology, social work and speech pathology. Examples include but are not limited to: a visit to an ocularist following eye removal; a visit to a prosthetic specialist following limb amputation; audiology services related to cochlear implant; occupational therapy for burns scar management.

WA – mammography is eligible if referred by a medical practitioner and a screening service is not available within an acceptable time frame, the assessment is covered by the MBS, or referred for diagnostic imaging evaluation of a palpable breast lump or other breast abnormality; Assisted reproductive treatment (IVF) is eligible for referral to specialist treatment covered by an item in MBS, the partner is eligible for assistance if referred to a specialist for an initial consultation and one visit per cycle of treatment as a patient.
Assistance is not available for education, pathology including semen analysis or counselling. Assistance is not available for parties involved in surrogacy including egg donation(s).
Wheelchair applicants eligible for assistance if referred for complex wheelchair assessment and review to medical practitioner, physiotherapist or occupational therapist.
Next Step: inpatient treatment for addiction for initial consultation, not accommodation.
Childbirth clients are eligible for accommodation subsidy before the birth based on a risk assessment undertaken by GP obstetrician or specialist obstetrician. Generally, this will be at about 37 weeks' gestation. Similarly, PATS assistance following birth will be available based on a risk assessment undertaken by GP obstetrician or specialist obstetrician. Generally, this will be available for up to five days following an uncomplicated birth. Extra nights may be approved if prevented from flying after the birth. PATS assistance is not available for an escort unless there are complications that put the mother or baby's life at risk or in cases when the mother and newborn may need an escort to return home, such as after a multiple birth or caesarean delivery.
Dental services for children eight years or under will be eligible for assistance for:

- hospital-based management of severe dental trauma or severe dento-facial infections, such as cellulitis.
- hospital-based dental services if they have a significant medical co-morbidity or other serious conditions

- treatment that requires a general anaesthetic including removal of a tongue tie for a newborn baby by a specialist paediatric dentist in cases where the child is not thriving.

Dental services for adults eligible:

- if they need hospital-based dental services and have a significant medical co-morbidity
- if they have special needs and require general anaesthesia.

Adults are not eligible for standard extractions including wisdom teeth, even if a general anaesthetic is required.
NT - Access to Allied Health services is supported in the following circumstances:
when treatment by an Allied Health service is required in conjunction with intensive or surgical treatment (that cannot be provided locally), assistance may be approved by the delegated officer for up to seven days before or after the intensive treatment or surgery. If further Allied Health treatment is required, the delegated officer, in consultation with the treating practitioner, can approve a further fourteen days of assistance incontinuity with the first seven days (a total of 21 days).

Assisted Reproductive Technology - patients receiving ART treatment for infertility, including In Vitro Fertilization (IVF), are eligible for assistance where there is a diagnosis of clinical primary infertility (WHO definition) within a current and existing relationship; or where there is a diagnosis of

secondary clinical infertility within a current and existing relationship and where a live birth has not been achieved, for example where the patient repeatedly miscarries or has a stillbirth. Access for both definitions ceases on the first live birth.
Medical termination of pregnancy – when a woman requires an early medical termination of pregnancy and does not have access to safe accommodation within two hours' driving time from a hospital emergency gynaecology service she will be eligible for financial assistance at the usual rate. Assistance provided will include transport and accommodation costs and automatic eligibility for an escort. The patient will be covered under the program until the patient is discharged by a suitably qualified medical practitioner. Any further follow up appointments required for this procedure will also be eligible.
Access is provided for Sexual Assault Referral Centre (SARC) clients in the following circumstances: children or adults who are travelling for forensic medical or medical examination following sexual assault at SARC or the nearest hospital are eligible for assistance. Children or adults with acute injuries that require a broader medical response, such as presentation at the Emergency Department and / or consultation with a paediatric service at the nearest hospital are eligible for assistance. Children or adults who are travelling for counselling only and are not receiving services in conjunction with the above are not eligible for assistance.
In the case of an emergency retrieval or evacuation, children and adults are eligible for assistance to repatriate to their places of residence as per the guidelines.

WA - exceptional rulings do not form precedents.They enable fair and equitable decisions to be made based on individual circumstances on a case-by-case basis.

Services not covered

NSW – Dental services provided to a patient under local anaesthetic are not considered eligible dental services. Health screening is not an eligible specialist medical service however a patient may be eligible for assistance to travel for further diagnostic testing at a screening location if the tests are performed by an eligible medical practitioner. A clinical trial is not an eligible specialist medical service. A patient must check if they are eligible for travel and accommodation reimbursement with their clinical trial operator before applying for support.
WA - Referrals to other health professionals, such as general or allied health practitioners, (e.g. speech pathology, physiotherapy, podiatry, clinical psychology, occupation therapy, audiology, pathology etc.) dentists and nursing health professionals are not medical specialists, and therefore do not meet the criteria for PATS assistance. However if such an appointment coincides with an eligible medical specialist PATS may assist in extending accommodation assistance by one or two days.
WA - does not cover:

- medical expenses or other costs associated with accessing specialist medical services, such as parking, taxi payments, meals, medical appliances, or medical gap costs
- diagnostic work-up visits, if available locally
- services related to surrogacy arrangements
- procedures that are excluded under Department of Health policy, including liposuction, gender reassignment surgery, varicose vein procedures, and tattoo removal
- services provided by a general practitioner at a skin clinic
- workplace medical assessment
- treatment in an emergency department, unless you have been referred by your doctor and you see a specialist in the emergency department.

Second opinion

QLD – allow eligible patients who have been referred to an eligible specialist service for a second opinion by another specialist are eligible for a subsidy if all other eligibility criteria are met.
Other states or territories – patients not eligible if patients initiate second opinion themselves

Special circumstances **SA** - where the treating medical specialist has determined that it is likely a client's life expectancy is 12 months or less, program will support the client to attend the specialist of their choice and not require them to access a specialist service nearer to their home, should one be available. **NT** - delegated officers have the authority to approve assistance for patients who may not strictly meet these guidelines if the circumstances can be justified. Such approvals are called 'Out of Policy Approvals'. Out of Policy Approvals will be audited from time to time and delegated officers may be required to provide additional justification for such approvals. A patient who originally lived more than 200km one way from the approved specialist service but relocated long term to a major centre for specialist renal or palliative care, is eligible to receive assistance for one return flight to country to 'finish up', regardless of howlong they have been away.
Car parking **ACT** - If the patient and escort/s return on the same day or there is no accommodation claimed either on behalf of the patient or by a third party, then a subsidy for carparking can be claimed up to a maximum of $20 per day.
Interstate travel assistance **ACT** - is financial assistance for travel using a private vehicle. If more than one patient is travelling in the same private vehicle at the same time, only pay the subsidy to one patient. A rental or hire car is considered to be a private vehicle, however there is no reimbursement of the cost of the hire. Travel using public transport to travel from Canberra to the city that client is receiving treatment is the cost of the ticket up to the maximum limit. The escort will also receive a payment for the cost of the escort's ticket, up to the maximum limit. **ACT Exclusions** – no financial assistance for: taxis; ride sharing (such as Uber); intercity rail or bus; cost of a hire car (can claim the cost of fuel used for a return journey), tolls or meals.
Additional services **NT** - Antenatal care - a pregnant woman can receive PATS support for routine antenatal appointments with a specialist obstetrician or a public hospital antenatal clinic in addition to those provided during obstetric confinement. The care can be provided by a registered midwife, resident or a visiting medical practitioner. The patient is eligible for a maximum of three appointments when antenatal care can be provided locally at an accessible health care centre, this includes Telehealth enabled centres and visiting specialists. The patient is eligible for a maximum of 10 appointments when antenatal care is not available locally. A patient with a medically or obstetrically complicated pregnancy will be eligible for assistance based on clinical need as determined by the referring and treating practitioners.
Assistance with accommodation All jurisdictions consistent with Tasmania.
Escorts **ACT**- If the patient is: under the age of 18 and is airlifted to the treating health facility and the escort is unable to travel with them, then will reimburse travel costs for the escort one way to the treating location, up to half the maximumrebate. **Vic** - an approved patient escort is responsible for the patient's transport and accommodation needs during treatment. Only one escort per patient is eligible for assistance unless the patient is under the age of 18 years. A patient who is a newborn infant (up to six months of age) is entitled to two escorts. Patients over six months of age and under the age of 18 years are entitled to up to two escorts (parents, guardians or family members) when the patient requires treatment or admission to a hospital over two or more days. An approved escort must: be capable of providing assistance to the patient and responsible for the patient's travel and accommodation requirements; be 18 years of age or older; be deemed necessary by the approved medical specialist; and accompany the patient while travelling for the forward or return journey or both.

Where an approved escort does not stay while the patient is receiving treatment but is required to transport the patient to or from home, they may be entitled to up to two return journeys when the patient is hospitalised. This also includes an accommodation subsidy for nights an escort stays in commercial accommodation after transporting a patient to the treatment location and nights in commercial accommodation prior to taking the patient home. Any journeys in the middle of a treatment episode where the escort returns home on one or more occasions are not eligible for assistance.
SA - required to be with a client for specific medical reasons, with each client being entitled to one escort only. Children who are 17 years of age or under are automatically entitled to an escort. Approved escorts must meet the following requirements: 18 years or older; able to cope with the medical needs of the client; deemed necessary by either the referring GP or approved medical specialist.
An escort is eligible for subsidy when: an approved escort accompanies the client during travel; an escort is travelling separately to the client because the client is travelling by emergency transport; the client is a child; the client has passed away during treatment and the escort is making the return trip.
QLD - patients receive automatic approval for an escort when:

- the patient is under 18 years of age and a dependent child;
- the escort is the patient's legal guardian and is required to make decisions in relation to the patients' healthcare;
- the patient requires assistance with basic requirements of life e.g. frail patients or those requiring oxygen or sedation
- the patient requires life-saving treatment
- active role in care: the escort is required to participate in treatment or rehabilitation e.g. patients undergoing major surgery, organ transplants or dialysis may require a carer/escort to participate in their care while at home
- the patient has a physical or cognitive impairment (e.g., brain injury or dementia), is legally blind, has a mental illness requiring a legal guardian/carer, orimpaired mobility.

WA - Escorts are automatically approved:

- for children under the age of 18;
- if Centrelink considers the escort a principal carer;
- for the nominated support person for a home dialysis patient receiving training
- for clients receiving cancer treatment
- if an escort is legally required to make decisions on your behalf (see Department of Health Consent to Treatment Policy here), and/or
- if your referring or treating doctor specifies in writing why an escort's presence is essential. Doctor has to explain why client would be unable to manage treatment alone.

NT automatically approved:

- If a patient is travelling interstate for surgery or intensive treatments.
- when a woman requires an early medical termination of pregnancy and does not have access to safe accommodation within two hours' driving time from a hospital emergency gynaecology service.

Who can refer?
ACT - Patient's GP will usually make the referral. Other referrals from a dentist to OMF surgeon or specialist orthodontist; midwife to obstetrician or gynaecologist; optometrist to ophthalmologist; medical practitioner to medical practitioner.
Vic - Patient's GP will usually make the referral.
NT - A requestor is a registered health professional or dental practitioner who has been authorised to request support for patients they are referring to approved specialist medical services. Before applying for services on behalf of the patient the requester must consider whether the service can be delivered via telehealth or by a visiting specialist. This applies in particular to reviews and follow-up appointments.

A recommendation by a Northern Territory resident specialist is required for referrals to some Northern Territory sub-specialities and for all interstate sub-speciality referrals.
Financial assistance - general **SA** - subsidies are only provided for the primary modes of travel to and from the client's permanent residence to the treatment location. The following modes of travel are ineligible for travel subsidies: use of a taxi; shuttle bus; Uber or other ride sharing platform to or from airports, medical appointments or accommodation; use of a rental car; travel by ambulance, Royal Flying Doctor Service or emergency vehicle travel that has been undertaken as part of an inter-hospital transfer.
Financial assistance – travel **ACT** - Financial assistance is available for the cost of the fuel in a private vehicle used for a return trip between the patients place of residence and the treating health facility up to the following maximums: Canberra to: Sydney: $110 – 286 km (0.38c /km); Melbourne: $220 – 676 km (33c /km); Brisbane: $300 – 1200 km (25c / km); Adelaide: $440 -1172 km (34c /km). The cost of an economy ticket used for a return trip between Canberra and the treating health facility up to the following maximums: Train from Canberra to: Sydney: $125, Melbourne: $230, Adelaide: $260, Brisbane: $260. Coach/Bus from Canberra to: Sydney: $90, Melbourne: $160, Adelaide: $290, Brisbane: $390. Itemised receipts must be submitted for all claims. **Vic** - 21 cents / km if a private car is used; full economy-class fare reimbursements for public transport; air travel reimbursement - only if the journey exceeds 350 kilometres one way and a commercial flight is used; taxi travel reimbursement - only to or from the nearest public transport when there are no other transport options. Taxi fares will only be reimbursed if you have no other means of transport available to travel from your permanent place of residence to the nearest public transport or from the public transport to your nearest most appropriate approved medical specialist. Travel within Victoria using a hire car service and a receipt is provided, will use the Taxi Services Commission's Fare Estimator to determine the equivalent taxi fare amount. Either the estimated taxi fare amount or the hire car fare will be reimbursed, whichever is the lesser amount. If no timestamp is listed on the receipt then midday will be used for the fare estimation. Regardless of the mode of transport used, travel assistance is only provided for: travel directly between your home and the location of the approved medical specialist service, return travel between the medical specialist service and your home. Travel undertaken during a treatment period is not eligible for VPTAS assistance. **SA** - reimburses private vehicle travel at 16 cents per km. A subsidy for public transport will be calculated based on a standard priced ticket. The application should include the original receipt (open tickets without travel dates are not acceptable), or a scanned copy showing the total cost of the fare and that of the approved escort, if applicable. **NSW** - patient may receive a subsidy for eligible travel between: their residence and health service; their residence and transport terminal; their residence and accommodation; the transport terminal and accommodation; the transport terminal and health service; their accommodation and health service. Unless otherwise stated, provides a subsidy for travel from the patient's residence to the health service and return. To receive a subsidy for in transit travel, a patient must provide the specific travel details in their application. Reimbursements are: 22 cents per kilometre for private car travel; full reimbursement for public transport (minus GST); full reimbursement for approved air travel (minus GST); Taxi reimbursement at the following maximum rate: 1 day appointment: maximum $20; 2-7 day appointment: maximum $40; 8-14 day appointment: maximum $80; 15 or more days appointment: maximum $160. **QLD** – 30 cents / km for private transport. Eligible patients and their approved escorts are subsidised for the most economical mode of transport to access their specialist health service. The mode of transport is determined by the most clinically appropriate and cost-effective mode of transport available. An eligible patient and their approved escort may have a clinical need to travel by transport other than the most economical and will be subsidised accordingly. The patient must meet one of the following:

Active clinical management: conditions that would be difficult to manage during prolonged road travel, or if away longer than one day. This includes (but is not limited to) patients requiring ambulatory oxygen, regular catheterisation self/carer, frequent nebuliser therapy (more frequent than four hourly), and dialysis patients.
Pain management: severe pain that is likely to be worsened by prolonged sitting,including (but not limited to) those experiencing post-operative pain (within two weeks of an operation), bony metastases, and acute disc prolapse neck/back.
Urgency: needing urgent treatment or referral, including patients called for organ transplant, those starting chemotherapy / radiotherapy/ dialysis and patients with sudden loss of vision e.g., retinal detachment.
Restricted mobility: This includes patients with quadriplegia / paraplegia / hemiplegia, and those requiring significant assistance with ambulation, whichprecludes other forms of transport.
Life threatening conditions: potentially life-threatening conditions (but not requiring emergency transfer), where a prolonged journey may compromise patient health. This includes patients with low-risk unstable angina pectoris, unstable epilepsy indicated by frequent seizures, large aneurysm requiring surgery and advanced pregnancy.
Musculoskeletal instability: This includes patients for whom prolonged jolting / jarring may compromise their treatment outcome such as splinted fractures not already stabilised, tendon repair (pre-op) and prolapsed vertebral disc with neurological signs.
Other factor: it is not appropriate for the patient due to factors such as the patient's medical condition, their age, time of the appointment, the length of time taken to travel and the need to ensure the patient's safety on arrival and access to accommodation.
For example, it is not necessary to book the most economical mode of transport if it would result in the patient arriving at an unreasonably early or late hour, taking into account check-in times for accommodation.
WA - may be eligible for taxi vouchers if client:

- are permanently unable to walk, or use complex walking aids
- are blind or have a severe visual impairment
- have a disability or condition that make it impractical for you to use other transport, such as an intellectual impairment
- are very ill and unable to use other transport, such as after a major surgical procedure.
- Taxi vouchers will only be provided for use in Perth, not for travel to your local airport or bus station.

NT - subsidy is fixed at 20c per km per patient, for up to three patients travelling together in the same vehicle (i.e., a maximum of 60 cents per kilometre claimable).
Will fund the lowest available fare from the bus departure point closest to the patient's home to the destination closest to the medical service, taking into account reasonable departure and arrival times and the patient's condition and individual needs.

Financial assistance – accommodation

ACT – can receive accommodation subsidy if it is unreasonable for you travel to the health service and back home in one day; treating health professional says you need to stay near the health service before or after your medical care. Assistance through if you stay in: a hotel or motel; a hostel; a bed and breakfast (B&B); an Air BnB; accommodation linked with Ronald McDonald House and other not-for-profit providers.Will pay you more if you have an escort staying in the accommodation with you. Rates $50 patient; $100 patient and escort $150 child patient and two escorts.
VIC - Applicants may be able to receive accommodation assistance up to a maximum of $45.00 per night ($49.50 including GST). This may be available to the applicant and their approved escort if: they stay in commercial accommodation - that is, any accommodation that is registered as a business and has an Australian Business Number (ABN). Registered commercial providers, such as hotels, motels, caravan parks, apartments, flats and accommodation facilities associated with a health service, are considered to be commercial accommodation. All original receipts or taxation invoices for commercial accommodation must be attached to the claim form for the accommodation portion of the claim to be processed. An EFTPOS or credit card receipt is not an acceptable receipt. Commercial accommodation receipts and taxation invoices must be provided on letterhead and

contain the following details: the name and address of the commercial accommodation provider; or accommodation facilities associated with a health service; the accommodation provider's ABN; the name of the patient and/or approved escort(s) accommodated; date(s) the patient and/or approved escort(s) were accommodated; the cost of each person(s) (patient and/or approved escort(s)) accommodation per night; and the total cost of accommodation. Receipts and tax invoices provided from the following places will be accepted as commercial accommodation provided they contain the information outlined above: short-term rental accommodation booked through a real estate agent or website such as stayz.com.au or airbnb.com.au
accommodation booked through booking engines such as Agoda, Expedia, Wotif and lastminute.com.au.
SA - Facilities providing rehabilitation (e.g., slow-stream rehabilitation involving physiotherapy or other therapies), primary care services (e.g. step-down units) and supported residential facilities are not considered commercial accommodation.
There is no subsidy payment available for a client who stays with family or friends.
Subsidies are available up to $40 (plus GST) per person, per night. If the cost of the accommodation is less than the maximum subsidy rate, the actual amount of accommodation will be paid. Clients are eligible to apply for an accommodation subsidy for up to two nights without medical authorisation.
Concession card holders are automatically eligible for a subsidy for up to two nights' stay. Non–concession cardholders are required to pay the first night's expenses in full but are automatically eligible for a subsidy for their second night's stay.
If the client needs to stay longer than two nights in commercial accommodation to attend multiple medical appointments, their medical specialist needs to authorise their length of stay in order for subsidies to be provided for the additional nights.
The automatic two nights are not in addition to those authorised by the specialist – they are only claimable if the specialist does not authorise any accommodation.
If, at the specialist appointment, the client is advised that they need to attend other services such as radiology orpathology for tests, the medical specialist should authorise the total required number of nights the client and/or approved escort are required to stay near the treatment location.
The specialist must also authorise that the client requires an escort to stay with them during this period ofaccommodation.
Payment of the accommodation subsidy for the client and escort is determined by the concession card holder status of the client. If the client is a child, the determination will be based on the concession card status of the escort.
Ante-natal patients and newborn infants
Once the client has given birth: the newborn becomes the PATS 'client' and the mother is the escort; in the case of multiple births, each newborn is entitled to an escort; if the mother has a medical condition and is unable to care for her newborn, the mother and the newborn may have one escort each
NSW - Accommodation is eligible if: it is unreasonable for the patient to make a return trip between home and the health service in one day; the treating practitioner confirms it is medically necessary for the patient to stay near the health service before or after the hospitalisation or appointment date(s); the patient stays in accommodation during outpatient treatment; the patient needs to stay before or after the appointment date due to limited availability of commercial air or public transport.
There are three accommodation types: for-profit accommodation; not-for-profit accommodation; and private accommodation.
Private accommodation: If staying with a relative or friend, you and your escort carer may be eligible for a subsidy of: $20 per night regardless of the number of nights you stay (or $40 per night if you are staying with your escort).
Not-for-profit accommodation: If you are staying in a not-for-profit organisation, for the first seven nights in a financial year you will be reimbursed at: $43 per night for single occupancy (or $60 per night if you are staying with your escort). Additional nights during the same financial year will be reimbursed at $65 per night for single occupancy (or $85 per night if you are staying with your escort).
For-profit accommodation (per financial year):

One to seven nights: $43 per night for single occupancy (or $60 per night if you are staying with your escort). Eight to fourteen nights: $80 per night for single occupancy (or $105 per night if you are staying with your escort). Fifteen nights plus: $105 per night for single occupancy (or $120 per night if you are staying with your escort).

QLD - eligible patients and their approved escort may be required to stay in accommodation ifthey meet any of the following criteria: Clinical / medical requirement; travel distance: a patient is approved to travel by private motor vehicle and would need to travel more than a total of 600 kilometres or eight hours in one day; appointment time: a patient has an early appointment / admission or has a late appointment/discharge and it is not practical to travel on the same day.

Eligible patients are required to pay the first four nights of accommodation (commercial or private) in each financial year, unless they meet the following criteria in which case the patient and their escort/s are exempt:

Patient is a minor (under 18 years of age); Concession card holder - if a patient holds one of the following valid cards: Pensioner Concession Card, Centrelink Health Care Card, Commonwealth Seniors Health Card, Department of Veteran Affairs Health Card (blue/white card only).

Eligible patients and approved escorts are entitled to a subsidy of up to $60 per person pernight (excluding the GST component) when staying in commercial accommodation. If a patient and approved escort choose to stay with friends or relatives (i.e. private accommodation) the subsidy provided is $10 per person per night (excluding GST as GSTdoes not apply here).

WA - eligible for accommodation assistance only if live more than 100 kilometres from the treatment centre and:

- the medical specialist certifies that you need to stay overnight for follow-up
- the forward and return journeys cannot reasonably be completed in one day because of factors such as: time required travelling, type of travel, transport schedules and availability, appointment or treatment time, or medical condition.

Interstate accommodation

SA - for approved interstate specialist service will subsidise the client's accommodation at a flat rate of up to $80 per night (plus GST). Applications for ongoing accommodation can be approved in a maximum of three-month blocks.

The referring health unit is required to monitor the length of stay and confirm ongoing eligibility for theaccommodation subsidy with the treating specialist team every three months.

GST

NSW - Patients are not eligible to receive a subsidy for the Goods and Services Tax (GST) part of their travel or accommodation costs. Applicable subsidies will be calculated using the cost of travel or accommodation excluding GST. All tax invoices should display the GST amount payable; if GST amount is not displayed one eleventh will be deducted from the total cost. Scheme may purchase travel directly for a patient if they are eligible for advance travel assistance. If an office is invoiced for travel costs as a result, the office can pay the GST component and claim back this component as an Input Tax Credit, provided they have a GST tax invoice charged to the service.

Patient contribution - travel

ACT - any rebate from PHI fund will be deducted from any amount payable through IPTAS

Vic - People receiving VPTAS assistance pay the first $100 each treatment year for their travel and accommodation, except for primary card holders of a Pensioner Concession Card or Health Care Card and patients aged under 18 years. After the initial payment the scheme covers all travel and accommodation costs for the remainder of the treatment year. A treatment year starts from the date of the first appointment with a specialist.

An approved primary card holder is the person detailed in the top left-hand section of a pensioner concession card or health care card. Additional people listed on a pensioner concession card or health care card (partner, dependents or children) are not recognised as approved primary card holders. In these circumstances the non-concession card holder policy will apply.

Deceased patient

Vic - If a patient passes away either during travel to receive, or while receiving approved medical specialist services, an approved escort is entitled to assistance for the trip home. Accommodation costs are not claimable for the deceased person or an approved escort after the patient dies, with the exception of one additional night for an approved escort(s). If the claim was lodged for the deceased person's travel and accommodation services before they died, the eligible claim(s) will be made payable to the person's estate. The escort's payment will still be made directly to the escort if this was requested on the claim form. A deceased person's estate is not entitled to claim for the costs of transporting the person's body. **SA** - If a client or escort should pass away during a subsidised journey or at the place of treatment, the travel subsidy payable is deemed to be the cost of the pre-planned return journey via the original mode of transport. Where relevant, an accommodation subsidy is permissible until the date of the client's discharge. The death of the client will not change the eligibility of the escort's travel subsidy to return home. A deceased estate is not entitled to apply for the full transportation costs associated with the return of a person who is deceased. Where a payment is made to a deceased person, it should be made to the estate of the deceased applicant and cannot be made directly to a relative or carer (or escort). **NSW** - may provide a travel subsidy to assist with the costs of transporting the body home. Escort travel may be available if a patient dies during treatment and the escort is on the return trip. If there were no eligible travel costs for the forward trip, the subsidy will be calculated using the private vehicle subsidy rate. **QLD** - In the case of the return transport of a deceased adult patient, a subsidy is payable to the patient's estate. The subsidy shall be equivalent to what was originally approved for the patient's return journey. If a patient has travelled with an approved escort, the escort's return journey is subsidised to the extent that was originally approved. **NT** When an eligible Northern Territory resident has died during an episode of treatment(whether interstate or intrastate) repatriation of the body to their place of residence is covered under scheme. This includes patients who have relocated to a major centre for longterm treatment; e.g. renal patients. **WA** – scheme organises the repatriation of the deceased.
How to make a claim **Vic** - applicants should lodge the claim by: submitting the completed claim form no later than 12 months from the date of the first listed approved medical specialist service; providing original receipts or tax invoices for travel and accommodation (petrol receipts are not required); completing the travel and accommodation diary within the claim form; ensuring all information provided is true and correct; making sure the medical specialist's details are correctly completed on the claim form and the specialist or their authorising officer has signed the claim form. The applicant should keep a photocopy of all receipts and documents, including the completed claim form. Processing time and payment takes approximately six to eight weeks from the claim lodgment date. Payment will be made via electronic funds transfer (EFT) into the provided bank account detailed in claim form.
Relocation **SA** - clients that have relocated will not be eligible for subsidies. A client is considered to have relocated if they are no longer living at their principal place of residence and: have accepted a long-term private rental contract (six months or greater) or ownership of a property near the location of treatment; no longer receive mail at this address; have updated their contact details for their health care card, driver's licence or enrolment details with AEC; utilities such as electricity or gas are no longer connected.
Advances **SA** - reimburse subsidies within a short timeframe, i.e. 48 hours for urgent payments (potentially the same day if the advance is requested before 11.00am). In addition, advance travel subsidies are available for concession card holders who are experiencing financial hardship at the time of an urgent appointment and cannot afford to pay the travel costs up front. To be eligible for an advance, the client must: hold a valid concession card; be

experiencing severe financial hardship; have received less than five business days' notice of an appointment and can provide evidence of this to the service. **NSW -** A patient will meet the advance travel criteria if: they have a valid concession card; and they can provide evidence of financial hardship. A patient will receive either: a private vehicle subsidy from their residence to the health service and return; a prepaid ticket for regional public transport travel (advance assistance is not provided for metropolitan travel); a prepaid ticket for commercial air travel, if the patient has a valid air approval.
Patient responsibility **QLD** the patient's responsibility to: provide true and accurate information (e.g. if the patient is eligible for funding from another source); provide required documents/proof to the approving hospital and health service to support their claim (e.g. signed accommodation confirmation form and any tax receipts); submit forms in a timely manner (e.g. submission of travel referral, following the receipt of an appointment date); provide additional documentation from their treating specialist if requested by the approving hospital and health service. Patient responsibility is part of the reservation/booking agreement i.e. once travel and/or accommodation has been reserved/booked, the patient agrees to the terms and conditions of the carrier and/or commercial accommodation (as a customer).

Appendix D: Key changes included in the revised Operational Protocol

Part 1 - Eligibility Criteria

Criteria	Description of change	Purpose	Comment / Justification
Tasmanian Residents	Allows applicants to prove they are a Tasmanian resident using 100 points of ID as an alternative to the electoral roll	Remove barrier to access	Aligns with consultation feedback, practice in other jurisdictions, and the COVID-19 interim arrangements
	Accommodates applicants with no fixed address	Remove barrier to access	Aligns with practice in other jurisdictions
Eligible medical services	Recognises previous 'special rulings' as eligible medical services (AH, midwifery, Jack Jumper, PGD)	Streamline processes	
	Clarifies dental service eligibility	Clarification of scope	
Ineligible services	Identifies private clinical services located on mainland Australia as an ineligible service.	Promote sustainability	
	Defines cosmetic surgery	Clarification of scope	
Clinical Trials	Changes 'special ruling' requirement for clinical trials to 'exceptional ruling' requirement	Consistency of application	The exceptional ruling process supports improved consistency of application of the scheme through a collective decision-making process. Exceptional ruling outcomes are not precedent forming
Approved service provider	Provides a definition of which providers are approved clinical service providers	Clarification of scope	Aligns with practice in other jurisdictions
Distance	Requires calculation of ground distance using Google Maps	Transparency of process, patient-centred approach	Aligns with consultation feedback and practice in another jurisdiction. Supports transparency through the use of a publicly available calculation tool. Enables reimbursement specific to the applicant's place of residence rather than a proxy marker
Nearest eligible medical service	Restricts PTAS assistance to access to Tasmanian services, where Tasmanian services are not available PTAS assistance is provided to the nearest eligible public service interstate. PTAS assistance is not available for access to private services interstate	Clarification of scope	Aligns with the recommended policy intent that PTAS is a publicly funded scheme that supports the sustainability of the Tasmanian health system Supported by consultation feedback
Nearest eligible medical service exemptions	Enables automatic exemption from the 'nearest eligible clinical service' rule in the situation of emergency and system-wide strategy or wait list	Stream line processes.	Aligns with consultation feedback and practice in other jurisdictions

Criteria	Description of change	Purpose	Comment / Justification
	reduction program. Enables one-time exemption for patients when a new eligible service becomes available closer to home	Support for system-wide service delivery initiatives	
	Enables an exceptional ruling request by applicants for an exception to the nearest eligible clinical service due to clinical urgency or practicality/cost-effectiveness	Patient-centred approach	Aligns with consultation feedback and practice in other jurisdictions
Patient escort	Clarifies the requirements of an approved escort	Clarification of scope	Aligns with consultation feedback and practice in other jurisdictions
	Provides criteria for automatic escort allocation	Streamline processes	Aligns with consultation feedback and practice in other jurisdictions.
	Clarifies escort arrangements for newborns, multiple births and the role of the mother as an escort to a newborn	Clarification of scope and streamline processes	Aligns with practice in other jurisdictions
	Clarifies criteria for Medical Authoriser approval of requests for an escort	Clarification of scope	Aligns with consultation feedback and practice in other jurisdictions
Modified eligibility criteria for residents of King Island and the Furneaux Group (FG) Islands	Describes the specific eligibility criteria that apply only to residents of the King Island and Furneaux Group Islands. Supports equitable application of eligibility criteria for 'very remote' residents regardless of the island they reside on	Remove access barriers due to remoteness. Address inequity between remote island residents	.
	Broadens the nearest eligible service exemption to include residents of the FI Group, and removes private health insurance status as an eligibility criterion for exemption	Address inequity	Aligns with consultation feedback, supported by data analysis
	Aligns obstetric confinement periods for residents of King Island and the FG Islands, and provides automatic extension of confinement periods on direction from an obstetrician or independent midwife	Address inequity, promote safety and quality in service access, streamline processes	Aligns with consultation feedback
	Enables additional support to return home during an extended treatment program	Patient-centred approach	Aligns with consultation feedback
	Enables support to access Allied Health and preventative health services as part of an approved PTAS journey or for those who have not received	Remove access barriers due to remoteness	Aligns with consultation feedback

Criteria	Description of change	Purpose	Comment / Justification
	PTAS approved travel once per annum for adults and biannually for children		

Part 2- Financial Assistance

Type	Description of change	Purpose	Comment / Justification
Travel assistance - transport	Documents that personal stopovers and extended stays for non-medical reasons are not eligible for PTAS assistance	Clarification of scope	Aligns with Australian Government ministerial travel rules
Private vehicle transport	Enables payment of per kilometre usage rate for hire cars but does not cover hire car fees	Patient-centred approach	Enables hire car use whilst adhering to current Department of Health restrictions on payment of hire car fees
Air transport	Allows patients to book their own flights, and clearly articulates the patient risks and responsibilities associated with self-booking	Patient centred-approach	Aligns with consultation feedback
Taxi subsidy	Enables taxi subsidy with approved travel by air for the purposes of transport from the airport to the place of treatment or to address issues of transport hardship in consultation with a social worker	Clarification of scope, patient-centred approach	Aligns with consultation feedback and practice in other jurisdictions
	Clarifies that all other forms of taxi travel are ineligible for subsidy	Clarification of scope	Aligns with practice in other jurisdictions
	Includes up-front provision of taxi vouchers (electronic or paper-based) for those required to travel by air to address hardship related to up-front taxi costs	Remove access barriers	Aligns with consultation feedback and practice in other jurisdictions
	Taxi voucher amounts are determined using a publicly available Taxi fare estimator	Transparency of process	Aligns with practice in another jurisdiction
Transport disadvantage	Provides recognition of transport disadvantage and the factors that can contribute to it. Facilitates social work involvement to assist in supporting patients on a case-by-case basis	Address barriers to access, patient-centred approach	Aligns with consultation feedback. Supported by Social Work representatives
Accommodation Assistance	Provides capacity to automatically approve accommodation subsidies for patients and approved escorts based on travel patterns, appointment times, flight schedules, and pre-medication prior to treatment	Streamline processes	Aligns with consultation feedback, supported by data analysis
	Clarifies accepted accommodation receipt types	Clarification of scope	Aligns with practice in other jurisdictions

Type	Description of change	Purpose	Comment / Justification
	Clarifies the responsibility of patients to pay for incidental costs associated with accommodation and any costs associated with damage to property	Clarification of scope	Aligns with consultation feedback and practice in other jurisdictions
Patient contributions	Removes contribution requirements for approved concession cardholders	Address barriers to access	Aligns with practice in other jurisdictions
	Restricts accepted concession cards to those that are means-tested	Clarifies scope for effective targeting of support	Aligns with policy requirement that the scheme is targeted toward those who have most need for support
	Contribution values and caps consolidated to Appendix A for ease of update. Contribution amounts revised and subject to indexation	Clarification of scope	
Hardship provisions	Clarifies process for an exceptional ruling based on hardship. Includes involvement of a social worker	Patient-centred approach, consistency of application using a collective decision-making approach	Aligns with consultation feedback. Supported by Social Work representatives
Postponed admissions or cancelled specialist appointments	Formalises requirement for PTAS costs to be journaled to the responsible hospital for additional costs incurred, as a disincentive for last-minute postponements or cancellations	Supporting system-wide strategy	Aligns with practice in other jurisdictions
Repatriation assistance	Includes a two-tiered cap for repatriation assistance that recognises the cost differentials between ground-based repatriation, and air plus ground-based repatriation of the deceased.	Transparency of process and clarification of scope	
	Clarifies the assistance provided to escorts when a PTAS approved patient dies in a treatment facility	Clarification of scope.	

Part 3 - Processes

Process	Description of change	Purpose	Comment / Justification
Application Process	Increases the time to submit an application or claim from 4 months to 6 months	Reduce barriers to access	Aligns with consultation feedback
Completing the application form	Updates the flow and section names of the application form in line with the revised application form	Clarification of process	Aligns with consultation feedback and practice in other jurisdictions
	Defines the process for when a referring medical practitioner refers a patient to themselves	Clarification of process, strengthens	Aligns with consultation feedback

Process	Description of change	Purpose	Comment / Justification
		appropriateness of decision-making	
	Allows for an 'authorised officer' to sign Section 3 on behalf of the clinical service provider	Streamline processes	Aligns with consultation feedback and practice in other jurisdictions
Incomplete application forms	Allows some PTAS staff to annotate non-critical and non-clinical parts of the application form when necessary	Streamline processes	
Approval processes	Requires patient notification of approvals within a specified timeframe	Improved customer service	
	Clarifies the escalation pathway for applications that do not clearly meet the eligibility criteria	Clarify process	
	Specifies the notification requirements for non-approved applications, including the requirement to notify patients of avenues of appeal	Clarify process, improved customer service	
Exceptional rulings	Includes an exceptional ruling process that enables case-by-case decisions for applications that meet the intent of the PTAS policy but do not meet the strict parameters of the eligibility criteria. Exceptional rulings do not form precedent, and utilise group decision making to strengthen consistency	Patient-centred approach, improved consistency of decision-making	Aligns with practice in another jurisdiction
	Describes the process by which exceptional rulings are requested, considered based on urgency, and recorded	Clarify process	Aligns with practice in another jurisdiction
	Describes the process and timeframe within which applicants are notified of the outcome of an exceptional ruling request	Clarify process, improved customer service	Aligns with consultation feedback and practice in other jurisdictions
Review of extended treatment access	Mandates review of long-term PTAS users by the PTAS AAC and allows for consideration of other avenues for support using a process of collective decision making		Aligns with consultation feedback and practice in other jurisdictions
Travel bookings process	Allows for provision of taxi vouchers at the time of flight booking	Reduce barriers to access	Aligns with consultation feedback and practice in other jurisdictions
	Increases the timeframe by which patients must notify PTAS staff of changes to travel arrangement, to prevent financial penalties to PTAS	Clarify process	
	Clarifies the responsibilities of patients who chose to book their own travel and the process when self-booked travel arrangements change	Patient centred approach, clarify process	Aligns with consultation feedback and practice in other jurisdictions

Part 4: Outcome appeal and patient feedback

Feedback	Description of change	Purpose	Comment / Justification
PTAS appeal Process	Clarifies the process by which (and timeframes within which) an appeal is lodged, assessed, and recorded	Clarify process, improve customer service	
	Describes how and when appellants are notified of outcomes	Improved customer service	
Compliments and complaints	Clarifies the process by which applicants can provide compliments, complaints and feedback to PTAS, and the time frames for response	Clarify process, improve customer service	
	Describes the escalation pathway for unresolved complaints	Clarify process, improve customer service	

Part 5: Roles and responsibilities

Role/ Responsibility	Description of change	Purpose	Comment / Justification
Roles and responsibilities	Staff roles and responsibilities updated throughout in line with most recent Statements of Duties	Clarify processes and accountabilities	Aligns with consultation feedback and practice in other jurisdictions
	Roles and responsibilities of key parties updated throughout in line with the revised operational protocol	Clarify processes and accountabilities	Aligns with consultation feedback and practice in other jurisdictions
	Strengthens and clarifies role of PTAS Co-ordinators, PTAS Manager, and the PTAS AAC	Clarify processes and accountabilities	

Part 6: Service Standards and Performance Measures

Standards/ Measures	Description of change	Purpose	Comment / Justification
Service standards	Describes the standards of service provided by PTAS staff, including impartiality, accessibility, timeliness of processing and payment, privacy and confidentiality	Improved customer service	Aligns with consultation feedback

Standards/ Measures	Description of change	Purpose	Comment / Justification
Performance measures	Describes a new range of qualitative and quantitative performance measures that aim to: facilitate improvements in patient satisfaction, administrative efficiency, and fiscal responsibility; identify trends to inform ongoing operational protocol revision in line with intent and principles of the PTAS policy; and provide data to inform system-wide clinical service planning and strategy	Improved system performance, outcomes and advice	Aligns with consultation feedback and data analysis findings