Australia's Patient Travel Schemes - Compounding rural, regional and remote women's difficulties accessing appropriate health care.

Rural, regional and remote women are suffering the compounding effects of gender and geographic disadvantage when it comes to accessing health services. Australia's various patient transport schemes add another layer of difficulty for these women, by failing to properly cover travel costs for women to access the services they need.

Women face unique challenges accessing the health care they need

Women across Australia are more likely to suffer chronic illnesses, have multiple health conditions, and require specific reproductive health care (including pregnancy, infertility, and abortion services). There is strong evidence that women pay more to access healthcare and are more likely to delay accessing that care. Women are more likely to face barriers to accessing health services such as accessing child care.

This is compounded by geographic disadvantage

People living in rural, regional and remote parts of Australia have poorer health outcomes than their metropolitan counterparts. This is due to the lack of service availability in these areas and the associated greater difficulty and cost in accessing the appropriate services. The lack of rural services equates to a total annual rural health spending deficit of $8.35 billion.[1] Travelling to access those health services adds another layer of disadvantage. This comes not only from having to pay travel costs, but from longer wait times and lack of choice.

Travel schemes do not adequately cover costs

The patient transport schemes that operate across Australia do not adequately address the barriers that rural regional and remote women face. Nationalisation of patient transport support services and key improvements to scope and coverage can support better health outcomes for rural, regional and remote women (as well as their families).

[1] https://www.ruralhealth.org.au/media-release/rural-australians-miss-out-on-8-35-billion-in-healthcare-every-year-and-its-getting-worse/

Scheme overview

Australia's state-based medical transport subsidy schemes are remarkably similar in design. This is because it was originally a Commonwealth administered scheme, which was handed over to the states in 1987.[2] All schemes cover transport in a private vehicle, either as a payment per kilometre, or as a capped amount that patients can claim. They all cover accommodation, mostly as a set rate per night, with a capped total amount. They all cover commercial flights if that is the most efficient method of travel, or medically necessary. An escort is allowed under all the schemes if medically required and in most cases, if the patient is a child or identifies as Aboriginal or Torres Strait Islander, an escort is either automatically provided or two escorts are included. They all cover public transport to different extents, and most set a minimum distance in kilometres to be eligible.

Despite being very similar, there are some significant differences in the coverage of the schemes, which means patients in different states are not able to access consistent and equitable reimbursement. For example:

- The distance eligibility varies from 50km to 200km
- There is a significant range in payment rates for private vehicle travel
- There is a significant range in accommodation rates,
- Some schemes cover allied health services and clinical trials, others do not
- Most schemes cover taxi fares as part of the journey, but others do not.
- Some states offer a nominal nightly rate for non-commercial accommodation, others do not.

Not only are the schemes inconsistent and therefore inequitable, but the payment rates are inadequate, in particular the accommodation rates. Most of the accommodation subsidy rates are between $45 and $70 per night, leaving patients paying a very high out of pocket cost per night. The combination of out of pocket costs for both travel and accommodation, as well as other associated costs like meals or childcare, create an unreasonable cost burden for rural regional and remote patients. This means that rural patients either shoulder that burden and pay more, or they delay or choose not to receive treatment.

While all the schemes cover Medicare listed procedures and treatments, and women's health items are (at least partially) covered by Medicare, out of pocket travel costs add to the cost that women pay to access healthcare appropriate to their needs. There is growing acceptance of the fact that women pay more to access medical treatment than men, and are more likely to delay treatment. Both of these factors are exacerbated by travel costs. The requirement to be seen by

[2]https://www.aph.gov.au/~/media/wopapub/senate/committee/clac_ctte/completed_inquiries/2004_07/pats/submissions/sub182_pdf.ashx

the nearest specialist, not necessarily the best or most appropriate specialist, also disadvantages women who have experienced trauma, or those from different religious or cultural backgrounds.

Other issues include the lack of coverage of those without Medicare (including asylum seekers on some types of bridging visas), the lack of coverage for childcare, or allowances for escorts that account for the needs of mothers.

Recommendations

1. A single, national scheme that covers all rural remote and regional patients accessing specialist medical care.

2. Increased accommodation costs to adequately cover the cost of staying in commercial accommodation and cut out of pocket costs.

3. Increase fuel subsidy rate in line with the ATO's payment rate for individuals

4. Greater coverage of women's health services in the scheme, as well as relevant allied health care, specialist dental and advanced clinical trials

5. Inclusion of ability to choose specialist based on unique health needs (i.e. cultural, trauma etc)

6. Inclusion of childcare allowance, and/or accommodation allowance to cover pre-school aged children and an escort to travel with their primary care giver if travelling overnight

Scheme summary

Accommodation rate does not cover costs

While some states do not publish their accommodation subsidy rates, the ones that do demonstrate a substantial gap between the market rate of commercial accommodation and the subsidy rate. The average mid-week nightly rate for accommodation providers listed on the Royal Melbourne Hospital website was $154.50 per night. The average mid-week nightly rate of the 11 closest hotels to the Royal Prince Alfred Hospital in Sydney was $191.27.[3] Most schemes pay between $40 and $75 per night. This means that rural, remote and regional patients are likely to be facing significant out of pocket accommodation costs if they need to stay overnight to receive medical treatment away from home.

Variability in payment rates

While Victoria's scheme pays 21 cents per kilometre, if you are living in NSW or WA the rate is nearly double that amount (roughly 40 cents per kilometre). Victoria's accommodation rate is just $45 a night, but NSW, QLD and Tasmanian residents are all eligible for at least $70 per night. This gives rise to the situation where residents living in Wodonga, Victoria, may be able to access roughly half the travel rate as someone in neighbouring Albury (NSW) and roughly two thirds of the accommodation subsidy.

Different distance eligibility criteria

Most states set a minimum distance to be eligible to access the scheme at 100km, but Queensland is much lower at 50 kilometres and in the Northern Territory it is much higher, at 200km (or 400km/week for dialysis or oncology). NT patients are not only expected to travel further to access medical care, but are being penalised simply due to where they live. Aboriginal and Torres Strait Islander people are overrepresented in remote Northern Territory (31.4% of the population compared to just 3% of the rest of Australia).[4] The higher threshold to access the scheme in the Northern Territory is likely to compound the impact of the already well established poorer health outcomes experienced by Indigenous populations. On the other hand, QLD residents are accessing a subsidy that in other states they would be deemed ineligible for.

The distance eligibility criteria is arbitrary, and does not account for local transport conditions or road connections. For example, a patient may live just below the 200km threshold but the access to the closest medical facility may be by roads in poor condition, taking much longer to

[3] Average of all hotels listed on RMH website, 05.08.25. Average of 11 closest hospitals to RPA (30 min walk, via Google maps), 05.08.25

[4] https://www.abs.gov.au/census/find-census-data/quickstats/2021/IQSRA73

travel. But another community just 10-15km further away by distance, but better connected by road and requiring a short journey, would be covered by the scheme.[5]

Inability to choose specialist

A critical barrier to women accessing high quality healthcare using this scheme is that patient transport schemes strictly only cover treatment at the nearest treating specialist. Most schemes also specifically note that a second opinion is not covered by the scheme. While on paper, this may seem reasonable, patients accessing healthcare in metropolitan areas much easier to select a specialist (if several are all within easy distance). This means women in particular may be forced to see a specialist who is not necessarily the best provider for them (based on religious, personal or medical reasons). Women from culturally or linguistically diverse communities, or who have experienced trauma, may particularly be disadvantaged by this requirement. The schemes will also not cover a patient to see their previous/historical treating specialist if they are not the nearest provider.[6]

Inconsistencies in treatments included

Some schemes are more widely applicable than others. For example, NSW will cover several allied health care, non commercial clinical trials and voluntary assisted dying, but Victoria's scheme is limited to specialist practitioners approved by Medicare and explicitly excludes clinical trials or allied health services. SA does not cover allied health or clinical trials other than stage 4 trials. This means patients in some areas can claim for more treatments than in other states.

Those not covered by Medicare

Medical transport schemes are strongly tied to the provision of specialist medical services covered by Medicare. Australian citizens are covered by Medicare. Overseas visitors may be eligible if they have a reciprocal health care agreement with that country. Medicare also covers permanent residents, New Zealand citizens, temporary residents covered by a Ministerial Order or people who have applied for permanent residency.[7] While some protection visas include

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[5] The 2007 Senate review of PATS schemes provided this example: one community, which is approximately 193 km away from Alice Springs that can only be accessed via an unsealed road in poor condition, for all but 30km. For patients requiring specialist services, the journey often entails a four hour journey in a crowded Troup Carrier. Patients with similar health conditions who live outside the 200 km radius are often transported by air under the PATS scheme https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pats/report/c03

[6] https://www.wacountry.health.wa.gov.au/Our-patients/Patient-Assisted-Travel-Scheme-PATS/More-information-including-FAQs

[7] https://www.health.gov.au/topics/medicare/about#eligibility-for-medicare

Medicare coverage, some bridging visas[8] do not include Medicare access.[9] [10] [11] Wait times for visa outcomes can be lengthy, with some sources showing more than 30,000 people are still waiting for an initial decision on their Protection Visa application.[12] In addition to those waiting for an outcome or on bridging visa, there are close to 100,000 people whose visas have been initially refused and are waiting for review at the Administrative Review Tribunal, in the courts or through the ministerial intervention process.[13]

While the data doesn't give a clear picture of how many of these visa holders are in regional Australia, more refugees are living in regional Australia than historically.[14] The Australian Government settles humanitarian entrants in 21 regional locations across Australia. These refugees have higher rates of certain health conditions such as chronic illnesses and reproductive health issues.[15] Some states offer free public hospital treatment regardless of Medicare coverage and specific refugee health services. [16] However, refugee patients would not be eligible for patient transport schemes unless they were enrolled in Medicare.

Administration costs

Operating individual state based schemes is unlikely to be the most efficient model of service. Each state must manage its own claims processing, budget request and reviews and other governance and operating costs. The schemes are remarkably similar in design, and it is likely a more efficient model can be found. In 2022-2023, the NSW scheme paid approximately $36 million in reimbursements, but the total cost of the scheme, including staffing and administration, was not provided.[17]

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[8] Bridging Visa E (covering those pending departure, awaiting immigration decision and visa outcomes) do not include Medicare https://immi.homeaffairs.gov.au/visas/getting-a-visa/visa-listing/bridging-visa-e-050-051

[9] https://asrc.org.au/policy-safety/

[10] https://immi.homeaffairs.gov.au/visas/getting-a-visa/visa-listing/temporary-protection-785#When

[11] https://immi.homeaffairs.gov.au/visas/getting-a-visa/visa-listing/safe-haven-enterprise-790#When

[12] https://www.refugeecouncil.org.au/asylum-community/5/

[13] https://www.refugeecouncil.org.au/asylum-community/5/

[14] A decade ago, about one in 10 humanitarian arrivals settled in regional parts of Australia but in the first three months of 2019, data from the Department of Social Services reveals that figure was up to almost one in four. https://www.abc.net.au/news/2019-06-29/refugees-feel-more-welcome-in-regional-australia-than-they-once/11224910 As settlement outside metropolitan areas continues to grow, reaching ~ 45% of the total humanitarian intake in 2019 (Australian Government Department of Home Affairs, 2020) https://www.sciencedirect.com/science/article/pii/S0743016723002176

[15] https://www.aihw.gov.au/getmedia/5b96dbdc-1c7c-4771-9b4a-1a1ea0cc5b86/health-of-refugees-and-humanitarian-entrants-in-australia.pdf?v=20240116150341&inline=true

[16] https://www.health.qld.gov.au/public-health/groups/multicultural/refugee-services/refugee-and-asylum-seeker-services

[17] https://www.health.nsw.gov.au/regional/Publications/iptaas-monitoring-evaluation.pdf

Escort provision for mothers

The lack of automatic escorts could also lead to rural regional and remote women being disadvantaged when accessing obstetric care. Escorts are usually only provided at the advice of the specialist, which could lead to circumstances of women travelling for obstetric or birthing services without an escort being covered by the scheme. The Northern Territory scheme which provides obstetric confinement from 38 weeks, states there is no automatic escort for obstetric confinement. SA's scheme notes that the mother is the patient until the baby is born, but then the baby becomes the patient and the mother the 'escort'. This could give rise to occasions where support persons must either pay their own costs or mothers may have to give birth in hospital alone. WA's scheme now includes an automatic escort for a birthing mother, but previously had been the subject of complaints of vulnerable young mothers from remote areas being forced to travel to Perth and give birth without support.[18]

Poor awareness of the schemes

A 2022 NSW government review of their IPTAS scheme found that only 2 of every 5 rural, regional remote residents knew about the scheme.[19] It is highly likely this number is consistent across jurisdictions. This means that it is likely many rural patients are unaware of the scheme and are not accessing rebates they may be eligible for.

Private road travel rates are variable are not inline with ATO claim rates

The fuel subsidy rates for each scheme vary from just 21 cents a kilometre in Victoria to 40 cents in WA and New South Wales. While this cost roughly covers the standard cost of petrol, it does not account for wear and tear on the vehicle and associated running costs like tyres, servicing, insurance and registration. These rates are significantly below the Australian Tax Office payment rate of 88 cents per kilometre.[20]

Remote areas pay more for fuel already

The schemes are also unlikely to cover costs in remote areas where fuel prices can be much higher than metropolitan or regional areas. For example, while the petrol and diesel average prices in the Northern Territory were 16 and 24 cents per litre higher than in Darwin.[21] Across

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[18] https://www.abc.net.au/news/2021-07-21/kimberley-mothers-hit-by-flawed-scheme/100307360

[19] https://www.health.nsw.gov.au/regional/Publications/iptaas-monitoring-evaluation.pdf?utm

[20] https://www.ato.gov.au/individuals-and-families/income-deductions-offsets-and-records/deductions-you-can-claim/cars-transport-and-travel/motor-vehicle-and-car-expenses/expenses-for-a-car-you-own-or-lease#Centsperkilometremethod

[21] https://nteconomy.nt.gov.au/prices-and-wages/retail-fuel-market

Australia it is widely accepted that fuel costs more in regional areas, due to lower demand and less competition, as well as higher costs for transport and storage.[22] This demonstrates the extent to which remote areas are paying a premium in their fuel costs and therefore the subsidy is much less likely to be covering costs.

Women and children

There are some circumstances where the schemes do not adequately consider the needs of young children and their parents. The NT scheme includes an escort if a child under 2 is traveling with the patient, but the other schemes do not specify this. While older children may have no need to travel with an unwell mother, it could be traumatic for young children to be separated from their mother for an extended period of time. For example, a mother with multiple young children who needs specialist care away from home may not be able to receive a subsidy to have her children (and an escort) travel with her. In cases where the patient is a sick child, the provision for just one escort may also not be appropriate support, or consider the needs of the primary carer, other young children in the family, or the secondary carer.

Non medical health services for women

These schemes are for specialist *medical* treatment, with most states not allowing allied health services (Vic, SA, WA, ACT) and some including limited allied health if it is part of a post procedure recovery plan (NT, QLD, TAS). This means women cannot claim travel costs for accessing other health services particularly relevant to women, such as women's health physiotherapy (especially following childbirth), mental health services (in particular domestic or sexual violence counselling) and lactation support. NSW includes coverage of highly specialised allied health services.

[22] https://www.accc.gov.au/consumers/petrol-and-fuel/fuel-prices-in-regional-locations

Linda's story

Linda, a 70 year old woman who lives in Jindabyne, NSW, has used the Isolated Patients Travel and Accommodation Scheme several times over many years for herself and her husband. She recently travelled to Sydney for specialist treatment and used the scheme to help cover her travel costs. To get to Sydney for the appointment in the morning, she had to stay overnight in Canberra the night before and catch the 6am bus to Sydney. After her treatment she stayed one night in Sydney and then after a follow-up consultation the next day, travelled back to Canberra before going home to Jindabyne the following day. In Canberra, she pays between $120-135 a night but in Sydney it costs her nearly $240 a night. The Scheme pays $75 per night, leaving Linda out of pocket roughly $275, just for accommodation. While the additional costs of bus travel to Sydney from Canberra return were covered, the Uber and taxi fares paid to get to the appointments and hotels are only covered for travel on the day of appointments leaving another out-of-pocket expense of more than $50 for that trip alone.

Anneleise's story

Anneleise is a 58 year old woman who lives in Port Kenny on the Eyre Peninsula in remote South Australia. Her nearest specialist medical facilities are in either Whyalla (329kms away) or Port Lincoln (233kms away), and sometimes Adelaide, which is 700kms away. She has used the SA Government's Patient Assistant Transport Scheme several times for various medical treatments for both her and her husband. One recent trip she and her husband (escort) were reimbursed $88 for accommodation that cost $190. Not only is the subsidy ($44 per person per night, with patients paying the first night) way below the true cost of accommodation, but the claims process is difficult and often requires following up and fighting to have your cost covered. Sometimes, it can take months to receive a payment. "You've got to fight for it, you've got to go back to your doctor every time to get the forms signed," Anneleise said. "You get exhausted from feeling as though you're not entitled to it and you are entitled to it."