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

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

treatment. Both of these factors are exacerbated by travel costs. The requirement to be seen by 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

State	Eligibility	Private vehicle	Public Transport	Flights	Accom	To note
VIC	≥ 100 km one-way or ≥ 500 km/ week	A$0.21/km*	Economy fare *Taxi to and from nearest public transport where no other options	Approved costs reimbursed (>350 km flights)	$45/night for patient and carer	Lowest payment rates of all schemes Patient pays first $100 of every treatment year
NSW	≥ 100 km one-way or ≥ 200 km/ week	A$0.40/km	Full economy fare *Taxi - appt limits	Full economy with pre-approved code (from referring practitioner)	$75/night (1–7 nights); $120/night (8+); private/family stays: $40/night	Includes allied health, clinical trials
QLD	> 50 km each way	A$0.34/km	Full economy fare	Economy fare	$70/night ($10 a night for private accom)	Lowest distance criteria
TAS	75km specialised service or 50km for cancer or dialysis centre	A$0.24/km	Full economy fare	Island/interstate patients (incl Spirit of Tas) Taxi eligible for flights and Spirit of Tas	$76/night or $98/night for interstate	Co contribution of $82 for each trip PTAS will cover interstate travel if service unavailable
SA	>100 km	A$0.32/km	Calculated based on standard priced ticket	Approved (medical specialist approved pain etc) Taxi not	Subsidies are available up to $40 (plus GST) per person, per night. Commercial	Birthing mother is patient until birth, then becomes escort No allied health

				approved	accom only	Pregnancy Advisory Centre BreastScreen SA included
WA	>100 km (Limited assistance for travel between 70 and 100 kilometres (one way) for renal or cancer treatment.	$0.40/km $20 per return trip for renal or cancer treatment	Economy fare	More than 350 km and receiving cancer treatment, economy fare More than 1,200km - economy fare Or essential for medical reasons Taxi- limited	Up to $110 per night and an additional $15 for an approved support person Private: $20 per night each person Not eligible (70-100km cancer or renal)	Special treatment for renal or cancer treatment Automatic escort for birthing mothers
NT	>200 km (or >400 km/week for oncology/renal)	$0.20/ km	taxis and buses - up to $50 for the entire approved trip will be paid when you provide receipt/s	Full reimbursement, cheapest fare	up to $60 each night	Automatic escort if travelling with a child under 2 No automatic escort for obstetric confinement Sexual assault counselling - in conjunction with forensic/medical examination or acute injuries

ACT	interstate	Claim limits for each city, i.e Sydney: $165 Melbourne: $330	Does not cover taxi, buses, interstate rail or bus	Yes, if medically required and stated by specialist	Night limits i.e. $70 per night or $140 per night with an escort.	No allied health Abortion care is free in ACT

Issues

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

[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

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 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.

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

[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

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 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.

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

[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

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]

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,

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

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 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.

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[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

[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."

Rural, regional and remote women face specific challenges accessing health care

All rural people are more likely to have poorer health outcomes than metropolitan populations. And all women face challenges accessing appropriate health care. But the data shows that rural regional and remote women face compounded disadvantages - experiencing the 'worst of both worlds'.

Rural people have poorer health outcomes

Roughly 7 million people – or 28 per cent of the Australian population – live in rural and remote areas. People living in rural and remote areas have higher rates of hospitalisation, death and injury and also have poorer access to, and use of, primary health care services, than people living in major cities.[23] According to the National Rural Health Alliance, each person in rural Australia is missing out on nearly $1090 a year of healthcare access, which equates to a total annual rural health spending deficit of $8.35 billion.[24]

To access the care they need, rural people must travel. In addition to the time and physical toll that travel takes, the cost of travelling is a significant barrier to accessing health services for rural, regional and remote Australians. A study of regional populations in Australia, Canada and Sweden found travel costs and logistics were highlighted as significant challenges besides the distance factor. This included transport expenses required to reach healthcare services, accommodation fees if participants had to stay overnight to access treatment, and expenses related to the healthcare service and/or the necessary medications. The study found that costs associated with travel was a significant challenge for all participants who also cited an unwillingness to travel when they were sick.

Women's unique health care needs

Women require specialised health services related to sexual and reproductive health. These services can be harder to access in rural areas. One study of more than 800 rural women found that birthing services, mental health, women's health and counselling, as well as aged care and domestic violence services, were the hardest to access.[25]

Medicare covers IVF with medically diagnosed infertility - but significant cost gaps remain. For example, according to Monash IVF, the gap for one embryo transfer is approximately $6,000.[26] Donor procedures and surrogacy are not covered by Medicare. Abortion is partially covered by Medicare and health insurance, however there are out of pocket costs. These start at around $500 for a telehealth medical abortions or at around $800 for a surgical abortion.[27] In addition to out of pocket costs, there are other costs including other healthcare appointments (e.g. for referral, laboratory testing, or ultrasound), prescription medication, contraception, sanitary items,

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[23] https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

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

[25] https://www.rrh.org.au/assets/article_documents/article_print_475.pdf p.6

[26] https://monashivf.com/costs/treatment-ivf-costs/

[27] https://www.msiaustralia.org.au/costs-and-prices/

child-minding, and counselling services.[28] Abortion services are free of charge in the ACT.[29] It is estimated that one in four Australian women experience an unintended pregnancy during their lifetime, with rates even higher in non-urban areas. [30]

Not only are there out of pocket costs associated with abortion care in Australia, but there are limited service providers, especially in regional, rural and remote areas. In Queensland, there are 9 listed surgical abortion providers, none further west than Longreach.[31] Access to abortion in regional Western Australia, which has only recently decriminalised abortion, is unclear.[32]

In Victoria there are sexual and reproductive health care 'deserts' - according to Women's Health Victoria. Their data showed that of the 24 high disadvantage regional and rural LGAs in Victoria

- 67% did not have any listed surgical abortion providers
- 45% did not have any listed medication abortion providers
- 29% did not have any listed IUD providers
- 25% did not have an STI or cervical screening provider, and
- 60% did not have any listed medication abortion dispensing pharmacies.

Their data shows that women wishing to terminate a pregnancy over 9 weeks gestation were more likely to be from disadvantaged backgrounds or underserved communities. This indicates that rural regional and remote women may be more likely to delay seeking pregnancy terminations and be forced to travel further to access appropriate medical care.

In NSW, large areas of the state are abortion care deserts. There are only three public hospitals that are listed as formally offering surgical abortion in NSW. The only public hospitals openly providing abortion outside of a medical emergency are in Broken Hill, Newcastle and the Royal Women's Hospital in Sydney. Accessing services for people living in a desert requires (at a

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[28] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-024-06758-8#Tab5

[29]https://www.theguardian.com/australia-news/2023/apr/20/act-becomes-first-australian-jurisdiction-to-offer-free-universal-access-to-abortions

[30] The Senate Community Affairs References Committee Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia.May 2023 p.11

[31]https://findaservice.childrenbychoice.org.au/?abortion_surgical=true#6,-23.453168015916184,144.26147460937503

[32] Surgical abortion up to 13 weeks is available in Dunsborough, other locations are not listed. *'Local WA Country Health Service facilities vary in their ability to provide abortion care. For hospitals and services that can provide abortion services, a referral is required.'* https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Abortion/Abortion-CHO-approved-information-for-patients

minimum) access to a form of transport, a minimum round trip of four hours by car, possible overnight accommodation and additional travel funds beyond the cost of the abortion itself.[33]

Another study of rural women accessing maternity and perinatal services outlined the burden of travelling to access care including fuel costs, the need to take more sick leave to attend appointments in other locations, and physical exhaustion from travelling. This study also raised the range of other support services (in addition to birthing services) that are critical for new mothers and babies, that were available in some areas and not in others, for example perinatal mental health services, lactation support, physiotherapy and home midwifery services.[34] One participant in this study estimated she was travelling 1,000kms a week to access her pregnancy care.[35] Another study of Australian women from regional areas accessing abortion care showed patients travelled between 2-10 hours and waited between 1-6 weeks to access an appointment, due to the lack of services in their area.[36] These examples demonstrate that travel costs are compounding the barriers women face to access specialist women's health services.

Women's health challenges

Women and girls face barriers accessing the right medical treatment in general, not just related to sexual and reproductive health or rural access. This can lead to poorer health results like delayed diagnosis and treatment, over prescribing and dismissal of pain.[37]

Women pay more and are more likely to delay their treatment. In fact, women are nearly twice as likely to delay seeing a GP, with 1 in 25 women delaying care in the past 12 months, compared to 1 in 40 men. [38] Women are often more likely to prioritise the care of others around them, often at the expense of their own health.[39] Rural women in particular, who are known to be stoic and used to adversity, may be at risk of delaying medical care and prioritising the wellbeing of their family members.[40]

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[33] https://www.theguardian.com/australia-news/2024/dec/17/nsw-abortion-deserts-just-three-of-220-public-hospitals-provide-terminations-research-finds and https://www.theguardian.com/australia-news/ng-interactive/2024/dec/16/how-hard-is-it-to-access-an-abortion-in-nsw-these-maps-show-the-deserts-for-care-in-the-state

[34] https://www.sciencedirect.com/science/article/pii/S1871519224002695

[35] Ibid

[36] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-024-06758-8#Tab5

[37] https://www.health.gov.au/news/end-gender-bias-in-australias-healthcare-system

[38] https://www.theguardian.com/australia-news/2024/nov/12/alyses-chronic-health-conditions-have-cost-her-400000-doctors-say-the-system-unfairly-penalises-women#:~:text=Many%20women%20are%20missing%20out,to%20one%20in%2040%20men.%E2%80%9D

[39] https://www.rrh.org.au/assets/article_documents/article_print_475.pdf

[40] https://www.rrh.org.au/assets/article_documents/article_print_475.pdf

Women are more likely to have a chronic health condition compared to men. They're also more likely to report having multiple chronic conditions.[41] Adult women have a higher overall rate (56%) of having at least one of 10 common non-gendered chronic conditions compared with adult men (49%), with an especially higher prevalence for conditions including osteoporosis, arthritis, asthma, mental and behavioural conditions.

Recently, attention has been drawn to gender inequity that is built into the MBS. The gaps are greater for many women's health procedures, with rebates sometimes higher for faster and simplex procedures for men. For example, rebates for many gender-specific Medicare items including pregnancy scans have not changed in more than three decades, despite becoming more detailed and more complex, leading patients of obstetricians and gynaecologists to have the highest out-of-pocket expenses out of all medical specialties.[42] Even if the rebate is the same for men and women, the rebate may be applied differently.[43] The Commonwealth Government is currently conducting a review into medicare rebates for women's health care procedures.[44] But, this review has been criticised for its limited scope, which only focuses on diagnostic imaging and specific MBS procedures. In looking only at these procedures it overlooks women's mental health, menopause support, chronic pain and endometriosis.[45]

All women face barriers accessing the appropriate health care. But rural, regional and remote women are at a greater disadvantage than their metropolitan counterparts, by having fewer locations to get the right treatment and the cost burden of travelling to get there. That cost barrier can be removed by improving PATS schemes to better accommodate women's needs.

Background of the scheme

The Isolated Patients Travel and Accommodation Assistance Scheme was originally established by the Commonwealth in 1978 to provide financial assistance to patients living in isolated and remote rural communities throughout Australia who needed to travel more than 200 kilometres to access specialist medical treatment. The scheme was transferred to the States and Territories in 1987 in recognition of the fact that the States are better placed to provide patients

[41]https://theconversation.com/women-spend-more-of-their-money-on-health-care-than-men-and-no-its-not-just-about-womens-issues-243797
[42]https://www.theguardian.com/australia-news/2024/nov/12/alyses-chronic-health-conditions-have-cost-her-400000-doctors-say-the-system-unfairly-penalises-women
[43]https://www.abc.net.au/news/2024-04-04/medicare-bias-costing-women-more-mbs-schedule/103664726
[44]https://www.health.gov.au/ministers/the-hon-ged-kearney-mp/media/reforming-the-health-system-to-improve-sexual-and-reproductive-care
[45] https://www1.racgp.org.au/newsgp/professional/medicare-gender-audit-misses-the-big-picture

living in country areas with [more effective] travel assistance complementary to their existing health care delivery (Commonwealth Budget Papers 1986-1987, p.128).

At the time funding was provided in the form of special revenue (financial) assistance grants to the States and Territories to administer the schemes. However, in 1999, the States and Territories surrendered the Financial Assistance Grants in return for the revenue from the Goods and Services Tax. This funding is granted for the provision of free public hospital services through the AHCAs, under these agreements states and territories must ensure that people have access to public hospital health regardless of their location, and PATS schemes are a way to do this.[46] However there is now no specific funding allocated for PATS schemes. The political context was criticism from various sources including consumer advocates, social workers and State and Federal MPs. Their concern was that the Commonwealth did not have adequate local knowledge and delivery mechanisms to respond to the needs of different geographical communities.[47]

Senate review

In 2007, the Senate completed an enquiry into the operation and effectiveness of Patient Assisted Travel Schemes (PATS) called 'Highway to health: better access for rural, regional and remote patients'. The review highlighted issues such as administration inconsistency and complexity (application and approvals), distance thresholds (eligibility and lack of concern for local conditions), the requirement to see the nearest treating specialist (removing choice and access to the best possible treatment), improved access to escorts. It found that many of the schemes were suffering from a lack of flexibility in responding to complex circumstances and, the guidelines too rigid, the system too bureaucratic and decision making constrained. The ACT Health Department's submission stated the schemes were 'under-funded, overly bureaucratic and unfairly restrictive". [48]

This review recommended the development of a set of national standards for PATS schemes and a performance monitoring framework, making the scheme simpler to administer including the development of simplified generic application form and review payment rates to better reflect costs, develop memoranda of understanding for cross border travel and expand access to procedures such as clinical trials, organ donation.[49]

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[46]https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pats/report/c01

[47]https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pats/report/c01

[48]https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pats/report/c07

[49]https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/pats/report/b01

Non commercial accommodation

Some schemes travel non-commercial or private accommodation costs (usually a nominal amount). For example, the NSW scheme covers commercial (operated by a business or a non profit) or private (family home, not a business) accommodation.

Ronald McDonald House Charities provide accommodation for families of seriously ill or injured children who need to travel for treatment in 19 locations around Australia. They also assist mothers with high-risk pregnancies. Priority is given to families whose children have been recently diagnosed, seriously injured or who require emergency treatment, and families traveling long distances from their home.[50] Stays at Ronald McDonald Houses are free, however in some cases families who are eligible can utilise patient accommodation funding which contributes to covering the cost-of-service delivery.[51]

Women with disability

Rural and regional women with disabilities face barriers to accessing health services. These include geographical barriers, lack of demand and supply (and therefore choice) and a lack of infrastructure that often result in limited access to essential services and support, posing significant challenges in relation to the availability, accessibility, diversity, quality, and safety of supports and services.[52] The National Disability Insurance Scheme (NDIS) covers some transport costs.[53] However, for the most part, the NDIS and PATS schemes operate independently, with most PATS schemes specifically noting that patients are not eligible if they are claiming payments from other sources. QLD's guidelines specifically state that patients eligible for NDIS funding can not access the travel subsidy.[54]

Processing delays

While information on time taken to approve a claim was not available for every jurisdiction, it is clear some states have experienced delays for processing claims. In February 2025, claims

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[50] https://rmhc.org.au/frequently-asked-questions/

[51] https://healthcarefunding.specialcommission.nsw.gov.au/assets/Uploads/publications/Listing-of-Submissions-48/Submission-112-Ronald-McDonald-House-Charities-Australia.pdf

[52] Women With Disabilities Australia Response to the Inquiry into NDIS Participant Experience inRural, Regional and Remote Australia Joint Standing Committee on the National Disability Insurance Scheme, Feb 2024

[53] https://www.ndis.gov.au/participants/creating-your-plan/plan-budget-and-rules/transport-funding

[54] Patients are not eligible for PATS eligible to claim assistance from a third party (e.g. WorkCover, Department of Veterans' Affairs, Motor Accident Insurance Commission, or some NDIS packages and private health insurance) https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-travel-subsidy-scheme/guideline-for-the-patient-travel-subsidy-scheme

were made that processing in Victoria[55] was taking several months[56] and last year problems with applications were also raised in the Victorian Parliament.[57]

Appendix 1 (Scheme details by state)

Vic

- Clinical trials and allied health excluded
- Specialist must be Medical approved specialist practitioner (or dentist providing specialist dental services (surgery or royal menthol dental hospital) See guidelines Appendix 4
- Non concession card holders pay first $100 of every treatment year
- Escort -Yes (only if specialist approved on the form) 2 escorts if infant under 6 months
- Commercial accom only
- Also covered: hyperbaric treatment, lymphoedema treatment at the Lymphoedema Clinic, Mercy Hospital, Melbourne, paediatric dental services by a registered dental practitioner at specific locations

QLD

- One escort, approved by health service/clinical reason https://www.qld.gov.au/health/services/travel/subsidies/ptss-subsidies#about-escort
- Accomodation - would need to travel more than a total of 600 kilometres or eight hours in one day, are each entitled to an accommodation subsidy while travelling or, are attending an early appointment/admission or have a late appointment/discharge may be eligible for an accommodation subsidy.
- 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). A signed private accommodation confirmation must be submitted as proof

[55]https://www.parliament.vic.gov.au/parliamentary-activity/hansard/hansard-details/HANSARD-974425065-29593?utm
[56]https://www.parliament.vic.gov.au/parliamentary-activity/hansard/hansard-details/HANSARD-2145855009-31194?utm
[57]https://www.parliament.vic.gov.au/parliamentary-activity/hansard/hansard-details/HANSARD-974425065-25376?utm

- Eligible patients who are accessing allied health services as an essential component of their treatment plan, and have been referred by a specialist,

NSW

- Includes non-commercial clinical trial, voluntary assisted dying and approved allied health clinics (i.e high risk foot clinic)
- Escort Yes (1), 2 escorts if under 18 or Aboriginal or Torres Strait Islander
- Eligible health services include:
    - recognised specialist medical services
    - highly specialised allied health services
    - dental services
    - prosthetic or orthotic services
    - high risk foot services
    - non-commercial clinical trials
    - highly specialised publicly funded oral health clinics in NSW
    - voluntary assisted dying services
- Covers: Reproductive endocrinology and infertility and Reproductive endocrinology and infertility
- Taxi limits
    - 1 day appointment: maximum $20
    - 2 - 7-day appointment: maximum $40
    - 8 - 14-day appointment: maximum $80
    - 15 or more days appointment: maximum $160.

TAS

- Escort - yes
- Approved treatments -
    - most public hospital services
    - most specialist medical services covered under Medicare
    - cancer or dialysis treatment
    - lymphoedema treatment
    - Jack Jumper Allergy Program
    - allied health services that a specialist has ordered as an essential part of your treatment plan
    - independent midwifery services for women who have a low-risk or uncomplicated pregnancy
    - Where access to an eligible clinical service is not available in Tasmania, a PTAS subsidy will be provided to travel to the nearest eligible public clinical service interstate.
    - Clinical trials not covered

- You are required to contribute the first $82.50 towards the cost of each patient return journey. Patient contributions are capped at $330.00 per financial year. The patient and any approved escort meet the total cost of the first 2 nights' accommodation per travel journey. If you are a concession card holder, or the child of a concession card holder, you will only have to pay the gap between the subsidy and the actual cost of travel.
- https://www.health.tas.gov.au/publications/ptas-policy
  https://www.health.tas.gov.au/sites/default/files/2023-03/patient_travel_and_assistance_scheme_ptas_policy_-_accessible.pdf

SA

https://www.pats.sa.gov.au/am-i-eligible/
https://www.pats.sa.gov.au/wp-content/uploads/2024/08/brochure-sa-health-pats-guidelines.pdf

- escort Yes (under 17, aboriginal patients, otherwise must demonstrate need)
- Taxi/uber not included
- Not included - clinical trials or experimental treatments other than phase IV trials • appointments with a medical specialist for a second opinion • surgery provided for cosmetic reasons only • monitoring programs.
- The following health professionals are not classified as medical specialists and **do not** meet PATS eligibility criteria:
  - allied health professionals
  - general dentists
  - nursing and midwifery professionals
  - General Practitioners (GPs)
- Clients awaiting the birth of a child may be medically required to remain near the treatment location prior to the birth. In these situations, the expectant mother is the client. 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.
- Escorts if under 17, Aboriginal, clinical approval (administering care, decision-making)
- Cross border travel If the client lives near a South Australian border, where the nearest medical service is over the border in an adjoining state or territory, this travel will still be eligible for a PATS subsidy.

WA

- If you travel between 70 and 100 kilometres (one way) to receive cancer or renal treatment, you are eligible for a flat rate travel subsidy for each return trip. This is regardless of whether the trip is by private vehicle or other paid transport, and regardless

of whether you are accompanied by a support person. The subsidy can be used towards travel or accommodation.
- No allied health
- Escort Yes (if under 18 or clinical requirement, cancer etc) + If you are travelling over 100km (one way) to give birth, or your doctor requires you to be near a hospital before or after birth, including for perinatal loss or late termination and threatened preterm labour (Previously an automatic escort was not provided for pregnancy/birth.[58]
- Renal treatment includes pre-dialysis education, dialysis treatment, surgery and follow up, appointments with a nephrologist or vascular access consultant and home therapy training. Cancer treatment includes chemotherapy, radiotherapy and/or palliative intervention, surgery and follow-up. It does not include diagnosis, consultations or treatment planning.
- Taxi only in limited circumstances
- Road travel greater than 500km. You may be able to claim one night of accommodation for every 500km (most direct and practical route) travelled in a private vehicle.

NT

https://digitallibrary.health.nt.gov.au/nthealthserver/api/core/bitstreams/b889bd43-42cc-4cf1-a59e-4f9b6fda8e65/content

- IVF (page 7 and 8 of the guidelines), dental surgery, some allied health, Medical termination of pregnancy included. Guidelines page 23
- Referring practitioner will decide if you need an escort.
- An escort is automatically approved in all of the following cases:
    - you are under 18 years old
    - if you have a child under two years old travelling with you
    - you are travelling interstate for surgery or intensive treatments.
- Obstetric confinement from 38 weeks - There is no automatic approval for an escort to accompany a patient travelling for obstetric confinement, except in circumstances where the patient has a child under the age of two who is travelling with them.
- Sexual Assault Referral Centre (only if in conjunction with forensic or medical examination or acute injuries) counselling alone is not included.

ACT

- Covers clinical trials, does not cover allied health or prosthesis
- Capped trip costs and nightly limits ($70 per night for patient, $140 per night with escort. If ia child, two escorts are covered at a higher rate and different rates apply for non

[58]https://www.parliament.wa.gov.au/Parliament/commit.nsf/(Report+Lookup+by+Com+ID)/763CA24D4868976848257E660025B7EB/$file/pc.pat.150609.rpf.025.xx.pdf

commercial accommodation)
https://www.canberrahealthservices.act.gov.au/__data/assets/pdf_file/0007/1985479/IPTAS-Guidelines-July-2023.pdf

- Does not mention IVF, covers medical termination of pregnancy, just that must be referred by GP, Dentist, midwife or optometrist.
- Escort Yes - two escorts for child, Aboriginal/Torres Strait Islander