## CHAPTER 25 - TRANSPORT

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Executive Summary

Health services in NSW are major generators of passenger transport demand. Travelling to and from health facilities is often difficult for people who cannot use or have difficulty in accessing public and/or private transport. Transport disadvantaged people are more likely to be those also experiencing the greatest socio-economic and health disadvantage, or who live in rural and/or isolated communities. This in turn affects NSW Health’s ability to reduce the gap between those people in the community with the best and poorest health.

NSW Health, Transport for Health

Transport for Health establishes a policy framework to assist NSW Health to simplify and improve patient access to health services by:

- responding to the health transport needs of patients in a consistent, strategic and efficient manner;
- developing and maintaining effective working partnerships with transport providers and stakeholders;
- facilitating recognition and consideration of the role and importance of health transport in service planning and delivery within the New South Wales health system.

Transport for Health integrates all non-emergency health related transport service provision throughout the Area Health Services in New South Wales (NSW) into one multifaceted program. These services are delivered by a variety of transport providers with support from a range of NSW government agencies. Transport for Health includes the former programs:

- Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
- Health Related Transport Program (HRTP)
- Inter-facility transport
- Statewide Infant Screening-Hearing (SWISH) Travel
- Services funded under the former Transport for Health program

Transport for Health is aimed at supporting Area Health Services to be more strategic in identifying, consolidating and integrating a full range of transport services and resources to increase efficiencies and reduce duplication. It will do this by the creation of:

1. Health Transport Units as central point of contact within Area Health Services for responding to health transport issues.
2. Health Transport Networks that will provide a formal channel of communication between Area Health Services and health transport stakeholders in order to achieve better collaboration in the planning and provision of improved patient transport solutions.

Priority of access to Transport for Health services will depend on an assessment of how the health of a patient is likely to be affected if transport is not provided or obtained. No eligible person shall be denied access to a service on the basis of inability to pay a requested contribution. Priority is to be given to requests for assistance that will have the effect of:

1. Preventing the further development of a medical condition or,
2. Reducing the chance of an existing health condition becoming more severe.
TRAVEL ASSISTANCE/TRANSPORT SERVICES

Individuals who are not eligible for assistance through Transport for Health are:
1. People who require transportation by the Ambulance Service of New South Wales.
2. People whose medical condition or behaviour constitutes a danger to themselves, others or property.

Transport for Health, subsidies are available for patients who are disadvantaged by distance and isolation, and need financial assistance to use transport services. Transport for Health provides assistance to transport disadvantaged patients by:
- Purchasing or providing direct transport assistance through either brokerage/contractual arrangements or direct service provision.
- Subsidising the cost of patient transport to medical specialists, dental surgeons and, audiologists (for babies screened under the Statewide Infant Screening-Hearing (SWISH) program).

This assistance was provided under the former programs:
- Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS)
- Statewide Infant Screening-Hearing (SWISH) Travel

New provisions for the Transport for Health - Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) will commence on 1 July 2006. These will:
- cut the eligibility distance for Transport for Health - IPTAAS from 200 kilometres to 100 kilometres; and
- increase the vehicle allowance from 12.7 cents per kilometre to 15 cents.

This is consistent with Australian Health Ministers’ Advisory Council (AHMAC) national standards.

Transport for Health, which includes transport service providers and financial assistance schemes, reflects NSW Health’s commitment to promoting fairer access to health services and increasing equity in health outcomes. The reforms promoted by this document will provide efficiency gains for Health Services and more effective and equitable delivery of health care to rural and metropolitan communities. Transport for Health will also enable NSW Health to make a valuable contribution to the development of a whole of government approach to better meet the passenger transport needs of communities across NSW.

Part 1: Policy Framework

1. Why transport is important for NSW Health?

Fairer access to health care and increasing equity in health outcomes are key objectives of the New South Wales health system. Two important NSW Health reports (Ministerial Advisory Committee on Health Services in Smaller Towns, 2000 and NSW Health Council, 2000) established that timely and appropriate access to health facilities for transport-disadvantaged people is essential for the cost effective and equitable delivery of health care. These reports highlight that a shortage of affordable transport and the centralisation of specialist medical services were the most significant barriers to achieving this goal.

Transport for Health presents an opportunity to integrate all NSW Health funded non-emergency health transport programs under one umbrella within each Area Health Service. With all key stakeholders working collaboratively to improve the planning, coordination and provision of health related transport services, patients will directly benefit from improved access to the health care they need.
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Health related transport demand

NSW Health is a major generator of passenger transport demand. Current public transport services and private transport are often not available or accessible to a significant number of people living in NSW. This can at times result in people experiencing considerable disadvantage in accessing transport. Transport disadvantage is one of many underlying social factors impacting on people’s everyday lives that contribute to health inequalities and impacts on NSW Health’s capacity to reduce health inequities. The impact of transport disadvantage is often greatest for people who are already vulnerable to the effects of broader social inequalities such as people living in remote communities, housing estates, urban fringes, or Aboriginal or Torres Strait Islanders, the unemployed and those living with a disability etc.

In addition, patients are often required to travel between health facilities to access necessary specialist diagnostic and treatment services. Non-emergency inter-facility transport services have been established at many health facilities to meet this need.

The Transport for Health policy provides a guide to the principles of non-emergency health related transport and the steps involved in developing a coordinated and efficient system for responding to patient transport demands.

2. What is Transport for Health?

*Transport for Health will integrate all non-emergency health related transport into a single streamlined and efficient program in each Area Health Service. It aims to improve patient access to health services across NSW and subsequently to improve health outcomes.*

Transport for Health is concerned with demand responsive non-emergency health related transport, which caters for the travel needs of people who cannot reasonably get to or from local health facilities by their own arrangements, and whose condition is not of an acute nature requiring Ambulance transport. The spectrum of Transport for Health services is illustrated in the following diagram.

At the lower end of non-emergency health related transport are people who have a short-term medical condition or a frailty that prevents them from using conventional private or public transport. Many of these people have minimal requirements for assistance and are often capable of using public transport if these services are available at a suitable time, location and cost. Children can also present unique health transport issues including the need to accommodate siblings, secure a transport setting that complies with child protection measures and the fitting of vehicles with appropriate child restraints.
In certain special circumstances such as when a patient has to be transported on a stretcher or requires active (clinical) monitoring or management, the Ambulance Service of New South Wales may provide a non-emergency patient transport service. In some cases an appropriately fitted and monitored Area Health Service vehicle can also provide such services.

Non-emergency health related transport service providers

The needs of transport-disadvantaged patients are addressed by a diversity of transport service providers with support from a range of government agencies. NSW Health is committed to working closely with all key stakeholders to develop integrated solutions that reduce the negative impacts of transport disadvantage upon the health of individuals and communities.

Transport for Health, non-emergency health related transport services include:

- Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) - Rural Area Health Services.
- Transport for Health - Rural Area Health Services and South Eastern Sydney Illawarra Area Health Service.
- Statewide Infant Screening-Hearing (SWISH) Travel.
- Health Related Transport Program - Rural and Metropolitan Area Health Services.
- Inter-facility transport services.
- Greater Metropolitan Clinical Taskforce (GMCT) Inter-facility Transport - Metropolitan Area Health Services and Hunter New England Area Health Service.

A significant volume of health related transport is provided by community based non-government organisations funded by NSW Government programs such as Home & Community Care (HACC) and the NSW Community Transport Program.

Aboriginal community controlled health services and Aboriginal transport organisations also provide health transport and in many cases Aboriginal communities are best served by such specialist non-emergency transport services.

Mainstream public transport including taxis, buses and long distance coaches are also an important source of transport for persons travelling to health facilities, and there is potential to significantly increase this sector’s contribution to health transport services.

Transport Assistance

Transport for Health - subsidised travel schemes are financial reimbursement schemes for patients who are disadvantaged by distance and isolation and need financial assistance to use transport services to access specialist medical services not available locally.

Transport for Health provides assistance by either purchasing or providing direct transport assistance through brokerage, contractual arrangements, or by direct transport provision by an Area Health Service for example. The program also provides assistance by subsidising the cost of patient transport to medical specialists, dental surgeons and, audiologists (for babies screened under the Statewide Infant Screening-Hearing (SWISH) program).

Transport for Health subsidised travel schemes currently funded by NSW Health include the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) and the Statewide Infant Screening-Hearing (SWISH) Travel.
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Non-emergency inter-facility transport services

Non-emergency inter-facility transport services are health related transport services for transporting admitted and/or non-admitted patients between health facilities. This may include stretcher equipped transportation, operated by an Area Health Service.

Non-emergency services provided by the Ambulance Service of New South Wales do not form part of the NSW Health, Transport for Health program.

3. Why a transport policy for NSW Health?

Transport for Health is the key strategy through which NSW Health is working to improve access to health facilities for transport-disadvantaged patients and between facilities for those needing to travel to other sites for health services. The Transport for Health (2006) policy recognises that both transport disadvantaged patients and the NSW health system will derive considerable benefit from a comprehensive and consistent approach to non-emergency health related transport service planning across the State.

Transport for Health has been developed to improve patient access to health services by:
- addressing the non-emergency health related transport needs of patients in a strategic manner;
- integrating all non-emergency NSW Health funded or operated transport services or financial assistance schemes (eg IPTAAS, SWISH Travel, Health Related Transport Programs, non-emergency inter-facility transport programs and Transport for Health) into a single multi-dimensional health related transport program;
- developing, strengthening and maintaining effective working partnerships with all transport providers and stakeholders;
- facilitating recognition and consideration of the important role of non-emergency health related transport in service planning and delivery within the New South Wales health system.

Transport for Health will play a valuable role in the development of a whole of government approach to meet the transport needs of rural and metropolitan communities in an efficient and cost effective manner. Transport for Health is intended to contribute to the process of integrating a range of NSW Health resources and strategies by bringing them into operational alignment, with the broader resources and systems supported by the NSW Government, public transport system and community services sector. Integration of non-emergency health related transport programs will result in improved patient access to health services, better health outcomes, and provide for operational efficiencies in the administration, planning and management of patient care.

Transport for Health recognises the role of the NSW Aboriginal Health Partnership Agreement 2001 in improving the health outcomes for Aboriginal people by promoting cooperation and collaboration between NSW Health and Aboriginal community controlled health services. The Transport for Health policy supports and encourages the development of partnerships between Area Health Services and Aboriginal community controlled health services that will promote the provision of culturally appropriate non-emergency health related transport services for Aboriginal people.

4. The policy outcomes

Transport for Health supports whole of government responses to transport needs by supporting a partnership approach between NSW Health and other transport funders and providers. It aims to provide a more efficient use of non-emergency health related transport resources through the improved coordination and integration of transport programs.
The *Transport for Health* (2006) policy aims to improve access to health services for transport-disadvantaged people, particularly in relation to those with the greatest needs, and ensuring a consistent NSW Health approach to this objective. The intention is to support:

1. Consistency and transparency in the processes and standards relating to non-emergency health related transport operations, including eligibility, passenger and service classifications, purchasing decisions, performance management frameworks and quality assurance.

2. Effective utilisation of transport systems and networks to cater to non-emergency health related transport demand.

3. Development of non-emergency health related transport service systems comprising of a mix of service types appropriate to the unique needs of each Area Health Service.

4. Improved information on and understanding of non-emergency health related transport need, levels of service provision, costs and expenditure.

5. Consolidation and integration of Area Health Service transport budgets and programs into a single multifaceted Area based program.

6. A single point of access for clients requiring transport assistance.

7. Statewide dissemination of information on best-practice *Transport for Health* program coordination and delivery.

8. Development of mechanisms for improving the coordination between the scheduling of outpatient appointments, admissions and discharges and available non-emergency health related transport services.

9. Area Health Services being equipped to more effectively identify, consider and address the transport implications of all strategic, service and facility planning and review processes.

5. **The core principles**

*Transport for Health* draws on the following core principles.

1. The availability and accessibility of appropriate and affordable transport is a fundamental determinant of a patient’s ability to receive timely and appropriate health care.

2. Improved access to health facilities for transport disadvantaged patients is fundamental to achieving the goal of reducing health inequities within the community.

3. Effective and well coordinated non-emergency inter-facility transport is important for patients who need to access health interventions at other sites.

4. Considerable benefits will be derived by establishing a comprehensive and consistent approach to non-emergency patient transport issues across New South Wales.

5. Through effective partnerships NSW Health will add value to and derive value from services funded or provided from other (non-health) sources. This will improve overall system efficiency and community wellbeing.

6. Non-emergency health related transport services should respond appropriately to the cultural requirements of communities and of individual patients in order to facilitate access to health care.
6. The policy objectives

The *Transport for Health* (2006) policy provides a structure to promote the following objectives:

1. Document NSW Health’s approach to planning, funding, coordinating, providing and monitoring non-emergency health related transport programs that promote improved access to health care.

2. Describe the role of NSW Health in supporting and funding the planning, development and delivery of non-emergency health related transport programs by Area Health Services.

3. Support NSW Health in establishing and consolidating effective working partnerships with other government agencies.

4. Support Area Health Services in establishing and consolidating effective working partnerships with transport providers, including community based operators.

5. Provide standard approaches to the planning, management and delivery of non-emergency health related transport programs.

6. Facilitate coordination of non-emergency health related transport services and financial assistance schemes within and across Area Health Service boundaries.

7. Maximise opportunities for operational efficiencies across all non-emergency health related transport programs.

8. Provide a standard approach to the monitoring and evaluation of non-emergency health related transport program delivery.

9. Provide clear guidelines for utilising non-NSW Health providers of non-emergency health related transport.

10. Provide stakeholders including health care providers, transport providers, consumers and community representatives, with mechanisms for consultation on and participation in the planning and monitoring of non-emergency health related transport programs.

11. Establish safety and risk management standards relating to non-emergency health related transport services.

7. Roles and responsibilities

This section outlines the roles and responsibilities of the NSW Department of Health and the Area Health Services implementing this policy.

**Department of Health**

1. Develop and maintain the *Transport for Health* (2006) policy and convene as necessary a statewide *Transport for Health* Implementation Group.

2. Coordinate implementation of the *Transport for Health* (2006) policy and support Area Health Services to implement and develop *Transport for Health* at a local level.
3. Develop in consultation with Area Health Services and other key stakeholders appropriate performance indicators to evaluate program effectiveness.

4. Work in partnership with other agencies to facilitate a whole of government response to the transport needs of communities.

5. Facilitate communications between government and community agencies and industry sectors relevant to Transport for Health.

**Area Health Services**

1. To provide executive support and leadership by the Chief Executive delegating responsibility for Transport for Health to a member of their executive management team. These responsibilities include the requirement to:
   - Develop, implement and monitor an Area Health Service, Transport Implementation Plan.
   - Establish arrangements for Area-wide coordination of Transport for Health through a Health Transport Unit.
   - Progressively consolidate administration of non-emergency health related transport resources, budgets and funding from internal and external sources into a single, multifaceted Transport for Health program.
   - Provide consumers with a single point of access to Transport for Health services.
   - Ensure compliance with non-emergency health related transport funding and regulatory requirements.
   - Provide reports to Department of Health on the Area Health Service implementation of Transport for Health.

2. To establish a Health Transport Network to facilitate communication between Area Health Service and non-Area Health Service stakeholders, and provide a mechanism to inform the development, operation and enhancement of Transport for Health systems and services.

8. **Health Transport Units**

**Functions**

Health Transport Units are to provide a means to consolidate the expertise, resources and administrative systems necessary to facilitate access to health services for transport disadvantaged patients. The primary functions of these units are to develop, enhance and sustain an Area Health Service based non-emergency health transport system that includes:

- Health transport services and transport assistance schemes provided by Area Health Services and non-government organisations.
- Spare capacity within transport services funded under other non-health government programs which can cater to health transport need.
- Health transport sourced through mainstream public transport systems.

The Health Transport Units will provide a major coordination role in the Area Health Service for non-emergency health related transport provision and related transport operations within the Area.
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Scope of operation

Health Transport Units are to provide a focus for health transport coordination and are responsible for recognising and responding to the needs of key stakeholders including patients, a patient’s carer or immediate family, health service staff and transport providers.

This role will involve among other things:
- Managing Area Health Service health transport resources.
- Providing information on health transport assistance.
- Providing information on mainstream public transport services.
- Supporting the implementation of the Transport for Health (2006) policy.
- Negotiating with clinical service providers to ensure complementary alignment of appointment or treatment times and health transport operations.
- Supporting efficient discharge planning processes.
- Taking health transport bookings.
- Providing transport referrals as appropriate.
- Administering non-emergency health related transport assistance schemes.

It is the Health Transport Unit’s role to ensure effective utilisation of all available resources within and external to NSW Health funded services, in order to maximise the productivity of Area Health Service transport resources and to assist the efficient delivery of health services. The key tasks are to:

- Develop, implement and monitor the Area Health Service, Transport for Health Implementation Plan using the NSW Health, Transport for Health Implementation Plan Development Guideline as a reference.
- Pursue a whole-of-government approach to addressing the health transport needs of local residents, including improving network efficiencies and economies of scale in service provision across all modes of transport, and sectoral and funding programs.
- Ensure that Transport for Health strategies and systems are, wherever possible, aligned to and integrated with the transport coordination initiatives of other government agencies.
- Hold the budget for the Area Health Service transport funding.
- Negotiate and manage contracts and/or agreements for the provision of Area Health Service funded health transport services by non-Area Health Service transport providers.
- Collect and analyse health transport service data in order to account for funding expenditure, identify demand and service use trends, and be able to respond to opportunities for improvement in service coverage or efficiency.
- Establish and maintain links with Health Transport Units in other Area Health Services to ensure appropriate and efficient cross border transport services and to support effective inter-Area networking of health services.
- Maintain a register of health transport services that could be used by transport disadvantaged people within Area Health Service boundaries.

9. Health Transport Networks

Function

Each Area Health Service (AHS) is to establish a Health Transport Network, which will provide a formal channel of communication between AHS and non-AHS health transport stakeholders. These networks are to provide a mechanism to inform the development, operation and enhancement of Transport for Health systems and services. Area Health Services that receive Transport for Health enhancement funding are required to resource and support a Health Transport Network.
The primary function of a Health Transport Network will be to achieve and maintain better collaboration between the Area Health Service and other health transport providers contributing to the Area’s service system. The aim is to facilitate coordination of non-emergency health transport resources to:

- Optimise access to health services for transport disadvantaged patients.
- Maxitimise the quantity of available health transport services.
- Ensure the quality of health transport services.
- Identify gaps in health transport service provision.
- Identify duplication or over-supply of health transport service provision.
- Ensure health transport services and transport financial assistance schemes are delivered by the most efficient and equitable service mode.
- Identify and address barriers to cross-sector resource coordination.
- Inform the planning, development and delivery of health services and facilities and non-emergency health related transport.

Membership

Health Transport Networks are to include representatives from the following groups:

1. Health transport providers including the Ambulance Service of New South Wales, community transport organisations, taxi operators, bus and coach service operators.
2. Major generators of health transport demand including Area Health Service (AHS) discharge planners, AHS day surgery departments, rehabilitation departments, aged and extended care departments, community health services, oncology departments, renal services departments and Aboriginal Hospital Liaison Officers.
3. Agencies that fund health transport and/or provide financial assistance schemes including the NSW Department of Ageing Disability and Home Care (DADHC) and NSW Ministry of Transport (MOT).
4. Health transport stakeholders including consumer, local government and divisions of general practice representatives, as well as representatives of any significant equity groups within the Area.

Meetings

Health Transport Network meetings should be chaired by the Area Health Service designated Transport for Health director and convened at least twice a year. Health Transport Network sub-groups may be established to manage regional or local based issues in Area Health Services covering larger geographical areas. Area Health Services will, where appropriate, convene a reference group with Aboriginal community stakeholders, reporting to the Area Health Transport Network and the Area Health Service designated Transport for Health director.

10. Area Health Service - Implementation Plans

As a key element of implementation of Transport for Health, Area Health Services will develop a Transport Implementation Plan that describes how the Area Health Service is addressing the Transport for Health’ (2006) policy objectives. Implementation Plans will focus on the potential to utilise all available transport solutions to meet the non-emergency health related transport needs of the Area’s communities. The plan will also demonstrate how NSW Health non-emergency transport funding will be used to complement and enhance existing local and community transport service
systems. Area Health Services will need to liaise with key stakeholders such as the Ambulance Service of New South Wales during this process as changes in transport service systems within the Area Health Service may impact on the workload of other organisations. The *Transport for Health*, Implementation Plan Development Guide (2006) can be used to assist Area Health Services in developing a Transport Implementation Plan. A copy of this guideline is available from NSW Department of Health.

The Area Health Service Implementation Plan is to identify and address the following key issues:

1. The significant demographic, geographic and health service related factors influencing health related transport demand and delivery in an Area Health Service.
2. Current non-emergency health related transport service delivery, including, the services provided by mainstream public transport, local and community transport and other funded transport services.
3. Current provision of health related transport assistance schemes, including IPTAAS, SWISH Travel, non-emergency health related transport programs, Greater Metropolitan Community Transport (GMCT), non-emergency inter-facility transport assistance and any other similar schemes.
4. Gaps in current non-emergency health related transport program delivery and the opportunities to develop services and/or programs. This should include strategies to improve efficiencies through better coordination and integration of existing services and programs.
5. A description of structures and systems either established or planned for the coordination of non-emergency health related transport programs. This may include the identification of key partnerships as well as establishing program development and delivery goals, timeframes etc.
6. Ensure that a risk management plan is in place to ensure patient safety.

Area Health Service, *Transport for Health*, Implementation Plans are to inform and may well be part of the Ministry of Transport’s Integrated Transport Plans, Service Planning Guidelines and other instruments developed by the Ministry of Transport such as the recommendations outlined in the *Review of Bus Services in NSW 2004*.

Area Health Services may, where appropriate, develop local operational policy that is consistent with the NSW Health, *Transport for Health (2006)* policy to address unique regional or local non-emergency health transport issues.

11. **Monitoring and review**

The Area Health Service in consultation with its Health Transport Network is responsible for monitoring the effectiveness of the NSW Health, *Transport for Health (2006)* policy. This includes promoting equitable access to health services to residents. Area Health Services are to establish local mechanisms for the effective measurement of user satisfaction rates and improved patient outcomes within the NSW Health, *Transport for Health* services.

The Department of Health will monitor the effective implementation of the *Transport for Health* (2006) policy by reviewing Area Health Service reports on service delivery and the Area Health Service, Implementation Plans. The *Transport for Health* (2006) policy will be reviewed in consultation with Area Health Services and key stakeholders every three years. Additional requests for review of any specific aspect of the Policy should be referred to the Director, Primary Health and Community Partnerships Branch, NSW Department of Health. The Department will establish a formal mechanism for monitoring the overall implementation of *Transport for Health*. 
25. TRAVEL ASSISTANCE/TRANSPORT SERVICES

Part 2: Transport for Health - Policy Implementation

1. Eligibility

Decisions concerning priority of access to Transport for Health assistance will be informed by reference to considerations such as the availability of other alternative transport options, a person’s eligibility to receive transport assistance from other government programs, their destination and how their health might be affected if transport or financial assistance to the requested destination is not provided or obtained.

The Transport for Health (2006) policy provides a framework for Area Health Services to assist people who cannot reasonably gain access to local health services by either public or private transport means, or to assist people who need to access specialist medical or oral surgical treatment services not available locally.

It is also recognised that the incidence of transport disadvantage is considerable and that demand for health transport services is likely to exceed NSW Health’s capacity to respond. The policy’s eligibility provisions provide a practical guide to help to ensure that the allocation of finite resources is prioritised to those most in need.

1.1 Who is eligible for Transport for Health services?

Transport for Health (non-emergency health related transport) services are to be provided on the basis of a patient’s inability to reasonably gain access to local health services by either public or private transport, rather than convenience.

The appropriateness of a request for Transport for Health services may not always be readily apparent. Expert advice from relevant health professionals or appropriate community representatives may be required to clarify eligibility for services, particularly requests from or made on behalf of mental health patients, patients with disabilities, patients with challenging behaviours, members of specific cultural groups, and day-surgery patients.

Transport for Health services do not include transport services provided by the Ambulance Service of New South Wales.

1.2 Capacity to use private or public transport to access local health services

Persons seeking access to Transport for Health services should be encouraged to make use of private transport options or alternative mainstream public transport services where these forms of transport can be reasonably accessed and utilised. The factors that should be taken into account when assessing what is ‘reasonable’ include:

- A person’s ability to physically gain access to a vehicle or service.
- The impact of a person’s health condition.
- Distances and duration of travel.
- Waiting times and times of operation, departure and arrival times.
- Number of transfers between services, or different modes involved in making a journey.
- Physical and mental stress involved in organising or making a journey.
- Conditions of roads.
- Availability of suitable assistance or support by a carer or appropriate helper.
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- A person’s capacity to meet the costs associated with the journey.
- Impact of using public transport on the wellbeing of carers or helpers.
- A person’s ability to safely drive to and from the destination.
- The ability of the friends or relatives to safely drive the person both to and from the destination.
- Availability of suitable parking and/or waiting facilities at destination.
- The frequency of a particular journey and the cumulative effect of the above factors involved in multiple journeys.

1.3 Patients who are not eligible for Transport for Health services

There are certain categories of patients who are generally not eligible to receive Transport for Health services. These groups are:

1. people who may require an Ambulance service because of the acute nature of their health condition;
2. people whose medical condition or behaviour constitutes a danger to themselves, others or property.

1.4 Priority setting for service delivery

**A key question is how the health of a person will be affected, if transport to the requested destination is not provided or obtained?**

Priority is to be given to requests for assistance that will have the effect of preventing the development of a medical condition or reducing the chance of an existing health condition becoming more severe. Decisions concerning priority of access will also be informed by reference to the availability of alternative transport options including public, local and community transport services, and a person’s eligibility to receive transport assistance from other government programs.

1.5 Additional Transport for Health eligibility & prioritisation considerations

**NSW Health recognises that accommodating cultural needs can significantly contribute to the recuperation and/or overall health and wellbeing of patients. Transport for Health services should, as far as possible, be responsive to the cultural needs of individuals.**

The following is a guide for managing requests for assistance from groups that may require additional considerations when determining priorities for transport assistance.

1. A patient’s carer, particularly in the case of children, where it is necessary for them to accompany the patient during their journey and/or to remain with them during the period of treatment.

2. Persons seeking to visit relatives or friends staying within Area Health Service facilities who cannot reasonably gain access to those health facilities by either public transport or private transport. Where service capacity is limited, a person who is seeking assistance to attend a medical appointment or treatment will have priority over a person seeking assistance to visit a friend or relative.
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3. Every effort should be made to accommodate culturally related requests for particular health transport service attributes (e.g., drivers of a particular gender). Where a person requests, for cultural reasons, to be accompanied in transit by friends or relatives, and where it is determined that this may impact on their accessing health services, all efforts should be made to accommodate that request. Relevant staff should be provided with appropriate cultural awareness training when dealing regularly with specific groups.

4. The capacity of transport-disadvantaged patients to access transport assistance through other government funding programs such as the Home & Community Care (HACC) Community Transport Program, and the Department of Veterans’ Affairs’ Booked Car with Driver Scheme, should be taken into account when prioritising a person’s access to Transport for Health services. Such decisions should also be supported by a local non-emergency health related transport service system that is planned and implemented in partnership with these other programs.

5. Persons whose care and support needs are fully funded from government or private sector sources such as workers’ compensation or insurance payments are eligible to utilise Transport for Health services. Area Health Services should seek full cost recovery from those funding sources for any service provided.

2. Approved destinations

Ongoing improvements in the organisation and delivery of services by NSW Health means that many aspects of health care that were traditionally delivered in hospital settings are now provided in community or private settings. These services, including primary health care services, remain part of an Area’s extended network of health care services and are important in maintaining the health of the community.

Transport for Health reflects NSW Health’s commitment to promoting access to health services for residents of New South Wales. Approved Transport for Health destinations include any health facility or health care that:

- caters to the needs of Area Health Service residents with acute or chronic health conditions;
- provides a recognised diagnostic, therapeutic (including oral health) or primary health care service;
- provides a recognised service that promotes good health or prevents illness.

The term ‘recognised’ refers to any health service that is considered to be beneficial to a person’s health or wellbeing by a suitably qualified health professional. Where demand for Transport for Health services to “approved destinations” exceeds capacity, priority should be given to requests in accordance with the provisions outlined in 1.4 and 1.5.

3. Patient contributions

Transport for Health aims to balance an expectation, promoted by the Australian Government’s approach to the Home & Community Care (HACC) program, that community transport services should involve a co-payment with the reality that some transport disadvantaged patients, particularly those with chronic illness, have limited capacity to make a financial contribution towards the cost of the transport they require to access the health services they need.
Income derived from patient contributions can increase the scope and capacity of Transport for Health service provision within an Area Health Service. Contributions can also be effective in discouraging inappropriate use of non-emergency health related transport services and might in some cases provide an incentive for patients to pursue alternative public and private transport. There is a need to balance the potential revenue and other benefits derived from patient contributions for use of Transport for Health services against the costs of administration and management.

It is important that any approach adopted in relation to personal contributions does not inadvertently preclude a transport-disadvantaged patient from seeking assistance through Transport for Health even when no suitable transport alternatives are available.

The following principles aim to support a consistent approach to the use of personal contributions for Transport for Health services delivered within an Area Health Service and between different health transport service providers.

3.1 Principles of patient contribution

Health transport providers should seek a financial contribution from patients as currently occurs with the Home & Community Care (HACC) program transport providers but no eligible person shall be denied access to a service on the basis of inability to pay a requested contribution.

1. Providers of health transport services should normally seek a financial contribution from a patient.

2. Patient contributions relate to an occasion of service and do not include donations and bequests that may from time to time be provided to a service provider.

3. The level of a contribution will as far as possible match that applying to comparable non-Area Health Service providers of similar transport service types.

4. No eligible patient shall be denied access to a Transport for Health service on the basis of inability to pay a requested contribution.

5. Providers of health transport services may reduce or waive user contributions based on a reasonable and informed assessment of a patient’s ability to pay and the effect of payment upon their general circumstances.

6. Health Transport Units and providers of Transport for Health services should as a matter of standard practice consider reducing or waiving user contributions for members of identified equity groups such as Aboriginal communities or other very disadvantaged groups.

7. All service providers should make available to any interested party on request a schedule of recommended user contributions and advice regarding provisions for reducing or waiving an individual’s contribution.

8. Health Transport Units should in conjunction with Health Transport Networks and through contracts and/or agreements with non-Area transport providers attempt to minimise significant variance in contribution rates for similar service types across the Area’s health transport system.

9. Health transport service user contributions will not incur GST as long as the patient is accessing the services of a fully qualified health professional.
4. Health transport purchasing by Area Health Services

Area Health Services should purchase health transport services in a manner that optimises the outputs derived from available funds. The sustainability of service delivery needs to be taken into consideration. Transport services purchased should produce quantifiable outputs, supported by accountable and transparent decision making processes. Financial contributions made by passengers shall be treated as being part payment to the provider towards the full cost of service delivery.

Each passenger trip is comprised of three cost components:

- Administration as a portion or multiple of an hourly rate.
- Vehicle staffing as a portion or multiple of an hourly rate.
- Distance being a multiple of a kilometre rate.

Area Health Services should use the *Transport for Health* Costing Framework (Appendix 3) to:

- Identify accurate output costs for *Transport for Health* service delivery.
- Identify cost differentials between *Transport for Health* services catering to different Passenger Classification levels (see Part 2, Section 5).
- Inform decisions related to purchasing and commissioning *Transport for Health* services.
- Assist in determining the relative merits of in-house or out-sourced *Transport for Health* service solutions.
- Assist in developing service solutions using funding from different government agencies and programs.
- Assist in planning or facilitating service partnerships, where different *Transport for Health* sub-tasks can be carried out by different agencies and the total service payments apportioned to different agencies working in partnership (e.g., a community transport organisation provides administration, including bookings and data capture, for a *Transport for Health* service and a mainstream bus operator provides the vehicle and driver).

Where non-emergency health related transport is purchased by Area Health Services using *Transport for Health* funds purchased from external sources, the terms should be recorded in contract/or agreement in line with the AHS Procurement Process documented in the Purchase and Supply Manual for Public Health Organisations (January 2006.) Health transport providers should periodically invoice Health Transport Units for services provided under the terms of their agreements and compile invoices using the cost components identified within the *Transport for Health* Costing Framework (see Appendix 3).

It is recognised that some non-emergency health related transport providers, particularly community based services, have developed services and financial systems dependent upon grant funding paid in advance. In such cases, Area Health Services are encouraged to investigate the establishment of volume purchase agreements that provide health transport providers with necessary levels of stability and security, and also allow Area Health Services to align *Transport for Health* funding to units of service purchased at a specified price.

There may be opportunity for Area Health Services to benefit from NSW Ministry of Transport initiatives for regional integration of purchasing strategies across NSW Government agencies in accordance with the recommendations of the 2004 *Review of Bus Services in NSW*. Area Health Services are encouraged to explore strategies for streamlining the purchase of health transport or improving the value of these purchases in partnership with the Ministry of Transport and other NSW Government agencies.
The care and support needs of eligible Transport for Health passengers vary greatly as do the levels of skill, understanding, and ability of health transport service providers to respond to these needs. A service solution that is appropriate and cost effective for one passenger may be unsafe for another.

The care and support needs of eligible Transport for Health passengers vary from those who are relatively able-bodied and may simply not have access to public or private transport, to those who are frail or have multiple care needs and require the assistance of skilled and trained staff. Accordingly, a service solution that is appropriate and cost effective for one passenger may be unsafe for another.

There is considerable variation in the levels of skill, understanding, medical knowledge and ability to respond to the spectrum of patient care needs among potential health transport providers. The potential therefore exists for misunderstanding, and for situations where passengers are referred to inappropriate service solutions.

The Transport for Health Classification Framework provides a uniform standard for communication and risk management to promote the development of effective and appropriate health transport service solutions. The Framework should be used by all Transport for Health stakeholders in order to:

- Ensure that health transport services are appropriate to the care and assistance needs of each patient.
- Minimise risk to patients and health related transport providers.
- Establish a common language used by all Transport for Health stakeholders to assist booking, referral, purchasing, planning and monitoring activity.

There are two principal components of the Transport for Health Classification Framework.

1. The Passenger Classification system is used to assign eligible passengers through a simple screening process to one of three levels of need (low, medium or high) based on their functional ability and care or assistance requirements (see Appendix 2, Table 1). This process, which may be assisted by the use of the Passenger Screening Tool, provides the basis for all decisions made regarding Transport for Health bookings or referrals (see Appendix 1).

2. The Service Classification system is used to assign Transport for Health services to one of three levels (low, medium or high) based on the ability of a service type to appropriately cater for the care and assistance requirements relevant to Passenger Classification System levels (see Appendix 2, Table 2 & 3).

All Transport for Health passengers are to be assigned a classification level in accordance with the content of the screening tool. The screening tool may be applied to patients remotely (by telephone) or as part of a comprehensive assessment activity. While the screening tool does not need to be completed for each applicant, all patient classification determinations should be able to be explained in terms of the screening tool’s elements.

Transport for Health service providers are responsible for ascertaining any changes to a passenger’s classification level each time a booking is made in order to take account of changed capabilities or care needs following treatment. In addition to advice provided by the applicant, information relevant to the screening and classification process should also be obtained, where appropriate, through information or feedback received from drivers and other service staff, health professionals, carers and their immediate family.
25. TRAVEL ASSISTANCE/TRANSPORT SERVICES

Health Transport Units should develop Fitness to Travel Certificates for use by non-Area Health Service Transport for Health providers. These documents should be consistent with and incorporated within Area Health Service discharge policy and procedures. They should record the certification of an appropriately qualified Area staff member that a patient is fit to travel on a Transport for Health service of a particular Service Classification level after receiving a particular treatment or medical intervention.

Health Transport Networks should aim to ensure that Transport for Health service systems contain an appropriate mix of service classification levels to address the full range of patient needs. The NSW Department of Health will work with other government agencies to promote uniform adoption of policy and processes compatible with the Classification Framework across funding programs contributing to Transport for Health service systems.

6. Training and accreditation

The Training and Accreditation standards for Transport for Health services are linked to the Transport for Health Classification Framework and are consistent with the requirements of the Passenger Transport Act 1990. NSW Health will work with other NSW Government agencies to streamline, standardise and enhance the availability of training relevant to the provision of Transport for Health services. Details of the registration, training and accreditation requirements relating to services operating at the low, medium and high levels of the Transport for Health Classification Framework are outlined in Appendix 2, Table 2 and 3.

7. Physical accessibility of services

NSW Health acknowledges its obligations under the Commonwealth Disability Discrimination Act 1992 and has ensured that these are reflected in all aspects of this Policy Framework. Transport for Health service providers should make every effort to ensure that, wherever possible, vehicles providing Transport for Health services are equipped with wheelchair/passenger lifts, and that these devices are used in order to minimise manual lifting and handling, and to reduce the risk of falls for passengers with restricted mobility or balance problems. Any Transport for Health service providers not utilising accessible vehicles for service delivery should be able to demonstrate clear financial or operational reasons why an accessible vehicle cannot be used.

8. Information and reporting systems

A passenger trip is an international standard for measuring outputs of passenger transport services. It is defined as one-way travel between two points. Commonly an episode of health care delivery will involve two passenger trips: one inbound and one return. All service delivery data must be reported in relation to passenger trips.

NSW Health, Transport for Health commitments

1. To work in collaboration with relevant government agencies to develop a common minimum data set for funding programs contributing to Transport for Health services.

2. To work in consultation with Area Health Services, government agencies, peak bodies, and other stakeholders to develop a common reporting framework that will be used to monitor and evaluate performance for Transport for Health services funded by NSW Health. The reporting system will be designed for electronic data collection and transmission and will be flexible enough to address the breadth of service types and organisations contributing to Transport for Health service systems. It will be comprehensive enough to facilitate efficient evaluation of both service and network efficiency at local, Area and State levels.
3. To identify an appropriate computer based *Transport for Health* information management program and support the acquisition of this software by Area Health Services and provide all necessary training in its use to staff.

**Principles**

The following are principles for guiding the development of an appropriate and effective *Transport for Health* information system.

1. The provision of individual *Transport for Health* services that are safe and efficient requires the efficient management of data.

2. Integrated coordination of *Transport for Health* service systems involves the efficient transfer of specified data between separate service providers and other stakeholders.

3. Effective information sharing, to facilitate cooperative service delivery and planning depends upon the compatibility of the data collected.

4. Effective planning, monitoring, review and enhancement of government funding programs is dependent upon the efficient collation and analysis of accurate and comprehensive service delivery data.

5. Effective cross-program planning and resource coordination, necessary to avoid duplication and yield network efficiencies at local, area and state levels, is dependent upon compatibility of service provision data across government funding programs.

6. Streamlining accountability requirements across funding programs offers considerable opportunity to improve efficiency in service administration by *Transport for Health* providers and to improve upon the effectiveness of integrated coordination of *Transport for Health* service system components.

**Area Health Services**

Area Health Services have distinct geographic and demographic features, which provide unique challenges and many opportunities for the development of service solutions to meet the needs of transport disadvantaged people and those who need to travel between health facilities for health interventions. These variations will influence and lead to diversity in *Transport for Health* priorities established by each Area Health Service.

Factors that contribute to an Area Health Service’s individual needs and service profile are:

- Population demographics including Aboriginal population, health status and socio-economic status of communities.
- Number, nature, size and distribution of health services.
- Geographical area and topographic features.
- Availability of mainstream public transport services and resources.
- Availability and nature of community transport services and resources.
- Nature and levels of non-NSW Health non-emergency health related transport provision.
- Baseline resources for in-house provision or purchasing of non-emergency health related transport services.
- Baseline resources for in-house and external non-emergency health related transport planning and coordination.
25. TRAVEL ASSISTANCE/TRANSPORT SERVICES

- Strategies that reduce the need for non-emergency health related transport such as Telehealth systems.
- Groundwork completed by previous transport development initiatives or projects.

Area Health Services are to endeavour to collect as a minimum the following data in relation to Transport for Health services in relation to each passenger trip purchased or provided:

- Name of Passenger.
- Age of Passenger.
- Equity status (ATSI, CALD, disability).
- Passenger Classification Level (for trip).
- Service Classification Level.
- Service mode used (eg. community bus, taxi etc.).
- Date of service delivery (passenger trip).
- Purpose of trip.
- Trip point of origin.
- Trip destination (including information on health facility or hospital department).
- Patient co-contribution.
- Trip cost (if possible).

Assessment and monitoring data

All providers participating in the health transport system will contribute to determining the process for the initial and any ongoing assessment of a person’s eligibility under Transport for Health. This includes non-health transport providers such as community transport organisations that may determine on an Area’s behalf an individual’s eligibility to receive Transport for Health services.

The collection of a minimum data set including core user data is an essential requirement for the effective planning and efficient delivery Transport for Health service systems. It is expected that a person’s eligibility will be monitored in order to take account of any changes in their care and support needs. Non-Area Health Service health transport services funded under Transport for Health should be able to provide Health Transport Units with relevant patient and service delivery records upon request. The minimum information to be collected for each patient should include:

- Date of initial assessment of eligibility.
- Person and organisation conducting the assessment.
- Assessment eligibility status; and
- Grounds for determining eligibility.

Health Transport Units should also collect and analyse data on unmet non-emergency health related transport demand. This will assist the identification of coordination efficiencies and make valuable contributions to whole of government strategies to improve efficiency and effectiveness of local and community transport networks. Data on unmet demand should include:

- Intended destination.
- Classification of intending passenger.
- Point of trip origin.
- Purpose of trip.
- Frequency of transport requested.
- Representation of a specific disadvantaged group (eg people of Aboriginal or Torres Strait Islander origin, people with a disability, people with a chronic illness and their carers).
9. Effective transport coordination

Effective transport coordination is essential in order to optimise the use of available health transport resources. Effective coordination of health transport will promote:

- Equity of access to health services for transport disadvantaged patients.
- Improved choice, quality and flexibility in health transport for transport disadvantaged patients.
- Health transport demand being met efficiently and cost effectively.
- Balance in responding to the wide range of needs for access to health services.
- Better value being derived from government transport funding programs, coordination initiatives, and transport systems catering to the broader needs of communities.
- Minimise risk to patients being transported.

The core elements associated with effective transport coordination are:

1. Program integration.
2. System-wide coordination.
3. Modal efficiency.
4. Aggregation of patient flows.
5. Demand coordination.
6. Mobility management.

Each of these elements is an essential part of overall effective coordination and should be applied in appropriate combinations based on local context and needs.

9.1 Program integration

Program integration refers to the financial and operational integration and co-location of the range of programs to assist transport disadvantaged patients and those requiring transport assistance to travel between health facilities for treatment or assessment.

9.2 System-wide coordination

System-wide coordination refers to the utilisation of overall health transport capability available through all commercial, non-commercial and community sector resources and service modes. The effective working partnerships required to achieve this objective will be facilitated and supported by the systems and structures promoted in the Transport for Health Policy. The main aim of system-wide coordination is to align existing parts of existing health transport programs in a complementary manner, in order to:

- Optimise system coverage and capacity.
- Minimise duplication.
- Reduce the unit costs of provision across the system.
- Increase viability for operators within the system.
- Minimise “silos” of inefficient resource deployment and operation.

System-wide coordination of health transport programs requires Health Transport Units to identify all existing and potential programs and to maximise their use by developing close partnerships with all relevant funding agencies and transport providers.
9.3 Modal Efficiency

Modal efficiency refers to the different service modes within a transport system (volunteer transport, cars, taxis, community buses, public transport buses, charter buses, spare capacity in Area Health Service patient transport vehicles etc) and the need to recognise the relative merits of these modes in responding to different health transport needs. Modal efficiency recognises that:

- Transport modes have different capabilities, limitations, flexibility and operating costs.
- Carrying more passengers in multiple occupancy modes (buses) than in low occupancy modes (cars) reduces the average unit cost of provision.
- The need for flexibility and demand responsive services also means that there is an important, cost effective and ongoing role for low occupancy modes of health transport.

Modal efficiency requires Health Transport Units to identify accurate operational costs for all components of an Area’s non-emergency health related transport service system in a format that allows for meaningful comparisons (see Part 2, section 4). It is also important to ensure that there is an appropriate balance between multiple occupancy health transport services and low/single occupancy services, and between high-level and low-level services.

9.4 Aggregation of Passenger Flows

*It is essential to develop strategies to aggregate passenger flows wherever possible, and appropriate. This generates greater efficiencies in travelling to and from key destinations within an Area Health Service. Travel arrangements will be generated at specific times of the day and may involve particular transport corridors and/or modes of transport.*

Aggregation of passenger flows recognises that certain destinations or groupings of destinations within an Area Health Service will generate regular and predictable volumes of non-emergency health transport demand. Travel to and from these key destinations should be generated at specific times of day and may involve particular transport corridors.

If passenger flows to common destinations are fragmented, then transport will generally occur in low passenger occupancy modes (cars) at a relatively high unit cost. If the flows are aggregated then multiple occupancy mode transport solutions, such as bus services, can be employed at a lower unit cost. Groupings of destinations can be based on locality, rather than purpose such as in attending health services. Flows that accumulate in towns and communities along a transport corridor to a regional centre might mean that patients are only one category of transport-disadvantaged persons that can benefit from a more broadly coordinated passenger transport solution.

9.5 Demand coordination

Demand coordination refers to health services being responsible for ensuring that, wherever possible, appointment and treatment scheduling practices take account of the difficulties that transport disadvantaged patients can experience in travelling. Transport scheduling arrangements need to complement the availability of transport options. This is critical to the aggregation of passenger flows and achievement of modal efficiencies across a service system.

Health facilities can greatly assist the work of Health Transport Units and health transport providers by:
25. TRAVEL ASSISTANCE/TRANSPORT SERVICES

- Identifying patients’ needs to access health transport services prior to scheduling appointment or treatment times.
- Setting appointment or treatment times in consultation with the Health Transport Unit or transport provider.
- Setting or altering appointment times to align with the availability of transport.
- Setting or altering appointment times to “smooth out” peak demand times for transport.
- Grouping or prioritising blocks of appointment times for health transport passengers from particular localities to allow them to travel on scheduled services.
- Allocating appointments to allow patients to use existing, scheduled health transport or other transport services.

9.6 Mobility management

The best value that can be derived from NSW Health transport funding and the greatest benefits to be gained by local communities occurs when service solutions are developed that focus upon desired outcomes, rather than inputs.

Mobility management involves matching patient need to the most cost effective and appropriate transport service, rather than the most immediate or expedient, transport solution. This will normally involve referral to an existing transport service but can also include the development or commissioning of new service solutions.

A Health Transport Unit fulfilling a mobility management function becomes a “travel agency” where the destination is a health service or home. It will “shop around” to satisfy each instance of transport need in the most appropriate and cost effective way. It does this by taking into account and considering all available transport solutions. Mobility management applied cooperatively and uniformly by stakeholders across a health transport service system can create a “virtual” one-stop shop for patients. In this situation a patient is seamlessly referred to an appropriate transport solution irrespective of their point of entry to the system.

Key considerations in mobility management are:

- **Patient care and support needs.** The Classification Framework outlined in Part 2, Section 5 provides a mechanism through which patient care and support needs can be identified and matched to appropriate transport services.

- **Cost comparisons.** Service solutions that provide best value for money for both Area Health Service budgets and for patients should be utilised subject to these arrangements being able to appropriately cater to a patient’s care needs.

- **Spare capacity** should be utilised wherever possible before allocating or procuring fresh resources to cater to a health transport need. Spare capacity within services that are not necessarily health focused should always be considered.

- **Transfer of passengers needing different levels of care** between health transport services may be examined as an option where appropriate. This can include the transferring of passengers between services or operators.

- **Referral of a passenger to services funded under other programs** that gives priority to the passenger’s needs is also an option where appropriate. A frail older person living independently in the community who needs to visit a general practitioner may be a low priority for Transport for Health but is eligible for Home and Community Care (HACC) services and may be a higher priority for the HACC transport sub-program.
25. **TRAVEL ASSISTANCE/TRANSPORT SERVICES**

- **Service partnerships** offer a means to harness the relative strengths of different transport providers. Examples of these partnerships include use of mainstream bus fleet resources supported by the bookings and funding administration systems of local community transport services, and taxi voucher schemes provided cooperatively by local taxi providers and Area Health Services.

- **Standardised coordination** is required in a broad based health transport service system comprising Area Health Service, community based and private sector providers.

10. **Subsidised travel**

*Transport for Health* has two former assistance schemes under its jurisdiction these are (1) the NSW Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) and (2) the Statewide Infant Screening-Hearing (SWISH) Travel.

10.1 Travel subsidies to visit medical specialists and oral surgeons includes the *Transport for Health - Isolated Patients Travel and Accommodation Assistance Scheme* (TFH-IPTAAS).

For detailed information on the administrative and procedural requirements of *Transport for Health - IPTAAS*, see the *Transport for Health* - Isolated Patients Travel and Accommodation Assistance Scheme - Procedures Manual available from the NSW Health at [http://www.health.nsw.gov.au](http://www.health.nsw.gov.au)

The *Transport for Health - Isolated Patients Travel and Accommodation Assistance Scheme (TFH - IPTAAS)* is designed to assist people in rural communities to gain access to specialist medical treatment and oral surgery not available locally.

*Transport for Health - IPTAAS* provides direct financial assistance to patients to help them meet the costs associated with this travel.

The patient’s local doctor plays a key role in applying for assistance under *Transport for Health - IPTAAS*. The doctor makes sure that if specialist treatment is not available locally the patient is referred to the nearest relevant specialist. The patient’s doctor is also required to confirm in the application form that the patient meets the eligibility requirements for assistance.

*Transport for Health - IPTAAS* is not a full reimbursement scheme. The scheme provides financial assistance towards the cost of travel and accommodation where the patient needs to travel more than 100km (each way) to access specialist care. The cost of meals and incidental expenses, such as parking costs and booking fees, are not reimbursable.

*Transport for Health - IPTAAS* financial assistance can only be used for travel to access specialist medical treatment where the patient is referred by a local medical practitioner. It is not to be used for travel that is undertaken for other reasons.

Residents of New South Wales (including metropolitan areas) who need to travel interstate to access specialist medical treatment that is not available in NSW are also eligible for assistance.

**Eligibility for assistance**

Assistance under *Transport for Health - IPTAAS* is only available to permanent residents of NSW or Lord Howe Island and applies to the patient’s usual place of residence.
Financial assistance may also be provided for an escort where a patient is less than 17 years old or where it is medically necessary for an escort to accompany the patient during the journey and period of treatment.

**Aboriginal health**

An Aboriginal Health Organisation may claim assistance under *Transport for Health - IPTAAS* if it provides transport for the patient and if the patient is eligible to receive assistance.

**Referral to specialists**

A patient may only be referred for treatments listed in the Commonwealth Medical Benefits Schedule Handbook, which are not available in their own locality. The referral can only be made by:

- A medical practitioner
- An optometrist
- An accredited dental practitioner

**Nearest specialist requirement**

*Transport for Health - IPTAAS* is limited to patients living in isolated areas who need to travel at least 100km from where they live (by the most direct route) to receive specialist health care.

Exemption from the nearest specialist ruling may be granted where referral to a more distant specialist is required due to the waiting time for treatment or the patient’s medical condition.

**Who is not eligible for assistance?**

The following persons are not eligible for assistance.

- Overseas residents seeking specialist medical treatment including residents of other countries that are subject to reciprocal health care arrangements with Australia.
- NSW residents seeking specialist medical treatment outside Australia.
- Residents of Norfolk Island.
- Persons receiving living expenses under Commonwealth, State or Territory Schemes.
- Patients who have been transported under another Government funded program such as the Department of Ageing, Disability and Homecare (DADHC), Home & Community Care (HACC) funded community transport program.
- Patients are not eligible for Transport for Health - IPTAAS financial assistance if the injury or illness is the subject of Workers Compensation or Third Party Insurance Claim. If such patients require interim assistance with travel and accommodation costs prior to the settlement of the claim they should apply to the relevant insurer.

Inquiries concerning residents of Norfolk Island and referrals to or from overseas should be referred to the Australian Government Department of Health and Ageing.

**Veterans and War Widows**

Veterans and war widows can only claim financial assistance under *Transport for Health - IPTAAS* if they are not eligible to receive assistance to access specialist medical treatment assistance through the Repatriation Transport Scheme (administered by the Australian Department of Veterans’ Affairs).
10.2 *Transport for Health - Statewide Infant Screening-Hearing (SWISH) Travel*

The *Transport for Health - SWISH Travel* assists parents with the costs of travel (100km one way) to access diagnostic audiology services associated with the NSW SWISH Program.

**Eligibility criteria for obtaining assistance under the Scheme**

To be eligible to obtain financial assistance under the Scheme the following criteria apply:

- Distance - travel at least 100km (one way) from their place of residence to the assessment facility.
- Referral a formal referral must be made by the SWISH Area Coordinator to one of the three identified tertiary assessment facilities.

The SWISH program provides screening for all babies within the first few weeks of being born, at their local hospital or community health centre. It enables the early identification of newborns with potentially significant hearing impairment, which requires follow-up diagnostic audiology services.

**Travel assistance available under the Scheme**

- Wherever possible, the diagnostic assessment facilities should ensure that appointment times for rural patients are scheduled with due consideration given to travelling time, thereby avoiding the need for an overnight stay.
### 11. Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Community Controlled Health Services</td>
<td>Aboriginal Health Care Organisations that are party to Area Health Service Partnership Agreements reflecting the agreement at a State level between the AH&amp;MRC and the NSW Department of Health.</td>
</tr>
<tr>
<td>Accreditation</td>
<td>Systems for quality assurance and regulation of services provided for under legislation and associated regulations.</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>Transport services provided by the Ambulance Service of New South Wales.</td>
</tr>
<tr>
<td>Area Health Service Facility</td>
<td>Area Health Service premises (and mobile centres) used for the direct provision of health services including hospitals, community health centres, outpatient clinics and other locations from which Area Health Service funded services are provided.</td>
</tr>
<tr>
<td>Area Health Service transport provider</td>
<td>A health transport service that is provided directly by an Area Health Service.</td>
</tr>
<tr>
<td>Community Transport</td>
<td>A community based passenger transport service that receives some form of financial operating subsidy either government, non-government or private.</td>
</tr>
<tr>
<td>Designated Director</td>
<td>A member of an Area Health Service executive management team, nominated by the Chief Executive with primary responsibility for Transport for Health.</td>
</tr>
<tr>
<td>Fully qualified health professional</td>
<td>“A fully qualified health professional” would include health professionals with a medical background such as doctors (including psychiatrists, dentists, medical specialists etc), nurses, midwives and allied health professionals such as psychologists, social workers etc.</td>
</tr>
<tr>
<td>Health Related Transport Program</td>
<td>NSW Health funding initiative.</td>
</tr>
<tr>
<td>Health transport</td>
<td>Non-emergency health related transport primarily catering to the needs of sick or injured persons who are not inpatients and are not eligible for transport provided by the Ambulance Service.</td>
</tr>
<tr>
<td>Non-emergency inter-facility transport service</td>
<td>A non-emergency inter-facility transport service is primarily concerned with the transporting of in/out patients needing to attend (a) diagnostic services not available at the referring health facility or (b) those in/out patients who need to be transferred to another health facility for treatment not available at the referring health facility and not requiring the services of the Ambulance Service of NSW.</td>
</tr>
<tr>
<td>Non-Area provider or non-Area Health Service provider</td>
<td>A health transport service that is provided by any organisation other than an Area Health Service.</td>
</tr>
<tr>
<td>Non-Area Health Service Facility</td>
<td>Premises other than an Area Health Service facility used by health professionals in providing health services, including general practitioners, medical specialist private consulting rooms, diagnostic and therapeutic providers, dentists and other private health care providers.</td>
</tr>
<tr>
<td>Not for profit services</td>
<td>Services provided on a non-commercial basis by State government agencies, local government, incorporated associations and other charitable organisations.</td>
</tr>
<tr>
<td>Passenger Trip</td>
<td>A standard measure of transport output representing the conveyance of a single passenger one way between two given points eg home and hospital. A trip from home to hospital, followed by a return trip will equate to a total system output of two passenger trips.</td>
</tr>
</tbody>
</table>
### Passenger contribution

A contribution made by a passenger towards the cost of a trip (or trips) provided by a community transport service. The transport provider records this for budgetary reporting purposes as a ‘service contribution’. It does not include gifts or donations.

### Patient Transport Service

A service, usually stretcher equipped, operated by an Area Health Service for inter-facility transport of inpatients.

### Service system

A network of individual services and service types working together to jointly cater to a specific area of need or demand.
Appendix 1

Transport for Health - Patient Screening Tool

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>YES</th>
<th>WITH HELP</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Passenger is alert and oriented to time, place and person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Can walk from home to car/bus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Can manage 2 steps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Can get in and out of a car/bus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Can manage alone during appointment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Carer going and will provide all necessary help</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Will need to travel with mobility or personal medical aid**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Reason for transport request - To/from medical treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* “WITH HELP” is defined as any form of non-weight bearing physical assistance the passenger may require.

** Mobility or personal medical aid includes wheelchairs, walking frames and portable oxygen equipment but excludes walking sticks or other light weight items.

Question 8 should be linked to a document maintained by Health Transport Units that aligns commonly received medical interventions to levels of post procedural risk relevant to health transport service provision. This document should be regularly reviewed and updated by Health Transport Units and distributed to all registered Transport for Health providers within the Area. The Department of Health will assist in ensuring the uniformity of this document across the State.
### Transport for Health - Classification Framework Tables

#### Passenger Classification

<table>
<thead>
<tr>
<th>Level</th>
<th>Passenger</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>- Requires door to door transport</td>
<td>- From door to door.</td>
</tr>
<tr>
<td></td>
<td>- Requires empathy and reassurance.</td>
<td>- Can provide sympathetic and reassuring service.</td>
</tr>
<tr>
<td>Medium</td>
<td>- As for low level, plus:</td>
<td>- As for low level, plus:</td>
</tr>
<tr>
<td></td>
<td>- Requires some limited (non-weight bearing) assistance to enter/exit vehicle or destination.</td>
<td>- Can provide limited, non-weight bearing physical assistance.</td>
</tr>
<tr>
<td></td>
<td>- Requires some awareness of care needs related to their condition</td>
<td>- Can provide some assistance to manage/cope at destination.</td>
</tr>
<tr>
<td>High</td>
<td>- As for low level, plus:</td>
<td>- As for low level, plus:</td>
</tr>
<tr>
<td></td>
<td>- Requires significant (weight bearing) assistance to enter/exit vehicle or destination.</td>
<td>- Can provide weight bearing physical assistance.</td>
</tr>
<tr>
<td></td>
<td>- Requires trained staff to deal with care needs</td>
<td>- Can provide trained staff to deal with passenger care needs</td>
</tr>
<tr>
<td></td>
<td>- May need observation for post procedural complications</td>
<td>- Can undertake observation for post procedural complications</td>
</tr>
<tr>
<td></td>
<td>- <em>May require management of challenging behaviour or formal supervision</em></td>
<td>- Can manage challenging behaviours or provide formal supervision</td>
</tr>
<tr>
<td>Very High</td>
<td>- Requires a stretcher and appropriate clinical and/or behavioural management</td>
<td>- Can provide appropriately trained clinical staff to deal with passenger care needs</td>
</tr>
</tbody>
</table>
### Service Classification

**Table 2. Service Classification - requirements for providing Low to Medium classification services**

<table>
<thead>
<tr>
<th>Component</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Operators</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drivers</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vehicles</strong></td>
<td></td>
</tr>
</tbody>
</table>
Service Classification

### Table 3. Service Classification - requirements for providing High classification services

<table>
<thead>
<tr>
<th>Component</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td>1. Registered with the Area Health Service Health Transport Unit</td>
</tr>
<tr>
<td>Operators</td>
<td>1. Satisfy all requirements of the 1990 Passenger Transport Act and associated Regulations relevant to the service type to be delivered.</td>
</tr>
<tr>
<td></td>
<td>2. Apply the Transport for Health Classification Framework to assess passenger eligibility for services and carry only passengers who conform to the Classification of the Service type being provided.</td>
</tr>
<tr>
<td></td>
<td>3. Not carry any person who is eligible to receive transport from the Ambulance Service of NSW.</td>
</tr>
<tr>
<td></td>
<td>4. Able to demonstrate the provision of a training program to drivers and other relevant personnel, sourced from a recognised training provider or from a qualified health professional in:</td>
</tr>
<tr>
<td></td>
<td>- Senior First Aid</td>
</tr>
<tr>
<td></td>
<td>- Manual lifting and handling of patients</td>
</tr>
<tr>
<td></td>
<td>- Management of challenging behaviours (excluding those that may constitute a threat to person or property)</td>
</tr>
<tr>
<td></td>
<td>- Other training relevant to the care needs and health conditions of, or treatments being received by, passengers transported by the service</td>
</tr>
<tr>
<td></td>
<td>5. Ensure that drivers and other relevant personnel have attained the competency levels set for satisfactory completion of each of the listed training programs including any requirements for refresher training associated with maintaining currency of competency or qualification.</td>
</tr>
<tr>
<td><strong>Drivers</strong></td>
<td>1. Satisfy all requirements of the NSW Passenger Transport Act 1990 and associated Regulations relevant to the service type to be delivered.</td>
</tr>
<tr>
<td></td>
<td>2. Satisfactorily complete basic training in the capabilities of the Classification of health related transport service being provided.</td>
</tr>
<tr>
<td></td>
<td>3. Satisfactorily complete training and refresher training as required to maintain qualification or currency of skill, in accordance with point (4) above.</td>
</tr>
<tr>
<td><strong>Vehicles</strong></td>
<td>1. Must satisfy all requirements of the NSW Passenger Transport Act 1990 and associated Regulations relevant to the service type to be delivered.</td>
</tr>
</tbody>
</table>
Appendix 3

Transport for Health - Reporting Framework

The reporting framework will include the number and proportion of trips for patients requiring:
- Cancer treatment
- Renal dialysis
- Other

The reporting frequency is quarterly.

The provisional Key Performance Indicators are as follows:

<table>
<thead>
<tr>
<th>How much?</th>
<th>How well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individual people assisted (some people are assisted more than once but are only counted once for the purpose of this measure)</td>
<td>Proportion of multiple passenger trips</td>
</tr>
<tr>
<td>Number of trips provided</td>
<td>Proportion of CALD, ATSI, concession card holders</td>
</tr>
<tr>
<td>Number of multiple passenger trips</td>
<td></td>
</tr>
<tr>
<td>Number of CALD, ATSI, concession card holders</td>
<td></td>
</tr>
</tbody>
</table>

Is anyone better off?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of funding spent on direct patient assistance</td>
<td>Proportion of funding spent on direct patient assistance</td>
</tr>
<tr>
<td>Number of patients who find out about TFH - IPTAAS after their trip commences</td>
<td>Proportion of patients who find out about TFH - IPTAAS after their trip commences</td>
</tr>
</tbody>
</table>

A Transport for Health, reporting framework template is provided to Area Health Services in the Transport for Health Implementation Plan Development Guide.

Definitions

<table>
<thead>
<tr>
<th>How Much</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trips</td>
<td>One-way travel between two points by one person</td>
</tr>
<tr>
<td>Mode</td>
<td>The type and capacity of vehicle used for a trip usually categorised as either Low Occupancy and Multiple Occupancy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is anyone better off?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and distance of trips by mode</td>
</tr>
<tr>
<td>Number of available transport options</td>
</tr>
</tbody>
</table>

Is anyone better off?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and distance of trips by mode</td>
</tr>
<tr>
<td>Number of available transport options</td>
</tr>
</tbody>
</table>

How Much

<table>
<thead>
<tr>
<th>How Much</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trips</td>
<td>One-way travel between two points by one person</td>
</tr>
<tr>
<td>Mode</td>
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</tr>
</tbody>
</table>

Is anyone better off?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and distance of trips by mode</td>
</tr>
<tr>
<td>Number of available transport options</td>
</tr>
</tbody>
</table>

Is anyone better off?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and distance of trips by mode</td>
</tr>
<tr>
<td>Number of available transport options</td>
</tr>
</tbody>
</table>
Appendix 4

Transport for Health
Service Costing Framework

June 2006
## Transport for Health Costing Framework

<table>
<thead>
<tr>
<th>Low/Medium Service Classification</th>
<th>High Service Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Single Passenger</strong></td>
<td><strong>Multiple Passenger</strong></td>
</tr>
<tr>
<td><strong>Rate/item</strong></td>
<td><strong>Rate/item</strong></td>
</tr>
<tr>
<td>Administration</td>
<td>1</td>
</tr>
<tr>
<td><strong>Charge</strong></td>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Driver</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Carer</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Kilometres</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Total service cost</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>Total capacity</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Practical capacity</strong></td>
<td>9</td>
</tr>
<tr>
<td><strong>Contributions</strong></td>
<td>10</td>
</tr>
<tr>
<td><strong>Total Invoice Charge</strong></td>
<td>11</td>
</tr>
<tr>
<td><strong>Trip Cost</strong></td>
<td>12</td>
</tr>
</tbody>
</table>

| **High Service Classification**  |                             |
| **Single Passenger**             | **Multiple Passenger**      |
| **Rate/item**                    | **Rate/item**               |
|                                 | 1                           |
| **Charge**                       | **Cost**                    |
|                                 | 2                           |
| **Driver**                       | 3                           |
| **Carer**                        | 3                           |
| **Kilometres**                   | 5                           |
| **Total service cost**           | 7                           |
| **Total capacity**               | 8                           |
| **Practical capacity**           | 9                           |
| **Contributions**                | 10                          |
| **Total Invoice Charge**         | 11                          |
| **Trip Cost**                    | 13                          |

*Note: Number points below correspond to numbered cells in the table. Bullet points provide general information or comment.*

### Overview
- This framework is designed to assist Non Emergency Health Related Transport providers develop costings for the delivery of services funded under the *Transport for Health* program and to assist Area Health Services understand how charges for service are calculated by service providers.
- The framework is not intended to be used to cost each unit of service for which an Area Health Service is charged. It should however, be used to provide Area Health Services with information on how providers charge for services and can be used to explain how a charge for a particular service, if queried, has been determined.
- Uniform application of this framework will assist Area Health Services compare the costs of different service providers and service solutions.
- This framework only addresses the delivery of services that commence and conclude within the same day.

### Cost Categories
- Two primary categories of service provision are catered to: Low/Medium and High (refer to *Transport for Health* Classification Framework).
- The main difference between Low and Medium level services is experience and training of a volunteer. This is an operational consideration and not necessarily indicative of any major cost difference, therefore the two are grouped for costing purposes.
- Two secondary categories are identified within each primary category: single passenger and multiple passengers. With single passenger services, all costs are attributed to one passenger. With multiple passenger services, total service costs should be shared between the total number of passengers. Cost sharing between passengers facilitates readily accountable multiple funding sources for single services.
Administration Cost Component

The Transport for Health program does not support administrative costs being levied on a per kilometre basis. Administrative costs are generally not related to the distance travelled by a particular service. They are represented in this framework as a (relatively) fixed cost per unit of service.

1. The Administrative cost should be based on an hourly rate for administering a unit of service for a particular type of service. This should include all wage and overhead components. Service providers should be able to break down and account for the components of this cost if required.

2. The total charged for administration of a passenger trip. This should be a portion or multiple of the hourly rate.
   - This cost component provides a means to factor in the overhead cost component of service delivery on a per-booking or per trip basis.
   - There is provision for addressing and difference in administrative inputs between service types. Eg. a request that would need to be catered to in single service provided by volunteer car would normally require more administration than a request that could be allocated straight onto a scheduled bus run.
   - In day to day operations, it is assumed that a fixed rate per service would be levied for ease and efficiency of administration. This would be based on an average administrative time per service type request. It is however feasible that a particularly administration intensive request for service could be reflected as an abnormal charge.
   - NOTE: The average admin charge per booking provides a benchmark against which comparisons can be made and improvement targets set.

Variable Operational Costs

A “trip” can be 5 or 500 kilometres. Distance and duration of a trip should, in every case, be the most variable factors in determining the actual cost of the service.

3. In the case of high level services, this would be an hourly wage rate, inclusive of on-costs (for either driver, carer or both). In the case of volunteer services, this may only include an amount for reimbursement of meal or refreshment costs for services above a minimum duration, as set by the service provider.
   - Under the Transport for Health model, it is assumed that any paid employee engaged in service delivery will be trained to provide a high level service (in accordance with the Transport for Health Classification Framework). Payment for waged staff providing low level classification services should not generally be approved. (Note: this does not mean that a high level service cannot provide transport to a low or medium level passenger.)
   - A high level service may be provided with a volunteer driver, provided that a suitably qualified carer is engaged who is capable of providing level of care and assistance commensurate with Transport for Health high level Service Classification descriptors.
   - High Level Services can, particularly in the cases of multiple passenger services, be a cost effective source of health transport for people who conform to the low and medium levels of the Transport for Health Passenger Classification Framework. Having a low or medium level passenger classification should not automatically exclude a person from receiving transport on a high level NERHT service.
4. The total charged for personnel costs for the passenger trip. This should be a portion or multiple of the hourly rate noted in 3.

5. The kilometre rate for the service. This should incorporate both fixed costs (insurance, registration etc) and variable costs (fuel, maintenance, depreciation). This amount might be based on historical operational costings determined by the service provider or identified from a source such as the NRMA. This figure should reflect average or projected annual kilometres travelled by the service vehicle/s, as the higher this figure the lower the cost per kilometre.

6. The total service kilometre charge. This will be a multiple of the figure noted in 5. This framework assumes that depreciation is a variable cost factored into the kilometre rate of service delivery.

7. The subtotal of administrative and operational costs. This should represent the final (gross) cost of service delivery.

Costing for Multiple Occupancy Services

8. The total passenger capacity of the service vehicle, eg. 10 seats, 20 seats.

9. The practical passenger capacity of the service or, the number of passengers who are normally carried eg a 20 seat bus may normally carry 10 passengers on a particular service run. To carry more may be impractical for reasons of trip duration, passenger fatigue etc.

Items 8 & 9 commence the difficult process of apportioning the operating costs of multiple occupancy services and attributing them to individual passengers/funding programs by acknowledging that it is virtually impossible, for a wide range of reasons, to fill any service all the time and that it is normal for some spare capacity to exist in a multiple occupancy service.

- Practical capacity does provide an important measure, or benchmark for of operational efficiency. The higher the practical capacity, the lower the final cost per passenger.
- The practical capacity can also represent the target capacity for full cost recovery, with additional (above normal operating) capacity being available at marginal cost.
- An inflated practical capacity figure will disadvantage the operator. A deflated practical capacity figure will disadvantage the Area Health Service. The onus will rest upon operators to ensure that practical capacity figures reflect the operational norm, and that this figure is checked regularly to identify changes in service use trends. Area Health Services will reserve the right to review operational documentation from time to time to ensure that practical capacity figures are reasonable.
Passenger (Fare box income) and a Revenue Guarantee Purchasing System

9. Income received from the passenger/s through contribution.

11. The net cost of the service. The total amount for which the Area Health Service will be invoiced for the trip. This will be the cost of the trip, less the income received from the passenger. This represents the amount the provider will invoice the purchaser. The deduction of passenger income from payment for service supports a **Revenue Guarantee** model for *Transport for Health* model and is consistent with a subsidy based service funding model and policy guidelines which ensure patient entitlement to access services regardless of ability to pay.

Determining cost of Passenger Trip outputs

12. The full cost to the Area Health Service per Passenger Trip (the primary output measure for the service or funding programs) in a single occupancy service, being the invoice charge (cell 11) divided by the number of trips provided (usually two for a return journey).

13. The full cost to the Area Health Service per Passenger Trip (the primary output measure for the service or funding programs) in a multiple occupancy service, being the charge (cell 11) divided by the practical operating capacity (cell 9) divided by 2 (representing a return journey being the norm).

- The method outlined in 12 is a compromise, which endeavours to achieve efficiency in the financial planning and administration of multiple occupancy services and which recognises the many variable factors in catering to individual health transport needs in such a service mode. It also provides the means to plan multiple occupancy services based on program funding from a range of sources (virtual funds pooling).
- It is not seen that this approach would prevent or obstruct the collection of real data for actual passengers carried for the purposes of accountability or reporting.
ISOLATED PATIENTS TRAVEL & ACCOMMODATION ASSISTANCE SCHEME POLICY FRAMEWORK (PD2012_070)

PD2012_070 rescinds PD2009_042.

PURPOSE

This policy provides the revised governance framework for the Scheme following changes to IPTAAS eligibility criteria and subsidy levels introduced in January 2012, and reform of IPTAAS claims processing from 1 January 2013.

IPTAAS is designed to financially assist people, particularly in isolated or rural areas, who have to travel significant distances to access specialist medical and/or oral health surgical treatment which is not available locally. The key aim of IPTAAS is to reduce the impact of this disadvantage upon the health of individuals and communities.

MANDATORY REQUIREMENTS

The IPTAAS Policy Framework mandates the eligibility criteria, types of assistance provided, roles and responsibilities within NSW Health, and the monitoring and evaluation process. The Policy Framework is put into practice through separate procedural documentation developed and updated as required by EnableNSW.

IMPLEMENTATION

Section 2 of the IPTAAS Policy Framework outlines the key roles and responsibilities of the NSW Ministry of Health, EnableNSW and Local Health Districts in implementing IPTAAS. The Ministry of Health is responsible for the development and review of IPTAAS policy, whilst EnableNSW is responsible for IPTAAS operations and procedure. Key roles and responsibilities of LHDs vary depending on whether or not the LHD has an operational IPTAAS office, and are specified in the Policy Framework.

SECTION 1: INTRODUCTION

1.1 Isolated Patients Travel And Accommodation Assistance Scheme (IPTAAS)

The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) is a NSW Government initiative designed to financially assist people, particularly in isolated or rural areas, who have to travel significant distances to access specialist medical and/or oral health surgical treatment which is not available locally. The key aim of IPTAAS is to reduce the impact of this disadvantage upon the health of individuals and communities.

The focus of IPTAAS is on patients who are able to use public or private transport, but are disadvantaged by the distances they need to travel to access specialist treatment not available locally. It provides direct financial assistance to patients and their escorts/carers (if required) to assist with the costs associated with this travel.

IPTAAS is a subsidy, rather than a full reimbursement, scheme. Currently, it provides a subsidy to assist with the cost of travel and/or accommodation where the patient needs to travel more than 100km (each way), or at least 200km cumulative distance per week, to access specialist medical treatment.
The cost of meals and incidental expenses such as road tolls, parking and booking fees are not reimbursable. All eligible patients must make a contribution towards each claim, or a weekly contribution if eligible under the 200km per week cumulative distance rule. Pensioners and Health Care Card Holders are not required to make a contribution.

The IPTAAS Fact Sheets provide full details regarding eligibility for IPTAAS, how to make a claim, benefits payable and terms and conditions.

Patient eligibility criteria, application documents and further information about IPTAAS can be found at:

1.2 IPTAAS Policy Framework

With respect to IPTAAS, the policy framework sets out the eligibility criteria, types of assistance provided, roles and responsibilities within NSW Health, and the monitoring and evaluation process.

The policy framework is put into practice through separate procedural documentation developed and updated as required by EnableNSW.

SECTION 2: KEY ROLES AND RESPONSIBILITIES

This section outlines the key roles and responsibilities of the NSW Ministry of Health, EnableNSW and Local Health Districts (LHDs) in implementing IPTAAS.

2.1 NSW Ministry of Health

The Ministry of Health is responsible for:
- The development and review of the IPTAAS policy framework.
- Providing policy analysis and advice relating to IPTAAS to the Ministry’s Senior Executive and the NSW Minister for Health.
- In conjunction with EnableNSW, reviewing IPTAAS expenditure, performance indicators and funding allocations to LHDs.
- Facilitating communication between Government, community agencies and key stakeholders on matters considered relevant to the IPTAAS policy.

2.2 EnableNSW

EnableNSW (part of HealthShare) is responsible for:
- The development and review of IPTAAS procedural documentation and information on IPTAAS for patients and health care professionals.
- Where agreed, processing IPTAAS claims on behalf of Local Health Districts.
- Compliance with the Minister for Health’s requirement that claims must be processed within 30 days of their receipt.
- Oversight of the scheme’s operational processes.
- Ensuring that IPTAAS eligibility criteria are applied in a consistent and equitable manner across NSW.
- Providing training for IPTAAS staff as required.
- Implementing key performance indicators (KPIs), and reporting against the indicators to the Ministry of Health.
25. TRAVEL ASSISTANCE/TRANSPORT SERVICES

2.3 Local Health Districts

The key roles and responsibilities of Local Health Districts (LHDs) vary depending on whether or not the LHD has an operational IPTAAS office.

2.3.1 LHDS with an IPTAAS office are responsible for:
- Their own IPTAAS budgets.
- Employment of IPTAAS office staff.
- Implementation of and compliance with IPTAAS policy and procedures.
- Compliance with the Minister for Health’s requirement that claims must be processed within 30 days of their receipt.
- Providing training for IPTAAS staff as required.

2.3.2 LHDS without an IPTAAS office are responsible for:
- Their own IPTAAS budgets.
- Maintaining a strong IPTAAS customer support and assistance function at the local level.

SECTION 3: MONITORING AND EVALUATION

This section outlines the key roles and responsibilities of the NSW Ministry of Health, EnableNSW and LHDs with respect to monitoring and evaluation of the IPTAAS program.

3.1 NSW Ministry of Health

The Ministry of Health is responsible for:
- Monitoring implementation of the IPTAAS policy framework by reviewing EnableNSW reports on service performance at the statewide and local levels.
- Evaluating performance against the agreed KPIs.
- In conjunction with EnableNSW, and LHDs where relevant, taking action to address areas of underperformance.
- Undertaking a review of the IPTAAS policy framework at least every three years in consultation with EnableNSW, LHDs and external stakeholders.
- Reviewing specific elements of the IPTAAS eligibility criteria and/or subsidy levels at the request of the Minister for Health or the Ministry’s Senior Executive.

3.2 EnableNSW

EnableNSW is responsible for:
- Monitoring the use and overall cost of IPTAAS.
- Monitoring and evaluating performance against the agreed KPIs. The current KPIs, which will be monitored monthly, are:
  - Average time for claims payment
  - Percentage of applicants paid within 30 days of receipt of claim
  - Average administrative cost per claim processed
  - Percentage of applications received that are incomplete
  - Percentage of applications received that are ineligible for IPTAAS
  - Number of complaints received
  - Number of complaints received as a percentage of number of claims received.
- In conjunction with the Ministry and LHDs where relevant, taking action to address areas of underperformance.
- Undertaking a review of IPTAAS reform in 2014.

172(10/01/13)
3.3 Local Health Districts

3.3.1 LHDS with an IPTAAS office are responsible for:
- Monitoring their own IPTAAS expenditure.
- In conjunction with the Ministry and EnableNSW, taking action to address areas of underperformance, if required.

3.3.2 LHDS without an IPTAAS office are responsible for:
- Monitoring their own IPTAAS expenditure.
- Monitoring and evaluating their ongoing local IPTAAS customer support and assistance function.

SECTION 4: ELIGIBILITY FOR IPTAAS ASSISTANCE

4.1 Key Eligibility Criteria

The key criteria for potential IPTAAS eligibility are:
- **Specialist medical treatment and/or oral health surgical treatment not available locally** – the treatment required must be an item listed in the Commonwealth Medicare Benefits Schedule Handbook or the Commonwealth Medicare Benefits for Services by Dental Practitioners Handbook or the Commonwealth Medicare Benefits for the Treatment of Cleft Lip and Cleft Palate Conditions Handbook;
- **Distance travelled** – patients must travel at least 100km (each way), or a cumulative distance of at least 200km per week, from their usual place of residence to access the nearest treating medical specialist;
- **Specialist status** – the specialist visited must be registered as such on the Health Insurance Commission Medicare Provider File to be recognised as a specialist, except as otherwise provided for in this policy framework.

Unless all of these criteria are met, a patient is not eligible for IPTAAS.

4.2 Patients who may be eligible for IPTAAS assistance

4.2.1 NSW and Lord Howe Island residents

Permanent New South Wales or Lord Howe Island residents, and temporary residents who are Medicare eligible, may be eligible for assistance. Interstate residents should direct inquiries and applications for assistance through the Health Authority in the State in which they reside.

4.2.2 Dual residents

Dual residence status refers to people who usually reside in more than one location, such as boarding school students and people who have houses in different locations in which they periodically reside. Dual residence does not include holiday accommodation. The standard eligibility criteria apply to dual residents.

4.2.3 Itinerant workers and persons of no fixed address

Itinerant workers in NSW may be eligible for assistance, providing proof of itinerant status can be provided. Persons of no fixed address may also be eligible for assistance.

The actual place or location of residence at the time of referral will be used for the purpose of assessing the distance the person is required to travel to access specialist medical treatment.

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4.2.4 Transplant recipients and donors

Organ transplant patients and donors who satisfy the IPTAAS eligibility criteria are able to claim assistance in relation to:
- Pre-post transplant consultations.
- The actual transplant procedure.
- The immediate post-operative period while under specialist care.

An interstate transplant donor is eligible for IPTAAS assistance if the transplant recipient is a NSW resident. NSW residents who are donors for interstate patients should contact the relevant Health Authority in the State/Territory in which the transplant recipient/patient resides for travel assistance.

Note however that patients on waiting lists for organ transplants are not eligible to receive assistance for travel and accommodation costs associated with relocating for the purposes of remaining on a pre-transplant waiting list.

4.2.5 Prostheses/Orthotics Referrals

A patient may be eligible where a prosthetic or orthotic service is part of an approved surgical treatment regime. The nearest specialist and the nearest prosthetist or orthotist should be consulted for the surgery and for the fitting and manufacture of appliances.

4.2.6 Aboriginal health

It is recognised that for a range of reasons some Aboriginal patients find it difficult to make use of the assistance available to them under IPTAAS. At the same time, many Aboriginal Health Organisations are transporting eligible Aboriginal patients to specialist appointments.

An Aboriginal Health Organisation may receive IPTAAS payments if it provides the patient transport and the patient being transported is eligible to receive assistance. Only one IPTAAS claim may be submitted for each return trip by the organisation’s vehicle even though the vehicle may be carrying more than one patient. This arrangement does not permit advance payment of travel costs.

4.3 Patients who are ineligible for IPTAAS assistance

4.3.1 Interstate, overseas and Norfolk Island residents

Interstate residents accessing specialist medical treatment in NSW are ineligible for IPTAAS, but may be eligible for assistance through their state/territory travel assistance scheme. They should be referred to the relevant Department of Health.

Overseas residents seeking specialist medical treatment in New South Wales including residents of other countries that are subject to reciprocal health care arrangements with Australia. Australian Reciprocal Health Care cards are not recognised for eligibility purposes.

Residents of Norfolk Island seeking specialist medical treatment in NSW are not eligible for treatment. Inquiries concerning residents of Norfolk Island and referrals to or from overseas should be referred to the Australian Department of Health and Ageing.
4.3.2 NSW residents seeking specialist medical treatment outside Australia

NSW residents who are seeking specialist medical treatment outside Australia are not eligible for IPTAAS.

4.3.3 Persons undertaking business or recreational travel

A condition of eligibility is that patients are referred for specialist medical treatment and travels from their usual place of residence at the time of illness or injury in order to access this treatment. IPTAAS does not cover illness or injury that occurs during travel that is undertaken for other reasons.

If such patients are subsequently required to travel from their usual place of residence to access ongoing specialist treatment, their IPTAAS eligibility is to be assessed in accordance with the standard requirements.

4.3.4 Persons eligible for, or in receipt of, workers compensation, motor vehicle third party insurance entitlements, private health insurance or any other payment or entitlement in the nature of damages or compensation

Benefits towards travel and accommodation costs are not payable where such costs are payable through Workers Compensation, Third Party or any other form of insurance scheme. Claimants who require interim assistance prior to the settlement of the claim should apply to the relevant insurer.

If a patient makes an IPTAAS claim and subsequently recovers the cost of travel and accommodation benefits from any other source, NSW Health will require reimbursement for the benefits paid out under IPTAAS.

4.3.5 Persons eligible under Commonwealth, State or Territory schemes

Benefits towards travel or accommodation costs are not payable where such costs may be or have been provided through another Commonwealth, State or Territory Scheme.

Veterans and war widows (and their carers) may be eligible for assistance through the Repatriation Transport Scheme administered by the Australian Department of Veterans’ Affairs. A patient who is eligible for financial assistance under the Repatriation Transport Scheme is not eligible for assistance under IPTAAS, nor is their escort/carer.

A veteran or war widow must check their eligibility under the Repatriation Transport Scheme before making a claim through IPTAAS. The claimant must submit with their claim documentation from the Department of Veterans’ Affairs confirming their status under the Repatriation Transport Scheme. If a veteran has received financial assistance for travel and accommodation costs through the Repatriation Transport Scheme but no financial assistance for escort/carer accommodation costs while the veteran is in hospital, the veteran cannot claim under IPTAAS for the escort/carer’s accommodation costs.

Patients receiving treatment at specialised services, such as Redbank, may be eligible for assistance with costs associated with the specialist treatment through other NSW Government agencies, such as the NSW Department of Education and Training or Department of Community Services. Where financial assistance is available through another government and/or non-government agency in respect of specialist medical treatment, patients must demonstrate that they have applied for assistance through that process.

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4.3.6 Clinical trials and unproven medical treatments

IPTAAS is intended to assist eligible patients to access only recognised specialist medical treatments as defined by the policy. A clinical trial can involve testing a drug, surgical or other therapeutic or preventative procedure, or a diagnostic device or service. For the purposes of IPTAAS, a treatment which does not meet the definition of ‘specialist medical treatment’ as defined in the policy framework (see “Recognised specialist medical treatments” under Definitions) is deemed to be ‘unproven’ even when the treatment is provided by a recognised specialist.

4.3.7 Health screening programs

Financial assistance is not available for health-screening programs such as cervical and breast cancer screening.

4.3.8 General dentistry

IPTAAS is not available for treatment associated with general dentistry including extractions, except where the patient is a cleft lip/palate patient.

The extraction of wisdom teeth is usually regarded as general dentistry. In some circumstances wisdom teeth extraction (associated abscess) does comply with the oral health surgical treatment provisions of the policy (Medicare Item No and performed under general anaesthesia). Eligibility will apply where there is confirmation of a relevant Medicare Item Number as listed in the Oral & Maxillofacial category of the Medicare Benefits Schedule Book (refer to Definition Section – Oral & Maxillofacial surgery).

4.3.9 Allied health services

IPTAAS is not available for patients to access services such as physiotherapy, occupational therapy or social work services.

SECTION 5: THE NEED FOR SPECIALIST MEDICAL TREATMENT NOT AVAILABLE LOCALLY

5.1 Referring practitioner and recognised specialist treatment

A person seeking assistance must be referred for treatment by one of the following categories of health practitioners:

a. A medical practitioner to a specialist or consultant physician for items listed in the Commonwealth Medicare Benefits Schedule Handbook.

b. An optometrist to an ophthalmologist for items listed in the Commonwealth Medicare Benefits Schedule Handbook.

c. An accredited dental practitioner to a specialist or consultant physician for oral surgery conducted in an operating theatre of an approved hospital and listed in the Commonwealth Medicare Benefits for Services by Dental Practitioners Handbook.

d. An accredited dental practitioner to a specialist or consultant physician for orthodontic and associated dental treatment rendered by an Accredited Dental Practitioner where the patient is registered as a cleft lip and palate patient and the treatment is listed in the Commonwealth Medicare Benefits for the Treatment of Cleft Lip and Cleft Palate Conditions Handbook.


The Handbook can be searched by Item Number or service provided at: http://www9.health.gov.au/mbs/search.cfm
5.2 Confirmation of specialist status

A recognised specialist must be registered on the Health Insurance Commission Medicare Provider File, except as may otherwise be provided for in the Policy Framework. Enquiries concerning specialist recognition are to be directed to the Health Insurance Commission. Medical practitioners (including registrars) employed as specialists by the Commonwealth or State or by an approved hospital must provide written confirmation of their specialist status from the relevant agency or facility.

Specialist status may be conferred on general practitioners in rural areas who are recognised by Local Health District Chief Executives as being appropriately qualified and trained to undertake sexual assault medical examinations.

Peer recognition does not constitute grounds to confer specialist status under the scheme.

5.3 Medical practitioner certification

It is not necessary for the referring doctor (or his/her authorised representative) to complete section B of the IPTAAS Application Form, except when:

- It is medically necessary for the patient to travel by air and/or be accompanied by an escort/carer.
- The patient is not accessing the nearest medical specialist.

The treating specialist (or his/her authorised representative) must complete the relevant form and certify the actual date(s) of consultation or treatment before claims can be processed.

An ‘authorised representative’ is any person who is able to:

- Confirm that the patient accessed specialist medical treatment, on either an inpatient or outpatient basis, on the date(s) shown on the claim.
- Provide either the MBS Item Number(s) or specify the treatment provided on the date(s) shown on the claim.

5.4 Subsequent specialist appointments

Once an initial IPTAAS Application Form has been submitted, there is no requirement for another form to be submitted for subsequent treatment within a twelve-month period, except when:

- The patient visits the same specialist, but at a different location.
- The patient visits a different specialist.
- The patient travels by air.
- The patient’s travel requirements change, for example it becomes necessary for the patient to be accompanied by an escort/carer.
- Personal circumstances (such as new address, telephone number, bank account) change.

Subsequent visits to the same specialist can be claimed by submitting an IPTAAS Travel Diary Supplement signed by the specialist or authorised representative, together with copies of all receipts for travel by public transportation or accommodation.

5.5 Referral to nearest treating specialist

A basis for IPTAAS eligibility is that if specialist treatment is not available locally it should be sought from the nearest possible specialist. As a medical referral scheme, IPTAAS relies on the opinion of doctors in ensuring these grounds for eligibility are appropriately discharged.
A patient seeking assistance is required to attend the nearest specialist in the particular specialty. This includes specialists who provide Outreach, “Fly In - Fly Out” or visiting services. The nearest specialist is defined as the specialist in a particular specialty closest to where the patient usually resides. State borders are not relevant in considering the nearest specialist for the Scheme’s purposes.

Patients are not eligible for IPTAAS if they (or their referring doctor) choose as a matter of preference to bypass the nearest treating specialist.

5.6 Exemption to nearest specialist ruling

Exemption from the nearest specialist ruling may be granted where:
- The referring doctor certifies that after taking into account factors including: the clinical appropriateness of the nearest specialist; the urgency of the referral; the waiting time for treatment at the nearest available specialist; and the patient’s capacity to pay for the nearest available specialist service, it is necessary to refer the patient to a more distant specialist.
- The nearest specialist certifies that referral to a more distant specialist in an unrelated specialty is required on medical grounds.
- The nearest specialist refers a patient to another specialist in the same or a related specialty.
- Family support is considered to be a valid medical reason for bypassing the nearest specialist, when assessed in conjunction with the gravity and duration of treatment and where there is demonstrated clinical advantage in treatment and recovery. In this case, the referring doctor or nearest specialist must certify that family support will provide a clinical advantage for a patient’s treatment and recovery. Travel and accommodation assistance is payable at usual rates.

5.7 Second specialist opinion

A patient who is referred by their nearest specialist to another specialist for a second opinion is eligible for IPTAAS assistance.

5.8 Visiting specialists and registrars

A visiting specialist or registrar who is employed as a specialist in a public or private hospital is deemed to be the nearest specialist.

5.9 Interstate referrals

Subject to the exceptions specified in this Policy Framework, the ‘nearest available specialist’ rule always applies, regardless of which state the specialist practices in. Accordingly, residents of NSW (including metropolitan areas) are eligible to apply for assistance to travel interstate to access specialist medical treatment or specialist surgical oral health services when:
- The interstate specialist is nearer than any equivalent specialist in NSW
- The required treatment is not available in NSW.

5.10 Referrals to specialised services

A patient may be eligible under IPTAAS if they are referred to a specialised health care service where the primary purpose is for consultation with a medical specialist for treatment not available locally. Such specialised treatment may include Rivendell and Redbank (mental health services for children), Royal Far West Health Scheme, and the Cerebral Palsy Alliance.

Children attending Rivendell, Redbank or Royal Far West may also be eligible for assistance with travel and accommodation costs from other government or non-government organisations.
SECTION 6: TRAVEL

6.1 Distance travelled

Patients must travel either at least 100km one-way, or a cumulative weekly distance of at least 200km, to be eligible for IPTAAS assistance.

A uniform method for measuring and calculating the most direct route and distance travelled from the patient’s usual place of residence to the treatment centre is to be used for all IPTAAS claims. Some claims may need to be considered on their individual merit, with primary focus on the ongoing specialist medical needs of the patient.

IPTAAS utilises http://maps.google.com/ to calculate distances. This mapping system allows the distance travelled to be calculated from the residential address of the patient to the address of the treating specialist or place of treatment.

Further details on the methodology for calculating the distance travelled is set out in the Guidelines for Assessment document.

6.2 Remote travel

Limitations on travel options in remote locations should be taken into account when assessing a claim. Whilst it is important to ensure consistency when calculating distances, discretion regarding the 100km-distance limit should be exercised where it is impractical for the patient to take the most direct route.

6.3 Air travel

There must be a valid medical reason, detailed by either the referring doctor or treating specialist, why the patient needs to travel by air for both the forward and/or return journeys. The continuing need for air travel for subsequent visits must be considered and approved on each occasion.

6.3.1 Prior approval

The referring doctor or specialist, or their authorised representative, must contact the relevant IPTAAS office for a Prior Approval Number and enter this number on the Application Form. Allied health professionals do not qualify as an authorised representative. Lord Howe Island permanent residents are exempt from having to seek air travel approval.

The referring doctor can obtain prior approval for both the forward and return journeys simultaneously. If there is a medical reason for the patient to make the return journey by air, the treating specialist will need to obtain prior approval for this trip. However, if, during the period of treatment, air travel becomes necessary for clinical reasons, the relevant professional treating the patient at the time must seek approval and complete the relevant section of the form.

6.3.2 Extended air authority

Where a patient’s referring practitioner, treating specialist, or their authorised representative, confirms the ongoing need for air travel due to a specific medical condition, consideration may then be given to granting an extended air authority for a period of up to three months.
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6.3.3 Responsibility for booking air travel

It is the claimant’s responsibility to arrange and pay for an air ticket. The IPTAAS office may arrange for an advance purchase through a travel agent where financial hardship can be demonstrated, provided that at least four working days’ notice is provided. Claimants who wish to apply for an advance payment must advise the relevant IPTAAS office at the earliest opportunity.

6.4 Travel benefits

6.4.1 Travel benefits for patients

Eligible patients may claim travel costs for journeys directly from the usual place of residence to the place of treatment and return, less a mandatory personal contribution (not applicable for pensioners and Health Care Card Holders). See Terms and Conditions outlined in the Application Form and the Guidelines for Assessment document.

6.4.2 Travel benefits for escorts/carers

Approved escorts/carers accompanying eligible patients may claim travel costs for journeys directly from the patient’s usual place of residence to the place of treatment and return, less a mandatory personal contribution (where applicable) when separate costs are incurred by the patient and escort/carer. Escorts/carers are not eligible under IPTAAS for journeys undertaken when not accompanying the patient, except when the patient is:

- An emergency transfer and the treating specialist certifies that it is medically necessary for the escort/carer to remain with the patient during hospitalisation or to provide assistance with transport following discharge.
- Under 17 years of age.

Where an approved escort/carer travels separately to the patient, reimbursement of the escort/carer’s costs is based on economy travel or the standard fuel subsidy rate for private motor vehicle journeys less a mandatory personal contribution by the escort/carer if applicable.

6.4.3 Deceased patients

Where a patient has died prior to making the return journey from the place of treatment, consideration may be given to providing a reimbursement for the transport costs associated with bringing the deceased person’s body home. The reimbursement should be equal to the costs of the return journey using the mode of transport that was used for the forward journey. A deceased patient’s approved escort/carer is entitled to financial assistance towards the cost of the return journey on the same basis. Where there are no costs associated with the forward travel, reimbursement for the return journey is calculated using the applicable rate for motor vehicle travel.

Where a patient has died prior to their claim being processed, the claim is to be paid to the deceased’s spouse. Where there is no living spouse, the family should be asked for the name of the solicitor or Public Trustee that is handling the deceased’s Estate. If these situations do not apply, depending on the amount of reimbursement, the relevant funds may be provided to a funeral director to help cover funeral costs. In other cases, depending on the value of reimbursement, advice should be sought from the Office of the Public Trustee.

IPTAAS may be held liable by any entitled beneficiaries if a reimbursement is paid to a person who is not entitled to receive these funds.

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6.5 Travel benefits available

IPTAAS subsidies are available for travel by private motor vehicle and public transport (including air travel and taxis). The currently applicable rates are specified in this document and in the Guidelines for Assessment document.

A patient and approved escort/carer may claim assistance towards public transport, taxi fares and kilometres for in-transit travel, that is, journeys undertaken from:
- The claimant’s usual place of residence to the local transport terminal and return.
- The metropolitan transport terminal to treatment centre or accommodation and return.
- The accommodation site to place of treatment and return.

Travel benefits for public transport are reimbursed at economy rates. Eligibility for upgrades may be considered when:
- A patient’s medical condition would be exacerbated by, or prevents their use of economy travel.
- The patient requires urgent (but not emergency) treatment and no economy class seating is available.

The referring doctor or treating specialist must certify that there is a medical reason for this mode of travel, otherwise economy rates will apply.

Bariatric patients may require two seats on public transport. If there is no alternative mode of transport available, IPTAAS subsidies are payable for both seats.

Fares for journeys using public transport are reimbursed minus the GST component – see ineligible benefits below.

6.6 Concessional travel benefits

Claimants who have a valid concession travel permit are not eligible to claim assistance towards travel costs unless the travel permit does not cover the full costs of the journey.

Parents/guardians accompanying patients to the Royal Far West Health Scheme are provided with travel vouchers in relation to specific appointments. The extra expense incurred by the parent/guardian in purchasing a full fare ticket (voucher equals half fare) can form part of a claim.

Assistance towards travel is not normally available where the parent/guardian chooses to use a private motor vehicle instead of the vouchers. However, the motor vehicle subsidy rate will be paid if using the vouchers to access public transport would cause unnecessary hardship (extensive distances, significant inconvenience, need for transport at destination, child with disability causing disruption to other public transport users, child with a physical disability that has special transport needs).

6.7 Advance payment of travel costs

Advance payment of commercial travel costs is only to be considered where there is evidence of financial hardship. A pension/Health Care Card must be presented for eligibility. A minimum of four working days’ notice prior to travel is required.

The failure to lodge a completed claim on completion of travel associated with specialist treatment will negate the claimant’s right for further advance payments and IPTAAS reserves the rights to adjust subsequent claims to meet any overpayments associated with advances.
6.8 Advance payment of travel costs by non-government organisations

Claims submitted where organisations provide financial assistance directly to the claimant prior to travel (such as advances for petrol, purchase of tickets etc) and accommodation may be accepted if the claimant meets eligibility criteria. In all instances where a non-government organisation provides advance assistance to the claimant, a completed Application Form, signed by the claimant, must be submitted along with all original or copies of receipts and accounts.

The amount payable to the organisation must not exceed the amount that would have been payable directly to the patient (the personal contribution/s is deducted from any travel and accommodation benefits payable prior to disbursement to the organisation).

6.9 Ineligible travel costs

6.9.1 Emergency medical transport

Emergency medical transport costs including ambulance, air ambulance or the Royal Flying Doctor Service are not eligible for reimbursement. Inter-hospital transfer costs where a patient is transported from one hospital to another for specialist medical treatment, including those transferred interstate from NSW are also not eligible for reimbursement. These costs are the responsibility of the referring hospital.

Patients discharged from specialist regional or metropolitan treatment centres following inter-hospital transfer may apply for assistance towards the cost of the return journey provided the IPTAAS eligibility criteria are met.

6.9.2 Booking fees

Assistance is not available for the cost of fees for booking travel arrangements. In the event that confirmed travel arrangements need to be amended due to circumstances beyond the control of the patient (for example if surgery is rescheduled or cancelled) then rebooking fees may form part of a claim.

6.9.3 Community transport

Government-funded community transport organisations are not eligible for IPTAAS assistance for the provision of health-related transport. Patients who have been transported by a Community Transport Organisation are not eligible for assistance under IPTAAS for any travel costs incurred, as this service is already Government-subsidised.

Where a Community Transport Organisation is not subsidised by any Government funding, IPTAAS assistance may be available to an eligible claimant for travel costs, provided the patient attaches relevant receipts to the Application Form, and the Community Transport Organisation verifies that it is self-funded.

6.9.4 Goods and Services Tax

The Goods and Services Tax (GST) component of travel and/or accommodation expenses is not reimbursable. Where GST is not identifiable, one eleventh is to be deducted as the GST portion of the total cost.

On rare occasions, travel and/or accommodation for eligible claimants is purchased directly by a Local Health District (e.g. advance purchase of travel or bulk billing of accommodation costs) and the subsequent cost is paid directly by the LHD. In this instance the LHD should recover the GST component.
SECTION 7: ACCOMMODATION

7.1 When an accommodation subsidy is available

Provided the patient meets the relevant IPTAAS eligibility criteria, IPTAAS subsidies for accommodation associated with travel to attend specialist medical appointments are available when:

- The referring medical practitioner or treating specialist confirms that in-transit accommodation is required for medical reasons.
- The patient is not able to complete the journey in a single day due to the distance being travelled and/or road conditions.
- Limitation of transport schedules means that the claimant needs to stay overnight prior to the specialist medical appointment or hospital admission and/or delay the return journey home.
- Specialist medical treatment is carried out on an outpatient basis (e.g. radiotherapy, renal dialysis treatment/training).

The patient is required to remain near the location of the treating specialist pending test results.

7.2 Accommodation benefits

7.2.1 Commercial accommodation

Assistance towards commercial accommodation costs is paid on a per night basis. Originals or copies of tax invoices/receipts (with ABN) must be provided. Single and double room rates apply.

Commercial accommodation includes hotel, motel, apartment, hostel (not registered or licensed as a Public or Private Hospital) and caravan park accommodation. Commercial accommodation providers must be able to provide an ABN.

7.2.2 Private accommodation allowance

Assistance towards private accommodation costs is paid on a per night basis. In order to calculate the allowance payable, the length of stay in private accommodation will be determined by the dates of the treatment episode as certified by the treating specialist. Claimants must provide details of the private accommodation in the relevant section of the Application Form.

7.3 Accommodation for escorts/carers

Financial assistance towards accommodation costs for escorts/carers who accompany a patient during their period of treatment is available in the following instances:

- Short stay procedures where the cost of accommodation for the escort/carer is less than the cost of a return trip.
- Where the escort/carer is required to act as a carer during long-term specialist outpatient medical treatment.

Where the patient is hospitalised and the treating specialist certifies it is medically necessary for the escort/carer to remain.

7.4 Bulk billing of accommodation costs

Bulk billing of accommodation is a special provision set up to assist financially disadvantaged claimants or patients who are required to remain for treatment for longer than three days.
Accommodation providers who wish to bulk bill must provide IPTAAS Offices with a schedule of the standard room rates, including any changes or updates to this schedule. Bulk billing of accommodation costs should be treated as the exception rather than the rule as IPTAAS is primarily a patient reimbursement scheme.

7.5 Ineligible accommodation costs

Inpatient hospital accommodation costs are not eligible for IPTAAS subsidies.

SECTION 8: IPTAAS BENEFITS AND CONTRIBUTIONS

8.1 Travel benefits

The rates of reimbursement at the time of publication are outlined in this Appendix. The current rates that apply can be found on the IPTAAS Fact Sheets and the following web pages:


Under the IPTAAS scheme claimants may be eligible for a financial subsidy to assist with the cost of travelling to specialist appointments via private or public transport services. The rates of travel subsidy at the time of publication of this policy are:

- A standard subsidy rate of 19c/km is available to assist patients travelling to specialist treatment centres by private vehicle or hire car.
- Fares for relevant journeys using public transport, including airfares, are reimbursed at economy rates minus the Goods and Services Tax (GST).

The following maximum subsidy is available for taxi fares. This subsidy cap applies regardless of the number of trips undertaken for specialist assistance:

- One visit/consultation - Maximum $20
- Short term visit (2-7 days) - Maximum $40
- Medium term visit (8-14 days) - Maximum $80
- Long term visit (15 days or more) - Maximum $160

Financial assistance for transport by air can be claimed where there is a valid medical reason why the patient needs to travel by air for the forward and/or return journeys.

8.2 Accommodation benefits

Financial assistance towards accommodation costs associated with travel to attend specialist medical appointments is provided, under certain circumstances, to those staying in private or commercial accommodation whilst seeking treatment.

Commercial accommodation is typically identified as motel, hostel, hotel or leased accommodation. Verification of a commercial accommodation provider’s legitimacy is required through the supply of the commercial provider’s Australian Business Number (ABN) as a part of the IPTAAS claims process.

Private accommodation is where an individual is accommodated at a private residence whilst seeking treatment. The rates of subsidy for both types of accommodation are:

Commercial accommodation subsidy

- Up to $43.00 per night per single room; OR
- Up to $60.00 per night per double room (Patients and approved escorts/carers).
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Private accommodation
- An allowance of $140 per week ($20 per night) is payable to eligible patients

8.2.1 Bulk billing of accommodation

Bulk billing of accommodation costs should be considered under special circumstances where patients are required to remain for treatment for longer than three days.

8.3 Patient contributions

Pensioners and Health Care Card Holders are not required to make a contribution.

All other patients must make a contribution (currently set at $40) towards each claim, or a weekly contribution if eligible under the 200km per week cumulative distance rule. To assist patients who are required to travel frequently or to travel long distances regularly, a cap on contributions applies. Once a patient’s IPTAAS subsidies reach a set level (currently set at $1,000) within a one year period, the contribution is waived for the remainder of the year.

In cases of financial hardship, the requirement to make the personal contribution may be waived.

Patients under 17 years of age are not required to make a personal contribution. When an escort/carer travels with a patient under 17 years of age, the standard rule applies in determining whether the escort/carer is required to make a contribution.
## APPENDIX 1

### DEFINITIONS

| **Escort/Carer** | An escort/carer is a person who for medical reasons is approved to accompany an IPTAAS patient while travelling to specialist medical treatment and/or during their period of treatment. Escorts/carers are generally adults able to cope with the special medical needs of the patient. There is no requirement for an escort to be related to, or the usual carer of, the patient. |
| **Financial disadvantage** | A patient or parent/guardian (where the patient is less than 17 years of age) is considered financially disadvantaged if they receive a Commonwealth Government Pension or have a weekly income equivalent to or less than the maximum pension, or have been issued with either a Commonwealth Health Care Card or Commonwealth Seniors’ Health Care Card. |
| **IPTAAS** | Isolated Patients Travel and Accommodation Assistance Scheme. |
| **Itinerant worker** | With respect to IPTAAS, ‘itinerant’ means a person who has no permanent fixed place of work, but who stays in accommodation (of any kind) at the location of the temporary workplace. |
| **Patient** | Reference to a patient may include a patient eligible for assistance under the Scheme or where applicable, a parent or guardian in the case of a person under 17 years of age, or a guardian in the case of a child under guardianship. |
| **Proof of financial status** | Evidence of a patient/guardian’s financial status means the presentation of a current Pension, Health Care or Commonwealth Seniors’ Health Care Card issued by the Australian Government or a statement from their employer detailing average weekly income. |
| **Recognised specialist medical treatments** | These are treatments that are:  
  a. Recognised by the Health Insurance Commission and identified in the Commonwealth Medical Benefits Scheme for the purposes of Medicare benefits, and  
  b. Where any drug/s used in association with such recognised treatment is approved for this purpose by the Commonwealth Therapeutic Goods Administration. |
| **Specialist medical practitioner** | For IPTAAS purposes, specialist means:  
  - A medical practitioner who is recognised as a specialist or consultant physician in a particular specialty for the purposes of the Health Insurance Act 1973, and recorded as such by the Health Insurance Commission under codes 001 – 099 of the Medicare Provider File.  
  - A medical practitioner (including a registrar) employed as a specialist by the Commonwealth or State or by the proprietors of an approved hospital, where written confirmation of this specialist status is provided.  
  - A dental practitioner registered as an oral surgeon contracted to render oral surgery in the operating theatre of a hospital established under the Health Insurance Act 1973, and recorded as such by the Health Insurance Commission under code 102 – Dentist (Approved) (Oral Maxillofacial Surgeon), of the Medicare Provider File. |
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| **Specialist oral health surgeon** | For IPTAAS purposes, specialist oral health surgical treatment means:  
- Treatment by an accredited Dental Practitioner who is a specialist or consultant physician for oral surgery conducted in an operating theatre of an approved hospital and listed in the Commonwealth Medicare Benefits for Services by Dental Practitioners Handbook; or  
- Orthodontic and associated dental treatment where the patient is registered as a cleft lip and palate patient and the treatment is listed in the Commonwealth Medical Benefits for Services by Accredited Dental Practitioners in the Treatment of Cleft Lip and Cleft Palate Conditions Handbook. |
| **Specialist oral and maxillofacial surgery** | Oral and maxillofacial surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region and includes:  
- Repair of wounds  
- Lıpectomy  
- Upper aerodigestive tract endoscopic procedures  
- Tumours  
- Aspiration of haematoma  
- Osteotomy of the jaw  
- Genioplasty  
- Fracture of mandible or maxilla |
TRANSPORT FOR HEALTH-IPTAAS - GUIDELINES FOR MEDICAL PRACTITIONERS AND SPECIALISTS (GL2009_012)


The Guidelines provide information for referring medical practitioners and treating specialists about the criteria and administrative requirements for the Transport for Health-Isolated Patients’ Travel and Accommodation Assistance Scheme.


CONCESSION FARE TRAVEL FOR HANDICAPPED CHILDREN ATTENDING FOR PUBLIC WARD TREATMENT

Provision has been made by the State Rail Authority and Urban Transit Authority of New South Wales for concessional travel by rail and bus services for certain handicapped children required to attend for treatment at Public Hospitals.

Handicapped children under 16 years of age, eligible for Public Ward treatment and attending for regular outpatient treatment or therapy at least twice a week for a period of one month or more at any public hospital served by Government buses, may be granted concessional bus travel between the home address and the hospital for each attendance. Concessions may also be applicable to an escort accompanying the child. Bus concession fare certificates are available on application to the Social Worker, at the hospital attended, and entitle the patient to travel by bus for any number of sections on one route at a concessional rate.

Bulk supplies of certificates are supplied to Royal Alexandra Hospital for Children, Royal Newcastle Hospital for Children, and Prince of Wales Hospital. Other hospitals requiring concessions for eligible outpatients should contact the Concession Fares Office, State Rail Authority, Box 29, GPO, Sydney, NSW, 2001 (telephone 9290 4768).

Concessional rail travel may be obtained for crippled children under 16 years of age and their attendants, to any station in New South Wales for medical treatment, upon production of a certificate from the Department of Family and Community Services, the New South Wales Society for Crippled Children, or the Newcastle and District Association for Crippled Children; or from a Medical Practitioner, setting out that the child is travelling for medical attention in connection with his or her disability and indicating the name of the attendant.

Upon presentation of the certificate at any Railway Booking Office, return tickets for journeys wholly within New South Wales, may be purchased at one quarter the ordinary adults fare for the crippled child and one half the ordinary adult for the attendant.

Additional assistance in meeting expenses, and the like, may be available from the nearest District Office of the New South Wales Department of Youth and Community Services.
AMBULANCE TRANSPORT CHARGES

Refer to the Fees Procedure Manual for Ambulance Transport Charges.

TRANSPORT OF PEOPLE WHO ARE MENTALLY ILL (PD2005_139)

This Circular provides further information to staff in Area Health Services and should be read in conjunction with the Memorandum of Understanding between NSW Police and NSW Health, (page 13.90).

As with other illnesses and injuries, people with mental illness may require ambulance transport. Ambulance transport is appropriate where the skills of Ambulance officers and the facilities and equipment of an Ambulance vehicle are required to meet the needs of the patient, and their condition prohibits the use of alternative means of transport. In keeping with the Ambulance Transport Guidelines, the use of an Ambulance will be appropriate in a range of mental health emergency situations. These may include, as determined by the on-duty psychiatrist or their delegate, people in an acutely disturbed mental state, people who have attempted suicide and people who have a high suicide risk.

A Memorandum of Understanding (MOU) has been developed between NSW Police and NSW Health for dealing with mentally ill persons. The MOU outlines a variety of situations when Police vehicles, Ambulances and other health service transport may be used. Routine transport situations will be met by Area Health Service transport arrangements using Area vehicles. Police vehicles will only be used in situations where they have a statutory role or where there is a risk of a breach of the peace.

The Ambulance Service will always respond to an emergency (000) call in the community for transport to a hospital. For interhospital transports, where the Ambulance Operations Centre is first notified of a patient who appears not to meet Ambulance transport guidelines (as clarified in this circular) they are to contact the referring agent directly to seek clarification of the situation, and if the patient does not meet Ambulance Transport Guidelines (as clarified in this circular) to assist them to make alternative arrangements. It is the responsibility of the Area Health Services to provide or arrange for the transport of such patients, but common sense should prevail in making the most suitable arrangements.

It is the responsibility of those requesting Ambulance transport for a patient, for example hospitals, mental health teams and general practitioners, to make arrangements for a suitable escort if this appears to be needed. If Ambulance officers on arrival have additional concerns or if the situation is deteriorating this should be discussed with the requesting agency and a suitable escort provided. The Police have undertaken to ensure the safety of all parties by providing an escort where the referring agency or ambulance officers believe the patient is violent or may become violent, or where there is a genuine threat of a breach of the peace.

Standard charges for interhospital transport of mentally ill patients will occur in accordance with usual interhospital charging arrangements.

The MOU proposes the development of local protocols. This is encouraged as prior knowledge and arrangements, which take into account local service issues, will enable planning at an appropriate level.

Where issues occur which are not able to be resolved at a local level, Area Health Services must have in place a clear process to involve appropriate senior staff, for example, Area Director of Mental Health Services, Area Director of Operations, Area CEO, to resolve the issue.

If any staff require further information relating to the transport of mentally ill patients they should contact their Sector or Area Director of Mental Health Services in the first instance.
MANAGEMENT OF NSW POLICE FORCE OFFICERS’ FIREARMS IN PUBLIC HEALTH FACILITIES AND VEHICLES (GL2013_002)

GL2013_002 rescinds GL2005_035.

PURPOSE

This guideline provides information to staff in public health organisations and in NSW Ambulance about the management of NSW Police Force officers’ (police officers’) firearms and “appointments” (NSW Police Force terminology for ‘Electronic Control Devices’ (ECDs), commonly called Tasers, and ‘OC Defensive Spray’), in public health facilities and vehicles, including NSW Ambulance vehicles.

KEY PRINCIPLES

Police officers are bound by the legislative requirements of the Firearms Act 1996 (NSW) (the Act) and the policy requirements of the NSW Police Force Handbook to relevantly ensure the safekeeping of firearms and “appointments”.

A police officer’s decision to remove his or her firearm and/or “appointment” and store it elsewhere is made by the individual police officer taking into consideration operational and environmental circumstances at the time.

Police officers’ obligations under the Act override local health facility policies and procedures and NSW Ambulance protocols in this regard. Staff in public health organisations and NSW Ambulance should not make the removal of police officers’ firearms and “appointments” a condition of their entry to the facility or vehicle.

USE OF THE GUIDELINE

Public health organisation and NSW Ambulance protocols relating to the management of police officers’ firearms and “appointments” must be consistent with this Guideline.

CHANGE TO IPTAAS DISTANCE CRITERION FOR RENAL DIALYSIS PATIENTS
(IB2010_063)

PURPOSE

To provide information on the change to the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) distance criterion for renal dialysis patients.

KEY INFORMATION

The Minister for Health has determined that from 1 January 2011, a new IPTAAS distance criterion will apply to renal dialysis patients only.

From 1 January 2011, patients who have to travel a cumulative distance of at least **200km per week** to access renal dialysis services will be eligible for IPTAAS travel subsidies. Claims from renal dialysis patients for cumulative travel of at least 200km per week undertaken prior to this date are not to be accepted.

The $40 co-contribution for non-pensioners/health care card holders will continue to apply, and is to be levied on the cumulative weekly distance travelled by these patients. Patients in this category are advised to contact their local Health Transport Unit to discuss the effect of the co-contribution on their claim before submitting an IPTAAS Application Form - refer to Application Form for Health Transport Unit contact details.

This Information Bulletin is to be read in conjunction with PD2012_070 Isolated Patients Travel & Accommodation Assistance Scheme Policy Framework.

Implementation

**Eligibility:**

Eligibility to access IPTAAS will be on the same basis as other claimants, except that renal dialysis patients will be eligible if they travel a minimum distance of 200km cumulative per week to access their dialysis (compared to 200km per round trip to access specialist medical treatment for other claimants).

Health Transport Units are to calculate the distance travelled by claimants using the standard method set out in the Isolated Patients Travel & Assistance Scheme Policy Framework (PD2012_070).

**Submission of claims:**

1. Submission of a valid form to cover treatment period
   - Renal dialysis patients claiming under the new rule for the first time must submit an IPTAAS Application Form with all sections completed. As for all patients undergoing continuing treatment over a twelve month period, the referring medical practitioner is not required to complete Section B of the IPTAAS Application Form for subsequent claims. However, a new referral must be provided every 12 months. In the case of renal dialysis, the referring medical practitioner and treating specialist may be the same person.
   - Usually, the treating specialist is required to complete section C of the Application Form for each subsequent claim, as a means of confirming that the treatment took place. However, as renal dialysis is essential and regular treatment, the Travel Diary (available from the local Health Transport Unit) is acceptable as confirmation of attendance for **renal dialysis patients only.**
Therefore renal dialysis patients making IPTAAS claims only need to submit a new Application Form once every year, unless their personal and/or payment details change, in which case the relevant Section of the form is to be submitted with the next claim made following the change(s).

2. Claiming the subsidy after travel
   - Claims made by renal dialysis patients are to be paid on a monthly basis. In circumstances where the requirement to claim on a monthly basis causes financial hardship for the patient, payments may be made on a weekly basis.
   - Renal dialysis patients should submit their monthly claims using the single page travel diary, available from their local Health Transport Unit.
   - Claims using the Travel Diary must be submitted in the timeframe on their claim form. If a patient is making monthly claims, they will be able to make twelve of these within the one year validity period of their claim form. The final trip on the last monthly claim for that year must fall within the timeframe for validity of the specialist referral on the claim form.
   - Claims made using the travel diary will only be valid with evidence from the renal dialysis unit to confirm that the patient used private transport to access their care. Evidence includes a signed notation on the diary by the Nurse Unit Manager of the Dialysis Unit, or system printout providing the necessary validation.

**Monitoring and Evaluation**

All NSW Health Transport Units are to collect data to enable accurate monitoring of the cost of implementing this change to the IPTAAS distance criterion. The data to be collected is as follows:

- Number of claims made by renal dialysis patients.
- Cost of claims made by renal dialysis patients.
- Additional administrative costs associated with the change, expressed as additional Full Time Equivalent staff required to process the additional claims received.

The collected data is to be reported to the Department of Health on a six-monthly basis, commencing with data for the period 1 January - 30 June 2011. Reports should be submitted to the Manager, Primary Health and Equity, NSW Department of Health, Locked Mail Bag 961, North Sydney 2059. A copy should be emailed to PHCPBmail@doh.health.nsw.gov.au marked to the attention of the Manager, Primary Health and Equity.
SERVICE SPECIFICATIONS FOR TRANSPORT PROVIDERS – NEPT (PD2014_013)

PURPOSE

The purpose of this policy is to outline the minimum Service Specifications (safe and reliable) to be adhered to by Non-Emergency Patient Transport (NEPT) providers operating for NSW Health.

The aim of these minimum Service Specifications is to ensure consistency across the NEPT network. Ensuring appropriate patient transport vehicles, equipment and staff will provide a safe service for patients using NEPT.

This policy is intended to be a component of a contractual arrangement with the Health Administration Corporation.

MANDATORY REQUIREMENTS

This policy requires all NEPT providers adhere to the requirements contained within the NEPT Service Specifications for Transport Providers.

IMPLEMENTATION

NEPT providers must ensure that a review of their services be undertaken to ensure compliance with the NEPT Service Specifications for Transport Providers. Where NEPT providers do not comply with these Service Specifications, a process to obtain compliance must be completed.