

The National Travel Assistance Scheme

Policy Recommendations Report

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Introduction

The National Travel Assistance Scheme (NTA Scheme) provides financial assistance for travel and accommodation to people who need to travel a long distance or very frequently to attend specialist hospital treatment.

Improving the NTA Scheme provides a real opportunity for the health and disability sector to think about how reducing travel and accommodation costs, as barriers to access, could contribute to a better experience of the system for patients and more equitable health outcomes across the New Zealand population.

Travel assistance can directly benefit a patient's health outcomes by helping them to attend appointments. It is also of value to the health and disability system if it enables a positive treatment outcome and, by treating the patient earlier, prevents the costs associated with complications and hospital inpatient stays.

What this report covers

This report outlines the findings of the review of the NTA Scheme and makes recommendations for how to improve it.

The four chapters that follow cover:

- eligibility and scope
- governance and accountability
- administration and information technology (IT)
- funding.

Each chapter introduces the topic, describes and discusses what the review found and makes recommendations.

The review has highlighted significant room for improvement within the NTA Scheme as it currently operates. It also indicates that this improvement work is required to prepare the Scheme for the possibility of more significant change.

The report has two sets of recommendations. The first set of recommendations focus on how to improve the operation of the current NTA Scheme in the shorter term. The second set of recommendations suggest a series of future considerations concerned with where to take the NTA Scheme in the medium to long term.

Further, in considering travel and accommodation needs, this report makes observations about:

- what contributes to quality health care
- the importance of good service planning
- what might improve access to services and reduce inequity
- the impact of social and economic factors on health.

Understanding the National Travel Assistance Scheme

The NTA Scheme provides a financial contribution to the cost of travel and accommodation for people who need to travel a long distance or very frequently to attend specialist hospital treatment. One or two support people may be eligible for assistance as well.

The NTA Scheme is governed by the national NTA Policy that sets out the criteria under which district health boards (DHBs) must administer their part of the funding. The reimbursement differs according to a person's age, the distance they have to travel to treatment, the frequency of their treatment and their income level (see Appendix 1 for the basic eligibility criteria).

The Scheme was funded at approximately \$36 million per year in 2005. An additional \$4.2 million per year was allocated from 2009/10.

Reasons for reviewing the NTA Scheme

The Ministry of Health (the Ministry) began to review the Scheme in late 2017 following ongoing interest in improving it, particularly among cancer advocacy groups. The national Scheme has been in place since 2005, so a review was overdue to understand whether it was working well for patients. Some existing views were that the process of registering for and claiming travel assistance was onerous, that some people were not getting the support they needed despite difficult circumstances, and that the Scheme was administered inconsistently between regions. A number of stakeholders had genuine concerns that some people simply do not access treatment unless they have financial assistance for travel and accommodation.

In New Zealand, DHBs offer a variety of health and disability services. Some offer more complex tertiary or quaternary services as areas of specialisation. As a result, patients in DHBs that do not offer these services who are referred to a specialist practitioner may need to travel to receive their treatment. The NTA Scheme recognises that people should not be disadvantaged in accessing health and disability services because of where they live.

Investigating how the NTA Scheme is working gave the Ministry an opportunity to think about the wider question of access to services, and how reducing transport and accommodation costs (as barriers to access) could contribute to better health outcomes. The review raised questions about not just the value of providing travel assistance to patients, but also the extent to which the health and disability sector should accommodate social and economic needs, as part of delivering holistic, patient-centred care.

Travel assistance can be of direct benefit to the patient's health outcomes in encouraging appointment attendance. The Ministry considers it to be of value to the system because of the potential savings available to DHBs in improving access to services. These savings include reducing appointment 'did-not-attends' and avoiding the larger cost of an inpatient stay if, for example, a patient is able to see through their full course of chemotherapy and stay well.

Review objectives

This review has been about how we can improve the NTA Scheme. The objectives that guided it were to ensure that:

- the Scheme is fair and equitable
- those with the highest needs are accessing the Scheme
- administration of the Scheme works for people
- payment levels represent a reasonable contribution to people's costs
- the national guidance document, the *Guide to the National Travel Assistance Policy 2005* (Ministry of Health 2009), is clear.

These objectives have shaped our thinking throughout the review, including in helping us determine the kind of questions we asked in our surveys, and the nature of the discussions held with our sector leadership group. We have considered our recommendations and observations in light of whether they achieve these objectives.

Equity

Contributing to the improvement of equity was a key objective. We asked participants how they defined equity. Responses ranged from believing that the health and disability system should treat everyone the same (achieving equality) to the belief that

we should be designing a system that identifies those people who have the poorest health outcomes and the most difficulty in accessing health services.

Another strongly held view was that no one should be disadvantaged by where they live in accessing health services. Some people referred directly to the known definitions of equity. We chose the definition articulated by the World Health Organization to guide our thinking. According to this definition, equity is the:

absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically.¹

Those who carry out further work to improve the NTA Scheme will need to reflect on the range of views expressed and what it might mean for how the eligibility criteria are designed in the future, or how transport options are funded.

We have also been mindful of the special relationship between Māori and the Crown under Te Tiriti o Waitangi. Under the Treaty, the Crown has made a commitment to a partnership to improve the participation and health status of Māori. The public health and disability system has a responsibility to improve the health outcomes of Māori people as citizens and the tangata whenua of New Zealand. This is reflected in the New Zealand Public Health and Disability Act 2000.

Approach to the review

For the review to achieve its objectives, we needed to capture a wide range of views, from those who have used the NTA Scheme or supported someone to travel, to people who work with and are funded by the Scheme. To gather these diverse views in a collaborative way we formed the sector leadership group. This group was tasked with being the central point of discussion and ideas about how effective the Scheme was, and how it could be improved. Members were asked to canvas their networks and provide patient stories to validate what the group had discussed. Members included DHB travel coordinators, clinicians in renal and cancer services, patient advocates, and people with understanding of Māori, Pacific and rural communities. The membership of this group is listed on the Ministry of Health website (www.health.govt.nz).

DHBs are a key partner with the Ministry in making the NTA Scheme work for patients. DHB staff have been involved in the review in a number of ways. Some were members of our sector leadership group, and some DHB Planning and Funding Managers belonged to our Governance Group. We have also engaged travel coordinators themselves to give us their insights into the current state of the Scheme. We want to partner closely with DHBs as the recommendations in this report are considered.

Working with the non-governmental organisation (NGO) sector has also been key to understanding the significant contribution travel and accommodation providers and volunteers give to making the patient experience a positive one. This review has shown that supporting patients receiving critical treatment must be a partnership between the

¹ www.who.int/healthsystems/topics/equity/en/

health and disability system, the NGO sector and families, because it cannot be achieved successfully by one of these groups alone.

We divided the project into the following three phases.

Phase One: Building understanding

The outcome of this phase of work was for the Ministry and stakeholders to come to a joint position on:

- the evidence base about how the NTA Policy operates currently
- what the issues are with the Policy and how it operates
- what we expect to get out of this review
- understanding the constraints on possible solutions.

Phase Two: Developing choices

The outcome of this phase of work was to use the understanding built in Phase One to scope options for improving the NTA. In particular, its purpose was to:

- ensure we have all the evidence required to develop options for change based on the issues identified
- review whether the current principles and objectives of the Scheme are still fit for purpose, in light of the Phase One discussion
- develop ideas for change and improvement
- consider implementation requirements.

Phase Three: Making decisions

The outcome of this phase is to test the completed draft of the work with stakeholders and against the system's wider policy and operational settings before seeking approval of a final set of recommendations from the Minister of Health.

The review also involved:

- undertaking two surveys – one of patients and their support people, and one of the range of professionals involved with the NTA Scheme
- holding two workshops to gather knowledge and experiences from our sector leadership group, and asking its members to canvas their networks for patient stories and insights
- interviewing stakeholders, including DHB staff, NGO representatives and some patients
- undertaking some data analysis about who was using the Scheme and what was spent

- examining how a wider set of data held by the Ministry could be used in future to inform decisions
- linking with researchers whose work related to the review.

Stakeholders who have taken an interest in and contributed to the review include: the Cancer Society, Cancer Consumer NZ, Heart Kids NZ, Grey Power, Kidney Health NZ, (the then) Rural Health Alliance Aotearoa NZ, Ronald McDonald House, St John Ambulance and Whakaue Research. The project team would like to thank all those who have been involved in making the review a success.

Summary of findings

By improving the NTA Scheme, we have an opportunity to ensure that individual New Zealanders have, as far as possible, a positive experience of the public health and disability system when travelling for treatment. For the system, we have the opportunity to ensure more people complete their course of treatment, improve population outcomes, improve equity of access to services and potentially manage costs.

To achieve this vision and our review objectives, the NTA Scheme needs to be more patient focused, providing practical but empathetic solutions for its clients. We need to modernise and streamline how the Scheme works. We need to ensure it is both more consistent between regions, and has flexibility where discretion is required to allow for local circumstances and to provide equitable access to services.

The following themes emerged consistently throughout the review's engagement process.

- Those who have received travel assistance value it highly. It provides them with some certainty about how they will access their treatment at an often stressful time.
- The NTA Scheme is not always well known or understood as a source of assistance for patients; levels of awareness vary between regions and services.
- Those working with the Scheme want it to be fair and to recognise the patient need that is presenting to them.
- Participants believed equity is about:
 - using a consistent approach to providing assistance (equality)
 - determining where health outcomes are poorest and targeting assistance to those who most need it.
- Participants believed people should not be disadvantaged in accessing services because of where they live and the resources that they have.
- Good process is important to make the Scheme work well.
- We do not have complete information about how much is spent on travel assistance at a national level or an accurate estimate of unmet need and likely demand.

The review has also highlighted a number of wider themes about access, equity and how the system operates.

- Empathy and compassion should be at the heart of what we do in the health and disability system. Patients need a human touch in the assistance they require in a time of high stress.
- To truly improve access, it is necessary to consider a patient's personal situation in addition to the quality of services. For example, how will they get to treatment? Do they have family to support them?
- Practical solutions that work for patients and providers are key. For example, one solution might be to pay up front for a taxi to and from dialysis to ensure all patients complete their treatment and do not risk complications, and to make best use of resources.

- Investing in access returns significant savings if it avoids the need for more costly inpatient treatment in the future.
- In making access to the system easier for Māori, Pacific peoples, those with disabilities and other vulnerable populations, the basics matter: treating people with respect, understanding their values and culture, and including support people in the solution.
- Some facets of the system are designed to meet clinician or system need, without considering the impact on patients. For example, the time and day of appointments are critical when a person is travelling some distance to them.
- Good service and regional planning is key to funding the right solutions for patients in a cost-effective way.
- Having integrated data and information available to inform decisions is really important.

Recommendations

The recommendations in this report are in two groups. These are recommendations for:

- improving the current NTA Scheme
- further work to enable more ambitious change.

Through the process of creating an evidence base for improvements to the Scheme, we identified that the information (eg, demographic data about clients of the Scheme, appointment attendance, claims data) held by the Ministry and DHBs requires improvement work beyond the scope of this review. We need to accurately understand how effective the current Scheme is before we make a decision to redistribute the funding or change the eligibility. At this stage, we would not understand the degree of investment required to make a real impact on improving population outcomes and equity.

The Ministry acknowledges that, with our DHB partners, we need to improve data collection and integration to enable more ambitious development of the NTA Scheme. This is why we have placed the recommendations into two groups.

Focusing on improving the current NTA Scheme means, for example: determining what best practice looks like from end to end, for the process of registering patients and claiming; ensuring the national NTA Policy is clear and transparent about what assistance is given and why; and examining how we can improve the data we hold about the Scheme.

Group One: Recommendations for improving the current NTA Scheme

The Ministry of Health will lead a programme of work over 2019–2020, in partnership with DHBs, to improve and mature the NTA Scheme to a point where a second phase of more significant change and investment can be considered to further meet the objectives outlined in the Introduction.

Governance and accountability

1. The Ministry of Health will lead a review of the *Guide to the National Travel Assistance Policy 2005* (Ministry of Health 2009) to incorporate what best practice is developed, and clarify existing policies.
2. The Ministry of Health will partner with DHBs to provide education and support to travel coordinators and others administering the NTA Scheme, to support consistent and transparent decision-making.

Administration and information technology

3. The Ministry of Health, in partnership with DHBs, will design and implement end-to-end best practice and guidance for the process of registration, claiming and making payments.
4. The Ministry of Health, in partnership with DHBs, will review the data related to the NTA Scheme to improve what is collected and how it is used, in order to support implementation of best practice and transparent decision-making.
5. The Ministry of Health will automate registration and claiming under the NTA Scheme by 2021, as part of an internal continuous improvement plan.
6. DHBs should consider how to integrate navigation/brokerage roles into the NTA registration process as an option for more vulnerable people who value assistance.

Funding

7. DHBs should review how they plan for and commission travel and accommodation services, with the goal of ensuring the provision of services is sustainable for all parties, and does not further increase costs to patients.

Group Two: Recommendations for future work

The purpose of the NTA Scheme was a key point of discussion throughout the review. Who should be receiving what level of assistance? Our sector leadership group concluded that the current eligibility criteria should be redesigned, and an investment in the Scheme was necessary, to really boost the impact of travel assistance.

The recommendations below have a wealth of insight and understanding underpinning them, but we believe more work is needed in providing data to evidence their impact, before we can progress them.

As part of a second phase of development for the NTA Scheme, we make the following recommendations for further work.

Eligibility and scope

1. The eligibility criteria for the NTA Scheme could be redesigned to better contribute to improving equity of health outcomes.
 - a. The existing eligibility criteria for distance and frequency should be refreshed, to ensure the thresholds are appropriate to capture major treatment pathways.
 - b. Assessment of eligibility could be either:
 - i. a two-stage process, whereby if patients fall outside of the core distance and frequency criteria, they may be assessed as eligible through a matrix of criteria related to need (accounting for factors like ethnicity, living in a high-deprivation area, being a single parent, having no family or supports), or
 - ii. supplemented by an exceptions process that considers the kinds of criteria above (1.a.i), but in a less structured format.
2. The scope of services the NTA Scheme covers could be expanded to include a patient's first specialist assessment, if they go on to meet the NTA eligibility criteria.

Governance and accountability

3. Strong national leadership of the Scheme should be established for a year, before considering devolving decision-making about travel assistance completely to DHBs, with the objective of integrating travel assistance within wider access policies. Administration of the payment system should remain centrally managed.

Administration and information technology

4. Retrospective payments to patients should be one of a range of payment options.
5. Use of external-facing technologies like online application and payment tools should be considered to provide a more modern, efficient option for people to access travel assistance.
6. Internal-facing technologies, most importantly a platform that enables integration of data, should be developed as part of wider IT improvement in the health system.

Funding

7. Consideration should be given to investing in the NTA Scheme, because it has the potential to:
 - a. directly improve patient experience
 - b. contribute to patient outcomes through increasing access to and completion of treatment
 - c. improve equity when targeted to those people who are vulnerable or otherwise find it hard to access specialist services
 - d. manage system costs by preventing the use of more costly inpatient bed days.
8. The rate of assistance provided for private mileage (petrol) and accommodation should be reviewed to:
 - a. ensure a sound methodology is behind the rate
 - b. recognise that the level of assistance provided has remained static while costs have risen.
9. The cost of parking to attend appointments should be considered for inclusion within assistance provided by the NTA Scheme.

Eligibility and scope

Throughout the review, many discussions focused on what the NTA Scheme was set up to do originally, what it should now achieve for patients, and therefore who should receive what assistance. The answers to those questions will essentially drive what part the NTA Scheme plays in the health and disability system in the future.

The scope of services included within the Scheme, and who is eligible, needs to be underpinned by this Government's priority of improving equity of outcomes for different groups within the New Zealand population. This is particularly important in the context of the NTA Scheme, because providing financial assistance to patients to travel to treatment is a direct way of removing barriers to access.

Beyond that, we considered examining eligibility and scope critical to achieving the review's objectives of providing a consistent, fair process for patients and ensuring the Scheme meets the needs of those people who need it the most.

Findings about the current situation

Patient feedback through our survey indicated that people strongly support the NTA Scheme and would recommend it to others. The Scheme receives few complaints through the Ministry of Health national call centre.²

Eighty-one percent of people who answered our survey for patients and their support people said that the NTA Scheme was 'extremely important' in helping them to travel to treatment.

Ministry of Health (2018)

However, our engagement process also raised a number of valid points about how the Scheme could be refocused to better address the range of need in the community.

DHBs differ in their interpretation of the national Policy (Ministry of Health 2009). They also differ in the extent to which they create exceptions for patients who have a clear need but do not meet the eligibility criteria. This difference in practice creates inequity across DHBs because some patients receive more or different assistance compared with others. One of the most common examples is the circumstances under which a DHB will fund a second support person to travel with a patient.

² In the last two years, the national call centre has received 11 complaints related to the NTA Scheme.

Our survey of patients and support people found that the complaints about the eligibility criteria came most often from patients who are just outside the access threshold. DHBs have told us that they regularly deal with these people and may provide alternative supports to those with a clear need. This suggests that the way the travel assistance criteria are currently written may not match the need in the community, and more flexibility could help us achieve our objectives.

The most common reasons patients gave for being declined included the travel distance being too short and not having a Community Services Card. Respondents also commented on not being allowed a support person, which was often viewed as essential.

Ministry of Health (2018)

It is important to understand that other options exist for some patients to travel to treatment, though what is available is not standard across regions. Many DHBs provide health shuttles between hospitals, with varying levels of success. Community-based volunteer drivers make up a significant proportion of additional support available, and travel coordinators in some regions appear to rely on them frequently as an alternative to the NTA Scheme.³

Since the national Policy was introduced in 2005, the way treatment is delivered has changed. For example, an average course of radiotherapy is approximately 13 sessions and one of the frequency thresholds under the Policy is 22 or more visits within two months. Because the distance and frequency criteria are central to eligibility for the Scheme, they should closely match typical treatment patterns in order to ensure major patient groups are not unfairly excluded.

Some stakeholders noted the NTA Scheme could include more than 'specialist to specialist' appointments (ie, where a specialist has referred the patient to a specialist appointment). For example, general practice appointments or first specialist assessments could be made eligible appointments. The aim of this change would be to increase the focus on prevention and increase access to services earlier in the treatment pathway.

The Community Services Card's failure to capture all people with a financial need, such as those on an income above the threshold who cannot work due to their treatment, was highlighted, particularly by those who work closely with clients (eg, nurses and social workers). Consider the research finding below, which speaks to the need for compassion and flexibility in considering eligibility for the NTA Scheme.

³ Cancer Society volunteer drivers made almost 20,000 trips with cancer patients alone in the 2016/17 financial year.

The NTA eligibility criteria of a current community services card is causing a barrier for whānau accessing NTA support. The renewal process for community services cards is often lengthy and difficult and this creates additional stress for whānau who require immediate support to travel with/to their unwell whānau member. More immediate assistance is required (i.e. petrol vouchers on the spot) and there should be flexibility around the community services card requirement when there is urgent need.

Masters-Awatere et al (2018)

Discussion

As mentioned, the eligibility criteria and scope of services covered by the NTA Scheme have been discussed regularly throughout the review. Participants raised questions about the degree to which the criteria match the needs of various community groups and whether 'distance' to travel is the best way of determining need. To determine whether the current parameters of the Scheme are appropriate for the objectives we are trying to achieve, we need to be able to describe what the role of the NTA Scheme should be, within the wider context of what the health and disability system is trying to achieve.

The current role of the NTA Scheme

At an individual level, the purpose of the NTA Scheme is to assist a patient by providing them with a financial contribution towards the cost of their travel and accommodation and having a support person, when they are receiving treatment from a specialist in the public health and disability system.

This focus is quite specific. The NTA Scheme is mainly aimed at enabling access to tertiary-level services (with the exception of some disability support services). Only about 33,000 people access the NTA Scheme per year, out of the approximately 1.8 million users who access specialist health services. This is a small proportion (1.8%) of those who may need assistance accessing services, and an even smaller proportion (0.7%) of the total New Zealand population.

Under the national NTA Policy, the guiding principle behind the Scheme is to assist with equitable access to specialist services for all New Zealanders. Improving equity is a priority for the Government, and a reflection of the statistics on health outcomes that show us not all population groups benefit from access to health services to the same degree. Access to cancer treatment and treatment outcomes for Māori and Pacific people, for example, have been persistently poorer compared with the wider population over time.

As mentioned above, the NTA Scheme sits within a much bigger system of support for patients(which includes families) individual volunteers and major NGO contributions. Losing these other elements would have a significant impact on the success of the NTA Scheme itself. It is likely that hospital staff and community supports capture a segment of need that NTA Scheme funding does not meet at all.

In summary, it is important to remember that the NTA Scheme plays only a small role in assisting New Zealanders to access services when considering its future role, and what the provision of travel assistance (in isolation) has the ability to address. But it is an example of what can be done. Should the NTA Scheme be used to tackle a much wider issue about transport to public services? Should it be used to tackle the much wider issues associated with poverty and health literacy? Our sector leadership group concluded that these were much more complex and significant issues that currently the Scheme can help to address but cannot address in isolation.

Other barriers to access that respondents to our patient and support people survey noted were:

- geographical isolation
- poverty
- mobility of patients
- frailty in older age
- health literacy and education
- the need for time off work
- timeliness of the process
- the need for childcare.

The desired focus of the NTA Scheme

We established a review of the NTA Scheme with the objectives that it should contribute to improving equity and be administered in a way that is fair and transparent. The eligibility criteria are one of the main levers we have to ensure the Scheme is meeting these objectives.

We have interpreted 'improving equity' as meaning improving the use of travel assistance for groups that face the highest barriers to access due to travel and accommodation. Accordingly, the main groups we have focused on are Māori and Pacific people, people with English as a second language, people with a disability, and those living in rural and remote areas.

Noting that the Scheme's current focus is narrow and that participants consider it is not always well matched to the need that exists in communities – but that those who use it in its current form value it highly – we discuss below a way of adjusting its focus to bring its intent closer to the need that exists, without losing what people value about the current Scheme.

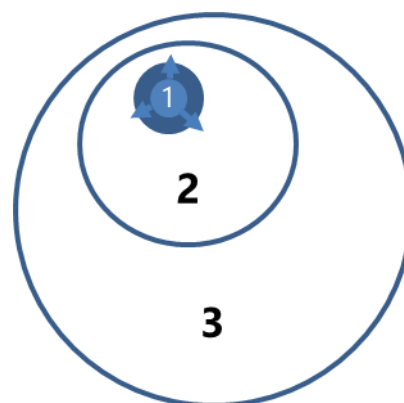
If an affordable future investment was made in the NTA Scheme, we consider it most appropriate to both:

- retain the essence of the original Scheme, as our survey shows it is of high value to patients
- increase the flexibility of the criteria so that it can meet a wider range of need and so that the Scheme can make a stronger contribution to improving equity.

The diagram below shows how we see the current and future focus of the NTA Scheme.

1. Current NTA users per year (33,000)
2. Patients receiving specialist treatment, but not accessing NTA (about 1.8 million)
3. Rest of the New Zealand population (about 2.9 million)

Aim: Target those people at the edges of the current Scheme who demonstrate a financial or social need.



This approach, to keep but widen the main purpose of the NTA Scheme, has been taken considering that an overall review of the health and disability system is under way that may significantly affect the way that services are planned and delivered. The NTA Scheme is a critical part of future system design and service planning.

Services to capture within the NTA Scheme

Another theme arising throughout the review is whether the landscape of service delivery has changed enough to warrant a change in the services covered by the NTA Scheme. Specific suggestions were to include first specialist assessments (FSAs) and general practice referrals to specialist services within its scope. Also noted was that there are many ways to minimise the need for travel to services. At scale, telehealth could reduce the need to travel for some communities. Should we incentivise travel when a local solution to service provision would be the preferred long-term solution?

A stronger system-wide focus on prevention and early intervention should lead us to providing assistance with access to services much earlier in a patient's journey. In this context, should we provide assistance for people to travel to general practice appointments, general practice referred appointments or first specialist assessments?

Although early intervention may mean better long-term outcomes for patients and create value for the health dollar, some of the strongest feedback from the survey and through clinicians is that patients who receive specialist care are particularly vulnerable, and may be in a high-stress situation. Once a patient has a treatment pathway identified, they may face a significant financial burden in attending ongoing appointments; and completing treatment will be absolutely required for a good patient outcome.

Expanding the NTA Scheme beyond specialist treatment would grow the eligible population significantly. To achieve this expansion, either it would need to be funded or the existing funding would need to be rationed. We consider significant expansion of the Scheme into primary care, for example, is not affordable currently, when other barriers to access and the entire orientation of treatment would need to shift towards early intervention to enable this investment to have an impact.

In the case of FSAs, for the majority of patients, we have concluded that the burden of travelling to one appointment could be reasonably accommodated within that person's financial and social means. If we funded travel to FSAs as one-off appointments under the NTA Scheme, the current funding would be significantly diluted as thousands of FSAs occur every year. So while clearly of benefit to patients, funding FSAs as a general approach would not be the best use of limited funding, as in many cases we would not be making a direct impact on treatment outcomes.

Rather we consider our priority should be assisting people who go on to receive a course of treatment or follow-up, as opposed to those who are required to travel only once. Therefore, our leadership group concluded that, where a patient does go on to meet the NTA Scheme criteria, that person's FSA should then be counted as an eligible appointment.

Proposals

Our recommendations about changing the eligibility and scope of the NTA Scheme are written with the intention that significant work will be undertaken to improve how the current Scheme operates, before more ambitious change is considered. The proposals listed here are for future work that we consider would be necessary to really make a step change in the impact travel assistance has on equity and outcomes for patients.

Participants have provided a wealth of stories and insights that give us a clear picture of how patients experience the Scheme. The themes arising from our engagement have been consistent. However, currently no population-level analysis is undertaken regularly with a thoroughly tested methodology about who in our community is receiving travel assistance and what needs it is meeting. This makes it difficult to understand, beyond the individual stories and perspectives provided to us, whether the Scheme is contributing to improving equity or population outcomes.

Our conclusions here do not preclude Government from giving further consideration to investment in wider transport strategies to ensure that health services are accessible. Our research through the review has demonstrated that basic barriers to access (transport, parking, childcare, lost income) are still a very significant problem for many New Zealanders living in poverty or isolation.

Future change

1. The eligibility criteria for the NTA Scheme could be redesigned to better contribute to improving equity of health outcomes.
 - a. The existing eligibility criteria for distance and frequency should be refreshed, to ensure the thresholds are appropriate to capture major treatment pathways.
 - b. Assessment of eligibility could be either:
 - i. a two-stage process, whereby if patients fall outside of the core distance and frequency criteria, they may be assessed as eligible through a matrix of criteria related to need (accounting for factors like ethnicity, living in a high-deprivation area, being a single parent, having no family or supports), or
 - ii. supplemented by an exceptions process that considers the kinds of criteria above in 1.a.i, but in a less structured format.
2. The scope of services the NTA Scheme covers could be expanded to include a patient's first specialist assessment, if they go on to meet the NTA eligibility criteria.

Governance and accountability

The Ministry and our sector leadership group want patients to have a seamless, high-quality experience of the NTA Scheme no matter where they live in New Zealand. Our goals in improving the governance and accountability of the Scheme are again to ensure that improving equity and creating a fair Scheme are our focus, and that the national NTA Policy supports this.

We have concluded that good leadership, clear and appropriate accountability, and development of best practice are required in the short term to enable the development of a more effective, modern and patient-friendly Scheme in the long term. We know that the current arrangements have been adequate to operate the Scheme, but have not provided the degree of leadership and accountability needed to assure us that the NTA Scheme is really effective in achieving its objectives.

Findings about the current situation

The *Guide to the National Travel Assistance Policy 2005* (the Guide) (Ministry of Health 2009) governs the NTA Scheme. It provides minimum standards DHBs should meet and describes a number of circumstances where they have discretion in interpreting the Policy. It details the eligibility criteria for patients and support people, processes for registration, and the travel and accommodation reimbursement rates.

When the first edition of the Guide came into effect on 1 January 2006, it replaced all existing regional travel assistance policies. The Policy was nationalised, but decisions about the delivery of the Policy were devolved to DHBs, including decisions on how they might choose to supplement the assistance the NTA Scheme provides. A Ministry and DHB reference group was established at the time of the changes to the Policy and Guide, to provide a forum for issues to be discussed and resolved. This Group was subsequently disbanded, which has left a leadership gap in the Scheme.

The NTA Scheme is referred to in the Operating Policy Framework for DHBs,⁴ but has no accountability measures or other reporting attached to it. The Ministry collects financial and claims information through administration of the payment system, but this information is incomplete. Some financial information is communicated back to DHBs.

⁴ The Operating Policy Framework (OPF) is a set of business rules, policy and guideline principles that outline the operating functions of DHBs. The Minister of Health endorses and signs the OPF. Each DHB is responsible for ensuring compliance with the OPF.

DHBs have created various ad-hoc exceptions to the Policy, designed to meet local needs (which is allowed under the Policy as written). For example, patients living in certain geographical areas or receiving certain services may be considered eligible, even though they fall outside the distance criteria. At least two DHBs have independently created exceptions processes to accommodate patients who are not eligible for travel assistance. Others use prioritisation tools to determine a patient's care needs, taking account of the need for travel assistance.

One DHB region has increased its own contribution to accommodation costs, recognising that accommodation is becoming more expensive (than the \$100 contribution under the Scheme) for its population.

All of this activity suggests that the current national guidance (even without considering funding levels) does not always describe and recognise actual local needs.

Roles and responsibilities

Each DHB runs its travel services slightly differently. In particular, we found that travel coordinators have developed their own systems for registering patients for the NTA Scheme and organising travel. Some systems are based on personal relationships established with the services that most patients who are eligible for travel assistance come from. These relationships are used to find eligible patients, verify appointment attendance and confirm appointment timing. Some travel coordinators have frequent contact with patients, who they become familiar with and may offer a high level of assistance to.

Some travel coordinators have customised their forms and processes to make the Scheme work better for patients. For example, they may pre-register all patients who they know, due to the treatment pathway, will meet the appointment frequency criteria. Some coordinators have established good partnerships with Work and Income and NGOs like the Cancer Society, which gives them easy access to a wider range of assistance available to patients in their region. This kind of collaboration is generally not actively promoted.

The role of the travel coordinator is critical to the success of the NTA Scheme, as the following finding from our surveys indicates.

An overwhelming number of respondents also gave credit to the travel coordinator knowing the purpose of the scheme but also understanding the scheme and being able to help explain it and help fill out the forms.

Ministry of Health (2018)

The Ministry processes all patient registrations and most claims. It also makes payments directly to patients (see 'Administration and information technology'). A benefit of this arrangement is that the Ministry's Payments Team provides a national touch point that DHBs can use to query how to deal with particular cases. The Team also acts as an external quality check. However, the Ministry does not hold a complete picture of all activity related to the NTA Scheme, nor does it intervene actively in DHBs' decisions. DHBs have autonomy to operate under the Policy as they wish.

Discussion

Many patients and their families have told us they want to see that everyone is being treated consistently through the NTA Scheme process. They believe this is not always happening across the country, in part because patients receive different amounts or types of assistance, but also because of different levels of awareness about the Scheme. Our sector leadership group, clinicians and NGOs also believe that the NTA Scheme should be fair. They consider that no matter where you live, you should be able to access health and disability services.

Another strong theme throughout the review has been how we can make sure the Scheme accommodates the range of needs within local populations. How should it take into account differing geography between regions and the range of deprivation levels within communities?

Travel coordinators are working to their local needs and constraints. We know (because of its narrow focus) that what can be provided through the NTA Scheme does not always meet the patient need presenting. Travel coordinators know pockets of their communities are not eligible for assistance due to the distance criteria. But many are also aware of the need to operate a good process, to ensure patients are treated fairly. Some nurses tell us they are concerned the need for assistance extends beyond the current realm of the Scheme; most often, this concerns social or economic needs among, for example, people without a Community Services Card.

We have interpreted these challenges as meaning that governance and accountability under the NTA Scheme need to strike the right balance between achieving **national consistency** in application of the national NTA Policy and **regional flexibility** to allow DHBs to make the Scheme work for their local populations. Transparency in our decision-making and process is very important. Achieving this is a difficult balance but will both contribute to the overall **fairness** of the Scheme and improve **equity** of access to services.

Any discussion about the right balance between national consistency and local flexibility must be driven by an understanding of the needs of the patients requiring travel and accommodation. We know from patient stories collected through the review that patient needs are:

- diverse on an individual, personal level – for example, I don't want to be a burden to others
- diverse in terms of geography and travel requirements – for example, there is no public transport from my home to the hospital
- affected by their social and economic circumstances – for example, I am a single parent with three small children
- different according to family structure and cultural values – for example, my extended family will share the responsibility of driving me to appointments.

Consider the patient story below about a population cohort that may not come to mind first in response to the question: "Who is most in need of travel assistance?".

Often [the NTA Scheme] is most challenging for younger patients, employed with young children, [who] don't qualify for NTA nor WINZ support due to spouse working. No financial support or assistance [is] available to help with the treatment phase. Patient has decided against treatment, or [is] choosing less than ideal treatment options based on a financial reason.

Cancer nurse coordinator

Need for national governance and leadership to guide local decisions

The Ministry of Health does not provide governance and leadership of the NTA Scheme, except through its role in managing payments and advising DHBs on individual claims. DHBs have created local administrative arrangements to meet their needs. Travel coordinators work across regions and liaise with each other for peer support, but may not be formally mandated to work collaboratively. This situation does not support strong national consistency.

The need for both individual and regional flexibility within the NTA Scheme and/or local solutions that supplement the national Scheme has been clearly demonstrated throughout the review. The following are specific examples of local needs that are not being met.

- In the Hutt Valley (Wellington region), patients who live in parts of Naenae and Taita are not eligible for assistance to travel to Wellington Regional Hospital, even though many families in these suburbs are in financial need (both suburbs are in the category of highest socioeconomic deprivation, decile 10).
- Patients travelling from Levin to Palmerston North Hospital are not eligible for travel assistance, despite many low-income people needing to travel to the Regional Cancer Centre there.
- The Auckland region has many patients who only just miss out under the distance criteria (for example, people living in Waiuku or Warkworth) but find travelling to the central city very time-consuming in heavy traffic. Others do not qualify for accommodation, despite being very sick as a result of their treatment.

- If we compare the West Coast or Tairāwhiti with inner-city Wellington or Auckland, it is clear that some regions have vastly more public transport options than others. Public transport is deemed the default method of transport in the national NTA Policy.

Presenting another part of this picture are the examples of how people may receive different levels of assistance, despite travelling to the same facility. Families who are flown to Starship Hospital in Auckland often have time to share their experiences with each other and compare what assistance their DHB of domicile (the DHB where they live) has provided them. Sometimes second supporters are assisted to travel; sometimes they are not. In some circumstances, patients are expected to travel to Auckland and back in one day; in others, they may be provided with accommodation to allow families to travel at reasonable times with sick and/or young children.

The Auckland Regional Transplant Unit has observed a number of concerns from patients. Some are provided with taxis to and from their accommodation, and others are not. Sometimes accommodation is refused for Auckland region patients who have to travel for a significant time across town to the transplant unit.

Need to improve the *Guide to the National Travel Assistance Policy*

The *Guide to the National Travel Assistance Policy* effectively acts as a minimum standard, though this has not been clearly communicated, so implementation has grown in an ad-hoc way in the last 10 years. There is no formal accountability mechanism to ensure DHBs are following the Policy.

Common differences in interpretation of the Guide are illustrated through the patient story and the sector leadership group observations that follow.

Accommodation was provided under the NTA for an out of Auckland patient receiving a kidney transplant by his DHB. However, the patient did not have a vehicle to allow him to get to appointments. His DHB of Domicile declined to pay the cost of taxis, so this cost was borne by Auckland DHB. At the same time another patient receiving a transplant had all of her transport costs to and from the hospital while in Auckland covered. Many transplant patients are immune compromised, so it is not appropriate for them to take public transport.

Cancer nurse coordinator

Our sector leadership group agreed that DHBs operate variations to the Policy and/or choose to interpret it very strictly. They believe there is more pressure on small DHBs, which have a lot of patients travelling out of the region, to manage the NTA Scheme tightly. Two specific examples are detailed below.

The Guide states that two supporters may be approved by a clinician to travel with a patient, where that clinician considers this necessary for the patient's care. Where this criterion for a second supporter is applied differently between families, or a decision appears to be made by someone other than a clinician, advocacy groups tell us this is perceived as unfair. (See 'Administration and information technology' for further discussion.)

Guidance under the Policy about patients travelling over water does not provide a practical and transparent framework for making decisions. The Guide states that travel over water is at the discretion of DHBs, but that where possible the cheapest option for travelling must be chosen: 'as a rule, ferries should be used as a less expensive alternative form of transport' unless a specialist clinician decides air travel is necessary. Having such wide discretion, but predetermining the mode of transport, seems to inhibit transparent and practical decision-making that is focused on the best patient outcome.

These examples highlight how the balance between national consistency and local flexibility is not always supported by a robust decision-making framework in the Guide, and therefore is not transparent. They demonstrate how leadership and ongoing review will be needed to ensure that a refreshed Guide is interpreted and applied consistently. Best practice for administration of the Scheme will need to be developed alongside improvements to the Guide, as well as support provided to travel coordinators in their implementation role, to ensure the intention of the Policy is met.

Improving how the Scheme is governed will also support many of the improvements recommended around the use of the national Policy by setting a national expectation about what the NTA Scheme should achieve and how.

Need to consider accountability and reporting

Currently accountability for the effective operation of the NTA Scheme sits primarily with individual specialists and travel coordinators, in terms of the decisions they make for patients. It should also sit at organisational and system levels, through a shared understanding of and accountability for whether we are meeting the purpose of the Scheme, and what it is achieving for patients and populations.

We have found that, within DHBs, roles and responsibilities often need to be clarified. One example discussed by the sector leadership group was the degree of flexibility needed in who can authorise travel assistance claim forms. Varying views were expressed about achieving a balance between using clinical information and using a wider understanding of the patient's circumstances in making decisions. Making the process more efficient and patient-friendly was seen as important.

Consider this feedback from an NGO provider about who is responsible for registering patients.

[We] operate a community health shuttle service in some communities in New Zealand. [Our volunteers] find that a number of patients are referred to their services with no knowledge of the NTA Scheme, so by default it becomes the responsibility of the volunteers otherwise St John will receive no payment for transporting the person.

St John community shuttle provider

The NTA system is not user friendly, we have to find any details the client has forgotten to fill in, then check that the hospital tally matches ours before we send them off. The hospital then must sign off every visit ...

Volunteer

The Guide states that: 'It is the responsibility of DHBs to first assess a person's eligibility for NTA prior to registration. All DHBs have NTA travel coordinators who can assist patients and Specialists with any aspect of the registration and claiming process.' It does not define the role of DHB planning and funding teams, and the relationship the travel coordinator has with their management team varies. This strategic planning lens on how the NTA Scheme is commissioned and operating in each DHB could be strengthened.

There was also some confusion among stakeholders about the role of the Ministry, with many assuming its role is wider than simply administering payments. Reconsidering and making clear who is responsible for what will make the process work much better for patients. More leadership from the Ministry can support DHBs in their role of being accountable for good patient outcomes and spending funding effectively.

The Ministry has information about most of the activity occurring under the NTA Scheme because most claims are processed centrally. The Ministry provides basic financial reporting back to DHBs based on this, as well as details of registrations for NTA within the individual DHB's region.

But we know and share little information about the population as a whole that is using the Scheme. This information gap makes it difficult for DHBs to understand how effective the Scheme is currently, and how they each compare with the national picture. The Ministry's data⁵ is not integrated or used to understand the outcomes for patients, nationally or regionally.

As mentioned, the Operating Policy Framework for DHBs refers to the NTA Scheme, but no accountability measures or reporting are attached to this.

⁵ To analyse the NTA Scheme, data must be integrated across the following databases: the National Minimum Data Set; National Non Admitted Patient Collection; primary health Organisation data set; National Health Index Data; and the Client Claims Processing System.

To establish that the NTA Scheme is effective for patients and achieving the outcomes we have described as desirable throughout this report, data collection and analysis would need to improve significantly. This would be necessary to design meaningful measures that tell us about, for example, patient experience and equity of access.

In summary, to improve accountability for the NTA Scheme, we need to:

- reconsider and clarify roles and responsibilities, and define them within the national Policy
- improve data collection and use data to generate a shared understanding of how effective the Scheme is
- develop an appropriate level of reporting, possibly through the Operating Policy Framework, to ensure we can measure the Scheme's effectiveness.

Proposal

The governance and accountability attached to the NTA Scheme is of critical importance to addressing many of the issues, small and large, that have been raised throughout the review process. The Ministry believes this is one area that we should prioritise to progress first, in accordance with the recommendations below.

To improve the current Scheme

1. The Ministry of Health will lead a review of the *Guide to the National Travel Assistance Policy 2005* (Ministry of Health 2009) to incorporate what best practice is developed, and clarify existing policies.
2. The Ministry of Health will partner with DHBs to provide education and support to travel coordinators and others administering the NTA Scheme, to support consistent and transparent decision-making.

Future change

3. Strong national leadership of the Scheme should be established for a year, before considering devolving decision-making about travel assistance completely to DHBs, with the objective of integrating travel assistance within wider access policies. Administration of the payment system should remain centrally managed.

Administration and information technology

Many people in the health sector make the NTA Scheme work for patients, despite the challenges they face working within the current system. These people include, among others, travel coordinators who proactively identify eligible patients, nurses who ensure forms are filled out and social workers who advocate for patients.

It is important to remember that, for the majority (72%) of patients and support people who answered our survey, their experience of the NTA Scheme was positive and they would definitely recommend it to others. Many of the issues raised about the Scheme that could be addressed by improving the basics of how the current Scheme is administered.

In improving the way the Scheme is administered and how information technology is used, our goals are to ensure:

- patients are at the centre of the process and we make it work for them
- the way the Policy and guidance operate avoid and eliminate inequity wherever possible
- best practice is established and adopted by those working regularly with the Scheme
- the quality of the data collected is improved, integrated and used to understand the effectiveness of the Scheme.

Findings about the current situation

As discussed in 'Governance and accountability', the *Guide to the National Travel Assistance Policy 2005* (Ministry of Health 2009) provides the minimum standard that DHBs should meet in administering the NTA Scheme. Underneath that overarching document are the systems and processes that support how the Scheme runs, in accordance with the Policy. Currently, DHBs set up these systems and processes individually. The payment system is largely centralised in the Ministry.

Data and IT infrastructure

The NTA Scheme is a largely paper-based system, requiring patients to manually fill in forms to register and claim assistance. Separate IT systems are run within each DHB (or sometimes across regions) to record NTA activity. Invoices and appointment attendance may be recorded elsewhere in the DHB and manually integrated into a travel coordinator's database. These databases vary in the breadth and depth of information they hold.

Additionally, the Ministry of Health runs a separate system to record registrations, issue client identification numbers, receive claims and make payments. Within the Ministry, information about claims is held in one database with the attached NTA client identification number. However, not all DHBs submit information to the Ministry. The Ministry-held financial information is aggregated and communicated back to DHBs.

Data about patients using the NTA Scheme can be linked to other Ministry-held national databases (the National Minimum Dataset (NMDS) and the Client Claims Processing System (CCPS)) using a patient's National Health Index (NHI) number. The NMDS holds every NHI holder's demographic data and hospital-based activity. In attempting to build a data model using all the available metrics, to provide a picture of NTA eligibility and demand, we have found an absence of clear linkages from the policy requirements to the data collected, as well as gaps in what is collected. For example, though the NTA Policy requires that, to receive travel assistance a patient must attend a 'specialist to specialist' referred appointment, this data category is not specifically contained in the NMDS and a definition and code would need to be built. Clarifying linkages between the policy requirements and the data collected would make it possible to measure the Scheme's effectiveness.

In summary, a number of data sets within both DHBs and the Ministry hold data relevant to the NTA Scheme, some of which is incomplete, or is not easily matched to the NTA eligibility criteria. This would require further work to create an accurate picture of current and future activity.

Administration of the Scheme

Similarly to the data infrastructure described above, the forms and process used to administer the NTA Scheme are largely unique to each DHB, other than communications from the Ministry of Health, which are standard for all patients. Breaking down the NTA Scheme's administration into its core steps reveals the following about how it currently operates.

1. Raising awareness

The national Policy states that it is the clinical specialist who should initiate registration of patients they think will be eligible for travel assistance and refer them to the travel coordinator. It does not allocate the broader responsibility of raising awareness of the Scheme to any particular role.

Some travel coordinators actively identify patients within services where patients are commonly eligible (eg, neonatal). Other professionals may be involved in referring a patient – where the person has a disability or is linked to a social worker, for example. Many travel coordinators have knowledge of the services that NTA Scheme clients are using so are to a certain degree able to anticipate their needs and link with them through clinical teams. One concern raised about this part of the process was that some clinical staff raise patients' expectations that they will receive travel assistance when they are not eligible. This situation could be improved by increasing knowledge about the Scheme among DHB staff.

Visibility of the NTA Scheme varies between DHBs. A general lack of awareness of the Scheme was a significant theme arising from research and discussion about Māori and Pacific experiences of travelling for treatment (Masters-Awatere et al 2018). However, the number of Māori accessing travel assistance is high relative to the percentage of the population that is Māori (see Appendix 2).

The Ministry of Health provides a call centre phone line to answer queries and provide information.

2. Registering patients

Registering patients is the responsibility of the DHB. The travel coordinator may simply provide the documentation needed for a patient to register themselves, or may assist them with the forms. Forms are sent to the Ministry, so that the patient is entered into the NTA database and given a client identification number. A patient is registered for five years, or shorter if deemed appropriate.

The Ministry provides a quality check in reviewing forms and ensuring the right information is provided. This is a point in the process where some of those we surveyed commented that their registration was significantly delayed if they provided incorrect information.

3. Booking travel and accommodation

Booking travel and accommodation is the responsibility of the DHB or patient. If the travel and accommodation are urgent, they may be booked on behalf of the patient. Some travel coordinators actively book travel and accommodation for patients where they can do so in advance. If a patient is driving, taking public transport or booking their own accommodation, an itemised invoice needs to be collected in order to make a claim to the Ministry for payment.

4. Making a claim

Making a claim is the responsibility of the patient. Some travel coordinators will assist patients with forms and, if the DHB has booked the travel, the claim may come directly from the DHB to the Ministry. Not all DHBs submit their patient claims to the Ministry.

The Ministry provides a quality check in reviewing claims and liaising with the patient or DHB to ensure the right information is provided. Claims are made retrospectively, after the criteria are met and the travel has been completed. The inability to pre-register patients in anticipation of them meeting the NTA Scheme criteria was raised as a concern because of the extra time it adds to the claims process.

5. Payment

Generally the Ministry of Health processes claims and makes payments either directly to patients or to the DHB. Payments are made retrospectively. Some providers of travel and accommodation have invoiced the Ministry directly in the past.

6. Dealing with exceptions

Dealing with exceptions is the responsibility of the DHB. Some DHBs will use their Planning and Funding Managers (or equivalent) to make decisions about exceptions. At least two DHBs have a formal process for dealing with exceptions. The Ministry provides advice, but does not determine the outcome of these cases. How to deal with exceptions is discussed under 'Eligibility and scope'.

Discussion

The review revealed some highly consistent themes about how we could improve the way the NTA Scheme is administered.

Inconsistent practice between DHBs

The diverse stories this review has collected of how individual patients experience the NTA Scheme demonstrate the range of practices across DHBs that have developed over time. Throughout discussions, our sector leadership group raised the concern that patients view these differences as unfair. These differences also create inefficiency for providers.

Consider the comment below.

Clarity and consistency amongst DHBs would be helpful for us in reducing the significant administrative burden that comes from having to apply different rules for different DHBs in funding.

Service Provider

The following examples illustrate how DHBs can differ in their administration of the Policy.

- When patients are referred to the Auckland Renal Transplant Unit, only some have taxis to and from the airport, or from the hospital to their accommodation, paid for by their DHB of domicile.
- Not all babies and children are granted assistance for two supporters when attending Starship Hospital in cases where a mother may be breastfeeding the baby, or accompanied by other children that need to be cared for.

- Not all patients are given choice around the day and time they travel, to make that travel easier.
- Some DHBs have endorsed various exceptions to the national Policy where communities in their region are given access to travel assistance despite being ineligible under the distance criteria.

It is important to remember that most cases of inconsistent practice occur in areas where the policy allows for discretion. The key question is whether the NTA Policy is written in a way that accounts for patient needs.

Another strong theme that emerged both through the sector leadership group and in talking with those involved in patient care is that the NTA Scheme must have the flexibility to take into account local factors and the real need for assistance among some people who do not meet the current eligibility criteria. Patient stories have demonstrated that local factors (such as geography, traffic and availability of transport and accommodation) play an important role in determining what assistance a patient may need.

The following story about a DHB's decision involves obvious clinical and cost considerations yet the appropriateness of the priorities is less clear.

[A] man was required to travel for a post-op follow up appointment, he was driving instead of flying up. He had an internal hemipelvectomy, so travelling five hours each way was not appropriate. He was provided with petrol vouchers instead of flights.

Nurse

The Policy for assisting second supporters was raised frequently as an example of inconsistent practice throughout the review. The Policy states that:

Additional funding for a second support person may be approved in any of the following situations:

- a second support person is required to learn technical skills for ongoing care of the client and cannot learn these skills from a local health or disability support service provider, the first support person or the client
- a child client is in a critical condition
- a second support person is required to be present to make a decision about whether to proceed with surgery.

These criteria create a minimum standard, but obviously require clinical judgement. Any other circumstances under which a second supporter is approved are essentially outside of the current Policy, even if they are valid. Whether the minimum standard needs to be more generous because the need for that is clear across all cases, or whether the Policy should be more principles-based to encourage a more holistic approach to meeting patient need, will be considered as part of a wider review of the Policy recommended in this report.

As a basic framework for decision-making, inconsistencies in interpretation of the Scheme due to decisions driven purely by funding or convenience should be minimised. Where differences are driven by a decision that meets a particular clinical or social need, this should not be discouraged, but made transparent through a much better description and understanding of best practice, and roles and responsibilities within the NTA Scheme pathway.

As well as considering how we could improve the national Policy, as part of developing best-practice, we will streamline the forms and processes of DHBs to create more consistency and to support travel coordinators to make good decisions in their jobs.

Outdated, cumbersome process for registration and claiming

Review participants were easily able to pinpoint where the process of registering and claiming for NTA was less than ideal. The review has generated a good base of knowledge about the administration process through calls coming into the national call centre, from discussions with our sector leadership group and travel coordinators, and through feedback received in our surveys.

We have found that small things matter. Consider the following issues raised by travel coordinators about how they work with the system and then by the patient story.

Adding and approving additional facilities: for the 6x6 [appointment frequency requirement] the process of adding facilities is complex, as the client must be assessed for each facility. I'd like to suggest that if a client applies during the time that their registration is valid, the facility can be added automatically if a public funded approved facility. Why must we reassess [the client] each time when we know that within the public health system the referrals on to the next facility are not made until the initial [NTA] assessments has been done.

DHB travel coordinator

The automatically generated form for patients from the Ministry of Health needs to be changed as it is misleading and confusing to patients in how it refers to all forms of assistance given under the eligibility criteria.

DHB travel coordinator

Our client completed the NTA registration form. All treatment centres that she would be required to attend were included on the form. She was required to travel to:

- Invercargill for first appointment / planning / CT (380km return)
- Dunedin for radiotherapy treatment (550km return)
- Dunstan for oncology appointments / chemotherapy (166km return)

Patient advised that she would have to fill out a new form for each treatment centre as opposed to being registered for all under the Southern DHB. That registration would only be completed once she had reached one of the criteria for eligibility. That there would be a delay in her ability to claim for NTA assistance by at least six weeks as this is how long it takes from the time the registration is submitted to it being complete.

So even though her treatment plan showed that she would be eligible for NTA – this was delayed until it could be proven that she would be entitled to assistance.

The administration burden placed on clients to get three forms completed (signed by their treatment physician) on three separate occasions is quite challenging for many of our elderly, poor literacy and unwell clients – not to mention the financial pressure it places on them to at times cover six weeks of radiotherapy accommodation due to the delay in the registration process.

Cancer Society

We consider the NTA Scheme could be modernised and made more efficient through two main avenues, to improve the patient experience:

1. improvements in information technology
2. design and implementation of best practice.

Having only a paper-based process available for patients registering and claiming for NTA is outdated in a technology environment where people expect to have the option of completing forms online and receiving a quick response.

In our survey of patients and support people, the most popular choice (31 percent of respondents) about the most important improvement that could be made to the NTA Scheme application process was: 'I should be able to make a claim on my computer or phone (online)'.

Patients are being text[ed] or called regarding their hospital appointment, and as an NTA Coordinator I wait for a scheduled appointment (as proof of appointment) to arrange travel. This can be up to two weeks later. A number of elderly patients do not have mobile phones, printers at home and rely on information being sent to them. A letter can take up to four days in the post now.

DHB travel coordinator

The feedback above emphasises that information technology is now mixed in with more traditional paper-based systems. We aim to provide flexibility to patients rather than phasing out paper systems entirely. Improvements to information technology would benefit the NTA Scheme in several ways. Some of the points below are exploratory, others are more critical if we are to understand current use of the NTA Scheme and plan for the future. Improvements to the technology will be a step-by-step process over time as they are largely dependent on development of the IT infrastructure of the wider health and disability system.

- Internal-facing system improvements: The NTA Scheme needs an integrated data system that gives travel coordinators and others the same platform through which to generate, view and use information. This would support standardisation and best practice. It could be linked to Ministry-held data and managed centrally as part of the Ministry's stewardship function.

Example: One idea generated from our sector leadership group is to place a 'flag' in hospital patient management systems that alerts clinicians to someone's eligibility for travel assistance.

- External-facing, patient-focused improvements: Patients need an online, timely option for completing the NTA Scheme process. This option might be a web page or app through which patients could enter and view their information, find information and make claims. It would be in addition to the traditional paper-based system.

Example: We could phase out retrospective payments by considering technologies that allow for pre-paid funding to be made available.

The next two most popular answers to our survey question about improvements to the NTA application process were the desire to have:

- a claim processed more quickly
- travel and accommodation prepaid.

Processing claims in a timely way is a reflection of how well systems and processes are designed. To provide an idea of the volume of work required in processing claims, in one week in August 2018 the Ministry's payments team received 1,215 travel assistance claims, of which approximately 25 percent were not processed due to missing information not held centrally. We would expect to make large gains in timeliness through developing best practice, improving the registration process and increasing the Ministry's leadership of the Scheme.

One of the most significant limitations of the paper-based system is that it creates the requirement to reimburse people after they have paid up front. This is also an outdated practice in the modern technology environment, but any revised approach must be accompanied by an appropriate level of accountability. A method to validate client identity, for example, is required to mitigate the risk associated with providing funding to clients in advance. This work would be exploratory and aiming for longer-term improvement of the Scheme.

Need to be more patient-centred

Being 'patient-centred' is about improving the face-to-face interactions we have with patients and their families. It should also be built into the process we design to enable access to and easy use of the NTA Scheme.

The following illustrates how, if people are whakamā or feel shame about applying for assistance, and find the process itself creates barriers to accessing assistance, they may quickly become disengaged.

Having to see, talk to, too many people meant [the patient was] too hoha, so couldn't come.

Nurse

A research finding on Māori experiences of accessing travel assistance is detailed below.

Rethink the need for patients to 'prove' that they are 'needy' and/or that they are at the hospital supporting their unwell whānau member by getting practitioners to sign off their NTA form. This only adds to the hospital environment being a controlling environment that actively seeks to reduce whānau rangatiratanga.

Masters-Awatere et al (2018)

The Pacific members of our sector leadership group observed that many families are unlikely to engage with the process of registering and claiming for NTA because of the strong sense of family responsibility. It can simply be viewed as too hard to apply and follow through all of the steps, when family members are there to do essentially the same job, albeit at their own cost. In addition, the NTA Scheme does not recognise having more than one or two family members to support a patient, which can further discourage these families from applying for assistance.

Engaging with a person's culture, and their family if desired, and understanding the impacts on their decision-making are basic expectations we should have of all people working with the NTA Scheme. Finding ways to support and accommodate different family structures and support systems is also important. Trusted navigators or brokers can connect people to the system. These aspects of the Scheme require work to improve equity of health outcomes.

Proposal

To improve the way the NTA Scheme is administered, our goals are to minimise processes that create inequity, put patients at the centre of our decisions and encourage the adoption of best practice.

From the feedback gathered, we know that the way the Scheme is operated can be improved significantly, within its current funding and structure. These changes should be supplemented by improvements to governance and leadership, and information technology in particular. This ground work can prepare and mature the Scheme for future, more ambitious change.

The Ministry is developing a programme of work to improve the payment processes it runs centrally. The NTA Scheme will be a feature of this work.

Our first priority will be to automate the registration and claiming process, to make it more user-friendly for patients. We aim to achieve this within the next four years.

We consider the priority in exploring these technologies is to eliminate the need to reimburse payments to patients. The current approach of requiring patients to pay costs upfront negates the positive impact of providing assistance in the first place.

To improve the current Scheme

3. The Ministry of Health, in partnership with DHBs, will design and implement end-to-end best practice and guidance for the process of registration, claiming and making payments.
4. The Ministry of Health, in partnership with DHBs, will review the data related to the NTA Scheme to improve what is collected and how it is used, in order to support implementation of best practice and transparent decision-making.
5. The Ministry of Health will automate registration and claiming under the NTA Scheme by 2021, as part of an internal continuous improvement plan.
6. DHBs should consider how to integrate navigation/brokerage roles into the NTA registration process as an option for more vulnerable people who value assistance.

Future change

4. Retrospective payments to patients should be one of a range of payment options.
5. Use of external-facing technologies like online application and payment tools should be considered to provide a more modern, efficient option for people to access travel assistance.
6. Internal-facing technologies, most importantly a platform that enables integration of data, should be developed as part of IT improvement in the wider health system.

Funding

How the NTA Scheme is funded is one lever we have to make it more effective, and to ensure it is contributing to improving equity. This chapter discusses what we have found out about the NTA Scheme in terms of the overall funding structure and also how individual payments are made.

We consider the NTA Scheme to be a good candidate for future investment. However, further work is required to understand the full picture of current travel assistance activity, including what is spent each year. Clear views were expressed about what the ideal situation should be, so this chapter looks to the future as well as discussing possible immediate improvements.

Findings out about the current situation

How NTA Scheme funding is allocated

Funding for the National Travel Assistance Scheme is distributed through the Population Based Funding Formula (PBFF). The PBFF is the funding formula the Ministry uses to distribute the majority of health funding to DHBs each year; and to determine an appropriate share of NTA Scheme funding for each DHB, from the total nominal pool available. Because NTA Scheme funding is provided to DHBs as part of their 'baseline' funding, it is not a separate ring-fenced budget.

The PBFF takes into account the number of people who live in each DHB catchment, along with their age, socioeconomic status, ethnicity and sex. The formula includes factors to compensate DHBs that service rural communities and areas of high deprivation. This element is very important to note, because one of the target populations for travel assistance discussed throughout the review was those people living in rural and remote areas of New Zealand.

Each year, most DHBs use the previous year's budget and an estimation of increased demand to ensure their travel assistance budget matches their costs from year to year. How this travel assistance budget is arrived at may not be related to the amount given through the PBFF, because the PBFF is designed to give DHBs flexibility to decide how they use funding to meet their local population's needs.

Individual DHBs face different challenges in meeting the needs of their populations, which raises the challenge of how to distribute funding in a way that is fair but also consistent. At this stage, with a wider review of the health and disability system under way,⁶ we do not consider it timely to examine the way in which the overall budget is distributed.

Cost of the NTA Scheme

In 2005 funding of \$36 million was allocated to the new NTA Scheme. The national claims database indicates that the annual spend is now on average between \$33 and \$35 million per year.⁷ However, this figure is likely to be an underestimate, given at least two DHBs do not submit claims to the Ministry for payment. We consider the national claims information to otherwise be reasonably accurate, based on our verification of national numbers against what the DHBs count. Ensuring that we have a complete financial picture of NTA Scheme costs is an area for further work.

We also know that the contribution from NGOs is significant. The Cancer Society provided approximately 20,000 car trips nationwide in the 2015/16 financial year, and Ronald McDonald House more than 42,000 bed nights in the last year. Both organisations rely on a large amount of NTA Scheme funding to provide these services to patients. However they report that the NTA Scheme is becoming a smaller part of their overall funding each year. It was clear through our interviews for the review that the charitable sector is providing a significant proportion of additional support to the patients who are eligible for travel assistance and others as well.

Funding that patients receive

Travel assistance is intended to be a contribution to a person's costs to attend appointments. It is not intended to cover full costs. Under the national Policy, patients and support people may receive:

- full reimbursement for flights
- full reimbursement for public transport, for the lowest-cost option
- up to \$100 per night for accommodation costs
- \$25 per night when staying with family or friends
- 28c per litre of petrol for private car travel
- full reimbursement for airport or public transport terminal transfers to and from treatment centres.

⁶ For the Terms of Reference for the review, go to: <https://systemreview.health.govt.nz/about/terms-of-reference/>

⁷ This is an average across the years 2012–2016.

In 2015, approximately 33,000 unique patients made a claim for travel assistance, at an average cost of \$1,000 each. The amount of funding given to a patient (calculated for the 2015 calendar year) ranges from an average of \$580 for females aged 85 years and over, to \$1,428 for males aged 45–49 years. We also think the amount people receive on average differs according to where they live in terms of the level of deprivation in that area and whether it is rural or urban (see Appendix 2).

Since the review began, a few DHBs have independently decided to increase their contribution to accommodation costs. Their reason for this decision was that \$100 is not enough for patients to access accommodation in the regions they travel to.

This difference in treatment of flights and car travel (full reimbursement compared with a capped amount) is potentially contributing to inequity within the Scheme. It disadvantages those people who either are not eligible for a flight, or would prefer to travel by car to allow family to accompany them and to have independence once they reach their treatment location.

Ways of purchasing transport and accommodation services

Patients may book and pay for their own travel and accommodation, or the DHB's travel coordinator may do this. If a patient books and pays, they submit a claim to the Ministry to be reimbursed. If the DHB pays, cost to the patient is avoided, and in most cases this is processed through the Ministry's payment system. As noted, not all travel assistance activity is captured nationally.

A small number of well-established providers of travel and accommodation draw on NTA Scheme funding (eg, the Cancer Society, Ronald McDonald House and St John Ambulance). A range of local providers has arrangements with individual DHBs for accommodation and/or travel services. From our knowledge, there are no bulk contracts for travel assistance services, so these providers claim NTA Scheme funding on a per patient basis. As mentioned, this arrangement also creates a significant administrative burden on providers.

In some DHBs, items like taxis are purchased and coded under other services such as the emergency department or intensive care unit. In many regions, shuttle services are provided – for example, between Wellington and Kenepuru hospitals – but are not funded under the NTA Scheme.

Discussion

We have reviewed funding for the NTA Scheme within the context of our objectives of ensuring the Scheme treats patients fairly and consistently, and contributes to

improving equity. We have also considered how the NTA Scheme fits within the overall strategic direction of the health and disability system.

We have tried to create a picture of how NTA Scheme funding could ideally contribute to these goals, and compared that with how it is working in practice.

Meeting the need in the community

Many comments made through our survey of patients and support people were about their frustration at being just outside the eligibility criteria (see Ministry of Health 2018).

Many comments from the survey of professionals were that travel assistance is very valuable to patients but not quite enough to really break down barriers to access (particularly the cost of accommodation) or not reaching some really needy patients.

Consider the case study below of someone declined for travel assistance.

Client requiring ongoing plastics treatment for removal of metastatic melanoma. Treatment is provided in Dunedin and Invercargill

Completed x5 trips to Dunedin in 6 months / 10 trips in 12 months but always outside of the criteria of 6x6

This gentleman and his wife were required to travel

- 2040 km total during treatment where did not meet the criteria (Invercargill to Dunedin)
- Required to stay in hospital for 10 days
- Wife required to find accommodation – supported by the Cancer Society
- NTA assistance denied as did not meet the 6x6 criteria.

Cancer Society

Research into common barriers to access tells us that the people within the group we may not reaching through the NTA Scheme are likely to be some of those who face the biggest barriers to accessing services. They are, for example, those who live in remote areas and are not connected into the health system, and those who do not find the system easy to navigate because they have a disability or English as a second language.

Our sector leadership group had a number of discussions about the ability of NTA Scheme funding to make a substantive impact on barriers to access, where poverty means a patient simply cannot afford any travel costs. Work and Income provides assistance, but only where a person is not eligible for NTA Scheme funding.⁸

⁸ www.workandincome.govt.nz/eligibility/health-and-disability/travel-costs.html

The following patient story is another example of a patient who is just outside the eligibility criteria.

A cancer support worker had to drive a person from Shannon to Capital and Coast DHB for surgery and had to collect him – not a good use of support workers time. There was no volunteer driver, as it was not proven that he had cancer until after the surgery. The patient was not able to take public transport and did not have a Community Services Card. Petrol vouchers would have been good.

Nurse

This patient may not have received a confirmed diagnosis if the system had not provided an alternative way of getting to the hospital. Taking the time of the support worker into account, the patient's travel in fact cost the health and disability system more than if they had been assisted under the NTA Scheme.

Stories like those above raise the question as to how we use the NTA funding most effectively to ensure those people who face real cost barriers to accessing services, due to the distance or frequency with which they need to travel, are able to overcome those barriers. Are we meeting the needs of those who are most vulnerable in our communities, and therefore contributing to improving equity? At this stage, we do not know whether that is the case.

The potential cost benefit of providing assistance

Funding for travel and accommodation needs to be carefully weighed up against other ways of making the health system more accessible for people – for example, by investing in more community-based outpatient clinics and telemedicine. Bringing services 'closer to home' is a theme in the *New Zealand Health Strategy 2016* that we should keep in mind for the future, as we do not want to incentivise travelling to treatment when the system could be shifting more services into communities. Use of specialist outpatient clinics and telemedicine are both successful around the country, but do not as yet negate the need to travel for specialist treatment.

Clearly if a patient is supported through a reliable transport and/or accommodation option to attend an outpatient appointment, rather than being admitted to hospital as an inpatient, the patient benefits from reduced travel and stress. The system can also save costs through this approach.

The patient story below illustrates some of these cost implications.

Hemi is a 40-year-old man living in Auckland who requires chemotherapy. He needs to travel 90.5 km each way to treatment – therefore doesn't qualify for accommodation under the National Travel Assistance Scheme (as the threshold is 100 km).

His chemotherapy schedule requires him to have five days of chemo, 7.30 am–4 pm every third week. This means he would need to travel both ways in peak hour traffic. He would likely be leaving home before 6 am and not getting home until well after 6 pm.

His chemo is known to result in severe gastrointestinal upset and vomiting, therefore it is unlikely he would have been able to travel.

A social worker liaised with the NTA coordinator to get approval for special circumstances to allow for accommodation for the week where he will be having chemotherapy. This took about five days and many hours of time, getting support letters from the oncologists and liaising between the accommodation provider and the NTA coordinator.

If this man wasn't accepted under special circumstances, it is likely the hospital would have had to admit him for this week at significant cost, or he wouldn't have had the treatment and his cancer would have progressed.

Hospital social worker

The sector leadership group discussed many scenarios in which not being able to finish a course of treatment would result in a patient becoming ill and being submitted to hospital as an inpatient. The NTA Scheme has the potential to avoid some of these situations, where the cost of a taxi or night of accommodation is much less than a hospital bed.

If better data were available, we could track a patient's journey through the health system and model how much their treatment cost (including travel assistance). We could then compare this with several alternative scenarios where travel assistance is provided, to fully understand the possible cost savings of an investment in travel assistance.

We definitely see the potential, through a further investment in the NTA Scheme, for achieving not only better patient outcomes, but also savings in terms of avoided admissions to hospital, inpatient costs and professional time (particularly nurses). Such potential could be realised if the NTA Scheme is able to better meet the needs of patients that those working in the sector see.

Making a reasonable contribution

What a reasonable contribution to a patient's costs might be was discussed throughout the review and raised by people working with the NTA Scheme – particularly in relation to the contribution made to private car mileage and accommodation costs. Providers also raised the issue of the reduction they have seen in the contribution that NTA Scheme funding makes to their costs and meeting the needs of their patients.

Starting from the patient's point of view, we want funding mechanisms to encourage achieving equity. The Scheme is currently imbalanced, in that patients who fly have all

of their cost covered and may have a support person's cost covered too; whereas a person who drives and takes family members with them is reimbursed 28c per litre of petrol.

The NTA Scheme should be flexible enough, perhaps through a formal exceptions process, to assist those most serious cases of need. This is particularly important where a person has no family or whānau supports available to them, or is eligible for some NTA Scheme funding and therefore not able to access assistance through Work and Income.

For first specialist assessments, in most cases it is reasonable for a person to pay to travel to one appointment where no follow-up or treatment is required. However, it is unreasonable where that patient then goes on to receive a course of treatment that then qualifies them for travel assistance (see discussion in 'Eligibility and scope').

Anecdotally we think there is a case for making these kind of changes to the Scheme to better meet patient need. Because data related to the NTA Scheme is not integrated, it does not easily allow us to model funding scenarios, in order to make an effective investment in the NTA Scheme. However, there is a definite case for investigating what kind of investment in the Scheme would improve equity and provide value for money.

Scope of travel assistance

We are not recommending a major change to the scope of clinical services that travel assistance can be provided for. What was more concerning throughout the review was that in some instances travel assistance essentially became ineffective in reducing barriers to access because associated costs (like parking) made travel, and therefore treatment, unaffordable for patients.

In addition to the inequity created by the different funding for flights and car travel, a further imbalance is created with the lack of assistance provided for parking costs. If a patient travels in a taxi, they receive door-to-door assistance. If a patient takes their car, they pay most of the petrol cost and all of the parking cost. We consider the additional cost of parking is outweighed by the benefits of a patient being self-sufficient in using their car and being able to bring support people with them at no extra cost.

Our survey of patients and support people identified the cost of parking as a clear financial barrier to attending an appointment. It also showed that the preferred travel option for most people was driving their own car.

Another issue raised frequently was decision-making about the need for some patients to have a second supporter. We consider that having a 'one-size-fits-all' approach to this issue is much more difficult, and that it is best addressed through a review of the national Policy to ensure the Policy and the role of clinical decision-making is clear (see 'Governance and accountability').

Relationship with providers

Those providing accommodation or transport services informed the review that they rely on NTA Scheme funding to keep up their contribution to the system. We know through our conversations with DHBs that the NGO sector makes a highly valued and significant contribution to the system of support for a person travelling for treatment. However, the sector leadership group observed that NTA Scheme funding has not kept pace with costs. Ronald McDonald House supported this observation, demonstrating that in 2009, NTA Scheme funding made up 80 percent of its cost of service; in 2017 the proportion was 50 percent.

To ensure the sustainability of the significant charitable contributions that many organisations make, key relationships need to be made sustainable at a local level, because the system would not survive without the combined effort of families, charities and the health system itself. We consider it worthwhile for DHBs to purposefully create sustainable relationships with key organisations, in order to ensure the sustainability of the NTA Scheme and reduce the administrative burden for providers of claiming on an individual basis.

Proposal

We recommend further exploring the possibility of making an investment in the NTA Scheme, after work to improve data related to the NTA Scheme is completed so that any cost modelling can be undertaken accurately.

We do not think the funding mechanism, the Population Based Funding Formula (used to determine the overall level of funding and its distribution) needs to be canvassed in this report. There are other avenues through which the formula can be examined, and it remains Ministry of Health policy at this time to fund DHBs in this way.

To improve the current Scheme

7. DHBs should review how they plan for and commission travel and accommodation services, with the goal of ensuring the provision of services is sustainable for all parties, and does not further increase costs to patients.

Future change

7. Consideration should be given to investing in the National Travel Assistance Scheme, because it has the potential to:
 - directly improve patient experience
 - contribute to patient outcomes through increasing access to and completion of treatment

- improve equity when targeted to those people who are vulnerable or otherwise find it hard to access specialist services
 - manage system costs by preventing the use of more costly inpatient bed days.
8. The rate of assistance provided for private mileage (petrol) and accommodation should be reviewed to:
- ensure a sound methodology is behind the rate
 - recognise that the level of assistance provided has remained static while costs have risen.
9. The cost of parking to attend appointments should be considered for inclusion within assistance provided by the NTA Scheme.

Glossary

Community Services Card: People can apply for a Community Services Card from the Ministry of Social Development if they meet certain eligibility criteria, such as earning income below a certain threshold. The card entitles them to reduced costs for particular health services. It is one of the eligibility criteria for travel assistance.

District health board (DHB) of domicile: The district health board where a patient lives.

District health board (DHB) of service: The district health board where a patient is receiving treatment.

First specialist assessment: An appointment between the patient and a specialist, at which the specialist assesses the person's condition and recommends the best option of care for them.

Population Based Funding Formula (PBFF): A technical tool used to help equitably distribute the bulk of DHB funding according to the needs of each DHB's population.

Specialist treatment: Under the NTA Policy, a health specialist can be a clinical specialist (for example, an oncologist or general physician) or a medical officer special scale, or a nurse practitioner employed by a DHB. Psychiatrists are the only mental health clinicians who can refer people for travel assistance.

References

Masters-Awatere B, Cormack D, Brown R, et al. 2018. Hospital transfers: Maintaining active whānau engagement. Submission to the National Travel Assistance Policy Review Committee. Hamilton: Hospital Transfers Team.

Ministry of Health. 2009. *Guide to the National Travel Assistance (NTA) Policy 2005*. Wellington: Ministry of Health.

Ministry of Health. 2018. *National Travel Assistance Scheme Review: Summary of surveys*. Wellington: Ministry of Health.

Appendix 1: Basic eligibility criteria for National Travel Assistance

From the *Guide to the National Travel Assistance (NTA) Policy 2005* (Ministry of Health 2009)

If a client answers 'yes' to any of the four questions listed below and they have been referred for National Travel Assistance by a publicly funded health or disability specialist (not their General Practitioner or another primary health care provider or a private specialist), they are eligible to claim travel assistance under the NTA scheme.

1. Do they travel per visit:
 - a. (child under 18) over 80 kilometres or more one way?
 - b. (adult) over 350 kilometres or more one way?
2. Do they (adult or child under 18) attend more than 22 visits in two months?
3. Do they attend more than five visits in six months, and travel per visit:
 - a. (child under 18) over 25 kilometres or more one way?
 - b. (adult) over 50 kilometres or more one way?
4. Do they hold a Community Services Card and:
 - a. (child under 18) travel over 25 kilometres or more one way?
 - b. (adult) travel over 80 kilometres or more one way?

Other criteria are used for organ donors, neonates and patients staying for long periods of time away from home. You can view the guide at:

www.health.govt.nz/system/files/documents/pages/nta-policy-guide-v2-nov2010.doc_0.pdf (accessed 21 September 2018)

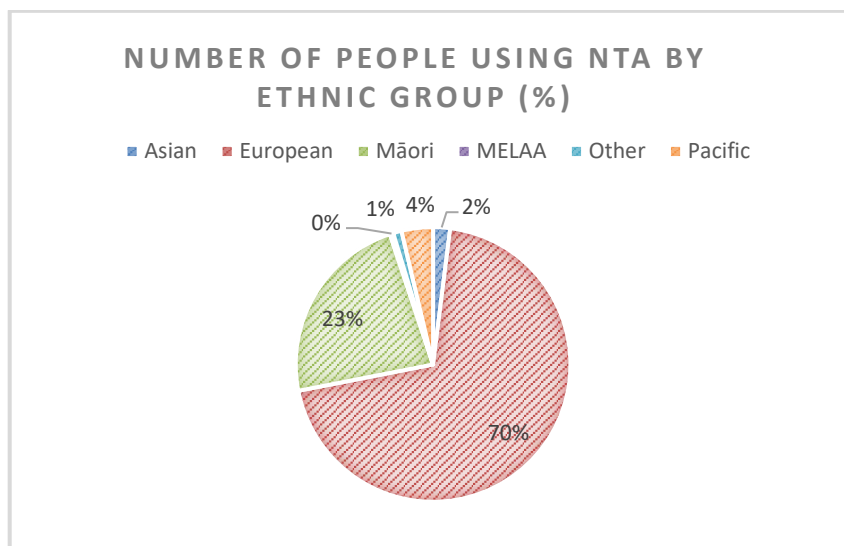
Appendix 2: Data about people who use the NTA Scheme

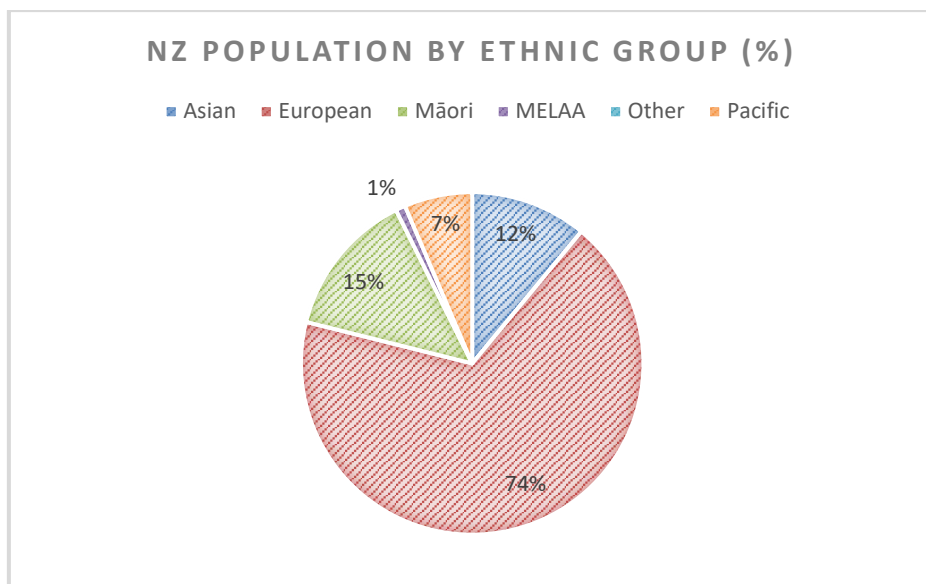
This appendix contains a basic analysis of data about who is using the NTA Scheme currently. The numbers are only approximate, as they are drawn from several data sets that count things in different ways.

In 2015, approximately 33,000 individuals made a claim for national travel assistance. On average they received \$1,000 each. The amount received ranged from \$580 to \$1,428.

The information below shows who has used the NTA Scheme in terms of their ethnic group, age and gender, deprivation level and whether they live in rural or urban areas. It gives us a general picture of how equitable the NTA Scheme may be. In the future, we can compare this information against who we think might have the greatest need for access travel assistance.

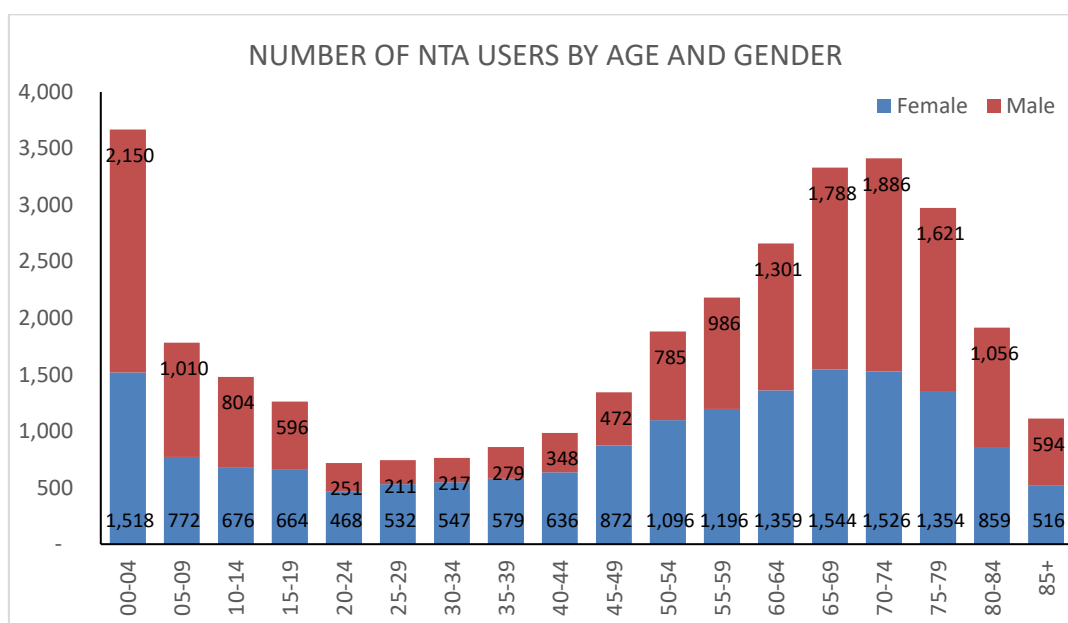
1 By ethnic group





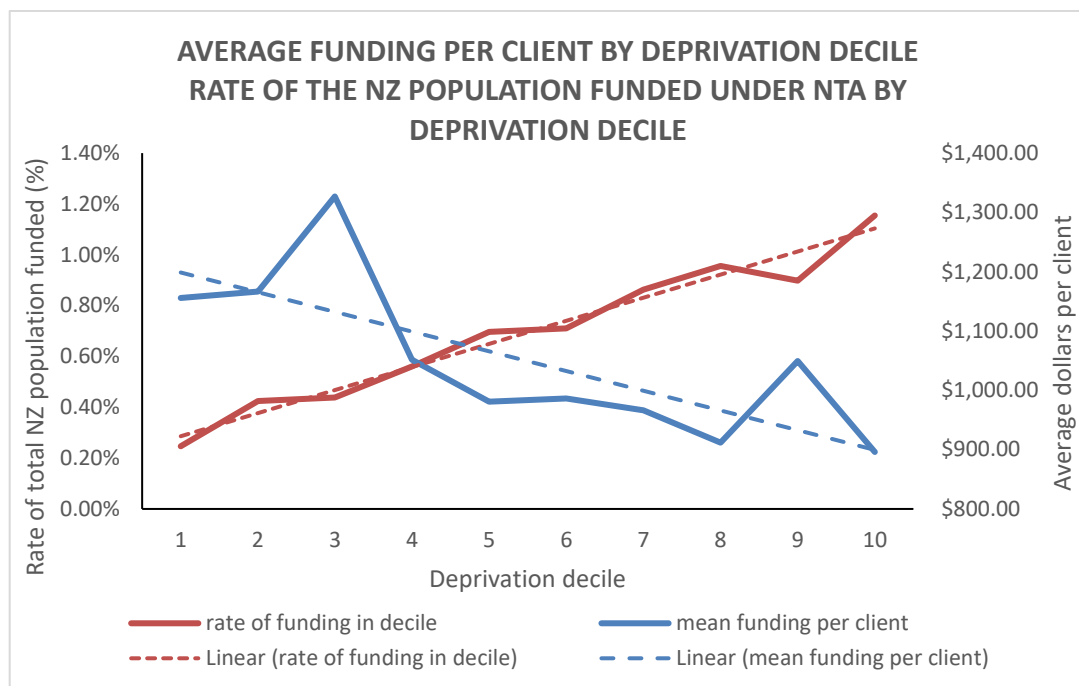
These graphs tell us that Māori people access travel assistance at a higher rate than the proportion of Māori within the total population, but that the rate for Pacific peoples is lower than we would expect based on the proportion of the population they represent.

2 By age and gender



This graph tells us that the highest users of NTA are males between the ages of 0 and 4 years, followed by males between the ages of 65 and 74 years. Females use the Scheme the most between the ages of 65 and 74 years.

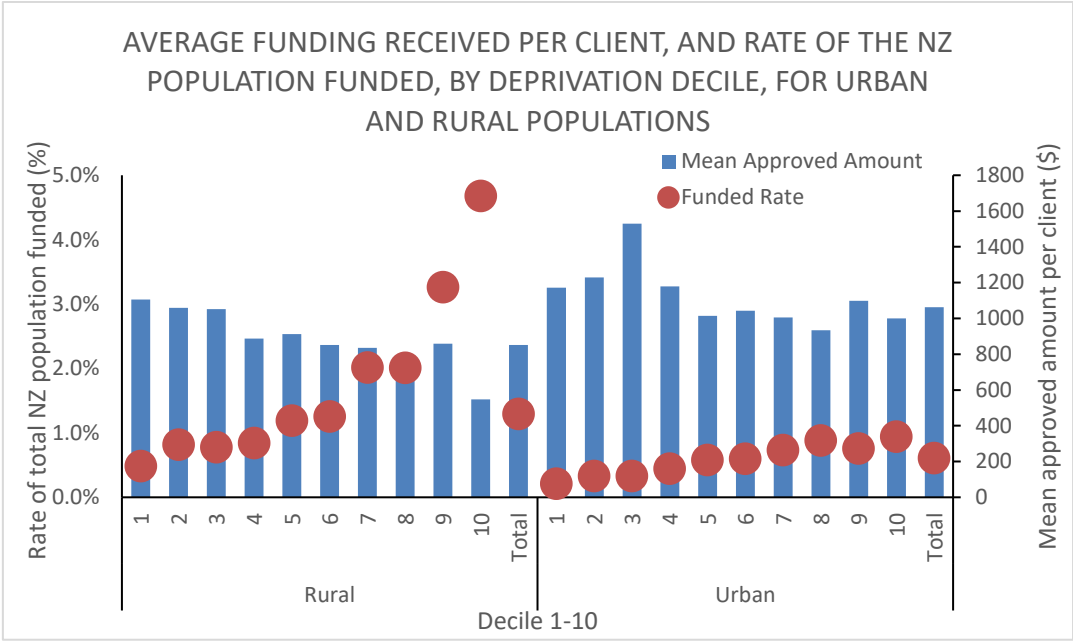
3 By socioeconomic deprivation level⁹



This graph suggests that people living in areas of New Zealand with the lowest level of deprivation (decile 1) receive a higher level of funding each, but are funded at a much lower rate than people living in areas of the highest deprivation (decile 10). This suggests that the Scheme is enabling higher access to people with higher needs, but not assisting them at the same level.

⁹ NZDep2013 is a measure of the level of socioeconomic deprivation within geographical areas of New Zealand. It combines census data relating to income, home ownership, employment, qualifications, family structure, housing, access to transport and communications. NZDep2013 groups deprivation scores into deciles, where 1 represents the areas with the least deprived scores and 10 the areas with the most deprived scores. A value of 10 therefore indicates that a geographical meshblock is in the most deprived 10 percent of areas in New Zealand.

4 By rural and urban populations



This graph tells us that more people living in rural areas receive NTA Scheme funding, compared with those living in urban areas (orange dots), particularly in high-deprivation areas.

However, people living in rural areas receive a lower amount of funding than people living in urban areas.