Bulgarr Ngaru Medical Aboriginal Corporation

ABN: 67 006 943 078 ICN: 1044

P.O. Box 170,
South Grafton NSW 2460

Email: info@bnmac.com.au

Phone: 02 6644 3500
Fax: 02 6644 3599

Supplementary notes and answers to questions on notice following evidence given on 27 November 2023 to the Select Committee on Remote, Rural and Regional Health inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health.

Question on notice regarding IPTAAS

The committee asked if BNMAC had noticed any improvements since the recent changes to IPTAAS.

In preparing this answer we also consulted with Bullinah Aboriginal Health Service (BAHS) in Ballina.

Our understanding is that the changes to IPTAAS involved an increase in the kilometre allowance for private vehicle transport from 23 to 40 cents per kilometre and an increase in the nightly hotel allowance from $43 to $75 per night. The change to the kilometre allowance is welcomed as is the increase in the hotel allowance, although it should be noted that there are very few hotels for $75 per night.

However, since these changes to IPTAAS neither BNMAC nor BAHS have felt that overall it is any easier for people to use the system nor any increase the number of clients making use of it.

The paperwork system is still cumbersome and onerous for both patient and the referring GP and discourages many people from applying for IPTAAS funding.

The client can pay for travel and accommodation and be reimbursed by IPTAAS. However, very few clients of AMSs are able to pay these costs in advance and so this system does not work for most.

The alternative system of IPTAAS paying the costs directly or paying the client in advance also does not work well for most AMS clients. Doing the paperwork in advance for either of these possibilities usually takes 10-12 days. Only a small number of hotels are “registered” for IPTAAS to pay them directly and will accept the IPTAAS fee as full payment. These hotels are often fully booked for a couple of weeks in advance. But very often medical appointments are confirmed and arranged with less notice than this. Therefore, getting the paperwork done in time and being able to arrange accommodation and or payment frequently does not work.

IPTAAS will reimburse fuel costs at 40 cents/km, but not all AMS clients have a private vehicle. IPTAAS will usually require these people to use public transport but some people live in places where there is no public

transport. This then requires special lobbying by the AMS to get IPTAAS to (sometimes) agree to funding for alternative transports.

Both BNMAC and BAHS report that because of these difficulties, the IPTAAS system is very underutilised.

In practice BNMAC often funds or supplements patients travel and accomodation themselves from other resources.

BNMAC feels that a better system would be for BNMAC to have a quarterly budget for patient travel and assistance which could be regularly acquitted. This would make the system less onerous for BNMAC clinical staff and patients and less work for NSW Health staff.

Supplementary information to an answer given in oral evidence

Dr Tait gave an example of the work on Rheumatic Fever and Rheumatic Heart Disease that BNMAC did with the LHD which the chair of the panel noted. Another committee member commented on this work of doing both clinical work and this other work of liaising with the LHD and made comment to the effect that it must be demanding and asked how it could be supported.

Clinicians within AMSs are a valuable resource not just for their ability to see individual patients, but also for their ability to work on clinical quality improvement, AMS health service program and policy development and to work with other agencies, such as health departments and primary health networks, on issues that require consultation or input from the AMS sector.

It is important that AMS staff and clinicians especially engage in this type of activity, but this takes time and takes the clinician away from their only activity that is specifically funded: that is seeing patients for medicare receipts. This non-clinical activity needs to be worked into clinic schedules and specifically funded. But, there is currently no government funding source that acknowledges this and provides for it. Until recently, many clinicians have often done so on their own time. In northern NSW the 3 AMSs have made a decision to fund this type of clinician activity themselves from cobbled together money and other sources.

BNMAC would urge the NSW health department to consider funding AMSs for this type of work. This is an area where dedicated government funding would be very helpful in supporting AMSs to provide an overall better service, but also to be able to engage with the LHD and add value to public health initiatives and improving care within the LHD.

Another possibility would AMSs being able to charge LHDs for the time spent by their clinical staff working at the request of the LHD on working groups or committees. This takes AMS clinical staff away from their usual duties which needs to be covered.