



## Rural Medical Justice Phone-In Findings August 2011

### INTRODUCTION:

A partnership of community service, health and rural organisations in South Australia combined to run a state-wide 'phone in' during March 2011 to hear from country people who are struggling to afford basic health care.

This paper is a result of this collaboration. The findings have been prepared by UnitingCare Wesley Port Pirie for other agencies to use in their research, advocacy and policy development work.

This paper has been developed as an exercise in *listening* to health consumers in rural areas. These consumers self-selected their participation by contacting a 'phone in' established over three days in March 2011. This exercise was hence neither a full-scale survey of the issues nor a thorough consultation of the numerous players in the rural health field, but more an opportunity to hear from consumers in rural areas as to their needs from health services.

In particular UnitingCare Wesley Port Pirie's interest in participating in this process is due to its concern over the effectiveness of the PATS Scheme, issues of community transport for people in the Iron Triangle accessing health services in Adelaide and a broader range of health medical practices that may affect low income people accessing appropriate health care in the country. Beyond this, the issues outlined in this paper have been identified by a broad group of organisations, and include issues such as the rising cost of GP services, GP and specialist billing practices, the growing 'gap' payments, and the growing cost of transport to Adelaide for specialist and essential medical treatment.

The organisations involved in the 'Phone In' were:

- UnitingCare Wesley Port Pirie
- Health Consumers Alliance (HCA)
- South Australian Farmers Federation (SAFF)
- South Australian Council of Social Services (SACOSS)
- Health Consumers of Rural and Remote Australia (HCRRA)

The 'Phone In' was designed to check anecdotal information these organisations have been hearing regarding reports that many children and their parents are avoiding basic medical care support in country areas due to their inability to pay above the gap.

Over the three days of the 'Phone In' took 56 calls and heard a wide variety of issues from rural health consumers.

## **THEMES:**

In brief the most common themes were:

### **Theme 1 : Access to quality care and services**

Hospital Services:

- Problems with local hospital quality
- Closure/reduced service at local hospital
- Concern about hospital overload and slipping standards, loss of City support (clinics not hospitals e.g. excess administration versus quality service) since SA Government take over
- Reliance on Locums- loss of continuity of care (this may be seen as necessary in that it provides support for rural GP's often overstretched)
- Public hospital service wait times

Non-acute care and services:

- Lack of preventative medicine
- Overseas trained doctors, quality/cultural difficulties
- Lack of timely access to GPs and specialist services
- Inconsistency within GP practices - loss of continuity of care
- Limited pharmaceutical service
- Hearing service closed or lacking
- Dental costs

### **Theme 2: Cost of transport /accommodation**

This relates to the Passenger Assistance Transport Scheme (PATS) a SA Government funded scheme to assist with some of the costs associated with rural patients for travel and accommodation expenses when they need to travel more than 100 km for medical attention.

Many callers complained about aspects of the scheme and many callers did not know of its existence. Of those who complained about the scheme their issues were often:

- Re-imbusement of 16 cents per kilometre was meagre compared to the real costs
- The bureaucratic nature of the scheme meant that it was extremely difficult to apply each time
- Re-imbusement for accommodation was inadequate and doesn't cover the first night (for non—pensioners) which meant on most occasions people couldn't use it

Some callers spoke highly of buses operated by local councils that provided either free or very affordable regular bus services to Adelaide to help people attend medical appointments.

### **Theme 3: Medical Service costs**

People raised concerns about the general costs of services and for some people that meant not accessing health care - particularly preventative care – due to the cost. The types of issues people raised on cost were as follows:

- Specialist gap costs
- GP gap costs
- Lack/limited of bulk billing and emergency care
- Forced to retain private insurance
- Upfront payment practice impacts
- Medication costs and frequency of GP visits to gain scripts
- Specific income loss given location of treatment
- Concern about over testing
- Ineligibility for Health Care Card

### **Theme 4: Intersection of service restrictions, travel demands**

As with many issues in health and community services where there are multiple factors the system can fall down in providing pathways for people to access appropriate support and care. The Phone In found where medical cost and transport issues intersected people were at their most vulnerable.

### **CASE STUDIES:**

The following case studies illustrate some of the combination of issues and how they impact on people's health care.

#### **1. Margaret – Financial Counsellor in Regional SA**

Margaret is an experienced senior financial counsellor who has worked in a regional city of South Australia for over 15 years. In this role she supports a wide range of people who come to her organization seeking financial assistance and crisis support. In the last five years she has noticed a worrying trend with more people coming in each year for assistance for medical related costs.

Margaret reports this trend is influenced by the following factors in the medical and health services sector. These issues are seriously restricting people living on low incomes accessing appropriate health care.

- a. Consumers having to pre-pay for basic medical health care. While this sounds reasonable in one sense for people on low incomes it means they have to borrow or beg for the funds to pay the full upfront medical payment, from the local charitable organization. For many people living on a low income this limits their options for access to both emergency assistance and medical care. For such clients if they were allowed to pay just the gap they would seek health care more appropriately.

- b. The cost of travel to the Adelaide for medical appointments means that many clients open no interest loan accounts with Margaret's organization, to cover their full costs as the Government subsidized Passenger Assistance Transport Scheme or PATS is viewed as inadequate and unrealistic by many consumers. Margaret reports that over the last five years low income consumers have borrowed about 100 loans (valued at \$100,000) for medical related expenses.
- c. The timing of appointments of rural people in the city means that unnecessary overnight stays become an additional cost burden.

Margaret reports that these issues are becoming a more common occurrence for people on low incomes and putting greater pressure on non-Government charitable organisations in rural areas. Margaret also believes that preventative health of children and elderly people in low income households is greatly diminished by the both the lack of financial hardship policies in local GP services and the inadequacy of the PATS scheme.

## **2. Jack's story**

Jack lives in a rural town about 450kms from Adelaide. Jack is retired and lives on the Aged pension with his wife. He has no private medical insurance as he cannot afford it. Jack has to often visit the Doctor for ongoing health issues as does his wife. The current gap is \$18.50 so when they both have to visit it is \$37.00 and they don't get bulk billed by the local GP. The clinic used to be completely free.

Jack and his wife are concerned about these costs and the growing waiting lists in their small town. They now choose to travel to a larger centre where they have to pay for 100km round trip so they can be bulk billed and so he doesn't have to wait 4 to 5 weeks to get an appointment.

Jack and his wife are most concerned about the cost of travel to Adelaide for specialist appointments and the gap costs for seeing specialists, which they believe are driving them into poverty. Wherever possible, Jack prefers a local anaesthetic to a 'general' as he cannot afford the gap costs of the latter.

Jack was pleased with the local PATS scheme in using the fuel card system which he felt worked well.

## **3. Pat's story**

Pat is a pensioner and pays for private medical insurance. Pat lives in a very small town, which has a small medical clinic. Pat is a full-time carer for her husband and receives \$110 per fortnight on top of their pension to care for him.

To see a doctor she needed to travel to the local hospital, which as time went on had an ever-increasing revolving door of Doctors. Seeing the same doctor became almost an impossibility, which she believed was threatening her health.

Pat believes private medical insurance is vital to her to ensure appropriate access to health care although this is becoming increasingly questionable given the changing costs and access to services issues in her local area.

Pat and her husband often need regular medical support at a major centre to see specialists. After an expensive experience in Adelaide with the high costs of accommodation and travel Pat has chosen to travel interstate to a regional city for all specialist care for them both. In this Victorian centre they have a range of benefits they believe are not available in Adelaide for support in their visits for this specialist care. These include higher quality and cheaper accommodation for medical patients, and no gap payments associated with medical specialist care expenses.

Pat has found that for specialist care required frequently for her husband she can pay anywhere between \$20 and \$200 gap over and above the private health insurance rebate. On one occasion her husband was quoted \$550 per visit for five visits to a specialist for the removal of skin cancers. They received the same service interstate at a specialist interstate for free in one visit.

For her own health, Pat refuses to go to any GP or specialist if a gap is required. She also puts off any preventative health care for herself unless she thinks it may risk her capacity as a carer, in which she seeks medical attention.

For Pat and her husband their lives and their budgets are balanced between the regular cost impost of private medical insurance to ensure access and then driving hundred's of kilometres to fund bulk billing specialist and GP services which in many cases means they drive interstate to manage their fortnightly budget.

Pat is seriously considering dropping out of private medical insurance for cost reasons. Pat chooses not to use the PATS scheme as she feels the re-imburement is not sufficient for the effort and time required to complete the paperwork, and the great difficulty in getting doctors to sign the paperwork. Pat also is ineligible for PATS as she chooses to travel past medical services to get to a service of her choosing which under the rules of the scheme make her ineligible. PATS does not consider the cost of gap services in its guidelines as a reasonable cause to reimburse travel expenses.

#### **4. Susan's story**

Susan runs a small business in a rural location over 300 km from Adelaide. Her husband was suddenly diagnosed with a serious cancer condition that gave him a very short time to live.

As a result of this situation Susan needed accommodation for several months for her and her two children in Adelaide while they were all supporting their husband and father. Susan found that the options in Adelaide for family accommodation were minimal amongst the subsidize accommodation facilities, the accommodation generally was not suitable for families with small children, and the social work support to access this accommodation was inadequate. Susan had to move four

times – between subsidized and private accommodation - while she was pregnant and in this time she lost the baby she was carrying. Bureaucratic mismanagement was a significant unnecessary factor in her having to move her family so many times. Susan was eventually housed at Seaview Lodge where the repayment processes were more straightforward.

Even with the PATS subsidy – a subsidy which she still does not understand due to its complex nature – Susan paid \$4,010.07 out of her own pocket over this time. Susan says she is not ungrateful and was very pleased for the financial support provided by PATS however for families with serious illnesses that require long-term stays in Adelaide for treatment to a family member, the scheme is inadequate. Susan believes that PATS should not be means tested in order to push out higher income rural families with these types of serious longer-term issues as the cost of supporting a family member in her situation was massive.

“What I don’t understand is why we are not reimbursed for the times that my husband did not have any treatment, was out of hospital but we could not return home. PATS works well for patients who only have day appointments, or less serious illnesses,” said Susan

Susan’s husband has made a full recovery from his condition.

## **5. Tracey’s story**

Tracey is the mother of two children and with her husband they care for their daughter who has multiple disabilities. Her daughter has been diagnosed and received medical attention, mostly in Adelaide over the last 8 years.

The story Tracey tells is of a rural medical system that struggles to diagnose and support children with complex and multiple needs. Tracey’s daughter requires 24 hour care and this combined with the pressure of trying to access medical and diagnostic support for her family led to mental health issues for her which put greater strain on her family. Coming on top of the numerous stress of managing inadequate local health support for her daughters needs the costs associated within the first 2-3 years of diagnosing her daughter’s condition were beyond that which the family could bear.

As she required paediatric services for her daughter that were only available in Adelaide, and given the lack of bulk billing at her local GP, Tracey’s only reason to visit the GP was to obtain a signature on a PATS form. Given her re-imburement was so small and the high level of multiple pressures on her already to manage specialist appointments in Adelaide (which often meant a two day trip) she found the additional bureaucratic pressures of PATS not worth the trouble. Tracey ceased using PATS after several attempts as she felt the extra pressures associated with trying to claim were counter-productive to her families overall well-being, as it added just another pressure in a life that was becoming a merry-go-round of travelling, temporary accommodation in Adelaide and constantly seeking medical support for her daughter, while she tried herself to understand her daughter’s condition.

Tracey lives 300 km from Adelaide and finds that there is great inconsistency across her region as to what services GP's will and won't bulk bill. Some provide bulk billing for children while others do not. Tracey believes these issues for low income families in rural areas mean there is a great variation in medical care for children across the region.

These days Tracey chooses not to see local doctors who won't bulk bill and for her own health needs only seeks attention as a last resort. For her son she rarely takes him to the Doctors, for cost reasons.

## **6. Jane's story**

Jane is a community services worker, supporting people living on a low income in a rural community about 300-km from Adelaide. Jane has been concerned for the three years that she has worked in this role of the growing number of people in these circumstances who risk their lives rather than visit the doctor.

The reason Jane gives for this behaviour is:

- No local bulk billing doctor
- People don't seek an appointment as the local GP practice will not make it clear whether or not bulk billing is available, until the consultation has commenced
- Patients who are 'struggling' are not necessarily bulk billed however friends and associates of the GP practice may well be
- Payment of the upfront gap is at the time of the appointment
- Negotiation of other repayment options happens in full view of the other patients which is humiliating as many of the other patients in a small community are known to them
- Difficulty in getting an appointment due to high waiting lists and difficult appointment systems
- Costs associated with using out of hours doctors at the hospital which can require up to \$200 upfront gap payment in the case of an emergency
- Attitudes of some medical staff in relation to mental health and drug and alcohol addicted consumers

Jane reports that she has only assisted one consumer to access PATS and found it a lengthy and complicated process requiring a strong literacy level.

The upfront costs at their local medical centre is \$20 so many low income people who cannot manage this upfront cost in their weekly budget will travel the extra 100 km round trip to access bulk billing. Although when factoring in petrol costs they may be worst off overall, it is still more affordable in the short-term.

Jane feels that as an observer to these issues over three years that people living on low incomes are driven into further ill health due to the practice of many medical services over gap payments and upfront fees.

## **GENERAL DISCUSSION:**

### **Passenger Assisted Transport Scheme (PATS)**

A large part of the picture of the cost of access to medical services in rural locations is the PATS Scheme. This is a scheme managed by the State Government to reimburse patients requiring accommodation and transport for medical specialist care more than 100 km from their place of residence.

The reports to the Phone In indicated that the funding level of PATS, the bureaucracy associated with it, the general poor understanding of how the system operated all meant that its usage as a support measure was limited. Most people who called in either did not know about the scheme or choose not to use it due to the poor reimbursement level of the complexity of the scheme.

The funds for PATS come out of the Commonwealth-State health funding pool. It is an uncapped scheme allowing claims to be made annually as the need arises within the community.

The eligibility for the scheme outlined in the 2004 (most recent) PATS brochure is as follows:

#### ***Travel Assistance***

*Claimants are required to make a personal contribution of \$30 which is subtracted from the eligible travel benefit.*

*Assistance will generally be limited to public transport fares or an allowance for use of a private vehicle*

*Re-imbusement for private car costs is based on an allowance of 16 cents per kilometre for treatment commenced on for after 1 December 2001*

*Air travel costs may only be reimbursed where it is medically endorsed*

*Taxi fares, hire cars, parking costs and around town expenses at the treatment location are not eligible for re-imbusement*

#### ***Accommodation Assistance***

*Eligible claimants and an approved escort are:*

*Only eligible for assistance when staying at a commercially registered organization*

*Each entitled up to \$30 per night for authorized accommodation eligible for assistance from the first night's accommodation if the patient holds a Pensioner Concession Card or a current Health Care card*

*Only entitled to claim benefits for the first night if a photocopy of the patient's Concession Card is submitted with each application*

*Required to meet the full cost of the first paid night's accommodation per journey if the patient does not hold a Pension Concession Card or a current Health Care Card*

PATS is managed within the State Government by Country Health SA. The PATS project officer estimates 49,000 claims per annum for PATS.

PATS volumes are affected by a number of factors. As the service landscape changes people claim for new items. This happens primarily in two ways, firstly when the Commonwealth Government makes other specialist service types eligible for PATS or secondly when local services close and people need to travel further to receive a medical service. Despite this the PATS project officer understands claim levels have been reasonably steady for some time.

Processing of the 5 page form is difficult for patients and GP's alike. If GP's are not aware of PATS or don't wish to print out the form (when they have run out of hardcopies) then often the claim process is not offered. Most processing of PATS is done via mail.

PATS does not cover physiotherapy or rehabilitation services only specialist medical services.

PATS is connected with the Community Passenger Transport Network. Patients using this network are also eligible for PATS. There are numerous community buses and private car transport systems managed by the Department for Families and Communities for which patients can link into and for which PATS can be a reimbursement supporting these systems. There are gaps where such networks do not exist notably in the Port Pirie and Port Augusta regions.

As for accommodation PATS links in with the Cancer Council which provides accommodation for cancer patients with lengthy stays in Adelaide for treatment. The funding of these accommodation services is directly linked to the PATS subsidy, which is the payment for the accommodation. The Cancer Council does not ask patients to pay over and above the PATS payment. Many patients through the case Rural Medical Phone In indicated a difficulty into getting into these facilities at short notice due to demand issues.

### **Future of PATS**

In 2009 a Senate Enquiry was held into Passenger Assisted Transport schemes across Australia. A wide ranging set of recommendations were put forward however these have not been acted upon. The Rural Health Standing Committee, a sub-Committee of COAG, is still looking at elements of these recommendations.

Country Health SA has prepared a draft set of new guidelines for PATS. These have not been signed off by the Minister and have not gone out for general public consultation.

At the time of the development of the existing PATS brochure (2004) new guidelines were written. These never received Ministerial sign off and were never made public. The guidelines prior to this that did have Ministerial sign off are out of date and not relevant to the real practices under which PATS now operates. For instance these earlier guidelines reflect a 200 km distance and a smaller per kilometre re-imbusement that currently exists.

Country Health SA is also viewing to develop a new form and exploring use of electronic forms.

### **Questions about the current scheme**

Given the per km rate re-imbusement hasn't changed since 2004 and petrol prices have risen by between 40-50% is the current rate still fair? Moreover the cost of accommodation has also risen in this time by upwards of 20% then one can question its fairness also.

Fairness questions also arise regarding the nature of the fund. It operates essential as a medical rebate system first and a safety net system second.

Low Income groups, people with literacy issues, poor access to transport, highly dysfunctional lifestyles, drug and alcohol affected individuals would find PATS a difficult to access re-imbusement system. For some groups such as Aboriginal groups this has been recognized with the intervention of Aboriginal Pathway Project Officers throughout SA being given roles within the Health system to assist these groups access medical services – including PATS - more easily.

For self-funded retirees with high levels of literacy and good access to transport PATS is a far more accessible re-imbusement model.

PATS is not means tested, nor does it take into account people's medical condition in re-imbusement models. The Rural Medical Phone In illustrated for those people with high frequency of medical visits to Adelaide or long term stays in Adelaide, the gap in PATS with real costs, made for much greater hardship.

### **Similar Schemes to PATS across Australia**

Similar schemes operate in other states and the varying re-imbusement rules are outlined in the tables below.

Extracts from *Policy Principles for Patient Assisted Transport Schemes (2009)*

<b>Distance Threshold / Eligibility/Fuel Subsidy (per km)</b>		
<b>NSW</b>	100km	15c
<b>VIC</b>	100km	17c
<b>QLD</b>	50km (from nearest public hospital)	15c
<b>WA</b>	100km (70km for renal & oncology)	16c
<b>SA</b>	100km	16c
<b>TAS</b>	75km (50km for renal & oncology)	19c
<b>ACT</b>	--	16c
<b>NT</b>	200km	15c

<b>Patient Contribution</b>	
<b>NSW</b>	\$40 for non-pensioners / health care card holders for each return journey (previously \$20 for pensioners / health care card holders abolished from 1 July 2009)
<b>VIC</b>	Non concession card holders required to pay \$100 each year No contribution required for concession card holders or patients under 18years old
<b>QLD</b>	None required
<b>WA</b>	No contribution required (previously required \$50 towards first four trips in a 12 month period, and no subsidy was granted for the first 3 nights accommodation)
<b>SA</b>	\$30 contribution for non pension / health care card holders for each return journey On negotiation no contribution required for pension/health care card holders
<b>TAS</b>	\$15 for card holders, \$75 for non card holders either invoiced or deducted from reimbursements.
<b>ACT</b>	None required
<b>NT</b>	None required

<b>Accommodation Subsidy</b>	
<b>NSW</b>	Single: \$33 per night Double: \$46 per night
<b>VIC</b>	Commercial: \$35 per night (+GST)
<b>QLD</b>	Commercial: \$30 per night Private: \$10 per night Non concession card holders pay first four nights
<b>WA</b>	Commercial: \$60 per night Private: \$20 per night
<b>SA</b>	\$33 per night (including GST) per night for patient and \$33 per night for approved escort Non concession card holders pay first night
<b>TAS</b>	Intrastate: \$46 per night Interstate: \$64 per night
<b>ACT</b>	Commercial: \$35 per night Private: \$10 per night

<b>Degree of Flexibility for Patient Choice</b>		
	<b>Patient Choice</b>	<b>Second Opinion</b>
<b>NSW</b>	Only where 'family support' is determined (by the nearest specialist) to be a valid medical reason for bypassing the nearest specialist.	Only covered when the patient is referred by the nearest specialist for one.
<b>VIC</b>	It is expected that GPs will refer to the 'most appropriate' specialist. In circumstances where patients choose to travel beyond the nearest specialist, subsidy will be calculated to the nearest and most appropriate specialist.	Not covered.
<b>QLD</b>	If a patient has been visiting a particular specialist but another similar service has been established closer to their nearest public hospital, transport and accommodation subsidies can be approved for one additional visit to their original specialist.	Not covered.
<b>WA</b>	Not covered, but flexibility may be considered if there are clinical reasons to justify it, however this is exceptional.	Not covered.
<b>SA</b>	Not covered, but flexibility may be considered if there are clinical reasons to justify it.	Not covered.
<b>TAS</b>	Not covered, but some flexibility around closest specialist requirements.	Only if required by the treating medical specialist.
<b>ACT</b>	Patients have choice if referred by specialist in ACT. Closest specialist requirements not usually flexible – dependent upon costs.	Not covered.
<b>NT</b>	Not usually covered, but patients can "appeal" to be sent to another city if they have family there, but it is authorised on a case by case basis, and subsidy is calculated to the nearest specialist.	Only approved if practitioner declares the procedure is outside their expertise.

## **Recommendations for PATS**

That an independent review be undertaken of the re-imburement level of PATS to re-set the funding structure to real price levels for the 2011-14 period and subsequent review occur every three years.

That the draft PATS guidelines be circulated for public consultation and the findings of the consultation influence the future of the scheme.

That administrative arrangements and eligibility criteria take into consideration:

1. The needs of households with multiple long-term medical issues,
2. That the scheme relative merits of means testing and
3. That the Community Transport Network provide a statewide service within 12 months.
4. That consideration be given to methods to remove barriers to access the scheme for highly vulnerable groups in our communities.

For the Commonwealth Government working with all States through COAG and its relevant Health sub-Committee(s), implement the core recommendations for the 2009 Senate Enquiry into passenger assistance schemes.

## **BROADER MEDICAL ISSUES:**

The Rural Medical Phone In found that there was a range of intersecting issues making the affordability, access and health of rural people was increasingly deteriorating. This was influenced by a number of factors.

Respondents to the phone in referred to their feeling or perception that there is a declining level of health services in country regions brought about by the closure of hospitals the high turnover of GP's the ever-changing access to specialist services and the perceived decline in quality of GP's available in the country.

It was also reported to the Phone In that the practices of some rural GP's and specialist services in terms of the gap payments meant that some people were driven further into poverty and in some cases choose not to seek medical attention. The nuances of a fortnightly budget for people living on or near the poverty line did not align with many GP practices which had payment schemes that required full payment upfront. These cash flow issues for many low income people meant that some people reported they would travel large distances for bulk billing health services rather than pay upfront with a significant 'gap' on a fortnight when they had no funds to do this, but they had fuel in their cars.

Local GP practices are essentially private businesses with the capacity to choose whatever funding model and debt recovery strategy it decides suits its business model. This is not regulated. It was reported through the process of the Phone In that some debt recovery methods have included:

1. Not passing on medical records to 'poor payers' when the move to a different GP until a debt has been settled,
2. Refusing to see a patient with an outstanding debt unless it is an emergency and
3. Insisting on pre-payment of the full fee prior to consultation

Pensioners in country areas reported to the Phone In that the combined impact of declining local health services, increasing gap payments, the ever-reducing true value gained from PATS re-imburement led to poor standards of living, greater health risks and deeper poverty related issues.

Families with multiple health issues reported these same factors which meant significant financial and health disadvantage and for working families loss of income exacerbated the financial problems associated with these issues.

Consequently the intersection of many of the issues outlined, means for some households, medical attention and preventative health measures were less likely.

## **RECOMMENDATIONS:**

- Country Health SA in its relationship with local GP practices provide a set of guidelines for bulk billing encouraging consistent and publicly accessible information to patients. That this process also includes Country Health SA providing its own suggested hardship policy for bulk billing as a recommended template for local GP practices in South Australia.
- That Country Health SA make public the evaluation of the impact of the 'consolidation' of rural health services on consumers.
- That Health Consumers Alliance and Health Consumers of Rural and Remote Australia pursue further data collection on the rates and access to bulk billing GP care in South Australia, with a view to assess the needs of particular rural communities without access to this financial support.
- That the NGO and Health Organizations develop a set of criteria for GP practices to make them 'rural friendly medical services'. For rural practices this would include a range of supports for PATS and improved bulk billing and debt recovery practices. For Metro medical services this would include a range of supports for rural medical patients including improved appointment systems to reduce travel for country people, and better understanding of support services for country people.