

*NATIONAL TRAVEL  
ASSISTANCE  
SCHEME*

Descriptive Literature Review

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## Introduction

The National Travel Assistance Scheme (NTA) is a Ministry of Health administered policy which provides financial support to patients who need to travel far or often to access specialist healthcare services in Aotearoa. Following the introduction of Te Whatu Ora in 2022, the scheme is now administered by Te Whatu Ora. This report provides a descriptive review of the current literature on the NTA scheme, with an objective of creating a platform for future research in this area.

The NTA scheme was set up in 2005 and funded at approximately \$36 million per year, increasing to over \$40 million per year since 2009/2010<sup>i</sup>. The NTA scheme is governed by the NTA Policy 2005<sup>ii</sup>. Initially, a District Health Board (DHB) reference group was established to revise and improve the scheme, however this group has since disbanded leaving the policy static since it's last revision in 2009<sup>i</sup>.

The policy outlines that the aim of the NTA scheme is to provide financial assistance to patients who are referred by their specialist to receive ongoing specialist treatment, and who need to travel far or often to receive this treatment. In doing this, the scheme seeks to “assist with equitable access to health and disability services for all New Zealanders”<sup>ii</sup>.

## Background

Access to health and disability services in Aotearoa remains inequitable, with recognised disparities across people of different ethnicities, geographical locations, and socioeconomic levels. This research project was undertaken with the initial aim of describing the ethnicity, rurality and socioeconomic deprivation of patients utilising the NTA scheme in the Southern District Health Board (SDHB). This was at the request of the SDHB in early 2022, with an aim to increase clarification around the extent to which the NTA improves access to health services for vulnerable groups in the Southern region.

Over the following months, the data required for this research question was unable to be obtained through either local or national data collections. This is not to say that the question can never be answered – reported travel assistance data includes patient NHI's and therefore gives potential to link ethnic and geographical information of patients utilising the scheme. However it does reflect

the complex nature of the administration and data reporting of the NTA as it currently stands, and the need for improvements to data collection and reporting regarding the scheme.

The inability to clarify what is currently known about the ethnicity, rurality and socioeconomic deprivation of patients accessing the NTA in the Southern region drove the evolution of this project, to instead review the current literature on the NTA. The aim is to distinguish what we know and what we need to know to ensure the scheme is effective in helping the people who need it. In doing this, this project aims to provide a platform for future research.

## Methods

A descriptive review of the current literature regarding the NTA was carried out, to determine what is currently known about the policy and identify areas for future research. The primary research question was ‘What is the New Zealand National Travel Assistance Scheme’, therefore literature directly relating to the NTA scheme was the primary focus of this review. Literature on the concepts of access, and inequitable access to healthcare within New Zealand was also reviewed to provide a theoretical framework, and to provide context to the scheme and this research. International literature was excluded from this study, as it was difficult to draw clear and relevant comparisons with overseas health care policies seeking to increase access to healthcare services.

Scoping searches of databases were used to search for publications relating to the NTA and access to healthcare in New Zealand, in order to provide context for the scheme. Using Boolean logic, the search strategy below was used to scope literature on the NTA, along with contextual literature on access, inequities in access, and secondary health services in New Zealand.

**Table 1: Search Strategy**

<b>Key Concepts;</b>	<b>National Travel Assistance Scheme</b>	<b>Access</b>	<b>Secondary Health Care Services</b>	<b>New Zealand</b>
	NTA Scheme	Entry	Specialist healthcare services	Aotearoa
	NZ National Travel Assistance Policy	Availability	Secondary care	NZ
	National Travel Assistance Policy	Travel to	Specialist care	National
	National Travel Assistance Scheme	Admittance	Hospital care	
	NTA Policy	Equity of travel	Specialist treatment	
	NZ NTA	Inequities in access	Health and disability services	
			Specialist treatment	
			Specialist health care	

Databases searched included Google, Google Scholar, Otago University Library database, the Ministry of Health website, and the NZ Medical Journal. The research was guided by my supervisors and influenced by staff in the Southern DHB who have generously shared their experiences with me.

Literature on ‘access’ to healthcare was used as a starting point for this research, to provide a conceptual theoretical framework for access, and a lens to consider the effect of the NTA on access to healthcare in New Zealand. There is extensive literature on the concept of access of healthcare, therefore syntheses of published literature were selected to provide a comprehensive conceptual framework for this research<sup>iii</sup>, <sup>iv</sup>. Sources included are highly cited publications accessed via the University of Otago Library.

Broad searches e.g ‘(NTA OR "national travel assistance scheme" OR “national travel assistance policy”) AND (access OR entry OR facilitator) AND ("secondary healthcare services" OR “secondary health care services” OR “secondary care”) AND (“New Zealand” OR Aotearoa OR NZ)’ were used to scope literature. This revealed a stark absence of literature on the NTA directly, aside from grey literature published on the Ministry of Health website, and the Awatere et Al Hospital Transfers Project <sup>xiii</sup>.

The fundamental publications on the NTA currently include the *Guide to the NTA Policy 2009* <sup>ii</sup>, the *Policy Recommendations Report 2018* <sup>i</sup>, and the *NTA Scheme Review Summary of Surveys* <sup>2019</sup>. Information from these three key documents (primarily the *Guide to the NTA Policy 2009* <sup>ii</sup>, the *Policy Recommendations Report 2018*) has been adapted to produce an array of NTA information resources available for patients and staff which include but are not limited to: physical print outs in health care settings, webpages on Ministry and DHB / regional health websites, and information distributed via a range of NGO and health organisations.

## Findings

There is currently sparse literature published on the NTA scheme, immediately reflecting the need for further research in this area. The primary information on the NTA currently consists of grey literature published by the Ministry of Health via the Ministry website. The body of literature on access to healthcare in NZ consistently demonstrates current inequities across populations, and several publications reference the NTA as a means of improving barriers to access. Groups and individuals, including the Ministry of Health itself, have called for specific improvements to the NTA scheme. However, with the current lack of research into the scheme and lack of leadership within the scheme, there have been no improvements to the policy in over 13 years.

Though the data for the original question could not be obtained through SDHB or Ministry records, information regarding the ethnicity, rurality and socioeconomic deprivation of patients utilising the NTA is provided in the Policy Recommendations Report 2018 (Appendix 2).

## History of the NTA Policy;

The NTA Policy was introduced in 2005, replacing all previous regional travel assistance policies from 1<sup>st</sup> January 2006. The scheme was initially funded at \$36 million per year, and was to be periodically reviewed by a DHB reference group established at the time. Decisions around the delivery and processes of the scheme were devolved to DHB's, which developed individual processes for administering the scheme according to the policy<sup>i</sup>.

Initially, the policy allowed the funding of 20c per km for driving travel reimbursement, and up to \$75 towards accommodation per night for patients meeting eligibility criteria. Following revision to the scheme in 2009, funding of the scheme was increased by \$4.2 million per annum to allow reimbursement of 28c per km and up to \$100 toward accommodation per night. However, since the discontinuation of the DHB reference group there have been no changes to the policy since 2009.

In 2017-2018, a review of the NTA scheme was conducted by the Ministry of Health (*Policy Recommendations Report 2018*). The recommendations filed in the report discuss significant room for improvements to the scheme, particularly regarding the eligibility, governance, administration, and funding of the scheme. Recommendations are broken into short-term and long-term improvement goals. As the only extensive review of the scheme, it provides the most current information on the operation and effectiveness of the scheme. However, despite clear short term improvement recommendations, including “the Ministry of Health will automate registration and claiming under the NTA Scheme by 2021<sup>ii</sup>”, there have been no changes to the policy or administration of the scheme following the release of the report.

## Aim of NTA

The guiding principle of the NTA policy is to ‘assist with equitable access to publicly funded specialist health and disability services for all New Zealanders’<sup>ii</sup>. The scheme does this by providing financial assistance to patients who need to travel far or often to access specialist health and disability services, to contribute to the costs of travel and accommodation for treatment. The aim of the NTA is a reflection of recognised inequities in accessing healthcare in NZ.

The philosophy of the NTA policy is founded upon the government’s commitment to “improving access to specialist health and disability services... to those with the highest need”<sup>ii</sup>, and to reducing inequalities<sup>ii</sup>. The philosophy is in alignment with the New Zealand Public Health and Disability Act 2000 and Te Tiriti o Waitangi, and reflects the responsibility of the public health and disability system to improve the participation and health outcomes of Māori<sup>i</sup>. More research is required to create a clearer picture of whether these aims are being met by the scheme currently.

## NTA Policy Guidelines

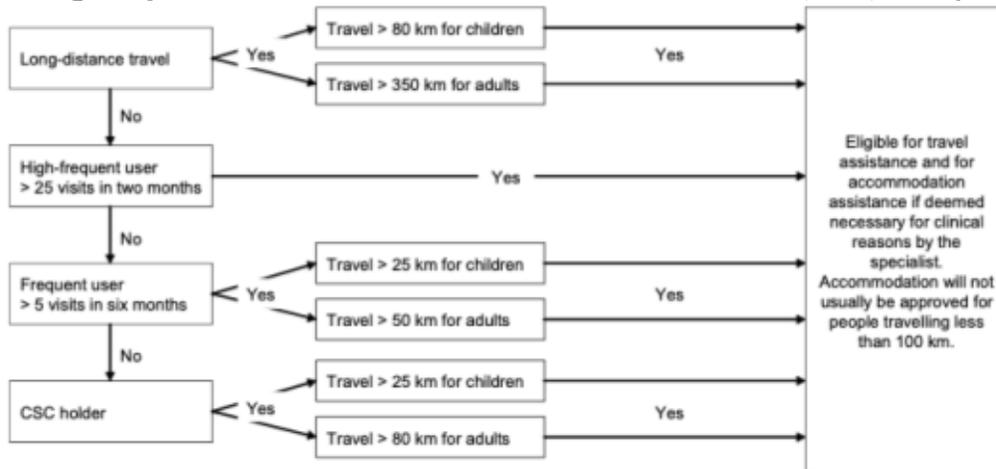
The NTA is governed by the *Guide to the National Travel Assistance (NTA) Policy 2005*<sup>ii</sup>, which outlines the eligibility criteria and the minimum standards by which the NTA scheme should be

administered by each DHB. DHB's were responsible for the administration of the scheme while the management of claims and payments is centrally managed by the Ministry's NTA payment team<sup>(ii)</sup>.

There are currently no changes to the policy guide or the administration of the scheme following the introduction of Te Whatu Ora, and it is unclear how the removal of DHB's will affect the delivery of the scheme in future. As far as it appears in the literature, the scheme is still administered by DHB staff (nurses, social workers, travel coordinators and healthcare specialists etc), who are required to assist patients with filling out registration forms. Registrations are sent to Te Whatu Ora and assessed against the eligibility criteria, and eligible patients are then sent claim forms to fill out. There is a significant administrative burden associated with the current operation of the scheme, reflected consistently throughout surveys in the Policy Recommendation report<sup>i, v</sup> and in recent media<sup>vi, vii</sup>.

Basic eligibility criteria for travel assistance is shown below:

NTA Eligibility Criteria, *Guide to the National Travel Assistance (NTA) Policy 2005*.



The policy guide provides finer detail on the eligibility criteria, and different criteria for support people, organ donors, neonates, patients staying away from home for extended periods who are also eligible<sup>ii</sup>.

## Funding

Funding for the NTA was allocated using the national Population Based Funding Formula (PBFF) by the Ministry, and provided to DHB's as part of their baseline funding. As written in the policy guide, the 'DHB's of Domicile (the clients' homes) fund the NTA, and the Ministry's NTA payment team provide the national administration system, which includes registrations and claims payments'<sup>ii</sup>. The funding of the NTA scheme is a source of confusion identified in interviews with patients in the research by Awatere et Al<sup>xiii</sup>, and in the policy recommendations report.

The actual cost of the NTA scheme is not known. Reported figures in the literature provide an incomplete picture, and there is significant further research required to understand the complete cost of the NTA, and thus the effect the scheme has on improving access to healthcare.

The National Claims Database estimates that the average annual cost was between \$33 - \$35 million per year from 2012-2016, however at least two DHB's did not submit claims to the Ministry for payment therefore this is likely to be an underestimate<sup>i</sup>. Some NTA funding is used to support NGO's including the Cancer Society and Ronald McDonald House, which provide substantial support toward travel and accommodation for patients, however the exact amount is unclear. In 2015 it was reported that 33,000 unique patients made a claim for travel assistance, at an average cost of \$1,000 each<sup>i</sup>. Due to the nature of the scheme, the number of unique patients using the scheme is far lower than the number of individual claims made (e.g there were 42,932 claims in 2021, though the number of unique patients and average spend is unreported).

The administrative cost of the scheme is also absent in current literature. With the allocated funding of the scheme since 2009/10 being \$40.2 million<sup>i</sup>, and the average annual cost lying between \$33 and \$35 million, there is approximately \$5 million per year unaccounted for and requiring further investigation.

### Access to Healthcare in New Zealand

'Access' to healthcare is a broad concept, which is defined in a myriad of ways throughout the reviewed literature. Dimensions of access discussed in the literature include accessibility, accommodation, affordability and acceptability<sup>viii</sup>, extending the concept far beyond the ability of patients to get to and pay for healthcare.

An important national policy seeking to improve access to healthcare in Aotearoa is the NTA policy. While the NTA primarily aims to reduce the financial burden of accessing healthcare, the administration of the scheme further influences access to healthcare by contributing to patient experiences within the system. The NTA is poised to not only influence the affordability of healthcare, but the approachability and acceptability of the health system itself. Thus, the implementation of the NTA policy has the potential to reduce or potentiate inequities in health outcomes between groups.

Access is something that cannot be fully measured, and we will never know the complete extent to which the NTA improves access to healthcare in Aotearoa. The utilisation of a system reflects realised access, but not potential access or the people missing out on care altogether. Therefore, it is important to note that all literature on access to healthcare, and access to the NTA itself, does not reflect the scope of people missed by the scheme or the health system altogether. This is especially important given that current information on the utilisation and effectiveness of the scheme does not incorporate those who are never offered assistance, those who can't engage with the system, and those who never access assistance for any reason.

While we don't have the full picture of access to healthcare within New Zealand, the literature shows that certain groups face greater barriers to accessing required care. Currently around 25% of Māori live in rural areas, and 32% of those who live in the most remote areas of Aotearoa are

Māori<sup>ix, x</sup>. Recent research into access to liver cancer care in New Zealand shows that Māori needed to travel 120km or over two hours on average to access their first surgery, as opposed to 60km or under one hour on average for non-Māori<sup>xi</sup>. Additionally, stark socioeconomic disparities remain with 40% of Māori living in the two most deprived deciles for the past several decades, compared with under 15% of NZ European people<sup>xii</sup>. Jason Gurney in a recent NZ Medical Journal editorial summarises that ‘Māori are not only more likely to need to travel further to access health-care in Aotearoa, but also less likely to be able to cover the costs of that travel’<sup>x</sup>.

The NTA policy lies within the context of Te Tiriti O Waitangi, the New Zealand Health and Disability Act 2000, and the new Pae Ora (Healthy Futures) 2022 legislation, all of which express the obligation and commitment to strive for equity in the access and outcomes of healthcare in New Zealand, particularly for Māori. Therefore, it is imperative that the NTA operates in a way that is suitable and effective for Māori.

## Discussion

This descriptive review has identified significant gaps in the current literature on the New Zealand NTA Scheme. The gaps identified raise a number of questions, and signify the need for further research in this area.

The 2018 NTA Scheme Ministry review provides the most recent published information on the NTA Scheme, and identifies immense need for improvements to the scheme. However, since the publishing of the review there have been no changes to the policy, and no published action plan for improving the scheme. The information provided within the report is itself over four years old, and needs updating to make informed improvements to the policy. While it is understandable that the Ministry of Health has been placed under immense stress over these past few years between the Covid-19 pandemic and the introduction of the new health system in 2022, it remains critical to review and improve the scheme to ensure the policy is operating and helping those in need in the most effective way possible.

Increased qualitative and quantitative research is required to drive improvements to the scheme, and ensure the scheme is effective in helping those in need. Understanding of patient experience of the NTA scheme is through qualitative research done by Awatere et Al (*National Travel Assistance Entitlements are Inaccessible to Whānau Māori*<sup>xiii</sup>), in the *Summary of Surveys*<sup>xiv</sup> as part of the 2019 Ministry Review, and from patient experiences reported in recent media<sup>v, vi</sup>. The largest of these is a survey carried out by the Ministry in the policy review, in which 455 patients and support people were interviewed<sup>v</sup>. This provides insight from a small proportion of those accessing the NTA scheme, but misses the voices of those who do not receive assistance. Generally, the interviews in the literature reflect confusion about eligibility criteria, and the need for improvements to the current administration of the scheme, signalling the need for more research in this area.

Similarly, very little is known about how well DHB staff currently understand the NTA scheme, or how well the scheme is being advertised to both staff and patients. In a survey carried out in the policy review, only 14% of 385 professionals working with the scheme understood it “very

well”, with an average rating of 3.05/5 for understanding. Considering the nature of the survey and that those who responded are more likely to understand the scheme to start with, this identifies need for clarity in the policy, and education of staff on the scheme and their role in promoting it.

The policy guide does not specify who is responsible for administering the NTA scheme, thus each DHB developed different processes. These systems rely on specialists and professionals understanding the scheme, and actively promoting it to eligible candidates and assisting them with forms. Research by Awatere et al reflects that this system potentiates power imbalances within the hospital system, and diminishes mana and authority among patients<sup>xiii</sup>. The findings also further identify confusion among patients around their entitlements to support, and how to get it.

Currently qualitative data on the NTA scheme is incomplete and unclear. While different sources include total annual claims numbers, annual spends, and breakdowns of the ethnicity, rurality and socioeconomic deprivation of people accessing the NTA, these are estimates and missing travel activity from at least two DHB’s<sup>i</sup>. There is also no published research to show how the Covid-19 pandemic, new health system, and significant increases in fuel and living costs have affected the need and use of travel assistance. Specific areas of further research may begin with integrating data to show the actual cost, and actual utilisation of the NTA scheme.

Further, there is currently no research into the extent to which the NTA is failing to assist eligible candidates, providing an area and need for further research. Research into distances travelled by patients could be carried out through comparisons of treatment addresses, and home addresses, to understand travel activity related to accessing healthcare across the board. Integrating this with data from the NZ deprivation index would increase understanding of how many patients are potentially eligible for NTA funding, and thus create more of an idea around the extent to which the NTA is currently filling that need. This sort of qualitative, wide scale analysis is needed to drive improvements to the way in which the scheme is administered, and for the development of a more proactive approach in which eligible candidates are identified automatically as needing assistance.

With little evidence and clarity around the NTA, it is an area in need of extensive further research. This review of current literature on the NTA Scheme raises the further research questions:

- To what extent does the NTA Scheme meet its aim?
- How many patients accessing specialist health and disability care in New Zealand meet NTA eligibility criteria?
- What proportion of eligible candidates for the NTA scheme receive reimbursement?
- How many patients struggle to pay travel and accommodation costs upfront?
- To what extent would upfront payment of costs associated with travel and accommodation for treatment improve access to specialist healthcare in NZ?
- Why do eligible people not access the NTA scheme? How can it be improved so that they do?

- How many ‘Did Not Attend’s’ relate to travel and accommodation costs?
- What was the complete number of clients and claims under the NTA in 2020, 2021, and 2022? (including from the DHB’s that did not submit claims nationally).
- What is the annual cost of the NTA Scheme?
- What is the administrative cost of the NTA Scheme?
- What are the characteristics of people utilising the NTA scheme?
- To what extent do specialists and healthcare staff understand the NTA scheme?
- Who is responsible for distributing information to eligible candidates?
- To what extent do specialists and professionals promote the scheme?
- What travel and accommodation assistance is currently provided by NGO groups for patients requiring treatment?
- What training are staff currently given on assisting patients to access the scheme?
- Who is responsible for the NTA administrations and improvements to the scheme?
- How will the policy operate within the framework of Te Whatu Ora?
- Does provided assistance need to increase with rising living costs?
- What factors prevent people with late-stage disease in New Zealand from accessing healthcare earlier?

Initially with a focus on the ethnicity, rurality and socioeconomic status of people accessing the New Zealand NTA Scheme, this project shifted to review current literature on the NTA Scheme. This review has identified a small body of literature directly related to the NTA, and a broader selection of contextual literature on access and inequities within access to healthcare in New Zealand. The NTA probably creates significant improvements to the access of specialist healthcare in New Zealand, and more research is required to propel future improvements to the policy and the operation of the scheme.

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