STANDING COMMITTEE ON PUBLIC ADMINISTRATION

INQUIRY INTO THE PATIENT ASSISTED TRAVEL SCHEME

TRANSCRIPT OF EVIDENCE
TAKEN AT PORT HEDLAND
MONDAY, 1 SEPTEMBER 2014

SESSION TWO

Members

Hon Liz Behjat (Chairman)
Hon Darren West (Deputy Chairman)
Hon Nigel Hallett
Hon Jacqui Boydell
Hon Amber-Jade Sanderson

Hearing commenced at 1.59 pm

Mr BRIAN WILSON
Operations Manager, East Pilbara, WA Country Health Service, Pilbara, sworn and examined:

The CHAIRMAN: On behalf of the committee, Brian, I welcome you to the meeting. I will just run through the introduction of the committee members again so that you are aware. Starting from my left here we have Hon Amber-Jade Sanderson from the East Metropolitan Region; the deputy chair, Hon Darren West, from the Agricultural Region; I am Hon Liz Behjat and I am from the North Metropolitan Region; Felicity Mackie, our advisory officer; Hon Jacqui Boydell from the Mining and Pastoral Region; and Hon Stephen Dawson from the Mining and Pastoral Region. First of all, I ask you to take the oath or affirmation.

[Witness took the oath.]

The CHAIRMAN: Could you state the capacity in which you are appearing before the committee today?

Mr Wilson: I am the operations manager for East Pilbara, WA Country Health Service, and as part of that role I also oversee the regional responsibility of the patient assisted travel scheme.

The CHAIRMAN: You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Mr Wilson: Yes, I have.

The CHAIRMAN: These proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of the hearing for the record and, as with the microphones at the hospital, just be aware of them and try not to cover them with any paper or make too much noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you want to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing—but I do not think we are going to get to that stage! Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Brian, what we have been doing is visiting the various regions in our tour in the course of this inquiry, first of all asking each person the same question, which is whether they could just outline for us in their opinion and in their experience what the efficiencies are and what the deficiencies are of the PAT scheme as it currently stands.

Mr Wilson: I will start with the efficiencies. In the current scheme there is a very well-designed policy, and guidelines for the administration of that policy and the entitlements contained in that. In November 2012, WA Country Health Service also implemented a new PATS database, which they refer to as the Share online system, and that has greatly improved the quality of both the information regarding people applying for patient assisted travel and how those applications are considered and processed. All communication regarding an application is recorded in that system, and that includes requests for exceptional rulings; so, certainly the system has improved. Within the Pilbara region, we operate what is referred to as a centralised system for the processing of

applications. So, all applications are taken in Port Hedland. They come in either in person or by fax or email. They are processed centrally by the team, and all arrangements in terms of bookings for travel, accommodation and reimbursements are all done through that central office. Again, that is an efficiency in how it is administered here. It also helps in that across the Pilbara there is a fairly uniform application of the guidelines by just that central team rather than a number of people throughout the region.

The CHAIRMAN: How many centres use the centralised team? You have Port Hedland.

Mr Wilson: Within the Pilbara?

The CHAIRMAN: Yes.

Mr Wilson: Starting off from the west, we would go across from our facilities at Onslow, Karratha, Roebourne, across to Port Hedland, the nursing posts at Marble Bar and Nullagine, and then inland at Newman, Tom Price, Paraburdoo; and then we also have links to all of the various clinics, whether they are remote clinics or whether they are AMS clinics, which extend right through to the Western Desert.

The CHAIRMAN: Roughly, how many of those clinics would there be?

Mr Wilson: In the Western Desert there are seven remote clinics that I am aware of.

The CHAIRMAN: How do you, through this scheme, advertise and promote PATS to the people who are in this region that you cover?

Mr Wilson: There is information distributed to all clinics—all general practices, including the AMSs throughout the region. The regional coordinator, who in our case is the clinical nurse manager for PATS and ambulatory care, has made regular visits throughout the whole region. She has even been out to the remote clinics in the Western Desert. She has been to Jigalong and Kunawarritji to have discussions with clinicians and medical officers, and to make staff more aware of the system and how they apply for the system. That is the main way it is done to the health professionals; it is that face-to-face contact. There has been only ad hoc advertising of PATS through local media, and that has usually been coordinated by the central office, particularly when there have been changes to the system or to its administration or changes to the eligibility.

The CHAIRMAN: So, the central office in Perth?

Mr Wilson: Yes.

The CHAIRMAN: Could you also talk to us about the education and training that are given to your PATS clerks here when they first start in that role and what sort of ongoing education and training you have for them?

Mr Wilson: All PATS staff, before they commence working in the PATS office, need to participate in some online training. Some of that is the mandatory training, which is mandatory for all WACHS Pilbara staff. Some of that is specific to PATS, so there are some specific modules about the operation of PATS that need to be completed before they are given access to the online system; so all of our staff have participated in that training. We have identified that there is not readily available some good modules for customer service training, so that is something we are concentrating on over the next six months in terms of improving customer service training and generic skills for that group of staff. One of the things which we are very conscious of and make an effort of in the Pilbara is ensuring that all staff participate in cultural awareness training so that they are aware of the specific needs of that group of the population.

The CHAIRMAN: What about the medical personnel who are the users of PATS, the GPs and things like that; is training provided to them when they first come to the area?

Mr Wilson: That is challenging. As I said, our manager of PATS and ambulatory care goes out to visit all the services on a regular basis. Because of the size of the region, she may only get to each

location probably once in a 12-month period, and then she may make special trips if she notices that there is a particular issue at one place or another. The challenges include that you have places like Newman where the private general practice there is run by a corporate health provider, and they seem to have a higher than normal run of locums that are not necessarily repeat locums. So, certainly, that would be, if I had to pinpoint one location, where we probably have the most inconsistency in terms of the applications, and Loreen has concentrated on doing work with their equivalent. They do not have a practice manager based there, which is a challenge in itself. Normally, you would make contact with the practice manager and ask that person to orientate the doctors as they come through, but that is probably the one area. In other cases, it is a case of working with the practice managers to make sure that they have all the information available so that if they have doctors coming in, they can provide that. Port Hedland is relatively well serviced with a good proportion of resident general practitioners in the town as well. Karratha, I believe, has some more stability in their GP workforce as well, so we are not seeing the same sorts of issues from those areas.

The CHAIRMAN: What about exceptional circumstances? How often are you receiving requests for exceptional circumstances, and if you can give us some examples? In fact, one of the things I am going to ask you at the end of this section of questioning—and we have asked this in other regions as well—is to provide us with your exceptional circumstances register over the last 12 months, with, obviously, personal information redacted, but just the register of those. Can you just talk to us about yours?

Mr Wilson: Yes, and I received an email just on Friday. I believe Cathy Hey from the central office has provided the information to the committee in terms of the exceptional circumstances that are recorded in the system across the state.

The CHAIRMAN: Has she?

Mr Wilson: Yes.

The CHAIRMAN: That is very good.

Mr Wilson: I reviewed that information for the Pilbara. There was only one exceptional circumstance reported. So that has come out of the Share database. What I have identified here is that, using the 2013–14 year, we had nine requests for exceptional circumstances. Of those nine requests, five were granted and four were declined. I am looking into why those are not being properly reported in the Share system—why they had only reported one, and yet I know of nine that were recorded, just within our email system.

[2.10 pm]

Some of the examples—these are just ones that have occurred more recently, so they are good examples to use. It is different from region to region because of the staff who are administering the system. The question is always: do we provide just an administrative function, or do we provide some sort of clinical assessment of some of these applications? As was mentioned this morning, we have a clinical nurse manager who oversees the area, so we have a degree of clinical governance, and then any questions are referred to the regional medical director, as they are in most regions. Just recently we had a patient apply. Their referral was actually to a plastic surgeon in Perth. Most plastic surgical procedures are not covered under the patient assisted travel scheme unless they are reconstructive or related to something like that. In particular, the information that the referring practitioner had put on the form was that it was for abdominoplasty. As far as the guidelines are concerned, if we are managing the system administratively, we had to apply that and say that that has been declined based on the information that has been provided. As is often the case when we make an initial decline of an application based on the evidence that is provided to us, we then say that if there is further information that we are not aware of, the doctor can provide that. In this particular case, after having two children and having lost a significant amount of weight, the person

also had what is called the divarication of the abdominal rectus muscles—a separation of the abdominal muscles, which requires surgical repair. Had all that information been put in the system, then it would not have been declined the first time. The fact was that that surgery is performed by a range of general surgeons through to plastic surgeons. So it is quite normal when doing that type of surgical repair that you are also doing excess skin removal at the same time.

That is a classic example whereby the doctor had said that the procedure was not available locally—there is no question about that; it was not available locally—but with the information they initially provided, it was also a procedure that was on the excluded list. The question is: under the administration of the system, when the doctor has said that they should go down there for PATS, do we just take that, or do we request this further clinical information where it is required?

The CHAIRMAN: In that sort of circumstance, did the patient themselves know that they could appeal that decision and seek exceptional circumstances?

Mr Wilson: We have a standard communication that goes out to people if their application has been declined, and that includes the invitation to supply further information. We also have a standard part in there referring to the appeals process and that they can also appeal to the Health Consumers' Council. That information is provided.

I have another example here, which has occurred just in the last week. This is probably one of the more challenging ones. I recognise the issues confronting residents, particularly of the inland Pilbara area—the Pilbara, Tom Price and Paraburdoo. You do accept that for many people the concept of being referred to the nearest available specialist is not always the best one for them—to expect people to drive in excess of four hours to Port Hedland to attend the nearest specialist, as opposed to a less-than-two-hour plane trip to Perth for what is not the nearest. Certainly, if I lived in the inland, I know which way I would want to be going as well. Most of those people have family supports and other things in Perth, whereas if they come to Port Hedland, there are not those options. Under the scheme, however, we are obliged to only pay PATS to the nearest. We have made some case-by-case exceptions to that, and one of the typical exceptions which is made is in the case of birthing services, whereby a person, particularly if it is a moderate to high risk pregnancy, would be referred to come to Port Hedland three weeks prior to the birth of their child. The only accommodation option we have is the South Hedland hostel. If they have other children that need caring for, there is no facility really for them to have those children there, and then they feel isolated. It is not the most ideal circumstance. What we have done on a case-by-case basis is that each time one of these cases comes up, we look at the costs. Many of these people, if they went to Perth for three weeks prior to confinement, would have family or friends that they could stay with. So we assess the costs of Port Hedland versus Perth and we make an assessment that is both financially sound but also takes in the circumstances of the individual, and often when they have other older children who need care, it is often supported that they go down to Perth for those types of cases.

Another example, just last week, was ENT appointments. For ENT, again, we have a visiting service up here eight times a year. Basically, it is monthly during the nice time of the year, and they do not come during cyclone season, because there are too many potentials for interruption of service. Again, this was a Newman family. They had three young children who have all had recurring ear infections from time to time. One of those three children currently has a very badly infected ear and has been referred for urgent review and most likely insertion of grommets. The mother, quite logically, has requested that all three children be reviewed, possibly with all three of them requiring that type of procedure. Under the scheme, certainly with the frequency of the visits, it was perfectly reasonable to approve for the youngest child, who had the current infections, to go down. It did not make sense to decline the other two children, although they did not require it from a clinical urgency point of view. They could have waited until a review here, and they could have had the procedure here. But, again, we looked at that; we assessed all of the costs. We looked at the

issues relating to that particular family and said that it makes sense for that family to go—the mother and the father with the three children—to one specialist in Perth at one time, so that was done.

We try to make pragmatic judgements considering all the factors where possible, but, as you can see, those are just a few examples whereby we regularly have to go outside of the strict adherence, and with the administrative staff in their capacity, their delegation is only to approve things that fit the system, and anything else they have to decline. They decline and they refer it to the manager.

The CHAIRMAN: Is the Pilbara service the only one you know that uses a clinical nurse manager in the role that you do?

Mr Wilson: It is the only one that I know of that does.

The CHAIRMAN: It seems to me that that is a very sensible thing to do—to have someone with that qualification who can do that, almost like triage assessment, is it not?

Mr Wilson: Yes.

The CHAIRMAN: The other thing that we have been hearing while we have been travelling around is that the PAT scheme itself, and what is allowed to be done under the PAT scheme, has not kept pace with modern technology and advancements in medicine. The classic one that we did hear of was cochlear implants, where the surgery for the implant is allowed, and that is fine, but everyone who knows about cochlear implants knows that the surgery is really the first stage in that process, and the most important stage then is the switching on, which you have to wait for until that has healed, but that is not covered. Do you think that there is a need for there to perhaps be a more rigorous review of what is covered under PATS?

Mr Wilson: I am aware that in its submission to the committee, WACHS' central office said that a broader range of those allied health specialties and dental health are being looked at at the moment because of exactly those issues. The ongoing program requiring both audiologists and speech pathologists is essential. There is no point having funded the actual surgery if it is not going to be effective. More and more that is not an exceptional situation; it is actually quite a common situation. There are numerous types of interventions that require follow-up by multidisciplinary team members who are not necessarily the specialist. Without having any strong evidence to support this statement, there is a perception of some "gaming" of the system whereby if a person is having problems after bariatric surgery and they specifically need to see the dietician associated with that service, the doctor may put on the form that they are going to see the bariatric surgeon when the suspicion is that that is not always the case. Bariatric surgery is another good example of the benefit of having a clinical nurse manager who oversees both the outpatients area as well as PATS. She saw a general increase in the number of people applying for PATS assistance for bariatric surgery. In the past 12 months she has worked with a bariatric surgeon to introduce a visiting service in Hedland. She worked with that same practice to look at expanding that to a visiting service in Newman. One has just commenced in Karratha as well. That is great, because it means that people can have their initial consultations locally and then we are funding only the trip to Perth for the surgery. Usually there is just one follow-up in Perth, then most of the follow-up can occur locally. That has been a good example. However, having said that, unfortunately a lot of people experience complications with that procedure and there is a need for them to go to Perth more than the ideal textbook case, if it follows everything properly, and a lot of those follow-ups are often for things like dietetics.

[2.20 pm]

The CHAIRMAN: Because there is quite a difference between lap banding and sleeve gastrectomy.

Mr Wilson: And most of them are sleeve gastrectomy nowadays.

Hon AMBER-JADE SANDERSON: With the "gaming" of the system, does not the patient need to have the surgeon sign the form to say that they have seen them? How can they see a dietician when it says that they are seeing a bariatric surgeon?

Mr Wilson: Quite often the dietician will be associated with that particular clinical practice and there will be an arrangement for them to sign. I cannot say that categorically.

Hon AMBER-JADE SANDERSON: I know.

The CHAIRMAN: I know that some clinics have bariatric surgeons with a gym, dietician and psychologist on-site. Theoretically, they are seeing the bariatric surgeon.

Mr Wilson: Yes. There is no doubt that they will be seen by the dietician, but the information from the dietician will be discussed with the bariatric surgeon and the patient may not necessarily see the surgeon on that visit.

The CHAIRMAN: In keeping with the theme of always looking at and updating the system, one of the things that has struck us as we have gone around is that it is very cumbersome from the patient's point of view—and, I think, from the GP's point of view—to fill out the yellow form and the blue form. If they do not fill out the form right, there is a backwards and forwards thing. I am not talking about having the scheme centralised in one location, but certainly having it computerised to the point at which a GP would, at the first visit, generate a case number for that particular case. They would have that information on file from a patient anyway, one would imagine, and then go through that step-by-step phase. Do you think that would alleviate some of the issues for patients?

Mr Wilson: Yes, I feel strongly that that would definitely improve the system. The fact that here—and not just here because I am very familiar with the Kimberley as well—we have to rely in some parts of the Pilbara and Kimberley on a turnover of the medical workforce. They do not always know what services are available locally so it would be good to have an electronic system that provides them with more information. Doctors are busy people and they do not want to be filling out a paper-based form when everything else that they do in their practice is computerised.

Hon JACQUI BOYDELL: Brian, can we go back to cultural awareness training and dealing with, whether or not they are Indigenous clients, English as a second language? Do you use an interpreting service?

Mr Wilson: There is no Pilbara interpreting service. There is an organisation in the Kimberley called KIS, Kimberley Interpreting Service, which covers all the main language groups in the Kimberley.

Hon JACQUI BOYDELL: But there is not one in the Pilbara?

Mr Wilson: There is none in the Pilbara. I recognised that when I first came down here and attended the cultural awareness training at the Wangka Maya Pilbara Aboriginal Language Centre here. We raised this issue with them and since then we have worked with Wangka Maya and Wirraka Maya as well to put them in touch with Kimberley Interpreting Services. They are looking at developing an interpreting service here in the Pilbara. It is challenging because, in the strictest sense, interpreting services that are nationally recognised are governed quite stringently—and for very good reasons—but it is challenging to do that within the context of a variety of small language groups and having people who can interpret those languages who do not necessarily meet the stringent requirements in terms of their accreditation status et cetera. In the absence of that, we use our network of Aboriginal liaison officers that we employ. We also tap into Aboriginal Medical Services and utilise one another on a goodwill basis. In most cases there is a lot of use of family. I know that that is not always appropriate, but that does happen by necessity in many cases.

Hon JACQUI BOYDELL: That leads to my next question. We have heard this evidence in other places, so it is not just here, of Indigenous people in particular going to Perth having never been out of their community and not speaking English as their first language. They are quite frightened and

stressed, let alone unwell. I think there is clear evidence for escorts for patients from a clinical perspective. I personally—I am interested in your opinion—think that there is a gap between dealing with those allied health services and the social and emotional support for the patient through the PAT scheme. Sharon from Newman made the comment this morning that she was under the impression, but could not confirm, that in the Pilbara some Indigenous patients had been able to access escorts to travel with them to help them interpret what will happen to them from a medical perspective and to give them some emotional support. Have you considered that? You did not mention that in the exceptional circumstances cases you referred to; I know you cannot mention them all. Do you think they would qualify under the current eligibility criteria point (e)?

Mr Wilson: As well as the clinical aspect, the scheme refers to the broader wellbeing and mentions things such as people who are frail or those who have some sort of infirmity or issues that could impair their ability to successfully negotiate the system. Yes, language difficulty is often cited by the referring doctor; and, in those cases where it is clear that that is required, escorts are approved. There is also Country Health Connection in Perth.

Hon JACQUI BOYDELL: Can I just stop you there? Approved under exceptional circumstances, or approved under the criteria?

Mr Wilson: No, approved under the criteria if the referring doctor has said it is required for that person.

Hon JACQUI BOYDELL: How would they do that? I know it is clear from a clinical perspective.

Mr Wilson: In the section where it indicates whether they want an escort. Normally, yes, they would put clinical reasons, but they will often cite issues about the person having difficulty with their mobility or language, or they have never travelled there before et cetera, and request it on those bases.

Hon JACQUI BOYDELL: And you are approving that?

Mr Wilson: Yes, I would not say every single time; we look at what we can see of the person and what we know of their clinical condition, so I would not say every single one was getting approved but, yes, where it is known that they have particularly got language issues, then that has been considered.

Hon AMBER-JADE SANDERSON: Would that not require someone at the time of the appointment to indicate that they need support and that might not necessarily be the case? A busy doctor in a clinic is not necessarily going to think that it will be a challenge for this person; they are just thinking from a clinical perspective that they need to see a person in Perth.

Mr Wilson: Particularly the doctors that are working with those groups that have the most challenges; they are very conscious of it. A typical example is the Western Desert communities. They have been blessed with a doctor out there, Doctor Spargo, who has been there for more years than anybody can remember, and he is very good at advocating for those patients and highlighting exactly what the special needs are for those patients.

Hon DARREN WEST: I understand you are trialling a new PATS form. Can you tell us a little bit about that?

[2.30 pm]

Mr Wilson: I have provided Lauren with copies of both the form and the information sheet that is going along with it. It was opportunistic; the wheatbelt is currently going through a process of centralising its PATS management, and in doing that it also wanted at the same time to look at whether it could trial a different version of the form. The current form is effectively four pages, so the aim was to get everything that is needed for governance and to be able to make a proper decision onto a single sheet—back and front. After a lot of effort, all of the necessary information has been squeezed into that.

Hon DARREN WEST: So is it a very small font?

Mr Wilson: Personally, I do not think the number of pages is a defining issue. I think it is more a case of how easy it is to navigate the form and answer the questions it asks. Certainly there are guidelines as far as disability access is concerned, which talks about how all of our forms should be in a minimum of 12 and in Arial font et cetera. To achieve this we had to go outside those things to come up with this, but it does manage to put everything that was on those four pages into just a back-and-front form. It also gets rid of the separate yellow and blue form. On the back of the form, down the bottom section, is the specialist certification section.

The CHAIRMAN: That is the blue form now, basically—there, in the blue section?

Mr Wilson: Yes. The wheatbelt is very different and, as I mentioned to some of you this morning, having worked in the south west and great southern, those areas along with the wheatbelt, the majority of people are travelling by road and just seeking fuel reimbursement. A very simplified system whereby they fill out one form and take it with them and get the specialist to certify it, and they lodge it when they return, is a really good idea and it makes absolute sense. For the Pilbara, the Kimberley and the goldfields, I would have said that those forms need to first come in because a lot of the time those people are needing assistance with making flight bookings and assistance with accommodation et cetera. What we are doing in order of testing this form out here is because we scan everything and store it electronically, we are then handing the form back to the person so, again, they still take it and they are just getting the specialist to fill out that section on the back. Having said that, a lot of people are very used to the fact of getting this separate blue form, taking that with them and getting it signed off, so we are doing pre- and post-implementation of this. We are doing surveys of two groups: regular PATS users and first-time PATS users, in both cases, and we will measure what sort of improvement this change in the form might make.

The CHAIRMAN: The Pilbara has centralised their service and now the wheatbelt—whoever is doing it. Is there any cost benefit to WACHS to do that or is it just really from a convenience point of view?

Mr Wilson: Having worked in both decentralised and centralised systems, I can say confidently that when it is centralised you get a much greater consistency of the application of the guidelines and a much greater consistency of the decision-making and what is approved and what is not approved. Having lived in many different small communities, it was always challenging for the administration officer working in a small country hospital in a small community. They have firsthand knowledge, they see these people in the community and they feel in some cases more pressured to approve PATS. I am not saying that they do, but I can see that that could be the case. From my own experience, I have seen probably more inconsistencies in a decentralised system than I have in a centralised system. The fact that it operates in this particular case as more of a call centre, they are away from it and can make much more of an impersonal assessment of it based on the information and convey that back. Is that a good thing or not? The Office of the Auditor General has done a review on the PATS system before, and one of the issues that they do look at regularly is the consistency of the interpretation of applications. We have never had a question about that raised in terms of the centralised system.

The CHAIRMAN: From what I have heard today and over the last few days, I am thinking that having the whole thing computerised would be of great benefit but it would be better to have it as a federation of systems rather than one centralised system. For instance, they were talking today about getting somebody from one of the outstations to Newman, to here and then to Cotton Creek and back, and things like that. You really need that local knowledge to be able to do that rather than having someone in Perth because they are not really going to have that, and then you would also have the local knowledge of the patients themselves and the community they have come from. Is it a fair way of looking at it, do you think?

Mr Wilson: I just reflected, even since our discussion this morning, a model that I can see would have some clear benefits would be, number one, yes, more of a web-based type system, with the actual decision-making that could be made centrally anywhere in the state, and you would get better consistency. Once it had been approved, then that approval can go to the particular region to make all of the arrangements for travel that can be quite complex. You need that local knowledge of all the resources.

Hon AMBER-JADE SANDERSON: How many PATS applications did you have in 2013–14?

Mr Wilson: I think it was 9 500. Yes, 9 478.

Hon AMBER-JADE SANDERSON: Have you seen an upward trend of PATS applications over the last few years?

Mr Wilson: What happened—I only have 2012–13 to compare it to at the moment—is that in 2013–14 there was a 43 per cent increase over 2012–13. I would have to say I would qualify those figures because during that period there was also the introduction of the new database for recording the information, so I am not sure whether the 2012–13 figures may be understated because that was a year when the majority of it was on an old database and then they moved to a new database, so I could not guarantee the integrity of the data. Interestingly, the data in the old system for 2012–13 averaged around 1 500 trips per quarter, and in the 2013–14 year, we have been averaging around 2 400 trips per quarter.

Hon AMBER-JADE SANDERSON: You still have a set amount of money for PATS and the rest. When you see an increase, that has come out of the operational budget of the hospital; is that right?

Mr Wilson: No, it is funded centrally from WACHS.

Hon DARREN WEST: So you have had the extra —

Mr Wilson: Number of trips?

Hon DARREN WEST: Applications—the numbers of trips; they're successful applications, I presume.

Mr Wilson: Yes.

Hon DARREN WEST: What is the difference in how much the actual scheme costs you?

Mr Wilson: Interestingly, in the 2012-13 financial year the average cost per trip was $1 276, and for the 2013-14 financial year, the average cost of a trip was $808.

Hon DARREN WEST: So there might be a data entry error then, given that you might not have all the information, as you suspect, because that would sort of say that it has cost them 50 per cent —

Mr Wilson: Yes, although it is, sort of, initially counterintuitive that the number of trips significantly increased, yet the actual expenditure we managed to decrease in the year that had the higher number of trips.

Hon DARREN WEST: So the total spend on those years was less in the second of those two years?

Mr Wilson: In the last financial year just gone, it was less.

Hon DARREN WEST: It was less than the first year? So 2013-14 was less than 2012-13?

Mr Wilson: Yes.

Hon DARREN WEST: Your PATS budget is $3.8 million?

Mr Wilson: I can just check that. The expenditure in the most recent financial year—2013-14—was $7.6 million, and the budget was $7 million.

Hon DARREN WEST: Okay. That answers my question. I was wondering how much you had passed on to the centrally to WACHS; it was $600 000 from this area.

Mr Wilson: Yes.

Hon STEPHEN DAWSON: On the same issue, how many of the 9 400 had to go to the metropolitan area or to Perth for treatment?

Mr Wilson: I could not tell you from the information I have here in front of me, but we can certainly —

Hon DARREN WEST: Put that on notice?

Mr Wilson: Yes.

Hon STEPHEN DAWSON: Anecdotally, would you have a sense?

[2.40 pm]

Mr Wilson: I would have said, anecdotally, at least two-thirds of that is to Perth, with about one-third being intra-regional, even though a lot of visiting services are available at Karratha. There will be regular PATS subsidies paid for people moving from Onslow to Karratha for services. For Tom Price and Paraburdoo, there is a bit of a mix; some people go to Karratha for services and some come to Port Hedland. People from Newman tend to predominantly come to Hedland for services.

Hon STEPHEN DAWSON: For every person who needs to come to Hedland for treatment, do they always get housed in the hostel or is there sometimes a requirement to have them in a hotel or a hostel?

Mr Wilson: With the system we operate, we are fortunate that we have a hostel that has beds available for PATS, and that the PATS subsidy covers the full cost of that, so there are no out-of-pocket expenses. When I first came here at the end of 2011 and early 2012, there was no accommodation available in town at all and the prices were quite horrific. With the construction of that—it opened in May 2012—since then we have been able to accommodate everybody who has needed accommodation there. Having said that, if people choose not to stay there, then our position is that they should feel free to make whatever bookings they want wherever they can, and then apply for the reimbursement of the same rate.

Hon STEPHEN DAWSON: For those people who do go to Perth, one of the concerns raised with me is that the accommodation allowance is not substantial at all, and in fact for many people it would not buy a bed in a dorm at a youth hostel rather than hotel. Do you have the same feedback from people?

Mr Wilson: Yes. I am aware, again, that in WACHS' submission to the committee they said that instead of a flat system for subsidising accommodation, they are looking at the accommodation subsidy having to be reviewed to take into account different local market conditions. They gave the example earlier today where in Broome, especially during peak tourist season and the fact that the Aboriginal hostel in Broome is fully occupied by permanent renal patients, there is no hostel accommodation, and there is very little in the way of low-cost affordable accommodation in Broome. Most people who have to go to Broome for any services are put up in anywhere from the caravan park to Pinctada resort. It would be very difficult to defend a system whereby we said, "We're only going to fund you $60", and depending upon which time of the year it is, you were lucky or unlucky and you could be funding anything up to $200 a night. I do not know if it still happening, but certainly when I left the Kimberley three years ago it was quite a regular practice to cover the full cost for Broome. However, in the Pilbara we have the ability of the hostel that covers the full cost, so that is what we apply, and that is in accordance with what the system says; we do exactly the same thing when people go to Perth. Our Aboriginal residents here are no different to the non-Aboriginal residents; some people will be quite happy and comfortable going into Jewell House, which soon will be no longer, or one of the other hostels, but even many of the Aboriginal people will say, "We're not comfortable, we don't feel safe in those types of environments, and we would like to stay somewhere else."

Hon JACQUI BOYDELL: I just want to go back to one of your examples—the abdominoplasty. When it was approved by the doctor for travel but rejected by the PATS office because it did not meet one of the medical requirements, how did you relay the opportunity for the patient to appeal that under exceptional circumstances?

Mr Wilson: In this case, where people provide their email address and they are happy for email communication, we will send an email back to the person saying it has been rejected, and if there is information that was not available that is relevant, then please provide the additional information. If you do not have any other additional information, then you can apply for an appeal and these are the appeal processes.

Hon JACQUI BOYDELL: Again, going back to a populated form, if the document was available for the doctor, that would eliminate that?

Mr Wilson: Yes.

Hon JACQUI BOYDELL: You were talking about referral to the closest medical specialist. To me that seems as if we are basing it purely on kilometres. In the Pilbara and the Kimberley, where you qualify for air travel anyway, actually the closest medical specialist is in Perth in most instances. I do not understand why—is it purely because of the kilometre time, but actually the travel is less?

Mr Wilson: Yes.

Hon JACQUI BOYDELL: That is purely an administrative change, I would have thought, because you qualify for air travel anyway.

Mr Wilson: Yes, you do qualify for air travel.

Hon JACQUI BOYDELL: Which is less time.

Mr Wilson: Paying a person the kilometre rate from Newman to Hedland, and allowing for the fact that the hostel is fully subsidised under PATS, it is cheaper for people to come to Hedland from Newman and Tom Price, but it is certainly not more convenient for those people. As I said, I feel for those people; if I was living in those areas, I would be choosing to go to Perth as well, where there would be family or other supports, instead of coming to Hedland where you probably have no extra support.

Hon DARREN WEST: I know we are running out of time, but just very quickly: do you have association with Northern Territory communities—people coming in to use the PATS services in Western Australia or people going to Alice Springs from the eastern areas?

Mr Wilson: No; very little of that happens. There was one case, though, and it was just within the last fortnight, whereby somebody had been transferred to Darwin and so we paid PATS for them to come back from Darwin. What you will see when you get to the Kimberley is that the Kimberley has a formal contract for beds at Royal Darwin, and so particularly residents of the East Kimberley will go to Darwin, and PATS is used to bring those people back.

Hon DARREN WEST: It makes a bit of sense. Thank you.

The CHAIRMAN: That brings us to the end of the hearing. Thank you very much indeed firstly for showing us the facility today at Port Hedland—we are very impressed with the hospital; it is fabulous—and for taking the time to give us this evidence now. As I have been saying, it is a big jigsaw puzzle—the whole PAT scheme—and each place we are going to we are getting a much different piece of that puzzle. It has been well worth us coming to each of these regions, and we appreciate all the time that has been spent in putting together the information.

Hearing concluded at 2.47 pm