STANDING COMMITTEE ON PUBLIC ADMINISTRATION

INQUIRY INTO THE PATIENT ASSISTED TRAVEL SCHEME

TRANSCRIPT OF EVIDENCE
TAKEN AT NORTHAM
THURSDAY, 6 NOVEMBER 2014

SESSION ONE

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Members

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

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Hearing commenced at 12.40 pm

Ms BEVERLEY HAMERTON
Operations Manager, Western Wheatbelt, WA Country Health Service, sworn and examined:

The DEPUTY CHAIRMAN: We declare this hearing of the public administration committee open. Before we start, I would like to acknowledge the traditional owners of the land that we are holding this hearing on and pay my respects to their elders past and present. Welcome. On behalf of the committee, I would like to welcome you to the meeting. Before we begin, I must ask you to take either an oath or affirmation.

[Witness took the affirmation.]

The DEPUTY CHAIRMAN: Please state the capacity in which you appear before the committee.

Ms Hamerton: I am here before the committee as operations manager of the western wheatbelt but also the portfolio holder for the regional coordinator of PATS.

The DEPUTY CHAIRMAN: Excellent, thank you. You will have signed a document titled "Information for Witnesses", have you read and understood that document?

Ms Hamerton: Yes.

The DEPUTY CHAIRMAN: These proceedings are being recorded by Hansard. 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 this hearing for the record and please be aware of the microphones and try to talk into them. Ensure that you do not cover them with papers or make noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish 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. 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.

Would you like to make an opening statement before the committee?

Ms Hamerton: Yes, please.

My name is Bev Hamerton and I have been employed as the operations manager for the western wheatbelt for the past 20 months. In this role I hold the executive portfolio of regional coordinator of the patient assisted travel scheme and this is my first experience in my career of managing the PATS program. In general, the scheme works well. It is appreciated by those who use the assistance offered to access medical specialist services. A consumer satisfaction survey that we conducted in the wheatbelt in the last quarter of 2013 revealed that 98 per cent of the persons using the scheme found it very helpful. However, the qualitative data within this survey clearly illustrate that the patients found the application process confusing and the frequent delays in receiving their subsidies irksome. Some of the complexity of the scheme lies in the multiples of case scenarios that do not quite fit the parameters of the policy guidelines and therefore require a decision-maker to balance the health needs of the client with the intent of the policy whilst complying with the governance structures inherent in the necessarily narrow scope of a public policy of this nature.

Early this year, broad stakeholder consultation was held with the relevant sectors of the WA Country Health Service to help inform the Department of Health's submission to the Standing

Committee on Public Administration inquiry into the patient assisted travel scheme. This document covers the majority of issues that I deal with daily. I believe the suggested solutions related to the level of funding for transport and accommodation; the eligibility for funding; the administrative processes; the exceptional ruling processes; expanding the scope to include non-specialist treatments; access to some allied health and dental services; and maternity services, those of the newborn and the administrative processes associated with those are practical and would lead to efficiencies through streamlining and standardising across the WACHS regions. However, it must be kept in mind that investment is needed in the recurrent human and financial resources of such improvements. In addition to these solutions, further efficiencies could be realised through the use of smart, contemporary technology by establishing a fully integrated electronic platform from which to manage each phase of the PATS process from referral through access to validation payment, systems reporting and audit.

In September 2014, the wheatbelt and Pilbara regions, following several months of consideration and consultation, embarked on a trial of a simplified application form to manage the processes associated with both prospective and retrospective PATS payments. Concurrently, the wheatbelt is trialling a centralised and standardised PATS administration process. The trial is due for completion on 12 December. Early indicators from the midpoint evaluation suggest that both arms of the trial will have some successful outcomes, albeit with the need to make small remedial adjustments in accordance with the final evaluation findings.

In conclusion, the most important principle of PATS is to provide assistance to ensure access to medical specialist services is a reality for rural residents. In my opinion, consideration should be given to those specialties and tertiary services that are non-medical but have the clear capacity to improve the quality of the client's life, particularly if an appropriate service is not available in the resident's local area. Many of these services have the potential to provide early intervention efficiencies by preventing or ameliorating longer-term chronic conditions that may require expensive ongoing therapies.

The DEPUTY CHAIRMAN: Excellent. Thanks very much, Bev. You have answered a lot of my questions I that, but I will re-ask them just to get them clearly on the record. I think you have touched on most of them. From a wheatbelt perspective, or western wheatbelt perspective more specifically, could you once again articulate the efficiencies and the deficiencies of the current PAT scheme as it stands today?

Ms Hamerton: I think we are a bit of a different region because we pretty well hug the metropolitan area. When you are talking about a PATS process, from all those different elements of the wheatbelt, the closest town for the closest specialist might not be available to people, for instance. A lot of the people from the western wheatbelt and the eastern wheatbelt go to Perth, but if you are in an area like Boddington, Williams or Narrogin, your closest specialist might be either Mandurah, Bunbury or Perth and there might be only three or four kilometres difference in that, but you can only pay to the closest. Similarly, in some of the southern aspects, they might be closer to Albany than they are to Perth, but you cannot get what you want in Albany. I think some of it is about the policy not allowing a little leeway to make commonsense decisions about what the closest specialist is or having a get-out clause that might say "pay to Perth". For instance, you are making decisions about a patient going from Boddington to Mandurah because that is the closest specialty, but to get there by the closest way they have to go through some manky back roads that are full of trucks and are quite dangerous roads; otherwise, they have to go to Perth and then go to Mandurah to get to the closest specialty. They might have parents or people in Mandurah that they can stay with, for instance, so their accommodation costs are $20 a night for a private stay, whereas if you make them go to Perth, the actual cost of the trip might be less than $10 but you are then paying $65 or $75 for their accommodation to stay overnight. There are those sorts of complexities here that are not necessarily in another region like the Pilbara, the Kimberley or the midwest because it is clear that they have to come to Perth because there is not a specialist in the area.

The DEPUTY CHAIRMAN: Do you feel that you do not have enough flexibility in making those sorts of decisions—that it is a little bit too rigid?

Ms Hamerton: Yes.

[12.50 pm]

The DEPUTY CHAIRMAN: So, a little bit of local decision-making and a bit of flexibility on that decision would be useful.

What about the 100-kilometre radius line from Perth? Does that give you any level of concern? Does that cause an issue with clients and staff?

Ms Hamerton: Again, you are making judgements that this person who lives three kilometres that side of the line cannot have it and that person who lives three kilometres this side of the line can have it no matter what their needs are. I get the fact that there has to be some border that is actually put there, because if you do not have some parameters, then the shift is too broad. It would not be affordable to say, "Oh, well, we'll have a 50-kilometre radius where we can shift those boundaries to." But where it is very small and the actual number of patients accessing those services is small as well, I think those types of decisions could be made locally, given the clinical situation of the patient, because what generally tends to happen is, you have got less than $30 or $5 or $10 difference in the payment, so you decline one because it does not fit with policy and accept another, and then when you get a letter of complaint—a ministerial—those sorts of things that take hours to deal with. At my hourly rate, you have not really saved anything in terms of making a decision to say, "I'll give this patient assistance, based on a number of parameters, not just one."

Hon JACQUI BOYDELL: Thanks, Bev. I want to go back on a couple of your comments. You made the comment that people in the southern half of the wheatbelt might have to actually access Albany because that is the closest specialist, but you cannot get what you want there. Can you just expand on what you mean by that in terms of specialist services?

Ms Hamerton: In terms of specialist services —

Hon JACQUI BOYDELL: If you cannot get the specialist service, would they not be referred to where the closest specialist is that they need if they are not in Albany?

Ms Hamerton: Yes, I get what you mean. The doctor refers them to a specialist. The closest specialist in that field might be in Albany in a direct line from where they are, but they are actually being referred to Perth.

Hon JACQUI BOYDELL: I am still not getting that, sorry. Why would they be referred to Perth if the specialist is in Albany?

Ms Hamerton: Because that is what the doctors do.

The DEPUTY CHAIRMAN: Does that make them ineligible?

Ms Hamerton: That makes them ineligible.

Hon JACQUI BOYDELL: That sounds odd.

The DEPUTY CHAIRMAN: To get it very clear—I think we are all thinking the same thing—the patient is in the southern wheatbelt and the closest specialist is in Albany, but the patient is referred to Perth by their GP; therefore, they become ineligible for PATS.

Ms Hamerton: Ineligible, yes, unless there is a clinical reason why they should go to that Perth specialist who does orthopaedics instead of an Albany specialist who does orthopaedics, because that guy might not do shoulders and this might be a shoulder, and if they had written that clinical reason, then that is eligible. But if there is no clinical reason to delineate why they have gone to a Perth specialist when the same service is in Albany, they are not eligible.

Hon JACQUI BOYDELL: When we were talking to the PATS clerk earlier today in the hospital, there was a lot of reference made to going backwards and forwards about the clinical decision with the doctor. Is that not picked up in that process?

Ms Hamerton: If the doctor puts in a clinical reason, it very well picks up the process. In the PATS form it says, "If the referral is not to the closest, you must supply a clinical reason"—mandatory. That is not always the case. They might go "recurrent: seen by this person before, ongoing care" or something like that, which is not a clinical reason.

Hon JACQUI BOYDELL: A lot of the circumstances that you were talking about where patients are experiencing difficulty with the PATS system at the moment and there needs to be some form of local decision-making, how are you applying that to assist those patients? Are you utilising exceptional circumstances and so are you meeting the needs of your patients through exceptional circumstances as a means to help them fit that eligibility?

Ms Hamerton: We have done two things. We went to the RD—the regional director—with a group of frequently occurring circumstances that were a mildly grey area of the policy. For instance, if the closest specialist is less than $10 for the return trip—given the Bunbury–Mandurah scenario—if the actual cost of the reimbursement was less than $10, then we could approve it without having to go through an exceptional circumstances program. We have got a little thing that we review every year to say that they are exceptional accepted grey areas of the policy that we can make a decision locally without going through the exceptional —

Hon JACQUI BOYDELL: You have implemented that almost like a step before you have to assess exceptional circumstances.

Ms Hamerton: There are only about eight of them that are frequently occurring things in this region and the regional director reviews them yearly to see whether they are still relevant and still the types of questions that are coming up. Anything outside that and you can see a really good clinical cause for that to happen. For instance, there was a child in Lake Grace who had to have orthotics to make her walk. She had some syndrome and she had no way of accessing that type of allied health thing within the region, not even close to Lake Grace. Those types of things are done on an exceptional ruling.

Hon AMBER-JADE SANDERSON: Would it be possible to provide a summary of those eight exceptional circumstances as supplementary.

Ms Hamerton: Yes.

[*Supplementary Information No 1A.*]

Hon AMBER-JADE SANDERSON: While we are talking about exceptional circumstances, it links to some of the efficiencies and deficiencies. Are there any allied health services that you think could benefit from being eligible for PATS?

Ms Hamerton: Again, I think it is the sort of things that are tertiary and specialist allied health services that you cannot access locally. Some of the particular speech pathology things, some of the lymphedema treatments for patients who have had mastectomies and some of the real specialist podiatry stuff is very helpful. Some of the patients who have really advanced peripheral vascular disease and require specialist wound management—those types of things—would be really helpful. Some of the physiotherapy things they are doing in town now, I guess—you cannot make broad generalisations, but with individual cases, if it is actually accessible only in a tertiary service or accessible only through a specialised clinic that deals with that, I think they are very, very simple things to do.

The DEPUTY CHAIRMAN: I wanted you to outline to us how you advertise and promote the PAT scheme to people in the regions and by what means are people made aware of PATS, and do you have any examples of how you do that?

Ms Hamerton: Yes. All the stuff has been reviewed recently because of the PATS trial. We updated the website, which included the trial information on that and we had brochures that went out to all the surgeries and we had a DHAC forum—District Health Advisory Council members' meeting. We did a day's workshop on the PATS with them, getting their input into what the communities wanted and how they would utilise the scheme. That went out through their network, through the local health advisory committee. With the introduction of the trial and the new information sheet in the last three months, we have done a complete road trip around every surgery in the PATS region, talking to their doctors and their practice managers, so that the information that is available is there for them. We get minimal complaints or queries—we get them occasionally from people who did not know about the PAT scheme. Often somebody has told them about the PAT scheme, "You could have applied for this", and they have gone back to their GP, put in a retrospective application, got the blue sheet and then applied, saying, "I didn't know this was available", and, generally, that is passed for the first time. Then we give them information and they are on their own after that.

[1.00 pm]

Hon JACQUI BOYDELL: I guess this goes back to what we were discussing about Albany and given that you have got your new super clinic starting with your GPs, can you expand on training the GPs on how PATS works as a region?

Ms Hamerton: Generally, through the medical advisory committee. I sit on the medical advisory committee and if anything changes in PATS or anything that we want them to comply with or anything that we think the patients are missing out on because they have not actually done their bit, is generally managed through the medical advisory committee and most of the GPs in town attend that medical advisory committee and they get the minutes from it. I attended the Narrogin and the Merredin MAC.

Hon JACQUI BOYDELL: Do you find that you get a good response from GPs and communication is good?

Ms Hamerton: They still want the yellow form because they could see that the yellow form was the yellow form as an application form. This is a bit confusing because it is blue and white, so that came back to us. If they have any queries, it comes back through the MAC or from the eastern and southern ops managers because I hold the portfolio; I am the one point of contact, so it comes back to me.

Hon JACQUI BOYDELL: Can you stipulate the end of the trial period?

Ms Hamerton: It is 12 December.

Hon JACQUI BOYDELL: When you get to that point, given it is only Pilbara and wheatbelt at the moment, is the idea for all the WACHS regions to adopt that form? Do you think that will happen?

Ms Hamerton: Yes.

Hon JACQUI BOYDELL: Is that the response you are getting from the other WACHS regions to make the process easier?

Ms Hamerton: Yes. A PATS working party sits in conjunction with this that has representation on other regions. They met yesterday. We discussed the mid-point evaluations of the trial so far and nobody went, "Well, we won't be doing that." Yes, I think there is general acceptance and I think everyone recognises that this will—given it is not a fully electronic system; we are still using paper base in a shared data system—actually simplify their life. We have not really counted it all up. How many bits of the form were missing, what were the trends in the bits of the form that were missing, was something more commonly missed than others? That type of thing. We will make those adjustments on the form once the trial is finished. The idea was always to have the form fit

an electronic format so that that could transpose over fairly easily once they can afford to go to an electronic format.

The DEPUTY CHAIRMAN: It was good to talk with your staff today about the issues they are having with interfacing the forms with the system. That was most useful.

The next thing I want to talk to you about is the education and training provided to the PATS clerks when they commence in that role and I would like to know also what, if any, continuing education and support is provided to your PATS clerks on the front line?

Ms Hamerton: They have some mandatory training requirements. They have to do the PATS online training, ethical decision-making and record keeping as the first thing before they can get access to the shared system. Because of the complexity of the policy, central office has some training that is available. I could ring Tyana and say, "I've got three new PATS clerks, can you come up?" and offer them some training. That is generally only a one-off of four or five hours. Sometimes when you are new to a system, it is not really helpful to have a whole pile of stuff at one time. I have redesigned the little team I have to allow some hours for the team leader to come out of her job and do support teaching and answer common questions—that sort of stuff. But that is not within the funding. There is no actual dedicated funding for learning and development.

The DEPUTY CHAIRMAN: Do you pick that up out of your budget?

Ms Hamerton: Out of the operational budget.

The DEPUTY CHAIRMAN: The committee would like to know how people are made aware of their rights to appeal a decision that may not be favourable to them. How often are appeals received and, in general terms, please explain the sorts of decisions that have been appealed?

Ms Hamerton: In the PATS information brochures—the old ones and the new ones and on the website—there is information about the appeal and having your application reassessed and putting it through the exceptional ruling process. Most of our letters of decline are templated and changed to fit the particular circumstances, but there are certain sentences that stay within it, such as, "This service is not eligible under the policy; however, if there is exceptional circumstances that may be related to health disadvantage or financial disadvantage, you can have this form reassessed", and it tells you how to do that. That usually comes to me first and I then gather the information together around: What are the exceptional circumstances? Do we have any verification that those are true exceptional circumstances or true circumstances? What would be the cost impost of the particular thing of paying it or not paying it? Does it set a precedent in that, if you say yes to these particular people, are you going to have to say yes to 100 others and what is the cost impact of that? Then it goes to the RD for her consideration. She may send it back to me with more questions.

The DEPUTY CHAIRMAN: What level of frequency is that; do you get an appeal a day, a week or a month?

Ms Hamerton: No; I think this year we have had about four.

The DEPUTY CHAIRMAN: So they are relatively rare.

Ms Hamerton: Yes.

Hon JACQUI BOYDELL: Were they granted?

Ms Hamerton: Yes.

The DEPUTY CHAIRMAN: The four were reassessed and approved?

Ms Hamerton: Yes. Mostly it was around financial hardship. I recall one case where we paid the full PATS payment rather than the $20 a day for the 70 to 100 kilometre cancer treatments. It is that type of thing. Where they would not be eligible normally, we pay because of their financial difficulties.

The DEPUTY CHAIRMAN: Can you give us an idea of how many might have appealed and not been successful?

Ms Hamerton: It is rare here. Unless we are really setting a precedent of opening up a floodgate of applications because we allowed one through with no real backing, mostly they are approved.

The DEPUTY CHAIRMAN: It would be a fair statement to make that people who are declined for whatever reason, usually just cop it on the chin and do not come back for another go?

Ms Hamerton: Yes. People can be quite upset that they have been declined. For instance, we have been able to reduce our complaints from, I think, 21 in the 2012–13 years and there have been five this year. So, by streamlining our processes, better customer service and getting better information out there, we have been able to reduce the complaints about, "How dare you tell me who I can go to", and those sorts of things, because we have got better information out there through what we talked about before about closer medical specialty and all those sorts of things.

Hon AMBER-JADE SANDERSON: When we talked earlier, I think we spoke to some of the PATS clerks, Jenny mentioned that the separation of systems has led to greater efficiency of approvals and claims. Can you describe that process?

[1.10 pm]

Ms Hamerton: In the old system, somebody could put a claim in at Merredin, enter it into the system, approve it and send it for payment and it would be paid. The OAG report that came in May 2013 said no, it has to come from somewhere because they were worried about the conflict of interest in small towns. So we have set up processes so that very little of it is done on the sites and it all comes to a central office. That gives us less chance of having to say yes or no or approving or not approving an aunty or cousin or someone you know. That was one thing they were worried about. When it comes in, it is picked up generally in towns. The PATS clerks are responsible for a series of towns. They go into the basket of towns and pick up the application and then one lot of clerks puts it on data entry. It is approved for approval process by another processing clerk and then it goes to payments, which is finance, so that gives us three points of separation.

Hon JACQUI BOYDELL: I am not sure that this fits directly into our line of questions at the moment. A couple of reasons I was going to ask this question is the demographic of your patients and, I guess, the emotional and emotive social work care they have in how they engage with the health system generally. In other hearings we have heard a lot about patients having to travel to Perth with no experience, no family support, speaking English as a second language, and that sort of thing, and there has been a very glaring gap of, I guess, duty of care to the patient in terms of their emotive support and how they deal with the system. In other areas there are Aboriginal liaison officers who work specifically with Indigenous patients. In the wheatbelt area I think the administrative process of PATS there has a lot of focus on that but there is not a lot of focus on, and probably a lot of areas we have heard complaint about, the lack of compassion in the system and the lack of support to engage in the system. Do you have social workers in the hospital who work with patients who may not have family support or family support with friends when they get to the other end when they are visiting their specialist? Because the administrative process, as we all know when you are ill, is a very difficult thing to engage with and, in my opinion so far, that is probably where people are feeling they have a lack of support. Can you just expand on how you provide patients with either social work service at your end at referral at the other end where they are engaging with their specialist and how they get home, how they find their accommodation et cetera?

Ms Hamerton: I would have to agree with you. There is a lot of emotion attached to a lot of PATS claims because people are at a time when they are very vulnerable and the bureaucracy associated with PATS drives them mad, particularly in the wheatbelt where the actual amount of money they are claiming becomes, "How could you be arguing over $30", or something like that. It is a problem. The PATS clerks are very good at coming to me and going, "Look Bev, this is the

situation. This is the circumstance, is there anything we can do?" We will give the patient a call. As the girl said, there is constant calling back and forth. We have a social worker within the hospital we can call on. A lot of the Aboriginal people who live in Northam access the Aboriginal Medical Service here and they have an Aboriginal liaison officer and Aboriginal health workers, who are very good at helping them to get where they need to go. There has been some interaction, not frequently, but in cases of exceptional circumstance where people from either the GP network will come to me or people from the Aboriginal Medical Service will come to me and go "Bev, this is what I've got; what can we do to help?" There have been no occasions that I know of where that has not ended up in a good result in being able to supply accommodation for families and children while mothers go to town and that sort of thing. I think we have got a pretty good system.

When they are in town the social workers from the referring hospitals frequently ring us up to ask what they can do about this, about that, particularly in cases where the patient is very vulnerable. In terms of the decision-maker staying in town, if they are not able to make their own decisions—patients in ICU unable to make decisions about their treatment—it is about keeping their decision-maker and carer in accommodation that is close et cetera. There are occasions that are tricky, particularly if they have been discharged from a public hospital at six o'clock at night or 10 o'clock at night; getting home to Northam, getting home to Wyalkatchem is almost impossible. One man caught a taxi home from Northam that cost him $400, which he had to pay because he was taken out of Royal Perth Hospital. They just said "No more beds". That was picked up by the CEO and the Minister for Health and a memorandum went around after that particular instance to say, "You can't do this; you must find him accommodation overnight so that they can come home by public transport booked by the PATS officers the next day." It is tricky because, as I said earlier, no two days in PATS are the same; no two cases are the same. We try to deal with everyone's issues on the level that will give them the best outcomes for what we can do.

Hon JACQUI BOYDELL: Thank you.

The DEPUTY CHAIRMAN: The last questions I have are around funding and the budget allocations. I am quite happy to take this on notice if you do not have the figures at hand. I understand that. I am curious to know what your budget is for 2014–15 and for the last two financial years.

Ms Hamerton: I would not know that offhand exactly. I do know that in 2012–13, 17 000 applications were processed and in 2014–15 19 000 applications were processed, so it is trending upwards. As I said, the 2012–13 budget was marginally over in dollars and marginally over in FTE, and then the next financial year was online and slightly under with FTE.

The DEPUTY CHAIRMAN: So you are finding you are able to manage within the allocation?

Ms Hamerton: At the moment, yes we are.

The DEPUTY CHAIRMAN: Can I ask you on notice to provide us with 2014–15 budget and budget and actuals for 2013–14 and 2012–13? You touched on the other information that I would like, which is the number of patients you have seen in the 2012–13 and 2013–14 years.

[*Supplementary Information No 1B.*]

The DEPUTY CHAIRMAN: That has just about cleaned us out of questions. Is there anything else you would like to raise with us before we finish up today?

Ms Hamerton: No; the only thing we talked about before is that a fully electronic system that says, "You have not put in the name; cannot progress. You have not put in at clinical condition; cannot progress", or "You have put in a clinical condition for this speciality, it is not eligible", something that is smartly designed to not disappoint the patient. Often the patient goes through all this application process and goes to the GP and pays a fee and all that sort of stuff and we go, "No you'll not get anywhere with that because it is not an eligible service." If the doctor had an easy way of going, "Yes, that's eligible" or "No, that's not eligible", it would stop there and it would

allow the doctor the opportunity to go, "Well, this patient really needs this service, so I will put in some clinical data that will support that application going through another channel."

[1.20 pm]

The DEPUTY CHAIRMAN: I cannot help but deduce that the people who operate the PAT schemes all across the state might have had their heads together and had a discussion around this because we have found that it is a fairly commonly held view and I must say that committee members find it a little quirky that in 2014 we are carrying bits of paper around with us everywhere we go and being assessed after people have completed the paper. That is very useful information and thank you very much for giving your time to come and address the committee.

Ms Hamerton: The only other thing I have that is not really clear in the policy is private versus public patients. If your specialist is in Narrogin, for instance, and you get referred to the specialist in Narrogin, are you eligible for a PATS claim? That specialist might charge you private fees and you have got no way of saying, "Well, I want to go to the closest public specialist." You might get your $30 back from going to Narrogin for PATS but it has cost you $460 because you are a private patient and they do not cover the gap. It is a confounder for a lot of patients; there is no delineation in the program as to whether private or public is eligible.

The DEPUTY CHAIRMAN: To expand on that a little bit, if that was the case and you were referred to a specialist that visits Narrogin and they were a private practising specialist and you did not want to see a private practising specialist, so you chose to see another specialist, would that make you ineligible for PATS?

Ms Hamerton: It will make you ineligible for PATS. It is the closest medical specialist whether they are private or public. If you choose to go to a specialist that is public, you are not eligible for PATS because they are not the closest. It is very unclear in the policy as to the interpretation of that, but that is how it is described in the PATS user manual. You can choose to go to whatever specialist you want but you are not eligible for PATS if your closest one is a private provider.

Hon JACQUI BOYDELL: Do you think that will be an issue with the super clinic and your visiting specialists for patients here?

Ms Hamerton: It is an issue for us already.

Hon JACQUI BOYDELL: Regardless of PATS, obviously, because people live here, where they previously would have been eligible you will potentially now have a visiting private specialist?

Ms Hamerton: Yes. It is a PATS problem.

Hon JACQUI BOYDELL: Are you finding—going back to your demographic—that not many of your patients are covered by private health?

Ms Hamerton: In some towns a lot of patients are covered by private health insurance; in some towns, not many. I think Northam is one of the towns that has less private patient insurance than others. There are very few patients in Wyalkatchem, for instance. In Goomalling, almost 100 per cent of patients who access the hospital services are private. There is no line that you can draw in the sand to say that 50 per cent of all patients across the wheatbelt are private. Narrogin has a high level of private patients; Northam has a low level of private patients.

The DEPUTY CHAIRMAN: That is a new piece of information we were not aware of before. Thank you very much for raising it; that is excellent. Thank you again for your evidence and your cooperation with the committee today?

Ms Hamerton: Thank you, my pleasure.

Hearing concluded at 1.23 pm

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