THIRTY-NINTH PARLIAMENT

REPORT 25

STANDING COMMITTEE ON PUBLIC ADMINISTRATION

REPORT ON THE PATIENT ASSISTED TRAVEL SCHEME IN WESTERN AUSTRALIA

Presented by Hon Liz Behjat MLC (Chairman)

June 2015

STANDING COMMITTEE ON PUBLIC ADMINISTRATION

Date first appointed:

17 August 2005

Terms of Reference:

The following is an extract from Schedule 1 of the Legislative Council Standing Orders:

"**5. Public Administration Committee**

5.1 A Public Administration Committee is established.

5.2 The Committee consists of 5 Members.

5.3 The functions of the Committee are to –

(a) inquire and report on –

(i) the structure, efficiency and effectiveness of the system of public administration;

(ii) the extent to which the principles of procedural fairness are embodied in any practice or procedure applied in decision making;

(iii) the existence, adequacy, or availability, of merit and judicial review of administrative acts or decisions;

(iv) any Bill or other matter relating to the foregoing functions referred by the Council;

and

(b) consult regularly with the Parliamentary Commissioner for Administrative Investigations, the Public Sector Commissioner, the Information Commissioner, the Inspector of Custodial Services, and any similar officer.

5.4 The Committee is not to make inquiry with respect to –

(a) the constitution, functions or operations of the Executive Council;

(b) the Governor's Establishment;

(c) the constitution and administration of Parliament;

(d) the judiciary;

(e) a decision made by a person acting judicially;

(f) a decision made by a person to exercise, or not exercise, a power of arrest or detention; or

(g) the merits of a particular case or grievance that is not received as a petition."

Members as at the time of this inquiry:

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

Staff as at the time of this inquiry:

Felicity Mackie (Advisory Officer (Legal))
Tracey Sharpe (Committee Clerk)

Address:

Parliament House, Perth WA 6000, Telephone (08) 9222 7222
lcco@parliament.wa.gov.au
Website: http://www.parliament.wa.gov.au
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Government Response

This Report is subject to Standing Order 191(1):

> *Where a report recommends action by, or seeks a response from, the Government, the responsible Minister or Leader of the House shall provide its response to the Council within not more than 2 months or at the earliest opportunity after that time if the Council is adjourned or in recess.*

The two-month period commences on the date of tabling.

Abbreviations

AHLU	Aboriginal Hospital Liaison Unit
ALO	Aboriginal Liaison Officer
AMA	Australian Medical Association
CEO	Chief Executive Officer
CHC	Country Health Connection
Committee	Standing Committee on Public Administration
CRS	Central Referral Service
EFT	Electronic Funds Transfer
GP	General Practitioner
IPTAAS	Isolated Patients Travel and Accommodation Assistance Scheme
Nyoongar Patrol	Nyoongar Patrol Outreach Service
OAG	Western Australian Office of the Auditor General
PATS	Patient Assisted Travel Scheme
Rural Maternity Report	*The Rural Maternity Patient Journey, September 2013 Project Report*
Senate Report	Senate Standing Committee on Community Affairs report "*Highway to health: better access for rural, regional and remote patients*"
WACHS	Western Australian Country Health Service
Working Group	Western Australian Country Health Service PATS Working Group

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EXECUTIVE SUMMARY, FINDINGS AND RECOMMENDATIONS

EXECUTIVE SUMMARY

1 The Patient Assisted Travel Scheme (**PATS**) provides assistance in the form of travel and accommodation subsidies to patients for whom specialist medical care is not locally available.

2 The Commonwealth Government established the Isolated Patients Travel and Accommodation Assistance Scheme (**IPTAAS**) on 1 October 1978.

3 On 1 January 1987 the responsibility for IPTAAS transferred to the States and Territories with funding provided directly to the States and Territories through special revenue (financial) assistance grants.

4 At a regularly constituted meeting of the Standing Committee on Public Administration held on 26 February 2014, it was resolved to initiate an inquiry into the PATS in Western Australia. Submissions were called for and more than 100 were received from individuals, Government departments and agencies and Non-Government Organisations across the State.

5 The majority of the PATS is administered by the Western Australian Country Health Service (**WACHS**) and comprises seven regions, namely the Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern. The Committee travelled to each of these regions, taking evidence and visiting hospitals and PATS offices.

6 Many witnesses expressed their appreciation and gratitude for the assistance they receive through the PATS. It was acknowledged that the PATS is a fundamental instrument of government policy directed at ensuring that the general standard of health services in the regions, and access to those services, is comparable to that which applies in the metropolitan area.

7 However it was also clear from evidence received that improvements to the scheme are needed.

8 Many submissions identified problems with the PATS, and many witnesses provided examples of their personal experiences. The Committee has used the information provided in these submissions to highlight the areas where improvements can be made. It has also made recommendations which it considers will improve access to medical services for the many Western Australians living outside the Perth metropolitan area and large regional centres.

9 Of the number of recommendations made by the Committee in this report, the priorities for Government should be those recommendations that deal with subsidies for accommodation and fuel.

10 It is vital in any government program that reviews are carried out both regularly and consistently. This report makes reference in several sections to suggested time frames for specific reviews to be undertaken.

11 The Committee acknowledges and thanks the individuals, organisations and health care professionals who met with the Committee, particularly during its travel to regional areas. A list of submissions received and evidence given is provided at **Appendix 1.**

FINDINGS AND RECOMMENDATIONS

12 Findings and Recommendations are grouped as they appear in the text at the page number indicated:

Page 19

Finding 1: The Committee finds that the fuel subsidy provided by the Patient Assisted Travel Scheme is inadequate. Whilst the scheme was not designed to cover 100 per cent of out of pocket expenses, it does not reflect a realistic proportion of costs incurred by patients.

Page 20

Finding 2: The Committee finds that the fuel subsidy should be reviewed regularly, as announced in 2009 by the Health Minister and the then Regional Development Minister. It should be adjusted, if necessary, in line with inflation and fuel costs to ensure it continues to reflect a realistic proportion of costs incurred.

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Finding 3: The Committee finds that the fuel subsidy should be reviewed regularly, as announced in 2009 by the Health Minister and the then Regional Development Minister. It should be adjusted, if necessary, in line with inflation and fuel costs to ensure it continues to reflect a realistic proportion of costs incurred.

Page 20

Finding 4: The Committee finds that the accommodation subsidies provided by the Patient Assisted Travel Scheme are inadequate. Whilst the scheme was not designed to cover 100 per cent of out-of-pocket expenses it currently does not reflect a realistic proportion of costs incurred by patients. It should be increased.

Page 20

Finding 5: The Committee finds that the accommodation subsidies should be reviewed regularly and adjusted, if necessary, in line with inflation and rising accommodation costs to ensure they continue to reflect a realistic proportion of costs incurred by patients.

Page 20

Finding 6: The Committee finds that there is inadequate low cost accommodation available in the Perth metropolitan area for Patient Assisted Travel Scheme patients, making it difficult for them to find suitable accommodation which, in turn, leads to some of them experiencing homelessness near treatment centres. This short supply of suitable accommodation needs to be urgently addressed.

Page 20

Recommendation 1: The Committee recommends that the current fuel subsidy provided by the Patient Assisted Travel Scheme be increased to reflect a more realistic proportion of fuel costs incurred by patients.

Page 20

Recommendation 2: The Committee recommends that the fuel subsidy provided by the Patient Assisted Travel Scheme be reviewed annually.

Page 21

Recommendation 3: The Committee recommends that the accommodation subsidies provided by the Patient Assisted Travel Scheme be increased to ensure they reflect a realistic proportion of accommodation costs incurred by patients.

Page 21

Recommendation 4: The Committee recommends that the accommodation subsidies provided by the Patient Assisted Travel Scheme be reviewed annually.

Page 21

Recommendation 5: The Committee recommends that the Patient Assisted Travel Scheme be amended to include an annual escalation adjustment to subsidy rates to reflect changes to fuel and accommodation costs.

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Recommendation 8: The Committee recommends that the Patient Assisted Travel Scheme be amended to make allied health services eligible for Patient Assisted Travel Scheme funding where they are provided as an essential component of an integrated health care plan.

Page 33

Recommendation 9: The Committee recommends that the Patient Assisted Travel Scheme eligibility criteria be reviewed every two years to ensure that advances in medical technologies are taken into account for the purposes of Patient Assisted Travel Scheme eligibility.

Page 35

Finding 12: The Committee finds dental treatment is extremely important, especially for patients with chronic conditions and complex health care needs.

Page 35

Finding 13: The Committee finds that there is a lack of provision of dental services and oral medicine specialists throughout rural and remote Western Australia. This is of concern to the Committee.

Page 36

Finding 14: The Committee finds there is a lack of clarity about what dental treatments are eligible for Patient Assisted Travel Scheme funding at the administrative level; for example, the difference between oral and dental surgery.

Page 36

Recommendation 10: The Committee recommends that the Patient Assisted Travel Scheme be amended to expand the scope of dental services eligible for funding.

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Finding 15: The Committee finds that funding assistance for two weeks accommodation for women who live in remote areas with no birthing facilities is inadequate and contrary to the Western Australian Country Health Service stated policy.

Page 42

Finding 16: The Committee finds that it is important for women from remote locations who travel to their nearest birthing centre to deliver their baby to be accompanied by an appropriate escort if they choose.

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Recommendation 14: The Committee recommends that the Patient Assisted Travel Scheme be amended giving consideration to adhering to the provisions of the *National Healthcare Agreement 2012* with regard to the definition of regional Western Australia.

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Recommendation 15: The Committee recommends that the Patient Assisted Travel Scheme be amended to replace the requirement for 16 hours surface travel for eligibility for automatic air travel to bring it in line with current Western Australian Country Health Service policy.

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Finding 22: The Committee finds that the Patient Assisted Travel Scheme only provides subsidies to the nearest specialist, regardless of whether the specialist is public or private. This can cause a further financial burden to the patient if the specialist is a private practitioner.

Page 50

Recommendation 16: The Committee recommends that the first option for the Patient Assisted Travel Scheme should be to give patients access to the public health system even if that access is further away than the closest private specialist.

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Finding 23: The Committee finds that the policy with regard to patient escorts is well covered. On the basis of evidence heard, consistency around approvals and implementation of the policy could be improved.

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Finding 24: The Committee finds that the current system of regional coordination is working effectively.

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Finding 25: The Committee finds that given the expanding role of nurse practitioners, future consideration should be given to them being authorised to complete Patient Assisted Travel Scheme Application Forms.

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Finding 26: The Committee finds that this is inadequate notification of a core requirement for eligibility.

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Recommendation 17: The Committee recommends that the Patient Assisted Travel Scheme Application Form be amended to provide clear notification of the required time frame for lodgement.

Page 67

Finding 27: The Committee finds that implementing an electronic application system would assist in modernising the application process, support the utilisation of the already existing Share online data system and inevitably lead to greater efficiencies.

Page 67

Recommendation 18: The Committee recommends the implementation of an electronic Patient Assisted Travel Scheme application and claims form system to support the Share online data system.

Page 70

Finding 28: The Committee finds that medical professionals need to be fully aware of the Patient Assisted Travel Scheme eligibility criteria and what is required in addressing those criteria; for example, how to provide clear clinical rationales for modes of transport and eligibility for benefit.

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Finding 29: The Committee finds that there is a lack of understanding about the Patient Assisted Travel Scheme process in some areas of the medical profession. Better training for medical practitioners about the scheme, particularly for locum General Practitioners prior to visiting the regions, is essential.

Page 70

Finding 30: The Committee finds that there is a need for better training for medical professionals on how to complete Patient Assisted Travel Scheme applications forms on their patient's behalf to adequately substantiate the needs of that patient to the administrators of the scheme.

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Finding 31: The Committee finds that the Patient Assisted Travel Scheme Application Form makes no reference to an appeals process. Consequently a patient may not be aware that an appeal right exists when there is a dispute concerning the application of guidelines.

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Finding 32: The Committee finds that the appeal process must be transparent and consistent.

Page 72

Finding 33: The Committee finds that that the appeals process should be clearly set out on the Patient Assisted Travel Scheme Application Form.

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Recommendation 19: The Committee recommends that the appeals process be clearly defined on the Patient Assisted Travel Scheme Application Form.

Page 75

Finding 34: The Committee finds that Country Health Connection provides an invaluable service but budget constraints limit its capacity to service patients on weekends and after hours.

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Finding 35: The Committee finds that, for patients who are very sick or disabled or from remote regions of the State, public transport is often inappropriate. Greater use of taxi vouchers is an area that needs to be explored.

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Finding 36: The Committee finds that the Committee recognises that there is a lack of suitable, low cost hostel accommodation generally available in the Perth metropolitan area and some regional areas however the issue of behavioural evictions is a matter for further investigation.

Page 80

Finding 37: The Committee finds that there appears to be a lack of coordinated support for Aboriginal people coming to the Perth metropolitan area under the Patient Assisted Travel Scheme.

Page 88

Finding 38: The Committee finds that the exceptional circumstances process must be transparent and consistent.

Page 88

Recommendation 20: The Committee recommends that information regarding claiming for exceptional circumstances be clearly set out on the Patient Assisted Travel Scheme Application Form.

Page 92

Finding 39: The Committee finds that the current accommodation facilities suitable for Patient Assisted Travel Scheme patients in the metropolitan area are inadequate. As an example, the closure of Jewell House near Royal Perth Hospital and the opening of Fiona Stanley Hospital have brought increased pressure in the form of a lack of suitable accommodation.

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Recommendation 21: The Committee recommends that there needs to be further suitable accommodation facilities provided for Patient Assisted Travel Scheme patients.

CHAPTER 1

REFERENCE AND PROCEDURE

Inquiry pursuant to Standing Order 179

1.1 At a regularly constituted meeting of the Standing Committee on Public Administration (**Committee**) held on 26 February 2014, it was resolved to initiate an inquiry into the Patient Assisted Travel Scheme (**PATS**) in Western Australia with the following terms of reference:

The Committee is to inquire into and report on the Patient Assisted Travel Scheme in Western Australia, in particular:

1) how adequately PATS delivers assistance to regional people accessing specialist medical care, including:
    a. the level of funding applied to the transport and accommodation subsidies provided;
    b. eligibility for PATS funding;
    c. the administration process;
    d. whether there is consideration of exceptional circumstances; and
2) any incidental matter.

1.2 On 27 February 2014, the Committee notified the Legislative Council of the self-initiated inquiry pursuant to Standing Order 179(2). This was done by way of Report 19 of the Standing Committee, which is available on the Committee's website.

CHAPTER 2

THE PATIENT ASSISTED TRAVEL SCHEME

Introduction

2.1 The delivery of health services in country Western Australia is complex, due to the extensive geographical area and remoteness of services. According to the 2011 census, Western Australia has a population of 2.2 million, of which 22 per cent live outside the greater Perth area.

2.2 Western Australia's population is thus widespread and consists of many small communities. It is not always possible for people requiring access to specialist medical treatment to access it close to where they live.

2.3 The PATS provides assistance in the form of travel and accommodation subsidies to patients for whom specialist medical care is not locally available.

2.4 Funding for the PATS is provided as part of the annual budget process through the Department of Health's service appropriation. No funding limit is applied.

2.5 A breakdown of the annual budget allocations for the past six financial years and other financial and statistical data for the PATS is at **Appendix 2**.

2.6 The majority of the PATS is administered by the Western Australian Country Health Service (**WACHS**). The South Metropolitan Health Service supports PATS applications from the Peel region. The PATS in the South West health region has been outsourced to a private company.[1]

2.7 The administration of the PATS is decentralised, with offices in each region responsible for the operation of the scheme. This facilitates closer contact for country people seeking to access the PATS services.

2.8 The PATS provides a subsidy towards the cost of travel and accommodation for eligible permanent country residents, and their approved escorts, who are required to travel a long distance to access certain categories of specialist medical services.

2.9 It is an intrastate scheme, however assistance is provided for travel to another state if the referral is to the nearest specialist and all other PATS criteria are met. This primarily affects localities in the Kimberley and Goldfields where the closest specialist may be in Darwin, Alice Springs or Adelaide.

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[1] At the time of tabling this report, this contract was held by Medibank Health Solutions Pty Ltd.

2.10 Financial assistance is provided to eligible patients who need to travel more than 100 kilometres to access the nearest eligible medical specialist service (including a Telehealth service[2]). Under the scheme, closest medical specialist services include telehealth services, hospital employed specialists, visiting medical specialists to the region and GP (**General Practitioner**) Proceduralists, doctors who provide procedural services such as obstetric and surgical services in hospitals and emergency rooms.[3]

2.11 Country patients needing to travel more than 70 kilometres to access specialist medical treatment for cancer or dialysis, where the health service is unable to provide a transport service, are also eligible for some assistance.

2.12 The PATS provides a subsidy to eligible patients; it does not cover all costs associated with travel and accommodation. It provides assistance for a single trip to a treatment centre (the city or town in which the applicant visits an eligible medical specialist or accesses an eligible specialist service) for a period of not greater than six months.

2.13 There are some special circumstances relating to eligibility for the PATS that are dealt with later in this report.

History

2.14 The Commonwealth Government established the Isolated Patients Travel and Accommodation Assistance Scheme (**IPTAAS**) on 1 October 1978. The scheme provided financial assistance to persons living in rural and remote areas who had to travel long distances (more than 200 kilometres) to obtain specialist medical treatment and oral surgery.[4]

2.15 On 1 January 1987, the responsibility for IPTAAS transferred to the States and Territories with funding provided directly to the States and Territories through special revenue (financial) assistance grants.[5]

2.16 In 1999, that direct funding assistance was abolished in favour of the States and Territories agreeing to a revenue flow from the goods and services tax.[6]

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2 Telehealth provides financial incentives to eligible health professionals and aged care services that help patients have a video consultation with a specialist, consultant physician or consultant psychiatrist. A range of health professionals can participate in telehealth, including specialists, consultant physicians and psychiatrists, medical practitioners, nurse practitioners, midwives, practice nurses and Aboriginal health workers. Telehealth is available to residential aged care services that provide care and accommodation to residents under the *Aged Care Act 1997* and hold a residential aged care service (RACS) ID. (http://www.medicareaustralia.gov.au/provider/incentives/telehealth/, accessed 23 March 2015.)

3 http://www.wacountry.health.wa.gov.au/index.php?id=628, accessed 23 March 2015.

4 Senate Standing Committee on Community Affairs Report: *Highway to health: better access for rural, regional and remote patients*, September 2007, p4.

5 Id.

6 Ibid, p5.

2.17 In 2007, the Commonwealth Senate established an inquiry into the operation and effectiveness of Patient Assisted Travel Schemes across the country. The Senate Standing Committee on Community Affairs made 16 recommendations in its report, "*Highway to health: better access for rural, regional and remote patients*" (**Senate Report**). The link to the Senate Report is at http://www.aph.gov.au/~/media/wopapub/senate/committee/clac_ctte/completed_inquiries/2004_07/pats/report/report_pdf.ashx

2.18 The Commonwealth Government provided its response to the Senate Report in February 2010. The link to the Commonwealth Government's response to the Senate Report is at http://www.aph.gov.au/~/media/wopapub/senate/committee/clac_ctte/completed_inquiries/2004_07/pats/govt_response_pdf.ashx

2.19 Changes to the PATS were implemented by the State Government in Western Australia in 2009, partly as a response to the recommendations in the Senate Report. These included:

- The fuel subsidy increasing by up to three cents to 16 cents per kilometre;
- The accommodation subsidy increasing from $35 per night to $60 per night for patients travelling alone and $75 per night for patients travelling with an approved escort and $20 per night for private accommodation;
- The removal of the patient contribution requirement;[7]
- Residents of York and Northam becoming able to access the full benefits of the scheme;
- Expanded eligibility for approval for an escort to travel with aged and disabled patients and those undergoing cancer treatment;
- Making cancer patients needing to travel more than four hours by road one way to access specialist treatment eligible for air travel subsidies;[8]
- Making cancer patients eligible for an accommodation subsidy for a recovery night following treatment; and
- The carer/escort accommodation subsidy being continued for the period that a cancer patient is hospitalised away from home.

[7] Prior to the 2009 changes, eligible patients not covered by a concession card were required to contribute up to $200 per year per family towards their trips. They were not eligible for an accommodation subsidy for the first three nights of the first four trips per 12 month period.

[8] Prior to the 2009 changes, cancer patients had to travel more than 16 hours by road before they were eligible for air travel subsidies.

2.20 Royalties for Regions funding for the PATS commenced in 2008/09 as part of a program which involves the redirection of Government spending from the major population centres, particularly Perth, into the rural areas of the State. A total of $30.8 million was allocated between 2008 and 2012 to meet the projected increases associated with the policy reforms. Royalties for Regions supplementary funding of approximately $10 million per annum is currently approved through to 2014/15.[9]

2.21 As a result of the changes to eligibility criteria and subsidy rates, demand for the PATS services has grown rapidly. The number of subsidised trips has increased 72 per cent since 2009, from 53,000 trips to approximately 90,000 trips in 2013/14, with subsidies increasing by 71 per cent from $18.6 million to $31.9 million in 2013/14.[10]

Western Australian Country Health Service

2.22 WACHS is a Government statutory authority under the *Hospital and Health Services Act 1927.*

2.23 WACHS comprises seven regions which are supported by a central office in Perth. A map showing the seven WACHS regions and detailed information about them is set out in **Appendix 3.**

2.24 WACHS is the biggest country health service in Australia, covering an area of nearly 2.5 million square kilometres and delivering comprehensive health services to around half a million people.[11]

2.25 WACHS employs approximately 9,000 staff in its range of acute and community health services. Across its 70 rural and remote hospitals, WACHS handles almost as many emergencies as the metropolitan hospitals combined and almost as many births as the State's major maternity hospital.[12]

2.26 Overall, there are 124 staff (approximately 36 full time equivalent positions) associated with supporting the PATS. The estimated direct operational cost for the PATS is $3.5 million (including South West contract costs but excluding overheads and accounting costs).[13]

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9 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, p2.

10 Ibid, p3.

11 Western Australian Country Health Service, Annual Report 2012/13, p4, http://www.health.wa.gov.au/publications/annual_reports_2013_WACHS.pdf, accessed 23 March 2015.

12 Ibid.

13 Briefing Note tabled by the Western Australian Country Health Service at a public Committee hearing on 15 September 2014, p5.

Access to Services

2.27 Evidence received during the inquiry demonstrates that access to health services is a significant issue for people living in rural and remote Western Australia. Many smaller hospitals are not equipped to provide a full range of specialised services and people must often be transferred to Perth.

Referral Process

2.28 An applicant is to be referred to the nearest eligible specialist medical service by a referring practitioner who is to sign the appropriate section of the PATS Application Form.

2.29 If the referring medical practitioner considers that there is a valid clinical reason for referral to other than the nearest medical specialist, sufficient clinical detail is to be provided on the PATS Application Form to enable consideration to be given to this request.

Eligibility Criteria for Patients

Residency

2.30 An applicant must be a permanent resident of a WACHS region and eligible for Medicare to qualify for the PATS assistance.

2.31 Permanent residents of a WACHS region who are temporarily away from home, but still within a WACHS region of Western Australia, and require access to eligible specialist medical services are eligible to receive the PATS assistance. The minimum distance travelled criteria of 100 kilometres applies.

2.32 Fly in/fly out workers are not eligible for the PATS unless their permanent place of residence is in a WACHS region. Fly in/fly out workers who live in Perth are ineligible for the PATS.

Minimum distance

2.33 To be eligible for the PATS assistance, an applicant must need to travel more than 100 kilometres one way to access the nearest medical eligible specialist service.

2.34 The distance is calculated by:

- the kilometres from the home town General Post Office to the treatment centre (when a person resides within a town's boundaries); or
- the distance from the applicant's residence to the treatment centre (if a person resides outside a town's recognised boundaries).

2.35 Applicants residing within the town boundaries of Northam and York meet the distance requirement and are eligible for PATS assistance.

2.36 An applicant who is required to travel to access the nearest eligible medical specialist treatment for cancer or dialysis treatment and who needs to travel between 70 and 100 kilometres may be eligible for limited PATS assistance.[14]

Nearest eligible medical specialist service

2.37 Referral is to be to the nearest available eligible medical specialist service which can provide the treatment required, within the time frame deemed necessary by the referring practitioner, based on the urgency of the applicant's medical condition.

2.38 An applicant can choose to attend any eligible medical specialist service, but PATS assistance is only provided for the nearest eligible medical specialist service.

2.39 If an applicant has been visiting a particular eligible medical specialist service and subsequently an eligible medical specialist service is established closer to their home, the applicant will not be eligible for PATS to continue visiting their usual specialist, unless there are clinical reasons to do so.

Eligibility Criteria for Accommodation

2.40 An applicant is eligible for accommodation assistance only if their residence is more than 100 kilometres from the treatment centre and:

- the medical specialist certifies that the person needs to stay overnight for follow-up;
- the person is required to attend associated allied health specialist appointments, in which case they may extend their stay by one or two days; or
- the forward and return journeys cannot reasonably be completed in one day due to factors such as travelling time required, the type of travel, transport schedules and availability or the applicant's medical condition.

2.41 The accommodation subsidy is only payable for six consecutive months.

Eligibility Criteria for Patient Escorts

2.42 An applicant is eligible for an escort where:[15]

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14 "Limited PATS assistance" means where the patient receives a standard subsidy of $20 per return trip, irrespective of the mode of travel, the need for an escort or accommodation: Patient Assisted Travel Scheme Policy, 15 September 2009, p8.

15 Patient Assisted Travel Scheme Policy, 15 September 2009, p4.

- the applicant being escorted is a dependent child;
- Centrelink has determined that the applicant is under the care of a principal carer;
- home dialysis patients are receiving training (a carer is required to attend as a condition of the medical specialist treatment);
- the patient's escort is legally required to make decisions on behalf of the applicant; and/or
- the referring practitioner, prior to departure, specifies on the PATS Application Form the reason why a patient escort is essential based on their assessment that the applicant would be unable to manage their treatment alone, particularly if the applicant is undergoing treatment for cancer or is disabled or frail.

2.43 When an approved escort travels with the applicant, the escort is eligible to receive a travel subsidy equivalent to the applicant they are escorting for assistance with surface travel or airfare.

2.44 The accommodation subsidies for patient escorts are $20 per night for private home accommodation and up to $75 per night for commercial accommodation for an eligible applicant travelling with an approved patient escort. If the applicant is hospitalised, the subsidy for the patient escort is up to $60 per night for the nights the applicant is hospitalised.

Administration

2.45 Although the administration of the PATS is decentralised, the Kimberley, Pilbara and Wheatbelt regions have each moved to a more centralised model. In those regions, enquiries and PATS applications are received at each health site and claim approvals and processing is handled at the regional office. In the Goldfields, Great Southern and Midwest regions, the PATS claims are handled and processed at each site.

Transport

2.46 Travel must be undertaken on the most economical form of transport appropriate to the patient's medical condition as recommended by their doctor.

2.47 Road travel assistance may be provided under certain conditions.

2.48 People living in the Pilbara, Kimberley and some other remote areas are eligible for air travel if travel to the nearest specialist involves surface travel of more than 16 hours (one way) or is subject to excessive connection delays and prolonged stops.[16]

2.49 Applicants who are travelling for cancer treatment and who have to travel by road for more than 350 kilometres from their place of residence (if outside a town's recognised boundaries) or from their home town to the treatment centre are eligible for commercial air travel.[17]

2.50 Where the referring medical practitioner certifies on the PATS Application Form the existence of a specific clinical risk that will cause an adverse clinical outcome for the applicant if they travel by surface (road, train or bus), air travel may be approved for journeys of less than 16 hours equivalent surface travel.

2.51 Taxi vouchers are not routinely provided but will be considered in limited and exceptional circumstances.[18] Entitlement to taxi vouchers requires the referring medical practitioner to certify on the PATS Application Form that the patient's medical condition warrants the provision of taxi vouchers and provide clinical details to support the application. Reimbursement for the use of taxi travel must be approved by the local PATS office prior to departure.[19]

Comparison with Patient Assisted Travel Schemes in other Australian Jurisdictions

2.52 Each Australian jurisdiction has different subsidy levels and eligibility requirements for access to travel assistance. Examples of these schemes in other Australian States are summarised in the table in **Appendix 4**.[20]

16 http://www.wacountry.health.wa.gov.au/index.php?id=628, accessed 23 March 2015.

17 Id.

18 Id.

19 PATS Specialist Certification Form, Section B, Part 5 - "Instructions to Patient", instruction number 4.

20 Submission No 125 from the Department of Health, 19 May 2014, p17.

CHAPTER 3

THE LEVEL OF FUNDING APPLIED TO THE TRANSPORT AND ACCOMMODATION SUBSIDIES PROVIDED

3.1 The PATS is a subsidy scheme that is intended to provide assistance towards an individual's travel expenses. It is not intended to cover the full cost of the travel and/or accommodation. This was acknowledged in evidence provided to the Committee.

3.2 The current PATS subsidy rates are set out in paragraphs 3.6 and 3.12 of this report. They have remained fixed since they were last reviewed and increased in 2009.

Evidence from the Patient Assisted Travel Scheme Users

3.3 Based on the evidence to the Committee, the current fuel and accommodation subsidies provided by the PATS are insufficient and do not reflect a reasonable proportion of actual costs.[21] Evidence suggests that the subsidies put country people at a significant financial disadvantage in accessing medical care compared to those in the metropolitan area or large regional centres. In some cases, it becomes a matter of equity of access to medical treatment.

3.4 The Committee was provided with many cases where the out-of-pocket costs incurred by patients were significant.[22] Many submissions expressed the view that the current subsidies for fuel and accommodation should be increased.[23]

3.5 The Committee received evidence that some people who are eligible to make a claim choose not to as the payment would be so small that it would not be worthwhile.[24]

Fuel Subsidy

Western Australian PATS policy

3.6 The fuel subsidy in Western Australia under the current PATS policy is:[25]

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21 For example, submission No 5 from Ms Josephine Bedetti, 6 March 2014, p2.

22 For example, submission No 104 from Mr Vince Catania MLA, 16 May 2014, p3 and submission No 108 from Ms Alison Emin, 16 May 2014, p1.

23 For example, submission No 12 from Ms Denise Barber, 15 March 2014, p3.

24 For example, submission No 40 from Mr John and Mrs Pat McDougall, 26 April 2014, p1 and submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, p3.

25 Patient Assisted Travel Scheme Policy, 15 September 2009, p15.

- An applicant travelling by private vehicle may claim a fuel subsidy of 16 cents per kilometre. Only one claim per vehicle may be made.

- When two or more applicants are travelling in a minibus, or similar group transport vehicle, owned by a community or organisation, the fuel subsidy is 25 cents per kilometre per vehicle, payable to the relevant organisation.

Evidence

3.7 Many submissions noted that the fuel subsidy has not kept pace with current motor vehicle running costs and the cost of fuel, especially in regional and remote areas.[26] The Cancer Council Western Australia stated that "*Despite the fact that PATS are designed as a subsidy and not a full reimbursement, 16 cents is seen as grossly inadequate given the cost of fuel and the fact the patient is using their own vehicle.*"[27]

3.8 The Australian Taxation Office website indicates that the rates per business kilometre in 2013 used for claiming vehicle expenses ranged from 63 cents per kilometre for cars with an engine capacity of 1.6 litres to 75 cents per kilometre for cars with an engine capacity of 2.601 litres and above.[28]

3.9 Several submissions referred to these guidelines and suggested these were more reasonable rates than the current PATS subsidy.[29]

3.10 In announcing changes to the PATS in 2009, the Health Minister and the Regional Development Minister announced that "*the fuel subsidy will be reviewed on a six-monthly basis to reflect changes in fuel prices.*"[30]

3.11 The Committee queried with WACHS whether these reviews had been undertaken.[31]

> ***The CHAIRMAN****: One thing that I think would apply into the south west is that in a joint media statement announcing changes to PATS in 2009, the health minister and the then regional development minister stated that "the fuel subsidy will be reviewed on a six-monthly basis to reflect changes in fuel prices". Have those reviews*

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26 For example, submission No 113 from the Parliamentary National Party of Australia (WA), 16 May 2014, p7.

27 Submission No 76 from the Cancer Council Western Australia, 14 May 2014, p3.

28 https://www.ato.gov.au/Individuals/Tax-Return/2013/Tax-return/Deduction-questions-D1-D10/D1---Work-related-car-expenses/, accessed 23 March 2015.

29 For example, submission No 76 from the Cancer Council Western Australia, 14 May 2014, p3 and submission No 86 from Kidney Health Australia, 15 May 2014, p4.

30 Hon Kim Hames MLA, Health Minister and Hon Brendon Grylls MLA, Regional Development Minister, Media Statement, 15 January 2009, p1.

31 Mrs Tina Chinery, Chief Operations Officer, Southern, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p14.

been occurring, and what has been the outcome of those reviews; or, if they have not been occurring, why is that?

***Mrs Chinery**: They have not been occurring, to my knowledge, and I probably cannot give any further information to that. I suppose that part of having a centralised system is making sure that we do review and update that. But we actually do not have a mechanism currently in place to do that.*

***Hon LIZ BEHJAT**: That statement was made in 2009, and it is now 2014. So there have been no reviews carried out over that period of time—in that five years?*

***Mrs Chinery**: Correct.*

Accommodation Subsidy

Western Australian PATS policy

3.12 Accommodation subsidies are available for people who live at least 100 kilometres from the treatment centre and are required to stay overnight for medical reasons, distance or transport schedules. The subsidy limits are:

- Private home accommodation: $20 per night for an eligible applicant or $40 per night for an applicant travelling with an approved patient escort.
- Commercial accommodation [taxation receipts are required]: up to $60 per night for an eligible applicant or up to $75 per night for an eligible applicant travelling with an approved patient escort.

3.13 According to the *Deloitte Access Economics Tourism and Hotel Market Outlook 2014*, the average price per hotel room in Perth per night is $200.[32]

3.14 As can be seen, the PATS accommodation subsidy now covers less than one third of the average price per hotel room per night in Perth. It is not reflective of current market conditions.

3.15 The Committee acknowledges that not all PATS patients travel to Perth, however a detailed analysis of accommodation costs in major regional centres was not undertaken.

[32] http://www.deloitteaccesseconomics.com.au/uploads/File/Deloitte%20Access%20Economics%20Tourism%20&%20Hotel%20Outlook%20February%202014.pdf, accessed on 25 March 2015.

Evidence

3.16 Evidence received by the Committee indicated that expenses continue to increase and that many people believe that commercial accommodation is often out of their reach.[33]

3.17 The WACHS website, which is the central point for PATS information, provides a list of "*reasonably priced accommodation near the Perth metropolitan hospitals*"[34] for the benefit of country patients travelling to Perth for medical treatment. The point was made in several submissions that much of this accommodation, being backpackers and hostel type accommodation, is inappropriate for ill patients requiring specialist care.[35]

3.18 Evidence received suggests that low cost accommodation options are few, with limited availability and lacking purpose-built facilities.

3.19 The Cancer Council Western Australia advised that its nightly accommodation rates mirror the current PATS reimbursement regardless of the cost of delivering the service. However it submitted that "*unless the subsidy is raised regularly, we will need to allocate an increasing proportion of our community donations to ensure the continuity of our much needed accommodation service.*"[36]

3.20 The Disability Services Commission submitted that the PATS subsidy only covers basic accommodation which is very unlikely to be wheelchair accessible, contain facilities for food preparation (important for those with special dietary requirements and feeding procedures) or contain bathrooms with facilities for the disabled.[37]

3.21 Evidence from Carers WA was that the PATS funding for carers is insufficient, especially as carers are significantly over-represented among low income households and are therefore in a vulnerable position.[38]

3.22 Of great concern to the Committee is the evidence it received of people who cannot afford accommodation sleeping rough while they are in Perth seeking medical treatment.[39]

3.23 The Committee received evidence, in relation to Aboriginal patients, that:[40]

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33 For example, submission No 76 from the Cancer Council Western Australia, 14 May 2014, p2.

34 http://www.wacountry.health.wa.gov.au/index.php?id=630#c1136, accessed on 23 March 2015.

35 For example, submission No 113 from the Parliamentary National Party of Australia (WA), 16 May 2014, p6.

36 Submission No 76 from the Cancer Council Western Australia, 14 May 2014, p3.

37 Submission No 67 from the Disability Services Commission, 12 May 2014, p1.

38 Submission No 101 from Carers WA, 16 May 2014, pp2-3.

39 For example, submission No 104 from Mr Vince Catania MLA, 16 May 2014, p3.

40 Submission No 63 from the Western Australia Rheumatic Heart Disease Register and Control Program, Western Australian Country Health Service, Department of Health, 8 May 2014, p2.

> *Affordable and culturally appropriate accommodation is both limited and often some distance away. This in turn leads to difficulties for the group getting back to the community and can result in homelessness in Perth.*

3.24 Also:[41]

> *groups of people, mainly of Aboriginal descent are left homeless in areas surrounding treatment centres because of lack of accommodation services, lack of funds to secure accommodation, the inability for the family to stay with the patient, and the cost of getting the patient to the city for said treatment.*

3.25 Another concern raised was the impost on frequent users of accommodation facilities. The Ethnic Disability Advocacy Centre submitted that the PATS should be funded at a level that has regard to a safety net for frequent users of specialist services.[42] Another submission suggested there is a need for a two-tier subsidy system where those with severe disabilities or special needs have access to an increased subsidy to help them pay for accommodation more suitable to their needs, while those with simple travel needs receive a lower subsidy.[43]

Evidence from the Department of Health

3.26 The Department of Health submitted to the Committee that "*it is timely that rates are reviewed to reflect the higher costs of travel and accommodation.*"[44]

3.27 The current subsidy structure contains both capped rates for fuel and accommodation and uncapped rates for surface and air travel. The capped rates do not take into account the different travel-related costs experienced across the State.

3.28 The Department of Health acknowledged this and submitted that this:[45]

> *can disadvantage some country residents, particularly those accessing regional services where accommodation costs can be much higher. An alternative subsidy structure based on fixed surface travel, air travel for each location and regional accommodation rates is considered to be more equitable.*

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41 Submission No 86 from Kidney Health Australia, 15 May 2014, p6.

42 Submission No 109 from the Ethnic Disability Advocacy Centre, 16 May 2014, p4.

43 Submission No 116 from Mr Tony Mills, 16 May 2014, p2.

44 Submission No 125 from the Department of Health, 19 May 2014, p5.

45 Ibid, p3.

3.29 The Department of Health proposed alternative subsidy structures for travel and accommodation and also provided a number of rate adjustment scenarios and associated budget impacts in the event that the existing subsidy structures are retained. These alternatives are discussed under the next heading.

3.30 The Department of Health submitted that:[46]

> *Whichever subsidy model is adopted in the future, policy provision should include an annual escalation adjustment to subsidy rates to maintain parity with rising travel and accommodation rates and affordability by country residents.*

3.31 In answer to a question about indexing payments, the WACHS Chief Executive Officer (**CEO**) submitted that "*I guess we would just expect indexation alongside the normal health indexation formula.*"[47] He stated that "*…it is like medical service index terms, so it is slightly higher than CPI generally – not always, but generally. It tends to accommodate a level of demand growth as well and it does vary from time to time as demand in the system varies.*"[48] He advised that "*It is generally an agreed rate specifically between us* [WACHS] *and Treasury. That does vary a bit over time, but it is intended to reflect demand, if you like, in the system.*"[49]

Alternative Travel Subsidy Structure Proposed by the Department of Health

3.32 The Department of Health submitted that:[50]

> *A more equitable subsidy structure may be to set fixed rates per country location, one covering all surface travel based on the average cost of travel and a fixed rate for air travel (where applicable) based on 90% of the average economy commercial airfare inclusive of an incidentals allowance for the location. Adopting fixed rates makes the subsidy rates a resident will receive more transparent to plan their travel arrangements and will simplify claim processing.*

3.33 The Department of Health provided an illustration of how the subsidy currently operates and how it would operate under its proposed changes, using travel from Kalgoorlie to Perth as an example:

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46 Submission No 125 from the Department of Health, 19 May 2014, p5.

47 Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p6.

48 Id.

49 Id.

50 Submission No 125 from the Department of Health, 19 May 2014, p6.

3.33.1 Using the current subsidy rate, a patient travelling from Kalgoorlie to Perth via car receives $191 based on a return travel distance of 1,194 kilometres. In comparison, a resident travelling by train would receive approximately $220 (return train fare of $170 plus $50 in incidental costs) or, if they were eligible for air travel, would have all costs fully covered at approximately $600 including incidentals.

3.33.2 The Department of Health's proposed alternative travel subsidy structure would result in the fixed surface travel rate of $205 for Kalgoorlie to Perth and return and a fixed airfare subsidy of $540.

Subsidy Escalation

3.34 WACHS provided the Committee with a number of rate adjustment scenarios and associated budgeted impacts in the event that the existing subsidy structure is retained. That information is contained in the tables below.[51]

Table 1: Fuel Subsidy Adjustment of Cents per Kilometre Rate

Scenarios	Cents per kilometre	Estimated Annual Cost	Additional Budget Requirement
Current Rate	16	$7,135,699	$0
Adjusted for CPI	18	$8,027,661	$891,962
Match QLD Rate	30	$13,379,436	$6,243,737
ATO Rates	63-75	$30,772,702	$23,637,003

Note: Consumer Price Index adjustment based on WA Treasury Published CPI rates for 2009 to 2013 Q3.

Table 2: Accommodation Subsidy Adjustment

Scenarios	Subsidy per night	Estimated Annual Cost	Additional Budget Requirement
Current subsidy	Commercial $60 single ($75 w/-patient escort) – Private $20 per night	$8,490,822	$0
Adjusted for	Commercial $69 single	$9,535,193	$1,044,371

[51] Ibid, p5.

CPI	($85 w/- patient escort) – Private $23 per night		
50% of the average WA hotel room rate	$100 per night/$25 private	$14,094,764	$5,603,942

Note: Average WA Hotel Rate - $200 per night 'Deloitte Tourism & Hotel Market Outlook July 2013'

Alternative Accommodation Subsidy Structure Proposed by the Department of Health

3.35 In its submission the Department of Health noted that there are a number of organisations and facilities in the metropolitan area that offer PATS patients budget accommodation at or close to the current $60 per night rate.[52]

3.36 However, it noted that accommodation in regional areas is generally only available from commercial providers and the rates are well above the PATS subsidy rate. It submitted that this is inequitable for those residents who are required to travel to a regional centre to access the closest specialist service, particularly maternity patients who may need to relocate to the nearest birthing centre for up to three weeks before giving birth.[53]

3.37 It submitted to the Committee that establishing different accommodation rates for each regional area based on the local market rates would be more equitable.[54]

Patient Discretion for use of the Patient Assisted Travel Scheme Funds

3.38 The WACHS Goldfields Regional Director noted that:[55]

> *It is quite tricky trying to provide supports—one system for everybody. I wonder if people who are going to Perth, if we just gave them this amount of money rather than us making flights or train bookings or cars—I think that could be considered: "If you're going to Perth, this is what you get. Bring us back the blue form and then you make your own arrangements." I wonder if that would not be worth considering.*

52 Ibid, p6.

53 Id.

54 Id.

55 Ms Geraldine Ennis, Regional Director, Goldfields, Western Australian Country Health Service, *Transcript of Evidence*, 26 August 2014, p15.

Committee comment

3.39 The Committee's impression from the evidence received is that there are very few facilities in the metropolitan area that offer the PATS patients accommodation at or close to $60 per night. The Committee received many submissions indicating that the accommodation subsidy does not come close to meeting accommodation costs in Perth.

Department of Health Submission regarding Affordable and Supported Accommodation in the Metropolitan Area

3.40 The Department of Health submitted that access to affordable patient accommodation in the metropolitan area that also offers value add services such as arranging local transport, providing low cost meals and assistance with appointment bookings is key to achieving equitable access for country people, particularly for people and families who may be more vulnerable, such as Aboriginal families.[56]

3.41 It was submitted that low cost, short-term accommodation options in Perth for country patients and their carers can be limited.[57]

3.42 WACHS advised that it has reviewed the demand for patient accommodation in light of health service reconfiguration changes in the metropolitan area. It submitted that the relocation of certain specialist services to Fiona Stanley Hospital will shift demand for accommodation to the Murdoch area.

3.43 The Department of Health advised the Committee that WACHS has begun investigating other options for identifying low cost accommodation that are suitably positioned and fit for purpose. It advised the Committee that negotiations are progressing with interested providers.[58]

Committee findings – fuel subsidy

Finding 1: The Committee finds that the fuel subsidy provided by the Patient Assisted Travel Scheme is inadequate. Whilst the scheme was not designed to cover 100 per cent of out of pocket expenses, it does not reflect a realistic proportion of costs incurred by patients.

56 Submission No 125 from the Department of Health, 19 May 2014, p6.

57 Ibid, p7.

58 Id.

Finding 2: The Committee finds that the fuel subsidy should be reviewed regularly, as announced in 2009 by the Health Minister and the then Regional Development Minister. It should be adjusted, if necessary, in line with inflation and fuel costs to ensure it continues to reflect a realistic proportion of costs incurred.

Finding 3: The Committee finds that the fuel subsidy should be reviewed regularly, as announced in 2009 by the Health Minister and the then Regional Development Minister. It should be adjusted, if necessary, in line with inflation and fuel costs to ensure it continues to reflect a realistic proportion of costs incurred.

Committee findings – accommodation subsidies

Finding 4: The Committee finds that the accommodation subsidies provided by the Patient Assisted Travel Scheme are inadequate. Whilst the scheme was not designed to cover 100 per cent of out-of-pocket expenses it currently does not reflect a realistic proportion of costs incurred by patients. It should be increased.

Finding 5: The Committee finds that the accommodation subsidies should be reviewed regularly and adjusted, if necessary, in line with inflation and rising accommodation costs to ensure they continue to reflect a realistic proportion of costs incurred by patients.

Finding 6: The Committee finds that there is inadequate low cost accommodation available in the Perth metropolitan area for Patient Assisted Travel Scheme patients, making it difficult for them to find suitable accommodation which, in turn, leads to some of them experiencing homelessness near treatment centres. This short supply of suitable accommodation needs to be urgently addressed.

Recommendation 1: The Committee recommends that the current fuel subsidy provided by the Patient Assisted Travel Scheme be increased to reflect a more realistic proportion of fuel costs incurred by patients.

Recommendation 2: The Committee recommends that the fuel subsidy provided by the Patient Assisted Travel Scheme be reviewed annually.

Recommendation 3: The Committee recommends that the accommodation subsidies provided by the Patient Assisted Travel Scheme be increased to ensure they reflect a realistic proportion of accommodation costs incurred by patients.

Recommendation 4: The Committee recommends that the accommodation subsidies provided by the Patient Assisted Travel Scheme be reviewed annually.

Recommendation 5: The Committee recommends that the Patient Assisted Travel Scheme be amended to include an annual escalation adjustment to subsidy rates to reflect changes to fuel and accommodation costs.

CHAPTER 4

ELIGIBILITY FOR PATIENT ASSISTED TRAVEL SCHEME FUNDING

Introduction

4.1 Evidence gathered by the Committee during its inquiry indicates that, for many people, the current eligibility criteria present barriers to accessing the PATS funding.

4.2 Concerns raised by witnesses in relation to eligibility included:

- access to allied health and dental services;
- maternity, newborn and post-natal care; and
- detoxification and rehabilitation services.

4.3 In its submission, the Department of Health acknowledged that: [59]

> *broad coverage and scope of PATS eligibility criteria is subjective and is complex to administer. The scheme can be confusing for applicants, leading to complaints or requests for exceptional rulings. Clearer definition of eligible services and policy elements will reduce subjectivity and simplify administration process.*

4.4 The Department of Health accepted that "*Some policy parameters are also not aligned to current clinical practices or provide flexibility to consider family, psychological or other social determinants.*"[60]

4.5 The point was made that: [61]

> *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.*

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59 Submission No 125 from the Department of Health, 19 May 2014, pp2-3.

60 Ibid, p3.

61 Ms Beverley Hamerton, Operations Manager, Western Wheatbelt, Western Australian Country Health Service, *Transcript of Evidence*, 6 November 2014, p1.

4.6 Witnesses' concerns about eligibility for the PATS funding and the Department of Health's evidence are discussed below.

Accommodation Subsidy Capped at Six Months

4.7 An accommodation subsidy is only payable under the current PATS policy for six consecutive months. The six-month cap on accommodation relates to a single trip to a treatment centre for continuous treatment over that period.

4.8 The accommodation subsidy limit also applies to patient escorts.

4.9 A patient is eligible to continue to claim the accommodation subsidy for the same or other approved specialist treatment for periods less than six months even where their accumulated accommodation may exceed six months. For example, a client may be required to attend a treatment centre for five months for cancer treatment. They then return home for three months before starting another round of cancer treatment for five months. They are eligible to claim both five-month periods.[62]

4.10 The Committee was advised that:[63]

> *The main issue under the current policy is that it states that accommodation is only payable for six consecutive months. Some specialist treatments exceed this period and clients become anxious that they will not receive the accommodation subsidy beyond the six month period to continue their treatment.*

4.11 This policy limitation is managed via an exceptional ruling to extend the accommodation subsidy beyond the six-month period. However, this requires the patient to apply for the extension and obtain justification from the treating specialist explaining the need to continue the treatment and time period for extension of the subsidy.

4.12 There are a number of treatments for various conditions that exceed the six-month threshold. The point was made in many submissions that the current six-month limit is inflexible and places an unnecessary burden on cancer patients given the standard treatment time frame of longer than six months is in line with normal treatment protocols.[64]

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62 Email from Mr Peter Collard, Manager, Governance, Western Australian Country Health Service, 28 April 2015.

63 Id.

64 For example submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, p3 and submission No 115 from the Department of Health, WA Cancer and Palliative Care Network, 16 May 2014, p4.

4.13 Evidence indicated that the same issue arises for dialysis patients for whom the six-month accommodation subsidy cap is "*a significant and ongoing issue*".[65] The Clinical Lead, Renal Health Network (WA), expressed his strong view that "*the six-month limit should be re-examined for dialysis patients.*"[66]

4.14 Evidence from the Department of Health was that "*Although the eligibility for accommodation should not be open ended, we feel that a more flexible approach is needed where an extension can be readily justified.*"[67]

4.15 The Department of Health suggested the following:[68]

> *Modify the current maximum allowable accommodation period which is capped at six (6) months to 'review requirement for continued accommodation subsidy after six (6) months continuous treatment.'*

Committee finding

Finding 7: The Committee finds that the current Patient Assisted Travel Scheme arrangements applicable to patients with treatment modalities greater than six months in duration should be reviewed to take into account the clinical needs of each individual patient, primary to the administrative requirements of the scheme.

Recommendation 6: The Committee recommends that the current Patient Assisted Travel Scheme arrangements applicable to patients with treatment modalities greater than six months in duration be reviewed.

Return to Home Visits During Long-Term Treatment

4.16 The current PATS policy does not make provision for patients undergoing continuous treatment over a long period of time, away from their home town, to return home for short periods.

4.17 The Committee received many submissions indicating that the social and emotional benefits obtained from patients being able to visit family and friends during lengthy treatment is important in assisting recovery. One cancer patient noted that the

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65 Submission No 124 from the Health Consumers' Council Western Australia, 19 May 2014, p1. Also see Dr Henry Moody, Clinical Lead, Renal Health Network (WA), Department of Health, *Transcript of Evidence*, 16 February 2015, p2.

66 Dr Henry Moody, Clinical Lead, Renal Health Network (WA), Department of Health, *Transcript of Evidence*, 16 February 2015, p3.

67 Email from Mr Peter Collard, Manager, Governance, Western Australian Country Health Service, 28 April 2015.

68 Submission No 125 from the Department of Health, 19 May 2014, p4.

treatment that she requires is not available in her home town and so she is required to travel to Perth, with her newborn baby, for a period of six weeks. She noted that the PATS will not cover air transport home on the weekends which is a *"complete stress to the family unit when already dealing with medical stress*."[69]

4.18 Evidence received in Kalgoorlie was that return to home visits are an issue with dialysis patients, some of whom may be away from their families for several years at a time:[70]

> ***Mrs Waters****: The biggest problem we have with dialysis patients is that, as everybody is aware, they are away from their family in Perth waiting for a chair for two, sometimes even three, years. So, if something happens at home, those clients will come home, and then they will end up acutely sick because they are not being dialysed, and then the hospital will not send them back on PATS because they have got here on their own steam anyway. Half the time they end up being RFDS'd out, so it would have been so much cheaper just to PATS them back. In that situation, I think we should be able to PATS the clients back to wherever they come from where there are dialysis chairs—work it out twice a year so that they at least have contact with their family or, if there is a death in the family and they need to come back for a funeral, to work out dialysis where there are chairs available, of course, so that they can do that, to stop those acute phases of them coming back, not being dialysed, and ending up acutely ill and being RFDS'd back to Royal Perth. It is big dollars.*

4.19 The Committee sought further information from Mrs Waters regarding the number of patients who had returned to their home and become acutely unwell. She advised that "*I have discussed this with all of our departments that have worked with these clients over the last 2 financial years. It is believed that on at least 16 occasions dialysis clients have returned to our region and required assistance to get back to Perth for treatment.*"[71]

4.20 The Department of Health suggested that the PATS policy should make provision for additional travel subsidies (limited to no more than one return visit to their home location per four weeks of continuous treatment) where this travel is supported by the treating specialist.[72]

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69 Submission No 97 from Ms Ruth Zahwe, 15 May 2014, p2.

70 Mrs Elizabeth Waters, Manager, Clinical Services, Bega Garnbirringu Health Service, *Transcript of Evidence*, 26 August 2014, p6.

71 Email from Mrs Elizabeth Waters, Manager, Clinical Services, Bega Garnbirringu Health Service, 4 May 2015, p1.

72 Submission No 125 from the Department of Health, 19 May 2014, p8.

4.21 The Committee sought further information from the Department of Health, which advised that "*… if all long term patients accessed the "return to home" option at each 30 day interval, the additional PATS travel cost would be approximately $500, 000 per annum.*"[73] It further advised that "*… it is estimated that 72 per cent of the long term treatment client cohort would qualify for an escort at an estimated additional cost of $360, 000.*"[74] It was estimated that "*… an additional budget allowance of $860, 000 would be required if this policy change was supported.*"[75] A detailed analysis of these figures broken down by WACHS regions is at **Appendix 5.**

Committee finding

Finding 8: The Committee finds that the social and emotional benefits obtained from patients being able to visit family and friends during lengthy periods of medical treatment are important in assisting recovery.

Recommendation 7: The Committee recommends that the Patient Assisted Travel Scheme be amended to include additional subsidies for return to home visits during long-term treatment.

Non-specialist Services

4.22 The current scope of the PATS policy is based on access to the nearest medical specialist. There are, however, other levels of health care that country residents need to access.

4.23 The Committee received many examples of situations where adequate health services are not available locally or the local health staff do not have the skills or equipment to manage more complex cases.[76]

4.24 This often results in a referral to a regional centre or metropolitan non-specialist service for review or treatment. Residents accessing these non-specialist services are currently ineligible for PATS assistance.

Allied health

4.25 Referrals to allied health professionals are not eligible for the PATS funding, unless they are approved as an exceptional ruling.[77] These ineligible fields include speech

73 Letter from Mr Shane Matthews, Acting Chief Executive Officer, Western Australian Country Health Service, 7 May 2015, p1.

74 Ibid, p2.

75 Id.

76 For example, submission No 26 from a private citizen, 2 April 2014, p1 and submission No 67 from the Disability Services Commission, 12 May 2014, p1.

pathologists, physiotherapists, podiatrists, clinical psychologists, occupational therapists, audiologists, pathologists, dentists and nursing professionals.

4.26 Access to allied health services is a major concern for people living in rural and remote areas. The Committee received much evidence outlining the difficulties people from these areas face in accessing allied health services, and calling for an extension of the PATS eligibility criteria to cover such services.

4.27 One example was provided by a mother whose child has cerebral palsy and who requires ankle-foot orthotics. This service is not available in her home town and the patient and her mother are required to travel to Perth on a regular basis for foot moulds and fittings. The PATS funding is not available for access to this service.[78]

4.28 Another child with cerebral palsy is required to visit a number of allied health professionals including physiotherapists, occupational therapists and speech therapists. The patient also requires orthotics, specialist wheelchair seating, hand splints and dental services. It was submitted by the child's parent that these are all services that help ensure the patient's continuing functionality. It was acknowledged that many of these allied health services are centralised in the Perth metropolitan area, however in the interest of equality of access for all Western Australians to these services, access to them should be made eligible for the PATS funding.[79]

4.29 One particular example that stands out for the Committee is audiology services. The Committee received evidence in Kalgoorlie of a child who was born profoundly deaf but who has now received cochlear implants. Although access to the surgery to implant the device is covered by the PATS, access to the follow-up audiology treatments to activate the electrodes and enable access to sound is not. In this case, the mother and two children were required to relocate to Perth for three months to access the necessary services. Evidence was that "*It has had an emotional impact on my children and myself and my husband. It has impacted on their education also.*"[80]

4.30 In contrast, the WACHS Goldfields Regional Director told the Committee that she had approved PATS funding for a cochlear implant patient to travel to Perth to access audiology services. This was done under an exceptional circumstance ruling. Her evidence was that "*I could not see the point in spending $30 000-odd on a cochlear implant and not tuning it in right.*"[81]

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77 See definition of "eligible medical specialist service" in the Patient Assisted Travel Scheme Policy, 15 September 2009, paragraph 2.2 and "Exceptional rulings", paragraph 2.8.

78 Submission No 26 from a private citizen, 2 April 2014, p1.

79 Submission No 116 from Mr Tony Mills, 16 May 2014, p5.

80 Ms Vanessa Hook, parent of a patient under 18 years of age, *Transcript of Evidence*, 26 August 2014, p2.

81 Ms Geraldine Ennis, Regional Director, Goldfields, Western Australian Country Health Service, *Transcript of Evidence*, 26 August 2014, p12.

4.31 These two examples demonstrate how relying on exceptional rulings to secure PATS funding for allied health services may result in the inconsistent application of the policy.

4.32 The point was made in Broome in relation to dental and allied health that:[82]

> *The people in the Kimberley who really need to access those services are quite disadvantaged socially … and do not necessarily have access to those services or do not have the means to access those services. That can be quite difficult when you are faced with people who really do need to access the service and you do not have capacity to be able to support them under PATS.*

4.33 Of particular concern to the Committee is the fact that allied health services that form an integral part of treatment, such as physiotherapy following orthopaedic surgery, are not covered by the PATS.

4.34 This point was made by the Leukaemia Foundation of Australia, which submitted that "*People with myeloma suffer bone damage requiring physical therapy support. These services need to be conducted by people with extensive blood cancer patient experience, which is not readily available in regional areas.*"[83] It submitted that:[84]

> *PATS should be made available for people to access allied health services – which will help improve their quality of life and maintenance of their overall health which will reduce the fiscal burden of the patient on the state healthcare system. Services should be inclusive of dental, physiotherapy, psychotherapy, occupational therapy, speech therapy as well as mental health services.*

4.35 Similarly, the Disability Services Commission noted that "*Allied health services have a major role to play in the health, development, and inclusion in community life of people with disability.*"[85] It submitted that "*access to allied health professionals, such as physiotherapy, occupational therapy and speech pathology is important in ensuring the well-being of the individual.*"[86]

4.36 The Cancer Council Western Australia noted that:[87]

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82 Mrs Kerry Winsor, Regional Director, Kimberley, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p2.

83 Submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, pp3-4.

84 Submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, p4.

85 Submission No 67 from the Disability Services Commission, 12 May 2014, p1.

86 Id.

87 Submission No 76 from the Cancer Council Western Australia, 14 May 2014, p5.

> *For many cancers there is significant need for allied health services both during cancer treatment and in the recovery phase from treatment. These valuable services can reduce deconditioning of the patient, support recovery and prevent complications that may arise from the treatment itself.*

4.37 It also made the point that:[88]

> *Although many large regional centres will have dentists and physiotherapists, few have cancer experienced allied health providers. Such cancer specific care can be integral to successful long term outcomes and in some instances impact upon survivorship. Access to multidisciplinary cancer care improves patient outcomes, reduces inpatient admissions, and which* [sic] *reduces the overall cost of cancer care to the community.*

4.38 Access to appointments with social workers is not eligible for PATS funding. Evidence was received that "*seeing various members of the allied health team is equally important for patients' physical functioning, maintaining independence, social and emotional well being and general quality of life.*"[89]

4.39 The Mental Health Commissioner noted that patient travel for psychiatrist services is currently eligible for PATS funding, however travel to see a clinical psychologist is not. He noted that where people are in acute settings or need to be in an acute setting, they tend to be transported outside of the PATS scheme. In those situations, patient transport is generally handled by the Royal Flying Doctor Service.[90]

4.40 Evidence was received that without access to allied health services, the quality of life for families, and their ability to obtain equitable socioeconomic outcomes as compared to their counterparts residing closer to specialist services, is limited due to reduced health outcomes.[91]

4.41 An example given in Broome was where a severely disabled child needs to see a specialist but also needs to be supported through a range of allied health services. The point was made that "*Unless you have got the allied health component going in tandem with the specialist, then the outcome is not going to be positive. So for that*

88 Ibid, pp5-6.

89 Submission No 87 from Oncology Social Work Australia, 15 May 2014, p2.

90 Mr Timothy Marney, Commissioner, Mental Health Commission, *Transcript of Evidence*, 24 September 2014, pp1-2.

91 Submission No 101 from Carers WA, 16 May 2014, p3.

allied health area, particularly for the severely disabled child in the Kimberley, there is a huge impost on families."[92]

4.42 A different perspective to the lack of eligibility for allied health services was provided by the Parliamentary National Party of Australia (WA), which suggested that such situations weaken the longevity of regional communities by forcing residents to relocate to metropolitan centres to access such services.[93]

Evidence from the Department of Health

4.43 WACHS representatives in Broome told the Committee that "*the criteria probably do need to be reviewed quite quickly, because it depends on the speed at which services develop and also at which technology develops. … I think they do need to be reviewed more regularly than currently what they are.*"[94]

4.44 WACHS noted in evidence to the Committee that the way in which medical services have grown and evolved over time means that services other than purely medical specialist services are required to provide the full spectrum of care.[95] The WACHS CEO stated that "*I guess there has been an intentional boundary put around the program in the past in terms of dental and allied health. It is probably a source of the most feedback and concern from country consumers.*"[96]

4.45 The Department of Health advised that the inclusion of allied health services delivered within the metropolitan area to country residents has the potential of increasing the cost of the PATS by more than $20 million per annum, as indicated in **Appendix 6.**[97]

4.46 The Department of Health submitted that it will, therefore, be necessary to develop criteria that limit PATS access to complex and/or specialist allied health requirements. It suggested that access could be confined as follows:[98]

- Referral/follow-up appointments with allied health services provided by tertiary hospital facilities (Fremantle Hospital, Royal Perth Hospital, Sir Charles Gardiner Hospital, King Edward Memorial Hospital, Princess Margaret Hospital), WA Health State-wide service (WA Health State Child

92 Mr Kim Darby, Operations Manager, Broome Health Campus, *Transcript of Evidence*, 2 September 2014, p6.

93 Submission No 113 from the Parliamentary National Party of Australia (WA), 16 May 2014, p5.

94 Mrs Kerry Winsor, Regional Director, Kimberley, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p5.

95 Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p5.

96 Id.

97 Submission No 125 from the Department of Health, 19 May 2014, p18.

98 Ibid, p9.

Development Centre or 'endorsed' private/Non-Government Organisation State-wide or specialist service providers).

- The service type must be defined as a tertiary level service as defined in the Clinical Service Framework (Level 5/6).

4.47 The Department of Health acknowledged that this criteria is still relatively broad and could result in substantial PATS cost increases. It submitted that further work would be required to define and narrow these criteria (for example, specification of clinics, service types and providers) and establish a control/check/triage system for referring clinicians to ensure that PATS applications meet all criteria specified.[99]

Committee findings

Finding 9: The Committee finds that access to allied health services is a major concern for people living in rural and remote areas. Access to such services has the capacity to significantly improve health outcomes.

Finding 10: The Committee finds that many allied health services provide early intervention efficiencies by preventing or ameliorating longer-term chronic conditions that may require expensive ongoing therapies.

Finding 11: The Committee finds that there should be a broadening of eligibility for PATS funding in recognition that access to a multidisciplinary team and coordinated treatment and support via allied health services provides better outcomes for patients and their families.

Recommendation 8: The Committee recommends that the Patient Assisted Travel Scheme be amended to make allied health services eligible for Patient Assisted Travel Scheme funding where they are provided as an essential component of an integrated health care plan.

99 Id.

Recommendation 9: The Committee recommends that the Patient Assisted Travel Scheme eligibility criteria be reviewed every two years to ensure that advances in medical technologies are taken into account for the purposes of Patient Assisted Travel Scheme eligibility.

Dental health

4.48 Most specialist dental services are not covered under the PATS. Support is only provided for serious oral conditions as set out in the Special Rulings in Schedule 6 of the PATS Policy document, which is attached as **Appendix 7**. Services that are eligible for funding under these Special Rulings include the management of facial trauma (such as jaw fractures, serious dento-facial infections and oral cancers), dental treatment for cleft lip and palate, and exceptional dental circumstances including specialist dental services for children (and for adults with special needs) when contemporaneous general anaesthesia is required.

4.49 The PATS generally does not cover extraction of third molars (wisdom teeth), orthodontic treatment (such as braces), crown or bridge treatment, root canal therapy or gum surgery or treatment.

4.50 Dr Graham Jacobs MLA, Member for Eyre, submitted that "*One of my real concerns is the almost complete lack of PATS subsidy for Dental services, specifically when the services relate directly to the health and well-being of a patient.*"[100] He submitted that "*Those that are treated under the MBS items in the Allied Health and Dental Care Services book (10975-10977) especially item 10977 should be a consideration.*"[101] These items apply to patients with chronic conditions and complex care needs where the dental condition is exacerbating the patient's chronic and complex medical condition.

4.51 An oral medicine specialist gave evidence that the lack of access for people from rural and remote Western Australia who are referred to an oral medicine specialist but who do not have the financial means to travel to visit one can have a significant impact on morbidity and even mortality for patients.[102]

4.52 The Committee received many submissions from people who required dental treatment but who were ineligible for PATS funding. An example which the Committee particularly noted, and which illustrates the issues under consideration, was from a patient requiring specialty dental treatment as a result of problems arising from radiation treatment for cancer of the mouth. The evidence was that access for

100 Submission No 19 from Dr Graham Jacobs MLA, 24 March 2014, p1.

101 Id.

102 Submission No 65 from Dr Alissa Jacobs, 11 May 2014, p2.

this treatment, requiring at least two visits to Perth from Three Springs every year, was ineligible for PATS funding.[103]

4.53 The Leukaemia Foundation of Australia noted that many people with blood cancers who undergo intensive treatment need to ensure they have full dental services completed before the start of treatment to reduce potentially life threatening infections. It submitted that access to dental services should be eligible for PATS funding.[104]

4.54 Evidence from the Australian Medical Association (WA) (**AMA**) was that:[105]

> *Doctors have recommended that consideration needs to be given to eligibility for PATS remuneration for patients accessing dental services. Many patients have poor oral health and a high incidence of rheumatic heart disease. Access to a dentistry service is difficult enough for these patients – even more so without access to PATS assistance.*

4.55 Evidence received in Carnarvon demonstrates confusion about eligibility for dental treatment. A patient who needed impacted teeth extracted by a specialist oral and maxillofacial surgeon was denied PATS funding, despite the referral clearly stating that the medical practitioner was a specialist and not a dentist.[106]

4.56 Another example received in Albany was evidence from a patient who was diagnosed with a problem with her tongue. She had difficulty having her claim approved as it was initially considered to be a dental condition:[107]

> *I got the form filled in. I took it to the PATS people at the hospital, and they said, "Oh, it's in your mouth—it's dental—so we don't cover it." I said it was not dental; it was my tongue. They ended up having to go off and came back a couple of weeks later or something, and said, "Yes, that's okay."*

Evidence from the Department of Health

4.57 In its submission, the Department of Health listed the following areas where the PATS coverage for dental treatment could be expanded:

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103 Submission No 33 from Ms Ann and Mr Lindsay Downing, 22 April 2014, p1.

104 Submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, pp3-4.

105 Submission No 85 from the Australian Medical Association (WA), 15 May 2014, p6.

106 Ms Fiona Hepple, Private Citizen, *Transcript of Evidence*, 29 August 2014, pp1-2.

107 Mrs Glenys Hoekstra, Private Citizen, *Transcript of Evidence*, 25 August 2014, p2.

- Increase the age for children requiring urgent critical dental procedures under general anaesthetic to 16 years which is in line with the age limits for Princess Margaret Hospital, where these procedures are performed.

- Expand the range of dental specialists that patients can attend and be supported by the PATS, including:

    a) Oral Medicine/Oral Pathology for oral cancer patients;

    b) Disability patients who are registered with the Disability Services Commission at Level 3;

    c) Patients who are dental phobic and require care under general anaesthetic;

    d) Patients who are medically compromised and need dental care in a tertiary hospital setting;

    e) Dental specialist services provided by the Oral Health Centre, which is the only centre in Western Australia with the expertise to provide the complex service for public dental patients.

4.58 The projected financial impact of expanding the scope of dental cover could add more than $1 million per annum to the PATS costs, as indicated in **Appendix 6.**[108]

4.59 The Department of Health accepted that further work will be needed to define the controls and guidelines to contain the PATS subsidies for non-specialist and dental services and to more accurately project the cost impacts.

Committee findings

Finding 12: The Committee finds dental treatment is extremely important, especially for patients with chronic conditions and complex health care needs.

Finding 13: The Committee finds that there is a lack of provision of dental services and oral medicine specialists throughout rural and remote Western Australia. This is of concern to the Committee.

[108] Submission No 125 from the Department of Health, 19 May 2014, p18.

Finding 14: The Committee finds there is a lack of clarity about what dental treatments are eligible for Patient Assisted Travel Scheme funding at the administrative level; for example, the difference between oral and dental surgery.

Recommendation 10: The Committee recommends that the Patient Assisted Travel Scheme be amended to expand the scope of dental services eligible for funding.

Maternity and Newborn

Maternity facilities in regional areas

4.60 Maternity services in regional Western Australia are not always provided by specialists and, in many communities, are provided by GP obstetricians. There are a number of communities that do not have birthing services and expecting mothers are required to travel and stay in the nearest town with a birthing centre until the birth.

4.61 In evidence to the Committee, the President of the AMA noted that many of the smaller rural obstetric units have closed over the years, which has created a huge disconnect for people. Pregnant women are ideally required to relocate to close to their birthing service by 36 weeks gestation, resulting in separation from their other children, family, community and other support for at least four weeks. Dr Gannon told the Committee that in an attempt to address this issue there has "*been a real move over the past 10 years or so to try to reinvigorate GP obstetrics in larger regional towns, and there are some real success stories*".[109] He gave Esperance and Geraldton as examples. Those centres have attracted and retained GPs who have had extra training and are able to perform caesarean sections.

PATS policy

4.62 The PATS Policy sets out special rulings in Schedule 6, including those relating to childbirth.[110]

4.63 The special rulings state that applicants who are entitled to PATS assistance for the delivery of a child are eligible for the PATS accommodation subsidy for a maximum of three nights prior to the delivery, unless medical reasons are provided by the GP obstetrician or specialist obstetrician as to why the applicant needs to be closer to the hospital earlier than this.[111]

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109 Dr Michael Gannon, President, Australian Medical Association (WA), *Transcript of Evidence*, 16 February 2015, p6.

110 Patient Assisted Travel Scheme Policy, 15 September 2009, p25.

111 Ibid, p30.

4.64 If a woman lives in a remote area where no birthing facilities exist, accommodation assistance is available for two weeks prior to the confinement date.[112]

4.65 Under the PATS Policy, Regional Directors may approve accommodation subsidy payments for periods of longer than ten nights but less than six months.

4.66 Assistance is not provided for a patient escort unless there are complications that put the mother or baby's life at risk or in cases when the mother and newborn may need an escort to return home; for example, a multiple birth.[113]

Accommodation assistance for women from remote areas with no access to birthing facilities

4.67 The WACHS *Maternity and Newborn Services* document, effective 10 September 2011, recommends that women with uncomplicated pregnancies should plan to move close to their maternity unit by 37 weeks gestation (that is, three weeks prior to the confinement date).[114]

4.68 This is in contrast to the PATS policy of providing assistance with accommodation for a maximum of three nights prior to the delivery for uncomplicated pregnancies and two weeks where the woman lives in a remote area with no birthing facilities.

4.69 The Maternal and Child Health sub-committee of the Kimberley Aboriginal Health Planning Forum submitted that "*Contradictory policies causes further confusion and frustration.*"[115] It submitted that assistance for two weeks accommodation is not enough and should be increased to three weeks in line with the WACHS guideline for uncomplicated pregnancies.[116]

4.70 The AMA has a strong view on this. It submitted that "*Doctors are concerned that PATS treats regional pregnant women poorly and is at odds with safe and reasonable maternity care.*"[117]

4.71 Similarly, a consultant obstetrician and gynaecologist submitted that:[118]

> *The rules do not support best maternity care practice and create unnecessary stresses for rural resident pregnant women, for health*

112 Id.

113 Id.

114 Department of Health, Western Australia Country Health Service document titled "WA Country Health Service Maternity and Newborn Services", effective 10 September 2011, p66.

115 Submission No 80 from the Maternal and Child Health sub-committee of the Kimberley Aboriginal Health Planning Forum, 14 May 2014, p2.

116 Id.

117 Submission No 85 from the Australian Medical Association (WA), 15 May 2014, p5.

118 Submission No 121 from Dr Diane Mohen, Consultant Obstetrician and Gynaecologist, 18 May 2014, p1.

> *care professionals who work in communities without access to the expertise and resources to support care during labour and the immediate post delivery period, and for the obstetricians and midwives who support rural women in district, regional and metropolitan maternity care units.*

4.72 Evidence received by the Committee indicates that the subsidy for two weeks accommodation is at odds with evidence-based pregnancy care, which is to defer induction of labour until 41 weeks gestation in uncomplicated pregnancies. If women leave home at 37 weeks, they may have four weeks wait until the delivery. It was put to the Committee that the additional financial burden of unsubsidised accommodation can put pressure on obstetricians to agree to induction of labour or an elective caesarean section when it is not clinically indicated.[119]

4.73 The AMA submitted that the provision of funding from 38 weeks gestation (in the case of uncomplicated pregnancies) is inadequate and "*inhibits women from travelling from some regional and remote settings until 38 weeks.*"[120] If a woman goes into spontaneous labour in a remote location, transporting her out "*can mean an extremely uncomfortable (and potentially dangerous) drive in labour from an outer Wheatbelt town, or RFDS transfer from a remote Kimberley community. It is a stressful exercise for all concerned.*"[121]

4.74 Evidence to the Committee was that women should routinely be encouraged to be near the place they will be delivering by at least 37 weeks, and routinely subsidised by the PATS for doing so.[122]

Patient escorts for childbirth

4.75 Evidence received during the inquiry indicated that, in some instances, the burden imposed on people leaving their community and travelling vast distances alone to seek medical treatment is too great and as such treatment decisions and health outcomes are compromised.

4.76 Issues raised in submissions regarding the lack of an escort include the missed opportunity for fathers to bond with their newborn babies, patients not understanding

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119 For example, submission No 85 from the Australian Medical Association (WA), 15 May 2014, p5 and submission No 121 from Dr Diane Mohen, Consultant Obstetrician and Gynaecologist, 18 May 2014, pp1-2.

120 Submission No 85 from the Australian Medical Association (WA), 15 May 2014, p5.

121 Id.

122 For example, submission No 85 from the Australian Medical Association (WA), 15 May 2014, p5 and submission No 121 from Dr Diane Mohen, Consultant Obstetrician and Gynaecologist, 18 May 2014, p1.

medical staff in relation to the procedure and follow-up care and care given that is not culturally appropriate.[123]

4.77 The Kimberley Aboriginal Health Planning Forum submitted that the PATS eligibility criteria for all women travelling to hospital for confinement should be extended to cover transport and accommodation costs for a support person and youngest child.[124]

4.78 To examine the needs of maternity patients in country Western Australia, A Rural Maternity Patient Journey Project was commissioned in July 2013 by the State-wide Obstetric Support Unit and the Aboriginal Maternity Services Support Unit. The need for the project was identified following longstanding anecdotal reports of scarcity of low cost relocation accommodation and the inability of the PATS to meet the needs of maternity patients required to translocate for birthing services.[125]

4.79 The resulting report, *The Rural Maternity Patient Journey, September 2013 Project Report* (**Rural Maternity Report**), noted that "*The levels of eligibility for PATS financial assistance toward accommodation is often a critical factor in the decisions women make, as is the ease of transport and access for other family members for visiting and being present for the birth.*"[126]

4.80 The Rural Maternity Report stated that for many women in very remote communities in Western Australia, travel and accommodation for childbirth to anywhere outside their home base, and especially to Perth, is an utterly daunting experience.[127] It stated that "*For these women, especially if it is their first child and in cases where they have not experienced much of life beyond their community, there is arguably a compelling case for sensible use of a competent escort.*"[128]

4.81 The Rural Maternity Report made the point that the concern expressed by clinicians appears to transcend help with the journey related issues and anxieties. Rather, it is about women being separated from their homes and families in late pregnancy and birth.[129] It suggested that "*The majority of women today would find that abhorrent and this highlights where PATS as a specialist access scheme is not able to respond beyond the basics to the needs of women and families having babies.*"[130]

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123 Submission No 100 from the Kimberley Aboriginal Health Planning Forum, 16 May 2014, p5.

124 Ibid, p6.

125 Submission No 125 from the Department of Health, 19 May 2014, p10.

126 *The Rural Maternity Patient Journey, September 2013 Project Report*, p18, in Submission No 125 from Department of Health, 19 May 2014.

127 Ibid, p25, in Submission No 125 from Department of Health, 19 May 2014.

128 Id.

129 Id.

130 Id.

4.82 Evidence was received that the lack of funding for a patient escort has a significant detrimental effect on many women, especially those from remote areas. One submission highlighted the importance of continuity of care and support during pregnancy, birth and the post-partum period to achieving improved birth outcomes. It noted the lack of access to continuity of care for women from remote Kimberley communities and submitted that because of this, it is even more vital that a support person be part of the birth process in order to ensure and promote positive outcomes for women and their families.[131]

4.83 The Committee received evidence that, for Aboriginal women, an escort ensures an element of cultural safety. Many Aboriginal women from remote areas are very shy and English is their second or third language. An escort provides them with a mediator, translator and advocate during what is often a very confusing time.[132]

4.84 It was submitted that the lack of funding for escorts means that fathers and partners are often not present at the birth. It was submitted that this results in families being separated at crucial times and parenting skills, family cohesiveness and relationship bonding being adversely affected.[133]

4.85 Evidence was also received that the lack of funding for patient escorts results in women refusing to travel to hospital to give birth, instead delivering locally without specialist staff available to manage any complications.[134]

Committee comment

4.86 Funding exists for patient escorts and funding approvals are determined on clinical grounds.

Post-natal accommodation

4.87 Several submissions raised the issue of funding for post-natal accommodation, stating that the PATS eligibility criteria should be reviewed to reflect safe post-partum care practice.

4.88 It was put to the Committee that post-natal accommodation funding should be available when a woman is discharged from hospital but needs to stay close to the

131 Submission No 80 from the Maternal and Child Health sub-committee of the Kimberley Aboriginal Health Planning Forum, 14 May 2014, p2.

132 Submission No 80 from the Maternal and Child Health sub-committee of the Kimberley Aboriginal Health Planning Forum, 14 May 2014, p2.

133 Ibid, pp2-3.

134 Submission No 85 from the Australian Medical Association (WA), 15 May 2014, p5.

hospital due to complications for the mother and/or baby and the woman is returning to a remote community with no regular post-natal services.[135]

Committee comment

4.89 The current PATS Policy is silent with regard to subsidies for post-partum accommodation.

4.90 It is also silent in relation to subsidies for accommodation where air service restrictions for post-operative patients apply.

Evidence from the Department of Health

4.91 The Department of Health acknowledged that:[136]

> *The provisions in the PATS policy for child birth are also not consistent with current maternity and new born models of care. The policy provisions relating to escorts are also restrictive and do not take into consideration family, psychological and other social determinants, particularly in remote locations where the mother may need to relocate for several weeks before and after the child is born.*

4.92 The Department of Health submitted that:[137]

> *Consistent with the Rural Maternity Report, PATS assistance for accessing maternity services should be reviewed and incorporate:*
>
> *PATS assistance to access the nearest maternity care where there is no birthing service available locally, taking into consideration family support availability, travel ability and costs. As a minimum, where an applicant chooses to attend a birthing centre other than the closest suitable centre due to family or support reasons, they should be eligible to claim the equivalent amount of travel cost as if they attended the closest birthing centre.*
>
> *Residents in remote communities where no birthing centre is available are currently eligible to two weeks accommodation prior to their confinement date. This needs to be increased to cover accommodation subsidy from 37 weeks gestation (three [3] weeks) to come in line with the current Maternity and Newborn models of care.*

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135 Submission No 80 from the Maternal and Child Health sub-committee of the Kimberley Aboriginal Health Planning Forum, 14 May 2014, p2.

136 Submission No 125 from the Department of Health, 19 May 2014, p10.

137 Submission No 125 from the Department of Health, 19 May 2014, pp10-11.

Provisions for an accommodation subsidy for up to 5 days post birth also should be available. In the case of mothers that have had a caesarean or other surgical procedure during birth, accommodation subsidy for up to 10 days may be necessary where post-surgery travel restrictions are imposed by airlines or transport carriers.

Consideration needs to be given to the family situation and potential risks to other children in the family where no other safe child care is available and the social and psychological impact on the mother being separated from the family and relatives. Flexibility is needed to provide travel and accommodation assistance for children or family support where assessed as being needed.

Committee findings

Finding 15: The Committee finds that funding assistance for two weeks accommodation for women who live in remote areas with no birthing facilities is inadequate and contrary to the Western Australian Country Health Service stated policy.

Finding 16: The Committee finds that it is important for women from remote locations who travel to their nearest birthing centre to deliver their baby to be accompanied by an appropriate escort if they choose.

Finding 17: The Committee finds that, in the case of patients from remote Aboriginal communities, escorts can provide an element of cultural safety and can fulfil the role of mediator, translator and advocate in what can be an overwhelming and difficult time.

Finding 18: The Committee finds that, without an escort in these circumstances, the medical outcomes for both mother and child could be compromised.

Recommendation 11: The Committee recommends that *Schedule 6: Special Rulings* of the Patient Assisted Travel Scheme be amended in relation to child birth to provide accommodation assistance for three weeks prior to their due date for applicants who live in remote areas where no birthing facilities exist.

Recommendation 12: The Committee recommends that the Patient Assisted Travel Scheme eligibility criteria be amended to provide funding assistance for a patient escort for all pregnant women travelling to their nearest birthing centre for delivery.

Distance Threshold

4.93 The eligibility criteria relating to the distance threshold are set out at paragraphs 2.33 to 2.36 of this report.

4.94 Witnesses raised a number of concerns with the use of a distance threshold for determining eligibility. They argued that the threshold distance is arbitrary, results in inequity of access to health services and imposes hardship on already ill patients.

4.95 A significant number of submissions were received from people living just inside the distance threshold (for example, in Bindoon and Toodyay). They argued that they are disadvantaged due to the arbitrary nature of the distance threshold. The Committee also heard evidence of inequities around other major regional centres, for example travelling from Bridgetown to Bunbury.

4.96 The Parliamentary National Party of Australia (WA) submitted that the rigid distance criteria for eligibility "*means that many regional patients are unable to access any form of cost recovery to receive specialist medical care.*"[138] It submitted that:[139]

> *By adhering to the National Healthcare Agreement 2012, any patient who resides in an area officially classified as 'regional WA', should in principle, be eligible for PATS. This would mean that a patient currently residing in Bindoon for instance, which is 84 kilometres from Perth, would be eligible for some cost recovery.*

4.97 The case of a family from Bindoon demonstrates the inequities of the current distance threshold requirement for eligibility. The family comprise a single mother of three very disabled children who live just inside the PATS distance threshold. The family's sole source of income is the carer's pension. The children require regular treatment in the Perth metropolitan area, as frequently as fortnightly. Evidence was that the family travel in excess of 2,500 kilometres every year. Despite these hardships, the family is ineligible for PATS funding as they live inside the distance threshold.[140]

4.98 Mr Shane Love MLA, Member for Moore, submitted that:[141]

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138 Submission No 113 from the Parliamentary National Party of Australia (WA), 16 May 2014, p4.

139 Id.

140 Submission No 74 from Ms Clare Parker, 12 May 2014, pp1-3.

141 Submission No 112 from Mr Shane Love MLA, 16 May 2014, p1.

> *Patients in York and Northam are recipients of an exemption from the 100 kilometre PATS rule. In view of the lack of medical services in Bindoon, Gingin and Toodyay and to bring these towns in line with Northam and York, I request that residents of Bindoon, Gingin and Toodyay be made eligible for PATS.*

4.99 The Shire of Toodyay submitted that its residents and ratepayers are "*unfairly disadvantaged in comparison to neighbouring Shires and discouraged from seeking needed medical care by difficulties relating to transport.*"[142] It submitted that "*Residents of Northam and York both enjoy special arrangements with regard to the PATS Scheme, while having better access to medical services in their own town: while Toodyay residents are ineligible under the PATS Scheme, in spite of having less local access to medical services.*"[143]

4.100 It was noted in several submissions that calculating the distance required to be travelled by reference to different criteria depending on where a patient lives can lead to inequity in eligibility. For example, in one case a family who lived outside the 100 kilometre threshold had no mail box and instead used a Toodyay Post Office Box as their address. This address was used to determine eligibility, and as a result they were denied PATS assistance.[144]

4.101 Much evidence was received that thresholds do not take into account local conditions such as poor roads, the availability and applicability of public transport and the existence (or lack thereof) of major transport routes. The Shire of Toodyay noted that public transport between Toodyay, Northam and Perth is severely restricted. It submitted that while Toodyay is 10 kilometres closer to Perth than both Northam and York, the difference in road conditions between the towns negate the advantage, instead creating longer travel times for Toodyay residents.[145]

4.102 The Shire submitted that Toodyay residents should be included under the same special arrangements extended to residents of Northam and York with regard to PATS assisted travel and accommodation.[146]

4.103 Mr Shane Love MLA, Member for Moore, submitted that it is likely that Gingin residents travelling to Perth for a medical appointment would have to stay overnight in Perth, given the current bus timetable.[147]

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142 Submission No 123 from the Shire of Toodyay, 19 May 2014, p1.

143 Id.

144 Submission No 36 from Ms Elvina McFaul, 23 April 2014, p2.

145 Submission No 123 from the Shire of Toodyay, 19 May 2014, p1.

146 Ibid, p2.

147 Submission No 112 from Mr Shane Love MLA, 16 May 2014, p3.

4.104 Another area of concern relating to the distance threshold relates to how far patients are expected to drive before they are eligible for air travel. Eligibility for air travel is automatic where travel to the nearest specialist involves a surface travel of more than 16 hours (one way) or is subject to excessive connection delays and prolonged stops.

4.105 The WACHS Operations Manager for the Gascoyne told the Committee that the WACHS safe driving policy is that staff should not drive for more than eight hours in one day. He noted that if patients were required to follow that policy, many would have to break their journey with an overnight stay. He suggested that to make it easier for those patients, the policy should be that an airfare is available within a safe driving distance from Perth.[148]

Committee findings

Finding 19: The Committee finds that a means other than the distance threshold should be identified to determine eligibility for Patient Assisted Travel Scheme funding that takes into account a broader range of factors such as access to public transport and road conditions.

Finding 20: The Committee finds that the mode of transport used must be the most suitable for patients, particularly those who are chronically or extremely ill.

Finding 21: The Committee finds that the current requirement that surface travel of more than 16 hours be undertaken before a patient is automatically eligible for air travel is excessive. The requirement should be in line with the Western Australian Country Health Service's own policy of no more than eight hours surface travel in one day.

Recommendation 13: The Committee recommends that a means other than the distance threshold be identified to determine eligibility for the Patient Assisted Travel Scheme.

148 Mr Gerard Burns, Operations Manager, Gascoyne, Western Australian Country Health Service, *Transcript of Evidence*, 29 August 2014, p5.

Recommendation 14: The Committee recommends that the Patient Assisted Travel Scheme be amended giving consideration to adhering to the provisions of the *National Healthcare Agreement 2012* with regard to the definition of regional Western Australia.

Recommendation 15: The Committee recommends that the Patient Assisted Travel Scheme be amended to replace the requirement for 16 hours surface travel for eligibility for automatic air travel to bring it in line with current Western Australian Country Health Service policy.

Cumulative Travel

4.106 Patients who live inside the threshold distance but who must make multiple trips over a given period of time due to the type of treatment they are receiving do not receive a subsidy. The only way such travel can currently be approved for funding is via an exceptional ruling.

4.107 Many submissions noted the lack of a cumulative weekly minimum eligible travel distance threshold. Evidence was that the financial impact of multiple episodes of short distance travel can be significant.

4.108 The Leukaemia Foundation of Australia submitted that for blood cancers, a subsidy system with identified cumulative kilometres in a period of time should negate the 100 kilometre rule. It proposed that in Western Australia, if a patient travels at least 250 kilometres in a week to access treatment, they be eligible for PATS funding.[149]

4.109 Kidney Health Australia submitted that more needs to be done in Western Australia to assist dialysis patients, as has been done in other states where a cumulative weekly travel figure has been introduced. It suggested that the cumulative weekly figure in Western Australia should be 200 kilometres.[150]

Evidence from the Department of Health

4.110 In its submission, the Department of Health recommended a revision of the distance required for road travel before eligibility for air travel is achieved. The Department of Health considers that the current criteria is excessive and may be placing country residents at risk of driving long distances.[151] It suggested that it may be more

149 Submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, p3.

150 Submission No 86 from Kidney Health Australia, 15 May 2014, p4.

151 Submission No 125 from the Department of Health, 19 May 2014, p7.

appropriate to define a distance that can be safely driven in one days travel, such as 800 kilometres.[152]

4.111 WACHS advised that it is currently considering the issue of cumulative travel to allow for approval of multiple trips per application.[153]

Committee comment

4.112 Recommendation 15, if adopted by the Government, would negate the need to address the issue of cumulative travel for those just inside the current distance threshold.

Access to a Second Opinion

4.113 The PATS funding to access a second opinion currently has to be approved under the exceptional circumstances rulings. This occurs only in very unusual and complex cases where, for example, there were issues between the medical practitioner, the patient and the family.[154]

4.114 Several witnesses felt that the PATS should cover travel to obtain a second opinion. For example, the Disability Services Commission stated that:[155]

> *Seeking a second opinion and the need for follow-up appointments are well-established practices and important to ensure key contributing factors are recognised and appropriate intervention strategies identified. Currently PATS will not cover seeking a second opinion…*

Alcohol and Other Drugs Detoxification and Rehabilitation Services

4.115 The PATS policy includes a special ruling covering Next Step (Alcohol and Drug Authority) applicants.[156] The special ruling allows applicants referred to Next Step specialist medical services delivered by a medical specialist in addiction to be eligible to receive PATS assistance for travel to the initial consultation for admission into a

152 Id.

153 Mrs Tina Chinery, Chief Operations Officer, Southern, Western Australian Country Health Service, *Transcript of Evidence*, 15 September, 2014, p15.

154 Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p17.

155 Submission No 67 from the Disability Services Commission, 12 May 2014, p1.

156 Next Step Drug and Alcohol Services is the clinical services directorate of the Drug and Alcohol Office. It provides assessment and treatment services for people experiencing problems associated with their alcohol and other drug use and support for their families. Next Step services include outpatient services, opiate and alcohol pharmacotherapy, clinical psychology, case management and counselling: http://www.dao.health.wa.gov.au/Aboutus/Organisationalstructure/NextStepDrugandAlcoholServices.aspx, accessed on 24 March 2015.

treatment or therapy program. To be eligible for PATS assistance under this special ruling, the applicant must meet the standard PATS eligibility criteria.

4.116 There are various 'sobering-up centres' and residential rehabilitation services in Western Australia. Most, however, are not serviced by specialists (such as consultant psychiatrists or drug and alcohol specialists) and therefore patients accessing those services do not automatically qualify for PATS assistance.

4.117 Evidence from WACHS, however, was that it provides assistance to people wishing to access rehabilitation services and the PATS is used for people to attend a hospital for the purpose of detoxification or referral to Next Step for detoxification or stabilisation on pharmacotherapy.[157]

4.118 Although rehabilitation services are available in Perth, evidence was received that:[158]

> *Where we have an issue is our Aboriginal clients prefer to go—and it is more appropriate for them to go—to Milliya Rumurra in Broome.*

4.119 Milliya Rumurra is a non-Government residential centre in Broome that provides treatment and rehabilitation to Aboriginal people wishing to address their drug and alcohol use. The centre's rehabilitation program is for a minimum of 12 weeks with the possibility of extension.[159]

Evidence from the Department of Health

4.120 WACHS advised that people in Carnarvon would be referred to a Next Step provider in either Geraldton or Perth. An exceptional ruling with medical justification and support would be required for approval to access the PATS to travel from Carnarvon to Broome to access an alcohol rehabilitation service.[160]

4.121 WACHS also advised that, in Carnarvon, a new dual-purpose centre to provide community alcohol and drug service by day and sobering-up service overnight was being constructed and was scheduled to open in October 2014.[161] It was officially opened on 9 October 2014.

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157 Supplementary Information Number A3, provided by the Western Australian Country Health Service, as a Question on Notice, 10 October 2014, p2.

158 Ms Taryn Duncan, Team Leader, Midwest Community Drug Service Team, *Transcript of Evidence*, 29 August 2014, p1.

159 http://www.dao.health.wa.gov.au/Gettinghelp/ServiceDirectory/Residentialrehabservices/MilliyaRumurra.aspx, accessed 24 March 2014.

160 Supplementary Information Number A3, provided by the Western Australian Country Health Service, as a Question on Notice, 10 October 2014, p2.

161 Id.

Nearest Treating Specialist

4.122 The Committee received many complaints about the requirement that patients be referred to the nearest treating specialist to be eligible for PATS funding.

4.123 The AMA noted that many of its members cite the lack of flexibility to allow for clinical judgement by the patient's treating GP or specialist as a serious flaw of the PATS. The requirement disregards the ability of the referring doctor to nominate a particular specialist who they believe is most appropriate to treat a particular patient.

4.124 Evidence was provided that, for patients in Mt Magnet, it is often quicker, easier and cheaper (as fewer nights' accommodation are required) to travel to Perth than Geraldton. However funding is only available for travel to Geraldton.[162]

4.125 Rural doctors cited frustration at having to attempt to convince the PATS staff to pay for a trip when there is a specialist service available locally, but it is not accessible soon enough or does not have the required specialist expertise.[163]

4.126 The requirement often results in patients having to change specialists during a course of treatment. This is seen by clinicians as being inappropriate in many cases and a serious failing of the PATS.[164]

4.127 The nearest treating specialist requirement may result in patients being ineligible for PATS funding if the specialist they have been seeing over a period of time moves away or another specialist moves closer to the patient and the patient wishes to continue treatment with their original specialist. This raises continuity of care issues.

4.128 An issue raised in Northam concerned the lack of any distinction in the PATS policy for funding for patients treated publicly or privately. It was put to the Committee that PATS funding is only provided for travel to the nearest treating specialist, regardless of whether that specialist works privately or in the public health system. In the example provided, if the closest medical specialist was a private practitioner, the patient would be eligible for PATS funding but would incur an out-of-pocket expense to cover the gap in fees. If the patient chose to travel further to a public specialist, and avoid the gap fee, they would be ineligible for any PATS funding.

4.129 In response to the Committee's query on this matter, the WACHS CEO advised that "*There is no distinction made if the specialist service is being provided by a private or public specialist. Patients may choose which provider they wish to access, however*

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162 Submission No 110 from The Country Women's Association of Western Australia (Inc), 16 May 2014, p2.

163 Submission No 85 from the Australian Medical Association (WA), 15 May 2014, p1.

164 Id.

they may not be eligible for PATS unless there is sufficient justification to support accessing other than the closest service."[165]

4.130 The WACHS CEO also stated that "*The private medical specialists working in country areas choose whether they offer bulk billing or services to public patients. A number of these country based specialists will bulk bill patients in certain circumstances, however this is at the discretion of the specialist.*"[166]

4.131 The Committee received evidence that the requirement that patients be referred to the nearest treating specialist to be eligible for the PATS means that, unlike their metropolitan counterparts, rural residents are unable to exercise choice if they require PATS assistance. For example:[167]

> *We are extremely limited in our choice of health professionals in remote WA. …*
>
> *Because I live in remote WA and exercise my right to choice of surgeon, does that mean I should not receive any financial assistance? I do not believe that should be so.*

4.132 Another related concern was not being able to access the PATS to see a specific specialist, especially if referred to one when that specialist came to the closest regional centre but has since moved to another centre. Patients want continuity of care rather than changing to another visiting specialist.[168]

Committee finding

Finding 22: The Committee finds that the Patient Assisted Travel Scheme only provides subsidies to the nearest specialist, regardless of whether the specialist is public or private. This can cause a further financial burden to the patient if the specialist is a private practitioner.

Recommendation 16: The Committee recommends that the first option for the Patient Assisted Travel Scheme should be to give patients access to the public health system even if that access is further away than the closest private specialist.

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165 Letter from Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, 30 November 2014, p1.

166 Id.

167 Submission No 12 from Ms Denise Barber, 15 March 2014, p3.

168 Submission No 60 from the Shire of West Arthur, 8 May 2014, p2.

Accompanying Children

4.133 The majority of submissions that raised the issue of children who accompany parents accessing medical services were provided from the Kimberley and Pilbara regions. One submission stated that "*The refusal to allow young children to accompany their mother on a PATS-funded hospital visit creates much concern and dissent in the community.*"[169]

4.134 An example provided in many submissions was the concern about the safety of children left behind.[170]

4.135 The Kimberley Aboriginal Health Planning Forum submitted that a formal process should be established to address the task of determining if a child left behind will be at risk. It suggested that this could involve the Department for Child Protection and Family Support. It also suggested that if accompanying children are approved to travel, then a patient escort should automatically be approved. Alternatively, hospitals which receive PATS patients should have arrangements in place to care for accompanying children where an escort has not been approved.[171]

Patient Escorts

4.136 The eligibility criteria relating to patient escorts are set out at paragraph 2.42 of this report.

4.137 Several submissions indicated that the requirement to travel alone is a major disincentive to commencing or completing a PATS-subsidised journey.[172] Many people want to have their partner with them during their treatment and recuperation.

4.138 Evidence received in Kalgoorlie was that many Indigenous patients have never previously been to Perth and find the prospect extremely daunting. They will simply not attend appointments if they are not supported properly.[173]

4.139 Evidence was similarly received that for patients who have English as a second language, the need for a patient escort is high. Evidence suggested there is little benefit for those patients to attend their appointment as they will not understand what

169 Submission No 100 from the Kimberley Aboriginal Health Planning Forum, 16 May 2014, p6.

170 For example, submission No 100 from the Kimberley Aboriginal Health Planning Forum, 16 May 2014, p6.

171 For example, submission No 100 from the Kimberley Aboriginal Health Planning Forum, 16 May 2014, p6.

172 Ibid, p5.

173 Mrs Elizabeth Waters, Manager, Clinical Services, Bega Garnbirringu Health Service, *Transcript of Evidence*, 26 August 2014, p2.

is being said to them, and will not ask. Having a patient escort who can translate will make them much more comfortable and more likely to attend.[174]

4.140 The Committee heard evidence in its travel around Western Australia that patient escorts are approved for clinical purposes but not necessarily for cultural purposes or where English is the patient's second language. Patient escorts in those circumstances would often only be approved under an exceptional ruling decision.[175]

4.141 The Committee is pleased to note that, in the Pilbara region, the broader well-being of patients and their ability to successfully negotiate the PATS system is considered in determining whether to approve a patient escort. This includes language and mobility difficulties and whether the person has previously travelled to the treatment centre. Evidence was that such requests are assessed under approved criteria (rather than under exceptional circumstances) if the referring doctor has indicated on the PATS form that a patient escort is required and the patient's needs are assessed as falling within the PATS criteria.[176]

4.142 Contrasting evidence in relation to patient escorts was received from the Patient Liaison Coordinator, Ngaanyatjarra Health Service in Alice Springs, who told the Committee that "*We find that sending escorts sometimes is more trouble than it's worth.*"[177] And "*We actually have banned escort lists because everyone wants to be an escort.*"[178] Evidence was that people volunteer to be an escort simply to obtain a free flight to Perth, and, on arrival, they abandon the patient.[179]

4.143 An issue with the current eligibility criteria for patient escorts was raised with the Committee in Albany where a patient turned 18 years old during her hospitalisation in Perth. Her mother had approved PATS funding for accommodation as her escort and carer while she was still 17 but, immediately upon the patient turning 18, her mother was no longer eligible for PATS funding. This was only three days into a lengthy hospital stay and follow-up treatment, leaving the family with significant out-of-pocket expenses.[180]

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174 Ibid, pp4-5.

175 For example, Ms Brenda Bradley, Acting Operations Manager, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p3.

176 Mr Brian Wilson, Operations Manager, East Pilbara, Western Australian Country Health Service, *Transcript of Evidence*, 1 September 2014, p7.

177 Miss Michelle Doyle, Patient Liaison Coordinator, Ngaanyatjarra Health Service, Alice Springs, *Transcript of Evidence*, 2 September 2014, p3.

178 Id.

179 Id.

180 Mrs Jane Forte, Private Citizen, *Transcript of Evidence*, 25 August 2014, p1.

Committee finding

Finding 23: The Committee finds that the policy with regard to patient escorts is well covered. On the basis of evidence heard, consistency around approvals and implementation of the policy could be improved.

CHAPTER 5
THE ADMINISTRATION PROCESS

Introduction

5.1 There are essentially two core components to current PATS administration:

- Claims reimbursement; and
- Travel coordination or prepayments for applicants unable to arrange their own health care or travel bookings.

5.2 The core processes for reimbursement and travel coordination are outlined in **Appendix 8** of this report.[181]

5.3 A number of issues relating to the PATS administration process emerged during the inquiry. The following provides an overview of the issues raised in evidence.

Current Administration Budget

5.4 The administration of PATS is currently devolved across WACHS's seven regions and is supported in approximately 70 locations. The Government's PATS budget allocation excludes associated administration and management costs.[182]

5.5 As noted previously in this report, the number of subsidised PATS trips has grown significantly from 2009 and this is forecast to continue. WACHS did not receive additional funding for administration under the 2008/09 policy changes and has been required to absorb this additional activity within its base budget. The current cost of administration is approximately $3.6 million per annum.[183]

5.6 The Department of Health submitted that any future policy or subsidy changes will need to consider the impact on administration costs and provide the necessary additional budget provision to cover implementation, marketing and ongoing administration costs.[184]

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181 Submission No 125 from the Department of Health, 19 May 2014, p13.

182 Ibid, p11.

183 Id.

184 Id.

South West Administration Process

5.7 The administration of the PATS in the South West is slightly different to the PATS in the other regions.

5.8 At its Perth hearing, WACHS told the Committee that the South West region has a different population cohort to the northern regions:[185]

> *all drive in, drive out access to Perth and into the region with, generally speaking, not too much case management in terms of the wraparound social services or accommodation bookings or management of various parts of people's destinations.*

5.9 The PATS in the South West region is a *"high-volume, low-cost service … low cost as in transport, petrol costs."*[186]

5.10 The South West region has contracted out the administration of the PATS (approximately $510,000 per annum[187]) to a private company whose offices are in Perth.[188] Applications are initially received via facsimile from the referring GP and follow-up phone calls and documents are made directly to the client.

5.11 As a result, people residing in the South West have a slightly different application process to those in the rest of the State. The GP must send a facsimile or telephone the South West PATS office to register a patient's claim. Prior to the appointment, the patient is required to contact the PATS office by telephone to complete the registration process and be advised on the status of the claim.[189] If the claim is approved, a Specialist Certification Form will be posted to the patient. The form must be completed and signed by the patient's specialist and returned to the South West PATS office within eight weeks of the appointment. Payment of any assistance will be paid directly into the patient's nominated account or posted out.[190]

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185 Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p14.

186 Mrs Grace Ley, Regional Director, Western Australian Country Health Service, South West, *Transcript of Evidence*, 17 November 2014, p1.

187 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, p5.

188 At the time of tabling this report, this contract was held by Medibank Health Solutions Pty Ltd.

189 This is a '1800' free call telephone number.

190 http://www.wacountry.health.wa.gov.au/fileadmin/sections/pats/Forms/SW_PATS_DL.PDF, accessed 24 March 2015.

5.12 As the call centre is in Perth, decisions about eligibility are made by people who do not know the patient or their personal and family circumstances. It was submitted to the Committee that:[191]

> *It can be an efficiency. I suppose some people like to deal with people they know face to face, but in this case I actually think it is probably more equitable that they are not dealing with their next-door neighbours and they are not dealing with people they know and know their family circumstance.*

Centralised and Decentralised Administration Systems

5.13 The Committee observed during its travel around Western Australia that some regions operate a centralised system for the processing of PATS applications. An example is the Pilbara region, where all applications are processed in Port Hedland. The claims come from eight hospital or nursing post facilities and seven remote clinics across the Pilbara region. They are submitted either in person or by facsimile or email and are processed centrally by the PATS staff. This includes all travel and accommodation bookings and claims reimbursements.

5.14 Evidence in the Pilbara was that:[192]

> *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.*

5.15 According to the WACHS East Pilbara Operations Manager:[193]

> *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.*

5.16 He noted that it is:[194]

> *challenging for the administration officer working in a small country hospital in a small community. They have firsthand knowledge, they*

191 Mrs Grace Ley, Regional Director, Western Australian Country Health Service, South West, *Transcript of Evidence*, 17 November 2014, p2.

192 Mr Brian Wilson, Operations Manager, East Pilbara, Western Australian Country Health Service, *Transcript of Evidence*, 1 September 2014, p2.

193 Ibid, p8.

194 Id.

> *see these people in the community and they feel in some cases more pressured to approve PATS.*

5.17 He also stated that:[195]

> *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 …*

5.18 The Committee heard evidence in Broome that the PATS used to be managed by each hospital. It has now been centralised with the Regional Co-ordinator and Operations Manager having oversight of the scheme. Evidence was that this has allowed some structure in reporting, enabled some standardisation of the administration of the PATS and facilitated education, training and compliance[196] and "*works exceptionally well.*"[197]

5.19 The Kimberley region still has PATS clerks at each site, however, and evidence was that "*those clerks are absolutely essential in ensuring that the patient gets the correct information and that the entire patient journey is planned by someone who is absolutely thorough in what transport routes are available, what community health person might be going out to a clinic for a day, and what charter company might be going in any which direction.*"[198]

5.20 It was also noted that medical staff in Perth are not always aware of the locations of some of the communities in the Kimberley and the logistics involved in a patient returning to their home. This leads to problems with discharge and travel arrangements.[199]

Committee finding

Finding 24: The Committee finds that the current system of regional coordination is working effectively.

195 Id.

196 Mrs Kerry Winsor, Regional Director, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p2.

197 Ms Sue-Ann Wiseman, Patient Assisted Travel Scheme Regional Coordinator, Broome Hospital, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p6.

198 Id.

199 Mr Kim Darby, Operations Manager, Broome Health Campus, *Transcript of Evidence*, 2 September 2014, p7.

Efficiencies of the current process

5.21 A witness from WACHS told the Committee that one of the efficiencies of the PATS is local administration. She noted that local staff have a good understanding of travel issues as they encounter those same issues. She stated that local PATS clerks "*advocate very well for the people because they are local. We have looked at a centralised system, but you may lose some of that local support and knowledge.*"[200]

5.22 It was put to the Committee that a web-based system, where decisions are made centrally anywhere in the State, would have some clear benefits, one of which would be more consistent decisions. Once a claim had been approved, each region could then take over the claim to make all the necessary and often complex travel arrangements that require local knowledge.[201]

5.23 The Wheatbelt region trialled a centralised and standardised PATS administration process for three months commencing in September 2014. Evidence received in November indicates that the trial will have some successful outcomes.[202]

Cumbersome Administrative Process

5.24 Many people who made submissions to the Committee commented that at a time when patients are dealing with significant health issues and are in need of support, they are faced with an inflexible and overly bureaucratic system in order to access financial assistance. Witnesses described the application process as lengthy, convoluted, cumbersome, archaic, inefficient and frustrating.

5.25 One patient noted that the PATS forms must be handled four times before they are lodged for processing. She commented that "*The process is far from simple, particularly for cancer patients.*"[203]

5.26 Another witness told the Committee that PATS reimbursement cheques are not itemised. "*You get this piece of paper with absolutely no idea of what the rate of payment is and what has actually been paid for.*"[204] The witness told the Committee that:[205]

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200 Mrs Tina Chinery, Chief Operations Officer, Southern, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p4.

201 Mr Brian Wilson, Operations Manager, East Pilbara, Western Australian Country Health Service, Pilbara, *Transcript of Evidence*, 1 September 2014, p9.

202 Ms Beverley Hamerton, Operations Manager, Western Wheatbelt, Western Australian Country Health Service, *Transcript of Evidence*, 6 November 2014, p2.

203 Submission No 18 from Ms Alysia Kepert, 20 March 2014, p1.

204 Mrs Jane Forte, Private Citizen, *Transcript of Evidence*, 25 August 2014, p3.

205 Id.

> *I ended up having to ring and say, "Look, can you tell me what all this is for?" which they did quite happily, but I thought it would have been much easier if that was on the bit of paper in front of me.*

Evidence from the Department of Health

5.27 Evidence received from WACHS in Broome was that they intend reviewing how much information can be obtained from the initial referral letter and questioning the need for a separate PATS form. The point was made that referral letters usually contain approximately 90 per cent of the data required to make an eligibility determination, and in many cases contain more information than the current PATS form.[206]

5.28 The Department of Health acknowledged that the forms are cumbersome and complicated for some people.[207]

Committee finding

Finding 25: The Committee finds that given the expanding role of nurse practitioners, future consideration should be given to them being authorised to complete Patient Assisted Travel Scheme Application Forms.

5.29 Given the expanding role of nurse practitioners, future consideration should be given to them being authorised to complete PATS Application Forms.

Time to Lodge a Patient Assisted Travel Scheme Application Form

5.30 Approval for PATS assistance must be obtained prior to travel. Applications submitted after travel will only be considered in exceptional circumstances.

5.31 If any component of an applicant's trip has been prepaid, the PATS Specialist Certification Form must be returned to the PATS office within eight weeks of the appointment date. Failure to do this will result in the applicant becoming ineligible for PATS assistance in the future.[208]

5.32 A PATS Application Form is valid for 12 months for the same medical specialist/speciality for the same medical condition.[209]

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206 Mr Kim Darby, Operations Manager, Broome Health Campus, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p5.

207 Submission No 125 from the Department of Health, 19 May 2014, p3.

208 Patient Assisted Travel Scheme Policy, 15 September 2009, p6.

209 Ibid, p8.

PATS Block Approval form

5.33 A PATS Block Approval form is used to approve PATS for multiple visits for treatment plans or dialysis. There must be a clearly identified treatment program of outpatient visits.[210]

5.34 The evidence received by the Committee indicates that this Block Approval form does not appear to be utilised and patients are instead required to complete a PATS Application Form for each claim to travel.

5.35 A PATS Application Form is to be certified by the referring medical practitioner, the treating medical specialist and the patient. It must be lodged by the patient prior to travel at the patient's nearest health service. Application forms are available from referring medical practitioners, local PATS offices or online. They can be lodged via facsimile, mail, email or in person.

5.36 Advice to the patient on the PATS Application Form is:

> *Please submit this PATS form to your PATS office (fax, mail, email or in person) **AS SOON AS POSSIBLE** and **PRIOR** to any travel being undertaken.*

5.37 In contrast to this conspicuous, bold type, the substantive requirement to lodge the form within eight weeks of the appointment is set out on the PATS Application Form in normal type under the heading "*Reimbursement of Costs."*

Committee finding

Finding 26: The Committee finds that this is inadequate notification of a core requirement for eligibility.

Recommendation 17: The Committee recommends that the Patient Assisted Travel Scheme Application Form be amended to provide clear notification of the required time frame for lodgement.

Claims reimbursement

5.38 The Department of Health acknowledged that the prepayment of applications is problematic in that there is little incentive for the applicant to obtain and return the specialist's certification of attendance for acquittal against the prepayment and closure of the application. This was identified as a financial risk by the Western Australian

210 Ibid, p9.

Office of the Auditor General and involves additional administration time in following up and obtaining the specialist's certification.[211]

5.39 The Department of Health submitted that the following would assist to streamline the process:[212]

- adopting a mandatory reimbursement model based on receipt of proof of travel and medical specialist certification of treatment; and
- publishing a list of specialists and services that are covered under the PATS and the fixed subsidy rates.

5.40 The Department of Health submitted that the time frame for lodging claims should be extended from eight weeks to six months, to provide flexibility for applicants to accumulate multiple small claims to lodge together.[213] The Committee notes that this is what Carers WA requested in its submission.[214]

5.41 The Department of Health submitted that, with these changes, it would be possible to centralise and automate claims processing to ensure timely refunds against the PATS claims.[215]

Paper-Based System

5.42 The Committee received many complaints from PATS patients and administrators about the need to repeatedly fill out complex paperwork and the imposition and pressure that completion of those forms places on both the patient and their medical practitioner. For example:[216]

> *Navigating the demands of the current PATS system is a significant additional burden for individuals and families in rural and remote areas struggling with cancer diagnosis and treatment. The inefficiency of the current system and requirement for complex paperwork can be an additional source of distress for those already fatigued due to the effects of treatment and travel.*

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211 Submission No 125 from the Department of Health, 19 May 2014, p14.

212 Id.

213 Id.

214 Submission No 101 from WA Carers, 16 May 2014, p11.

215 Submission No 125 from the Department of Health, 19 May 2014, p14.

216 Submission No 83 from Dr Lisa Miller, Consultant Liaison Psychiatrist, Sir Charles Gardiner Hospital, and Clinical Lead, Psycho-Oncology Collaborative, WA Cancer and Palliative Care Network, on behalf of the WA Cancer and Palliative Care Network, Psycho-Oncology Collaborative Group, 14 May 2014, p1.

5.43 The Committee is concerned about anecdotal evidence it received that some medical practitioners charge higher consultation fees to process PATS paperwork.[217]

5.44 The Committee received evidence that the process of completing PATS forms is so complex that some patients do not attempt to make a claim for reimbursement.[218] The Shire of Nungarin submitted in relation to the administration process that:[219]

> *The most common complaint in this area is that the application form and the amount of information that is required is too lengthy and time consuming where it comes to the point that eligible people do not even worry about applying for the PATS funding.*

5.45 Anecdotal evidence received by the Committee demonstrates another disadvantage of the current paper-based system. The Committee was told that it is reasonably common for doctors to simply sign PATS Application Forms and give them to patients to complete. A patient may indicate on the form that they are entitled to a flight, but provide no reasons. The PATS clerks must then follow-up with the doctor for further information to substantiate the claim.[220]

Electronic Forms

5.46 While many submissions discussed the disadvantages of using a paper-based claim system, many argued in favour of an electronic system. They noted that patient forms must be submitted to the PATS clerks during office hours but argued that as medical emergencies also occur outside these hours, it is essential that PATS forms can be submitted electronically. It was submitted that the long-term efficiency gains and improvement in patient access to the PATS system would outweigh the cost outlay for implementing the electronic system.[221]

5.47 The Committee received much evidence that a computerised form, generated and populated by GPs, would significantly improve the administration of the scheme.[222]

5.48 Evidence was received that parts of the Pilbara and Kimberley regions have a high turnover of medical staff who are not always familiar with the services provided in those regions. A computerised system would assist those practitioners.[223]

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217 Submission No 113 from the Parliamentary National Party of Australia (WA), 16 May 2014, p10.

218 For example, submission No 51 from Mr Vincent Fordham Lamont, Deputy Chief Executive Officer, Shire of Coorow on behalf of community members of the Shire of Coorow, 4 May 2014, p2 and submission No 62 from Ms Maureen Muir, 8 May 2014, p1.

219 Submission No 45 from the Shire of Nungarin, 2 May 2014, p1.

220 Ms Geraldine Ennis, Regional Director, Western Australian Country Health Service, Goldfields, *Transcript of Evidence*, 26 August 2014, pp2-3.

221 Submission No 113 from the Parliamentary National Party of Australia (WA), 16 May 2014, p9.

222 For example, Ms Sue-Ann Wiseman, Patient Assisted Travel Scheme Regional Coordinator, Broome Hospital, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p4.

5.49 Electronic forms would result in a faster and more efficient approvals process, thus providing more time for patients to arrange their travel and other aspects of their trip. This would reduce patient's stress levels.[224]

5.50 Some submissions acknowledged that not everyone will be able to access and complete forms online, however they noted that it would be a significant improvement for a large proportion of patients and carers.[225]

5.51 Evidence received in Broome was that, although some small communities in the Kimberley region do not have internet access, those patients access the PATS through health clinics which have internet access. Lack of internet access would, therefore, not disadvantage those patients as they access the PATS via the clinics in any event.[226]

5.52 The Ngaanyatjarra Health Service in Alice Springs negotiated an electronic form at least six years ago. The yellow PATS form is on their computer system and is only available to their doctors. The doctors open the form online, complete it and send it by facsimile to the Ngaanyatjarra Health Service with the referral and any other required forms. Evidence was that the system works well.[227]

5.53 The President of the AMA told the Committee that:[228]

> *The blue form is not overly onerous for specialists in the city to complete and it might actually add to the burden further. It might be that opening up a PDF or a Word document might actually make things more complicated. So, for the specialists themselves, the completion of the blue form or us being asked to correct it or fill it out retrospectively is not a great burden. The feedback that we get is more from the GPs and from the patients themselves.*

5.54 Dr Gannon told the Committee that:[229]

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223 Mr Brian Wilson, Operations Manager, East Pilbara, Western Australian Country Health Service, *Transcript of Evidence*, 1 September 2014, p6.

224 Mr Gerard Burns, Operations Manager, Western Australian Country Health Service, Gascoyne, *Transcript of Evidence*, 29 August 2014, p4.

225 For example, Submission No 94 from the Wheatbelt Health Memorandum of Understanding Group, 15 May 2014, p4.

226 Mrs Kerry Winsor, Regional Director, Western Australian Country Health Service, Kimberley, *Transcript of Evidence*, 2 September 2014, p6.

227 Miss Michelle Doyle, Patient Liaison Coordinator, Ngaanyatjarra Health Service, Alice Springs, *Transcript of Evidence*, 2 September 2014, p3.

228 Dr Michael Gannon, President, Australian Medical Association (WA), *Transcript of Evidence*, 16 February 2015, p2.

229 Id.

> *…we sought feedback from doctors around the state and then got substantial feedback from people—one of the areas where there was not a complaint was the completion of paperwork. If you compare it with other areas of paperwork filling out—the amount of paperwork that the GPs need to fill out for Medicare these days is quite significantly onerous—the blue form seems to work fairly well.*

Evidence from the Department of Health

5.55 The WACHS CEO told the Committee that "*We would like to see a more web-based online system with stronger information systems to support both applications from providers that refer for PATS, as well as from families. So, we would like to see better information systems, if you like, to improve efficiency, management reporting and transparency of the scheme.*"[230]

5.56 WACHS advised the Committee that, in December 2012, a new PATS online administration system was implemented and rolled across all regions, including Peel. In 2013/14 a business case was submitted for the PATS, which included $1.08 million project funding for the review and implementation of administrative reform and policy review of the PATS. The project included work on scoping and developing a web-based application process.[231]

5.57 WACHS advised the Committee that the business case was unsuccessful. It noted that the current PATS application involves multiple certifications by third persons as well as payments in advance and retrospectively. It noted that the development of an online system that will cater for the various criteria will be complex.[232]

5.58 When asked to expand on the reasons why a web-based program has not been approved for the PATS, the CEO told the Committee that:[233]

> *My understanding is that we have not been resourced specifically to develop that system. The resources that come into PATS are targeted very heavily towards system administration and delivery of PATS reimbursement. One-off additional funding would be required to develop a web-based system …*

5.59 He also stated that "*We are certainly very keen to modernise access to the system for providers, clients and ourselves.*"[234]

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230 Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p4.

231 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, p6.

232 Id.

233 Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p6.

5.60 WACHS advised in September 2014 that an electronic form for GPs was being developed and trialled by the Central Referral Service (**CRS**). The outcomes of this development work will provide a good basis to develop a similar system for GPs to lodge PATS applications for their patients.[235]

Trial of electronic referral forms

5.61 The trial commenced in December 2014 following development and testing of electronic GP referral templates. The trial covered two components: an electronic referral template and secure electronic messaging.

5.62 The electronic templates were developed for six of the most common GP practice software packages used in Western Australia. The templates can be uploaded into the GP software package to facilitate auto-population of some fields from the GP's patient records.[236]

5.63 The Committee was advised that once final testing is complete, these electronic templates are planned to be released to GPs more widely via the CRS website.[237]

5.64 A trial also commenced in late 2014 for bi-directional secure messaging (incoming and outgoing) to deliver and receive the electronic referral templates. The trial is limited to GP practices that use WACHS's contracted secure messaging provider as their provider. The Committee was advised that overall there have been no significant issues with secure messaging where the messaging provider is the same as that used by WACHS.[238]

5.65 The Committee was advised that a communication strategy is being developed to promote this form of referral transmission between GPs and CRS to gradually expand its use.[239]

Share Online Data System

5.66 WACHS implemented a new PATS database in November 2012, referred to as the Share online system. Evidence was received that this has greatly improved the quality of both the information regarding people applying for patient assisted travel and how

234 Id.

235 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, p7.

236 Email from Mr Peter Collard, Manager, Governance, Western Australian Country Health Service to the Committee dated 11 February 2015, p1.

237 Id.

238 Id.

239 Id.

those applications are considered and processed. All communication regarding an application is recorded in that system, including requests for exceptional rulings.[240]

Committee finding

Finding 27: The Committee finds that implementing an electronic application system would assist in modernising the application process, support the utilisation of the already existing Share online data system and inevitably lead to greater efficiencies.

Recommendation 18: The Committee recommends the implementation of an electronic Patient Assisted Travel Scheme application and claims form system to support the Share online data system.

Patient Assisted Travel Scheme Offices – Staffing, Location, Advertising and Promotion

PATS clerks

5.67 The Committee met a number of PATS clerks during its tours of health campuses and hospitals in regional Western Australia. In all cases the PATS clerks were very cooperative and provided the Committee with useful information for its inquiry. The Committee thanks those clerks for their contribution to the inquiry.

5.68 The Committee acknowledges that training is currently provided to PATS clerks around the State. This includes training in ethical and accountable decision-making, maintaining confidentiality, cultural awareness and education about the PATS process itself.

5.69 Informal discussion with PATS clerks in several locations indicated that they too thought a pre-populated computerised form may help to streamline processes.

5.70 The Committee is of the view that PATS offices should be easily accessible with clear signage at the entrance to hospitals and health campuses. During its tour of regional health facilities the Committee was pleased to observe that PATS offices were prominently placed at most locations.

5.71 Information displays about the PATS varied between regions, with some PATS offices displaying a great deal of information such as PATS guides and brochures, accommodation options, and consumer feedback forms and others providing very little.

240 Mr Brian Wilson, Operations Manager, East Pilbara, Western Australia Country Health Service, *Transcript of Evidence*, 1 September 2014, p1.

5.72 The Committee is of the view that there should be uniformity in both the information provided in all PATS offices throughout the State and the manner in which it is displayed.

5.73 The amount of money spent on advertising and promoting the PATS in total and by region is set out in the table below:[241]

Region	2009/10	2010/11	2011/12	2012/13	2013/14
	$	$	$	$	$
Goldfields	0	0	0	0	0
Great Southern	0	0	0	0	0
Kimberley	0	0	0	1,257	563
Midwest	200	0	639	883	129
Pilbara	0	0	0	0	0
South West	1,057	1,543	0	0	0
Wheatbelt	0	0	0	0	795
Total	**$1,257**	**$1,543**	**$639**	**$2,140**	**$1,487**

Note: Costs Include production costs for PATS material including brochures, posters pamphlets and forms.

5.74 PATS information is available on the WACHS Internet and Intranet sites, which are prime sources for PATS information for consumers and health services. A summary of the number of 'hits' against the PATS sites is shown below:[242]

Web Site	2009/10	2010/11	2011/12	2012/13	2013/14
Intranet	1,725	3,153	4,524	7,765	5,492
Internet	5,606	25,965	20,166	30,628	47,234

5.75 Evidence was received that some patients are unaware of the PATS and that the advertising and promotion of the scheme is insufficient. One user of the scheme advised the Committee that "*my ability to use PATS came about by a chance conversation with a work colleague and not via the medical centre that was in charge of my health care. Since then it has become clear to me that many in my locality are also ignorant of the PATS Scheme…*"[243]

5.76 The Leukaemia Foundation of Australia submitted that "*Many patients have reported that they did not know about PATS, or that they are eligible to receive PATS. A more concerted effort to ensure all patients are made aware of their PATS entitlements is very important.*"[244]

5.77 PATS information is publicly available and electronically accessible from the WACHS website. During its travels around Western Australia, the Committee

241 Supplementary Information Number A1, provided by the Western Australian Country Health Service, as an Answer to a Question on Notice, 10 October 2014, p3.

242 Id.

243 Submission No 4 from Ms Ashley Thompson-Brown, 14 March 2014, p1.

244 Submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, p4.

observed other means by which the PATS in each region is advertised and promoted. It was also very interested to note how Aboriginal people and those from culturally and linguistically diverse backgrounds are made aware of the PATS.

5.78 The table below shows how information about the PATS is advertised, promoted and distributed in the various WACHS regions of Western Australia:

PATS Resources and Information within WACHS Regions

WACHS Region	Posters & Brochures	Roadshows & Presentations	Help-desk	Local Newspapers & Radio	Country Health Connect	Aboriginal Liaison Officers	Aboriginal Health Workers	'My Travelling Booklet'	Translating and Interpreting Service	CaLD
South West	✓	✓				✓		✓	✓	✓
Great Southern	✓				✓	✓	✓	✓	✓	✓
Wheatbelt	✓		✓	✓		✓	✓		✓	
Goldfields	✓			✓						
Midwest	✓			✓		✓		✓	✓	✓
Pilbara	✓	✓		✓		✓				
Kimberley	✓							✓	✓	

Medical Practitioners' Awareness of the Patient Assisted Travel Scheme

5.79 Each WACHS region faces different issues, and has varying degrees of success, in relation to educating and training medical practitioners about the PATS.

5.80 A number of submissions suggested that there is confusion within the medical and specialist professions about the PATS system and how it works. This is particularly the case with visiting medical practitioners who may not have dealt with the PATS prior to practising in the regions.

5.81 Evidence received by the Committee was that many doctors, particularly specialists, do not understand what the PATS system requires of them. Hon Dave Grills MLC, Member for Mining and Pastoral, advised the Committee that a number of constituents had attended his office with forms which, not having been signed by the specialist, would not be honoured by the PATS office. He submitted that "*Consideration of the bureaucratic nature of medical administration and the degree to which it is foreign to patients again suggests better training for medical administrative staff is warranted.*"[245]

5.82 Evidence received in Port Hedland was that providing training to medical practitioners when they first come to the region is challenging.[246] Some locations such as Port Hedland and Karratha are relatively well serviced with a good proportion of resident GPs, while others, such as Newman, have a higher than average number of locums who are not necessarily repeat locums. This, combined with the fact that there is no

245 Submission No 91 from Hon Dave Grills MLC, 15 May 2014, p2.

246 Mr Brian Wilson, Operations Manager, East Pilbara, Western Australian Country Health Service, Pilbara, *Transcript of Evidence*, 1 September 2014, p2.

practice manager at Newman to induct new medical practitioners, leads to inconsistency in PATS applications.[247]

5.83 Evidence was received in Carnarvon that doctors who go to the town are quite often locums, and WACHS makes sure they are aware of the scheme. It was submitted, however, that occasionally the locum doctors will refer for things that are not currently eligible under the PATS because they are unfamiliar with the scheme.[248] Further, overseas-trained doctors are often not familiar with the PATS, and WACHS has constant communication with the various practices, the Aboriginal Medical Services and the private medical centre to reinforce to the doctors what claims are eligible and what are not.[249]

5.84 Part of a doctor's orientation to the Carnarvon hospital, especially if they are unfamiliar with the PATS, includes training in relation to PATS processes and procedures.[250]

Committee findings

Finding 28: The Committee finds that medical professionals need to be fully aware of the Patient Assisted Travel Scheme eligibility criteria and what is required in addressing those criteria; for example, how to provide clear clinical rationales for modes of transport and eligibility for benefit.

Finding 29: The Committee finds that there is a lack of understanding about the Patient Assisted Travel Scheme process in some areas of the medical profession. Better training for medical practitioners about the scheme, particularly for locum General Practitioners prior to visiting the regions, is essential.

Finding 30: The Committee finds that there is a need for better training for medical professionals on how to complete Patient Assisted Travel Scheme applications forms on their patient's behalf to adequately substantiate the needs of that patient to the administrators of the scheme.

247 Ibid, p3.

248 Mr Gerard Burns, Operations Manager, Western Australian Country Health Service, Gascoyne, *Transcript of Evidence*, 29 August 2014, p2.

249 Id.

250 Ibid, p3.

Inconsistent Application of the Patient Assisted Travel Scheme Policy

5.85 The Committee received many comments about the lack of consistency of interpretation and application of the PATS guidelines. Many submissions indicated that the guidelines are subjective and lack consistency within and/or between regions.

5.86 One submission stated that some patients know the names of PATS staff they will not deal with due to poor and inconsistent service delivery.[251] Another submission reported inconsistencies in relation to the degree of support a family is considered eligible to receive depending on the PATS clerk involved.[252]

5.87 A common problem was the inconsistent provision of taxi vouchers and flights. Evidence was that, in some cases, there is inconsistency even for patients from the same regional area.[253]

5.88 The Committee received many suggestions to improve the consistency of the application of PATS guidelines. Witnesses commented that improved training of PATS clerks was required.[254] Other witnesses suggested that a centralised agency deal with all PATS applications. This is discussed in paragraph 5.13 to 5.20 of this report.

Appeals

5.89 It was put to the Committee that the appeal process is very subjective and the applicant is provided with no guidelines to assist in determining whether to appeal a decision. It was also claimed that the lack of transparency raises concerns about the potential for decisions to vary between regions based on the personal views of individual PATS Regional Coordinators. It was suggested that a transparent appeals process should be implemented to ensure consistency across the State.[255]

5.90 Evidence in Kalgoorlie was that the most common reasons for appeals against PATS decisions in the Goldfields region relate to the mode of transport (air versus surface), approval of escorts and additional travel support such as taxi vouchers.[256]

5.91 Evidence was also received in Kalgoorlie that centralising the appeals process would slow the process down, but would be far more consistent than is currently the case. It

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251 Submission No 59 from the Leukaemia Foundation of Australia, 8 May 2014, p3.

252 Submission No 101 from Carers WA, 16 May 2014, p4.

253 Submission No 115 from the WA Cancer and Palliative Care Network, Department of Health, 16 May 2014, p5.

254 For example, submission No 76 from the Cancer Council WA, 14 May 2014, p10.

255 Submission No 113 from the Parliamentary National Party of Australia (WA), 16 May 2014, p13.

256 Mr David Bowdidge, Operations Manager, Kalgoorlie Hospital, Western Australian Country Health Service, *Transcript of Evidence*, 26 August 2014, p13.

would also distance the region and the hospital itself from the issue under consideration. The point was made that a PATS conflict can end up in the media, which, in turn, affects the public's perception of the hospital. This is despite the fact that the PATS is a scheme separate from the hospital. Evidence was that the more the PATS can be separated from the hospital itself, the better for the hospital.[257]

5.92 Evidence in Carnarvon was:[258]

> ***The CHAIRMAN****: Roughly how many appeals are you dealing with in a year, do you know?*
>
> ***Mr Burns****: Very, very few. I cannot really remember the last one.*
>
> ***The CHAIRMAN****: Is that generally because the explanation as to why it has been rejected is very up-front and people understand that?*
>
> ***Mr Burns****: Exactly. The clerks, the people who administer the scheme administratively, as I say are very empathetic to the clients. We are there to try to make their trip a little bit easier, not to put the blockage in front of them.*

Committee findings

Finding 31: The Committee finds that the Patient Assisted Travel Scheme Application Form makes no reference to an appeals process. Consequently a patient may not be aware that an appeal right exists when there is a dispute concerning the application of guidelines.

Finding 32: The Committee finds that the appeal process must be transparent and consistent.

Finding 33: The Committee finds that that the appeals process should be clearly set out on the Patient Assisted Travel Scheme Application Form.

257 Ibid, p10.

258 Mr Gerard Burns, Operations Manager, Gascoyne, Western Australian Country Health Service, *Transcript of Evidence*, 29 August 2014, p3.

Recommendation 19: The Committee recommends that the appeals process be clearly defined on the Patient Assisted Travel Scheme Application Form.

Country Health Connection

Background

5.93 The Country Health Connection (**CHC**) Unit was first established in the 1970s under the title Aboriginal Hospital Liaison Unit (**AHLU**). Its aim was to support and advocate for Aboriginal patients in tertiary care settings, coordinate the safe transition of Aboriginal people to and from country Western Australia, participate in discharge planning and assist in the coordination of follow-up care, arrange transfer of the deceased to their homeland for burial, convey information to the patient and relatives as to their health condition, treatment and medical needs and cultural brokerage between the patient and clinical staff.[259]

5.94 As the role of the AHLU expanded and the numbers of Aboriginal people travelling to the metropolitan area for health care increased, the AHLU became the CHC Unit. In January 2012, the CHC Unit transitioned across to the Aboriginal Health Improvement Unit. This transition was as a result of the implementation of the *Closing the Gap National Partnership Agreement* which funded the creation of over 40 Aboriginal Liaison Officers (**ALOs**) across Western Australia.[260]

Current operations

5.95 The CHC Unit is entirely funded by WACHS from a base recurrent budget. For 2014/15 the CHC budget is $556,908.91.[261]

5.96 There has been a steady and significant increase in the number of Aboriginal patients requiring travel to the metropolitan region for health care since the 1970s. The CHC Unit assists more than 2,000 clients a year.[262]

5.97 The CHC Unit has a total of four full time equivalent positions, as well as one 0.8 and one 0.6 full time equivalent positions.[263]

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259 Letter from Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, 23 September 2014, p1.

260 Id.

261 Ibid, p2.

262 Country Health Connection information sheet, available at http://www.wacountry.health.wa.gov.au/fileadmin/sections/pats/WACHS_IS_CountryHealthConnection pdf, accessed 24 March 2015.

263 Letter from Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, 23 September 2014, p2.

5.98 The CHC Unit operates between the hours of 8.30am and 4.30pm Monday to Friday 52 weeks of the year. Evidence to the Committee was that hours of operation are currently determined by the available budget and full time equivalent positions. Patients who require transport outside these hours are provided with cab charge vouchers.[264]

5.99 CHC cab charge voucher expenditure for the previous two financial years was:[265]

- 2012/13 - $89,323.85; and
- 2013/14 - $24,715.71.

5.100 The Committee was advised that taxi expenditure decreased in the 2013/14 financial year due to CHC employing two full time Aboriginal drivers.[266]

5.101 CHC cab charge voucher expenditure for the first six months of the 2014/15 financial year was $17,810.47.[267]

5.102 CHC nurses visit clients at Fremantle Hospital, King Edward Memorial Hospital, Royal Perth Hospital (including the Shenton Park campus), Sir Charles Gardiner Hospital, Bentley Hospital, Derbal Bidjar Hostel and Allawah Grove Hostel.

5.103 The CHC information sheet states that PATS clerks are required to phone the Department of Health to obtain a referral sheet, and that bookings for the service are essential.[268]

5.104 Evidence was received that the current means of providing cab charge vouchers causes problems for some Aboriginal patients. Vouchers are not provided directly to Aboriginal patients prior to their arrival in Perth, but instead the CHC Unit negotiates with Aboriginal Hostels Limited for them to provide the patient with the taxi voucher once they reach the hostel. Witnesses from CHC told the Committee that they have raised concerns with PATS staff that some clients do not receive taxi vouchers.[269]

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264 Id.

265 Email from Ms Dianne Murphy, Business Support Officer, Western Australian Country Health Service, Country Health Connection, 26 March 2015, pp2-3.

266 Ibid, p3.

267 Ibid, p4.

268 Country Health Connection information sheet, available at http://www.wacountry.health.wa.gov.au/fileadmin/sections/pats/WACHS_IS_CountryHealthConnection.pdf, accessed 24 March 2015.

269 Ms Charmaine Hull, Senior Project Officer, Aboriginal Liaison, Western Australian Country Health Service, *Transcript of Evidence*, 24 September 2014, p3.

Committee finding

Finding 34: The Committee finds that Country Health Connection provides an invaluable service but budget constraints limit its capacity to service patients on weekends and after hours.

Taxi Vouchers

5.105 A common theme in the submissions that were made to the Committee was that taxi vouchers should be more routinely available under the PATS scheme.

5.106 Witnesses commented that although a person may be eligible for airfares to Perth, taxi and public transport costs are often not covered to and from the airport. Similarly, taxi and public transport fares are not usually covered from a patient's accommodation to their medical appointments.

5.107 Hon Dave Grills MLC, Member for the Mining and Pastoral Region, submitted that "*The stringent rules governing taxi vouchers creates real impracticalities and does not allow for individual circumstances.*"[270] He submitted that "*There is no direct bus or train link between Perth airport and the cancer support hostels and those patients do need assistance with travelling between the airport and the hostel.*"[271] Hon Dave Grills MLC expressed his hope that the criteria for allowing PATS taxi vouchers will be extended.[272]

5.108 The Carnarvon Medical Service Aboriginal Corporation supplements the PATS by providing taxi vouchers to patients travelling to Perth.[273] Information provided to the Committee indicates that:[274]

- For the 2013/14 financial year, the total paid for taxi vouchers for patients was $5,981; and
- For the 2014/15 financial year, the amount budgeted for patient taxi vouchers is $12,000.

5.109 A greater use of taxi vouchers was supported by, among others, the AMA,[275] the Kimberley Aboriginal Health Planning Forum[276] and the Aboriginal Health Council of Western Australia[277].

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270 Submission No 91 from Hon Dave Grills MLC, 15 May 2014, p1.

271 Ibid, p2.

272 Id.

273 Mr Shane van Styn, Chief Executive Officer, Carnarvon Medical Service Aboriginal Corporation, *Transcript of Evidence*, 29 August 2014, p6.

274 Supplementary Information provided by Mr Shane van Styn, Director, Carnarvon Medical Service Aboriginal Corporation, 2014, 18 September 2014, pp1-2.

Committee finding

Finding 35: The Committee finds that, for patients who are very sick or disabled or from remote regions of the State, public transport is often inappropriate. Greater use of taxi vouchers is an area that needs to be explored.

Evidence

5.110 The Health Consumers' Council of WA noted that the CHC service alleviates some problems experienced by Aboriginal people coming to Perth for medical treatment. However it submitted that it does not fully meet the demand, including not operating after hours or on weekends. It submitted that the establishment of ALOs and the State-wide coordinating roles are very positive developments towards better realising and meeting Aboriginal patient's needs. It submitted, however, that these services need more formal links with the PATS service.[278]

5.111 Evidence received in Carnarvon demonstrates inadequacies in the service that CHC is currently able to provide. One example was that because CHC is only open during office hours on weekdays, some patients are left stranded. For example, there is no CHC service in Geraldton and when the bus arrives at two o'clock in the morning, evidence was that some patients stay on park benches or under a tree until accommodation facilities are opened. Further, the bus to Perth arrives at Wellington Street at six o'clock in the morning which "*is not a good place to be.*"[279]

5.112 Aboriginal clients are put in touch with CHC through PATS clerks. PATS forms do not require an applicant to disclose whether or not they are Aboriginal. This may result in some patients who qualify for CHC assistance not being referred to the service if the PATS clerk either does not realise that they are Aboriginal or they simply do not make the referral.

5.113 Evidence was also that CHC is bound by policy and procedures "*and they cannot do this and they cannot do that, and their funds are being cut; and only if you are disabled or have got little kids with you that they will come and assist you; otherwise you are left to fend for yourself.*"[280]

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275 Submission No 85 from the Australian Medical Association (WA), 15 May 2014, p3.

276 Submission No 100 from the Kimberley Aboriginal Health Planning Forum, 16 May 2014, p4.

277 Submission No 111 from the Aboriginal Health Council of Western Australia, 16 May 2014, p7.

278 Submission No 124 from the Health Consumers' Council of WA, 19 May 2014, p2.

279 Miss Melanie Bellotti, Aboriginal Liaison Officer, Carnarvon Medical Service Aboriginal Corporation, *Transcript of Evidence*, 29 August 2014, p3.

280 Id.

5.114 WACHS made the point that CHC was set up separately from the PATS and the two schemes are not always coordinated. *"We are looking at how the two work together, but that is a sort of evolution. It was set up separately to PATS."*[281]

5.115 Similarly, in Broome, evidence was that *"They do not have the resources to be meeting people from everywhere. We only use them if we are really desperate."*[282]

Areas for future review and improvement

5.116 The WACHS CEO advised the Committee that a number of issues relating to the CHC service model, the State-wide Aboriginal Liaison Program and improving the Aboriginal patient's journey have been identified for further review. He advised that a large group of key stakeholders have been invited to participate in a working group to develop strategies to address and improve the Aboriginal patient journey.[283]

Aboriginal Liaison Officers

5.117 The Aboriginal liaison program was implemented as a response to one of five priority areas identified under the Council of Australian Governments' *Closing the Gap in Indigenous health National Partnership Agreement.* Consultation with Western Australian communities through Aboriginal health planning forums identified liaison, coordination, continuity of care and transport as a priority in supporting Aboriginal clients through the health care system.[284]

5.118 The aim of the program is to fix the gaps and improve the patient journey of Aboriginal and Torres Strait Islander people accessing health care services in metropolitan and regional areas of Western Australia. The Aboriginal Health Council of WA and WACHS Aboriginal liaison coordinators work collaboratively to support the introduction, implementation and evaluation of the State-wide Aboriginal liaison program, by providing leadership and support for staff involved in the program throughout the State.[285]

5.119 The WACHS CEO told the Committee that, in his view, accessibility to ALOs, where they are deemed to be required, is very important. He submitted that as well as the use

281 Mrs Tina Chinery, Chief Operations Officer, Southern, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p3.

282 Miss Michelle Doyle, Patient Liaison Coordinator, Ngaanyatjarra Health Service, *Transcript of Evidence*, 2 September 2014, p4.

283 Letter from Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, 23 September 2014, p3.

284 http://www.healthinfonet.ecu.edu.au/key-resources/programs-projects?pid=1232, accessed on 24 March 2015.

285 Id.

of ALOs, Indigenous staff who have worked with WACHS and who are familiar with administrative processes and community culture are very important.[286]

5.120 The Committee observed a very well developed ALO system in Broome and noted the dedicated patient waiting lounge and extended hours that acknowledge that patients do not always arrive during weekday business hours.

5.121 Evidence in Broome was that the use of ALOs is having a very positive flow-on effect to the PATS. As a result, WACHS is able to case-manage patients from remote communities by having someone meet the bus when it arrives in town, help patients get to the hospital, stay with them in the transit lounge if required, and assist them back to the bus for their return journey home. Evidence was that the ALO service is a critical component of patient care as without it, many people were missing appointments. Due to the ALO service, waiting lists at Broome hospital have decreased significantly resulting in a cost saving, and patients are obtaining the treatment they require.[287]

Nyoongar Patrol Outreach Service

5.122 The Nyoongar Patrol Outreach Service (**Nyoongar Patrol**) is a not for profit Aboriginal organisation providing patrol and outreach services to Aboriginal people at risk in public spaces in the Perth metropolitan area.

5.123 At a public hearing in Perth, the CEO of the Nyoongar Patrol told the Committee that the benefit of the PATS for Aboriginal people was that it provides financial and accommodation support, and allows people to access medical services regardless of where they live.[288]

5.124 She expressed concern, however, at the failure of some of the PATS processes in relation to Indigenous people from remote communities who come to Perth for medical treatment.

5.125 The clients who Nyoongar Patrol deal with are those who have "*fallen through the cracks* [of the system] *and become transient itinerants*"[289]. Ms McAtackney suggested this occurs for several reasons, as discussed below.

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286 Mr Jeffrey Moffet, Chief Executive Officer, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p11.

287 Mr Kim Darby, Operations Manager, Broome Health Campus, *Transcript of Evidence*, 2 September 2014, p7.

288 Ms Maria McAtackney, Chief Executive Officer, Nyoongar Patrol System Inc., *Transcript of Evidence*, 16 February 2015, p2.

289 Tabled Paper Number 1, tabled at hearing with Ms Maria McAtackney, Chief Executive Officer, Nyoongar Patrol System Inc., 16 February 2015, p7.

5.126 Firstly, Aboriginal people are assisted to come into an urban city without support; that is, once they leave hospital, no one is responsible for the continuation of their care.[290] It was put to the Committee that "*the minute they leave the hospital they are left out to fend for themselves, and they do not know how to fend for themselves in terms of manoeuvring through the transport system.*"[291]

5.127 Secondly, if a patient elects not to continue their medical treatment:[292]

> *there is not a tracking system in terms of their wellbeing and what happens to them once they are out of the hospital system. This is where Nyoongar Patrol tries their best to try to reconnect them back into the system, which is often very difficult because once we try to get them back into the medical system we will get a response, "Well, the hospital is not an accommodation facility; the people have to take responsibility for their own lives." We do get all sorts of reasons why it is extremely difficult to link them back into the medical services.*

5.128 Ms McAtackney stated that:[293]

> *If Indigenous people are coming from the remote communities into a setting where it is very unfamiliar for them, there needs to be a linkage of services in the spaces where they tend to gravitate and that there is coordination between services that are there and the hospital. There are a lot of resources that actually go into the clinical–medical setting in terms of PATS, but there are no resources, other than, of late, the Medicare Local, that provide services for people that do fall between the cracks and just do not return for their medical treatment.*

5.129 Thirdly:[294]

> *But if someone has been in Perth and they have fallen through the cracks and they have gone into a drinking binge and they are hanging around the parks and they have become homeless and after six months or so they want to go back home, then they are not flagged on the system as having their tickets paid for.*

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290 Ms Maria McAtackney, Chief Executive Officer, Nyoongar Patrol System Inc., *Transcript of Evidence*, 16 February 2015, p2.

291 Ibid, p3.

292 Ibid, p4.

293 Id.

294 Ibid, p3.

5.130 In order to address these issues, Nyoongar Patrol has developed a continuous management model for Aboriginal patients, carers and visitors receiving medical care in Perth, outside their community.

Accommodation

5.131 Nyoongar Patrol submitted that funding is insufficient to enable access to appropriate accommodation in Perth. It submitted that hostel policies impact on the success of the ongoing treatments; for example, no drinking on the premises policies often result in eviction early in the treatment schedule, with no accommodation alternatives. PATS funds are not refunded and therefore not able to be applied to alternative accommodation. Further, there is very limited appropriate accommodation available.[295] It submitted that "*The homeless journey starts here*."[296]

5.132 Nyoongar Patrol submitted that the accommodation subsidy should be increased to improve accommodation choices and enable safer, more appropriate accommodation to be accessed and to ensure sustainability of accommodation models.[297]

Committee findings

Finding 36: The Committee finds that the Committee recognises that there is a lack of suitable, low cost hostel accommodation generally available in the Perth metropolitan area and some regional areas however the issue of behavioural evictions is a matter for further investigation.

Finding 37: The Committee finds that there appears to be a lack of coordinated support for Aboriginal people coming to the Perth metropolitan area under the Patient Assisted Travel Scheme.

Governance

5.133 During the course of the inquiry, it was raised both through submissions and oral evidence that there is a need for better governance of the PATS.

5.134 A witness from the Wheatbelt Health Memorandum of Understanding Group raised the issue of governance arrangements over the PATS and said:[298]

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295 Tabled Paper Number 1, tabled at hearing with Ms Maria McAtackney, Chief Executive Officer, Nyoongar Patrol System Inc., 16 February 2015, p2.

296 Ibid, p3.

297 Id.

298 Mr John Scott, Independent Chair, Wheatbelt Health Memorandum of Understanding Group, *Transcript of Evidence*, 6 November 2014, p3.

> *It is not very transparent and I think that would be quite helpful from a community perspective if we had a better understanding of the governance arrangements.*

5.135 And:[299]

> ***Mr Scott**: I guess it goes back to the fact that there was a commitment by government to review the process every six months. That has not happened, for whatever reason. If there was a governance group, body or committee, then any concerns that would come from the community could be conveyed to government through that process. Furthermore, I would suggest that a lot of these more detailed comments would have been addressed along the way had there been a governance group in place.*

Western Australian Auditor General's Report 2013

5.136 In 2013, the Western Australian Office of the Auditor General (**OAG**) undertook an administration audit of the PATS. The OAG inquired as to whether the Department of Health was applying appropriate standards of governance to ensure accountability, transparency and fair and equitable customer service.[300] Although the report focused on the administration of the PATS scheme, many of the findings are relevant to the Committee's inquiry.

5.137 The OAG found that the Department of Health was managing some aspects of the scheme well:[301]

- Applications were assessed against eligibility criteria and payments were generally made according to policy.
- The Department provided good customer service. Accurate and necessary information about the PATS was available to patients and referrers to enable them to understand and make applications for assistance.

5.138 However it found that other aspects of the Department's administration of the scheme could be improved. Specifically:[302]

- processes for checking eligibility could be strengthened;

299 Ibid, pp3-4.

300 Western Australian Auditor General Report, *Administration of the Patient Assisted Travel Scheme*, Report 9, June 2013, p3.

301 Ibid, p6.

302 Id.

- controls over payments authorised by the PATS database could be improved; and

- information about the complaints process could be clearer.

5.139 The OAG found that the Department of Health should:[303]

- conduct a formal risk assessment and consider the risks of fraud, misconduct and potential conflicts of interest before further changes are made to the PATS and the way it is administered;

- ensure that decisions to approve PATS subsidies are made according to the current delegations schedule and are properly recorded and signed;

- ensure that adequate records of key decisions are maintained to comply with the financial delegation schedule and the *State Records Act 2000*;

- ensure that the business rules clearly prohibit variation in the subsidy rates prescribed in the PATS policy;

- ensure that conflicts of interest and the actions taken to manage them are properly recorded.

5.140 The OAG noted that the Department of Health accepted the findings and noted that appropriate action has already been taken to address many of the issues.[304]

Department of Health response to Auditor General's report

5.141 The Department of Health advised the Committee that, in response to the OAG findings, a number of immediate controls were introduced to strengthen the authorisation and payment of subsidies. It submitted that "*WACHS is continuing to review PATS processes and the information published about the scheme, however is limited in its capacity to fund any major reforms to the program.*"[305]

5.142 WACHS advised that a working group was set up after the OAG review of the PATS administration. The working group is looking at centralising and managing as many of the processes as possible consistently across seven regions. There is a plan to help standardise some of the administrative processes.[306]

303 Ibid, pp7-8.

304 Ibid, p8.

305 Submission No 125 from the Department of Health, 19 May 2014, p12.

306 Mrs Tina Chinery, Chief Operations Officer, Southern, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p11.

5.143 WACHS advised the Committee that one of the actions they have undertaken as a result of the OAG review was to complete a thorough risk assessment of the administration of the scheme, which has been completed. An example of an issue that has been addressed is where a PATS clerk is related to an applicant. A conflict of interest form has been created to allow the clerk to escalate the claim to another person. Another example has been to amend the delegation schedule to give PATS clerks proper authority to approve payments for flights.

5.144 Training for PATS clerks has also been strengthened as a result of the OAG review. There are now three mandatory training modules for all PATS clerks that are required to be completed prior to commencing processing of claims. WACHS advised the Committee that they would like to include some additional customer service modules.[307]

Paxon Consulting Group Review 2012

5.145 WACHS commissioned a review of the PATS by Paxon Consulting Group[308] in 2012 to consider the need for changes to the program.[309]

5.146 The key findings were as follows:[310]

- The PATS policy contains too many subjective elements.
- There is inconsistency in application of eligibility across regions and within regions.
- Inefficiencies exist in providing resources to make eligibility decisions that are subjective, which is consuming senior management time.
- The administration of the PATS is further complicated by assisting patients unable to coordinate their own health care requirements, compounded by the coordination of travel, accommodation bookings and pre-payments which are not the core competency of the health sector.

307 Mr Peter Collard, Manager, Governance, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p18.

308 *"Paxon Group is a leading Australian advisory and consulting firm offering expert advice to private and public sector clients."* http://www.paxongroup.com.au/about/, accessed on 24 March 2015.

309 Submission No 125 from the Department of Health, 19 May 2014, p12.

310 Id.

CHAPTER 6

CONSIDERATION OF EXCEPTIONAL CIRCUMSTANCES

Introduction

6.1 Exceptional rulings occur when a PATS applicant does not specifically meet the PATS eligibility criteria but meets the intent of the scheme. In those cases, applicants may request an exceptional ruling. The Regional Director makes a decision on the application based on the specific individual circumstances.

6.2 An exceptional ruling does not set a precedent for future decisions. An exceptional ruling may cover:[311]

- Referral to a treatment location other than the nearest service available;
- Extension to the time period for accommodation assistance for long-term treatment programs;
- Treatment and health services not specifically covered by the PATS where the patient's health status may be compromised if assistance is not provided;
- Additional financial assistance where the applicant does not have the means to cover extra costs or hostel or affordable accommodation options are not available; and
- Eligibility of patient escorts.

6.3 The statistics for the number of exceptional rulings for 2013/14 are set out below:[312]

Region	Exceptional Rulings				Applications Declined			
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
Goldfields	2	2	4	4			1	
Great Southern	0	0	2	3			1	
Kimberley	1	6			1	1		1
Midwest	3	12	7	10	1	1	2	1
Pilbara		1			1			
South West	10	3	5	2		4	1	
Wheatbelt	10	9	1	3	1	1		
Total	26	31	19	22	4	7	6	2
Overall Totals	98				19			

311 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, p5.

312 Ibid, p6.

Evidence

6.4 The Committee received many submissions identifying problems with the way requests for exceptional circumstances are currently managed.

6.5 One submission expressed the view that "*There is no genuine consideration for the patients' needs and what they will be when they arrive in Perth or other destinations.*"[313] A similar view was that "*little consideration is given to the exceptional circumstances for certain patients given their personal, social and financial situations.*"[314]

6.6 Another submission expressed the opinion that "*a greater awareness of the exceptional circumstances of patients needs to be fostered in order for the outcomes of PATS to be more closely aligned with those of the health services in general.*"[315]

6.7 Mr Shane Love MLA, Member for Moore, submitted that there needs to be a degree of flexibility within a scheme such as the PATS. He noted that there will be some applications that will need assessing on a case by case basis and provision must be made for these patients. He submitted that flexibility needs to be matched with accountability.[316]

6.8 The Cancer Council noted that patients rarely take it upon themselves to take a dispute to the Regional Director, due to being unwell, fatigued and with the belief that it will not make a difference. Additionally, there may be fear that they will be 'black marked' and unable to receive future assistance. The submission recommended the development of more detailed client information on the appeals and exceptional circumstances process available.[317]

6.9 It was put to the Committee on numerous occasions that decisions about exceptional circumstances vary considerably from region to region.[318] An example is follow-up treatment for cochlear implant patients (refer to paragraphs 4.29 to 4.31 of this report).

Evidence from the Western Australian Country Health Service

6.10 Evidence received in Albany was that there are few requests for exceptional rulings in the Great Southern region. The most common request is where people need to be in

313 Submission No 95 from the Ord Valley Aboriginal Health Service, 15 May 2014, p2.

314 Submission No 109 from the Ethnic Disability Advocacy Centre, 16 May 2014, p3.

315 Submission No 73 from Mr Peter and Ms Josephine Smith, 12 May 2014, p1.

316 Submission No 112 from Mr Shane Love MLA, 16 May 2014, p5.

317 Submission No 76 from the Cancer Council WA, 14 May 2014, p8.

318 For example, submission No 113 from the Parliamentary National Party (WA), 16 May 2014, p10.

Perth for longer than six months and the accommodation assistance has been extended to up to 12 months.[319]

6.11 Applications for exceptional circumstances in Carnarvon are low. Evidence was that in 2013 they accounted for ten out of 2,079 trips, which is less than half a per cent.[320]

6.12 Evidence received in Port Hedland was that, for the Pilbara region, there is a discrepancy between the number of requests for exceptional circumstances reported in the Share online data system and those received by WACHS via email. The East Pilbara Operations Manager advised the Committee that he was enquiring into why the exceptional circumstance requests were not being properly reported into the Share online database system.[321]

6.13 Evidence was also that WACHS has a standard communication that is sent to people if their application has been declined, including the invitation to supply further information.[322]

Evidence from the Department of Health

6.14 The Department of Health noted that exceptional rulings "*are currently managed at a regional level which leads to inconsistency and potential conflict or frustration between the local service provider and resident.*"[323]

6.15 It submitted that a central independent review process would provide greater consistency and transparency for country residents.[324]

6.16 In a hearing with representatives from the Department of Health, Mrs Tina Chinery, Chief Operations Officer, Southern, WACHS, submitted that "*I think the challenge is to make that exceptional ruling decision-making much more consistent, so we have put in some draft procedures. But, again, I think that is an area that needs addressing from an administrative process.*"[325]

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319 Mr Neal Roberts, Business Manager, Albany Health Campus, Western Australian Country Health Service, *Transcript of Evidence*, 25 August 2014, p4.

320 Mr Gerard Burns, Operations Manager, Western Australian Country Health Service, Gascoyne, *Transcript of Evidence*, 29 August 2014, p3.

321 Mr Brian Wilson, Operations Manager, East Pilbara, Western Australian Country Health Service, *Transcript of Evidence*, 1 September 2014, p3.

322 Ibid, p4.

323 Submission No 125 from the Department of Health, 19 May 2014, p15.

324 Id.

325 Mrs Tina Chinery, Chief Operations Officer, Southern, Western Australian Country Health Service, *Transcript of Evidence*, 15 September 2014, p4.

6.17 Elaborating on that point, Mrs Chinery advised that the first PATS procedure to be redefined by the working group set up as a result of the OAG's review of the PATS has been the exceptional ruling process.[326]

Committee finding

Finding 38: The Committee finds that the exceptional circumstances process must be transparent and consistent.

Recommendation 20: The Committee recommends that information regarding claiming for exceptional circumstances be clearly set out on the Patient Assisted Travel Scheme Application Form.

[326] Ibid, p5.

CHAPTER 7

INCIDENTAL MATTERS

Patient Assisted Travel Scheme Working Group

7.1 WACHS established a PATS Working Group (**Working Group**) in April 2014 "*To review the PATS Policy and consider options to improve the administration, management and governance for submission to the PATS Inquiry by the Standing Committee on Public Administration.*"[327]

7.2 The scope of the Working Group includes PATS policy changes, improved PATS governance, alternate services models and funding projections needed to provide access to specialist services closer to home and alternative administration arrangements that will lead to streamlined access and consistency in service provision.[328]

7.3 Membership of the Working Group comprises the following members:[329]

- PATS Program Manager
- PATS Senior Project Officer
- Regional Representative (Nominated by the Regional Director)
- Project Officer, Finance (WACHS)
- Manager, Planning and Evaluation
- Manager Governance
- District Health Advisory Council consumer representatives (one from North and one from South)
- Representative, South Metropolitan Health Service
- Representative, Country Health Connection

327 Supplementary Information Number A2, provided by the Western Australian Country Health Service, as an Answer to a Question on Notice, 10 October 2014, p1.

328 Id.

329 Email from Mr Peter Collard, Manager, Governance, Western Australia Country Health Service, to Committee staff, 18 May 2015, p1.

7.4 The Working Group meets approximately every four to six weeks, or as needed on specific topics.[330]

7.5 Advice to the Committee was that the main areas the Working Group has focused on in the past 12 months include the following:[331]

- Development of fact sheets on specific areas of PATS eligibility for referrers. The Committee was advised that, as at May 2015, these fact sheets are undergoing medical review and will be published by the end of June 2015.

- Trial and evaluation of combined PATS Application Form and Specialist Certification Form. The trial evaluation concluded that the combined form improved application processing and there was generally positive feedback received from clients and referrers. The evaluation identified that refinements were required to the new form and PATS information provided with the Application Form. A small working group has been formed to incorporate the changes to the form and to develop an implementation plan for the roll out of the new form to other regions.

- Trial and evaluation of Electronic Funds Transfer (**EFT**) for PATS payments. Making PATS subsidy payments by EFT was trialled in the South West and also as part of the combined PATS Application Form trial in the Wheatbelt and Pilbara. Usage of EFT payments increased over the trial period with only a small number of incorrect transfers made due to clients providing incorrect bank details, which were easily corrected. A recommendation has been made to the WACHS Director Finance to roll out EFT payments for the PATS in other regions and implementation planning has commenced.

- Development of a PATS Reporting Framework to allow regions to better monitor PATS activity and trends. The Health Information Network commenced producing regular quarterly PATS reports to the regions from January 2015.

- Develop strategies for alternative PATS accommodation following closure of Jewell House on 30 June 2015. A Memorandum of Understanding has been established with Aboriginal Hostels Ltd to increase the number of beds used by PATS clients within their metropolitan facilities from 40 beds per night to 50 beds. In principle agreement has been reached with Genesis Lodge (in Salter Point) to provide a minimum of 15 beds per night for PATS Aboriginal

330 Email from Mr Peter Collard, Manager, Governance, Western Australia Country Health Service, to Committee staff, 18 May 2015, p1.

331 Ibid, pp1-2.

clients (at the $60 per night PATS rate[332]). The agreement with Genesis Lodge is being finalised and is scheduled to commence on 1 June 2015. Foundation Housing Ltd (an affordable housing provider) has identified potential suitable accommodation for PATS clients in the Fremantle area, which is being evaluated to determine if this will be suitable for PATS clients referred to the Fiona Stanley Hospital.

- Investigation of Electronic PATS Application Template. Investigations have been initiated on the conversion of the PATS forms into electronic format for upload into GP practice systems and lodgement by secure messaging. Technical assessment has determined that the majority of data elements captured on PATS forms can be mapped to data fields stored in GP practice systems. The implementation of similar electronic templates by the CRS has been monitored closely and they have only recently resolved a number of technical problems with the linkage of their electronic referral template with some of the GP practice systems being used by doctors. Take-up of secure messaging by GPs to send their referrals to the CRS has been low and is being investigated. A budget estimate for the further development of an electronic PATS Application Form template has been requested from the developers, and deployment and workflow issues will be considered by the Combined PATS Form Working Group (referred to in bullet point two above).

- Review of PATS Training and User Manual. Work has commenced on reviewing and updating this manual.

- PATS Online Application – User Group. A PATS online user group has been formed as a sub-group of the PATS Working Group to identify and to provide recommendations on system fixes and upgrades necessary to the PATS Online System. System testing and collation of system issues has commenced to facilitate prioritisation of system upgrades by Health Information Network.

Accommodation Facilities in Perth and the Regions

7.6 A table showing low cost accommodation facilities for PATS patients in Perth and the regions is set out below.

[332] Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates (Hansard)*, 14 May 2015, p3736b.

Accommodation Facilities in Perth and the Regions

Facilities	Hospital Style Room	Single Unit	Hostel Style Room-Beds	Twin Unit	Family Unit	House	Nurse Available	Carer or Family Accommodation	Transport to Appointments	Cost - Patient	Cost- Carer	Comments
Crawford Lodge - Nedlands		6		44	3				Yes	$60	$15	
Milroy Lodge - Shenton Park		24			2				Yes	$60	$15	
Agnes Walsh Lodge - Subiaco	12											
Jewell House - Perth			25							$60		Closing 30 June 2015
Kidney Health - Morley						2				Covered by PATS		
Derbal Bidjar Hostel - Maylands			31					No children or families				Not all PATS beds
Allawah Grove Hostel – South Guildford			46					Some family for short stays				Not all PATS beds
Genesis Lodge – Salter Point			15									From 1 June 2015
Broome Hostel	26						Yes					
Kabayji Booroo Hostel - Derby	21							Partners and escorts accommodated				
South Hedland Hostel			48							Covered by PATS		
Trilby Cooper - Kalgoorlie			48									
Broome Time Lodge										Covered by PATS		Private lodge

Committee finding

Finding 39: The Committee finds that the current accommodation facilities suitable for Patient Assisted Travel Scheme patients in the metropolitan area are inadequate. As an example, the closure of Jewell House near Royal Perth Hospital and the opening of Fiona Stanley Hospital have brought increased pressure in the form of a lack of suitable accommodation.

Recommendation 21: The Committee recommends that there needs to be further suitable accommodation facilities provided for Patient Assisted Travel Scheme patients.

Adequate Medical Services in the Regions

7.7 A number of witnesses noted the importance of maintaining services in rural and remote areas. One submission emphasised that "*delivering a stronger PATS should not come as a trade-off to the continued agenda to renew and develop new health care facilities in regional areas by the Department of Health and the WA Country Health Service.*"[333] It submitted that delivering a stronger and more effective PATS should

[333] Submission No 113 from the Parliamentary National Party (WA), 16 May 2014, p13.

be viewed as one part of the broader model to improve healthcare in regional Western Australia.[334]

7.8 The Mental Health Commissioner expressed his view that a scheme that enables people to travel to the metropolitan area is a second best option to one that brings services to the people.[335]

7.9 Mr Marney told the Committee:[336]

> *I actually have a view that the issue is not how we bring people to services in the city, in Perth, but how we actually get services to the people in regions. That is where our focus needs to be, because dislocating people from their community in dealing with mental health and supporting their mental health or recovery from mental illness is very damaging to that process.*

7.10 He submitted that there is a need to consider either how services are provided on location in the regions or outreach from Perth to regional areas by means of visiting specialists or telepsychiatry. He noted that although the infrastructure to operate remote videoconferencing exists, that equipment is not being used for the delivery of specialist mental health services.[337] Mr Marney noted that "*there are some legislative issues at the moment, but under the Mental Health Bill that is progressing at the moment, it addresses that.*"[338] The Commissioner made the point that "*there is an opportunity to actually change the model of service.*"[339]

7.11 In the mental health context, it was put to the Committee that early intervention is the highest priority in terms of providing health care to people in regional areas.[340]

7.12 Similar evidence was received from the Disability Services Commission, which stated that they have tried to ensure that therapy services are the best they can be for people in situ.[341]

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334 Id.

335 Mr Timothy Marney, Commissioner, Mental Health Commission, *Transcript of Evidence*, 24 September 2014, p6.

336 Ibid, p2.

337 Id.

338 Id. The Mental Health Bill was assented to on 3 November 2014.

339 Mr Timothy Marney, Commissioner, Mental Health Commission, *Transcript of Evidence*, 24 September 2014, p2.

340 Ibid, p6.

341 Mr Christopher Yates, Acting Executive Director, Disability Reform, Disability Services Commission, *Transcript of Evidence*, 24 September 2014, p7.

7.13 A witness from the AHIU provided an example of an Aboriginal medical service that was built three years ago in Mt Magnet to service remote areas. Evidence was that a visiting cardiologist saw 47 patients during a recent tour of the region. The patients who needed a follow-up consultation were seen in the Mt Magnet Aboriginal Medical Service unit via teleconnect services to Geraldton. The witness estimated that the savings from not having to fund trips to Perth for those follow-up consultations was approximately $37,000.[342]

7.14 Visiting specialist services are provided by WACHS in Kalgoorlie for cardiologists, urologists and ear, nose and throat surgeons. In deciding which specialists to support, WACHS stated it "*very much target approaches from specialists that will impact on our PATS costs and perhaps the inconvenience of travel for people to Perth.*"[343] Evidence was that were it not for the visiting specialists, many patients would ignore their medical condition and not travel to Perth for treatment.[344]

7.15 The savings to the PATS as a result of the visiting medical services is significant. It was estimated, for example, that each monthly urology clinic saves the PATS approximately $30,000.[345]

7.16 In relation to renal facilities in regional areas, Dr Moody stated that "*It is not only having the physical facility, the beds, the dialysis machines – they are relatively simple – it just costs money.*"[346] Dr Moody said "*we cannot get staff to adequately fill them.*"[347]

7.17 Dr Moody stated that "*not all nurses want to work in renal medicine and you cannot force them to work in renal medicine and there is no incentive to encourage nurses to work in renal medicine ...*"[348]

7.18 Dr Moody told the Committee that:[349]

> *you may have the beds and chairs there, but you may not be able to fully utilise them because you have not got the nursing staff to actually service that facility. I know that is a perennial problem in*

342 Mr Arthur (Sandy) Davies, Area Director, Aboriginal Health, Aboriginal Health Improvement Unit, Western Australian Country Health Service, *Transcript of Evidence*, 24 September 2014, pp6-7.

343 Ms Geraldine Ennis, Regional Director, Western Australian Country Health Service, Goldfields, *Transcript of Evidence*, 26 August 2014, p3.

344 Ibid, pp3-4.

345 Ibid, p5.

346 Dr Henry Moody, Clinical Lead, Renal Health Network (WA), Department of Health, *Transcript of Evidence*, 16 February 2015, p2.

347 Id.

348 Id.

349 Ibid, p3.

> *Geraldton and I am sure it must be the case in many other regional centres.*

7.19 And:[350]

> *one of the other vital things that we need to do is get more nurses working in renal medicine in regional areas.*

Interstate Transfers

7.20 WACHS has a contract with the Royal Darwin Hospital whereby they purchase six beds and have access to the intensive care unit. The Darwin beds are primarily for time-critical transfers. Most patients are from the East Kimberley, notably Kununurra. The PATS funds patient transfer back to Western Australia. Evidence was "*That has been an extremely good arrangement, not one that we would ever want to see not there.*"[351]

7.21 The number of claims for the Kimberley region in 2013/14 for travel to Darwin was 199 and, for the same period, to Perth was 2,869.[352]

7.22 Evidence taken in Broome in relation to whether it is best to send patients to Perth or Darwin was as follows:[353]

> ***Ms Bradley****: It depends what specialist service we are requiring. If it is specialist cancer services, probably Perth; Darwin is limited. It just depends. If it is a specialist service like neurosurgery and brain surgery and things like that, Darwin does not have those services or cardiac surgery. It just depends.*
>
> ***Hon DARREN WEST****: Going on from that, the services that Darwin does have, from a cultural perspective, especially for people from remote communities, all things being equal, is Darwin a far better option, slightly better or the same?*
>
> ***Ms Bradley****: It probably is the better option; yes, it would be.*
>
> ***Hon JACQUI BOYDELL****: I have one more question along the same lines as Darren's. I was going to ask you whether the meet-and-greet*

350 Id.

351 Mrs Kerry Winsor, Regional Director, Kimberley, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p10.

352 Letter from Mrs Kerry Winsor, Regional Director, Western Australian Country Health Service, Kimberley, 16 September 2014, p2.

353 Ms Brenda Bradley, Acting Operations Manager, Western Australian Country Health Service, *Transcript of Evidence*, 2 September 2014, p3.

> *services you have found are better in Darwin than in Perth? Are there more resources available in Darwin?*
>
> ***Ms Bradley**: It is varied. Usually, most of the commercial planes from Kununurra arrive in the daylight, which is a bonus. We have a direct flight from Perth to Kununurra to Darwin daily, so it arrives at 5.00 pm. That is bordering on business hours; it is only a business hours function. Often the planes in Perth arrive early evening to late in the evening. It is challenging trying to get even yourself around.*

7.23 Evidence taken in Kalgoorlie from Bega Garnbirringu Health Service was as follows:[354]

> ***Mr Holt**: We obviously cover any clients that present at the clinic here in Kalgoorlie, but then the mobile clinics go up as far as Laverton, and then the southern corridor runs all the way down to Esperance. We do often get clients presenting from South Australia, and we also have clients coming in from the Northern Territory as well. So it is a fairly broad geographic area that we cover.*
>
> ***The CHAIRMAN**: That is interesting. So the clients who come to you from the Northern Territory, if they require medical treatment to access the PAT system, are they flown back to Darwin or Alice Springs for that treatment or are they sent to Perth?*
>
> ***Mrs Waters**: If they present here, and it is our doctors that are treating them, they will go to Perth.*

7.24 In rare circumstances, patients from remote communities may be transferred to and from Alice Springs.

7.25 Evidence taken in Kalgoorlie from WACHS in relation to transporting patients to Adelaide was as follows:[355]

> ***Ms Ennis**: We have had offers, but we have got people to Perth, even though they have been people who wanted to go from Kalgoorlie to Adelaide because that is where their family is. We have a huge amount of interstate people who work here in mining. They might be from Queensland, and they would prefer to go and have their*

354 Mr Clive Holt, Chief Operations Officer, Bega Garnbirringu Health Service, and Mrs Elizabeth Waters, Manager, Clinical Services, Bega Garnbirringu Health Service, *Transcript of Evidence*, 26 August 2014, p6.

355 Ms Geraldine Ennis, Regional Director, Goldfields, Western Australian Country Health Service, and Mr David Bowdidge, Operations Manager, Kalgoorlie Hospital, Western Australian Country Health Service, *Transcript of Evidence*, 26 August 2014, p15.

chemotherapy in Queensland or Adelaide rather than here, but we say, "No; we only provide to Perth."

***Mr Bowdidge**: There is an interstate PAT scheme for highly specialised treatment—treatment not available in WA. We do have issues—RFDS flying into Eucla may well fly to Ceduna with the patient. Then, to what extent does WA support them getting back to Eucla or WA? Those issues are treated on a case-by-case basis. We will basically circulate the issue widely to get a proper opinion.*

Concerns Raised During the Inquiry that have been Addressed

Royal Flying Doctor Service

7.26 In evidence taken in Kalgoorlie, the CEO of the Goldfields Voluntary Regional Organisation of Councils raised the issue of funding for patients who had been flown to Perth by the Royal Flying Doctor Service to return home. He stated:[356]

I am not clear, but I am aware from other councils that are a bit further out from here, that if someone gets flown down by RFDS, it is not clear how PATS can get them home or if PATS can actually get them home. I do not know what the actual circumstances are, but it was raised by another council in GVROC that there is confusion about people who fly to Perth through RFDS, which is assuming that their local service cannot provide that, and they have to come back somehow and it is not clear whether PATS actually does that or how it does it. I do not know; I just raise that on behalf of the council.

7.27 The Operations Manager, WACHS Gascoyne, clarified what occurs in this situation:[357]

***Mr Burns**: That is catered for under the inter-hospital patient transfer. So, there are two ways they could come back. One is that if they were, say, injured up the road and were flown out from up the road, they are deemed to have been admitted to Carnarvon Hospital. Therefore, it is Carnarvon Hospital's responsibility to bring them back whether it is under the PAT scheme or the inter-hospital transfer scheme.*

356 Mr Don Burnett, Chief Executive Officer, Goldfields Voluntary Regional Organisation of Councils, *Transcript of Evidence*, 26 August 2014, p3.

357 Mr Gerard Burns, Operations Manager, Western Australian Country Health Service, Gascoyne, *Transcript of Evidence*, 29 August 2014, p4.

One way flights

7.28 The CEO of the Carnarvon Medical Service Aboriginal Corporation stated in evidence that:[358]

> *We believe that having people, for example, sent on one-way flights to Perth and being told to find their own way home is completely unacceptable and is a very obvious example of how bad the system is.*

7.29 The Committee requested from the Carnarvon Medical Service Aboriginal Corporation the number of patients sent on one way flights in these circumstances. The information provided was that the number of patients sent one way from Carnarvon to Perth between 1 January 2014 and 31 August 2014 was nine.[359]

7.30 The Operations Manager, WACHS Gascoyne, told the Committee that:[360]

> *Generally, if a patient is referred by air down there, their return journey is booked. It is not a very common occurrence where somebody is referred—to be honest, I have never heard where somebody has flown down and then been expected to drive back. It may occur, but I would certainly take a compassionate approach to that, but it has to be judged on a case-by-case basis.*

Checked-in luggage allowance

7.31 The CEO of the Broome Regional Aboriginal Medical Service told the Committee at its hearing in Broome that:[361]

> *One of the other faults with PATS, particularly with young mums when they go down to bear their children, many of them do not bring a lot of stuff with them and normally have a carry-on bag. When their flights are booked from Broome to Perth, they book a red deal, economy or cheap flight with only carry-on luggage. When they are down there and they have the bub and they buy some extra stuff to bring back with the bub, they cannot bring it on because they are allowed a ticket for carry-on luggage only.*

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358 Mr Shane Van Styn, Chief Executive Officer, Carnarvon Medical Service Aboriginal Corporation, *Transcript of Evidence*, 29 August 2014, p1.

359 Letter from Mr Shane Van Styn, Director, Carnarvon Medical Service Aboriginal Corporation, 18 September 2014, p1.

360 Mr Gerard Burns, Operations Manager, Western Australian Country Health Service, Gascoyne, *Transcript of Evidence*, 29 August 2014, p5.

361 Mr Henry Councillor, Chief Executive Officer, Broome Regional Aboriginal Medical Service, *Transcript of Evidence*, 2 September 2014, p4.

7.32 And:[362]

> *I have evidence to tell you that we forked out $500 at Perth Airport to ensure a mum could bring the rest of her stuff as excess luggage.*

7.33 And:[363]

> *I think it is about that if you do not bring luggage, then it is easier to get you on a red deal flight; it is all about the cost factor of what PATS do. Of course PATS are looking for cheaper ways and getting the most cheap flights down there, but nothing is taken into consideration on the return.*

7.34 The Committee wrote to the Regional Directors of all WACHS regions asking for their policy in relation to allowing checked-in luggage. The responses were as follows:

- Kimberley: *"For those flights where luggage is not included in the fare, we buy a luggage allowance on behalf of the patient.*"[364]

- Midwest: *"All flights are booked in consultation with patients to make certain their needs are met, including ensuring there is adequate luggage allowance provided. We have not had any issues within our region with clients not being able to check in luggage*."[365]

- Pilbara: *"Pilbara PATS staff utilise Carlson Wagonlit Travel (CWT) to book PATS flights. All flight booking types used via CWT, including Saver, Flexi, Fully Flex and Business Class have a checked luggage allowance. The 'Saver Lite' fares (without luggage) are generally the cheapest fares offered, however are not available for purchase via CWT contract. Therefore these types of air fares are not used, where Pilbara PATS staff arrange the booking*."[366]

- Goldfields: *"patients are booked on with checked in luggage and it would only be on a rear* [sic] *occasion due to lack of seats that patients would be*

362 Id.

363 Ibid, p6.

364 Letter from Ms Kerry Winsor, Regional Director, Kimberley, Western Australian Country Health Service, 16 September 2014, p2.

365 Letter from Ms Margaret Denton, Regional Director, Midwest, 19 September 2014, p2.

366 Letter from Mr Ron Wynn, Regional Director, Pilbara, Western Australian Country Health Service, 6 February 2015, pp1-2.

booked in with no luggage and this would be confirmed with the patient if this was suitable ie return same day travel."[367]

- Great Southern: *"For intra-regional air travel in Western Australia, Qantas and Virgin Australia automatically provide a checked baggage allowance of 23kg per person with an allowance made for those travelling with infants. Both airlines permit that specific infant equipment can be carried free of charge. However, Qantas permits an additional 10kg of luggage per infant, not available when travelling with Virgin Australia. Virgin Australia is the only commercial airline operating the Albany-Perth-Albany route. There are no instances when a Great Southern PATS client can be booked on a flight with no checked luggage allowance."*[368]

- South West: This issue is not applicable for this region.

- Wheatbelt: This issue is not applicable for this region.

[367] Letter from Ms Geraldine Ennis, Regional Director, Goldfields, Western Australian Country Health Service, 23 September 2014, p1.

[368] Letter from Mr David Naughton, Acting Regional Director, Great Southern, Western Australian Country Health Service, 5 January 2015, p1.

CHAPTER 8

CASE STUDY - PENNY'S STORY

8.1 Of all the people who gave evidence to the Committee, one stood out. She is an Aboriginal woman from Carnarvon who will turn 71 this year. She has a heart condition and is a full time carer for her grandson, who has mental health problems from drug and alcohol abuse. She brought up both of her grandchildren after her daughter died of multiple sclerosis at the age of 40.

8.2 The Committee would like to share Penny's story, as it was representative of a lot of the witnesses who gave evidence to the Committee. In particular, it demonstrates the complexity of health care needs in regional Western Australia and the difficulties faced by people obtaining suitable transport and accommodation away from home.

Penny's Story – Taken from Transcript of Evidence given in Carnarvon on 29 August 2014

> *I go down [to Perth] twice a year—a check-up for my heart. I have an echo heart, and my grandson, he comes down with me. I am a full [time] carer … for A and when he is sick, I go down with him. I am an escort for him and he also escorts for me. We go down by PAT—the PAT scheme papers and that. I go on the plane because I have got a hip replacement and I also have a walker, so they put me on the plane—me and my grandson. Sometimes I go to Geraldton and the specialist come up from Perth to Geraldton and I see the doctor there. Now, we get a PATS form from Carnarvon to Geraldton, a taxi voucher to the accommodation, the accommodation taxi voucher to the hospital, and a taxi voucher back to the accommodation, and the accommodation taxi voucher to the airport.*
>
> *Now, the Skippers is our plane and sometimes they travel twice a week and sometimes they are late. We were down there in Geraldton and the plane had to turn around in midair because there was a bit of a faultage in the engine and we never got on the plane until about nine or 10. The accommodation where I was staying in Geraldton, that was at the RSL and the PATS forms they pay for the beds only, so if you are going down like today, the PATS will say, "Well, you have got tonight and tomorrow night to camp there and then you have got to come back." So, if you are going down there early, you have not got the money because it is not my pay week this week, my pension, and we have no money.*

So, we go down on the PATS form and at the RSL place there they have got disability people living there. Well, we are just the patients and we do not get a feed there because we are not local. So, we have to have money to walk down to the shop to buy a pie or a cool drink or something. So, you stay there with nothing, and sometimes the staff, they see you with nothing, you know, they are all eating in the kitchen and everywhere, and they come along with a plate or something, a chop or a spud, and they will sort of, you know, feed you, more or less, and then you just sort of stay there until it is time for you to leave there.

Now, there is an Aboriginal accommodation, the Boomerang, and that has got local Aboriginals there, but I think they are permanently there staying, and sometimes you have got appointments for doctors' appointments and things there, and that is always full, so you cannot stay there, so they send you down to RSL. That is one part of it. And now going down to Perth for my heart again, I get on the plane—me and my grandson—and we go to Perth. There are two places down there where you can go. They will ask you at the hospital where you want to camp or which hostel you want to go to, and, well, I come from Perth. I left there in 1969 and I have been up here all that time, and Perth has changed and the people I know are all passed on, so you have got nowhere to go, so you just follow whatever they say. Well, Jewell House—talking about Jewell House. Well, from the airport to Jewell House, the taxi voucher—and you have got to have $20 to get in to get a bed [in a dormitory].

I find Jewell House very dirty because they have got dialysis men there and they all stand outside and smoke. I do not smoke or drink or anything like that and I do not go down there to watch what they do and all this and that; I go down for my doctor's appointment. But I have got nowhere else to live, so they put me in Jewell House there. Now, I have a bit of problems. I have a weak bladder too and I asked the Aboriginal people there if they could put me where the toilet is because I am always up and down to the toilet on account of my weak bladder, and they look up in the book and they say, "Well, we have not got a room in the flats for you to live in, because it is upstairs and downstairs".

So what they do is they put me up into the men's quarters up there, right next to the toilet, so my room is here and the toilet is over there, so I just slip in and out. But they have the patients that go there, and the dialysis patients—all men who smoke and that—and then they have got all the backpackers and things like that, so I have to hurry

along. My grandson will stand at the door and say, "Nanna is in there; she's having a shower", or something like that. One time, you know, I thought they were gone and I went and had a shower, and the bloke next door, he is having a shower too. I did not know nothing, and when I came out, I just put my nightie over me and I walked out all wet and when I looked, I saw him there, and he goes, "Oh, good morning", and I just said, "Oh, good morning; they put me up there, you know". So I went downstairs. You have the breakfast. They give you a feed. So, you have, you know, eggs, bacon, sausages and things like that. Good tucker they give you, but sometimes you are rushing for the doctor. This is at Jewell House.

So, you go across the car park and there is a big lot of stairs. That is where we have to go to check in to see the doctor there instead of going to Royal Perth, where the big church is there, so you just go straight across there. And you forget because you already had a bellyful and you forget to ask the lady to put something for lunch and supper. So we go to the doctors and we sit there till about three o'clock because we are not the only patients there in the room. So, we have to wait there that long, and when we come back, we go to our room and we have no money because it is not my pension day today, and tomorrow is not my pension day. It is on a Friday or a Thursday, and we seem to go down on a Tuesday, Wednesday and a Thursday. But we got to pay first before we get in.

And, anyway, we sit down and I ask one of the blokes, "Where do you get the soup from, you know, the soup kitchen, the truck or bus?" They have got a big bus there. Well, from here to Woolies, that is how far I have to walk with my walker, because my grandson, he gave up. So, I walk straight out down there to the corner and see all the druggies and whatever there; they see me standing there. "There! The bus is coming now! The bus is coming." So, I stand up in line and the lady said, "How many cups you want?" and I said, "Give us four cups"—pea and ham soup and a bun. I say thank you and I go back and have a good old feed and then I got to wait then. Sometimes we stay there for two nights.

And another thing I find down there in Perth, the taxis, because I have a walker and the taxis have got [a gas canister]… They refuse me because I forget what I want a taxi for. They say, "Oh, we cannot take you because we cannot put your walker in the car; it has got no room." I have got told plenty of times by the taxi man, "Oh, why do you not ring for a station wagon?" So I get on the phone again and ask for a station wagon, and I go down by that. Sometimes I have a

fuel card; sometimes I run it out, sometimes I do not. I have a taxi voucher. I have two when I am travelling or going up north or down to Perth, down for a funeral; I have one of these here. So, I was—how much is it? It is about 25 per cent, I think, the government pays half for me, so I have that. That comes in handy when I am going, because I have got no money, and if the taxi from here down to Woolies costs me $8, well, I do not have $4 on me because the government pays $4 on this here. So, it is very hard for me to get around, and especially when I have a walker and that there.

My daughter died of MS, 40 age, and I had to go to the Family Court because the other ones wanted my grandchildren, and I said, "Well, I moved out of Perth because, you know, I was an alcoholic and that and I came up here and I worked around and things like that", so I had to go back to Perth to the Children's Court and I won for my two grandsons—A and J. So, I brought them up here. A was four years old and J was two. But in the meantime I reared another little boy up—he was two—because his mother was a drug addict and she did not want him, so I had three little boys to look after, and A is still with me, like I just shown you the carers card I get, and I go to meetings and that there. A is mental distressed—he is a suicide—and I am 24/7 with him. I go to meetings, carers and that, from Geraldton; they come up. But nothing about mental people and things like that. So, for the last 26, 27 years that I have had A—he is 31 years old now—I never had a break. I never had a nervous breakdown because I am so calm and I manage and I am 24/7 with him …

When the carer people come up from Geraldton, they have got—what do they call that other thing, you know, in little children? They are like ADD kids. They have got all that and they have got a package for that and things like that. But I do not have a package for that because A is not one of those; he has been destroyed when he was young from drugs and alcohol, and his brain—in other words, excuse my expression, but I always say "shit for brains".

He has got a supervisor. I get the pension. I only get $340 and A gets his money. He pays two hundred and something for the rent; I pay two hundred and something. He pays $50 for light and I pay $50 for light and $10 for water and $10 for water and the rest goes on food. If he feels like he wants drugs or wants a drink, I cannot say no because that is his money. Because A has got a supervisor, I have to account for his money. With my money, we got a loan from the government of $1 000. Instead of buying rubbish, last year I said, "We'll buy a car, A." So he said, "All right, then, Nanna; buy a car." So I sent down

$1 000. I got my loan over $1 000. I put it down for the car, and when A got his loan, I said, "Are you going to help me?" and he said, "I'm not giving you all my money, Nan. I'll give you $500." So I said, "Well, give me $500", and I put it in the bank, and that went down, and then I had to scratch around again for the other $500 to make it two grand; it cost two grand….

Anyway, I went down [to Lottery House] and I asked Catherine for a handout for the vehicle, and she licensed my vehicle for me, so that was out of the way for 12 months. So once you have got a supervisor looking over your child's shoulder all the time wondering where the money is going, I have got to show for it, because I do not rob my grandson. I was never brought up like that—you know, taking money off people, because I have got my own. What we have not got in the house, like milk and sugar, I said to A, "Well, Nanna bought you two of this and two of that and we've got no sugar or milk; we've got to wait till Wednesday." And he said, "Oh, Nanna, can I go over?", and I said, "No; you go without, because you know why? You didn't make a spin out." You can only take so much and make the day to day what you want and then leave it for tomorrow—take like that. So I make him spin out and he gets very angry with me because he is a mentally unbalanced fella: "I jump on you and cut my throat and cut your throat." I just back off and look at him. For 26 years, I more or less got into his head. I know what he is thinking. I know if he is going to go and do suicide. I know how long he takes the car for. I got a driver's licence for him to help him go down to Perth for funerals and things like that. I cannot drive too far, so we exchange. I have got to think all the time for him. He puts a cigarette in the fridge. He puts the socks in the fridge on Wednesday: "Oh, Nan, where's my smoke?" And I will say, "Open the fridge and get the milk out." "Oh, there's my smoke there, Nanna. Did you put it in there?"

That is all I wanted to say.

Hon Liz Behjat MLC
Chairman

16 June 2015

APPENDIX 1

STAKEHOLDERS INVITED TO MAKE A SUBMISSION, SUBMISSIONS RECEIVED AND PUBLIC HEARINGS

Stakeholders invited to make a submission:

1. Mr Frank Prokop, Executive Director, The Health Consumer's Council (WA)
2. Ms Anne Donaldson, Director, Health and Disability Services Complaints Office
3. Ms Yasmin Montgomery-Howard, Executive Liaison Officer, WA Country Health Services
4. Ms Kerry Winsor, Regional Director for the Kimberley, WA Country Health Services
5. Mr Ron Wynn, Regional Director for the Pilbara, WA Country Health Services
6. Ms Margaret Denton, Regional Director for the Midwest, WA Country Health Services
7. Ms Geraldine Ennis, Regional Director for the Goldfields, WA Country Health Services
8. Ms Caroline Langston, Regional Director for the Wheatbelt, WA Country Health Services
9. Ms Susan Kay, Regional Director for the Great Southern, WA Country Health Services
10. Ms Grace Ley, Regional Director for the South West, WA Country Health Services
11. Ms Caroline Roper, Senior Project Coordinator, South Metropolitan Health Service
12. Prof Bryant Stokes, Acting Director General, Department of Health
13. Mr Timothy Marney, Commissioner, Mental Health Commission
14. Mr Paul Rosair, Director General, Department of Regional Development
15. Dr Ron Chalmers, Director General, Disability Services Commission
16. Dr Richard Choong, former President, Australian Medical Association (WA)
17. Mr Adam Johnson, Chief Executive Officer, Advocacy South West Inc.
18. Mr Andrew Jefferson, Executive Director, People with Disabilities WA
19. Hon Terry Redman MLA, Minister for Regional Development
20. Hon Dr Kim Hames MLA, Minister for Health
21. Hon Helen Morton MLC, Minister for Mental Health; Disability Services
22. Ms Yanyi Bandicha, Chairperson, NPY Women's Council Aboriginal Corporation
23. Mr Wayne Johnston, Chief Executive Officer, Bega Garnbirringu Health Service
24. Mr Henry Councillor, Chief Executive Officer, Broome Regional Medical Service
25. Ms Ganthi Kuppasamy, Chief Executive Officer, Carnarvon Aboriginal Medical Service
26. Ms Tammy Prouse, Chief Executive Officer, Derby Aboriginal Health Service
27. Ms Deborah Woods, Chief Executive Officer, Geraldton Regional Aboriginal Medical Service
28. Mr Juan Clark, Manager, Great Southern Aboriginal Health Service
29. Mrs Vicky O'Donnell, Chief Executive Officer, Kimberley Aboriginal Medical Service Council
30. Mr Eric Bedford, Chief Executive Officer, Marra Worra Worra
31. Chief Executive Officer, Puntukurnu Aboriginal Medical Service
32. Ms Joan Hicks, Chief Executive Officer, Mawarnkarra Health Service Aboriginal Corporation
33. Mr Andrew Amor, Chief Executive Officer, Milliya Rumurra Aboriginal Corporation
34. Mr Brett Cowling, Chief Executive Officer, Ngaanyatjarra Health Service
35. Mr Richard Whittington, Chief Executive Officer, Nangganawili Aboriginal Community Health Centre
36. Mr Ken Riddiford, Chief Executive Officer, Ngnowar Aerwah
37. Mr Grahame Cooper, Chief Executive Officer, Ord Valley Aboriginal Health Service

38. Mr Neil Fong, Chief Executive Officer, South West Aboriginal Medical Service
39. Ms Asha Bhat, General Manager, Southern Aboriginal Corporation
40. Mr Des Hill, Chief Executive Officer, Waringarri Aboriginal Corporation
41. Ms June Councillor, Chief Executive Officer, Wirraka Maya Aboriginal Health Service
42. Mr Ian Benjamin, Chief Executive Officer, Yura Yungi Aboriginal Medical Service
43. Dr Randy Beck, Chief Executive Officer, Primary Care WA
44. Ms Amanda Poller, Chief Executive Officer, GP Down South
45. Ms June Foulds, Chief Executive Officer, Koombana Health Network
46. Ms Margie Ware, Acting Chief Executive Officer, Boab Health Services
47. Mr Paul West, Chief Executive Officer, Wheatbelt GP Network

Submissions Received:

1. Ms Christiane Hodgson, Private Citizen
2. Mr Malcolm Smith, Private Citizen
3. Ms Patricia Carroll, Private Citizen
4. Mr Ashley Thompson-Brown, Private Citizen
5. Ms Josephine Bedetti, Private Citizen
6. Ms Diana Stockdale, Private Citizen
7. Mr Geoffrey Ebdon, Private Citizen
8. Mr Allan Barnes, Private Citizen
9. Ms Julia Hudson, Private Citizen
10. Mr John Nicoli, Private Citizen
11. Ms Yvonne Panting, Private Citizen
12. Ms Denise Barber, Private Citizen
13. Ms Beryl Davis, Private Citizen
14. Ms Theresa Bengtson, Private Citizen
15. Ms Fiona Chandler, Private Citizen
16. Private Citizen
17. Mr Alan James, Private Citizen
18. Ms Alysia Kepert, Private Citizen
19. Dr Graham Jacobs MLA, Member for Eyre
20. Mr Bruce Magurire, Senior Social Worker, Sir Charles Gairdner Hospital
21. J & P Whittaker, Private Citizens
22. Ms Kelly Lundie, Private Citizen
23. Ms Betty Campbell, Private Citizen
24. Ms Fiona Dinka, Private Citizen
25. Ms Merrilyn North, Private Citizen
26. Private Citizen
27. Private Citizen
28. Private Citizen
29. Mr Frank Heffernan, Narrogin Menshed
30. J & J Fletcher, Private Citizens
31. Mr James Livingstone, Private Citizen
32. A.B Gibson, Private Citizen
33. A & L Downing, Private Citizen
34. Dr Susannah Warwick, Derby Aboriginal Health Service
35. L.J Stevens, Private Citizen
36. Ms Elvina McFaul, Private Citizen
37. Ms Gwyneth Ingham, Private Citizen
38. Mr Wayne Johnson, Chief Executive Officer, Bega Garnbirringu Health Service

39. Private Citizens
40. J & P McDougall, Private Citizens
41. Mr Stephen Psaila-Savona, Acting Director, Health and Disability Services Complaints Office
42. Mr Clem Kerp, Chief Executive Officer, Shire of Goomalling
43. Ms Valerie Drage, Private Citizen
44. Mrs Sue McArthur, Private Citizen
45. Mr Bill Fensome, Chief Executive Officer, Shire of Nungarin
46. Mr Neil Ewart, Chief Executive Officer, Yungngora Association (Noonkanbah)
47. Ms Debbie Dowden, Private Citizen
48. Sharrie, Private Citizen
49. Roger Shordon, Private Citizen
50. Ms Rebecca Moroney, Private Citizen
51. Mr Vincent Fordham Lamont, Deputy CEO, Shire of Coorow
52. Ms Deb Cowan, Private Citizen
53. Dr Simon Evans, Royal Flying Doctor Service
54. Mr Stephen Cushing, Private Citizen
55. Mr William Robe, Private Citizen
56. T.A Nunn, Private Citizen
57. Ms Lyn Winzer, Private Citizen
58. Mr Ross Winzer, Private Citizen
59. Mr Andrew York, General Manager, Leukaemia Foundation
60. Ms Kate Johnston, Executive Support Officer, Shire of West Arthur
61. Mr Melvyn Crosby, Private Citizen
62. Ms Maureen Muir, Private Citizen
63. Ms Janice Forrester, Rheumatic Heart Disease Register and Control Program (Broome)
64. Private Citizen
65. Dr Alissa Jacobs, Oral Medical Specialists
66. Dr Rob Herman, President, The Australian College of Podiatric Surgeons
67. Mr Sam Ciminata, Acting Director General, Disability Services Commission
68. Mr Gary Tuffin, Chief Executive Officer, Shire of Chittering
69. Mr Donald Vincenti, Private Citizen
70. Mr Keith Rogers, Private Citizen
71. Mr Brian Wallbank, Private Citizen
72. Ms Suzette Geary, Private Citizen
73. P & J Smith, Private Citizens
74. Ms Clare Parker, Private Citizen
75. Ms Jodie Crane, Private Citizen
76. Ms Sandy McKiernan, Cancer Information and Support Services Director, Cancer Council Western Australia
77. Dr Sara Armigate, Director Obstetrics and Gynaecology, Geraldton Regional Hospital
78. Ms Helen Westcott, Executive Officer, Goldfields Voluntary Regional Organisation of Councils
79. Mr John Bolton, Private Citizen
80. Ms Donna Stephen, Regional Coordinator Maternal and Child Health, Kimberley Aboriginal Health Planning Forum
81. Ms Norma Peel, Private Citizen
82. Private Citizen
83. Dr Lisa Miller, Consultant Liaison Psychiatrist, Sir Charles Gairdner Hospital
84. Ms Sonia Hycza, Home and Community Care Coordinator, Pemberton Northcliffe Health Service

85. Dr Richard Choong, former President, Australian Medical Association, Western Australia
86. Ms Anne Wilson, Managing Director and Chief Executive Officer, Kidney Health Australia
87. Ms Shirley Witko, Oncology Social Work Australia, Sir Charles Gairdner Hospital
88. Mr E. Taaffe, Private Citizen,
89. Private Citizens
90. Ms Josie Farrer MLA, Member for Kimberley
91. Hon Dave Grills MLC, Member for Mining and Pastoral Region
92. Ms Alison Vos, Private Citizen
93. Hon Terry Redman MLA, Minister for Regional Development
94. Ms Helen Westcott, Executive Officer, Wheatbelt Health MOU Group
95. Dr Andrew Beveridge, Ord Valley Aboriginal Health Service
96. Mr Paul West, Chief Executive Officer, Wheatbelt GP Network
97. Mrs Ruth Zahwe, Private Citizen
98. M & L O'Donoghue, Private Citizens
99. Mrs Margaret Greathead, Private Citizen
100. Kimberley Aboriginal Health Planning Forum
101. Ms Delese Betti, Carers WA
102. Private Citizen
103. Private Citizen
104. Mr Vince Catania MLA, Member for North West Central
105. Ms Debrah Clarke, Private Citizen
106. Hon Terry Redman MLA, Member for Warren-Blackwood
107. Mr Tim Clynch, Chief Executive Officer, Shire of Bridgetown - Greenbushes
108. Ms Alison Emin, Private Citizen
109. Ethnic Disability Advocacy Centre, Western Australia
110. Mrs Anne Gething, General Secretary, Country Women's Association of Western Australia Inc
111. Mr Des Martin, Chief Executive Officer, Aboriginal Health Council of Western Australia
112. Mr Shane Love MLA, Member for Moore
113. Hon Martin Aldridge MLC, Secretary, Parliamentary National Party of Australia (WA)
114. Mr Alan Bradley, Executive Officer, Regional Development Australia, Midwest Gascoyne
115. Ms Rachel Jenkin, Coordinator of Nursing, WA Cancer and Palliative Care Network
116. Mr Tony Mills, Private Citizen
117. Mr Ian Mody, Private Citizen
118. L. Johnson, Private Citzen
119. Mr Bruce Manning, Chief Executive Officer, Great Southern Development Commission
120. Dr Emily Webb, GP Registrar, Bridgetown Medical Centre
121. Dr Diane Mohen, Consultant Obstetrician and Gynaecologist
122. Mr Tony Nottle, Chief Executive Officer, Shire of Dandaragan
123. Mr Stan Scott, Chief Executive Officer, Shire of Toodyay
124. Mr Frank Prokop, Executive Director, Health Consumers' Council WA
125. Hon Dr Kim Hames, Deputy Premier, Minister for Health
126. Ms Vivienne Piccoli, Chief Executive Officer, Shire of Yilgarn
127. Ms Wendy Duncan MLA, Member for Kalgoorlie

Public hearings:

The Committee held public hearings with the follow witnesses. Transcripts of the public hearings are available at the Committee's website at www.parliament.wa.gov.au/pub

1. Western Australian Country Health Service, Great Southern

    - Ms Kylie Oliver, Operations Manager, Albany Health Campus
    - Mr Neal Roberts, Business Manager, Albany Health Campus

2. Miss Roxanne Metcalf and Mrs Stephanie Metcalf, Private Citizens

3. Mrs Glenys Hoesktra, Private Citizen

4. Mrs Jane Forte, Private Citizen

5. Western Australian Country Health Service, Goldfields

    Ms Geraldine Ennis, Regional Director

    Mr David Bowdidge, Operations Manager, Kalgoorlie Health Campus

6. Bega Garnbirringu Health Service

    - Ms Elizabeth Waters, Manager, Clinical Services
    - Mr Clive Holt, Chief Operations Officer

7. Mr John Braven, Private Citizen

8. Ms Vanessa Hook, Private Citizen

9. Goldfields Voluntary Regional Organisation of Councils

    - Mr Don Burnett, Chief Executive Officer, City of Kalgoorlie – Boulder
    - Mr Rodney Hilton, Director, Community Services, Shire of Esperance

10. Mr Gerard Burns, Operations Manager, Carnarvon Multi Purpose Service, Western Australian Country Health Service, Midwest

11. Carnarvon Medical Service Aboriginal Corporation

    - Ms Camilla Thorne, Board Director
    - Mr Shane Van Styn, Chief Executive Officer
    - Miss Melanie Bellotti, Aboriginal Liaison Officer

12. Miss Elizabeth Harrold, Private Citizen

13. Ms Taryn Duncan, Team Leader, Midwest Community Drug Service Team

14. Mr Brian Wallbank, Private Citizen

15. Ms Fiona Joy Hepple, Private Citizen

16. Ms Penelope Walker, Private Citizen

17. Ms Kylie Laurie-Rhodes, Private Citizen

18. Mrs Sharon Boggetti, Inland Operations Manager, Newman Hospital, Western Australian Country Health Service, Pilbara

19. Mr Brian Wilson, Operations Manager, Hedland Health Campus, Western Australian Country Health Service, Pilbara

20. Ms Brenda Bradley, Acting Operations Manager, Kununurra Hospital, Western Australia Country Health Service, Kimberley

21. Western Australia Country Health Service, Kimberley

    - Ms Sue-Ann Wiseman, PATS Regional Coordinator, Broome Health Campus
    - Mr Kim Darby, Operations Manager, Broome Health Campus
    - Mrs Kerry Winsor, Regional Director

22. Mr Henry Councillor, Chief Executive Officer, Broome Regional Aboriginal Health Service

23. Ngaanyatjarra Health Service

    - Mr Brett Cowling, Chief Executive Officer
    - Miss Michelle Doyle, Patient Liaison Coordinator

24. Western Australian Country Health Service

    - Mr Peter Collard, Manager, Governance
    - Mr Jeffrey Moffet, Chief Executive Officer
    - Mrs Tina Chinery, Chief Operations Officer – Southern

25. Mental Health Commission

    - Mr Timothy Marney, Commissioner
    - Ms Elaine Paterson, Director, Health Relationship and Purchasing

26. Mr Christopher Yates, Acting Executive Director, Disability Reform , Disability Services Commission

27. Aboriginal Health Improvement Unit, Western Australian Country Health Service

    - Mr Arthur (Sandy) Davies, Area Director
    - Ms Susan Powe, Manager
    - Ms Charmaine Hull, Senior Project Officer Aboriginal Liaison

28. Ms Beverley Hamerton, Operations Manager, Northam Health Service, Western Australian Country Health Service, Wheatbelt

29. Wheatbelt Health Memorandum of Understanding Group

    - Mr John Scott, Independent Chair
    - Mr David Singe, Chair, Wheatbelt GP Network
    - Mr Graeme Fardon, Chief Executive Officer, Shire of Quairading

30. Western Australian Country Health Service, South West

    - Ms Andrea Hickert, Operations Manager, Bunbury Hospital
    - Mrs Grace Ley, Regional Director

31. Shire of Bridgetown-Greenbushes

    - Ms Megan Richards, Acting Executive Manager, Community Services
    - Mr Peter Seaward, Executive Officer, Strive Warren Blackwood Inc.

32. Mr Neil Fong, Chief Executive Officer, South West Aboriginal Medical Services

33. Dr Henry Moody, Co-Clinical Lead, Renal Health Network (WA), Department of Health

34. Dr Michael Gannon, President, Australian Medical Association (WA)

35. Ms Maria McAtackney, Chief Executive Officer, Nyoongar Patrol System Incorporated

APPENDIX 2

PATIENT ASSISTED TRAVEL SCHEME FINANCIAL AND STATISTICAL DATA

1.1 Details of PATS budget allocations against actual costs are shown below:[369]

Budgets	2008/09 $,000	2009/10 $,000	2010/11 $,000	2011/12 $,000	2012/13 $,000	2013/14 $,000	2014/15 $,000
RfR Contribution	4,200	8,700	9,000	8,900	9,300	9,700	10,080
State Service Appropriation	12,730	13,250	19,100	20,400	21,000	21,600	25,300
Total Budget	**16,930**	**21,950**	**28,100**	**29,300**	**30,300**	**31,300**	**35,380**
Actual	18,617	24,233	27,847	33,555	33,237	31,903	
Variance	-1,687	-2,283	253	-4,255	-2,937	-603	

1.2 As can be seen, a significant cost increase occurred after the changes to eligibility criteria in 2008/09.

1.3 Projected future budget provisions based on current policy parameters are set out in the table below:[370]

Funding Source	2014-15 $'000	2015-16 $'000	2016-17 $'000
Service Appropriation	25,300	25,900	26,600
Royalties for Regions)	10,080	10,584	10,584
Total	35,380	36,484	37,184

1.4 The direct administration cost, excluding corporate overheads, apportioned to the PATS for 2012-13 was $3.35 million and for 2013-14 was $3.51 million.[371]

369 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, p3.

370 Id.

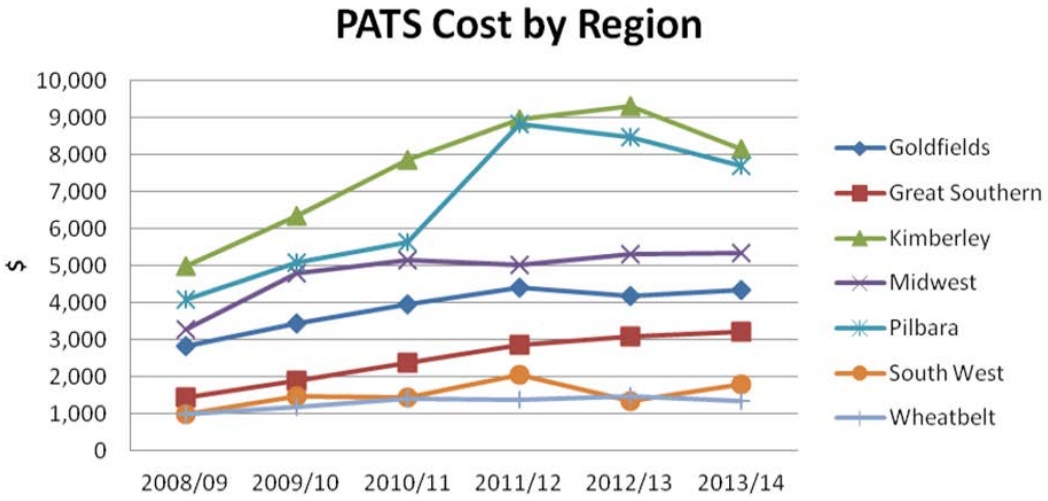
371 Supplementary Information Number A1, provided by the Western Australian Country Health Service as an Answer to a Question on Notice, 10 October 2014, p2.

1.5 Information about regional activity and costs are set out in the table below:[372]

	2008/09		2009/10		2010/11		2011/12		2012/13		2013/14	
Region	No of Trips	Cost of Trips $000	No of Trips	Cost of Trips $000	No of Trips	Cost of Trips $000	No of Trips	Cost of Trips $000	No of Trips	Cost of Trips $000	No of Trips	Cost of Trips $000
Goldfields	6,988	2,830	8,334	3,451	8,542	3,948	8,832	4,420	8,601	4,191	9,555	4,338
Great Southern	6,813	1,456	7,212	1,896	8,978	2,369	10,689	2,863	11,727	3,096	10,310	3,222
Kimberley	4,564	4,997	5,336	6,333	6,287	7,856	7,251	8,954	7,350	9,299	9,512	8,136
Midwest	9,536	3,290	11,417	4,803	12,632	5,156	13,167	5,035	14,471	5,319	13,796	5,359
Pilbara	5,017	4,075	7,059	5,083	7,750	5,641	9,676	8,827	6,597	8,481	13,902	7,698
South West	9,165	989	10,021	1,469	10,144	1453	12,444	2,062	12,740	1,358	18,603	1,795
Wheatbelt	11,132	980	12,624	1,198	13,994	1,424	15,413	1,394	16,408	1,493	16,124	1,355
TOTAL	**53,215**	**$18,617**	**62,003**	**$24,233**	**68,327**	**$27,847**	**77,472**	**$33,555**	**77,894**	**$33,237**	**91,802**	**$31,902**
% increase			*16.50%*	*30.17%*	*10.20%*	*14.91%*	*13.40%*	*20.50%*	*0.54%*	*-0.95%*	*15.10%*	*-4.20%*

1.6 Patients in the Wheatbelt access the PATS scheme more than those in any other region however the fact that the Kimberley region incurs the greatest total cost of trips is due to the requirement in that region for expensive air travel to Perth.

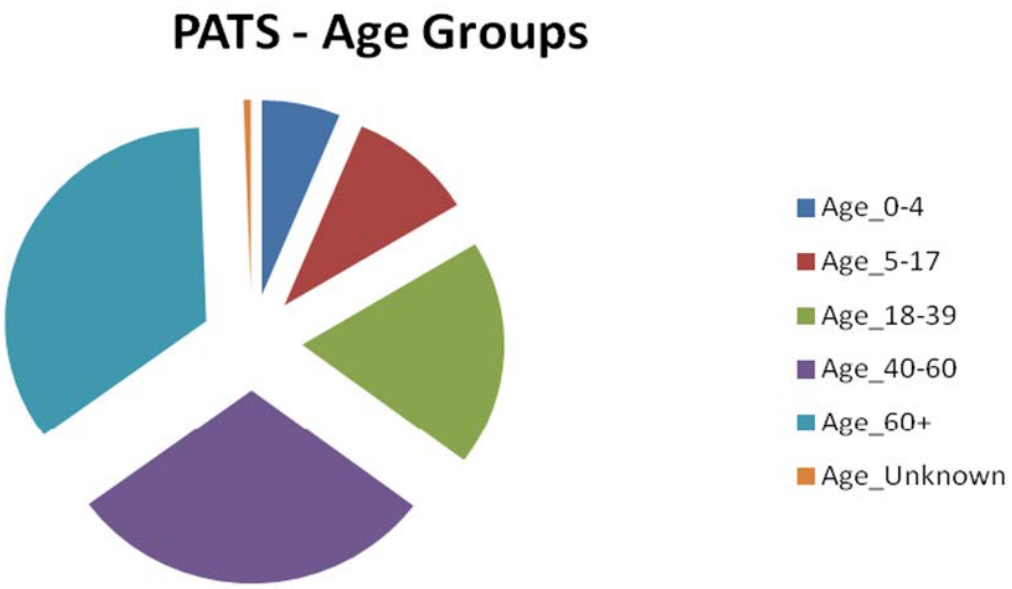
1.7 A graph showing the PATS cost by region is set out below:[373]



1.8 The age group accessing the scheme the most are those 60 years and over, closely followed by those in the 40-60 years age group.[374]

372 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, p3.

373 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, PATS Charts.



374 Briefing Note tabled by the Western Australian Country Health Service at a Committee hearing on 15 September 2014, *PATS Charts*.

1.9 The total costs of payments made under the scheme, broken down by transport, by type, and accommodation payments, are set out in the table below:[375]

Payment Type	2009/10	2010/11	2011/12	2012/13	2013/14
	$'000	$'000	$'000	$'000	$'000
PATS Escort Accommodation	NA	NA	NA	1,511.60	1,979.30
PATS Escort Travel	NA	NA	NA	4,159.00	3,981.80
PATS Patient Accommodation	NA	NA	NA	8,240.00	7,020.60
PATS Patient Travel - Airfares	NA	NA	NA	13,315.50	11,724.90
PATS Patient Travel - Surface	NA	NA	NA	727.10	469.20
PATS Patient Travel - Fuel Cards	NA	NA	NA	1,585.10	1,558.60
PATS Patient Travel - Mileage Reimbursement	NA	NA	NA	2,446.90	4,434.30
PATS Patient Travel - Other	NA	NA	NA	685.00	104.10
PATS Patient Travel - Taxis	NA	NA	NA	568.20	629.80
Total Cost				**33,238.40**	**31,902.60**
General ledger Total	**24,233.00**	**27,847.00**	**33,555.00**	**33,238.40**	**31,902.60**

375 Supplementary Information Number A1 provided by the Western Australian Country Health Service as an Answer to a Question on Notice, 10 October 2014, p2. Patient Assisted Travel Scheme (PATS) data is captured in the WA Department of Health's (DOH) general ledger and a PATS information system. A number of changes in the administration and recording of PATS information have been introduced over the past two (2) years resulting in improved data capture and level of reporting capability. These changes have included:

Implementation of a new accounting classification system, in 2012/2013 allowing PATS costs to be classified by payment type. Prior to 2012/2013 PATS costs were grouped in a patient transport classification in the general ledger. Therefore, it is not possible to accurately breakdown total PATS costs by payment type prior to 2012/2013.

A new PATS information system was implemented across the regions on the 4th December 2012. Prior to that time data was not being captured or recorded consistently across all sites.

It has not been possible to provide complete responses for each of the years identified in the request due to the reasons provided above.

1.10 The number of patients in each WACHS region who access the scheme is set out in the table below:[376]

Region	2012/13	2013/14
Goldfields	2,898	4,596
Great Southern	3,716	5,520
Kimberley	3,282	4,795
Midwest	4,222	6,314
Pilbara	3,724	5,070
South West	3,091	4,607
Wheatbelt	3,274	4,546
Total	**24,207**	**35,448**

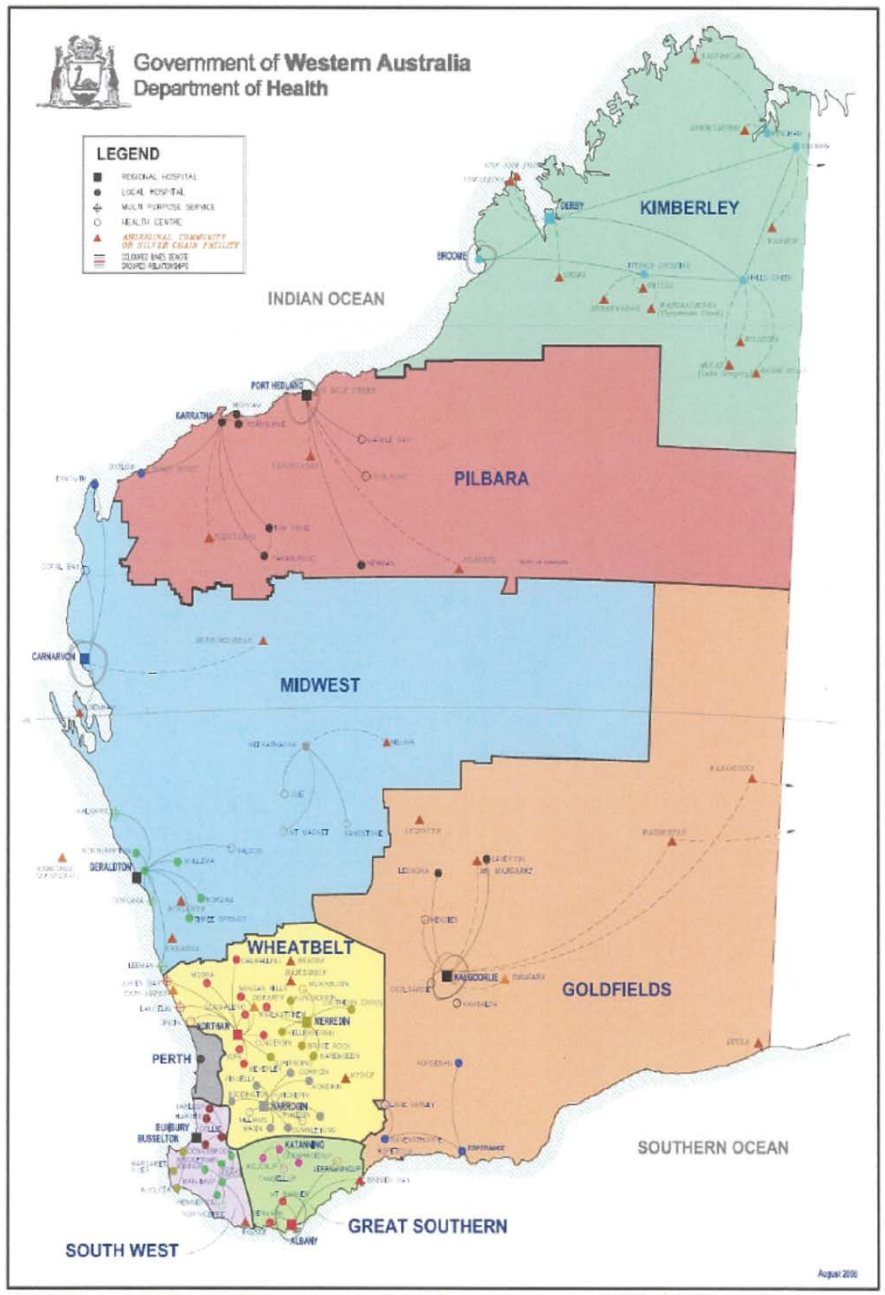
Note: 2012/13 data is from the 04/12/2012 onwards

376 Supplementary Information Number A1 provided by the Western Australian Country Health Service as an Answer to a Question on Notice, 10 October 2014, p7.

APPENDIX 3

WESTERN AUSTRALIAN COUNTRY HEALTH SERVICE

SCHEDULE 7: WACHS Map



This information is available in alternative formats upon request

Document valid at: 07/05/2014 12:47 pm

1.1 The Kimberley Health Region of WACHS is the State's most northern region. It encompasses an area of 424,517 square kilometres and is almost twice the size of Victoria. The major population centres in the Kimberley region are the towns of Broome, Kununurra, Derby, Halls Creek, Wyndham and Fitzroy Crossing. There are also more than 100 Aboriginal communities of various population sizes scattered throughout the region and nearly 100 properties servicing the pastoral industry. The region has a large indigenous population, with nearly one third of the region Aboriginal or Torres Strait Islander people.

1.2 The Pilbara Health Region of WACHS covers a total area of 507,896 square kilometres. Most of the inhabitants are located in the western third whereas the eastern third is largely desert with few inhabitants. The major population centres in the Pilbara region are the towns of Karratha, Port Hedland, Newman and Tom Price.

1.3 The Midwest Health Region of Western Australia covers more than 470,000 square kilometres, nearly one fifth of the State. Its population is concentrated along the coast with more than 70 per cent living around Geraldton-Greenough. The region is located in the northern middle section of Western Australia and incorporates four health districts-Gascoyne, Geraldton, Midwest and Murchison. Major population centres in the Midwest region are Geraldton, Dongara, Kalbarri, Morawa, Meekathara, Mullewa, Carnarvon and Exmouth.

1.4 The largest WACHS region is the Goldfields region located in the south eastern corner of Western Australia. It covers 770,488 square kilometres, more than three times the size of Victoria. The region covers almost one third of Western Australia's total land mass. Major population centres in the region are Kalgoorlie, Leonora, Laverton, Norseman, Esperance and Ravensthorpe.

1.5 The Wheatbelt region partially surrounds the northern and eastern parts of the Perth metropolitan area. It contains the majority of the State's grain growing areas. The Wheatbelt region has a scattered population dispersion, which has resulted in four sub-regional centres: Merredin, Moora, Narrogin and Northam.

1.6 The South West region contains the towns of Bunbury, Collie, Busselton, Manjimup and Margaret River.

1.7 The Great Southern Region represents approximately 1.5 per cent of the State's total area. Albany is the region's administrative and transport hub. The major population centres in the Great Southern region are the towns of Albany, Katanning, Denmark, Mt Barker and Kojonup.

1.8 The Peel region is not part of WACHS, however some residents of the Peel region have limited access to the PATS.

APPENDIX 4

COMPARISON OF JURISDICTIONS: PATIENT ASSISTED TRAVEL SCHEME SUBSIDIES

APPENDIX 1

Comparison of Jurisdiction Patient Assisted Travel Scheme (PATS) Subsidies

In each jurisdiction there are differences in the level of subsidy available and the eligibility requirements for access to travel assistance as summarised below:

Jurisdiction	Min Eligible Travel Distance	Patient Co-Payment	Fuel Subsidy c/km	Accommodation	Ground Travel (Taxis, airport shuttle, etc.)	Fares (Bus, Air, Train
WA	100 kilometres one way 70 kilometres one way, for renal and oncology services	Nil	18	Commercial $60 single ($75 w/-escort) - Private $20 per night	taxi if no other form of transport available	Full cover at most economical rate (Conditions apply)
NT	200 kilometres one way	Nil	20	Commercial $60 per person per night - Private $20 per person per night	$50 per trip (Escorts not eligible)	Full cover at most economical rate
QLD	The service is located 50 kilometres or greater from nearest public hospital.	First four nights accommodation paid by the patient in each financial year, unless a Pensioner Concession or Health Care card holder	30	Commercial $60 per night - Private $10 per night (Patient co-payment first 4 nights)	Nil	Full cover at most economical rate
NSW	100 kilometres one way or 200 kilometres cumulatively per week	$40 co-payment from the patient for each return journey unless a Pensioner Concession or Health Care card holder (max $1,000)	19	Commercial Single $43 per night; Double $60 per night w/- escort. Private: $20 per night	$20 for one day trip to $160 for 15 days or more	Full cover at most economical rate (less GST)
SA	100 kilometres one way	$30 for each travel claim	16	Commercial: $30 per person, per night; $60 maximum with two escorts	taxi if no other form of transport available	Full cover at most economical rate (Clinically approved only)
Vic	100 kilometres one way or 500 kilometres per week on average for five consecutive weeks (block treatment)	$100 co-payment every 12 months, unless a Pensioner Concession or Health Care card holder.	17	Commercial: $35 per night plus GST for each patient and escort (if approved). No private accommodation subsidy	taxi if no other form of transport available	Full cover at most economical rate (air travel > 350km)
TAS	75 kilometres one way, 50 kilometres one way, for renal and oncology services	$15 per trip for Pensioner Concession or Health Care card holder, capped at $120 per annum. $75 per trip for non-concession patients, capped at $300 per annum	19	Commercial: $46 per person per night for intrastate; $64 per person per night for interstate	Only if most economical form of transport	Full cover at most economical rate
ACT	N/A (Subsidy provided for interstate travel)	No co-payment	Up to $104.53	Commercial: $36.90 per night for patient and/or Escort - Private: $11.28 per patient and/or escort	Not covered	Full cover at most economical rate (air travel clinically approved only)

APPENDIX 5

PATIENT ASSISTED TRAVEL SCHEME RETURN TO HOME TRAVEL

Government of **Western Australia**
WA Country Health Service

Your Ref : pc.pat 15042 l.let.00l jm (A496141)
Our Ref : ED-CO-15-27894
Enquiries to : Peter Collard, Ph. (08) 9223 8713

Hon Liz Behjat MLC
Chair
Standing Committee on Public Administration
Parliament House
PERTH WA 6000

Dear Ms Behjat

PATIENT ASSISTED TRAVEL SCHEME - INQUIRY

Thank you for your letter dated 22 April 2015, requesting estimated cost information to support return home visits for eligible Patient Assisted Travel Scheme (PATS) clients undergoing long term continuous treatment away from their home location.

The table attached shows the number of PATS clients that have accessed PATS accommodation subsidies for continuous periods greater than 30 days during 2013/14. The average cost of a return trip for each region has then been applied to the number of clients with continuous accommodation at 30 day intervals.

Based on these numbers, if all long term patients accessed the "return to home" option at each 30 day interval, the additional PATS travel cost would be approximately $500,000 per annum. It is not possible to accurately determine how many of these PATS clients would obtain specialist support to return home during their treatment cycle. However, given the social and emotional benefits to patients having short breaks to return home, it is likely that a high percentage would obtain their specialist support.

Additional budget provision should also be allowed for escorts to accompany patients during these return visits. Approximately 46 per cent of the patients with long term accommodation needs are undergoing oncology treatment and under the current PATS policy would qualify for an escort. Six (6) percent are children and automatically qualify for an escort. It is estimated that 20 per cent of clients undergoing long term treatment, other than children or oncology treatment, are over the age of 65 or are being treated for conditions in specialties such as cardiology, neurology, respiratory medicine and haematology where they are likely to qualify for an escort.

Working together for a healthier country WA
Our Values: Community | Compassion | Quality | Integrity | Justice

Accordingly, it is estimated that 72 per cent of the long term treatment client cohort would qualify for an escort at an estimated additional cost of $360,000.

Based on these projections, it is estimated that an additional budget allowance of $860,000 would be required if this policy change was supported.

Please do not hesitate to contact Mr Peter Collard on Ph. 9223 8713, should you require any further clarification on this matter.

Yours sincerely

Shane Matthews
A/CHIEF EXECUTIVE OFFICER

7 May 2015

Government of **Western Australia**
WA Country Health Service

Number of Patients per Region with PATS Accommodation > 30 Day - 2013/14

		Goldfields	Great Southern	Kimberley	Midwest	Pilbara	South West	Wheatbelt	Totals
	Estimated return Travel Cost	$400	$455	$850	$430	$760	$80	$50	
Number of patients with continuous treatment	30 + Days	95	139	133	174	79	100	70	**790**
	Cost	$38,000	$63,245	$113,050	$74,820	$60,040	$8,000	$3,500	**$360,655**
	60 + Days	20	18	34	31	16	24	9	**152**
	Cost	$8,000	$8,190	$28,900	$13,330	$12,160	$1,920	$450	**$72,950**
	90 + Days	11	6	14	12	8	15	6	**72**
	Cost	$4,400	$2,730	$11,900	$5,160	$6,080	$1,200	$300	**$31,770**
	120 + Days	6	3	7	5	3	9	2	**35**
	Cost	$2,400	$1,365	$5,950	$2,150	$2,280	$720	$100	**$14,965**
	15o + Days	3	2	5	1	1	8	1	**21**
	Cost	$1,200	$910	$4,250	$430	$760	$640	$50	**$8,240**
	180 + Days	2	0	4	0	0	2	1	**9**
	Cost	$800	$0	$3,400	$0	$0	$160	$50	**$4,410**
	210 + Days	0	0	2	0	0	1	0	**3**
	Cost	$0	$0	$1,700	$0	$0	$80	$0	**$1,780**
	240 + Days	0	0	1	0	0	1	0	**2**
	Cost	$0	$0	$850	$0	$0	$80	$0	**$930**
	Total Cost	**$54,800**	**$76,440**	**$170,000**	**$95,890**	**$81,320**	**$12,800**	**$4,450**	**$495,700**

APPENDIX 6

WESTERN AUSTRALIAN PATIENT ASSISTED TRAVEL SCHEME ELIGIBILITY ADJUSTMENTS – PROJECTED FINANCIAL IMPACT

Western Australian Patient Assisted Travel Scheme (PATS) Eligibility Adjustments - Projected Financial Impact

1. Inclusion of Allied Health Related Services in Metropolitan Public Facilities

Code	Description	Occasions of Service	Projected PATS
4017	Audiology	954	$407,068
4021	Cardiac Rehabilitation	1567	$668,633
3008	Clinical Measurement	1479	$631,084
2004	Developmental Disabilities	196	$83,633
4026	Diabetes [40.46]	470	$200,547
4014	Neuropsychology	1	$427
4023	Nutrition/Dietetics	5853	$2,497,455
4006	Occupational Therapy	10374	$4,426,550
2017	Ophthalmology	4854	$2,071,185
4015	Optometry	440	$187,746
4016	Orthoptics	470	$200,547
4024	Orthotics	552	$235,536
4035	Palliative Care	4	$1,707
4009	Physiotherapy	11240	$4,796,069
4025	Podiatry	1062	$453,152
4029	Psychology	1184	$505,209
4012	Rehabilitation	1628	$694,662
4034	Specialist Mental Health	44	$18,775
4018	Speech Pathology	4080	$1,740,922
4022	Stomal Therapy	178	$75,952
4013	Wound Management	1662	$709,170
	Total	**48,292**	**$20,606,029**

Note:

- Projections based on 2012/13 metropolitan outpatient clinic presentations by rural residents.
- Cost based on the average PATS claim cost of $427.
- The above does not include regional referrals to Regional Resource Centres or private allied health providers.

2. Inclusion of Dental Related Services in Metropolitan Public Facilities

Description	Occasions of Service	Projected PATS
Specialist Dental Outpatient	1817	$775,308
Oral and Dental inpatient Procedures	460	$196,420
Totals	**2,277**	**$971,728**

Note: Projections based on public patient activity in public facilities and is likely to be considerably understated with most dental activity being delivered by private providers.

APPENDIX 7

SPECIAL RULINGS

SCHEDULE 6: SPECIAL RULINGS

Eligible Dental and Oral Services

Most specialist dental services are not covered under PATS.

Dental or orthodontic services are generally not covered under the PATS. Young children (under eight years of age) who require an urgent and critical dental procedure under general anaesthetic or those with severe trauma may be approved under the PATS as an exceptional ruling. Approved oral surgery is covered when the procedure is covered under Medicare and the oral surgeon is approved by the Commonwealth Minister of Health.

PATS support is only available for serious oral conditions including:

1. Eligible Medicare Benefits Schedule (MBS) items in the Oral and Maxillo-facial Medicare Benefits Schedule
2. Treatment provided under the Cleft Lip and Palate scheme;
3. 'Exceptional dental circumstances' including specialist dental services for children and for adults with special needs when contemporaneous general anaesthesia is required as below.

PATS generally does NOT cover:

- The extraction of 3rd molars (wisdom teeth) – including under GA or sedation
- Orthodontic treatment (braces)
- Non-surgical temporo-mandibular joint treatment
- Implant surgery or crown and bridge treatment
- Endodontics (root canal therapy)
- Periodontal (gum) surgery or treatment
- MBS items in the Allied Health and Dental Services book (10975 – 10977)

Oral Maxillo-Facial Surgery

Services in the Oral and Maxillo-facial Medicare Benefits Schedule relating to serious conditions are eligible for PATS. This includes the management of facial trauma e.g. jaw fractures, serious dento-facial infections, oral malignancy etc.

Medicare Benefit Schedules can be viewed by searching "MBS online" at www.health.gov.au

A list of registered specialist oral and maxillo-facial surgeons can be accessed at www.dentalboard.wa.gov.au

Note: Extraction of wisdom teeth, implant surgery and pre-prosthetic surgery are not covered by PATS.

Dental Treatment for Cleft Lip and Palate

Patients referred to PMH for items in the Cleft Lip and Cleft Palate Medicare Benefits Schedule (items 75002 – 75854) are eligible for PATS.

Medicare Benefit Schedules can be viewed by searching "MBS online" at www.health.gov.au

Exceptional Circumstances – Dental

There are no MBS items to describe most eligible dental services. Section A 2. Referral Details of the PATS Application form should state which eligibility category {see (a) – (e) below} the treatment fulfils.

Services for Children

(a) Hospital-based management of severe dental trauma or severe dento-facial infections e.g. cellulitis.
Transport will be to PMH.

(b) Hospital-based dental services for children with significant medical co-morbidity or other serious conditions.
Transport will be to PMH.

(c) Dental treatment requiring contemporaneous general anaesthesia.
Transport will be to PMH, OHCWA/ KEMH and private paediatric dentists.

A list of registered specialist paediatric dentists can be accessed at www.dentalboard.wa.gov.au

Services for Adults

(a) Hospital-based dental services for adults with significant medical co-morbidity.
Transport will usually be to RPH.

Note: Routine oral medicine services are not covered by PATS.

(b) Dental treatment for adults with special needs requiring contemporaneous general anaesthesia.
Transport will usually be to SDH.

For additional eligibility advice please contact:
Dental Health Services (Dr Martin Glick - 08 9313 0555)
The Centre for Rural and Remote Oral Health (Dr Kate Dyson – 08 9346 7249)
PMH Dental Department (Dr John Winters – 08 9340 8342)

This information is available in alternative formats upon request

Medical Imaging

Applications for PATS are approved for medical imaging consultation where the referring medical practitioner has indicated referral to a Radiologist for a procedure approved under Medicare. This may include referral to the closest service including x-ray, interventional radiological procedures, ultrasound, computed tomography (CT), nuclear medicine (NM), and magnetic resonance imaging (MRI) scan (MRI only if referred by a specialist).

While the patient may not see the Radiologist, a Radiologist must read the films in order for the patient to be eligible for PATS assistance.

Where the Radiologist reviews the films without seeing the patient, the Medical Imaging Technologist is appropriate to sign the *PATS Specialist Certification* form once the examination has been completed. The Medical Imaging Technologist should ensure they place a line through any question that is not relevant to them when signing the PATS Specialist Certification form.

Mammography

PATS assistance applies where:

- a screening service is not available within an acceptable time frame through the BreastScreen WA Mobile Breast Screening Service and the patient has been referred for a mammogram by a medical practitioner
- the mammography assessment is covered by the Medicare Benefits Schedule and the patient is transferred to the closest available mammography service

  or
- an applicant is referred for diagnostic imaging evaluation of a palpable breast lump or other breast abnormality. Referral may be made to a general surgeon skilled in breast assessment or to a relevant Breast Assessment Centre or medical specialist.

BreastScreen WA

PATS assistance applies can be recouped from BreastScreen WA under the following circumstances:

- A woman has attended the BreastScreen WA Mobile Breast Screening Service and an abnormality is identified which requires further investigation

  and
- A woman has an appointment at one of the Breast Assessment Centres that are part of the National BreastScreen Australia program to have further investigation of an abnormality detected at this screening. There are two Breast Assessment Centres that provide assessment as part of the BreastScreen WA program and these are located at Royal Perth Hospital and Sir Charles Gairdner Hospital.

Dialysis

Applications for PATS assistance are approved for attendance at dialysis clinics where the applicant is under the care of a Nephrologist for a procedure approved under Medicare. Where the patient undergoes dialysis without seeing the Nephrologist, the nursing staff supervising the procedure should sign the *PATS Specialist Certification* form once the patient has undergone dialysis.

PATS assistance is also approved for applicants attending a home therapies unit to undergo:

- training to perform their dialysis
- routine clinical review

  or
- assessment and treatment.

In this case the *PATS Specialist Certification* form is signed by the specialist dialysis nurse employed in the nurse lead clinic.

Assisted Reproductive Treatment (IVF)

Applicants receiving In Vitro-Fertilisation (IVF) treatment and other assisted reproductive treatment are eligible for PATS for referral to specialist treatment covered by an item in the Medicare Benefits Schedule (MBS).

The woman's partner qualifies when he visits the specialist for his initial consultation and investigation (i.e. as a patient), and for one visit per cycle of treatment (i.e. as a patient). Neither the patient, nor the partner will be eligible for PATS assistance for additional trips for education or counselling.

In these instances videoconferencing should be considered. There is no automatic entitlement for the partner to travel as an escort unless the eligibility for escort travel apply.

Deceased Applicant or Escort

If an applicant or escort dies following an inter hospital patient transfer/ primary evacuation or PATS assisted travel to a hospital, the family may be eligible for assistance with the cost of transporting the deceased applicant or escort to their place of residence. When the deceased applicant or escort held a valid concession card or lived above the 26th parallel, then the local health service is responsible for the cost of transporting the deceased applicant or escort back to the country hospital nearest to the applicant or escort's permanent place of residence, providing the case is not the liability of another agency.

For non-concession cardholders and people living below the 26th parallel, the following applies:

- If an applicant or escort dies during a journey, or at the place of treatment, the travel allowance payable is deemed to be at the level of PATS subsidy, had the applicant or escort been repatriated to their place of residence via surface travel or, if surface travel had involved travel of more than 16 hours, air travel.
- Accommodation costs are not payable for the escort of the deceased applicant beyond the time of the applicant's death, unless transport is not immediately available.
- Assistance is also provided to the mother and child where the child dies after birth.

Department of Health Technical Bulletin BB053/00 01 July 2002 Transport of Deceased Persons for further details: http://intranet.health.wa.gov.au/circulars/pdfs/7731.pdf

Refractive Surgical Procedures

Applicants referred for excimer laser photorefractive keratotomy (PRK) and LASIK are eligible for the PATS. Due to the highly specialised equipment required, these procedures are only carried out at the Lions Eye Institute and Murdoch Eye Centre.

To be eligible for PATS assistance, the applicant must:

- be referred by an ophthalmologist
  and
- have a range of myopia -2 to -6 diopters.

Wheelchair Applicants

Applicants who are required to attend the Rehabilitation Technology Unit at Royal Perth (Rehabilitation) Hospital (Shenton Park) for complex wheelchair assessment and review (wheelchair prescription and assessment of seating and pressure needs) are eligible for PATS assistance. Referral to this clinic can be by a medical practitioner, physiotherapist or occupational therapist. Less complex adjustments may be able to be completed by local physiotherapy and/or occupational therapy staff where available.

Next Step (Alcohol and Drug Authority) Applicants

Applicants referred to Next Step specialist medical services (delivered by a medical specialist in addiction) are eligible to receive PATS assistance for the initial consultation for admission into a treatment or therapy program.

Child Birth

Applicants, who are entitled to the PATS assistance for the delivery of a child, are eligible for the PATS accommodation subsidy for a maximum of three nights prior to the delivery, unless medical reasons are provided by the GP Obstetrician or specialist Obstetrician as to why the applicant needs to be close to the hospital earlier than this.

Where an applicant lives in a remote area where no birthing facilities exist, then accommodation assistance is available for two weeks prior to the confinement date.

Assistance is not provided for an escort unless there are complications that put the mother or baby's life at risk or in cases when the mother and newborn may need an escort to return home, for example, a multiple birth.

Where a woman lives in a remote area where no birthing facilities exist, then accommodation assistance is available for two weeks prior to the confinement date.

Note: Medical conditions that usually prevent air travel during pregnancy include:

- Multiple pregnancy after 36th week

  or

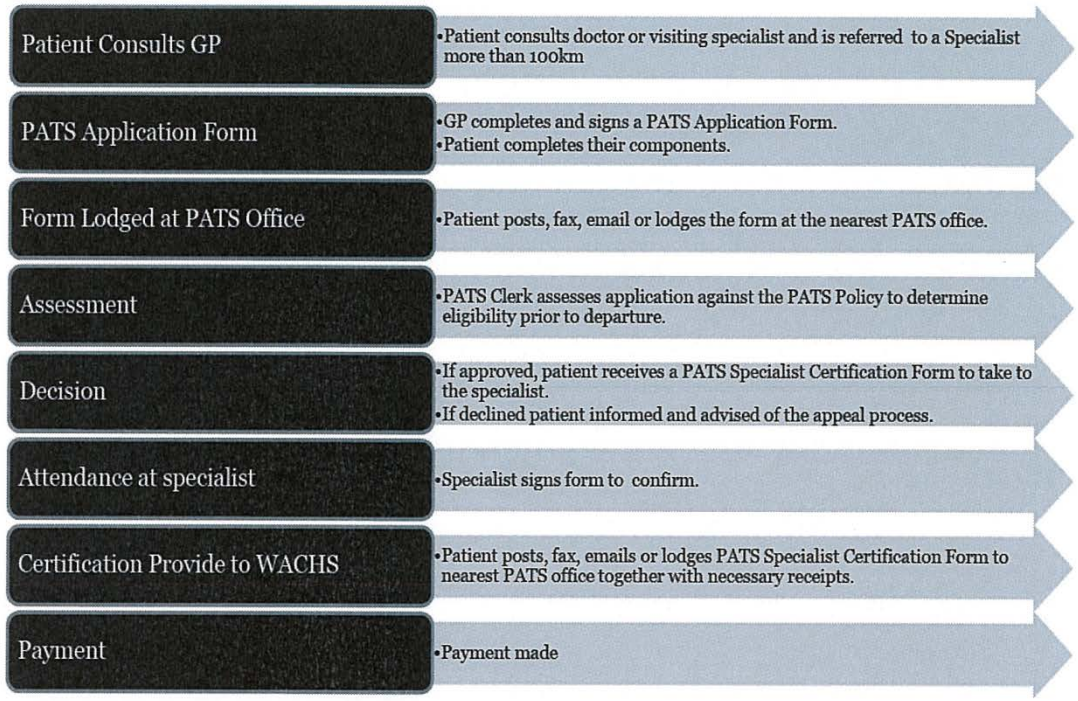
- Flights > 4 hours – single pregnancy after 36th week

PATS assistance is not provided for an escort unless there are complications that put the mother or baby's life at risk or in cases when the mother and newborn may need an escort to return home, for example, a multiple birth.

APPENDIX 8

KEY STEPS IN PATIENT ASSISTED TRAVEL SCHEME PROCESS

Key Steps in PATS Process -Reimbursement



Key Steps in PATS Process -Coordinated