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STANDING COMMITTEE ON COMMUNITY AFFAIRS

Reference: Patient assisted travel schemes

MONDAY, 23 JULY 2007

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**SENATE STANDING COMMITTEE ON
COMMUNITY AFFAIRS**

Monday, 23 July 2007

Members: Senator Humphries (*Chair*), Senator Moore (*Deputy Chair*), Senators Adams, Allison, Boyce, Carol Brown, Patterson and Polley

Participating members: Senators Barnett, Bartlett, Bernardi, Birmingham, Mark Bishop, Boswell, Bob Brown, George Campbell, Carr, Chapman, Cormann, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Fielding, Fisher, Forshaw, Heffernan, Hogg, Hurley, Hutchins, Joyce, Kemp, Kirk, Lightfoot, Ludwig, Lundy, Marshall, McEwen, McGauran, McLucas, Milne, Nash, Nettle, O'Brien, Parry, Payne, Robert Ray, Siewert, Stephens, Stott Despoja, Watson, Webber, Wong and Wortley

Senators in attendance: Senators Adams, Boyce, Carol Brown, Humphries, Moore, Patterson and Polley

Terms of reference for the inquiry:

To inquire into and report on:

The operation and effectiveness of Patient Assisted Travel Schemes including:

- a. the need for greater national consistency and uniformity of Patient Assisted Travel Schemes across jurisdictions, especially the procedures used to determine eligibility for travel schemes covering patients, their carers, escorts and families; the level and forms of assistance provided; and reciprocal arrangements for inter-state patients and their carers;
- b. the need for national minimum standards to improve flexibility for rural patient access to specialist health services throughout Australia;
- c. the extent to which local and cross-border issues are compromising the effectiveness of existing Patient Assisted Travel Schemes in Australia, in terms of patient and health system outcomes;
- d. the current level of utilisation of schemes and identification of mechanisms to ensure that schemes are effectively marketed to all eligible patients and monitored to inform continuous improvement;
- e. variations in patient outcomes between metropolitan and rural, regional and remote patients and the extent to which improved travel and accommodation support would reduce these inequalities;
- f. the benefit to patients in having access to a specialist who has the support of a multidisciplinary team and the option to seek a second opinion;
- g. the relationship between initiatives in e Health and Patient Assisted Travel Schemes;
- h. the feasibility and desirability of extending patient assisted travel schemes to all treatments listed on the Medicare Benefits Schedule – Enhanced Primary Care items such as allied health and dental treatment and fitting of artificial limbs; and
- i. the role of charity and non-profit organisations in the provision of travel and accommodation assistance to patients.

WITNESSES

BOND, Mrs Ailsa, Former National President, Country Women’s Association.....	40
BREWSTER, Mr David, Chairman, King Island Multi-Purpose Centre Advisory Committee	21
CHALLENOR, Ms Sarah Anne, Member, Kidney Health Australia	26
CRISP, Mrs Margaret, Board Member, Campbell Town Area Community Service Board Inc.....	14
HENRY, Mrs Susanne J, Member, Kidney Health Australia.....	26
LOVITT, Mrs Anna Margaret, Board Member (Staff Representative), Campbell Town Area Community Service Board Inc.....	14
MACKINTOSH, Mrs Carolyn, Health Services Manager, Kidney Health Australia	26
PERKINS, Mr Michael, Chairman, Beaconsfield District Health Service Community Advisory Board.....	47
RADFORD, Mr William Allen, Member, Kidney Health Australia	26
RENSHAW, Dr Peter, Director of Clinical Services, Launceston General Hospital and Chairman, Statewide Patient Travel Advisory Committee, Department of Health and Human Services.....	1
ROSE, Dr Donald, Branch Councillor, Tasmanian Division, Australian Medical Association.....	34
SANSOM, Mr Tony, Manager, Planning and Performance Review, Department of Health and Human Services.....	1
SMITH, Mr John, Director, Resources and Systems Performance, Department of Health and Human Services.....	1
TSANG, Ms Peggy, Project Officer, Department of Health and Human Services.....	1
WALKER, Ms Pamela Faye, Member, Kidney Health Australia	26
WARDLAW, Mr Andrew, General Manager, King Island Council; and Council Representative, King Island Multi-Purpose Centre Advisory Committee.....	21
WIGHTMAN, Mrs Myra, Member, Kidney Health Australia.....	26

Committee met at 9.06 am

RENSHAW, Dr Peter, Director of Clinical Services, Launceston General Hospital and Chairman, Statewide Patient Travel Advisory Committee, Department of Health and Human Services

SANSOM, Mr Tony, Manager, Planning and Performance Review, Department of Health and Human Services

SMITH, Mr John, Director, Resources and Systems Performance, Department of Health and Human Services

TSANG, Ms Peggy, Project Officer, Department of Health and Human Services

CHAIR—Good morning. I declare open this public hearing of the Senate Standing Committee on Community Affairs in Launceston, Tasmania. We are taking evidence on the operation and effectiveness of patient assisted travel schemes around Australia and it is Tasmania's turn today. I welcome representatives from the Tasmanian government. Thank you for your appearance here today and we thank the Tasmanian government for the submission that it made to the committee. Information on parliamentary privilege and the protection of witnesses in evidence has been provided to you, I understand. You will not, as departmental officers, be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. We want to ask questions about your submission, but would you like to begin by making an opening statement about the issues the committee is addressing?

Mr Sansom—I am happy to make a few opening statements before you ask some questions. Thank you for the opportunity to come and provide evidence before the committee. On the issue of variations and consistencies, which is one of the key themes of the inquiry, we accept that there are variations between jurisdictions in these sorts of schemes, but there are also many consistencies. If you look at some of the broad eligibility requirements, on the one hand you can look for differences and, on the other hand, you can look for similarities. In terms of the consistencies, it is quite common for health programs throughout jurisdictions to have differences in the way in which regions and states deliver particular programs. We have indicated a preference for continuing to have local flexibility, but we would not be averse to working with other states and territories to develop some broad principles around eligibility requirements.

Within Tasmania we have a state-wide PTAS committee which works well under the chairmanship of Dr Renshaw. There is an appeals process for issues that come up that may not be entirely clarified by the existing guidelines or where someone has some concerns with a decision that has been made with regard to their application. One of the other positive things that happens under this process is that when these sorts of things arise there is a register of decisions. So when things happen and are assessed outside the existing guidelines, or there is a clarification, or there is a particular case, these things are recorded to provide a guide for future consideration of cases.

In Tasmania the government has recently released a clinical services plan. There are some things in there that are relevant to access issues for health services. Firstly, the plan makes some comment on some highly specialised services that it believes should be considered for introduction into Tasmania. It also makes some comments on the importance of some highly specialised services that are currently not provided within Tasmania being provided on a single site or a state-wide basis. With regard to less specialised services, there are recommendations on the introduction of integrated care centres. That is the concept of delivering some services closer to where people live. For example, it has been identified that a service like renal dialysis could be provided by integrated care centres. That potentially has some benefits for people having to travel distances for those sorts of services. It was a very consultative plan and process. The issues around the importance of transport and access were made loud and clear during the consultation process. The plan finds that these things need to be reviewed, and that will be taken up during the implementation process.

Finally, I would like to recognise the efforts of the staff within our acute hospitals who operate the PTAS program; they work very hard with patients and families in sometimes urgent and unfortunate circumstances.

Senator ADAMS—I note the PTAS review committee meets periodically, and I note the people on it. Do you have any consumers on that committee?

Dr Renshaw—Not at the moment, no. It is not a bad idea. The committee was originally set up in the late 1990s to try and achieve some of the consistency that we were accused of lacking in the early stages after IPTAAS wound up. The three regions were dealing with issues about eligibility, sometimes in quite different ways. The issues in the three different regions were very different as well. However, since the committee's

inception, I believe that there certainly has been better consistency, that consumers have a better idea of what the eligibility is for patient travel. Tony mentioned the appeals process, which several people have been through to review decisions about patient travel. But there is also still a lot of flexibility in the system for individual medical authorisers for special circumstances. There are no possible guidelines that will cover every clinical and social circumstance. So there is a certain degree of flexibility still in the system but also the consistency. But as for the consumer involvement, we do not have that at this stage, no.

Senator ADAMS—Mr Sansom, you said that you had done a very wide consultative process. Who did you consult with?

Mr Sansom—We consulted in detail, in terms of the clinical services plan, with the clinical community through reference groups and meeting directly with clinical groups. In terms of public consultation, three issues papers were put out—two around primary health services and one around the acute health services. There were a number of public forums held around the state. Some of these were put in place by the minister, who attended personally.

Senator ADAMS—What was the result of those? What were the issues? We have a great, glowing report from the department, as we have in most states that we have visited but, unfortunately, when you look at the other submissions, it is completely the opposite. How aware is the public of the system? It is amazing how some GPs are prepared to promote it while others do not, often their reason being the red tape that is attached to it and the amount of time it takes for them to fill out the forms and all the other bits that go with it. Would you like to comment on that?

Dr Renshaw—The department, of course, has no control over what individual GPs do or do not recommend. We have made a very real effort to simplify the system as much as we can within the requirements of the state audit and so on. We are giving out hundreds of thousands of dollars of resources every year through the patient travel scheme. We now have online forms, we have forms through Service Tasmania, which has outlets everywhere throughout the state, and we regularly send out brochures regarding patient travel to all doctors' surgeries. They should be in everybody's waiting rooms. I know that in Launceston we have done an audit and we found that something like 86 or 87 per cent, I think it was, of our GP surgeries carry the written information. We have had that information run through to assess the simplicity and ambiguousness of the language. So we have made efforts but we cannot determine what individual GPs are doing. Doctors do not like filling out forms no matter how simple they are, and that is a common issue. I am sure you will find that around Australia as well.

Senator ADAMS—We certainly have. Let's turn to King Island. There are comments from the health committee there that it costs less for King Island residents to go to Melbourne for specialist treatment than to go to the mainland of Tasmania. In your submission you said that the specialist centres in Melbourne tend not to understand that people come from Tasmania and they have to stay a lot longer in Melbourne instead of having all their appointments made in one day so that they can go and come back. How does the department look at that cost?

Dr Renshaw—There are two elements to the cost. First there is the cost of the travel, and from the Bass Strait islands it costs about the same going either way. The problem is that, where the clinical service that they are accessing is already provided in Tasmania, the Tasmanian taxpayer has already paid for the provision of the services in the state and Victoria does not provide public hospital free of charge to people from interstate. So Tasmania does get charged for the provision of the clinical services. I suppose the one exception there would be private hospital services. We have an arrangement with King Island—for instance, in maternity—for private ladies on King Island to access private services in Melbourne. We will provide patient travel assistance for that. There are only two or three a year in any case, though. It is not as if we have a burgeoning birthrate. The issue is primarily that, if we are already providing the service in Tasmania, we would much rather that King Island residents access the service in Tasmania. It is not the cost of travel per se that we are talking about there.

Senator ADAMS—Speaking of obstetric cases, how do women who have to travel to a regional centre get on? Are they able to access PATS?

Dr Renshaw—They certainly are. We have clear guidelines. Are we talking about the ladies on the islands?

Senator ADAMS—Anywhere, really.

Dr Renshaw—I will start with the islands, because there are clear guidelines that allow women expecting children to leave the islands at least two weeks prior to the expected delivery date. Patient travel will pay for

their travel and also support their accommodation in the regional centres where they are going to have their babies. It is a similar situation on the east coast and west coast, I understand. I am not all that familiar with the west coast example, but certainly on the east coast we regularly have women travelling to Launceston about 10 to 14 days prior to the expected date of delivery, and they can certainly access patient travel assistance for that.

Senator ADAMS—Are they permitted to have an escort?

Dr Renshaw—We do pay for the husband to come over from the islands—not for the full two weeks but certainly for four days around the time of delivery. We just do not have the resources to support an escort for the entire two weeks. However, the accommodation that they come to tends to be close to the hospital, so the mother certainly has clinical support. At the time of delivery we do provide for partners to come for emotional support. I am not certain that we do that for people from the mainland of Tasmania. I cannot remember receiving requests on that. I would have to take advice about that.

Senator ADAMS—As far as psychosocial support for people with chronic disease—for example, somebody who is going to have to travel for radiotherapy and chemo—most guidelines state that the person going as the escort has to be able to provide medical assistance. What is the government's view on that?

Dr Renshaw—Escorts are primarily approved on the basis of clinical criteria. There are certain exceptions to this. One exception, particularly for interstate travel, is that if a person is going for a critical or life-threatening operation—say, they are going to Melbourne for a liver transplant, a lung transplant, significant cancer therapy and so on—and partners or support people have to be involved in the decision-making process, the medical authorisers will authorise an escort. That is for the emotional side.

There is also the physical side. If somebody has, for instance, severe allergies and is going interstate for treatment for anaphylactic reactions and desensitisation and so on, obviously the escort that goes with them must know how to, say, use an EpiPen or resuscitate a person who has had an acute anaphylactic reaction. Similarly, if somebody is going interstate for a cardiac arrhythmia, we would expect the person who goes with them to have had some experience in CPR and those sorts of things. It is silly sending somebody for clinical reasons if that person cannot provide the assistance that is required for safe travel.

Senator ADAMS—So for patients who are away for a long time receiving chemo or radiotherapy treatment and are usually going in for treatment every day as an outpatient, is there any provision for an escort to be with them to support them?

Dr Renshaw—Within the state, no; outside the state for a prolonged period—for example, with a cardiac transplant—we do.

Senator ADAMS—But not for radiotherapy or chemotherapy?

Dr Renshaw—No. We just do not have the resources.

Senator ADAMS—I will not go on too long. My last question is on kidney donors. Kidney Health Australia has been presenting to us in each state. It is quite a problem that a well person who is donating a kidney is not entitled to an escort.

Dr Renshaw—It has been a controversial issue, with escorts for escorts for escorts. When we originally looked at this issue, it was understood that the person donating a kidney was well to begin with. To be quite frank, I think we underestimated this. We have had feedback from people who have been through the procedure that the kidney donor often feels worse than the kidney recipient after that operation. I certainly accept that as being an issue. Over the last three years, we have not rejected anybody as an escort for a kidney donor as well as for a transplant recipient. Certainly, in my region, we have basically approved all escorts for both recipients and donors.

Senator ADAMS—But has the donor been able to get PATS, because they have not in most jurisdictions?

Dr Renshaw—Yes, the donor has—

Senator ADAMS—They can get PATS?

Dr Renshaw—Yes, so long as the donor is a Tasmanian resident. We have had instances where the donor has been from North Queensland and it is outside our jurisdiction to be able to provide patient travel for the donor in that circumstance, but we have had several donors from Tasmania who have had PATS to travel for kidney transplants.

Senator POLLEY—How does the PATS scheme work in comparison to other states? I have asked them in our travels whether there ought to be national outcomes criteria so that some judgement can be made about

how PATS schemes are working. Do you have any comments on whether there ought to be national outcomes criteria?

Mr Samson—We are not that familiar with how the schemes in other states work in detail because we are all separated. Being an island, Tasmania has no reason to work closely with people operating schemes in other states. But the point I was making in my opening address was that when you look at some of the benefits, like kilometres and accommodation, it is fairly similar between states and territories. I do not know whether my colleagues have any further comment on that, but we have indicated a preference for local flexibility. That does not mean that we are not prepared to work with other states and territories to consider some greater consistency of principles and broad criteria.

Senator POLLEY—How is the budget administered? Because Tasmania operates at regional levels rather than hospital board levels—which I am familiar with—is there a budget line item in the regional budgets or is this administered at a state level? How does PATS operate and what is the budget for it?

Mr Smith—Each hospital has its own allocation and administers it. When you were talking about region based funding, each of the three major hospitals has their own allocation for it.

Senator POLLEY—Is that a budget line just for PATS? Do they not have to take it out of their general budget for the hospital?

Mr Smith—It is part of their global budget allocation.

Senator POLLEY—There is no limit then. All of those people who meet the criteria in Tasmania are eligible and there is funding available for them.

Mr Smith—If it is approved by the committee, yes.

Senator POLLEY—From my experience, community cars do an excellent job within their local communities in transporting people, particularly for cancer treatment and other health issues. Is that really backing up the PATS scheme?

Dr Renshaw—PATS covers some of it—for instance, for people using community cars to come in for renal dialysis, PATS makes a contribution towards the costs of the community cars. It is not an addition; it is really part of the overall system. It has been asked why PATS does not run the community cars itself, and I am sure there is a debate that could be had around that. My preference is that the community cars remain as they are but we look at how PATS can provide support for people who have to use the community cars a lot.

Senator POLLEY—Women's Health Tasmania has put in a submission and I would like to get your comments on record in relation to women seeking abortions. Because the procedure is not done by a specialist, women are prohibited from getting PATS. Is that the case in Tasmania?

Dr Renshaw—No, that is not the case. It is not a huge issue in Tasmania, although obviously the submission has pointed out the issues. The procedure is available in Tasmania. We get the occasional patient travel assistance request. Admittedly there are not many, but certainly in the north we have not knocked back the more difficult cases—and there are some very difficult cases of a forensic nature where we have funded, through PATS, girls to go to Melbourne for private treatment. They are very specific circumstances, however the medical authoriser does have sufficient flexibility, I believe, to handle those sorts of extreme cases.

Senator POLLEY—Thank you. I think it is important to get that on the record. Can we get a figure for the percentage of PATS funding that is used intrastate, as opposed to interstate?

Dr Renshaw—Yes. In the 2005-06 financial year, the total amount spent was around \$2.4 million of which \$1.6 million was interstate and just \$800,000 was intrastate.

Senator POLLEY—In an ideal world, if you had the opportunity to express your views on how PATS could be better administered or whether more money needed to be allocated from the federal government, how could we improve service? There are complaints; it does not matter where you go. We were in Western Australia a week or so ago and their claim to fame is that they are more decentralised than any other state. Our population in Tasmania is more decentralised, except those in Western Australia have huge distances to travel. So they have their own problems. But it does not matter where you go in Tasmania, although we have an excellent health system there are always better ways of doing things, from my experience. What needs to be changed and what role does the federal government have in that?

Dr Renshaw—First, we are trying whatever we can to make the system easy for the consumer. I am sure we have a long way to go and still our paperwork, I agree, is certainly onerous to many people. The problem is

that where you have a system that is based on clinical priority, you need sufficient information in order to administer it. If there was not that requirement, if it was an open system and the patient just came with a piece of paper that said, 'I have been referred to this' and there were no questions asked, that would certainly make it interesting. I am not certain we will ever have the resources that would enable an open slather system.

The suggestion about having a consumer on the committee is important. Our local consumer reference group at the hospital here in Launceston has a standing item about patient travel. I attend the meeting and I must admit we have not had a lot of feedback in the last six months, but every so often an issue comes up and the consumers give feedback. I can see the issue but the problem is where do you take your consumer from? Consumers on the west coast have very different issues to consumers on Flinders Island or even consumers at Scottsdale or Gladstone and beyond. While it is a good idea, I am not certain how we would choose the consumer.

Senator ADAMS—It works in Western Australia.

Dr Renshaw—Yes. I have done a number of hospital surveys in Western Australia and whenever I go there I actually have a look at their PATS, and some of the things they do a very good. Some of those things we probably could not achieve and some of the things we do better. It is certainly an interesting area.

Senator POLLEY—In terms of the way the health system in Tasmania is changing and the creation of specialist services on the west coast now and in Launceston and Hobart, do you foresee a blow-out in the budget? That is a fairly important line item of any budget at any hospital, particularly in regional Tasmania. Are we going to see a dramatic increase in demand for PATS?

Dr Renshaw—I do not believe so, and that is for one reason and one reason only. The other function of the committee which we have not mentioned before is that we review the pattern of referrals interstate. Where there are peak demands for specialist services, we look at ways of bringing the services into Tasmania. For instance, we have had a number of people travelling interstate for cochlear implants. There is a lot of travel involved around cochlear implants in the post-operative trial as the patient has to go over to Melbourne once a week for a number of months. We have now established, through our speech therapy adviser in Tasmania, the testing procedures that will support having the operation in Melbourne but having the follow-up service provided in Tasmania. That is being done through the work from PTAS and the reallocation of PTAS funds. Similarly, where there are patterns of outpatient travel to Melbourne or Sydney, we have arranged for some specialists to come to Tasmania to do clinics—once again, funded through PTAS. If we are getting a peak then we look at that to see whether it is cheaper to bring the specialist down to Tasmania to see the patients rather than send the patients interstate.

I suppose the other vexed one at the moment is PET scanning. Part of our current clinical services plan is to have a PET scanner in Tasmania. We have noticed that peak, so we have put suggestions through. I do not know where we are in the process down that way, but that is certainly one area we would like to have.

Senator POLLEY—You may or may not have the figures with you today, but this committee is very interested in PET as we have had Dr Ware before us and we have had lengthy hearings into that matter. Can you provide to the committee, or take on notice, the number of Tasmanians who travel to Melbourne for PET scans?

Dr Renshaw—We had a very long take-off period. We did not experience the initial surge like other states did, but it certainly has picked up over the last 18 months to two years.

Senator BOYCE—You said that the PATS budget goes within the public hospital budgets. Can that run out? Do you just continue to pay PATS whenever it is required?

Dr Renshaw—Can it run out? Yes. Do we have overruns? Yes, every year.

Senator BOYCE—And that is funded out of the global—

Dr Renshaw—Out of the global hospital position, yes. We do try not to run over. Sometimes we may have delays in payments late in the financial year—

Senator BOYCE—What sort of delays? Reimbursements?

Dr Renshaw—Reimbursements three or four weeks later, right at the end of the year. We have had other problems with reimbursements that you will hear about in submissions, but those have been more personnel based and systems based rather than deliberate financial strategy.

Senator BOYCE—What is the average time for reimbursement?

Dr Renshaw—We try to get reimbursements done within 10 to 14 days.

Senator BOYCE—So it is possible that towards the end of the financial year the medical authorisers are being fairly stringent in their assessments?

Dr Renshaw—No. Because the medical authorisers are not directly responsible for the PTAS budget, I do not think there is a change in, if you like, the clinical behaviour of the medical authorisers at the end of the year. We take our job very seriously to make sure that people are getting the treatment they require on the basis of clinical priority. So I would say that does not happen—certainly not in Tasmania's case.

Senator CAROL BROWN—On your question about reimbursements and the time it takes to reimburse clients: you said that you try to take between 10 and 12 days. Do you keep figures on when reimbursements are made? We have heard evidence, particularly about Tasmania, of it being between four and six weeks.

Dr Renshaw—At one stage we were out to three months for some people, and that was primarily systems related. We had issues with personnel who were not processing claims as quickly as they should. In certain circumstances, especially with Flinders Island, where a number of people were claiming, we have set up a system to alert us to people in specific financial need, and we will fast-track those sorts of things. But yes, there were problems.

Senator CAROL BROWN—What is the figure now?

Dr Renshaw—As of this week, we are within one week of everybody getting their reimbursement within seven days. We are doing very well at the moment.

Mr Sansom—If I could clarify: the reimbursement delays are not statewide; the delays have tended to be in the north. As Peter said, they are generally up to speed at the moment.

Senator BOYCE—Mr Sansom, you talked about the scheme not providing financial assistance to people who are eligible for assistance through other sources. I can think of what some of those might be. Would you like to talk me through what you mean by 'other sources'?

Mr Sansom—Other sources might be people who have compensable entitlements such as MAIB, workers compensation and those sorts of things.

Dr Renshaw—There are some entitlements through Veterans Affairs, as well.

Senator BOYCE—We have taken evidence in other states about charity groups also providing assistance. Were you thinking of some of the not-for-profits as other sources?

Dr Renshaw—No, at no time.

Senator BOYCE—You have also commented on the difficulty of getting Melbourne specialists, sometimes, to hand follow-ups back to Tasmanian specialists. What you have done about that, or what could be done about that?

Dr Renshaw—This is an issue probably in one or two specialties only. We would only be seeking to get people transferred back to Tasmanian care if we have the appropriate specialist staff. Unfortunately, because there are sometimes professional rivalries between specialist groups, there is sometimes a desire to hang on to patients in a superspecialty centre rather than pass them back to the sticks. There are a couple of ways to do it. I have addressed this directly with a couple of specialists in Melbourne.

Senator BOYCE—With success?

Dr Renshaw—Not directly with the specialist, but when I have used my medical administration network there has been. I do not think we are having the same problems now. The last one I addressed was about 14 months ago. It was in paediatric oncology. We have some very good systems in place in Tasmania for follow-up of paediatric oncology and paediatric chemotherapy. We are happy for the superspecialist to do the prescribing and to start the treatment, but we believe we have the facilities and expertise to be able to carry on long-term. We have made that point particularly to the specialists in Melbourne. Admittedly it was probably only two out of the six or seven major specialities in paediatric oncology, but we believe we have seen a change in the pattern. It is probably a bit too early to tell whether it is going to be persistent. Every couple of years a new specialist comes along who feels that they have everything to offer and Tasmania has nothing. But we will deal with that as it arises.

Senator CAROL BROWN—Do you keep figures on applications that are not approved for any reason?

Dr Renshaw—Probably not formally, no.

Senator CAROL BROWN—You do not bother to track people who apply but who are not approved? I am interested in how many people who apply are denied assistance, particularly because they are not meeting the 75-kilometre distance criteria.

Dr Renshaw—We have not had many applications within the 75—at least not in the north. We do not reject applications out of hand. The most common thing we do is send it back to the doctor because insufficient information has been provided. For instance, the doctor may have requested an escort and provided no clinical reason why an escort is necessary. So it is much more common for us not to reject a claim but to return it. Our staffing is such that we are stretched at the moment gathering the statistics that we have: the numbers that are finally rejected. As far as I am aware, our numbers for rejections are very small. Mostly we send them back for clarification and eventually—

Senator CAROL BROWN—That is the next part of my question: do you ever see these applications again?

Dr Renshaw—I would have to ask our patient travel coordinators, the people who are at the coalface working with people. I would think that if they kept coming back I would hear about it, and I certainly have not heard about it. It is certainly a good question.

Mr Sansom—I would think that with the criteria there would be a lot of self-assessment, so people would look at the criteria, or the medical authoriser would look at the criteria. If someone is clearly not going to meet the criteria then they may not even put an application in.

Senator CAROL BROWN—I am only asking about ones that are not approved. Obviously they had to put an application in. With the application, how does it work in Tassie about receiving your reimbursement? Do you have to put an application in after every treatment?

Dr Renshaw—No. If there is a planned course of treatment—I will use cochlear implants as an example, where you go interstate for surgery—we do not insist on an extra form. We generally know how long the course is and we will take the form as being a bit like a specialist referral, which is good for 12 months. But we do want to have a reassessment by the referring doctor at the end of the 12 months. So the longest the form will last for is 12 months.

Senator CAROL BROWN—That sounds like a good way to go. I have been told that there has been a change in relation to people who have renal dialysis and that they are now required to put in an application after every treatment.

Dr Renshaw—They record their attendances, but it is a single sheet, where you just put the date and—

Senator CAROL BROWN—I am aware of that. That is not what they are talking about. This is a recent change.

Dr Renshaw—The form allows for seven visits within a three-month period, and there is a separate—

Senator CAROL BROWN—Yes, I understand that. Can you check that because the patient is saying that it is a very recent change. They used to be able to include the seven treatments. That would not be in a 12-month period; someone having renal dialysis would probably have that three times a week.

Dr Renshaw—Three times a week.

Senator CAROL BROWN—That is only a couple of weeks. Why do they have to put it in every couple of weeks?

Dr Renshaw—I was not aware of the recent change. As recently as two weeks ago I saw one of the big sheets being delivered which I think covers a month of treatment. It is not another blue referral form; it is just a list recording attendances, so we can pay them according to their attendances.

Senator CAROL BROWN—The sign-in sheet, the list, when they go in to have their treatment—that is good enough for their application for reimbursement?

Dr Renshaw—As far as I am aware. I am not aware of any other recent change.

Senator CAROL BROWN—Can you confirm that?

Dr Renshaw—I will certainly follow up on that.

Senator CAROL BROWN—In your submission you referred to the PTAS review committee. I do not know too much about how that works. Can you tell me about that? For instance, who is on it?

Dr Renshaw—Peggy is our scribe and she manages the business of the committee. I chair the committee. The committee consists of the three patient travel coordinators at the three hospitals. They generally attend by phone because they are usually busy in their own areas. It comprises myself as chair and medical authoriser for Launceston General Hospital and medical authorisers from the Royal Hobart Hospital. There are three medical authorisers at the Royal Hobart Hospital. Those medical authorisers, at least in paediatrics and in women's and children's, provide a state-wide service, so we get consistency with medical authorisers in specialty areas. We have a senior medical adviser from the health department, Dr Paul McCann. So it is a small committee.

Senator CAROL BROWN—There is no consumer advocate on the committee.

Dr Renshaw—No.

Senator CAROL BROWN—When was it set up?

Dr Renshaw—In 1997-98, around 10 years ago.

Senator CAROL BROWN—I note you have made a change in response to the needs of Tasmanian patients. How did that come about? Who put it on the agenda? Was it you?

Dr Renshaw—At every meeting we consider complaints about the system, and there was a consistent complaint about the level of reimbursement for using your own car, which at that stage was 10c a kilometre. As a committee, we knew that this had not changed since IPTAAS. We were aware of growing concerns that this simply was not in line with other states. As an advisory body we can put advice through the department and then it is really a resource issue. It did take two or three years to achieve the recent increase. I suppose we are in the hands of the resources. As with anybody else in the health department, we just have to keep putting up our hand and saying, 'These are the needs.' Then you have to judge between the level of angst in the community and the other things you can do with the money.

Senator CAROL BROWN—Are you saying that decision means it is going from 10c to 13c?

Dr Renshaw—Yes.

Senator CAROL BROWN—It is just that in your submission from the Tasmanian government I thought it was all about approving applications even though they were under the 75-kilometre distance criteria. It says in your submission that it is about renal dialysis patients having to travel from Latrobe, Devonport or Sheffield to Burnie.

Dr Renshaw—It is one of those grey areas where you cannot actually draw a steel wall at 75 kilometres or 50 kilometres.

Senator CAROL BROWN—I am interested in establishing how the flexibility is built into the Tasmanian scheme.

Dr Renshaw—I think we argued that it is the total travel in a week for renal dialysis that counts. That would be well and truly over 75 kilometres. That is the way we justify it.

Senator CAROL BROWN—So for renal dialysis, it is the total travel in a week?

Dr Renshaw—That is the way we justified it for renal dialysis.

Senator CAROL BROWN—Can explain to me how that would work.

Dr Renshaw—In Tasmania we think more in terms of travel times because 75 kilometres in Tasmania might be one hour's travel or it might be two hours' travel depending on where you are. It is a very variable thing. You can certainly travel a much shorter distance in the major metropolitan centres of this country and still take a lot longer than you would to travel in Tasmania. It is really for those areas. For instance, Beaconsfield is 48 kilometres from Launceston, which is just within the 50 kilometre range, and Scottsdale is just outside it. Those sort of major centres fall in the grey area. I think we have to make commonsense decisions—

Senator CAROL BROWN—What about going from Ulverstone to Burnie?

Dr Renshaw—Ulverstone to Burnie is about a 20-minutes drive.

Senator CAROL BROWN—But if you are doing it three times a week—

Dr Renshaw—I do not know what the north-west are doing; I just know what we are doing in Launceston with the people from Beaconsfield and those sorts of—

Senator CAROL BROWN—It says here that there was a change for people travelling from Latrobe, Devonport or Sheffield to Burnie, and that, even though they are under the 75-kilometre distance criterion, the decision was to cater for their needs because of the frequency of the visits required.

Dr Renshaw—I am not aware of—

Senator CAROL BROWN—I am just trying to understand whether there is another basis. You are saying that it is 75 kilometres altogether in a weekly period.

Mr Sansom—I think that is just a local decision that has been made that people who need to travel from those areas for dialysis and, as Peter said, are going backwards and forwards three times a week and 150 times a year should be eligible for travelling assistance even though they fall within the 75-kilometre range.

Dr Renshaw—Remembering that before the satellite renal dialysis unit was opened in Burnie those patients would have been travelling to Launceston at a significantly higher cost to PTAS. That may have been a factor in the local decision.

Senator CAROL BROWN—When was this decision made? I am sorry to harp on it; I am just trying to get it right in my head. When was this decision to allow those patients—

Dr Renshaw—Do you have a reference there, Senator?

Senator CAROL BROWN—It is on page 5 of the Tasmanian government submission. It is the second paragraph in point (b).

Mr Sansom—I am just looking down our register of decisions, and we have an indication here that it was relaxed in November 2004.

Dr Renshaw—29 November 2004, and it was just on the basis of local need, I think.

Senator CAROL BROWN—You would obviously have seen in the media in the last couple of months stories about the costs of transport for patients—especially for renal dialysis patients because of the frequency with which they require treatment—meaning the patients having to go without meals. Did you manage to see that in the *Mercury*? Are there any southerners here?

Dr Renshaw—I am a northerner; I don't read the *Mercury*! No, I have not seen that.

Senator CAROL BROWN—Did anyone see the article 'Skipping meals for dialysis'?

Mr Sansom—I have seen that.

Senator CAROL BROWN—I am just wondering whether the review committee would have seen something like that and may have contacted Kidney Health Australia.

Dr Renshaw—What is the date of that article?

Senator CAROL BROWN—30 June. They were probably busy getting their reimbursements out.

Dr Renshaw—30 June this year?

Senator CAROL BROWN—Yes, 30 June this year. And just recently there was a letter to the editor from the chair of the Tasmanian renal consumer participation committee about the heavy costs of transport.

Dr Renshaw—That would certainly be referred to our next meeting but we have not had a meeting since 30 June. Our last meeting was in March or April. We normally have our meetings quarterly. So, obviously, if we can get a copy—

Senator CAROL BROWN—I might leave those for you if that would help.

Dr Renshaw—That would be good. Thank you.

Mr Sansom—Also, other local assistance is provided. For instance, I know that in Hobart for all patients requiring dialysis there is a taxi voucher system to assist people. That comes out of the hospital budget. It is not part of PTAS. I think it was \$25,000 or \$30,000 a year that was paid out on those sorts of vouchers.

Senator CAROL BROWN—Is it the transport department that funds that?

Mr Sansom—Yes. The same people that administer PTAS would be looking after it, but the funds would come out of a different bucket of money.

Senator CAROL BROWN—That is right.

CHAIR—Thank you. Could I follow up on a question that Senator Adams raised about the people on King Island? The submission from the King Island advisory committee says that the airfares to Melbourne from

King Island are about 33 per cent cheaper than the airfares to Tasmania. But let us assume that they are roughly the same cost. You say that you insist that people come to Tasmania if there is a procedure that can be done in Tasmania. I assume that if they do not come to Tasmania they go to Melbourne instead and there is a cost, then, to the Tasmanian government through—

Dr Renshaw—Interstate charging?

CHAIR—Yes. There is still a cost, whether they go to Tasmania or to Melbourne. That might be a marginal cost in the case of Tasmania but it is still a cost. And if they do not come to Tasmania then presumably that frees a space on the waiting list for somebody else to occupy. So is there actually a greater cost to the Tasmanian taxpayer, given the supposedly lower fares between King Island and Melbourne, of having those patients treated in Victoria rather than in Tasmania?

Dr Renshaw—Certainly it is the committee's opinion that it is still more expensive to send patients from King Island to Melbourne, generally, if they are going for public hospital treatment, because we have to maintain an infrastructure for a smaller population in Tasmania, so it is relatively a lot more expensive to establish these sorts of services in an area of low population base. That has been our judgement. I do not know if we have done an in-depth audit in the last five years. I know there was one done at about the time of the millennium which showed that it was still better to have patients coming to Tasmania. Certainly, it is something that we probably should look at again.

CHAIR—It probably is. If you are paying the full cost in Victoria as opposed to the marginal cost I suppose that you might well have a case but you might not if you are paying the marginal cost in both places. After all, services have to be established in Tasmania whether the person on King Island uses them or not. So it would seem to me that—given the lower cost of airfares—you might actually be better off sending them to Melbourne than to Tasmania. But that is a matter you might like to follow up and explore.

Dr Renshaw—Certainly.

Mr Sansom—I would like to make a further comment on that. The other non-cost type aspect is the need to maintain the viability of some of our specialist services. In the Clinical Services Plan there was some comment around cardiac surgery. Our cardiac surgery numbers are relatively low but just enough to maintain a viable unit, but a proportion of patients choose to go to the mainland to have cardiac surgery—that is probably mainly private patients. Whilst totally respecting the rights of patients to choose where they wish to have their surgery, in terms of PTAS our policy is to say: 'If you require cardiac surgery, unless it is for something that is not available in Tasmania, we would like you to use the local service. If you wish to use a mainland specialist or service, then you are perfectly entitled to do that, but you will not be eligible for funding assistance for the travel.'

CHAIR—In every year, the handful of patients from King Island needing cardiac surgery are hardly going to make a difference to the viability of the specialist services in Launceston, surely.

Mr Sansom—The comment in the Clinical Services Plan was that there was concern about the little bit of leakage in those marginal sorts of services.

CHAIR—The AMA makes the comment in their submission: 'Tasmania's claiming process for such trips'—that is, for interstate travel—'would appear to be the most difficult of all states.' A number of submissions make the comment that you need to fill in two forms to access PTAS as opposed to one form in most other places. Do you have a comment on that?

Dr Renshaw—I am certainly not aware of what the second form would be. As far as I am aware we only have a single form for claiming patient travel assistance.

CHAIR—Quite a few of the submissions make reference to there being two forms.

Dr Renshaw—There might be two parts to one form, but there are not two forms.

CHAIR—We will explore that with them. So you are not aware that your red tape is any more—

Dr Renshaw—Redder than anybody else's—no.

CHAIR—The AMA also comments on the complaints process and says it is very complicated. Have you reviewed your complaints process in recent years, apart from the review that was talked about before?

Dr Renshaw—No, we have not.

CHAIR—In your submission you talk about the position of patients accessing treatment for rare and obscure conditions. You say that, if the condition is not covered by the Medical Benefits Schedule, then PTAS is not available for it. Is that correct?

Dr Renshaw—It has been a committee decision that experimental treatment is not covered—yes, that is true. However, when we say ‘for rare conditions’, until not so long ago, Perth was the only centre where they did embolisation for brain aneurysms. We sent a number of patients from Tasmania over there. It certainly was not an experimental treatment, although it was pretty well out there. That was the nearest centre that was providing the care, so we actually sent patients to Western Australia. It is now available in Sydney and Melbourne.

CHAIR—You say that the MBS is used to determine eligibility for access to PTAS in Tasmania. So, if a condition is not listed in the MBS, it could be because the procedure is experimental or it is so rare that there is not an item number for it?

Dr Renshaw—We have dealt with some of those on a case-by-case basis. We have also had people applying to go to faith healers and other sorts of non-medical type of treatment or pretty well alternative cancer treatments and so on, which certainly are not on the MBS schedule but probably do not fall within the bounds of conventional medicine either. I am certain that we have actually agreed to a couple of people going to experimental treatment in Sydney for a particular lung condition which is rare, and the treatment is certainly not on the MBS. I think it is taken on a case-by-case basis. I think it depends as much on the reputation of the centre to which they are going. If they are going to have experimental treatment in Oodnadatta, we would probably look at it a lot closer than if they were going to have experimental treatment at the Peter MacCallum Cancer Centre in Melbourne, for instance.

Senator PATTERSON—The federal government has a way of assessing whether somebody going overseas is going for a treatment which has a reasonable rate of success and which is not available in Australia. Would people qualify if they were part of that scheme?

Dr Renshaw—Yes, if there had been a national assessment of the treatment for which they were being sent for.

Senator PATTERSON—But you do not use that as your measure?

Dr Renshaw—We use a number of measures.

Senator PATTERSON—I mean for overseas treatment?

Dr Renshaw—I cannot remember whether we have ever funded anybody for overseas treatment.

Senator PATTERSON—It is rare and it is a difficult thing. I can understand why you would not be giving them a loan to go for some treatments overseas that have not been proven.

Dr Renshaw—That is exactly right. I do not think we have ever given anybody treatment overseas.

Mr Sansom—It is probably outside the PTAS, so even when these things arise—

Senator PATTERSON—You were talking about overseas at some point and I wonder whether you sent anybody,

Dr Renshaw—I think ‘overseas to Tasmania’ is still Australia.

Senator PATTERSON—You did say ‘overseas’, though. I thought somebody said ‘overseas’.

Dr Renshaw—Obviously, I do not listen to what I say.

Senator PATTERSON—Maybe I misheard you.

Dr Renshaw—It was over Bass Strait.

Senator PATTERSON—I would not have asked a question referring to ‘over Bass Strait’.

Dr Renshaw—As chairman of our committee, if I hear of a treatment that I am not familiar with there are a number of ways of getting information from the college of surgeons or the college of physicians and so on, which we can access, so we know that it is at least mainstream treatment rather than something that is purely experimental. The other issue is that some people are travelling as part of company-sponsored research. This is another one of those cases where they are entitled to treatment, so they would not be covered by PTAS. We have been concerned about some programs on the mainland where people have been required to come back many times. We are not always certain, nor do we have the expertise to say, whether it is for clinical reasons or whether it is because people are finetuning new technology. So there are a number of grey areas.

CHAIR—Just to clarify something, you said that kidney donors sometimes get assistance to travel for the purpose of making a donation.

Dr Renshaw—We have not knocked back a kidney donor in three years, at least in the north of the state.

CHAIR—It is just that the Kidney Health submission says that there is no assistance available for kidney donors in Tasmania. That is not true, though?

Dr Renshaw—I would certainly be happy to get the data on how many kidney donors we have helped in the last three years.

CHAIR—Thank you.

Senator POLLEY—Petrol prices are extremely expensive in Tasmania. The subsidy for the kilometre rate is very low. With respect to accommodation rates, I do not know anywhere in Australia where you can get a bed for \$30 a night or whether it is considered to be a reasonable amount, particularly in the light of the fact that, when patients are normally away from home, there are added expenses. I do not know whether an escort has been paid for by PATS. There are additional costs and usually people are taking time off work, so there is a great financial burden on those people. If you are living in Ulverstone and you need to see a specialist and there is a specialist in Launceston and one in Hobart, do you get a choice?

Dr Renshaw—I think PTAS guidelines state the nearest appropriate specialist.

Senator POLLEY—But if the patient's referring doctor suggests a specialist in Hobart, that would obviously be considered?

Dr Renshaw—It depends. Specialists have different subspecialties. I think the medical authorisers are pretty au fait with the skill sets of the specialists in their area and also the skill sets of specialists elsewhere in the state. So, although it is a potential issue, I do not know if it has been an actual issue. You might get issues where a patient does not like a particular doctor, even though they are the most appropriate. We would probably still pay the equivalent of going to that doctor even if they went to another one further away. They would still get some assistance; they would not get no assistance.

Senator POLLEY—Is there any move to bring the fuel and accommodation subsidies up to more realistic figures?

Dr Renshaw—I would have to defer to the department on that.

Mr Sansom—Unfortunately those subsidies are exactly that—subsidies. As you quite correctly say, medical and hospital care, and accessing medical and hospital care, often have substantial out-of-pocket costs. So it is probably a policy decision in terms of what the department and the government wish to do.

Senator POLLEY—The evidence that we heard in Western Australia last week was that, if there was to be any increase, that would mean that, because of the budget restraints on the health budget generally, there would be less money available for the majority of people. The Western Australian government said that was the best way for them to be able to administer and help as many people as possible. Would that be your position as well?

Mr Sansom—There is only a finite budget and, like any initiative or change, it would need to be assessed against other funding priorities.

Mr Smith—To date, as far as I am aware, there have not been decisions made on a financial basis, but certainly any additional costs would have to be considered in light of the competing policy decisions we have to make.

Senator CAROL BROWN—I would like to ask a question about the promotion of PATS. Some concern has been raised that it is not promoted adequately, so people who may be eligible do not know about it and are not putting in applications. How do we promote the Tasmanian scheme here?

Dr Renshaw—Every doctor's surgery should have brochures and posters in their waiting room. There is information at every Service Tasmania outlet. There should be a number of specialist rooms that also have information on those specialties which commonly refer interstate. There is information and an application form online as well.

Senator CAROL BROWN—How did the review committee promote the changes, particularly to the distance the renal dialysis patients were required to travel from Latrobe, Devonport and the Sheffield area to Burnie?

Dr Renshaw—I am not certain what was done locally, as that was a north-west issue particularly. I think the marketing is generally through the doctors who are making the referrals because they are the ones who actually advise patients.

Senator CAROL BROWN—How is that change promoted in your applications to access the service? If new patients in Latrobe, Devonport or Sheffield were picking up an application form, would they just read on the form, ‘a strictly 75 k distance’?

Dr Renshaw—They would still have that.

Senator CAROL BROWN—So you have not actually integrated this change that was made in November 2005 into any of the forms?

Dr Renshaw—I would think that if we integrated every change we would have a seven- or eight-page form. I agree that we probably need other ways in which we can get this information out, but I think—

Senator CAROL BROWN—It is the supporting information.

Dr Renshaw—Yes, but this was a specific local issue and not a general, state-wide—

Senator CAROL BROWN—So how is it promoted?

Mr Sansom—The renal unit service in Burnie would have been well aware of the change, so with all the patients going through there—

Senator CAROL BROWN—The Tasmanian branch of Kidney Health Australia do not know about it.

Mr Sansom—That may well be the case.

Dr Renshaw—We will follow up.

Senator CAROL BROWN—You probably need to look at putting some information in your supporting document.

CHAIR—Thank you very much for the evidence you have given today and for the submission that has been provided by the minister. Please thank the minister on our behalf.

[10.16 am]

CRISP, Mrs Margaret, Board Member, Campbell Town Area Community Service Board Inc.

LOVITT, Mrs Anna Margaret, Board Member (Staff Representative), Campbell Town Area Community Service Board Inc.

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mrs Crisp—On that board I represent the Northern Midlands Community and Health Interest Group.

CHAIR—We have given you information, I understand, on parliamentary privilege and the protection of witnesses and evidence, so you know how you are protected by being in the hearings today. We have a submission from the Campbell Town Health and Community Service Board. Thank you very much for that. That has been very useful. Our usual practice is to ask you questions about that, but first of all we would like to give you a chance to make an opening statement, if you wish, where you can talk about the issues in your submission.

Mrs Lovitt—Thanks for the opportunity to bring further focus to the issue of access to transport, which is a very big issue for our area. We have recently undertaken a fairly extensive needs analysis. It was timely that, when this inquiry was announced, access to transport was one of the major issues, particularly for older persons in our area. At the same time Mrs Crisp had brought to the board the concerns of that health interest group, particularly around access to medical services. So it was timely that we make this submission.

As we have outlined in the submission, the notion of 75 kilometres is a confusing one for our area. We operate as a multipurpose service and have a very large catchment area spread out. While it is a smaller population, it is spread over a very large area. Some residents of the catchment area would be well entitled to claim under the scheme. Others, certainly under the scheme as it stands, would have no entitlement. Yet in terms of where people access their medical services it is probably important to note—particularly for older people, for those without transport—that sometimes there seems to be quite a lot of inequity in how the scheme is administered. There is probably not a lot of understanding of the scheme. I know that there are a number who do not access the scheme because they do not think that they are eligible to do so. That is probably one of the main issues.

The other part—which goes hand-in-hand with the other issue—is the process of accessing the scheme and how easy it is to do that. I guess this has been highlighted for us. We have a cancer support group which have been quite active and very good at voicing their concerns. Why people have access to the scheme while others cannot has been an issue for them. They are a group that works with residents who are only a few kilometres apart, and it is those few kilometres that might make the difference between being able to access accommodation—or being able to at least top up their fares—or not being able to. They are probably the main points that we want to get across to highlight the problems for rural areas. As has probably been said many times in your inquiry, each rural area has its own different set of circumstances. Sometimes, those differences cannot be measured in just kilometres.

One example—and it has been highlighted particularly in the last few days with the sort of weather that we have been getting—is that some of our residents might have to travel up to an hour and a half to come into Launceston and if they have appointments early in the morning or are going to catch a 6 am flight for their medical services in Melbourne that means getting up at an extraordinary hour of the morning. Even more importantly than that, to catch that flight, which happens to be the cheapest flight under this scheme, there are dangers of black ice on a winter's day for people travelling at those particular hours. We need to have a process that enables this to work in a way that is in the best interests of patients trying to access medical care. Quite often, they may be facing life-threatening medical problems. Our main concern is about quality of life and enabling a level of access that many other people in Australia have. In rural areas, this is a hard process and at times it makes a difference to the decision of whether to continue treatment or not.

CHAIR—Thank you very much. Did you want to add anything, Mrs Crisp?

Mrs Crisp—I do not think so. I am here to support Anna. I know that filling in the forms can be a problem for people. People find that difficult. Occasionally, they drop out because it is too hard, and that gets on top of people—too many forms; too many worries.

CHAIR—Yes. We have heard that.

Mrs Crisp—To streamline things would be fairly good.

CHAIR—We have certainly had that comment made in a number of the places in Australia that we have been to. The forms tend to be a barrier to people getting access to the system, which is unfortunate. What do we do about this distance limit issue? If we changed it to 50 kilometres, you would have the people who are 49 kilometres from the health centre having that problem. What should we do? Should we abolish distance limits altogether, do you think?

Mrs Lovitt—I guess there are no easy answers to that. I suppose that we are thinking particularly of people on low incomes, for whom the cost of petrol—if they have a car or if they can get someone to drive them—can be quite significant, particularly if they are coming into Launceston for treatment several times a week.

There is assistance for people in that position but it is limited. For example, in Campbell Town there is a community car available and it is a really good service—there is no doubt about that. Under the present scheme the cardholder is responsible for the first \$15 of their travel. That does not apply if they get a community car. The community car is slightly less than that, so that is fine. It is a fantastic service that goes door to door. But, again, there are limits to that. There are limits depending on how far ahead you can book it and it is a car that is continually used almost to its limit. For someone who is having intensive treatment that may not be an available option. Similarly, it depends on whether Hobart has the closest specialist and for some people that is not the case. If they choose to go to Hobart then they are not eligible to claim the top-up between a community car and the additional \$13 expense that they would have to pay themselves. The other part of it is its retrospective nature.

To get back to your question, I think it would take a fairly radical reorientation of the scheme—and I am not talking about interstate travel but within the state—around a voucher system that allows for either petrol or access to a car and that is beyond the normal \$15, and I do not know if changing that \$15 is up for discussion. You could have a multipurpose service at the point where the referral is made initially—that is, a centre where people come in for particular services. There are several pilot schemes operating to help people access medical services, which are voucher systems. I gather that that works quite well. It may be that an assessment process linked to a voucher system needs to be looked at and streamlined or reorientated in a different way. Beyond that, the detail would need to be worked out. The issue seems to be more about where you go to get your first point of medical service rather than kilometres travelled.

Senator ADAMS—In your submission you say:

... the Patient Travel Assistance Scheme is viewed by many as not being valued, relevant or ‘user friendly’ in helping to address transport or accommodation affordability.

Before you came in, I asked the department about their review committee. My question to them was whether they have any consumer input, or whether there is a consumer on their committee. The answer, of course, was ‘No’, even though they said that they had done extensive consultation throughout Tasmania. As a board, have you approached the department to discuss the issues of the travel assistance scheme?

Mrs Lovitt—We have not as a board, and some of that has to do with timing. The issues in relation to our needs analysis have only come together over the last month or so. I think that would be a good thing to do, but the answer is no.

Senator ADAMS—It is just that, regarding a number of submissions, we have the department saying one thing and the different consumer bodies saying something completely different—the opposite. The department’s submission looks quite glowingly at things that are happening, but we are fully aware that it is not like that. I just wondered whether you had formally done anything like that. I have a question regarding problems with the form. The department says that specialists can fill in the form online. Do you know anything about that?

Mrs Lovitt—I am certainly aware—and I have a copy in front of me—of the form that is available online. I think that has actually been a good step in enabling people to understand the scheme or make the form more available. I think that in the past it was a blue form in someone’s filing cabinet, but now it is online, so that is really good to see. I cannot comment on the notion of a specialist filling it in online, but the process is set out that the patient needs to have both the person referring and the specialist signing it. Anecdotally we are being told that, particularly for people who are unwell, the last thing that they want to do or remember to do is pull out the form for a specialist. Someone spoke to us the other day about going up and down in a lift trying to find out where the specialist was. They pointed out that quite often, when you go for specialist treatment, the specialist is not actually at the premises at the time. So, while this is probably taking a very black and white view about what has to be done with the form, the reality is that that is what people think has to be done with the form. Of course, there is stress and confusion in the sense of: is this worth it?

Senator ADAMS—If a patient is seen by a registrar, as often happens—you might see the specialist once a month and for your next visit you see the registrar and then you see the specialist the next time—is the registrar able to sign the form in place of the specialist?

Mrs Lovitt—I am not sure about that at all. I am not sure about the finer parts of the process. I can only talk about the perception.

Senator ADAMS—The next thing I want to talk about is escorts, as far as psychosocial support rather than clinical support goes. It was put very strongly that you have to have someone who can give you clinical support to be able to get the escort subsidy. Do you have any examples of people being denied an escort? I would probably look more at longer term chronic diseases, as in having to travel for chemo or radiotherapy.

Mrs Lovitt—Unfortunately, I cannot give you a lot of detail about escorts, mainly because most of our experience is within the state and there is or is not a driver. However, the only comment we have heard recently is in relation to a person escorting a child. They went several times and, because their refund was retrospective, there was only a small amount against the accommodation. If they had known that, they would have made separate arrangements the next time because they were quite considerably out of pocket. That was probably more around understanding or not understanding the processes. I cannot really give you in-depth detail about escorts.

Senator ADAMS—I would like to ask you about breast screening. Do you have breast screening available at your health service or where do women have to go?

Mrs Lovitt—We certainly arrange it every two years. A breast-screen bus came, and I think that this year a health interest group pressured for that to come. That is a good service.

Mrs Crisp—It was only at Oaklands and St Marys; it did not stop at Campbell Town. We lobbied for that. They were bussing people to Oaklands, which was not very practical. Now it is really booked out; it is very hard to get an appointment. It is there for five days, I think. It has picked up a lot of cases that I know of.

Senator ADAMS—That is good. I forgot to ask—

Mrs Crisp—We are very happy with that set-up.

Senator ADAMS—You were talking about the emergency relief program, giving the example of the availability of petrol vouchers that are immediate and suggesting that PATS could follow a process like that. Could you explain the process of your emergency relief program?

Mrs Lovitt—In our area, through the Commonwealth we get several thousand dollars to cover urgent needs—for example, food. There are some occasions when people need petrol because they cannot come into town to go to the supermarket, or because they need to take a child into Launceston for medical care and a community car is not available. It is not used frequently, but we have an arrangement where we can give vouchers for petrol. The vouchers are able to be given out at the point of assessment so that the person can go across the road and fill up their car, enabling them to get to where they want to go. In that sense it immediately meets the needs of very low-income earners or people who at a particular time simply do not have enough money for the week. It is meeting a very vital need. That is what that example was about. There are cases where that \$5, \$10 or \$12 is hugely significant, particularly when you have treatment over several weeks. I acknowledge that this scheme does have a limit of around \$300 in a particular year. But having that money up-front is for some people absolutely vital. I think there needs to be some consideration of that. Okay, Campbell Town does not actually fit within the 75 kilometres—and that distance is up for negotiation—but certainly for people Avoca-way or Rossarden-way in Tasmania it is quite a considerable distance, even to get to the first point of medical service. There might be a mix of solutions to accessing specialist services, and one of them could be a voucher system for petrol.

Senator ADAMS—Is the distance for eligibility, 75 kilometres, taken from a person's home or from the first point of call, as in the Campbell Town multipurpose service?

Mrs Lovitt—The understanding is that it is from the person's home. Whether that is actually the case, I do not know.

Senator ADAMS—How long does it take to get from Campbell Town to Launceston driving at the speed limit?

Mrs Lovitt—I noticed on the internet it says it is 38 minutes to the LGH, but that is not true if you are driving at the speed limit. It is 45 minutes from the LGH to the Campbell Town multipurpose service.

Senator CAROL BROWN—Are you able to give me any information from your experience on the reimbursement times? How long do people have to wait? We have had different evidence presented. Some people say it takes quite a long time and others say that they have it down to a 10- or 12-day period.

Mrs Lovitt—My understanding is that it can take several months for reimbursement.

Senator CAROL BROWN—Is that lengthy reimbursement time more common than not, just in your experience?

Mrs Lovitt—Certainly one person told me that she was still waiting three to four months down the track for interstate reimbursement. But in my understanding it is a month or so.

Senator CAROL BROWN—In your experience are people having to apply after every treatment, even if they have a series of treatments that they need to access?

Mrs Lovitt—There is a form for multiple visits. If you were having treatment over three months you would hang on to this form for three months. You would be paying out for three months and then putting in the form. Or you could put one in every three months.

Senator CAROL BROWN—So as long as you have got lines left on your form you are right. That is section C of the form that you are looking at.

Mrs Lovitt—Certainly it is not my wish to denigrate the scheme or how it may work for people when it works well. Probably what is unknown to us and to those for whom it does not work well is the degree of negotiation that can be around the things we have talked about. What is the flexibility around that and the understanding? I guess we hear more about when it has not worked, and that is largely when people just do not access it at all because it seems too hard. I have certainly had a person say to me, 'If you persevere, you'll get some money back in the end.' As I said, I do not wish to denigrate it.

Senator CAROL BROWN—As you say, \$10 or \$15 to the people who are accessing this scheme is a lot of money, and you would like to see a timely turnaround in reimbursements. Have you used the complaints mechanism at all? Has your service called the PATS complaints service and put forward some concerns?

Mrs Lovitt—No, we have not. To my knowledge, speaking on behalf of the board, we have not done that. I could not comment on whether others who are part of the service have done that. Certainly there is a number that you can phone to have your queries answered very promptly by the coordinator of the end of line.

Senator CAROL BROWN—Is your service aware of the PTAS review committee? I was not aware of it either. The Tasmanian government submission says there is a PTAS review committee that meet. It is made up of, basically, doctors and people who administer the PTAS. They look at how it is working and suggest alterations. In November 2004 they agreed that renal dialysis patients who have to travel from Latrobe, Devonport or Sheffield to Burnie, even though they are under the 75-kilometres distance, will still be catered for because of the frequency of their hospital visits. I am interested in trying to establish if anyone outside the committee itself knows of the group.

Mrs Lovitt—Not formally, although I am aware that, for example, the mileage reimbursement has recently risen from 10c to 13c. I guess that tells us, yes, it is being reviewed. But I do not know formally of the body that has reviewed it.

Senator CAROL BROWN—If you do not feel like answering this one, it is okay. There is no consumer advocate on this review committee. Would that be advantageous to a committee such as this one, which is set up to review how the scheme is working?

Mrs Lovitt—I guess that, in general terms, having a consumer advocate would be a good idea.

Senator PATTERSON—You talked about the community car being a valuable asset. What happens if people volunteer to drive their own cars? Is there a problem with insurance?

Mrs Lovitt—It is interesting you should ask that. That has been up for discussion in the last few weeks.

Senator PATTERSON—I have not been eavesdropping in Campbell Town—

Mrs Lovitt—No!

Senator PATTERSON—despite the fact that you are going so well in bringing your community up. You won an award for local government, didn't you?

Mrs Lovitt—The Can-do.

Senator PATTERSON—Yes, the Can-do Award.

Mrs Lovitt—We have not got a definitive answer because for us it is really important that we increase a number of options not only to medical services but in general. Transport is important to health. It is a social determinant of health. That may include encouraging people to share or car-pool. A couple of schemes are starting up. For example, you may have heard from the Cancer Council about their transport to treatment scheme. As yet, we have not got that scheme going because part of that relies on the possibility of someone using their own car and they are questions we have not sorted out for ourselves either.

Senator PATTERSON—For argument's sake, say the PATS had some sort of component to recognise volunteers driving their own cars and cover the insurance, would there be people in Campbell Town who would be willing to do that?

Mrs Lovitt—It is a community that does rely on volunteers. We rely on volunteers to run our transport system. Mrs Crisp might like to respond as a palliative care volunteer who does transport. We know that there is a lot of informal transporting where people will offer lifts.

Senator PATTERSON—But you would not be able to claim PATS on that, would you?

Mrs Lovitt—No, of course not. I am also aware of people being reluctant to ask people to transport them, even though their neighbour might have been perfectly willing to, because they felt that they were unable to—

Senator PATTERSON—Contribute.

Mrs Lovitt—Yes, contribute or do that. I guess a whole mix of possibilities could be looked at, such as clarification around insurance to see if it is just your normal car insurance. We still have not answered that question for ourselves in devising this.

Mrs Crisp—We want to encourage people to ask friends and family. There is a tight schedule with volunteer drivers anyway. I took a friend to St Luke's recently and I have driven her to other appointments privately. I have had eye surgery myself and did not ask for any government help. We do try to do that if we can. I bussed to and from Hobart and did not claim that. I stayed with my family. We have tried to encourage that sort of thing to take the pressure off. I have not been asked to do any driving for palliative care. I was asked. A lady was admitted to hospital and I was to go to Nile and pick her up and take her to the Holman Clinic, but I did not need to do it. That must go through the palliative care volunteer coordinator. The hospital would not arrange that. That is another service. We have just opened the palliative care wing at the Campbell Town hospital and we are expecting that volunteers will be used more for that. But we would use our own car and get 13c a kilometre.

Senator PATTERSON—From palliative care?

Mrs Crisp—From palliative care. That is not through the hospital, but we are going to have to work more through the hospital now that we have opened the palliative care unit there; so it has got to be worked on.

Senator PATTERSON—Thank you very much. I am not sure of the insurance implications of that, when you get reimbursed for taking somebody else. I suppose we should try to get some legal advice on that, Mr Chair. If you do volunteer work for the Scouts or something, they give you 13c a kilometre to drive your car. There may be a difference between that and driving somebody else in your car. I think it needs to be clarified for everybody.

Mrs Crisp—It is just a private arrangement with friends and family—

Senator PATTERSON—If you have an accident and there is insurance involved, I have always been told that money thins blood faster than water.

Mrs Crisp—So you don't claim on it.

Senator PATTERSON—What I am saying is that when there is transport insurance involved, some people get advice from their solicitors to say that they should claim, and then there are difficulties. I think we should try to get that clarified. I do not know, and we should know.

Mrs Lovitt—Certainly that is a question that we need clarified before we use these schemes or promote them.

Senator POLLEY—Thank you for your submission. I want to put on the record that I think the Campbell Town multi-complex health centre has been well received and we are lucky to have it in Campbell Town and the surrounding areas. It is a very close-knit community and, as you said, it does not meet the kilometre requirements under PATS. You go down as far as Oaklands, is that correct?

Mrs Lovitt—The catchment is just north of Tunbridge, up to Mathinna, Mangana, it takes in Rossarden, Royal George, north to Epping Forest and then up to the Tiers.

Senator POLLEY—You said you have the community car—and we all know about the invaluable work they do. People are sometimes reluctant to ask a neighbour or somebody else, because of pride or whatever, when they are suffering hardship. My perception is that it is not just a matter of the kilometres but it is also a matter of whether we ought to be recommending other criteria as part of the funding for PATS. Have you any views on any other criteria? For instance, it is not just people on government benefits who suffer financial hardship; it is also—as we all know; it is often referred to in the media—the working poor. Families on one income, or even families with two incomes that are not very high, that are suffering financial hardship—should they not also be included within the criteria?

Mrs Lovitt—Obviously I cannot speak as having discussed this with the board, but you are absolutely right about single-income families, and there are young families on farms who do not have access to vehicles. But I am still not quite sure about your question.

Senator POLLEY—At the moment it is basically judged on distance. It is not for me to suggest, but if people do not meet the distance criteria, are there other criteria, like financial hardship, according to which they can be assessed to get that assistance?

Mrs Lovitt—The main thing is to be able to access the care you need. What does it take to do that? For some people, it is as simple as getting in the car and driving there, because they can do it; they have the petrol. For others, it is hard to get past the farm gate. They might not have a vehicle. They might be ill. They might have a mental illness and not be able to cope. There are a whole range of things. Each person's situation is unique, so how do we deal with that?

Senator POLLEY—We need to have more flexibility.

Mrs Lovitt—On cost alone, there need to be some different criteria to do with the affordability of access to care.

Senator POLLEY—Obviously, there should be criteria in terms of people's age. People of more senior years have different circumstances than people with young families. Do you know whether people from your catchment area have been denied PATS? You can take that on notice. It will give us some examples of the criteria on which people miss out on assistance.

Mrs Lovitt—I can certainly give you an example. I cannot tell you about their application process or how far they got with it or whether they were denied. I can only tell you anecdotally, I suppose, of someone who lived in the Ross area. They would have been eligible to go either way, because they were over the 75 kilometres distance. They chose to go to Hobart because that was where the specialist was for cancer treatment. That specialist was someone who was trusted and who had treated other family members. But, because that was not the closest specialist, they were not eligible. Going that further distance did mean overnight accommodation was required so that they could attend treatment early in the morning, so there was a significant cost to this person. Often, because of the longer distance, the community car was not available. So they had to face a series of hardships in order to receive their treatment.

Senator POLLEY—In your opening statement, you commented about the weather conditions. Knowing the Midlands Highway as well as I do from the experience that I have had on that road, the issue raised in relation to flying out of Launceston is a reason why the criteria need to be changed. People should not have to get up at three o'clock in the morning to make their way to Launceston on our icy roads in the middle of July and August, because those roads are fairly treacherous. That should be taken into consideration. One hundred kilometres in outback Australia is very different to 100 kilometres on a highway in Victoria, for instance.

Mrs Lovitt—That is why we emphasise that every community has its own particular and unique situation. That room for negotiation in what is available is important.

Senator POLLEY—If someone else has already asked this question, I apologise. You were in the room when I asked the department about their mileage and accommodation allowances. The general response from all governments is that there is only one pot of money and so therefore to enable the most people to access some subsidy they have to keep the subsidy low. While \$30 is better than nothing, it does not come anywhere near to subsidising accommodation. Should that be raised? Obviously, the overflow from that would be that a more limited number of people would be able to access that benefit.

Mrs Lovitt—That is a tricky one. Thank goodness I am not the politician who will make that choice. Accommodation these days would be much more than \$30. We are lucky here that in Launceston and Hobart you can obtain accommodation near the hospital at times for around \$30. But in general, and particularly interstate, accommodation costs are very high. There is some imperative to fly over and fly back in the one day, which can be absolutely huge, particularly if you are not well and are undergoing treatment. It would be great for both the kilometre and the accommodation rates to be much closer to the real costs. But that is to sort out—where that comes from. With a lot of health care, the movement is away from hospitals and out into the community, so the focus we give to financing a range of means of transport is becoming more important. Accessing care is where equity needs to be protected.

Senator POLLEY—The community cars are invaluable. Do you only have one vehicle available in Campbell Town?

Mrs Lovitt—There are several vehicles, but they are used for a number of programs. One of the great things about being a multipurpose service is that there are pooled monies, so we are not restricted to one car. Having said that, while there are several vehicles—and that enables vehicles to go at different times, so we do not just have the one car going up and down—that is limited to the number of drivers.

Senator POLLEY—Could an extra vehicle help alleviate some of the concerns in your community for PATS? Would that also assist in terms of flexibility?

Mrs Lovitt—Absolutely. I do not think we can give enough focus to the availability of transport, both for medical services and for a range of other activities. It is a huge focus, particularly in rural areas.

CHAIR—The community cars are not funded by government at all; they are supported only by local communities. Is that right?

Mrs Lovitt—I need to take care because I do not have a full understanding of the funding, but there is a community transport scheme.

Mrs Crisp—Longford run their own community cars through a charity. Ours are not run that way—I do know that. The community cars are run entirely from the hospital.

CHAIR—I see. The hospital budget supports them.

Mrs Crisp—Yes. I came in this morning with a lady who was being driven into the fracture clinic, and I will return with Anna, who has to return to work down there. That is the sort of thing they are used for.

Mrs Lovitt—We lease the cars through the community transport scheme. It is not like Lions or Rotary purchasing a car to give to the community.

CHAIR—That has been very useful. I thank both of you for appearing today and giving us this evidence, and I thank the board for the submission provided to the committee.

Proceedings suspended from 11.03 am to 11.25 am

BREWSTER, Mr David, Chairman, King Island Multi-Purpose Centre Advisory Committee**WARDLAW, Mr Andrew, General Manager, King Island Council; and Council Representative, King Island Multi-Purpose Centre Advisory Committee**

Evidence was taken via teleconference—

CHAIR—I welcome you both to this public hearing into the patient assisted travel schemes. You have had information on parliamentary privilege and the protection of witnesses provided to you, I understand, so you know how the rules of privilege work. We have a submission from your committee. That has been very useful. Do you wish to make a brief opening statement about the issues in that submission before we proceed to ask some questions?

Mr Brewster—Yes. Thank you for the opportunity to address the committee. Like most other rural areas in Australia, we on King Island appreciate the provision of travel assistance for those in need of medical services not available within our local community. However, unlike most other rural areas in Tasmania, we are situated close to a state border which predominantly experiences one-way leakage of patients. This leakage is created by attempts to achieve best economic and medical outcomes for patients. The state government has implemented measures to reduce the leakage by methods and means which do not always put the patient's health and wellbeing first. Given the one-way element of the leakage and the economic consequences of this, the Tasmanian government would appear to be significantly disadvantaged. That is based on the full costs of an interstate hospital bed versus the incremental costs of a Tasmanian hospital bed.

At present, the state exemption allowing obstetric patients to access travel assistance beyond the nearest available service recognises the benefits of family and friend support mechanisms. This is especially significant in the case of longer off-island stays not involving admittance to a hospital. Unfortunately, this extended assistance service, although appreciated, is only available interstate as far as Melbourne and intrastate to Hobart.

I am told that, prior to the implementation of the patient travel assistance scheme, persons with private health insurance would receive financial assistance with essential air travel for health purposes. Since the implementation of the present scheme, that assistance has been withdrawn. People on King Island with private health insurance have been disadvantaged through exposure to full travel costs to access many services not provided in Tasmania.

Statistical evidence dramatically supports the need for a system that allows and encourages access to the most appropriate sites for the patient's needs, as opposed to a system constrained by state or other boundaries. Length of waiting lists for procedures could then also influence delivery of services. This may also positively influence the siting of future medical facilities and associated infrastructure that might enhance health outcomes in the future.

In speaking to this submission, I bring to the attention of the committee a number of errors and ambiguities contained in the original submission provided to you. With your consent, Mr Chairman, I will read the relevant parts of the submission so that those inaccuracies might be corrected. In the submission, subparagraph (a) should read as follows:

- a. Travel and access times: The closest regional medical facilities to King Island is Burnie (40 minute plane flight and a further 20 minutes by road) however many patients are referred to Launceston (50 minute plane flight, and hour by road) or Hobart (2 hour plane flight) plus the associated road travel. Patients, if very lucky, can access services in Burnie and return the same day on an afternoon flight. However, this is very difficult in other Tasmanian centres. RPT flight scheduling and aircraft choice to Tasmania do not take into account any of the patient needs. Patients can access many services in Melbourne (a 50 minute plane flight and from 10 minutes by road) and return in the one day.

The road access components mentioned are by hire car or taxi service. Subparagraph (b) currently says:

- b. Aircraft: Access for frail and physically impaired residents onto the aircraft which travel to Tasmania is extremely difficult due to aircraft configurations ...

I am not aware that disabled passenger lifters are available to RPT services to Tasmania. Disabled passenger lifters and wheelchair access are available to passengers travelling to Victoria. Subparagraph (c) should read:

- c. Social Support Networks: many island residents have their family and support structures based in Victoria, and that would be possibly up to half of the population. This support is often essential in complex, longer term, or chronic illnesses when emotional support is crucial to improved health outcomes. There is also a practical aspect

with hospital visitations where assistance i.e. washing clothes and providing consumables, is required. Assistance with transport to and from treatments and airports is also of great value.

Subparagraph (d) should read:

- d. Economic Impact on residents: The cost to travel to Tasmanian centres can often be greater given times away from work (many up to 2 days) as in a rural area many people rely on self employment or contract work and suffer a significant loss in income. If unable to stay with family & friends they are required to pay the first two nights accommodation and receive a partial reimbursement of accommodation costs for further nights (\$30 per night). Transport costs also incur minimal reimbursement. Indirectly businesses suffer as employees are away for extended periods of time. The Tasmanian scheme has contracted a service provider to assist in transportation between Devonport airport and Launceston, which has been of great value to King Island patients.

I move on to paragraph (c), which should read:

- c) As can be seen local and cross-border issues compromise health outcomes for patients. Another example of this is patients who have previously resided in Melbourne or elsewhere prior to tightening of the Tasmanian guidelines, have traditionally seen specialists in Melbourne with whom they have established relationships and historical data are now required to abandon those services and travel to Tasmania.

Paragraph (d) should read:

- d) Our local scheme is well acknowledged by the community but inconsistencies exist as patients continually advocate for improved access i.e. pre-paid flights and lack of access to services in Tasmania, impacting on the administration of the services.

Paragraph (f) should read:

- f) The Tasmanian scheme is supportive of second opinions. This is of great value to patients who we are constantly encouraging to take more responsibility in their own health and well-being. The ability to access multidisciplinary services, in one visit, is often essential to patient outcomes both in relation to their medical condition and socio-economic factors, particularly as patients are suffering medical conditions, requiring more complex treatment. These are not always available in smaller regional settings such as Burnie. They are very accessible in Melbourne.

Paragraph (g) should read:

- g) King Island is part of the Tasmanian Telehealth network and has experienced a small degree of change in relation to e-health over the 7 years the system has been in operation. An example is that no Medicare assistance is available for dermatology clinics.

That concludes the correction of inaccuracies or errors in the original submission.

CHAIR—We need to make sure we have that all down accurately. You might forward us a revised copy of your submission with those changes. Is that okay?

Mr Brewster—That is certainly possible.

CHAIR—Thank you very much. Do you want to make a statement, Mr Wardlaw?

Mr Wardlaw—No, not at the moment, thank you.

Senator ADAMS—Thank you for your submission. We had the department here this morning and we asked them a number of questions about issues raised in your submission. The first thing I would like to ask you about is the PTAS review committee, which is a departmental state-wide committee. They meet periodically to make policy recommendations. Has your organisation had access to them with any representation as to the problems on the island?

Mr Brewster—Yes, they have but it has not been during the time that I have been the chairman of the MPC committee.

Mr Wardlaw—I am aware that this has been an issue for the community for some time. The issue was raised through a partnership agreement with the state government, and through the Community Wellbeing Group lots of issues were raised and put through that committee. Whether they were satisfactorily addressed is another question, but certainly we are aware of the committee and we have put some issues to them in the past, and have worked with that group. They are well aware of our issues, I would say.

Senator ADAMS—They did say that they had a consultative process. My second question is whether they consulted with you.

Mr Brewster—My answer is no.

Senator ADAMS—The question was raised about the airfares. You say in your submission that it is 33 per cent cheaper to travel to Melbourne for specialist appointments than to Tasmania. Their reply was that they did not encourage people to go outside the state if there was a specialist available. Could you give us examples of problems where there has been a specialist available and your people have had to bypass that specialist?

Mr Wardlaw—In the last discussion we had on this particular issue I think it can be said that the island community appreciate that if the service is available on the north-west coast—usually it would be in Burnie—then under the scheme we should probably go and support that. Importantly, however, when we need to go to Launceston or Hobart to get those services it is a huge disruption to the person who has to go. You may have to see a specialist, which could be a half-hour or one-hour visit. To go to Hobart to see that specialist you could be off the island for three days. If you have a small business or are an employee, that raises huge social issues for the person. If you go across to Melbourne not only would it be cheaper to fly than go all the way to Hobart but also it could probably be done in a day. There is less disruption to the small business or to the individual concerned. I think we support the fact that if the service is in Burnie then, yes, we should go there because it is the same to go to Burnie as it is to go to Melbourne. But when you have to go to Launceston or Hobart, you just cannot get there and back in a day, even if the visit is just a routine procedure or a visit to see a specialist. But you can get to Melbourne and back in a day.

Mr Brewster—Even to Burnie hospital it is still touch and go as to whether you can achieve it in one day. It is quite difficult.

Senator POLLEY—Good morning, and thank you for your contribution and your submission. I have asked witnesses this morning, and I am interested in your views, about whether there should be changes to the criteria for assistance. Rather than relying on distance alone there could be other things such as financial hardship. For King Island I guess there would not be too many denials of assistance but I wonder whether in the greater scheme of things you see that there is a need for more flexibility in making assessment.

Mr Wardlaw—In relation to that, when we did make a submission about this we did say that the criteria should think about the social aspects and not just the economic aspects. I agree with what you are saying, Senator: there is a need for the criteria to balance the social and economic factors to see what is best for the people who access the services. For the majority of things that need to happen, economically it would be far more affordable to go to Melbourne. However, and this complicates the issue further, when it converts into a bed place the result is huge financial penalties on the state with respect to those interstate agreements and those types of things. We have no control over that but on the front end of it all quite often there is a good argument to say that it is more beneficial to go to Melbourne. However, there is a reluctance by the state because of the sting in the tail they get when someone is admitted to hospital.

Senator POLLEY—When we questioned the department this morning about that aspect of your submission—about travelling to Melbourne—the response was that there is additional cost because Tasmanian patients are not covered by the Victorian government for treatments over there so in fact it would be better to have people come to Tasmania. It is also to ensure that Tasmania keeps good specialist services. You would be as aware as I am, if not more so, of how difficult it is to attract specialists and even GPs to rural and regional Australia, let alone Tasmania. Do you have any instances of or experience with people being denied access, and whether choice of specialist is an issue for King Islanders?

Mr Brewster—I would suggest that there are significant numbers of people who put their health in front of what assistance they might receive from this scheme—their health being not just their physical health but also aspects of social health that flow on from going somewhere where they do have support mechanisms in place that might assist them when they are not actually admitted to a hospital bed. I would be a good example of that myself. I have chosen not to take assistance from the scheme, and to go to Melbourne for treatment. Had I gone to mainland Tasmania I would have lost all connection with friends and relatives during that period in hospital. There would be a lot of people in the same position. There are figures documented that support what I have just said. If you look at those services where exemptions are provided, for example obstetrics, the number of patients who have actually received assistance to go to places other than Tasmania—and the only assistance they get is to go to Melbourne—equates to more than half of the obstetric cases. A significant number of the other cases where people have got assistance would have gone to the mainland had they been able to. You may find that because those statistics are actually lost, the numbers may be considerably higher. The numbers of people who have sought out those services would be higher than that which has been documented simply because they are denied access to the closest facility or to the Victorian facilities or to where they have other support mechanisms.

Mr Wardlaw—In relation to the comment about supporting specialists in the state of Tasmania, we can agree with that but our population is 0.3 per cent of the state's population. I would argue that the leakages that we have to Victoria—and we would like to have more leakages to Victoria; that is our argument—would not have a huge effect on the ability of those specialists to get a critical mass. We are talking about a small number of people in the scheme of things. If those leakages were allowed to happen they would comprise only a small percentage of the actual budget that they are talking about. It is not as if we have half the population of Tasmania and it is all going to leak to Victoria. It is only 0.3 per cent of the population and only a small portion of those leak into Victoria.

Mr Brewster—That 0.3 per cent is not going to make any difference to the number of specialists who end up in Tasmania.

Senator POLLEY—Thank you for your comments. Do you believe that we need to have a national scheme that is identical throughout the nation so that there can be some proper and accurate assessment of the outcomes of this program?

Mr Wardlaw—I certainly agree with that. I think there should be consistency right across the country in relation to it. I am not sure what happens in places like Albury-Wodonga, but I am pretty sure that if there is a good hospital in Albury, people are not necessarily forced to go to Melbourne; they are probably allowed to go across the border. I am not sure about those arrangements; I have not even looked at them. But I think there should be consistency right across the country in relation to how everyone is assessed.

Senator POLLEY—In terms of the mileage and kilometre allowance and the accommodation allowance, not only the evidence that the government gave to us this morning but also the evidence in other states that we have already visited all says the same thing—that they have a budget and that they cannot afford to pay any more in accommodation or mileage because if they were to try and do that then there would perhaps be fewer people having access to the scheme. Do you have any comment?

Mr Wardlaw—You might get 10c a kilometre in the current scheme when you are travelling. If you are living in the state of Tasmania and you choose to take your own car and you are travelling from, say, Queenstown on the west coast to Hobart, from Smithton to Launceston, or wherever it might be, you get 10c a kilometre for your own car. In our case, when we go, we either have to get public transport, which generally will not line up with our flight times and is usually inappropriate, or hire a car if we want our independence. Or we have to rely on a contractor that has been arranged, which is very well received, but—

Mr Brewster—Or take a taxi.

Mr Wardlaw—Or take a taxi. So the 10c to us is really a pittance when it comes to what it costs us. Obviously it would still be a pittance to those people who use their own vehicles, but at least they have that choice and they are getting a little bit back for their effort. We agree with what you are saying, but I appreciate the government's position, as the kilometre rate and the accommodation rate paid are nowhere near adequate. If you go in to Tasmania with no family support network, you are forced to go into hotel accommodation. You are probably lucky to get a bed for less than \$100 and I think you might get about \$20 back or something like that.

Mr Brewster—It is \$30.

Mr Wardlaw—Thirty dollars. We are forced, the majority of times, to at least stay one night, and sometimes when going to Tassie it is hard to get a flight and people get stuck there for two or three nights just trying to get back home. That is an issue for us. It is a big issue for the community here.

Senator POLLEY—Certainly, you would have something in common then with Flinders Island residents. Unfortunately, we have had nothing from Flinders Island, but they would be facing similar problems. But I thank you for your evidence.

Mr Wardlaw—They do not have as strong a leak into Victoria as we have.

Senator POLLEY—No, I realise that.

Mr Wardlaw—But, apart from that, their issues in going back to Tassie would be very similar in relation to flight times and being under the same schemes.

Senator POLLEY—And the expense of it all.

Mr Wardlaw—They have a hospital plane over there, I think, which, once a week or something, flies patients and specialists on and off the island. It is a separate type of system, whereas we rely totally on the RPT flight services.

Senator BOYCE—I have one query regarding your comment at (g) of your submission around e-health initiatives. It would seem to me that your comment suggests a fairly small and mild degree of praise for the system. Could you talk a little bit about what has happened in that area and what might happen that could assist PATS patients?

Mr Brewster—I have to confess that I am not completely au fait with all that happens in that area. I would be happy to get more information and provide it, but at this point in time I am probably not in a position to provide you with a great amount extra.

Mr Wardlaw—My knowledge is that we do have e-health. We have the ability to link with other areas, which we do use. We would need to get more detail about the specific benefits of that, but I do know that what we have allows us to link with the outside world more than we used to be able to. We might get back to you with a bit of detail on that, if we could.

CHAIR—That is fine. We are happy to take that evidence later on from you.

Senator ADAMS—With regard to breast screening, do your women have access to mammography?

Mr Wardlaw—The breast screening bus in Tasmania does come across to King Island every second year. If there are any issues, the women get taken off to Tasmania. I am told it is an excellent service.

Senator MOORE—So every second year you have access to screening on the island?

Mr Wardlaw—That is correct. The bus that goes around Tasmania comes over to the island on the boat for a couple of weeks. They bring the bus and the staff over here. The service we get here is probably no different to the service people get in country mainland Tasmania.

CHAIR—Paragraph (a) of your submission states:

... we are aware that there is inconsistency between jurisdictions and this creates confusion and frustration for many community members.

Apart from the people who look at one person's scheme and see that they have a different entitlement to someone in another scheme, are there any practical difficulties that flow to you as a service provider from those differences? Is there anything that makes it practically more difficult for you to access services by virtue of those differences between the states?

Mr Brewster—I think the greatest frustration comes from the fact that the assistance is not available to Melbourne for many of the services that patients on King Island require, whereas if they have connections, friends or relatives in Hobart, travelling to Hobart is fine for them. If they do not have those connections, frustration certainly creeps into things when they cannot receive assistance to go to somewhere which is quite a lot closer and has all the services they require closely located geographically. They also have their previous medical histories located, in many instances, with practitioners on the Victorian side.

Mr Wardlaw—With regard to the linkages we talk about, a lot of people choose not to go through the patient assisted travel scheme thing, but the state government gets that sting in the tail anyway because people have chosen to fund their own flights, and they might get admitted into a public hospital in Victoria. There is nothing stopping that from occurring. That would happen, I would think, on a fairly regular basis. Those people who have strong links into Victoria will still go that way and see their doctors because that is where they do all their business. If they get admitted to hospital that is what happens. There are linkages there and there are certainly some financial implications for the state regardless of this scheme. People are ignoring it because they do not have any linkages or support in Tasmania, so they look beyond the benefit of a refundable airfare.

CHAIR—That has been very useful evidence, and I thank you very much for that. I apologise again for the difficulties we had reaching you. Taking evidence by phone is never easy, but it has been more difficult than usual today. Thank you very much. We look forward to that extra information you will provide, and thank you again for your submission.

Mr Wardlaw—Thank you, Senator, and your fellow committee members.

Mr Brewster—Thank you very much.

[12.00 pm]

CHALLENGOR, Ms Sarah Anne, Member, Kidney Health Australia

HENRY, Mrs Susanne J, Member, Kidney Health Australia

MACKINTOSH, Mrs Carolyn, Health Services Manager, Kidney Health Australia

RADFORD, Mr William Allen, Member, Kidney Health Australia

WALKER, Ms Pamela Faye, Member, Kidney Health Australia

WIGHTMAN, Mrs Myra, Member, Kidney Health Australia

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mrs Mackintosh—I also represent the Tasmanian Consumer Participation Committee, which is a group of renal patients, carers and renal health staff that meets to advocate issues on behalf of other kidney patients in Tasmania.

Ms Walker—I am a dialysis patient from Hobart.

Mr Radford—I am a dialysis patient from Burnie and I am on the Tasmanian Consumer Participation Committee.

Mrs Wightman—I had the privilege of giving a kidney to my son and I am also on the Tasmanian Consumer Participation Committee.

Ms Challenor—I am also a social worker based at the hospital.

Mrs Henry—I am a carer for my husband, Jock, who is a renal patient.

CHAIR—Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you so that you can see how the rules on parliamentary privilege work. We have received a very comprehensive submission from Kidney Health Australia's Tasmanian committee. We thank you for that and we want to ask you some questions about that. Do you want to make a statement before we do that?

Mrs Mackintosh—Certainly. Hopefully, it is not too lengthy. I thought it might be worth while to take a moment to describe to you the process of dialysis, and you can ask the patients who are here more questions later.

CHAIR—Unfortunately, it is going to be difficult to get through a lot of comments in the time that we have available today. You were going to describe dialysis. I think, as members of the health committee of the Senate, we are all pretty familiar with how dialysis works, so I would not worry about describing dialysis. Can I ask you to go to the issues that you feel we need to know about with respect to the terms of reference of our inquiry? We have all read the submission that you have provided to the committee.

Mrs Mackintosh—Certainly. The key thing is the frequency of dialysis treatment. It has direct implications for the travel arrangements of kidney patients everywhere. Last year, Kidney Health Australia conducted a transport survey of all Tasmanian dialysis patients. It showed that too many patients were spending an average of \$30 a week just on their travel costs. Two-thirds received no financial assistance to cover these costs and some were forgoing basic grocery items to make sure they had sufficient funds to cover their travel costs. You have a full copy of the transport report, so I will not elaborate on the findings and the statistics. But, in light of that report, our Tasmanian Consumer Participation Committee has made some recommendations as to how the current PATS system could possibly be changed in Tasmania, and I would like to elaborate on those recommendations.

First, Tasmanian consumers would like to see the distance eligibility criteria abolished. They really do not account for the frequency of travel needed by dialysis patients. At the moment, people who travel less than 75 kilometres one way to get to dialysis do not qualify for any financial assistance. As an example, there is an elderly man living 60 kilometres from treatment. He travels three times a week. There are no community buses, and he relies on his family. He is not entitled to any health care card or benefits, yet he is travelling 360 kilometres every week, which is a big drain. We were able to get a special claim made on his behalf to waive some PATS conditions so that he did get some reimbursement, but he has been travelling like that for 14 months and he and his family are finding it increasingly difficult to cope. They are considering moving the whole family.

Second, we would like to see an increase in the kilometre reimbursement rate for those transporting themselves regularly to dialysis. At the moment, we receive 13c a kilometre for private road transport. DVA card holders receive 27c per kilometre. We would like to see an increase to around that figure. The Senate committee produced a report on poverty and hardship in about 2004 which identified Tasmanians' cost of living as being higher than for those in most other states for an average basket of consumer goods. Forty per cent of Tasmanians are in receipt of welfare payments. Added to that, the cost of petrol is higher in Tasmania. At the moment, it is around \$1.30 per litre. So we would like to see an increase in the cents per kilometre rate.

Third, we would like to see the PATS contribution payment abolished. The current PATS system in Tasmania states that those people who travel in excess of 75 kilometres one way and who hold a health care card must pay a contribution per annum fee of \$120. Non card holders have to pay \$300 per annum. We think abolishing this fee would positively impact on patients transporting themselves to treatment and would lessen time spent on administration costs. We think it would be simple to implement.

Fourth, we would like the application process for PATS simplified and the reimbursement process quickened. At the moment, the Royal Hobart Hospital distributes PATS forms to the renal unit, which is in New Town. Patients have to request these forms, even though they are on site in their unit, and they apply for their eligibility. If that eligibility is accepted, the patient uses a form to record, down in Hobart, 20 trips. This form is kept in the unit. When it is completed, it is forwarded to the PATS coordinator for the Royal Hobart Hospital for processing and payment. It is a shame that patients actually have to request that form. There are patients out there who have been on treatment for up to a year and do not know that they are entitled to anything. There is something not right in the procedure there.

Fifth, renal carers need to be considered under PATS. Currently, carers have a big role to play in dialysis, in caring for patients, getting them to and from dialysis, transporting and accompanying them, and getting them to other medical appointments, of which there are very many, even if you are on dialysis. Mrs Sue Henry is here today and she can answer some questions about the role of carers and how inadequately reimbursed they are at present.

Sixth, the issue of live donors has been raised in the past. On average, it costs \$82,000 per annum for a person to have haemodialysis in a renal unit or satellite centre. Kidney transplantation can significantly reduce those costs. Unfortunately, in Tasmania we do not have transplant operations; we have to travel interstate for that. At the moment, live donors donating their kidney do not get any travel or accommodation costs reimbursed, yet they are saving significant future costs for the patient because they come off dialysis. So we would like to see something done for them.

Finally, Tasmanian consumers would like to see a state-wide, coordinated transport system for patients. We understand that this would be difficult to implement but under the current system many regional dialysis patients are driving themselves to and from treatment when they really do not feel well enough, simply because there is no other alternative. It is just fragmented. That is all I have to say.

CHAIR—We might proceed to ask questions. Some of the other witnesses could perhaps help by providing information or insights into how these things work, as we ask those questions. That might be the best way of getting some insight into what is happening in Tasmania with respect to this scheme. Firstly, I want to clarify something. This morning we asked the department of health some questions about the issues in your submission—you raised some very important points. You said a moment ago that there is no support for kidney donors getting access to the patient travel assistance scheme. This morning the people from the department said that you can get access to assist kidney donors. In fact, they said that no donor request for supporters has been knocked back in the last three years. Are you aware of that assistance? Has it been communicated to you as to how a donor might access assistance under the scheme?

Mrs Mackintosh—I am not aware. Ms Challenor, are you aware of that?

Ms Challenor—Yes, I did pick that up; I did not get a chance to get back to you. Donors and a carer are able to get reimbursement for a similar amount that the patient gets—that is, \$30 towards accommodation, and the airfare as well. That is organised through the patient travel coordinator. Once again, the actual amount that goes towards accommodation is not enough. There is very limited accommodation in Melbourne and, although they do a good job there to try to allocate appropriate accommodation, there are still extra living expenses while being away. A lot of them are young couples with families back here in Tasmania, so some specific hardships can occur with respect to the donor and the carer and the escorts. The donor gets an escort and so does the recipient. So, yes, that is covered at this point, but it is a cost thing. I think it is still an issue.

Mrs Wightman—My son and I went first and then my husband came as one carer.

CHAIR—Was this to Melbourne?

Mrs Wightman—That is right. As soon as we both came out of hospital, which was in five days, my husband was no longer paid for. I had to be my son's carer, so we cared for each other.

CHAIR—I see.

Ms Challenor—That may have changed, but it is a good point because I have heard that that has happened in the past—that once the person is out of the hospital they are no longer eligible. But there is still a support factor for the person who has just given their kidney as well as for the recipient.

Mrs Wightman—But in 1999 there was not.

Ms Challenor—I still think that needs some clarification and something specific in the guidelines that clearly states that ongoing care and support are needed until the person comes home.

CHAIR—There is also a comment in the submission about a recommendation to develop and promote a single application form to access transport and reimbursement assistance for patients and carers. We were trying to get the department to explain that process this morning. One of the senators had a copy of the form, which appeared to cover those situations, but do you understand whether two of those forms are required or is it just one, with several parts required to be completed? Yes, I think that looks like the form we saw this morning. Are there several parts to that—is that correct?

Ms Challenor—This is given out to oncology and renal patients, who have to come in three times a week. This form really caters for a one-off visit—somebody coming in for treatment for a week or two weeks and then going home. Then that is completed. But patients in oncology or certainly in renal dialysis have to fill this in every month and put all their dates down. That is not just for their dialysis; it is also for their clinic appointments, because they sometimes have to come back to see the specialist. That is handed in every month.

CHAIR—Is that retrospective to the treatment or before the treatment?

Ms Challenor—Yes, that is right; it is on a monthly basis. One thing I am not sure about is that there seems to be a contribution that is made within each financial year. We had one patient who actually started dialysis just before the end of the financial year. They paid their upfront contribution and then fell into the next month and had to pay a contribution again. The PTS coordinator here did a lot to waive that, but those sorts of things should not happen; I think that is a real disadvantage to the patient. That patient was still waiting for a health care card and had to pay those sorts of things upfront. That is another aspect that can impact on the stress of patients in that situation.

Senator ADAMS—Thank you for your submission. As a consumer group, how much interaction do you have with the department's patient travel assistance review committee?

Mrs Mackintosh—Up until last week, when I met with Senator Carol Brown, I had never heard of them.

Senator ADAMS—We have had the department here earlier today, and in their opening statement they said that they had consulted widely. They did mention the problems associated with renal dialysis, but I would have thought that in their extensive consultations your group would have been one of the priority groups to talk to.

Mrs Mackintosh—You would have thought that, yes.

Ms Challenor—As a social worker within the hospital here, I consult quite frequently with the patient coordinator there. It is just raising issues of hardship that arise, but I did not know about the committee or how formally they meet. But we do raise issues, depending on the clients' needs.

Senator ADAMS—I did ask if they had a consumer on their committee. They do not.

Ms Challenor—That would be a good thing.

Senator ADAMS—If they called for applications or nominations for this committee, would you have someone suitably experienced to go forth as a consumer representative?

Mrs Mackintosh—We would have to fend them off!

Ms Challenor—We could put that to the consumer participation committee in the north. We have one participation committee for Tasmania, so we could put that up at our next meeting and see if anyone is interested.

Senator ADAMS—I think that is a very important issue, so please follow that through and we will see if the department calls for nominations for a consumer representative.

Senator CAROL BROWN—Connected with the review committee, in the Tasmanian government submission they did indicate that the review committee made some changes to arrangements for patients who were accessing renal dialysis in Burnie. I think it was also for patients from Sheffield, Devonport and Latrobe. Can you indicate whether those changes were conveyed to you? Do you know about the changes and were they conveyed to you—obviously not through the review committee, but through the PATS coordinators?

Ms Challenor—No, not formally. I read about it in a document that Carol gave me, so I was quite surprised that that had changed. But I think that was a positive move by the transit scheme up there. I would like to see a similar thing happen for those patients who come from places like Beauty Point, George Town and Low Head, who are within those 75 kilometres. That is an issue about travel patient coordinators operating separately within the guidelines and having some uniformity, whereas the Burnie travel coordinators obviously understood the issues and impact on consumers. I would like to see the same thing happening in Launceston. We have three patients here who are paying an average of \$45 a week—and they are all on pensions. Community buses are great and community cars are really helpful, but they do not get any reimbursement. Quite a few of them have to travel 50, 52 and 53 kilometres one way, and they do not fit the requirements. Some of them have been on dialysis for six or seven years.

Senator POLLEY—Are the community cars not of some benefit at the moment, then, for those people for whom distance is a criterion?

Ms Challenor—Yes, they are of great benefit, because a lot of people cannot drive because they do not feel well enough after they have dialysis. Some people are able to pay, but there are some people who cannot pay that \$15 per trip. There is one from Beauty Point and I think they pay \$15 a day.

Senator POLLEY—That would be cheaper than taking your own car, though, wouldn't it? It would cost you more than \$15 from Beauty Point, I would have thought, in an hour.

Ms Challenor—Probably, yes. An equivalent could be paid in mileage. If they drove their car, it might cost the same, but you have wear and tear on the car. Also, a lot of those patients do not have a carer to drive them in, and they really depend on the cars. A lot of patients appreciate it, but it is that overall eligibility and fairness—that people are reimbursed for the community car something that is equivalent to mileage for travelling by car.

Ms Walker—In actual fact, Red Cross are having a meeting on Thursday night to reassess the costing of community cars. They have the only community cars that I know of that are available in Hobart and they only have one that can help with dialysis. They are extremely good, but after their meeting on Thursday night they expect that it will be a user-pay system based on market value.

Senator CAROL BROWN—I want to go back to that decision about Burnie. That decision actually was made in November 2004 by the review committee. I am not sure when it came in. But I suppose that also goes to the question of the promotion of PATS—making people aware that it is available, how it is promoted and where it is promoted. Nowhere in the supporting information as to the eligibility for PATS could I find information saying that this change had been made, that if you lived in these areas you did not have to strictly adhere to the 75-kilometre distance criteria. Do you have any views on how the scheme could be better promoted?

Ms Challenor—All I know is that there is a yellow brochure made available for consumers about eligibility, but it is not always readily available. I have had problems getting hold of it within the hospital sometimes and that could be a printing thing. It is a fact that decisions are made like the one in Burnie that people in Launceston do not have the benefit of. It is the same for those people travelling from rural areas. There does need to be some uniformity. There is no appeals process for patients in any documentation, is there? So what is needed is something that is much more user-friendly that goes out to all patients and that is equitable across Tasmania.

Mrs Mackintosh—And as soon as they start treatment, not 12 months down the track.

Ms Challenor—Our unit here is not too bad actually, because the nurses assess that and we have the travel documents in the unit. I guess I am sometimes asked to advocate for somebody or to make sure that the paperwork gets in. But it is not something that social workers administer, because we are providing emotional and social support and counselling as well. I think if the guidelines were more consistent, we would not have to be advocating so much for those people who fall through the cracks.

Senator POLLEY—Thank you for your submission. Do you believe that national, uniform outcome criteria are needed?

Ms Walker—I think there is an increasing reluctance by doctors, understandably, to fill in forms. In particular, nephrologists are very thin on the ground in Tasmania. If there was a national scheme that made things easier, particularly for the practitioners, I am sure it would help the patient. Also, in terms of a national scheme or system, however you want to put it, I think it would take away the problem we have in Tasmania, which we often experience, with the differences between the north, the south and the north-west—the right arm does not know what the left arm is doing.

Senator POLLEY—Evidence this morning from the state government department in response to a question about the mileage and the accommodation allowances—and each state government appearing before the committee has said the same thing—advised that it is a line item in the budget and there is only so much money in that pot. In terms of increasing accommodation costs, how can that issue be dealt with and what services within the hospital do you suggest could be reduced to increase accommodation and mileage allowances?

Mrs Walker—I cannot see that the accommodation allowance would be used very frequently other than for transplant patients.

Mrs Mackintosh—And now many of those did we have last year? About 12 kidney transplants and one or two heart-lungs?

Senator POLLEY—You suggested in your statement that distance and the kilometres should be taken away. What sorts of things do you think ought to be taken into consideration in terms of assessing people's eligibility, if distance is not one of those criteria?

Mrs Mackintosh—The condition and the treatment that is required for that condition. We know with dialysis patients that the dialysis is so frequent and ongoing until they decide either not to continue with treatment or they get a transplant. It is looking at each individual condition, and the distance eligibility criteria really disadvantage those people who are going to be travelling three times a week forever.

Senator POLLEY—How many of your members are having dialysis at home?

Mrs Walker—It depends on what kind of dialysis you are talking about. If you are talking about haemodialysis, in Hobart there are only about four or five. PD dialysis is increasing, but with that you need support nursing care—home nursing.

Mrs Mackintosh—Only if you are elderly.

Mrs Walker—It certainly would not have a great effect on travel allowance.

Mrs Mackintosh—Eighty per cent of Tasmanians haemodialyse in a unit or satellite unit. That is the current trend.

Mr Radford—I am on the PD when I have got a Tenckhoff in. At the moment I have not got a Tenckhoff because I have got a bag on it, and they had to take it out and it was the only way they could clean it up. I am just about due for another one. I have the machine at home, and I find that very good. I put myself on at about half past 10 at night, the machine is taken off at seven o'clock in the morning, and my day is free. You do get little problems with it; the machine will go off and wake you up through the night. You might have 10 or 12 wake-ups through the night because you have lain on the pipe or you have twisted it.

Senator POLLEY—It stays in one place in terms of the extra stress on your body with all the travelling, I take it.

Mr Radford—Yes, and it is not as hard on your body as the haemodialysis. That is quite severe, because your blood pressure can go up and it can drop. You have what is called a 'bleed' and I am going through that problem at the moment. My needles leak through the process. They just dribble and blood goes everywhere, and then there is a clean-up job. When I come off the needles, where normally it would be five minutes and I would be up on my feet feeling a little bit woozy, now I am spending about 20 to 30 minutes lying back in the chair waiting to stop bleeding so I can get up.

Senator BOYCE—I have just a couple of questions. Within your experience, how long is reimbursement taking for people who claim for PATS?

Mr Radford—Sometimes it takes only a month, and sometimes it can be two months. There are patients who have not been reimbursed at all.

Senator BOYCE—Because their claim is queried?

Mr Radford—Yes, some people have had their claims queried. I submitted 27 claims a while ago, and I ended up getting paid for two trips to Launceston out of that.

Senator BOYCE—You asked for 27 trips and you got two?

Mr Radford—Yes.

Senator BOYCE—Why was that?

Mr Radford—It was because they reckon that I was not eligible for it. Professor Fassett signed the papers to say that I was eligible, but it made no difference.

Senator BOYCE—Are you appealing that decision?

Mr Radford—I think I am pushing it uphill. They have made up their mind that they are not going to pay it and I have to struggle with them and fight to get them to pay it. I am like most people: I will try for a while and when you run into a brick wall you say, ‘I will forget it and I will go again.’

Senator BOYCE—It is too hard; you move on. We heard evidence from the state health department this morning that the average time for reimbursement was about seven days. Could you comment on that?

Mr Radford—I have never heard of that. They must be on a different scheme to what we are on.

Ms Walker—I have heard of it taking five months.

Mrs Henry—Normally for my husband’s claims to come back it takes about two months.

CHAIR—How long ago was that?

Mrs Henry—Until he had a stroke in December he was travelling to Burnie for his dialysis. Since then he has had to be put in care in Launceston.

Senator BOYCE—So that is seven months ago.

Mrs Henry—Yes, that is seven months ago.

Senator BOYCE—There has obviously been a radical improvement in the last six months.

Mrs Henry—Obviously, yes.

Senator BOYCE—You talked about carers not being able to accompany patients if community transport is used or if taxi vouchers are provided. Are you saying that carers cannot travel in taxis?

Mr Radford—Yes, that is the case with quite a few of the patients at Burnie who only travel from Burnie down to the hospital.

Senator BOYCE—From Burnie to where?

Mr Radford—To the renal centre. I know one lady there who has two sons that come down with her. She will come down in the taxi and they will walk. She will go home in a taxi and they will walk back.

Senator BOYCE—Who prohibits them from using that taxi?

Mr Radford—I presume it is the taxi driver.

Senator BOYCE—Are you saying that it is a criterion of the voucher that no-one else travels with them?

Mr Radford—Yes.

Senator BOYCE—These are provided by the health department; is that right?

Mr Radford—Yes, it would be the renal unit that supply them.

Senator BOYCE—Who funds them?

Mr Radford—I do not know whether the taxi is part of the treatment or whether there is another department that funds it.

Senator PATTERSON—Mrs Mackintosh, could you clarify that by giving an example of a case study? You might be able to check with Mr Radford and send a note to the secretary saying, ‘Here’s an example of a case study of somebody who has a voucher and other people can’t travel in a taxi with them.’

Mrs Mackintosh—Yes.

Senator BOYCE—It may well be a criterion set by whoever funds it, but could we just clarify that. I am aware of some fairly bizarre little restrictions like that existing within the disability area. Often, once you point them out to someone, they can be dealt with.

Mrs Henry—Since my husband has been in care I have taken him home for a couple of visits in the maxi taxi. Because he is in a wheelchair I have been able to travel with him and have not had to pay. It might be different in different areas but I have not had a problem. When I have gone to appointments with him I have sat in the taxi with him and not had to pay.

Senator BOYCE—That is my understanding of how it works under a disability or mobility thing, but this appears to be some sort of different PATS requirement.

Senator PATTERSON—Are you travelling under PATS?

Mrs Henry—Yes, he has the patient access transport vouchers.

Senator PATTERSON—So you are saying you can travel in the taxi but somebody else cannot? Could you clarify that? It might be a situation where somebody is writing something on a voucher that should not be written on it or something.

Senator ADAMS—Mrs Henry, as a carer what do you think could be done to improve the whole system?

Mrs Henry—Have you got all day! As I said, my husband had a massive stroke in December. We were living at Latrobe and he was going to Burnie for his dialysis. Since then he has had to be put into care in Launceston because he could not be dialysed in Burnie because it is a satellite unit without a doctor on board. So he had to be put into care up here. I have had to sell my home in Latrobe. Before that I was travelling five days a week to visit him, which mentally and financially was getting me down, so the decision was that I had to sell my home and move to Launceston to be nearer to him. There is a lot that I could add. It has been very difficult, but I guess I am not the only person who has had to do that because of a sick partner. I did apply and ask if the government would reimburse me for at least the stamp duty on the purchase of my house. As yet I have not had a reply. I thought that may have been of some assistance, but that is nothing to do with the travelling.

Senator ADAMS—As a carer before your husband's illness, is there anything that would have helped you with travelling or with just the whole situation?

Mrs Henry—More renal units, but that is impossible. They are sick people, as I have said before, who are being herded around the state like cattle. They are very tired. We used to get up at five o'clock in the morning to get him ready to get the community car from Latrobe to go to Burnie. He would get home at about three o'clock just exhausted. It would take the next day for him to get over that, and then we were off again. It is not much of an existence, as far as I am concerned. It keeps them alive—and that is what he said: 'At least I'm being kept alive.' But as far as quality of life goes, it is hard. After I had moved to Launceston, the headlines were that maybe there would be a renal unit at Mersey in Latrobe. That would have been perfect for us, but I tell myself it is not going to happen in his lifetime. There are lots of things that we would wish for, but I guess finances are not available to help. But it is hard on the renal patient and hard on the carer.

CHAIR—One last question. Senator Brown?

Senator CAROL BROWN—In the kidney health survey you say that 22.8 per cent of patients used 'community service vehicles, non-urgent ambulances, or a form of patient transport assistance, predominantly those over age 60'. What are non-urgent ambulances?

Ms Walker—The ambulance service is not just used for renal patients. It is for any patients who, for example, would need to be transported from a nursing home to the Royal Hobart Hospital for some kind of treatment et cetera.

Senator CAROL BROWN—Regarding the proposed ambulance levy, how do you think that will impact on the transport costs of your clients?

Mrs Mackintosh—I am not sure because we have not been given details as to how that will impact on anybody travelling. Bill, you had some concerns about the ambulance levy, I believe.

Mr Radford—Yes, especially with the pensioners. If that is imposed and we get an increase in travelling allowance, we are going to lose it on the ambulance levy. At the moment I can be home and within 10 or 15 minutes of feeling unwell I can be taken to Burnie, assessed there and sent straight back through to Launceston by ambulance. So is that counted as one trip or as two trips?

Senator CAROL BROWN—There was an article in the *Mercury* on 30 June which arose out of the national survey that your organisation conducted. It says:

People are going without basic items to get a life-saving treatment.

There is also a very nice picture of you, Ms Walker. Are you able to give us some figures on how many of your clients are going without meals or other basic necessities so that they can afford the transport costs to get to their treatments?

Mrs Mackintosh—I do not think that that is quantifiable. At the end of the survey, people could write their own comments. It was not a specific question, so we cannot give you percentages. But it came up fairly frequently that their budgeting was significantly affected by the travel costs. That was one thing that they had to budget for. That came first, and everything else came after, and so people did have a few lag times there, especially if there was a long wait for reimbursement for their initial claims. It does cause difficulties, but we cannot give you an exact figure, unfortunately.

Senator PATTERSON—If I have some other condition that should be checked on a regular basis, I might be able to stretch it out a couple more weeks, but with dialysis I have to go. They are saying that transport is the highest priority because they cannot skip one if they are a bit short on cash.

Mrs Mackintosh—Skip a couple, and you will be dead.

Senator PATTERSON—So that is why it comes out for them more than for those with many other conditions.

Mrs Mackintosh—Yes. That has been a longstanding issue with the consumer committee in Tasmania. It is something that gets spoken about all the time.

Senator PATTERSON—Most other people with a condition can make it go a bit further, like with a haircut. If the doctor says, 'I've got to see you in three months,' you can stretch it out to four.

Mrs Mackintosh—This is non-negotiable.

Mr Radford—When you start off on renal, you go to Launceston and you are assessed. You come home and are probably home for a couple of days and then you go back to Launceston for more tests. You come back home, and then you go to Burnie. You run back to Burnie a couple of times, and then you go back to Launceston to have your needles placed in your arm. Then you go back to Burnie. Then things start to even out. But for the first five weeks it is continuous; it is every day. You either have to see your GP, your specialist or your nurses in Burnie. You are running between them all the time, and that will go on for about 10 days until you settle down. Then it is Monday, Wednesday and Friday. Your lifestyle alters to fit what has to happen on those three days. If you miss one of those, you are in trouble—and you are really in trouble if you miss a treatment.

CHAIR—I thank you all very much for appearing today and giving us an insight into the challenges that are faced by people who are either getting dialysis or dealing with donations. Those clearly need to be addressed if we are going to fix this scheme. Thank you very much indeed for your time today.

[12.45 pm]

ROSE, Dr Donald, Branch Councillor, Tasmanian Division, Australian Medical Association

CHAIR—Welcome, Dr Rose. I understand you have had information provided to you on parliamentary privilege and the protection of witnesses and evidence. We have a submission from the AMA in front of us. Thank you for that. Would you like to make any comments about the content of the submission or about the issues we are facing before we ask you questions?

Dr Rose—Briefly, we have not spoken to the state about our concerns with the system as yet. For some time they have been talking about doing a review of the patient assisted travel schemes. We have been invited to participate in that review—and we will—but as it has not yet taken place we have not had the opportunity to sit down with the state to speak to them about our concerns and to see whether we can resolve some of these things within our state.

The state review is very timely because we have just had a big revamp of our health system. The most important part of it is that the acute hospital in Devonport has been closed, which leaves a population of about 30,000 with 50 kilometres to travel for their acute medical services. At the moment, none of that travel would be assisted under this scheme, so we are keen to talk to them about how that is going to be addressed. I think the Senate inquiry is good in the sense that we hope it will propose some national minimum standards that should be met so that we can start negotiating with the state on how to deal with that fairly significant population that will now have significant distances to travel but that at this stage will not receive any assistance through this scheme.

I am sure you have heard it all before, but our main concerns about this travel scheme are the level of funding that patients receive and the very complicated claiming process that is in place. The marketing of the scheme is fairly flawed in the sense that most GPs in this state know little about it because we do not get involved in the system. I am a GP who was in rural practice for 10 years up in the tip of Tasmania, and I knew very little about the scheme when I was there because I did not have much involvement in it. Now that I am in urban practice in Launceston I am never involved in it. We just do not get involved in this system at all. We are not required to fill in the forms for patients and the referrals are through specialists so, to a degree, we are out of the system and we do not let patients know about it because we are not overly familiar with it ourselves. Another problem with the system that patients report is that there seem to be some inconsistencies as to how the guidelines are applied and that it depends upon whom you talk to as to how much you are likely to receive as a refund.

CHAIR—On that point you made a moment ago about complications with the form, I actually put that comment to the department this morning and they seemed to be unaware of any problems with the form. They seemed to feel that there was nothing particularly wrong with the form. May I make a suggestion? It might be a good idea if, using its national resources, the AMA were to look at the other forms in use around Australia and perhaps suggest to the Tasmanian government that they actually use some of the less complicated forms that are available elsewhere. They did not seem to be aware of that point at all.

Dr Rose—It is not so much the form itself; it is what you have to do to get the form filled in. That is the real bugbear. A universal complaint from every single patient who uses the system is this need to get a new form each time. Interstate travel is the big problem. Because there is a lot of interstate travel, this scheme mainly funds interstate travel—it does not fund too much intrastate travel, from what I can gather—and you need to get a new form each time. Chasing signatures when you are not well is not the thing that is foremost in your mind. Patients are obviously backtracking and trying to get forms filled in well after the event, and this is a considerable inconvenience to them. So the form itself may or may not be all right; it is the requirement to get a new one each time that is the most regular complaint we receive.

Senator ADAMS—Thank you, Dr Rose. This morning we had the department here and they told us that they have a state-wide patient travel assistance review committee, which meets periodically. I asked them questions about that. As an organisation, have you had anything to do with this particular committee?

Dr Rose—We have been invited to participate, but we have not been told that they have started meeting. I was not aware that they had started meeting. We were invited to participate one to two months ago, from memory, but we have not been told that they have met yet.

Senator ADAMS—This committee has been in existence for the last 10 years. It has medical authorisers on it from each of the teaching hospitals and travel coordinators from each of the three major public hospitals. I asked the question, ‘Do they have a consumer on it?’ but you have not had any dealings with them at all?

Dr Rose—My understanding is that there is a group that meets all the time, and have for many years, and they just coordinate the system. On top of that, they are going to have a review of the system, which is a formal review by another group—not by that group but someone else—to look at the whole system, and that is what we have been invited to participate in. The group that has been meeting for 10 years merely consists of the people who currently administer the system. As far as I know, they are not a review group. The review group will be formed or is in the process of being formed. I gather that a review has been talked about for a couple of years, but they have yet to get it off the ground. That group is not the review group; that is just the group that administers the system. The regions talk to each other about how it is progressing, I gather.

Senator ADAMS—Their opening statement was that they have consulted widely. That is why I was asking for your—

Dr Rose—They are in the process of starting to consult, but they have not had a meeting yet with the people they are consulting with.

Senator ADAMS—No—we are talking about two groups. Firstly, I want to establish the fact that this is the group, the review committee, which obviously comes under the auspices of the department. They have been going for 10 years, and they said that they have had a very wide consultation process. The problem is that I cannot find out, from all our witnesses, with whom they have consulted. That is the trouble. Obviously, they have not consulted with your group either.

Dr Rose—We have been invited, but—

Senator ADAMS—Yes, but this is a different group. You are talking about the new review.

Dr Rose—Yes.

Senator ADAMS—This is the old group that has been sitting there for all that time.

Dr Rose—We have never spoken to them.

Senator ADAMS—We have evidence from other states that, because of the complexity of this jolly form and the time it takes to fill it in, a number of GPs are saying to patients, ‘Come back and see me again and I will fill in the form.’ Have you heard any evidence of that?

Dr Rose—In Tasmania, the specialist needs to fill in the form. The main problem is that, if the patient has been referred interstate—say they are on the waiting list for a transplant or have had a transplant—often the care is then juggled between the GP and the specialist service on the mainland, but the subsequent referrals for follow-up have to be done by the specialist who originally referred the patient. So patients have had to book in with the specialist purely to get a travel form filled in, and the specialist will sometimes say, ‘I can’t fill in this form without seeing that person, because I don’t know what’s going on,’ and to a degree you can understand that view. Some specialists insist upon reviewing the patient each time they are asked to fill in the travel form. What we are trying to argue is that, in general practice, we see these patients quite regularly because they have to get renewals of their various prescriptions. We are the obvious people to fill in the forms for the follow-up visits, but at this stage we are not able to do that. I cannot tell you what the general practice experience is, because we do not fill in the form, but the specialists certainly often insist upon an appointment to fill in the form, because that is the only way they can catch up with the patient.

Senator ADAMS—It goes back to the start. As a GP, someone comes to see you and you want them to be referred to specialist X. This is where the problem has arisen. It comes from the other end in that way, but also, at the initial side of it, the patients start by being referred from a GP to a specialist. They then go to the travel clerk and that travel clerk says, ‘No, you can’t go to that specialist; you’ve got to go somewhere else because they are closer.’ Apart from that, they are saying that the form is so complex and the GP is absolutely flat out and cannot fill in the form at that time, so they say to the patient, ‘You’ll have to come back and see me again to get this form filled out,’ and then the process can start. Do you have any evidence of that happening?

Dr Rose—GPs do not fill in the forms; we do not get involved with the forms at all.

Senator ADAMS—Not at the start?

Dr Rose—No, we make a referral to the specialist and the specialist then refers the patient interstate to another specialist.

Senator ADAMS—I am not looking at interstate travel; I am looking at travel within the state.

Dr Rose—I am not sure about intrastate referrals—I have never done one. Because the patient has to contribute either \$15 or \$75 for each trip, it is hardly worth applying for much intrastate travel unless it is on a regular basis, so there are not many referrals for intrastate travel. Rural doctors can do them. I worked in Smithton, which is 100 kilometres from Burnie, which has the main hospital. I was there for 10 years and never did one referral for travel assistance because it was not worth the effort of getting all the forms and signatures done for, say, \$40. If you were paying the first \$75 you would get nothing. If you were paying the first \$15 you might end up with \$25 out of the process of getting four forms filled in. So I am not sure how much intrastate travel is claimed.

CHAIR—Is that the patients' assessment or the doctors' assessment?

Dr Rose—There is not a lot of awareness that you can claim for intrastate travel. I think there is a bit of ignorance on the part of patients and doctors. I can understand a patient not bothering with it when they see the number of forms they have to get filled in and the process for a fairly trivial rebate.

Senator PATTERSON—I want to get a bit of a picture of this. You were 100 kilometres from Burnie hospital—was it you as the doctor who made the decision that it was not worth it or did you mention it to patients, and then they had to make the decision as to whether to fill out the forms to get \$25 back?

Dr Rose—I am not sure. The cost of the travel was never a big issue. If people are going to stay anywhere for prolonged periods of time, then it would become an issue.

Senator PATTERSON—If they had to stay in Burnie overnight and they have accommodation and the travel—

Dr Rose—Yes, that is when you would be looking at it.

Senator PATTERSON—So none of your patients stayed in Burnie overnight?

Dr Rose—Not as an outpatient; it was not that sort of facility. If they went to Burnie they were going to be admitted—

Senator PATTERSON—I do not want to put words in your mouth, but are you saying that, as a doctor, you would not have been bothered telling patients 100 kilometres from the hospital? Was it all too hard for you and for the patient?

Dr Rose—No, I would not like to say that.

Senator PATTERSON—You just said that you never used it. I am trying to get at why people do not know about it. You said that it was not well publicised, but if GPs are not telling their patients how are they supposed to know?

Dr Rose—Because Tasmania is relatively small, travel between centres is not the big issue. Interstate travel seems to be the main thrust—

Senator PATTERSON—That is not what we heard from people. We have heard from a number of witnesses today, who are patients, that they want the 75 rule reduced, because 75 kilometres from Campbell Town is hard.

Dr Rose—I think that is right, and this is what will happen with the move of the Mersey acute hospital to Burnie. The smaller distances you have to travel to on a more regular basis are going to become the problem. An occasional visit a long way away is not the real issue; the regular visits to the closer facilities are going to be the real burden. The long, occasional visits are not the real issue; it is the regular visits to the closer facilities that are going to be the real burden. The long, occasional visits were not what patients complained about; it is when the acute hospital is 30 kilometres away.

Senator PATTERSON—You said that people do not know about it. We are trying to make a recommendation to put pamphlets in the surgeries of GPs. But you are suggesting that, if people are not making regular visits, it is not much use putting them there because it is too hard to apply, both for the doctor and for the patient. I cannot understand what you are saying. How many years were you 100 kilometres from Burnie?

Dr Rose—Ten years.

Senator PATTERSON—And no patient ever applied? You are a very active doctor; you are in the AMA. You are not a doctor who is sitting there and doing nothing.

Dr Rose—I would have done fewer than half-a-dozen, if any at all. There were certainly not many.

Senator PATTERSON—It raises the issue that if you, as an active doctor who is prepared to be on the AMA and is prepared to come here, do not use it, how are we going to get other doctors to use it?

Dr Rose—In Tasmania, because it is established as a specialist system, GPs do not have much involvement. Rural doctors do have that ability to make a referral to a major hospital. If a rural doctor refers a patient to a specialist who is more than 75 kilometres away, he can use the system, but I am not sure just how much the system is used. It certainly was not often used 20 years ago. I think the scheme was established in about 1989-90, but it certainly was not marketed at all when I was working as a rural doctor many years ago. I am not sure of what the experience is now.

Senator POLLEY—Can I just make the point that the evidence today from Dr Peter Renshaw was that a survey of Northern Tasmania found that 87 per cent of doctors in the 03 area of Northern Tasmania have PATS forms in their surgeries and are actively promoting the scheme in their surgeries.

Dr Rose—Is that is the north-west coast?

Senator POLLEY—It is north—Launceston, George Town, Beaconsfield. According to their recent survey, that was the evidence this morning. It is the 63 area.

Dr Rose—I am not able to confirm that. I am surprised by that.

Senator POLLEY—I am surprised that the AMA would not be aware of it. I would have thought that a lot of those doctors would be—

Dr Rose—The AMA is definitely not aware of that.

Senator ADAMS—Dr Rose, just as a hypothetical: if somebody who has been to breast screening and who has been diagnosed with a lump has to go from this area to Hobart for further investigation, would you advise them of the Patient Assisted Travel Scheme? They would probably be going to Hobart to have biopsies and then possibly surgery and further treatment. They would be away for a while, with considerable expense with accommodation. Would you consider advising them that the Patient Assisted Travel Scheme was available?

Dr Rose—They actually have a good system. What happens with breast screening is that people go directly to the service. If an abnormality is found then people from Launceston and from the north-west coast have to go down south to have the follow-up investigation. Patients do not come to see us about that. That is all organised through the service. The service actually funds the travel; it is not funded through the Patient Assisted Travel Scheme. The service has its own travel system—it is still the 13c per kilometre for petrol only—but it also covers accommodation at more realistic rates. I think the arrangement in Tasmania is that the service provides a night's accommodation if people want to stay but it is at a hotel. If the person chooses not to stay at that hotel, they get the equivalent of that hotel amount. It is more like \$90 a night rather than \$30 a night.

Senator MOORE—How is it funded?

Dr Rose—I think the service is funded by both federal and state money. It is a national service.

Senator MOORE—But only for breast cancer?

Dr Rose—Yes. It is a good system. Patients do not come to see their GP after they have had an abnormality picked up, so we do not have the opportunity to write referral forms; we do not do the referring. It is all done as a walk-in service.

CHAIR—We have heard nothing about that. I suspect it is a Tasmanian specific scheme and that it is funded by a Tasmanian cancer organisation of some sort. I would be very surprised if there was any federal money in that, but we will inquire.

Senator ADAMS—It is under PATS in some of the states.

Dr Rose—The good thing about it is that it is organised through the people who organise the service. When they contact the patient and say, 'You need to come down to Hobart,' they tell them what is available and give them the option of driving themselves or taking a bus. They organise that and book a hotel for them. It is a model travel service.

Senator POLLEY—Following up on the lack of information that is circulating within the community about PATS and what assistance is there, we have had evidence this morning that there is some ignorance

within the community about the assistance that is available. Wouldn't part of the AMA's responsibility be to ensure that GPs and their members actively promote whatever assistance is there for consumers?

Dr Rose—I am sure that is true. This has all been prompted by this review, and the review has made us think about how the service runs. We have now been invited to be involved in a state review, which we are keen to do, and hopefully something will come out of it. It is a neglected service that has been running quietly in the background and no-one has been marking it because it is not very well funded.

Senator POLLEY—Should there be national outcomes and criteria across the nation to ensure equity in the service delivery?

Dr Rose—I think that would be good. Tasmania has some rather unique problems because we have such a spread-out population. More than half the population live in the north of the state, and then it is spread out a long way. Smaller distances are a problem in Tasmania rather than bigger distances for intrastate travel, plus we have a lot of interstate travel so we have some unique problems. So to a degree the scheme probably needs to be run at a Tasmanian level because we are more aware of our problems, but the idea of having some national sort of benchmarks where you have to at least reach a certain level would be a start. I think Tasmania would need to run its own scheme because of its unusual geography.

Senator POLLEY—Because of its geographical size, Western Australia would also want to make sure it had that flexibility. How can the system and process be simplified? What sort of flexibility needs to be there to address those concerns?

Dr Rose—The claiming process is the thing we get the most feedback on as being difficult. The need to chase signatures puts a lot of people off and that is why a lot of people do not bother proceeding with claims. I have people who go interstate who just give up on the claiming process because it is so difficult.

Senator POLLEY—Are there any suggestions how we can clarify that? Should the responsibility for the signature lie with the practitioner or should another person do that?

Dr Rose—It is no problem for the referring doctors to fill in the form as long as it can be for a block of travel. If you are referred to Melbourne and you end up having a heart transplant or you go back to Melbourne when you need to have your heart transplant reviewed, you should not need to get referral forms each time. As long as the person on the mainland signs and says you have been there, the initial referral should be enough. The need to keep getting referral forms needs to be looked at to simplify the process. Whether they need to give out vouchers or cab charges rather than getting people to claim, is another question. The system in Tasmania encourages people to pay for their travel and it is refunded, even though the guidelines state the opposite—they state that they like to book everything. But they are too busy to book everything so they ask patients to book everything and then claim back. Then when they claim back they are not always sure that they are going to get paid. They have a new system now of direct credit into the account and they do not give you a statement so you do not know what you have successfully claimed or what you have not successfully claimed. The administration is poor because they are poorly staffed and they have too much work to do. Some sort of voucher system or cab charge system would work better than the current system. And block referrals would be better—once you are referred that is valid for a year or something along those lines. Also, some consistency about applying the guidelines needs to be introduced. There is evidence that it depends on who you are dealing with whether you get a bus amount paid rather than a cab amount paid for a trip from the airport to whatever service you are attending. They just need more funding. At the moment they keep saying they are running out of funding for the travel scheme. They cannot run out of funding—people have to get to where they have to go to. There just has to be more funding.

Senator POLLEY—Would it be fair to say from the evidence you have given us already that you would be encouraging better marketing of the fact that that facility is there? You said that getting \$15 or \$25 back may not be worth while for most people to claim; I suggest that for a lot of families a \$25 rebate is a lot better than nothing. Does it need to be marketed better?

Dr Rose—It definitely needs to be marketed better. The regular travellers definitely need to be able to claim it. It is the occasional travellers who have been overlooked. We as GPs do not encourage the occasional travellers to claim because we know they will have to chase it up, we are going to be filling in forms and they are going to be filling in forms. Regular travellers definitely need to know more about the system so they can start claiming.

Senator CAROL BROWN—The AMA submission has a number of conclusions. The AMA's position is that PATS in Tasmania should be run by the state but funded by both the state and the federal governments; is that correct?

Dr Rose—That is an ambit claim. If there were going to be nationally benchmarked figures, there would have to be a federal contribution to the scheme. If they are run purely by the states, the states obviously would draw up their own—

Evidence interrupted due to power failure—

[1.55 pm]

BOND, Mrs Ailsa, Former National President, Country Women's Association

CHAIR—I now welcome Mrs Bond, who is appearing on behalf of the Country Women's Association.

Mrs Bond—I am representing the National President of the Country Women's Association, who is out of the state at present. I was the national president between 1991 and 1994, so I am bit old hat, as you can imagine!

CHAIR—Information on parliamentary privilege and the protection of witnesses has been provided to you, so you understand how that works. We have a submission from the CWA. I see that it consists of submissions from the CWAs in three different states, and we thank you for that. We want to ask you some questions about the submission. Do you want to make any comments on that submission before we ask you some questions about it?

Mrs Bond—I would prefer you to ask me questions, because I have only had the information since Thursday. I have read it a few times, but it is fairly disjointed because it has come from three states.

CHAIR—That is fine. We will not get to those other states, so it is useful for us to be able to get somewhere and have several of them rolled together.

Mrs Bond—We would have had input to the National Rural Health Alliance submission. I have read that, and I found that very good and that it responded to all your points.

CHAIR—That is great. Could you clarify for us an issue that we have heard different things about? The Tasmanian section of the submission from the CWA talks about many patients being unaware of being able to get assistance from the PTAS. It seems that many practitioners are not passing the information on to their clients. The representative of the Australian Medical Association, whom you saw before, claimed that he had not personally referred anybody under the scheme—and he had been working for 10 years, I think he said, in rural Tasmania—which was rather extraordinary. Do you have any idea of why this does not seem to be happening? Do you think it is ignorance on the part of doctors of how the scheme works? Is their resistance based on the fact that the doctors are involved in having to sign the forms? Are they worried about the associated paperwork? What is the reason?

Mrs Bond—It has been discussed at our last two annual conferences. Very few of our members who were present at the conference knew anything about the scheme. Having personally been involved with the scheme, I can say that it is only the Holman Clinic, which is the cancer clinic in Launceston, that has the information. I have spoken to a few doctors, and they feel that the specialist needs to fill in the form because, in Tasmania, a specialist has to fill in the first part of the form, not an ordinary doctor. My doctor, whom I spoke to the other day, said that he had not referred people to it.

CHAIR—Where is he situated?

Mrs Bond—He is at Riverside. He is a suburban doctor. I am now living in Launceston. I do not think it is terribly well known about. The other thing is that, when you do apply, it takes up to four months after you have finished your treatment to get any money—and it might only be \$15. They felt that it was very slow and they were not encouraged. I rang up to find out who was funding it and the Launceston hospital told me the other day that, for the people who were referred to them, it came out of their funding.

CHAIR—That does not sound very good, does it?

Mrs Bond—I just took it that it was probably federal funding; I did not realise it was coming out of some of the hospital funding. Also, it is very difficult to find accommodation, particularly in Hobart. You get lists of places, but they are probably not within the price range of most people, whereas in Launceston we have Spurr—you have probably heard about Spurr Wing. We have accommodation up here and they now have two units, which is very helpful. If you have children you can go to Ronald Macdonald House, and they are very good, but some of the accommodation that was available for adults was not very suitable.

CHAIR—In the New South Wales Country Women's Association submission is the comment that e-health—the idea of electronic health processes—has had mixed acceptance. Can you tell us anything more about that and why that might be?

Mrs Bond—I am sorry; I cannot elaborate there, but I think it is because of the newness of it and not everyone understands. They were working with e-health and when I first heard it I thought it was going to be marvellous, but I have not had anything much to do with it over the last 10 years.

Senator ADAMS—We had the department here this morning giving evidence. They have what they call a state wide PTAS, the Patient Travel Assistance Scheme review committee, which meets periodically. It does not have a consumer on it.

Mrs Bond—I would love to get on to that.

Senator ADAMS—Could you make some inquiries, or ask your president to make some inquiries, as to a consumer representative or how they could accommodate the consultation process coming through? They have said that they have consulted widely, but we are yet to find from our witnesses today anyone they have consulted. For the CWA that might be a really good place to start.

Mrs Bond—Is this the LGH one or is it state wide?

Senator ADAMS—It is the state wide PTAS review committee. They have medical authorisers and the PTAS travel coordinators from each of the three major public hospitals. But they do not seem to have anyone else, and I think that for rural people, seeing it is something that is associated with rural people—they have your PATS specialist but they do not have any consumers.

Mrs Bond—I think it is very important because the consumer puts a different slant on the work altogether.

Senator ADAMS—I note from the New South Wales submission that the problem is that a lot of the states have different rules and guidelines for the patient assisted travel scheme. Here you are sent to the nearest, most appropriate specialist, but in New South Wales—as they say in their submission—the requirement is that the patient be referred to the nearest treating specialist. They are saying that this is totally unacceptable and must be abolished. That is really the difference. In Tasmania it is the most appropriate specialist, which is very important. In New South Wales, as their submission says, it is to the nearest specialist, as it is in Western Australia. That can really have a lot of problems for rural people—not being sent initially to the most appropriate specialist. Could you comment on that?

Mrs Bond—At the present moment in Tasmania our neurosurgeon books are closed. I know someone who has been waiting since last December to see a neurosurgeon in Tasmania. There is a visiting neurosurgeon who comes over monthly from Melbourne and who has rooms here and sees patients for two days each month. If you need surgery you have to go to Melbourne.

Senator ADAMS—This is one of the complications of the problem. Then the next visiting specialist may be someone different?

Mrs Bond—Yes.

Senator ADAMS—So once again you have to go right through the performance again.

Mrs Bond—The proceeds again, yes.

Senator ADAMS—That is just something for your New South Wales people. There is one more about BreastScreen and patients having to travel to Broken Hill. I give an example of how difficult it is and the fact that women in rural and remote communities visit the New South Wales BreastScreen mobile van in Broken Hill. There is no funding currently and the service is done in a mobile van, not a building. Would you be able to follow that one up?

Mrs Bond—Yes.

Senator ADAMS—Do you know about that? They have obviously investigated the situation but been told that it is not a building; it is a mobile van.

Mrs Bond—There are mobile vans in different states. In Tasmania, if, say, you have breast screening done here in Launceston and there is a query about it, you have to go to Hobart to have another screen and the reading because there is no-one in Launceston who can read it.

Senator ADAMS—We have been told that there is a special fund for the BreastScreen service. I do not know about that. We really need the department back to ask the question, because the AMA told us that that did not come under PATS; it came under something different, and so we are uncertain about that.

Mrs Bond—As far as I know, the people I know who have gone to Hobart to have the second screening have paid their own way. But there could be money. Unless you push these issues, or unless someone who has

had a similar event knows, you do not know anything about it. No-one is very keen to let you know about these things.

Senator ADAMS—The main thing is that it is coming out of the local hospital budget. The more people who know about it and the more people who access it, the more problems they have balancing their books. It is a problem. Is there anything you know that you think could improve the system?

Mrs Bond—Yes. This happened to me quite a while ago, but I found that in rural areas some of the doctors were not prepared to sign the scheme so that people could go away. They felt that, because they were rural people, they were asset rich and income poor. They looked affluent, but I know of a couple of doctors in the western district of Victoria who would not sign any application forms for people. Whether it is still happening—

Senator MOORE—There is no choice of doctor?

Mrs Bond—No, this is the thing—and the same thing used to happen on Flinders Island. If the doctor was away fishing during his time off—and I do not blame him having time off because he was the only doctor there—and you had an emergency and had to come to the mainland, you could not get any forms signed because he was having four or five days off and there was no-one to replace him. The patients just had to bear the costs themselves.

CHAIR—Can I just clarify this. We are told by the AMA that the GPs do not sign these forms.

Mrs Bond—Rural doctors can.

Senator ADAMS—They have to—to get it signed.

Mrs Bond—He is the only doctor on Flinders Island, so he has to sign the forms for them to come across to the mainland. I was talking to Don Rose afterwards and he said rural doctors and specialists. This is another thing with the application forms because there is a doctor's form and a specialist's form, which is a little bit confusing too, here in Tasmania.

Senator ADAMS—The GP starts the process. They refer the person to a specialist. They will sign the form but that form has to go to the local hospital administrator, or whoever is doing the PATS clerical work, to either approve or disapprove that travel. That is often where a problem arises. If they do finally get to the specialist, the specialist has to sign the form and it has to come back to the PATS clerk. It is quite a convoluted system.

Mrs Bond—It is time consuming in this present day when everyone is flat chat.

Senator BOYCE—I did not quite understand what you were saying about the fact that when the GP is not there you do not get PATS. How do you get into the system when the GP is away, so to speak?

Mrs Bond—They just have to wait or arrive on the mainland, come to the hospital and hope for the best.

Senator BOYCE—So they were getting themselves to the nearest casualty or emergency or something.

Mrs Bond—Yes. It was mainly for dentistry. If they had abscessed teeth or something like that, there was no dentist on Flinders Island and they would need to come to the mainland. The doctor was not available, so people just came.

Senator MOORE—In one of your answers you said that you had taken these issues to your conference and found out how little people knew about them. Can I get something on record about why your organisation considers PATS to be something that needs to be discussed?

Mrs Bond—In the present day, with rural people under a fair amount of stress because of the drought and what is going on, it is important that they get as much support and help as possible. More than the travelling part of it, the accommodation part is the thing that is the real worry because that is where the big expenses come in. Here in Tasmania we have buses which do not meet up with anything else. They do not meet up with flights or anything. I am 83, but in my group I am the only one who is driving now. I have to drive everyone places because lots of people are not driving—they have had to give up their licences—and it is very restrictive. A lot of women, particularly older women of my age, have never driven because their husbands drove and the husbands did not want them to drive. When they die, say at 75, it is too late to start learning to drive a car.

Senator MOORE—I think it is important to have on record why your association considers this to be important.

Mrs Bond—We are interested in any support—

Senator MOORE—In general wellbeing.

Mrs Bond—We try and make our members conscious of everything that is going on, good and bad, and at the present moment in Tasmania they are very dubious about where we are going with the whole health system—

Senator MOORE—The restructure.

Mrs Bond—because we are in a state of flux. It will probably be a lot better when it is finished but at this stage it is a question of where we are going. A lot of people are very scared, particularly at the Holman Clinic here in Launceston where our only oncologist is moving to Hobart in November. We will have no oncologist in Launceston—

Senator MOORE—That is the first time.

Mrs Bond—which is quite frightening.

Senator MOORE—Yes, very frightening. Thank you.

Senator POLLEY—I have to admit that I have known Mrs Bond for quite some time in a variety of roles. You were saying that some of the barriers for rural women in Tasmania are that they do not have drivers licences, we do not have a reliable public transport system and there certainly isn't any coordination between the services we do have. In terms of the evidence that we have had before us today and elsewhere, is it your evidence that you also are looking for more flexibility so that it is not just a matter of how many kilometres you are from a hospital but more a matter of your financial situation and the sort of health condition that you are suffering?

Mrs Bond—We need to have some better means of getting people from A to B, whether it is a community car—some of the councils have community cars—or something else. The fact that we are looking at paying for our ambulance service for the first time ever is quite frightening because no-one seems to know where we are going there. Australia-wide, as long as I have been in CWA—and I have been there for about 60 years—we have had problems with transport. The biggest concern we have had over the years is rural transport—getting people from A to B.

Senator PATTERSON—You did a big survey, back in 1980-something—

Mrs Bond—Dorothy Ross. That was the first—

Senator PATTERSON—and it was transport and roads.

Mrs Bond—Yes.

Senator PATTERSON—I remember reading it.

Mrs Bond—That is a long time ago. I nearly brought it today because really—

Senator PATTERSON—It is still relevant.

Mrs Bond—Yes, it is still relevant. All the things we brought out then have been nibbled at the edges, but it is still very relevant on rural transport. To me, that is the thing that is affecting rural people more than anything.

Senator POLLEY—I know that you were in the room when the AMA representative came before us. Do you share the view he gave in his evidence that seeking the subsidy is not really worth while? And, as far as your organisation is concerned, are your members and the community aware of PATS?

Mrs Bond—It is a very small amount. It is helpful, but if you have to fill in the forms and wait four months for the money that is not good, and it does not give you a very good impression of PATS, does it?

Senator POLLEY—The department told us today, particularly talking about the north, that there is about a week's turnover now, so they have improved things. Has that not been the experience?

Mrs Bond—Before Christmas it was not.

Senator POLLEY—Surprisingly enough, we do sometimes get versions from departments that are different to those from people who are on the ground having to complete these forms.

Mrs Bond—They might have put more staff in since Christmas, but prior to Christmas I knew of people who were waiting at least four months and nothing less than that for their money.

Senator MOORE—Were they standard, straightforward claims?

Mrs Bond—Yes.

Senator MOORE—So there was nothing complex about them?

Mrs Bond—They were the Holman Clinic claims from cancer patients who were going to Hobart.

Senator MOORE—So they were regular claims; there was nothing extraordinary about them. That is ridiculous.

Mrs Bond—There was no accommodation for them, because they need sterile places. They had to go to private homes. And there was no funding to help them. They had to live out of Hobart and there was no funding to go from where they were staying to the hospital every day. This went on for three weeks. There was no accommodation, because you cannot stay at a backpackers hostel when you are having stem cell therapy; it has to be sterile and that is not possible.

I would like to see accommodation in Hobart for adults. We have Spurr Wing in Launceston, which is very good, and I do not think there is any cause for it down the north-west coast unless they are going to put specialist services down there with the new planning. In that case, they would need accommodation. But I think accommodation is probably a bigger issue than transport because accommodation is more expensive.

Senator POLLEY—With accommodation you have the added expense of meals.

Mrs Bond—Could I bring up one other thing? I do not know whether we have discussed it. When a person is going to a specialist and that specialist moves somewhere that the person could still go to, the person is not entitled to travel to that specialist.

CHAIR—Because they are further away than another specialist?

Mrs Bond—Yes, they have to go and see another specialist. But if you have a good rapport with the original specialist and you are suffering from a fair amount of trauma, you are not in the best temperament to cope with the changes that go on.

CHAIR—Could I clarify that. If you are living in a rural community and you choose not to go to your nearest appropriate specialist but to the one who is another 50 kilometres further on, are you not entitled to a subsidy or are you entitled only to the subsidy that you would receive if you went to the nearest specialist?

Mrs Bond—The case I am quoting is one where a person was attending a specialist but that specialist moved to Hobart from the north-west coast. They had not claimed a travel allowance before that. They would have liked the travel allowance to see the specialist in Hobart with whom they had a good rapport, but there was no possibility of them getting it.

CHAIR—But could they still have claimed for the equivalent cost of going to the nearest specialist and then only used that to get to Hobart?

Mrs Bond—No.

CHAIR—They could not? Okay. Are there any further questions?

Senator CAROL BROWN—I am not sure if a question was asked about the promotion of the scheme. One was? Then I do not have any further questions.

Senator PATTERSON—Mrs Bond, have you been invited to give a submission to the state review of PATS? Did you know that there was a state review of PATS?

Mrs Bond—No. I am involved with three or four regular state health committees but I have not been notified.

Senator PATTERSON—Are you aware that there is a review committee of PATS, a standing committee that reviews PATS?

Mrs Bond—No. I would not mind. They might invite me there.

Senator PATTERSON—They might read the *Hansard* record of this hearing and ask you to make a submission, Mrs Bond. I suggest that they might do that.

CHAIR—There will be a queue after today's hearing of people who might want to make submissions to that process.

Senator PATTERSON—Apparently, two to three months ago—which is rather interesting, since that was about the time that we announced this committee hearing—they announced they were going to have a review.

CHAIR—The state committee?

Senator PATTERSON—The state government was going to have a review.

Mrs Bond—Probably next year.

Senator PATTERSON—I think it is now.

Mrs Bond—Is it?

Senator PATTERSON—Yes. So hopefully you will be advised about it. I do not know how you will find out about it but we have been advised that there is one; people have kept telling us so at the hearing today.

Senator CAROL BROWN—The AMA told us so.

Senator PATTERSON—The AMA told us that there was one.

Mrs Bond—Then I will get in contact with Dr Rose and ask him. He is with the AMA, isn't he?

Senator PATTERSON—But Dr Rose told us that he did not suggest that many people apply for PATS when they lived 100 kilometres from his old practice. They might have lived 100 kilometres away from Burnie.

Mrs Bond—Yes, he used to live right down the north-west and—

Senator PATTERSON—He only had six PATS ones he had recommended, I think he said, in 10 years. And in your submission you say:

... it seems that many general practitioners are not passing on the information to their clients.

Mrs Bond—They have signs in their surgeries, but who wanders around a surgery looking at signs? Unless you had a two-hour wait, you would not be wandering around the surgery looking at all the information around the walls; usually you would sit down and talk to the person beside you to fill in the time. Occasionally, if there is something on which I know some information has been put out, I will go and have a look in the doctor's surgery I go to, to see if there is some information on that. Or I might drop some information in there myself.

Senator PATTERSON—We have to make recommendations; that is one of the things we do. You are out there on the ground. How do you think we could get the message out to people that PATS exists? Signs in doctors' surgeries are not very effective. Have you any ideas?

Mrs Bond—Honestly, people do not want to know until it happens. I am sorry to say it but it does not matter what you try to get out to the public; on the whole most people are not interested in knowing until something happens. Something happens today and they expect everything to fall into place, but they have made no investigation beforehand.

We have numerous groups around the state, in the areas of aged care and positive health and things like that; if we got notification to those groups that might help. Carelink is an example. The work they are doing is just out of this world, but very few people understand or know a thing about it. It just dumbfounds me that no-one knows about it, and yet advertising has been done—

Senator PATTERSON—It has been advertised, I think, in *Pension News* or whatever it is called now.

Mrs Bond—It has been advertised everywhere ever since it started. And it does a fabulous job. But people do not know about it. It is amazing that when you say, 'Have you tried Carelink?' people will say, 'What is that?' So what do you do? I do not know how you get it out to people.

Senator PATTERSON—One problem is that doctors do not think it is worth while—that it is not enough money, which was one of the comments we received. But we were just chatting about that at lunch and saying that for some people \$25 can mean the difference between getting a meal on the table for a night or two or not. So even trying to get doctors to tell their patients is futile if they do not think that much money counts; so that does not help us either.

Mrs Bond—I find the Holman Clinic at the Launceston General Hospital is excellent. That is our cancer clinic. They do a very good job; they send the patients to the welfare officer and they work things out for them.

Senator PATTERSON—They tell them about it.

Mrs Bond—Yes, and that is great. But you can poke it right in front of people's noses and they will not see it unless they need it. So it is not easy. I do not envy you trying to promote it!

CHAIR—Thank you very much for providing us with your evidence today and for waiting for us to catch up with our program. We appreciate that very much. And please thank the other arms of the CWA which have contributed to the inquiry's submissions.

Senator PATTERSON—You are a great role model for all of us. We hope we are giving evidence at 83 as feistily and as strongly as you are.

Mrs Bond—That is why I am not allowed on some of the committees.

Senator POLLEY—Mrs Bond has been doing it for many years and she is a real credit to herself.

Mrs Bond—They do not like the look of me sometimes—and I am not squinty-eyed!

CHAIR—I think we will have your age struck from the record.

Senator PATTERSON—She has already told us.

Mrs Bond—I qualified as a chemist in 1944 before we had free medicines and antibiotics. So, as you can see, I have seen a lot of changes over the years. I have been retired from pharmacy only for about 10 years and I have two children who are pharmacists, so I am keeping in touch.

CHAIR—You certainly are.

[2.26 pm]

PERKINS, Mr Michael, Chairman, Beaconsfield District Health Service Community Advisory Board

CHAIR—Mr Perkins, welcome to the inquiry this afternoon. Do you have any comments to make on the capacity in which you appear?

Mr Perkins—I am also chairman of the board of the Beaconsfield Park retirement units.

CHAIR—I think you have been given information on parliamentary privilege and on how we protect witnesses and the evidence they give. We do not have a submission from you but I understand you have some things to tell us about your experience of the patient assisted travel scheme in Tasmania. We will ask you some questions about that but you might like to make a statement to us now and perhaps start by telling us where Beaconsfield is, for those not from Tasmania.

Mr Perkins—Maybe I could ask where Canberra is! Beaconsfield is situated on the western side of the Tamar River, approximately 60 kilometres from Launceston. It is a town of around a thousand people and it has a large rural community surrounding it. We have a health facility there which was formerly a hospital and is now mainly aged care, with some subacute beds. Across the road we have 24 retirement units where we have elderly people living. That retirement village is aimed at people from lower socioeconomic groups—people who have not had an opportunity to build up equity during their lives. The rents we charge them are substantially lower than what you find out in the wider world. The dearest one is around \$140 to \$145 a fortnight. They are the sorts of people that I am dealing with in the West Tamar.

I would like to say thank you very much for allowing me to appear here today. I only found out about this inquiry last Thursday and then made the phone call, so I do appreciate this opportunity. I have done some work over the last couple of days and I have a submission here which I would like to read to you. If you would like me to leave that with you I most certainly can.

CHAIR—Certainly.

Mr Perkins—The proposed changes to the delivery of health services in Tasmania and the costs of accessing those services are of concern to many people in the community. The residents of the West Tamar are becoming increasingly nervous about the current costs of accessing medical treatment in Launceston. And with the centralisation of services such as day surgery at Devonport, the additional financial strain that they will be burdened with is of great concern to them. Whilst one of the points of the Primary Health Services Plan as outlined by the minister recently is access to transport, there is a lack of detail available—and yet it has been three months since the budget was brought down. That is worrying to the elderly in our community.

The West Tamar is currently served by public transport four times a day—at 6.30 am, 7.25 am, 9.15 am and 2.15 in the afternoon, with return services at similar times. There are other services, associated with school bus returns, which people could access but, as one person put it to me, ‘After you’ve just had a day’s chemo treatment at the Launceston General Hospital, you don’t really want to go home with a lot of screaming kids.’ The current cost of a fare is \$10.25 one way. If you are on a concession you can get that reduced by \$5.15. The other transport service that is available is the West Tamar community car, operated by the West Tamar Council on behalf of the community, and that costs \$15 a return trip. This service relies very heavily on volunteer drivers and the anecdotal evidence is that getting volunteers to man that vehicle on a daily basis is getting harder day by day.

The current eligibility requirement for people wishing to access the patient travel assistance scheme is that they must reside 75 kilometres from the medical centre being accessed. That comes out of the Department of Health and Human Services hospital and ambulance service policy No. 5 of 99. We have a number of elderly people—in the main, pensioners—who reside within the 75-kilometre zone, and they are finding carrying the cost burden something of a struggle. We have one elderly patient who is required to travel from Beauty Point to Launceston three times a week for dialysis. Utilising the community car, it is costing her \$45 a week, \$90 a fortnight, and she is finding it somewhat of a struggle to make ends meet. Where eligibility for assistance can be established, there is criticism by our more senior people of the complexity of the claim form when filling it out, and of the often lengthy delays in receiving reimbursement for the claim, all of which adds to the hardship of day-to-day living for these people.

The patient travel assistance scheme is felt by the health providers that I have spoken to in the last two or three days to be too narrow and too restrictive where it applies to medical services and procedures. The cases

that I have had presented to me are of patients who need to access specialised services, such as suicide support and family-planning—and that is not necessarily contraception—but for whom, relative to family support, there is no travel assistance available. We have one such case, a client who, as a result of an accident seven years ago, is now on a disability pension, is suffering from depression and needs referral to psychological and suicide support groups. That person is now finding the rising cost of fuel becoming prohibitive, and at times the depression reaches the point where driving is just not an option. There is another case, of a young mother of three children under the age of six who needs to attend family support sessions late in the afternoon, at 4.15 pm, once a week, who has no car and to whom regular or voluntary transport is not available.

Support, we feel, is very important. In one case we have a teacher who is currently suffering from an anxiety problem and is away from work as a consequence of working with children who come from families with perceived family relationship difficulties. We do have a responsibility to assist families in this way because we do not always see the impact it is having on other people in the wider community, which is itself adding to the financial cost burden of the already very-stretched health system in this state.

With the impending closure of hospitals in rural and remote areas and the move to centralisation, we believe there is a need to review the travel assistance scheme and that it is paramount if we are to ensure that people in all parts of Australia are to be treated in a fair and equitable way. Thank you.

CHAIR—Great. Thank you very much. We will now go to questions.

Senator PATTERSON—Mr Perkins, are you aware that the state is having a review of PATS?

Mr Perkins—Yes. We have written to them as well.

Senator PATTERSON—How did you find out about that review?

Mr Perkins—I was informed by a person from the Department of Health and Human Services.

Senator PATTERSON—When was that?

Mr Perkins—That was last Wednesday.

Senator PATTERSON—You said you found out about this review last Thursday?

Mr Perkins—Last Thursday morning I was informed of this review.

Senator PATTERSON—But you knew about the state one?

Mr Perkins—Yes. I was informed of the state one on Wednesday. We have written to Jackie Mair, the coordinator at the Patient Assisted Travel Scheme, Launceston. At this stage I have not had a reply from them either.

Senator PATTERSON—You indicated that it was taking a considerable period of time to get the repayment. How up-to-date is your information?

Mr Perkins—I can only go on what I have been told this morning, and that is that it is taking sometimes six or seven weeks. If you want me to find out more detail—

Senator PATTERSON—That is okay. It is just that two people who have come before us have not had experience of it since before December and we thought there might have been some change. The department said today that it takes about a week.

Mr Perkins—I can only go on what I was advised by the person I spoke to this morning, who was a social worker.

Senator POLLEY—Earlier this morning the department indicated to us that there is now a turnaround of about a week and so there has been an improvement. It is always interesting to get the experiences of people on the ground. In Tasmania, 75 kilometres is not a true reflection of the geographical nature of the state, so would you like to see different criteria to a mandatory kilometre allowance?

Mr Perkins—I think the criteria should be based on need rather than a set distance. We need to look at the case of people who are on low incomes, pensioners, and if there is a genuine case of need for transport assistance then it ought to be judged on that instead of on some arbitrary 50-kilometre or 75-kilometre distance. In the case that I spoke about, that person lives about 72 kilometres out and, as I was told, the cost of fuel is getting up and up and they are finding it very difficult to access the services.

Senator POLLEY—I can see that if somebody has to come into Launceston from Beauty Point three times a week for dialysis then that is pretty expensive, particularly if, as a pensioner, you are on a limited income.

Even for those in the workforce, our petrol costs are really rising and it is an issue that does cause considerable hardship for families. Have you had any experience with the accommodation allowance?

Mr Perkins—No, I have not had any information given to me by people who have had problems with accommodation allowances, bearing in mind that the people I deal with in the main travel in and out of Launceston. It is only very rarely that we find somebody is taken to Hobart. In relation to the people I am dealing with, one of the things I believe will be an issue in the not-too-distant future is the delivery of oncology services. The resident oncologist—I think that is his title—at the Launceston General Hospital is resigning and moving away. That might mean we now have to send people to Hobart or through to Devonport. If they have to go to Hobart then there will be an accommodation issue, but I do not have any information on that.

Senator POLLEY—I think part of the reason he gave was his workload. Obviously there is a great need for more specialists, but would it be fair to say that you would like to see PATS extended beyond specialist services?

Mr Perkins—Most definitely so. I have had experience over the last two or three years with people who need to access services in the city other than medical and surgical procedures—it is in relation to family care—but they have not been able to get in because of travel difficulties. We do not enjoy good public bus transport, very much like the Midlands, which has a problem as well.

Senator POLLEY—Yes, they gave evidence earlier today. Obviously the community cars are of great assistance for people in rural areas. They do not really have a problem with volunteers as such, but they could do with an extra car. From your evidence, you are having trouble attracting volunteers just to drive the car you have.

Mr Perkins—As I understand it, the capacity of the community car on the West Tamar is stretched, but they are also having trouble with volunteers. That was raised at the community advisory board meeting last week. They were seeking more volunteer drivers—if they had more, they could provide more services. That was what the gentleman at the meeting said, so obviously they are having trouble getting volunteers. If it were not for volunteers these community cars would not operate and there would be an added financial burden on both the state and the Commonwealth.

Senator POLLEY—Yes, without volunteers in our communities, it would generally cost all governments—state and federal—a lot more money for a whole range of services.

Mr Perkins—That is very true, but it is not true of health services no matter where you go in this country. If it were not for volunteers, we would not enjoy the quality of life that we enjoy today.

Senator POLLEY—Yes, exactly.

Senator ADAMS—Within the department there is a state-wide PTAS review committee, and they apparently meet periodically to monitor the policy. Were you aware of their existence?

Mr Perkins—I only became aware of their existence on Thursday when I looked up their website. I was a bit surprised to find that some of the policies dated back six or seven years and were due for review in 2000. That obviously has not been done.

Senator ADAMS—So now they are going to do a review.

Mr Perkins—Yes, and bring it up to date.

Senator ADAMS—We have been told that. They say here that the committee consists of medical authorisers and PTAS travel coordinators from each of the three major public hospitals. I asked them if they had a consumer on their committee but they had not really thought about it. I would suggest, when they come along, that people such as you and the organisation you are dealing with could ask about having representation from the people who actually use the scheme.

Mr Perkins—That is a very positive suggestion. I would like to know how we get it implemented.

Senator ADAMS—I suggest that you go to that review. My geography of Tasmania is probably not as good as it should be. Can you tell me how far Devonport is from you? You talked about the oncologist going.

Mr Perkins—That would be around one hour and 10 minutes away from Beaconsfield.

Senator ADAMS—How many kilometres would that be? Is it over 74 kilometres?

Mr Perkins—It would be around 70 kilometres. That is the radial distance, but I could not put a figure on what—

Senator ADAMS—So they will still not be eligible. That was really my question.

Mr Perkins—No, I do not think they will be eligible. That is why I think that criteria based on need rather than distance would be a far more practical way of helping people.

Senator ADAMS—That is good. Your clients are mainly elderly; therefore transport is a huge issue.

Mr Perkins—Transport is a real issue, yes. The people I deal with are the elderly in hospital, at home and in retirement units. At the other end of the spectrum, we are now finding—especially with single parent families where they need help and support—that support is being centralised in the larger regional cities. People are finding it difficult to get access to those services. I cited a case of somebody who is off work and who is a cost on the system because they cannot get assistance and help. We are not able to help those families. There are families out there crying out for help to develop their parenting skills.

CHAIR—We have heard in other places, particularly in the Northern Territory where the transport system is very poor, that people with certain chronic conditions like kidney failure need to move closer to the large centres to get regular treatment. There are inadequate transport options for them to live in remote communities and commute. Have you had many cases around the Beaconsfield area of people who have had to move because they need to access health services on a regular basis?

Mr Perkins—Yes, we have had people leave the retirement units in Beaconsfield and go to Launceston because they needed access to frequent, reliable medical services. That is a fact. In fact, we have had three in the last 12 months.

CHAIR—If there had been good, reliable public transport between Beaconsfield and Launceston and a well-resourced travel scheme, might they have had to move?

Mr Perkins—I would venture to say that those people would rather have stayed in their local community amongst their family rather than move. That is one of the tragedies of people having to move from remote and rural locations. I am not saying that Beaconsfield is unique, but when you have to take people away from their local communities, their families and their friends, it is heart wrenching.

Senator CAROL BROWN—How many of your clients have been denied access to transport assistance?

Mr Perkins—I could not answer that question because I do not know. If you wanted me to find out, I could go back and research it. Having only found out about this hearing on Thursday, it has been a rather hurried job getting together the evidence.

Senator CAROL BROWN—How far is Beaconsfield from Launceston?

Mr Perkins—Beaconsfield is about 65 kilometres out of Launceston.

Senator CAROL BROWN—Earlier, the department indicated that they did not always have a strict distance criteria and if people put in an application, even though it did not meet the 75-kilometre criteria, sometimes they would be accepted. I wonder how many of your clients would have been accepted.

Mr Perkins—I cannot answer that question. The only thing I can tell you is the case that I quoted to you today where somebody did apply and was told they lived under the distance and therefore were not eligible.

Senator CAROL BROWN—Did they appeal?

Mr Perkins—I do not know.

Senator POLLEY—Is it not also an impediment for those people who live in outer rural areas to move into Launceston because of the increased real estate prices? Not everyone has the ability to afford to move closer to the facilities.

Mr Perkins—You do not get \$300,000 for a house in Beaconsfield, which is what is needed if you want to buy a house in Launceston. That is one of the problems that these people face, not that I would want to live in Launceston. I like the country fresh air.

Senator POLLEY—We think this is country fresh air here in Launceston.

Mr Perkins—It would be a real struggle for some people to be able to afford to move to Launceston. That is why we find with the park homes that if a unit is vacant today, it is gone tomorrow because of the affordability of it and the cost of living down there.

Senator CAROL BROWN—Do you have any evidence to suggest that people are doing without basic, essential living items so they can meet their transport costs?

Mr Perkins—I do not have any hard evidence on that. It is mainly anecdotal. Yes, there are people I know of who have gone without to put petrol in their car to get to Launceston.

Senator CAROL BROWN—More often than you would like to know about?

Mr Perkins—Yes.

Senator POLLEY—The reality is that if you are paying \$45 a week, \$90 a fortnight out of your pension, you do not have to be Einstein to work out that you have to go without something in order to meet that cost.

Mr Perkins—It is not just people on the pension; it is those who are—

Senator POLLEY—Working.

Mr Perkins—on the dole. There are people who are in receipt of that but still need to access services in Launceston. As I said, it is not just medical services, and that is why I think it ought to be broadened to include services that support people—for example, the chap with depression that I talked about, who needs to access psychological and suicide prevention support. I was told this morning by the social worker that, between herself, the local GP and the psychiatrist in Launceston, they have kept him going for the last two or three years. He goes through real depression states and she brings him into Launceston on occasions.

CHAIR—Mr Perkins, thank you very much for the time you have spent with us this afternoon and the insight you have given us to what is happening in rural Tasmania. Thank you very much for that and for generally being here this afternoon to wait for us to catch up with our program.

Mr Perkins—Thank you very much for the opportunity.

CHAIR—It has been a pleasure. That concludes our hearings in Tasmania. As members of the committee know, we are not meeting in Melbourne tomorrow. Our next meeting will be at the Gold Coast early next month, on 6 August. I thank Hansard and the committee secretariat for the assistance they have provided us today.

Committee adjourned at 2.52 pm