

NATIONAL RURAL HEALTH ALLIANCE INC

PUBLIC SEMINAR

'KEY ISSUES IN RURAL AND REMOTE HEALTH'

CANBERRA

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DISCUSSION

JOHN WAKERMAN: Thank you very much indeed for travelling here and presenting those case studies. I think they were great examples of a number of the sorts of issues that we have been talking about, and also thank you very much for keeping on time. I think those of us who are academics and present papers can really learn from your example. We've got half an hour or so now until morning tea, and I'd like to throw the floor open to any questions or comments you might have for the panel.

LIZ [off mic]: Pauline, as a person who writes out those forms and those referrals, it's a lot of red tape which could be out of the water and my system is even simpler than yours. If I want a travel reimbursement from my private health fund, all I do is I give them a Medicare docket. When the Medicare docket says that I have received a specialist service which is identified by a particular number, they look to see where that specialist is, they look to see where I told them I live, and I say, "Right, I'm 250 Ks", and they give me 500 kilometres worth of money.

The fact that I have a specialist reimbursement from Medicare means that I have a referral from one of my friendly general practitioners that I work with, but the Medicare system already verifies that. You would only require - for someone who was travelling for specific needs beyond the closest obvious service, you would only need a verification from your referring doctor that that was appropriate, and then from that point that doctor would say, "Oh, a five year follow up with a specialist is appropriate. Five years". That simple verification could cover that system and I wouldn't have to write out those forms.

FEMALE SPEAKER [off mic]: Just one problem with that, not all services have a Medicare some of the allied health funds which you can claim

PAULINE VENN: In my own experience, like the 12 monthly, you have to keep track of the calendar, because VPTAS, or VPTAS in Victoria certainly are, so once that expiry date goes by, they'll send it back to you, "This form is not validated until you go and get that 12 monthly referral, which in rural areas doctors in one part are very hard to get an appointment to see anyway, and all the other confusion. But there is no way around it. I have tried and tried and tried, but every 12 months, line up for your referral.

ANNE [off mic]: Hi, I'm Anne and I'm waiting for a lung transplant That is a good idea but it won't work for people who are outpatient attendees such as people waiting for organ donation because there's no there's no exchange of money, there's no Medicare card presented, and so forth. So that won't work for people who travel to one of the three centres in Australia who'd be waiting for a lung transplant. I just thought I'd tell you little stories of waiting for a lung transplant and I'll be quick.

The first was that here in the ACT where I'm based – and I know you all think that we Canberra people get a lot of things, but for the purposes of a lung transplant I'm regarded as rural because I have to travel to Melbourne or Sydney or to Brisbane. And recently – or last year linear accelerator in the ACT was broken, and so people with breast cancer in particular had to travel to either Wagga or to Sydney. It was pointed out that the IPTAS scheme in the ACT, as everywhere else in Australia, was woefully inadequate and in fact you couldn't get a park bench for the price that the IPTAS scheme was getting subsidised for travel.

So what was arranged was that in fact those people who were travelling because of their cancer and a broken down linear accelerator, they received all of the costs related to their travel and accommodation, whereas those who are commencing the scheme routinely who are desperately ill as well receive their \$10 a night which as I say didn't cover the park bench.

The second thing is the offers from health services are often insulting to cover your need to travel. So for example for me once I was offered a bed at a Sydney hospital in the old nurses home. It's, you know, patient accommodation, but I couldn't take my husband or child. I have a great big breathing machine at night. That would have to stay in the room with me, so there's no point in having a bed because I wouldn't sleep. There's no car parking. How the hell are we supposed to get there anyway? So there are all those problems, and I think finally I'd like to say that all your stories this morning highlight how patient patients are, that they on this important issue. Thank you for listening to me.

JOHN WAKERMAN: Thanks, Anne. Any comment?

JODIE ALTSCHWAGER: I just want to go back to the Medicare item comment. I think that's a good idea, particularly for people who perhaps don't have that 12 months worth of treatment where they are having to get different signatures on the referring section. I know in South Australia you can just do an ongoing referral and that's fine, they'll accept that, but say – it might work good for the IPTAS, the poor people in New South Wales, so you get referred to a specialist for say head and neck surgery, then you need radiotherapy which is related or chemotherapy which is directly related to your initial referral. You have to get a referral from the treating ENT surgeon to the radiation oncologist, you need to get one to the medical oncologist. So there's all these three forms and it's all, as far as the patient is concerned, the same cancer and the same treatment, so it may assist with some of those sorts of cases.

FEMALE SPEAKER [off mic]: Jodie, I was hearing that you've been in your position for quite a time, or for a few years. Have you got any statistics or any data that you've been collecting on the subject of transport?

JODIE ALTSCHWAGER: I've been in the position probably – this is the eleventh year now, and I have requested information from PATS schemes, but their systems are not often able to, as a lot of people in this room would be able to say, give me a breakdown of the types of patients and where they're from and what specialties they're accessing because the systems that they're entering it on – like their computer systems are not advanced enough to be able to do that. That's certainly the South Australian view.

I think transport is a big problem for rural people accessing health, and from my experience there's an increased pressure on healthcare providers and the health dollar to assist in transport for people. So there's this big thing that health now takes responsibility for transport and accommodation. Shouldn't transport government bodies take control of transport? Shouldn't the Transport Minister be fixing the transport problems and why should healthcare providers be manipulating the transport system to get people to healthcare?

FEMALE SPEAKER [off mic]: Because I was wondering, as Alan is the Chair of the Health Advisory Council, Alan, have you ever asked for data from your managers?

ALAN NEILAN: The Queensland system allows every district to go their own way and have their own party. Over the \$25 million which is the PTS budget growing gradually in Queensland, the component which is growing most significantly is actually accommodation charges, not so much air travel or kilometric allowance, which is only 10 cents a kilometre. And we've asked at district level for the break-up.

What we find is there are spikes in referrals to Cairns and Townsville, mostly Townsville, due to lack of specialists actually visiting Mt Isa. So all of a sudden if our ear nose and throat specialist would come and do the consultation, fine. But if that chappie isn't willing to do any surgery, the patient is referred back to

Townsville to the same doctor for the surgery. So it tends to peak when we have loss of specialists. If we lose anaesthetists, we shut down birthing. That's happened on a couple of occasions. So yes, not specific stats though, no. But the Transport Health Related Reference Group will actually bid for additional resources in that PTS section to break up the stats so we find out what's going on.

JOHN WAKERMAN: I'd like to ask a question. I think the problems are multiple and probably reasonably clear in terms of availability of transport, availability of appropriate transport, consumer knowledge about these schemes, difficulty in accessing funds, the red tape involved, lack of accommodation, problems with escorts and so forth.

The question I want to ask the panel and the audience is, we raised this as an issue with the parliamentarians and of course patient travel is a state responsibility, and so the feds can say, "Well, it's a state responsibility", and if we urge the feds to got to the states, the states can say, "Well, go away, it's our business, it's not your business". It seems to me that in some areas like education in relation to curricula, the federal government is willing to take a leading role and say, "Well, look, let's have some standardisation across the country", but in other areas they're quite reluctant to be involved.

I guess the question that I'd like to ask the panel as the experts and the audience generally is what do you think we as an alliance can do in terms of trying to sort out some of these problems that you so well described today?

JODIE ALTSCHWAGER: I think as the Alliance it's promoting - all changes occur to PATS schemes historically because consumers demand it, not because healthcare providers also demand it. So there's a lot of healthcare professionals that use these schemes have to fill the forms in that perhaps go, "This is terrible and I hate this", and just say it, but don't do anything else about that. They know that they hate having to fill this referring thing in and they don't think it's right, but through their bodies perhaps don't necessarily make enough noise to support the consumers that are also making the noise.

So I think that's where you guys are great in that you are already raising that. You're writing the position papers and I think on the ground roots level there needs to be more noise made as well and not just leave it up to organisations like yourselves, because I think that's where you make the wins and that's where the changes have always occurred to these schemes, is when there's enough noise.

When you look at the problems with accommodation costs, in Broken Hill when you go to Sydney for your treatment you'll get \$46 for you and your wife to stay in a motel. You go to Adelaide and you get \$66. That is a glaring inequality. Accommodation in Sydney is way more expensive. Then you compare what a politician gets per cents for kilometre and how much accommodation allowance they get, and that's all you need to say really.

JOHN WAKERMAN: Thanks, Jodie.

ANNE [off mic]: I'm having way too much to say good times so I think it's one of those days. I think that the Alliance should be demanding that patient transport assistance schemes be including in healthcare agreements and using some of those arguments there, this is a key out of pocket injustice when Australians pay taxes. We all pay taxes, we all pay our Medicare levy, yet it depends where we live as to what we can access.

JOHN WAKERMAN: Thanks, Anne.

ALAN NEILAN: John, just a comment.

JOHN WAKERMAN: Yes.

ALAN NEILAN: I think when it was decided that we have a hub and spoke model in tertiary hospitals in Queensland, there should have been some reciprocal strategy and policy to say, "Well, okay, we don't have surgical functions at Cloncurry any more. What impact is that going to have?" I think the model of tertiary hospitals and hub and spokes and community health centres and everything has overtaken Queensland. What they haven't looked at are the implications of the travel issues, and we've gone down the tertiary model far too quickly without thinking about the real problems that patients have. People aren't attending appointments because they can't afford a taxi fare. How silly is that?

FEMALE SPEAKER [off mic]: I'm just wondering whether these data could be put together. Leaving aside for the moment the difficulty in getting more specialists to go and live and work in the country, if you couldn't do that when you're paying working in more remote areas, which would end up costing the government more if we get political about transport and they actually pay a reasonable for the transport would that cost the government more than making go to the major centres? Does anyone have any idea?

JODIE ALTSCHWAGER: I think that's the crux of the whole problem. If South Australian PATS budget is \$6.5 million a year for the whole of South Australia, whoopee doo. The government must think that's fantastic because that's what they use to support country people. It's easier to have a PATS scheme that only costs them \$6.5 million than to go down the track perhaps of – this is just my view; perhaps I should say that, not the organisation I work for – but it is expensive to put specialists out there and it can be difficult to put those support services around that person that they need to provide that service that they do, because specialties are becoming more complex, so why would you bother - 6.5 million, it's nothing.

FEMALE SPEAKER [off mic]: 3:38:45 But it would be interesting if you added up the IPTAS's 6.5 scheme and then you added up the retrieval money that's also picking up done in – just in Bourke, I mean, 20 people a month go down at a cost of about \$2200 just to fly from Bourke to Dubbo.

JODIE ALTSCHWAGER: And that is a good point too, if you measure you bed days of country people in city hospitals that are demanding – having to cut their elective surgery because it's full of country patients because they don't have those services, then yes, that is a point that might get their attention.

FEMALE SPEAKER [off mic]: I just want to make a comment following on from because I think the cost and it's a shame there's not someone from the RFDS here and other ambulance services because in my experience that's the other additional burden that's placed on RFDS and ambulance services, transporting patients that perhaps don't need that high level of care, but there's no in between alternatives, so there's that factor as well which I think needs to be taken into consideration.

JOHN WAKERMAN: It's possible to collect a lot of data around patient transport and costs and alternative models and so forth. Somehow I don't think it's lack of data that is the main barrier to overcome here. I think we do come up against the nature of government and how health services are structured in this country, unfortunately. I think the idea about trying to get something up in a healthcare agreement is a good one to try and get some consistency and commitment across the country. There are a few experienced public servants here. I wonder if any of them are going to be – we won't tell anybody what you say, but just within this room, just within the confines of this room, are any of you willing to give us some ideas about what we can do to overcome some of these really serious issues about access to specialist health services? We'll turn off the tape recorders. No? Okay.

FEMALE SPEAKER [off mic]: I'm not in the Public Service. I'm with Carers Australia and Carers Australia is a member of the National Aged Care Alliance, and it at the moment is a discussion paper which has been sponsored by the AMA on transport primarily because so many patients are not able to make their appointments because they can't get transport there. And there's also a concern about having to use ambulance services and emergency departments when that person could just be treated by a GP if they could get there. So perhaps it would be worthwhile to perhaps talk a little about how could maybe work together on that.

JOHN [off mic]: John, I just want to make a comment. I'm not sure that I can answer your question, but it seems to me that this issue highlights the nub of what a lot of rural and remote health is about and has been about for a long period of time. The reality is that specialist services are never going to be equitably available. We've got to match, if you like, the requirements, the threshold requirements that they have and their location, against the fact that the need for these services is widely distributed. So we've got to get some sort of interface there.

Now, it seems to me there are probably a couple of things that we have to do to tackle this. One is just in terms of the overall kind of way we view healthcare. It is a right for all Australians. We have governments of all persuasion identifying

the fact that people should not be disadvantaged on the basis of your job or your socioeconomic status. So that I think we've really got to ram home hard in policy documents and policy that those ideals, if you like, or values need to be translated in an operational sense so that we don't have this sort of disjuncture. So my first point is that we've got to regard people as important and we've got to regard expenses associated with people as investment and not as an expense. That's the first thing, and I think that's got to underpin a lot of the policies that

The second thing is, the reality is that sometimes you've got to spend money to save money, so that I think the IPTAS type of arrangements are going to cost money. They're going to cost more than \$6.5 million, Jodie, and I signify to you I think it's tokenism to expect that you can deal with the issue on that basis. But I think part of what organisations and consumers need to do is to almost have demonstration models, not just of what the costs are to the individuals - and thank you all for those exemplary discussions this morning - but it's about the opportunity costs that we don't put a dollar value against.

What does it mean to the autistic child who foregoes the parent or is thrust in the situation that is really difficult for that family? What are the opportunity costs to the rest of the family and the community? And if we put some dollar values against those things that are foregone, I think you can start to mount a very strong economic case that upping the costs, whether it be public transport or patient support, is not really that significant in the bigger picture of things.

So I think we have a responsibility here to try and evaluate what these costs are to health services, to communities. It does mean bringing things together and quite frankly I don't see why we can't have a national approach to something like this. I really think it's nonsensical that we have the differences across the states. And I know Victoria and Tasmania are viewed as small states in comparison, but the reality of people that are living at Underbool in North West Victoria or or Benambra in East Gippsland or in some of those small communities, is just as real.

So I think the case is to be made at this national - it is going to cost more money, but the benefits of this are that you prevent problems down the track, you prevent costs to the healthcare system of delay or non-reporting, and I think overall you start to increase the attractiveness of communities in rural areas from the point of view that people realise that these are places you can live with quality of life, even if you do suffer health disadvantages, and be supported by the public.

JOHN WAKERMAN: Thanks, John. Any other comments or questions before we break for morning tea? Okay, that's fine, I think they were very good concluding comments. Thank you very much, John. And thank you very much to the panel for coming here, for travelling here and sharing with us your experiences. Can you thank the panel again?

PAULINE VENN: You may have noticed my beautiful patchwork quilt in the background there. We had a BCNA summit in Sydney in early September and I

was fortunate enough to be the recipient of that in the raffle. So it's sort of become my insignia and, well, it's not really a security blanket but it typifies who and what I am, I guess. It was made by a lady in New South Wales, so if you're wondering what it is, it's my pink lady quilt.

MALE SPEAKER [off mic]: I think it's very topical. Having watched the news last night and looked at Gogo Nassis [ph] and the link between Gogo Nassis [ph] which is a new fossil find in the Kimberley and people, I think you've captured it very nicely.

PAULINE VENN: Thank you.
