

STANDING COMMITTEE ON PUBLIC ADMINISTRATION

INQUIRY INTO THE PATIENT ASSISTED TRAVEL SCHEME

**TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 16 FEBRUARY 2015**

SESSION ONE

Members

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

Hearing commenced at 9.50 am**Dr HENRY MOODY****Clinical Lead, Renal Health Network (WA), Department of Health, sworn and examined:**

The CHAIRMAN: Good morning, Dr Moody. You are our very first witness for the Standing Committee on Public Administration for the year. My name is Liz Behjat. I am a member for North Metropolitan Region and I am the chairman of the committee. I will introduce my colleagues: Hon Amber-Jade Sanderson from the East Metropolitan Region; the Deputy Chair, Hon Darren West, from the Agricultural Region; Felicity Mackie, our advisory officer; Hon Nigel Hallett, who is from the South West Region; and Hon Jacqui Boydell from the Mining and Pastoral Region. We have most places covered, except the South Metropolitan Region. A really great cross-section of all of our regions is here. We appreciate you taking the time today to give us evidence in this inquiry, which we are just about bringing to an end now. We have had a very interesting time looking into it. Renal health has obviously been a major issue.

I have some formalities that I need to go through first. Please be very relaxed. Have you given evidence to a parliamentary committee?

Dr Moody: No.

The CHAIRMAN: It is not a scary process. We are really nice people. We are not out to catch anybody out or go on a witch-hunt or anything like that. We really just want to get lots of information. First, I need to ask you to take either an oath or an affirmation.

[Witness took the affirmation.]

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

Dr Moody: I have.

The CHAIRMAN: These proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphone and try to talk into it and ensure that you do not cover it with papers or make noise near it. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today’s proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

That is the formalities over and done with. Would you like to make an opening statement to the committee with regards to the Renal Health Network?

Dr Moody: Certainly. Thank you, first of all, for allowing the Renal Health Network to be represented at this meeting. We felt it was important that we present our point of view. I have read the submission you have already received from Kidney Health Australia relating to the WA experience. I have also read Kerry Winsor’s documents and transcripts of discussion that you have had with her. I am familiar that the committee itself is aware of the major issue of renal medicine and the impact of PATS.

I represent the Renal Health Network. For those who are unfamiliar with the health networks, we are a group of bodies within the health department that advise and formulate policy and strategy in the health department to help each of our various specialties. They are, of course, cardiovascular, diabetic and various other specialties. We are not silos; we work very closely together, particularly for us with the Diabetes Network because a very large proportion of our dialysis population also suffer from diabetes. For many of those, the reason for their renal failure is, in fact, diabetes. We also on our committees have both carers and consumers represented. As a body to deal with strategic matters of concern for our patients, we do have that added advantage of having both consumers and carers represented now in our committee. Therefore, transport and accommodation costs invoked for managing renal failure is very high on our list of priorities and that is why we felt it was important to come and present to this committee.

The CHAIRMAN: Terrific. Thank you. The general questions we have—you said that you have read some of the transcripts of evidence—relate to everybody's point of view of what they see as the efficiencies and deficiencies of PATS, so if you could talk to that from a renal point of view.

Dr Moody: From a renal point of view, wearing my hat simply as a nephrologist, I should also add that I work at a major teaching hospital, Sir Charles Gairdner Hospital, and I also provide a visiting renal service to the midwest—namely, to Geraldton—so I am very familiar with the pointy end of blue forms, which occupy a large percentage of your time. From my point of view, the system is relatively efficient in that I do not see what happens in a PATS clerk's office. They contact me occasionally, but basically I fill in blue forms. It is a relatively simple form to fill in, although there are some degrees of illogicality to it. To give you the main example that I find, when I am in Geraldton, I have patients visiting me from as far afield as Carnarvon and Meekatharra, for instance. They have travelled 400 kilometres one way, so they well and truly fulfil the PATS criteria. I am asked in that form could this not be a regional visit or telehealth, and it is. I have travelled 400 kilometres to get to Geraldton and I am not quite sure how I should actually respond to that. I always write, "This is a regional visit already", but patients still have to travel 400 kilometres to get there. Barring that, the blue form, if the patients bring it—of course, if they do not bring it, that can create a problem—I give it back to the patient. I assume the patient then deals with it appropriately. It is obviously in their best interests so to do, but I do not keep any copy of that, and I believe that has been an issue in the past.

However, I think the main concern that the Renal Health Network has is the expiry date of the PATS support scheme. You have heard of this already, but I wanted to really emphasise this today. Six months seems a very reasonable time to cover patients that are visiting specialists in Perth, it would seem. However, the term "visiting a specialist in Perth", if you are on lifesaving and life-sustaining therapy—namely, dialysis,—and you do not have an available spot in your regional centre, then you die or you stay in Perth, and it may take, unfortunately, longer than six months. I think that is an indictment on our system to some extent, and I am sure you have heard a lot of comment about that, particularly from Kerry Winsor. The government has done a good job in building more centres. We have a wonderful centre in Geraldton. It is not fully occupied, not because we do not have patients waiting in Perth, and I think we are going to hit that six-month benchmark very shortly, and I think we already have with one patient. Not only do we need the centres, which we did not have until recently, and we will always need more because there is a growth rate, particularly in regional centres, that is faster than the national average, and the national average is running at four per cent per year for patients entering dialysis programs, but also because we cannot get the staff to adequately fill them. I did not see that commented anywhere else. It is not only having the physical facility, the beds, the dialysis machines—they are relatively simple—it just costs money.

The nursing staff, and I know this from my experience in Geraldton—not all nurses want to work in renal medicine and you cannot force them to work in renal medicine and there is no incentive to encourage nurses to work in renal medicine, so you may well have the classic hospital with no

patients, as it were; you may have the beds and chairs there, but you may not be able to fully utilise them because you have not got the nursing staff to actually service that facility. I know that is a perennial problem in Geraldton and I am sure it must be the case in many other regional centres. Nurses who choose to work in regional centres are few and far between as it is, and many of them choose obs and gynae or general nursing or surgical nursing. It is actually the rare nurse who can be encouraged to go into renal medicine and do dialysis. In some ways it has some attractions for them: it is a very regular job; they are not working lots of night shifts and that sort of thing. But, by the same token, that sometimes is not the important aspect. Also, of course, that may invoke a financial penalty and they may be able to earn more as a general nurse on a ward than they can working in a dialysis unit—regular hours, eight to five, as it were. For all those reasons, one of the other vital things that we need to do is get more nurses working in renal medicine in regional areas.

[10.00 am]

The CHAIRMAN: You said that there is no incentive for nurses to work in renal medicine.

Dr Moody: There is no financial incentive over and above any other nursing job, no, which is procedural fairness, I suppose, in public service jobs, but we are desperately short of nurses in this area, both in the metropolitan area and in the regional centres.

Hon AMBER-JADE SANDERSON: How long is the specific training for renal nurses over and above the benchmark norm?

Dr Moody: To some extent I would have to take that on notice because I am not involved in training, but I think we are looking at three months or so to train a nurse to be competent in dialysis management—put needles in, run a machine and that sort of the thing.

The CHAIRMAN: So, it is just the nurses that look after the renal patients in these chairs throughout regional hospitals. You do not have to have a nephrologist present?

Dr Moody: Not for every dialysis, no. They are regarded as satellite dialysis units, so the nurse-to-patient ratio is at a lower level than it would be at a major public hospital dialysis unit, which reduces the cost to some extent. It means that these patients are already saving the government money.

The CHAIRMAN: Do you know what those ratios are?

Dr Moody: Yes, approximately, and it does vary from state to state and centre to centre and how many nurses you put on and that sort of thing, but approximately \$60 000 to run a satellite unit. The figure quoted in the Kidney Health Australia document is about \$79 000—something for an in-centre unit, which is the most costly, when they are in Perth; and when they are in a major teaching hospital, they are costing \$80 000. I have seen other figures quoting up to \$90 000 for that figure; it depends on how many hotel costs you roll into that and that sort of thing in the public hospitals—that is clearly the most expensive. The other thing to emphasise is that many of our dialysis patients, particularly in rural areas, are overrepresented on forms of home dialysis, be it peritoneal dialysis, which they run entirely in their home using a method of a tube in its own bag system, or home haemodialysis, where there is water and electricity available. That is more limited in most of our regional areas, but it is not impossible. They cost between—I have written the figures down here just so I would not forget—for home haemodialysis \$49 000 per year and for peritoneal dialysis approximately \$52 000 per year, and if you average that out, around \$51 000 per year for home dialysis. Those patients are saving the system nearly \$30 000 a year. If they spent six months in Perth for a dreadful illness and needed specialist care, that would cost the PAT scheme, excluding the initial travel, about \$11 000 for that six months, for instance, in a worst-case scenario. Overall, these patients are actually saving the system quite a lot of money and, therefore, I would argue fairly strongly that the six-month limit should be re-examined for dialysis patients.

The CHAIRMAN: You said in your opening statement that you had one patient coming very close to their six-month limit.

Dr Moody: That is from Geraldton only. Again, figures have been quoted in Kidney Health Australia, but from my own view they have had one patient stuck in Perth for five years and quite a number of patients—I think they mentioned 29 to 30 patients—well over six months staying in Perth.

The CHAIRMAN: They have had one patient from Geraldton here for five years?

Dr Moody: No, I am talking now statewide. I am quoting from Kidney Health Australia's document that you have already tabled. In Geraldton, we have generally been fairly fortunate in being able to get patients back within six months: somebody gets a transplant, moves to a different centre, whatever; we have a space and we can swap people in, but the pressure is increasing in Geraldton at the moment.

The CHAIRMAN: How many chairs in Geraldton?

Dr Moody: There are 10 chairs, I think.

Hon DARREN WEST: I had a question on that. If six months is inadequate, what would you see as a suitable term? Would you go to 12 months or leave it open ended, as long as it takes, and sort of hope that people do the right thing by the system?

Dr Moody: I would prefer the latter, obviously, because I do not think there is a figure one can set. We do not know what the pressures are going to be in the future to get people back to Kimberley, the midwest and all that. It really depends on the building program, the acknowledgement of growth and the number of nurses that can dialyse the patients. There are three variables, all of which are unpredictable. I think if we had it open ended that specified that it became open ended only for the sake of dialysis.

Hon DARREN WEST: Certainly. Secondly, you mentioned the shortage of nurses. Geraldton is my electorate, so I am fully aware of the situation there. Generally, across the state, would you say that we are 80 per cent covered in terms of nurses versus spots required? How close do we go to fully covering the number of nurses required in regional WA?

Dr Moody: In the metropolitan area, we are basically fully serviced, and in the regional areas, I really could not give you a figure, but to use a local example with which I am familiar, we can run a certain number of patients in Geraldton, which until recently has been just about adequate, with some people waiting a month or two before they can get back and that sort of thing, and we kind of live with that. So, it really depends on your definition. If there were enough patients and we had Geraldton fully open, then we would need more nurses. It is a somewhat elastic quantity. Once we get to that six-month point, we would certainly argue we need more nurses. We actually could do more dialysis in Geraldton. We have patients waiting; some of them are now breaching six months. We need more nurses to service that, absolutely, but I am sorry I could not give you a statewide figure.

Hon DARREN WEST: I will put it to you another way: would you say that the shortage of renal nurses in regional areas is acute? Is it at that stage?

Dr Moody: I think it is reasonable to describe it as acute, yes.

Hon JACQUI BOYDELL: Can you clarify whether you talking specifically in renal nursing?

Dr Moody: Yes; I am talking only about renal. I do not wear any other hats.

The CHAIRMAN: One of the things you did talk about was the blue forms, which we have all become quite familiar with—the blues, the yellows, and all those sorts of things. As we have been going around on this inquiry, we have been canvassing how that system could be improved. One of the things, it would seem to us, would be that if that was in electronic form, for instance, at the time of your consult with the renal patient as a nephrologist and you are assessing what needs to happen, presumably, you have a computer screen open at some stage anyway and you could start populating

a PATS form for that patient, which would then help you as you went along filling out the bits that you needed to. There is this issue, as you said, of people not turning up with their forms or where that form ends up, and whether you have a copy of it. Obviously, that would generate a number or a record identifier for that patient and then it can do its stages through the system, which would perhaps even alleviate issues of coming back to the doctor asking, “You said they needed taxi vouchers or air fares rather than train fares”, and things like that. Do you think that there would be some benefit in that? I do not want to seem like I am leading you.

Dr Moody: I have been through some of the submissions regarding this. From a purely personal point of view, ticking a few boxes, putting my signature on it and writing my address is a relatively quick thing to do. Yes, I run all my patients electronically. I have an electronic database for all my patients, so I have a computer screen open, but I would have to go to a different screen to do that form from the beginning, particularly if it were initially partially populated by the patient’s address, which the patients all do because I ask them to do that before they give me the form—they put their name and address on it and later I fill in the rest. I could probably, in truth, do it quicker than on a computer, but I understand the issues of a patient losing a form and it not getting back to PATS, and the financial consequences for them are large. In terms of feedback, I cannot think in living memory as a nephrologist of ever receiving a form back saying, “Why did you do this or why did you do that?” Perhaps that means I am not claiming enough!

The CHAIRMAN: Perhaps it means you are filling out the forms correctly!

Dr Moody: The patients seem happy with what I filled in. That has not been a major issue.

Hon DARREN WEST: That is useful, because you are the first person we have had at that third point of contact.

Dr Moody: Seeing the other side of the forms?

The CHAIRMAN: Yes, indeed.

Hon DARREN WEST: We have been in contact with PATS clerks and GPs. By the time it gets to you it is all sorted and it works.

Dr Moody: I must say that in Geraldton the PATS clerk being in the community health centre, if there were ever an issue—I think I have been around there and asked them about things on occasion—that has been very helpful to talk directly to a PATS clerk to make sure that I am doing the right thing, but I have never had one come back, as far as I am aware.

[10.10 am]

The CHAIRMAN: A gold star for you!

Dr Moody: Well, I do not know! As I say, maybe I am just not doing enough for the patients.

Hon JACQUI BOYDELL: Dr Moody, can I ask a couple of questions around Indigenous health? A lot of the anecdotal evidence we have heard, and certainly when I talk to people when I am out and about, is that for Indigenous patients, actually the amount of support that goes into assisting them—get the blue form, maintain a copy of it and get it back to their referring GP—is quite substantial in some instances.

Dr Moody: Yes.

Hon JACQUI BOYDELL: Do you ever see any issues for Indigenous patients in terms of those forms or are they accompanied, in your experience, by a carer travelling with them or someone from the Aboriginal medical service?

Dr Moody: Very frequently, they travel with a carer, with those long distances. If there are several people who have got to come to that clinic on the same day, they will have a car with two or three people in it, which is fantastic. Yes, I would say, “Do you have your blue form?” and if they do not, I think that is regrettable if they do not have it. So, yes, certainly, I do see some that are

forgotten. I am always happy to fill them in in retrospect because, as has been pointed out to this committee before, it is simply an acknowledgement the patient came. If they came, I am happy to write that three days later or a week later. I have got my electronic records that I have seen them, so I know that they have been seen. But that does not happen that often, I must say. I am sure it is a huge burden, and I do not see that back end of actually getting the patient there with the form. I only see it when they arrive and they give me the form, so I cannot comment on it. But I understand that it must be quite a degree of work. Of course, that reminds me—thank you—that many of the patients who do come to Perth and are using PATS services to see specialists in Perth, for instance, the cultural consequence to that, the movement away from their land and that sort of thing is just huge. They are almost certainly the ones that wait the longest, because they have a lot of medical issues that need to be sorted through; they need to be deemed stable enough to go back to a satellite unit where there are not doctors there all the time and where the nurse-to-patient ratio is reduced. They wait a huge amount of time and it must be just terribly soul destroying for them. Of course, if they cannot get into one of the well-known hostels around Perth, around our hospital I looked at the local costs of the Travelodge and those sorts of places where people are expected to stay, and they are well over twice the amount that PATS is currently paying per day. If they are here for a long time, it just financially destroys people.

The CHAIRMAN: Thank you very much indeed. That brings us to the end of this part of our hearing.

Dr Moody: Thank you very much for allowing me to present to the committee.

The CHAIRMAN: Thank you.

Hearing concluded at 10.12 am
