I invite the productivity commission to consider meeting with residents on Kangaroo Island to discuss the experiences we encounter with Isolation, The Kangaroo Island case study 2015 clearly outlines all the information needed to include our region on the special area list and I thank the Productivity Commision for the opening of the review in 2019.

Definition of remoteness

The state of being distant from something else, in particular from the main centres of population.

(As stated in the oxford dictionary)

Equity: the tax and transfer system should treat individuals with similar economic capacity in the same way, while those with greater capacity should bear a greater burden. – For example, a tax concession intended to compensate for a particular economic disadvantage should be designed so that only taxpayers affected by the disadvantage can benefit from it.

(as outlined by the Design principles for the tax and transfer system)

This report is set out by Lisa Thompson to indentify the remoteness of Kangaroo Island for the purpose of zone tax offset special area (ZTO), fringe benefit tax (FBT) and remote area allowance (RAA). There have been concerns by the residents of Kangaroo Island that the measures have failed to keep pace and since 1945, the changes to infrastructure, demographic isolation and the cost of living has changed considerably.

In 1982 the special area tax was introduced, places more than 250 kilometres from a town with more than 2500 people, as measured in the 1981 census.

Please note 250 kilometres from a town with more than 2500 people does not identify with the fact that water comes between the distance of Kangaroo Island and the mainland of Australia.

I am submitting this report for Kangaroo Island to be considered as most remote- Special area mostly due to the high cost of travel by Sealink (95% of residents use this ferry service to travel to the mainland with their vehicle or the use of the shuttle bus) . During strong winds the ferry service does not travel, leaving residents grounded either on the mainland or on Kangaroo Island, Preventing residents from attending important appointments, study workshops, medical services, and many other committments. Extra costs then include accommodation food and fuel.

MANY OTHER CONCERNS OF LIVING ON KANGAROO ISLAND INCLUDE:

SOCIAL AND ECONOMIC

https://www.abc.net.au/news/2015-07-02/kangaroo-island-cant-cope-with-families-sa-clients-liberal-mp/6589618

HAVING LESS MONEY DUE TO JOB SHORTAGES

Availability of Work The availability of work is a key factor in a region's future. Opportunities in the local labour market are central to a region's ongoing sustainability and its prospects for development. Over the last number of years there has been a significant and sustained decline and shift in employment opportunities available on Kangaroo Island. According to modelled estimates, net levels of employment on Kangaroo Island declined by 3.4 per cent over the period 2001 to 2013.23 Kangaroo Island's labour market has several other clear dimensions (refer to 'Labour Force Status' below): 🕐 relatively high labour force participation and low unemployment, however these characteristics are contributed to by the lack of job opportunities which leads many job seekers to leave the island looking for employment elsewhere. (Refer to 'Worker Outflow' below) 🕐 high rate of 'part-time' employment, incorporating extensive participation in a 'suite' of part-time jobs 🕐 seasonality – occupancy rates range from 70 to 80 per cent in summer to 30 to 40 per cent in winter24; and 🕐 relatively

very high proportion of 'contributing family workers' – indicative of a high level of agricultural employment and the highest amongst the reference group at 8.8 per cent.

The opportunities available to most residents are seasonal and relatively low-wage.

https://kangarooislandcommissioner.sa.gov.au/__data/assets/pdf_file/0008/249155/FINAL_The_Case_for_Kangaroo_Island.pdf

EVERYDAY ITEMS COST MORE IE: FOOD AND PETROL

DUE TO ADDED FREIGHT CHARGES

FUEL PRICE 161.90 DATED ON 24/03/2019

(listed on fuel spy website)

https://petrolspy.com.au/map/latlng/-35.66476772011836/137.63712776369448

Transport links to the mainland are a major constraint Above all, however, Kangaroo Island faces other challenges unique to island communities. Similarly-sized regional communities on the mainland don't have to rely upon sea transport for the shipping of goods and access to services that are nowadays mostly centralised in larger centres. Although KI is just 100 kilometres as the crow flies from the Adelaide CBD, getting there is a journey of over 4 hours that comes at a relatively great expense. As ground-truthed through interviews with local retailers, freight and passenger costs to and from the mainland are constraints in terms of the costs of goods, access to services and ultimately economic activity on the island. The SeaLink ferry service is widely considered too expensive, adding significantly to the cost of goods, inputs to infrastructure development and prohibitive for the island's residents to use to access services on the mainland.

Currently, the cost of a return trip with a passenger motor vehicle is approximately one half of the average weekly income of a Kangaroo Island resident. Air services operated from Kingscote Airport are presently hampered by the need to redevelop the runway to meet the requirements of modern fleets. Population

(The Australian Institute - 2015 Case study for Kangaroo Island)

https://kangarooislandcommissioner.sa.gov.au/__data/assets/pdf_file/0008/249155/FINAL_The_Case_for_Kangaroo_Island.pdf

RURAL AND REMOTE HEALTH

Australians living in rural and remote areas tend to have shorter lives, higher levels of disease and injury and poorer access to and use of health services compared to people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to a range of factors, including a level of disadvantage related to education and employment opportunities, income and access to health services.

Deaths & remoteness

Mortality rates in Australia increase with remoteness. In 2015, people living in Remote and very remote areas had a mortality rate 1.3 times as high as people living in Major cities (655 per 100,000 population compared with 522 per 100,000).

The higher death rates outside major cities, especially in remote areas, may reflect the higher proportions of populations in those areas who are Aboriginal or Torres

Strait Islander Australians. Indigenous Australians tend to have higher mortality rates and are more likely to live outside metropolitan areas when compared to non-Indigenous Australians [1].

Figure 1: Total deaths (age-standardised rate), by remoteness, 2015

Leading causes of death in rural areas

In 2015:

Coronary heart disease was the leading cause of death for all areas across Australia, with mortality rates 1.3 times higher in Remote and very remote areas compared with Major cities.

People living in combined Remote and very remote areas were 2.3 times as likely to die from diabetes, compared to those living in Major cities. Suicide was 1.7 times as high.

The rate of dying due to road transport accidents was more than 5 times as high in Remote and very remote areas than in Major cities (AIHW unpublished analysis of National Mortality Database).

References

ABS & AIHW 2008. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008. Cat. no. IHW 21. Canberra: AIHW.

Health conditions & remoteness

People living outside Major cities were more likely to have long-term health conditions including arthritis, asthma, back problems, deafness, long-sightedness, diabetes, heart, stroke and vascular disease. However, people living outside Major cities were less likely to be shortsighted. Rates of cancer, osteoporosis and chronic

obstructive pulmonary disease (COPD) were generally similar across all areas.

Proportions are not age-standardised, and in some instances higher prevalence may reflect the older age profiles in Inner regional and Outer regional/Remote areas.

'COPD' refers to chronic obstructive pulmonary disease.

'Blindness' includes partial and complete blindness.

'CVD' refers to heart, stroke and vascular disease.

References:

ABS (Australian Bureau of Statistics) 2015. National Health Survey: First Results, 2014–15. ABS cat. no. 4364.0.55.001. Canberra: ABS.

Access to health services

People living in Remote and very remote areas generally have poorer access to, and use of, health services than people in regional areas and Major cities. They also have lower rates of bowel cancer screening, higher rates of potentially avoidable hospital admissions, and lower access to selected hospital procedures [1].

In 2014–15, people living in Major cities were more likely than those living in regional and remote Australia to have visited a general practitioner (GP) in the last 12 months (86% compared with 83% in Inner regional areas and 84% in Outer regional and remote areas) [2].

In 2014, the full-time equivalent (based on total weekly hours worked) rate of employed GPs per 100,000 population was higher in Remote and very remote areas (137) than in Major cities (109); however:

the overall rate of employed medical practitioners (including specialists) was

lower (253 per 100,000 population compared with 409)

the number of GP services provided per person in Very remote areas during 2010–11 was about half that of Major cities [3].

Those living in Major cities were also more likely to have consulted a dentist in the last 12 months than people living in regional and remote areas of Australia (49% and 42%, respectively) [2].

People living in remote areas of Australia may need to travel long distances or relocate to attend health services or receive specialised treatment. For example, based on combined data for 2005–2010, 57% of people with end-stage kidney disease who lived in Very remote areas at the start of their treatment moved to less remote areas within 1 year.

In 2013–14, the rate for emergency hospital admissions involving surgery was highest for people living in Very remote areas (22 per 1,000 population) and fell with decreasing remoteness to be lowest among people living in Major cities (12 per 1,000).

References

AIHW 2016. Regional Australia Institute of health 2016. Australia's health no. 15. Cat. no. AUS 199. Canberra: AIHW.

Australian Bureau of Statistics (ABS) 2017. Health service usage and health related actions, Australia 2014¬–15. ABS cat. no. 4364.0.55.002. Canberra: ABS.

Duckett S, Breadon P & Ginnivan L 2013. Access all areas: new solutions for GP shortages in rural Australia. Melbourne: Grattan Institute.

LIMITED STUDY OPTIONS- THE CLOSING OF TAFE IN KINGSCOTE

Regional students to be hit hardest

One of the biggest talking points of the budget has been its impact on TAFE education services in South Australia.

link:

https://www.abc.net.au/news/2018-09-05/sa-state-budget-doctors-tafe-housing-rent/10201192

LIMITED SERVICES DUE TO TAX CUTS

Government cuts to Kangaroo Island region

Links: the link shows tax cuts on Kangaroo Island in the budget

https://www.abc.net.au/news/2018-09-04/sa-budget-cuts-jobs-spending/10198636

EXPENSE OF TRAVEL COSTS ON AND OFF THE ISLAND

Fares for Ferry 2019

Ferry ($AUD)

Standard Ferry Fares

Passengers One Way $49

Return $98

Child One Way $25

Return $50

Australian Student One Way $40

Return $80

Australian Concession One Way $40

Return $80

Infants Free of Charge

Vehicles

One Way $98

Return $196

https://www.sealink.com.au/kangaroo-island-ferry/fares/

LIMITED CHOICE OF SERVICES FOR THE ELDERLY AND

DISABILTY.

NO TAXI SERVICES

No Uber or Taxi services on Kangaroo Island

I STARTED A PETITION FOR THE REMOTE AREA ALLOWANCE IN 2016, I FIRST PETITIONED ONLINE VIA FEDERAL PARLIAMENT AND POSTED THIS VIA MY FACEBOOK PAGE.

REBEKHA SHARKIE AND HER TEAM BECAME AWARE OF MY PETITION ON FACEBOOK, NOT LONG AFTER A MEMBER OF HER TEAM EMAILED ME. REBEKHA

AGREED TO JOIN THE PUSH FOR ASSISTING WITH THE HIGH COSTS OF TRAVELLING ON AND OFF KANGAROO ISLAND.

IN 2013 MY DAUGHTERS BOTH WORKED IN ROXY DOWNS AND THIS IS HOW I FIRST FOUND OUT ABOUT THE $1173 SPECIAL AREA TAX REBATE. I COULD NOT UNDERSTAND WHY ALOT OF TOWNS IN AUSTRALIA WERE RECEIVING THIS SPECIAL AREA REBATE, WHEN THEY DID NOT SEEM AS REMOTE AS KANGAROO ISLAND EG. CANBERRA, TOWNSVILLE, CAIRNS AND MACKAY

REBEKHA SHARKIE HAS WORKED HARD TO HELP US ALL START A REVIEW FOR KANGAROO ISLAND TO BE INCLUDED ON THE TAX ZONE LIST.

Lisa Thompson (Resident of Kangaroo Island)

A GP from Kangaroo island medical Clinic has indentified below the model used by the medical system on Kangaroo Island.

PLEASE NOTE THE CLASSIFICATION IS MM7 - VERY REMOTE

Q: What is the Modified Monash Model?

A: The Modified Monash Model is a new classification system that better categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and town size. The system was developed to recognise the challenges in attracting health workers to more remote and smaller communities.

Q: How can I find the classification of my location under the Modified Monash Model?

A: You can find the classification of your location by using the Modified Monash Model locator.

Q: How are the categories different to the current model?

A: The previous model was the Australian Bureau of Statistics (ABS) remoteness classification

system, the Australian Standard Geographical Classification - Remoteness Areas (ASGC-RA 2006), which was based on residential data from the 2006 Census. The ABS has now updated their remoteness classification system to the Australian Statistical Geography Standard - Remoteness Areas (ASGS-RA), which uses the latest residential population data from the 2011 Census to determine the five remoteness categories. The Modified Monash Model uses the ASGS-RA as a base, and further differentiates areas in Inner and Outer Regional Australia based on local town size.

A summary of the current classification and the new classification can be found below.

ASGC-RA (2006)

RA1 – Major cities

RA2 – Inner Regional

RA3 – Outer Regional

RA4 – Remote

RA5 – Very remote

Modified Monash Category

Inclusions

MM 1

All areas categorised ASGS-RA1.

MM 2

Areas categorised ASGS-RA 2 and ASGS-RA 3 that are in, or within 20km road distance, of a town with population >50,000.

MM 3

Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.

MM 4

Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 or MM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.

MM 5

All other areas in ASGS-RA 2 and 3.

MM 6

All areas categorised ASGS-RA 4 that are not on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

MM 7

All other areas – that being ASGS-RA 5 and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

Q: Why is the change required?

A: There has been much criticism from rural doctors and rural communities that the ASGC-RA (2006) system implemented in 2010, which is used to determine eligibility and incentives under a range of health workforce programs for doctors working and training in rural areas, was creating perverse incentives for doctors to move to large, coastal towns, and did not recognise the challenges of recruiting doctors to small rural towns.

For example, doctors would receive the same incentives to move to Townsville, a coastal town with a population of approximately 172,000, as they did to move to Charters Towers, an inland town with a population of approximately 8,000.

Q: Why choose the Modified Monash model?

A: The Modified Monash model was developed by eminent rural academics at Monash University and was modified following consultation with key stakeholders. It is a consistent and well-understood system supported by the best available evidence.

Q: How will small towns in close proximity to larger towns be classified?

A:The Rural Classification Technical Working Group (RCTWG), established to consider the implementation of the Modified Monash Model, provided recommendations on the size of the buffer zones around larger regional towns to ensure equity at a local level. The buffer zones themselves are based on road-distance calculations provided by the Australian Population and Migration Centre.

Q: When will programmes start using the Modified Monash Model

A: One of the first programmes to transition to the Modified Monash Model was the General Practice Rural Incentives Programme (GPRIP).

Over time, the Government will consider the transition of other health workforce programmes.

Modified Monash Category	Inclusions
MM 1	All areas categorised ASGS-RA1.
MM 2	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are in, or within 20km road distance, of a town with population >50,000.
MM 3	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.
MM 4	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 or MM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.
MM 5	All other areas in ASGS-RA 2 and 3.
MM 6	All areas categorised ASGS-RA 4 that are not on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.
MM 7	All other areas – that being ASGS-RA 5 and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

In general terms, rural patients (across Australia) suffer from worse health outcomes, due to a mix of socioeconomic determinants of health, lack of access to services, cost (especially travel) and the insufficient medicare rebate from Government to patients, I am emphatically in favour of the remote allowance.

My concern is that PATS, good as it is, does not meet many of the discrepancies caused by the water gap. Health services on island per se may be fine but accessing the next level (specialist care etc) is highly costly and stress inducing and hence discriminatory towards islanders.

GP (Kangaroo Island Medical Clinic)

FOR THE PURPOSE OF MOTOR REGISTRATION KANGAROO ISLAND IS INCLUDED AS AN OUTER AREA.

DEPARTMENT OF PLANNING TRANSPORT AND

INFRASTRUSCTURE.

Outer areas concessions include:

Kangaroo Island

District Council of Coober Pedy and Roxby Downs

all other parts of South Australia that are not within a municipality or district council area or Iron Knob.

The benefit includes:

50% reduction in registration fees - valid for vehicles with a gross vehicle mass less than or equal to 4,500 kg

40% reduction in registration fees - valid for vehicles with a gross vehicle mass over 4,500 kg.

The concession covers most vehicles, motorcycles or trailers that are usually kept and used wholly or mainly in outer areas.

https://www.sa.gov.au/topics/driving-and-transport/motoring-fees/registration-and-licence-concessions

A letter from a local resident Anne A'Herran American River, Indicating health concerns and the experience of living in an isloated region of Australia (Kangaroo Island)

1. Carer costs

Case: Because of spinal degeneration exacerbated by injury I am in severe pain and cannot walk further than 10 metres. I cannot sit for an hour without pain. I cannot carry any weight including my own luggage.

My husband has to travel with me. As my condition is I hope short lived, since a fall Oct 16 (documented) I have not applied for any disability funding and wouldn't know how. My husband does everything for me, and is effectively my carer, until my recovery. I have surgery booked for March 27 & July 2019. At the moment, and for some unknown length of time, travel for both of us is a largely out of pocket cost, not to mention fraught.

Mainlanders would not suffer the discriminations I face. Yet I am not speaking selfishly for myself here. I am speaking on behalf of the many islanders in the same

boat.

On March 27 I have to be at the Memorial at 11 am for admission.

My husband has booked a hotel near the hospital for March 27 to 30 so he can visit me.

We are taking the car over as it has good suspension: my spine has to be cushioned and the bus is not acceptable as it is too bumpy. As well, we would get in too late for admissions (it gets in 11:30-12).

Alternative 1 would be one way plane flights for us, between $180 -$340 each. But morning flights do not arrive on time for my admission. The one way cost each, for husband and for me, with cab from airport to hospital would be (depending on availability) between $200 and $360 per person.

If husband flies to Adelaide with me, he has only the coach ferry option for return, cost for him only being a further $32.

Cost car, driver and passenger one way approx $160 by ferry & car, $200-300 for one way flight option

Return cost as you see above.

Cost husbands hotel (cheapest!) 3 nights $360

Can you imagine how inadequate PATS is to address all these options?

And for those of us who fail to comply with the PATS requirements, there is no course to any remote allowance, as do those on the mainland, who do get a remote allowance, and have few of the difficulties of the water gap that KI folk deal with constantly.

2. The surgeon's rooms estimate anywhere from 3 to 7 days in hospital for rehab post surgery, for this procedure. There will be longer recovery in hospital for the fusion, but I shall just take you through our travel options for the present one.

Does my husband stay with me for the full 3-7 days? This is highly problematic for us as he will be paying for hotel accommodation in Adelaide and it is expensive. But the travel options make it even more difficult.

1. He will have with him the car. As noted I cannot catch the coach from Cape Jervis to Adelaide. I can barely survive the car drive with special modification. He will have to return with it, by ferry. That cost will be approx $100 and PATS will not reimburse it. How they think he can get home is beyond us. Swim? So drive and ferry it will have to be.

2. The return journey for me after laminectomy, foramenotomy, discectomy and rhyzolisis has to be by plane. A 5 hour drive is NOT recommended for me. It can be done but is NOT preferable.

No mainlander would even have to consider a 5 hour drive post this procedure.

3. If my husband stays for fewer than the 5-7 days, for example 3 days, after which I will not be in need of physical or emotional support, I will lose him as carer on the home journey, but I will be

physically ready to go on a flight, though not a 5 hour drive. I can find a carer (her cost) for the Hospital to airport sector. Husband will return home to KI, to collect me at the island airport for my 30 minute drive home.

NB In this case, as I am not allowed to be discharged without a carer, a trip from

the Memorial to the airport with my niece (who will have to take time off work) as carer ($35), 20 min flight, husband collecting me from airport and a 30 m drive home is preferable, according to my surgeon, to a 5 hour journey by coach, ferry and car.

4. The alternative is logistically impossible: that my husband stay at the hotel accommodation for the full 5-7 days I am in hospital, so that he can take me to the airport, leave me there, drive down to the ferry, catch the ferry over, then somehow meet me at Kingscote airport and drive me to our American River home. Not necessary, and not logistically possible!

The problem is that PATS will not reimburse us for my husbands return travel with car, because I will not be with him. In my experience I doubt that they will reimburse my flight, they will only reimburse only the cheaper option, ferry.

I have now a battle to find that out.

Mainlanders with their remote allowance have none of this.

PATS does not adequately cover real costs.

Why do islanders not get the remote allowance to compensate for the many discrepancies

I hope this narrative helps you to see how fraught travel for islanders can be.

2. PATS Approval for Specialist access for emergency is over reliant on GP signature

Case: My husband had severe stomach pain and other symptoms that the KI GP could not diagnose. Neither did the gp admit to any need for mainland specialist and would not add a tick of approval to the PATS form p. 2. As a result, husband would have had to wait months for the specialist visit to KI. Due to severe pain and discomfort he opted to visit mainland specialist immediately. He ended up requiring a gut resection due to a very hard-to-diagnose Meckels, which was strangling the small intestine. This is a case where the patient had a need for a specialist, but the GP was unable to sign off. My husband has been unable to claim on his subsequent visits to the specialist, in particular for the subsequent hernia repair on that procedure. He is still in need of the specialist advice and management but because the GP was unable to sign off and has left the practice PATS is not available. My husband has given up trying to recoup anything from PATS - he is too busy with his volunteer roles for that battle - but it is not right that other islanders are put under this kind of stress, continually.

These are costs and stress not borne by mainlanders.

3. Visitation by specialists to KI is unreliable and untimely, prompting may islanders to seek mainland specialists, not reimbursed.

Case: My endocrinologist visits KI when the specialist feels like it, or so it seems. the specialist doesn't give forward noticeand so The clinic doesn't give forward notice. I have severe osteoporosis (-3.0 lumbar and femoral neck). Apart from not being able to have certain dental work done by other than the nonexistent endodontist, I need to know how my T Score is going.

I suffer from repeated compression fractures of the spine and spine instability, with severe pain and debility requiring epidural injections over the past two

months, and as of next week spinal decompression on two segments (51012) and as of July spinal fusion (at the Memorial Hospital Adelaide). I need more connection with my endocrinologist regarding my bone density progression but failing a visit in the near future, I may seek an Adelaide based specialist who can assess and treat more regularly. This will come at my own cost in terms of extra travel and accommodation, unrecoverable from PATS as I should be using the rare! island specialist visitation. Another cost (not to mention stress) borne by islanders, not mainlanders.

4. Mainland Appointment time does not always accommodate travel times, requiring accommodation overnight

Often the appointment time excludes same day ferry travel and one is obliged to get overnight accommodation. Yes, if you are a pensioner, PATS will cover your accommodation. But for islanders who are not pensioners, many of us? Overnight the cheapest accommodation is the CWA Kent

Town, $84. One needs a cab to get there from the specialist and next day, from there to the coach terminal: $25-30. Total cost to an islander that a mainlander does not have: $120.

These are costs and stress not borne by mainlanders.

5. Pension requirement for PATS Accommodation

As noted, There is no No PATS allowance for accommodation for those not on the age pension. Mainlanders whether pensioner or not, have their own homes as a base when they visit a doctor, dentist, specialist. We have no home base within 400 k of our specialist. Pensioner status or not on the mainland, you don't have to

pay for taxis and accommodation. Islanders do.

These are costs and stress not borne by mainlanders.

6. Dental care is limited on island.

* Two dentists practice on KI. Due to patient load they are not always available readily. This has forced many islanders to seek a dentist on the mainland in order to get timely attention. The cost of travel and accommodation for those trips, necessary as they are, is out of pocket and above what mainland people have to endure. And not covered by PATS, of course.

* Endodontists do not exist on KI. I have taken Fosamax for over a decade on the advice of two successive endocrinologists. Fosamax is recognised by dentists as a precursor to jaw necrosis, so if I have certain kinds of dental work esp on my top jaw I am compelled to visit an endodontist. There is none on island. I have to travel to the mainland. This is a cost PATS does not cover, it is all on me. Often the appointment time excludes same day ferry travel (as note below) and I am obliged to get overnight accommodation. The cost of endodontic care is therefore not only the cost of the endodontist: it amounts to a return trip via ferry coach and shuttle ($62) plus Accomm overnight (CWA Hostel Kent Town $84). Total $146. Plus taxi from specialist to accom, and next day taxi from accommodation to terminal $30. Total approx $180.

These are costs and stress not borne by mainlanders.

7. Mainland transport for disabled to specialist visits.

For Islanders, ferry/coach/shuttle, or flight.

* If one takes a car on the ferry (the only means of getting from KI to mainland and back) there is a cost of driver and car of approx $200 return. If a person is disabled there is the additional cost of $62 for that - often senior - passenger. Total trip: approx $260.

These are costs and stress not borne by mainlanders.

* IF one does not take a car, flight is one option, but expensive, and it may or may not be reimbursed by PATS. Then there is the taxi

* If one does not take a car, but travels by coach or plane, taxi costs are a burden. This is especially so for disabled and elderly islanders and it is not recoverable by PATS. Taxi costs when one doesn't take car (because one needs a carer, or is disabled enough to have difficulty walking and carrying luggage), are usually in the realm of $50 or less. (Taxi from KI Coach terminal to specialist, and return, approx $30). But taxi fares are not recoverable by PATS. It is possible to catch buses for the able and capable but many islanders are elderly and impeded by arthritis or similar disabilities. And that smaller cost is in recoverable by PATS. Another out of pocket cost that goes under the radar for islanders. The elderly and disabled are unable to navigate or to negotiate a timetable in a city we are not used to.

These are costs and stress not borne by mainlanders.

TO conclude:

We accept many of the things that set us apart from the mainland. We accept that we have no cinema, no traffic lights, only one chemist, only one clinic, and so on.

We don't mind, we live with that. We love this island enough to choose to live here. Then we get old, and sick. We suffer stress and financial hardship because of the water gap, as mainlanders - many on remote allowance - do not. Mainlanders with their remote allowance have none of this.

PATS does not adequately compensate.

Why is it that islanders do not get the remote allowance, when Townsville, with a population of 270000, 2 major hospitals, busy urban centres, sports stadia, transport systems, schools and magnificent health services and every other amenity under the sun, does?

I hope my stories here, though anecdotal, illustrate the problems of remoteness we suffer here on KI. Data is abundant. Anecdotes like mine can fill the gaps in understanding of the real problem.

letter from Anne A'Herran, resident of American River.

REBEKHA SHARKIE WELCOMES REVIEW INTO TAX HELP FOR KANGAROO ISLAND

Federal Member for Mayo Rebekha Sharkie has been advocating for the inclusion of Kangaroo Island into the Government's tax concessions for remote communities since 2016 and welcomes today's announcement of a Productivity Commission review in remote tax assistance.

“This is something I have been advocating for since coming into office because I believe it is incredibly unfair that people living on the Whitsunday Islands can claim tax concessions but Kangaroo Island residents cannot,” Rebekha said.

“I am also pleased to see that the review will involve broad public consultation when it begins in February next year because I know the island community will definitely respond.

“When I first began working on this issue a petition calling for KI to be included in the tax offset zone was organised by local Lisa Thompson and was signed by about 10% of the island’s population, nearly 500 people.”

Treasurer Josh Frydenberg announced the review into remote tax assistance this afternoon, saying there were concerns the concessions had “failed to keep pace with a changing Australia”.

The Zone Tax Offset, Fringe Benefit Tax remote area concessions and Remote Area Allowance provide financial support to people living in remote areas of Australia.

The locations eligible for these forms of assistance are determined by geographic 'zones', defined in tax legislation, which have remained largely unchanged since they were established in 1945.

Rebekha has been meeting with relevant Ministers since taking office in 2016, arguing that Kangaroo Island should be included in the tax area known as Zone B.

Zone B compensates for geographic disadvantage and could put between $57 and $1600 in the pockets of individuals and families on Kangaroo Island.

Two-parent families could be eligible for rebates of between $376 for their first child or student and $282 for each subsequent child, depending on their age and education status.

“On a map, Kangaroo Island might look close to Adelaide ‘as the crow flies’ but its residents experience significantly higher costs of living because of their isolation on the other side of Backstairs Passage,” Rebekha said.

“Everything from food and fuel to medicine and higher education costs more because of the high transport costs to and from the island and the lack of market competition.

“If King island in the Bass Strait can be classified in the Zone B for tax concessions, along with major urban centres such as Cairns, Townsville and Broken Hill, then Kangaroo Island warrants inclusion.

http://www.rebekhasharkie.com.au/rebekha_challenges_government_to_deliver_tax_relief_for_kangaroo_island