SUBMISSION

to the

National Senate Inquiry into operation and effectiveness of Patient Assisted Travel Schemes (PATS)
2007

Prepared by the Kimberley Aboriginal Medical Services Council Inc.
on behalf of the
Kimberley Regional Aboriginal Health Planning Forum

Introduction

The Patient Assisted Travel Scheme (PATS) provides considerable support for Kimberley clients requiring access specialist and other services which are not provided in their own towns and communities. However, the current system fails to adequately meet the need for our clients. This paper provides an overview of the major concerns raised over many years by individual health service providers, clients, communities and governing councils of Kimberley ACCHS.

In particular, it provides a summary of (1) the major shortfalls identified in (a) the PATS guidelines themselves, including gaps in patient support which can not be met by clients at particular socioeconomic and geographical disadvantage, yet are not currently met by either the State or the Commonwealth; and (b) the administration of the PATS system itself; as well as (2) recommended changes to the PATS system to address the some of the current shortfalls.

Unless otherwise stated, "PATS" in this paper refers specifically to the Western Australian PATS Policy Guidelines (2004).

Gaps in the current PATS scheme for remote clients

Section 2: Conditions for eligibility for PATS

Section 2 of the PATS guidelines outline a number of categories of eligibility, some of which are addressed here in turn:

2.1.2 Distance traveled

PATS support is limited to clients traveling over 100km. This is an arbitrary cut-off which disadvantages clients who may be within the 100km limit but for whom the cost of travel may be significant. For many Aboriginal communities transport options are limited, fuel is costly, roads may be challenging and / or impassible during the wet season, and accommodation options in the town where services are located may be limited and expensive. In the Kimberley, examples where this rule poses a potential barrier to care

includes clients from a community such as Pandanas Park traveling to the nearest services in Derby, or patients in Wyndham needing to travel to Kununurra.

Recommendation: The 100km limit should not apply to patients living in rural and remote towns and communities who otherwise meet the criteria for PATS eligibility

2.1.7 Escort eligibility

The guidelines provide for a subsidy for an escort provided it can be demonstrated that:

- The patient is a dependent child
- The escort is legally required to make decisions on behalf of the patient
- The patient requires significant assistance with daily living beyond the resources that can reasonably be made available during the journey and /or at the receiving centre; or
- The patient is in a life threatening situation

These guidelines do not adequately cater for Aboriginal clients whose first language is not English, and / or who are unfamiliar with a city such as Perth. This is the case for a significant number of Aboriginal people, particularly those living in remote communities, who may appear to have a working grasp of English and are deemed ineligible for escort support. In many instances, the experience of being “out of country”, having to interact in a language which is not their language of choice, in a cold and foreign environment, is intensely alienating and disempowering, and potentially jeopardizes their care. In addition to the adverse impact this has on the individual, there is also wider fall-out. Kimberley health providers spend much time and emotional energy trying to advocate from a distance for clients who can not do so for themselves. Families and communities also experience the fall-out, witnessing from a distance the distress experienced by the patient and themselves developing a reluctance to travel for health care when the need arises.

The particular experience of Aboriginal people dislocated from the familiar environment of home and country to access health care has been well-documented, along with the

importance of escorts / carers and the particular difficulties faced by escorts/ carers in these circumstances.[1].

The PATS guidelines currently state that:

"If the referring medical practitioner specifies that an escort is required for a reason other than a medical reason (for example, social reasons) then eligibility for the escort must be determined by a suitable, clinical health service employee, such as the HSM/DON". It is not appropriate that the decision rests with a (hospital) health administrator who is unlikely to have any first-hand knowledge of the patient and their circumstances.

Decisions regarding a patient's need for an escort, as well as the choice/ suitability of the escort, are most appropriately made by the regular health care provider(s) in conjunction with patient and family. In fact, it could be argues that the need for a patient to be supported by family or friend should be assumed rather than require special justification, in the best interests of their physical and emotional well being, as well as facilitating the task of the treating health providers. This applies to all patients needing to travel to a distant site for health care, but has particular importance for Aboriginal clients living in remote communities of WA.

The current PATS guidelines also make no allowance for change of escorts where a patient is required to remain away from home for extended period to access treatment. For Kimberley patients, the situation arises commonly for patient with end stage kidney disease accessing dialysis services. Patients are living 3000km from their communities for periods of months to years, which poses an immense burden on the chosen escort/ carer.

[1] McGrath P and Patton M. Relocation for specialist treatment for Indigenous people: escort issues. 2006. *Journal of Rural and Tropical Public Health;* 5: 16-26.

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In many instances, the escort / carer simply requests a break, with a period of time back in their community while another family member temporarily assumes the role. There is no allowance in the guidelines for this situation, with approval being at the discretion of the WACHS Regional Director. This poses an unnecessary administrative burden on the system, and with the lack of assurance of relief, provides a disincentive for escorts to travel in the first instance.

In some instances, it may be appropriate for the escort/ carer to participate in the role of interpreter for clients whose first language is not English. However, this can not be assumed and formal interpreter services should be available and offered for all clients whose first language is not English. Our experience is that this is not the case for Aboriginal clients at present and in many instances, false assumptions are made about their level of comprehension – a source of distress for the patient as well as potentially jeopardizing their quality of care.

Recommendation: Patient eligibility for an escort is taken on recommendation from the referring practitioner

Recommendation: PATS assistance is guaranteed for a change of escort where a patient is required to remain away from home for an extended period of time. A change of escort should be funded up to twice within a 6 month period, with a minimum period of 4 weeks between escort change. In addition, allowance should be included for exceptional circumstances such as a requirement for an escort to return home for a funeral / sorry business.

Recommendation: All clients for whom English is not the first language are offered the use of formal interpreter services, regardless of whether they are accompanied by an escort / carer.

2.2.2 Eligible specialist services

Lack of eligibility of dental services

Lack of access through the PATS system to dental services, other than for approved oral surgery or cleft lip/palate services is a major shortcoming in the PATS guidelines. For many people living in areas such as the Kimberley, there is no access to dental services in their town or community of residence and without support to offset travel costs, access to dental services is non-existent (see appendix 1 – Status of dental services in the Kimberley).

Timely dental care is essential for quality of life (addressing causes of dental pain, providing timely care to prevent disruption or loss of dentition). The link between poor dental health and chronic disease is well recognised, and prevention of complications of illness such as valvular heart disease is assisted by regular dental review and care.

Aboriginal people living in the Kimberley suffer high rates of rheumatic fever and rheumatic heart disease. Routine dental care is critically important in patients with a history of acute rheumatic fever and/or rheumatic heart disease. All patients when diagnosed should receive education about oral hygiene, and need to be referred promptly for dental assessment and treatment as required. This is especially important prior to valvular heart surgery, when it is essential to investigate and treat appropriately all oral/dental pathology in order to minimize the risk of infective endocarditis in both native and prosthetic cardiac valves, both potentially life threatening conditions.

National guidelines currently recommend “dental check and ongoing dental care…..is critical in the prevention of endocarditis. As patients without rheumatic valve damage may still be at long term risk of developing rheumatic heart disease, particularly in the event of recurrent episodes of acute rheumatic fever, dental care is essential, regardless of the presence or absence of carditis”[2]. Their recommended care plans include yearly dental review for all patients who have had acute rheumatic fever. Clearly the more

[2] Diagnosis and management of acute rheumatic fever and rheumatic heart disease in Australia: an evidence-based review. 2006. National Heart Foundation of Australia (RF/RHD guideline development working group) and the Cardiac Society of Australia and New Zealand

severe the damage to the heart from the initial episode of acute rheumatic fever, the more vital this becomes. This is reflected in the Kimberley region's protocol for the management of rheumatic heart disease (www.healthykimberley.com/chronicdisease).

Lack of adequate provision of dental services in or near to rural and remote clients' places of residence underlies the problem and requires fundamental solutions outside the PATS system. However, in the absence of services close to home, it is imperative that clients in rural and remote areas be able to access dental care elsewhere and to have the costs associated with travel and accommodation covered.

Recommendation: All dental services, both preventive and curative, are considered PATS-eligible services, with travel and accommodation costs covered for patients who re required to travel to access such services.

2.2.4 GP Proceduralist

The exclusion of eligibility for PATS support for patients requiring any of the listed procedures where a general anesthetic or major block is NOT required poses a significant barrier to appropriate care for patients in remote communities where a GP is not resident. In a number of remote communities across the Kimberley, visiting GP services are provided once or twice a week and from time to time, patients will need to travel rather than risk worsening of their condition (pain, sepsis, etc).

In most instances where the listed procedures are required, RFDS evacuation is inappropriate given the medically stable condition of the patient and the enormous costs associated with an air evacuation. However, the cost of patient travel must then be borne either by the patient or family themselves, or by the local community clinic which is not funded to provide such a service and which takes both a vehicle and a staff member out of the community.

Recommendation: These exclusion criteria are removed, so that clients needing to travel to access GP-type procedures but NOT requiring a general anesthetic or major regional block are able to do so with travel and accommodation costs met through PATS

Section 3: Assistance provided

There is no allowance under the PATS scheme for a meals / incidentals subsidy. For many patients who are socio-economically disadvantaged, finding funds usually with short notice to purchase individual food supplies (as distinct from the much smaller cost of sharing communal food supplies at home) poses a barrier to travel. While agencies such as Centrelink and DCD may be able to provide assistance, this adds a number of extra steps to the preparation for travel and securing this assistance in a timely manner may not be feasible for patients, particularly those in remote communities and with short notice. There are also inconsistencies in the way in which this assistance is applied from one site to the next and from one patient to the next. Lack of adequate funds for food whilst away accessing health services, sometimes for long periods, compounds the already marginal nutritional status of patients from poor socio-economic backgrounds.

Recommendation: A meal/food subsidy should be included in the support provided for patients eligible for PATS assistance.

3.1.1 Contribution rate for non-concession card holders

The requirement for the $50 patient contribution to be made up-front prior to travel “unless otherwise negotiated” poses a potential barrier for families who may not be eligible for a Health Concession Card yet struggle financially and may not have cash available at short notice. The additional financial burden on the patient / family of having to travel (meals, accommodation costs above the subsidy level) add to these constraints.

Recommendation: The requirement for up-front payment of the patient contribution for non-concession card holders should be removed from the guidelines

3.2.1 Fuel subsidy

The fuel subsidy is provided at a flat rate which in no way reflects the true costs of fuel, particularly in rural and remote towns. For example, the cost of fuel in a number of remote Aboriginal communities in the Kimberley is currently around $2.50 per litre. There is no public transport, and if a patient uses their own (or family member's) vehicle (of which there are few) their reimbursement amounts to less than half the true cost of fuel for the journey to the nearest larger town, an added disincentive for patients to travel. Although a higher fuel subsidy is provided where, for example, a clinic vehicle carrying a number of passengers is utilised, the reimbursement does not adequately compensate the true cost of fuel in remote towns and communities, let alone the cost of the driver/ clinic staff who are required to provide the travel.

Recommendation: The cost of fuel for PATS eligible travel should be fully reimbursed

3.2.6 Assistance with taxi fares

The eligibility criteria for receipt of taxi vouchers are too restrictive, and according to current PATS guidelines, decisions regarding eligibility are made at the discretion of the PATS clerk in consultation with a HSM / DON. Again, it is not appropriate for a hospital HSM/DON or PATS clerk with no knowledge of the patient and their physical and social needs to be the arbiter of such decisions. The experience of many health providers in this region is that there is inconsistency in the way the guidelines are interpreted and applied, and patients/carers who can advocate for themselves, or have a service provider advocating for them, are much more likely to be given taxi vouchers than clients without such skills /support.

Recommendation: Assistance with taxi fares should be provided automatically for all eligible PATS clients who meet the criteria outlined, with clauses granting discretion which may limit access ("PATS clerks…may determine", "taxi fares may be met" etc) removed from the guidelines

3.3 Accommodation subsidy

3.3.2 Escort eligibility for accommodation subsidy

In virtually all cases where an escort is required for assisting the patient's transport, the escort is also required to support the patient during their stay in the town where treatment is being accessed.

Recommendation: Eligibility for escort accommodation should be granted automatically at the same time as the escort is deemed eligible for PATS travel support.

3.3.3 Boarders at KEMH

Recommendation: Where a child / infant is seriously ill and the mother is accommodated as a boarder, the partner/ other parent should be automatically eligible for PATS support for travel and accommodation with no limitation placed on the period of accommodation eligibility

(guidelines currently limit stay to 10 days, with further 10 days dependent upon decision of a regional delegate).

3.3.4 Accommodation assistance payable

The level of assistance provided is inadequate. Where hostel accommodation is available, the maximum level of subsidy is usually appropriate. However, pressure on hostel accommodation, in Perth and to an even greater degree in regional towns across WA, is extreme and alternative options are limited.

In Broome, the Kimberley Satellite Dialysis Centre provides specialised support services for e.g. clients on peritoneal dialysis (PD) who require periods of review and re-training, as well as support for PD clients who require hospitalisation or more intensive outpatient care during periods of inter-current illness. This now poses a major problem for patients when there is no hostel accommodation available (which is now the usual situation) and

patients are therefore accommodated in a hotel, which despite being at the cheapest end of the range, costs 2-3 times the maximum PATS subsidy. In two recent cases, the patients were left with bills of four figures which they were unable to pay, and local ACCHS ultimately bore the cost.

In Halls Creek, where there is no hostel accommodation, women and children from remote communities who require an overnight stay while awaiting care in Halls Creek, or connections for transport to larger centres, are routinely accommodated in the women's refuge while men are put up in boarder beds at the local hospital. When these options are not available, the next alternative is hotel accommodation at 3 times the rate of the PATS subsidy.

Patients who are not able to access services close to home should not be financially penalised. People living in rural and remote areas suffer higher levels of morbidity and mortality than their urban counterparts, and have lower access to health resources generally. The burden of both acute and chronic illness is highest and access least for Aboriginal people[3]. There is ample justification for directing resources towards improving access for rural and remote clients to all levels of health care.

Recommendation: The real cost of accommodation for PATS eligible clients should be met in full

3.3.6 Extended periods of Accommodation Assistance

The guidelines state that "after 6 months a patient is considered to have changed their permanent address and should be expected to relocate into permanent accommodation". In most instances this applies to dialysis patients.

[3] Australian Institute of Health and Welfare (AIHW) 2006, *Australia's Health 2006*, AIHW, Canberra.

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In the Kimberley, the vast majority (99%) of patients requiring dialysis are Aboriginal. Very few patients remain in Perth by choice, staying only as a result of the lack of services available in the region. Many of the patients dialysing at the Kimberley Satellite Dialysis Centre in Broome are not from Broome, and again are there only because of the lack of services closer to home. For some clients, Broome is still 800km from home. The occasional client has grown used to Perth or Broome and chosen to make this their permanent home – for all others, the notion is anathema.

In making the determination that the town where a patient accesses care automatically becomes their place of residence after 6 months, the PATS guidelines exclude these patients from any support to return to what they will always consider to be their home.

For patients undergoing dialysis in Broome, options for "permanent accommodation" are now severely limited, with public housing in limited supply and waiting lists growing, and private accommodation beyond the means of most dialysis patients.

One particular aspect of this determination which has posed problems for Kimberley patients is the ruling that if a patient dies following inter-hospital transfer, the Health Dept of WA will meet the cost of transporting the cadaver back *to the country hospital nearest to the patient's permanent residence.* In one example, a patient from the East Kimberley who had been dialysing in Broome for more than 6 months was transferred to, and later died in, Perth. Transport of the cadaver was therefore back to Broome only, despite the fact that her family, country and "home" were 800km away.

Recommendation: A patient's permanent residence should be determined by the patient themselves, made only where a patient has made the choice to relocate.

Administration of the PATS system

There are a number of issues regarding the manner in which the PATS system is administered:
(1) The role of the PATS clerk in an area such as the Kimberley is difficult and complex. In most cases, patients are not in a position to arrange their own travel, the distances are vast, options for public transport are limited and language and cultural barriers compound the task;

The quality of the PATS clerk is an important factor in the efficiency and responsiveness of the system. The job description requires a full-time, senior administrative clerk, with experience in managing human relations, an ability to think laterally, and a commitment to providing a responsive service, particularly for the most disadvantaged in the region. This is not always the case, and in some instances, junior clerks are employed who lack the skills and experience required to carry out the role. In particular instances, the lack of skill and experience along with a level of disinterest and disrespect for the role and the clients, has contributed to ill-feeling amongst patients and health providers, and discouraged patients from undergoing travel to access care.

There are many examples of PATS clerks who show commitment to the role and to the patients on the receiving end, and the difference is stark.

Recommendation: The positions of PATS clerks should be appropriately classified and funded to encourage recruitment and retention of senior-level, high-quality administrative staff.

(2) Communication and coordination with local health service providers is frequently overlooked. Health providers in the Kimberley generally report that the advent of the "Meet and Greet" team in Perth has improved this situation somewhat, particularly for patients on arrival in Perth. Stories continue however of patients arriving back in the region without knowledge of local service providers and without means to get further than the end of the booked public transport line, reflecting lack of, or inadequate, discharge planning.

Difficulties arise outside of the hours of operation of the "Meet and Greet" team and of the PATS clerks, the latter usually being less than full-time positions. PATS problems inevitably arise when the PATS clerk has finished for the day, and after-hours arrangements are usually less than ideal.

Recommendation: The positions of PATS clerks should be appropriately resourced to ensure *at least* cover of usual office hours. A centralised after-hours PATS "emergency line" may assist in addressing problems with PATS arrangements which arise out of the usual hours of operation of the local PATS clerk.

Recommendation: Resourcing of the "Meet and Greet" should be extended to ensure that country patients arriving outside of usual business hours are appropriately care for.

Recommendation: A review of discharge planning from tertiary and regional hospitals should be reviewed, with priority given to improving discharge planning for country clients

(3) While the guidelines state that return travel is provided through the PATS scheme for patients once discharged, and that the travel is provided **to their usual place of residence**, in practice those administering the PATS system often consider that support goes as far as the public transport route and not further. This has resulted at times in patients being left stranded in a town some distance from their home community, exposed to the ills of town life which they are able to avoid in their own community – including homelessness, exposure to alcohol, lack of access to food, and so on.

At present, responsibility for ensuring arrangements are in place for a patient to travel all the way back to their remote community falls through a gap and this gap needs to be closed by making explicit where the responsibility lies.

Recommendation: The responsibility to ensure a patient has transport back to their place of origin must lie with the agent /agency responsible for administering the PATS system. While this will often involve liaising with the local clinic or community office to assist with travel arrangements, the responsibility must lie with the PATS administrator to ensure arrangements are in place.

(4) In an area such as the Kimberley, matching clients to transport routes is a complex task. In many instances, service providers in a local community are best placed to know what vehicles/ planes/other are travelling in and out, where people reside and whether they are e.g. out of the community for a funeral etc.

In the Halls Creek / Kutjungka area in late 2006, the Kimberley Aboriginal Community Controlled Health Service and WACHS reached agreement to have the responsibility for administering PATS for Kutjungka clients transferred to KAMSC. This followed a period during which PATS arrangements were continually breaking down, and a rising level of concern from families and communities in the region about the consequences of travelling as a result of the experiences of their relatives, as well as heightened frustration from the PATS office, the KAMSC clinical service providers in the Kutjungka, and Palyalatju Maparnpa Health Committee (PMHC), the local Aboriginal Community Controlled Health Service in the Kutjungka providing cultural and other non-clinical health services in the region.

While it is early days still, the general sense is that this "trial" is proving highly successful, with:

- Almost as many patients travelling in the first four months than had travelled for the whole preceding 12 month period (all PATS eligible patients accessing approved specialist services)
- Of all the patients who travelled during the first four months, only one patient did not attend booked travel
- Cost-neutral forms of transport for patients in and out of the Kutjungka have been maximised – including routine KAMSC clinic charters from Broome and Halls Creek, seats on charters arranged by almost all other agencies in the region have been utilised, seats in vehicles travelling in and out of the region for other purposes, and so on. Projected costs for the first year are promising.

This provides an example of regional cooperation which has resulted in an effective model proving beneficial for patients in the region. Elements which are considered critical in the success of this model include: (1) Commitment on the part of the PATS coordinator and local service providers to ensuring safe, coordinated travel for clients;

(2) being located within the community, the PATS "clerk" is well-placed to keep abreast of travel options in and out of the community(s); (3) as community controlled services, KAMSC and PMHC are governed by the communities they serve, with structures that facilitate responsiveness to community need.

The shift of PATS responsibility has occurred without any transfer of funds to KAMSC to perform this function, and this will need to be addressed if this model is to be sustainable and/or transferable to other sites.

Recommendation: While centralising PATS functions may in theory create greater efficiency, in practice, more flexible models for PATS administration may be required which are able to adjust to meet particular local and regional circumstances. In this instance, devolution of responsibility for PATS administration to a local Aboriginal Community Controlled Health Organisation is proving successful. The model should be assessed and appropriately funded to ensure sustainability.

Other models have also been suggested for shifting the locus of administration of the PATS system. The following comments are provided by a GP who has lived and worked in the Kimberley for many years:

"*The process is cumbersome and for many patients involves too many steps to negotiate - eg. getting a health care card (from office separate from hospital or left at home in their community), bringing it back to the hospital, or finding $50 cash at short notice, getting shoes so they are allowed on the bus, finding warm clothes to travel south, organising alternative care for their children or property, getting a lift back to the hospital on the right day. For patients facing the prospect of unpleasant, scary or unknown future at their destination these hurdles become excuses and blockages to access. The process is also time consuming from a medical and administrative point of view, involving much time in explaining, organising, following-up and coordinating. A process which was simpler would allow that time to be put to better use (eg. in actually delivering health services).*

I think it could work better if a separate agency was responsible for the transport - an agency co-located with other social services (eg. Centrelink, and involve social workers or community workers) and which has access to more flexible financial arrangements. Then issues such as payment, access to money when away from home, advance payments to allow patients to travel with ease could be sorted at the same time. It would also separate the medical service providers - who are not trained social workers - from the process. The doctors/service providers would determine the need (without the budget man on their shoulder nagging), complete a form to certify this, and the patient can then go and get it sorted cohesively. Alternatively - employ social workers to manage the PATS, and have direct linkages to Centrelink to enable the financial assistance/card numbers to be done painlessly."

Although flexibility is allowed within the existing guidelines for use of air or road charters where a number of patients are travelling and other forms of transport are not available, this requires a specific request to the Regional Manager for approval. Our experience is that where the request is reasonable, approval is routinely granted, but the process adds an unnecessary administrative burden and at times, has caused delay and missed appointments.

Recommendation: PATS clerks should be granted permission to arrange air or road charters from remote communities when three or more patients are required to travel and no other form of transport is available.

Other issues affecting patient travel

A significant barrier to patient travel in the Kimberley is not just a lack of availability of public transport for patients travelling from remote communities, but also the lack of convenient timetabling of the transport that does exist. For example, women returning to areas such as the Fitzroy Valley or Halls Creek region with a newborn baby following delivery in Broome or Derby Hospital, board the bus late in the evening and arrive at

their destination in the middle of the night (Fitzroy) or in the very early hours of the morning (Halls Creek), with no guarantee of being collected off the bus on arrival. This is a source of much distress, both for the travellers and for the health providers knowingly sending them on their way.

Recommendation: At the very least, there should be appropriate resources allocated to ensure that arrangements are supported and coordinated for PATS patients to be collected off the bus and taken to their home / accommodation.

Recommendation: For particular PATS patients such as pregnant women travelling to the town of delivery, women with their newborns returning home, and the frail /elderly, plane travel should be considered as the first and most ethical option, despite NOT being the cheapest alternative.

For a patient returning to Halls Creek from Broome it is the difference between a 2.5 hr flight arriving at 4pm, or an overnight 8 hour bus ride arriving at 4.30am and the additional cost is justified.

Recommendation: Ultimately, local and state government bodies need to ensure that regional transport services are able to meet the needs of residents who are required to travel to access services not available in their own towns and communities – for example, providing local and intra-regional bus services during daylight hours.

Appendix 1: STATUS OF DENTAL SERVICES IN THE KIMBERLEY REGION OF WA

INTRODUCTION

Access to dental care in the Kimberley, for many of its' residents, is restricted by the large distances they have to travel to the available facilities, compounded by transport difficulties (poor roads, often cut off during the wet season, lack of personal vehicle ownership and limited public transport facilities and lack of money to pay for such transport even if it were available). Half of the 40,000 population of the Kimberley comprises Aboriginal Australians, who have some of the highest rates of infectious disease and prevalence of non-communicable chronic disease in the world. For example, over 30% of Aboriginal and Torres Strait Islanders (ATSI) have diabetes, and the prevalence of rheumatic heart disease, chronic kidney disease and end stage renal failure far exceed the Australian national average. The incidence of dental conditions such as severe caries, periodontal disease and dental abscess is also extremely high in our region.

CURRENT SERVICE PROVISION.

Two sectors exist to provide dental health services to the population of the Kimberley.

Private Dental Clinics

These are owned and operated as a business by registered dentists. These clinics provide dental services on a full fee-for-service basis to the attending population. Occasionally they will provide emergency only dental care to people eligible for government subsidised dental treatment at the subsidised rate. These services are provided out of fixed dental clinics.

Public/ State Government Dental Services

General Dental Clinics are operated by the WA Health Department (Dental Health Services). These clinics provide dental services at a government subsidised fee-for-service rate, to "eligible" people. People are deemed eligible if they hold a current Centrelink issued Health Care Card or Pension Concession Card or are in receipt of a qualifying Centrelink payment. Proof of eligibility is required in the form of presentation of the valid Health Care/ Pension Concession Card and a current income statement from Centrelink.

These clinics may also provide dental services on a full fee-for-service basis to the population not eligible for subsidised dental treatment, in areas where access to private dental services are unreasonable. These services are provided out of fixed public dental clinics, which also serve as the base from which itinerant / mobile dental services are provided to surrounding communities.

Dental Therapy Units are operated by the WA Health Department (Dental Health Services). They provide limited dental services to students enrolled at school and who provide written consent and enrollment with the School Dental Service, by a legal guardian. These services are provided at no cost and are accessible during the school term. These units operate out of a dentally equipped caravan and provide an itinerant service across their designated area.

Dental Services in the Kimberley (described by central clinic)

Broome Dental Clinic
Private Dental Clinic (Principal: Peter Ellies. Assistant Dentist: Phil Robson)

At present, this is the only fixed dental clinic in Broome. It provides full fee-for-service dental care to the population of Broome with two full-time dentists. It has the capacity to be staffed by three full-time operators.

This clinic also provides support and limited clinical sessions to the Broome Dental Therapy Unit.

Broome Dental Therapy Unit
School Dental Service (Therapist: Sandie McCaig)

This unit provides limited routine and emergency dental care to primary and secondary school students enrolled in school in Broome during the school term. It is staffed by one dental therapist and one dental assistant. These services are provided in a caravan sited at the following schools throughout the school year.
Broome Primary School
Broome Senior High School
St Mary's College
Cable Beach Primary School

Derby Dental Clinic

Public Dental Services and School Dental Services (Dentists: Ronelle and Chris)

This is the only fixed dental clinic in Derby, sited at the Derby Regional Hospital. It is the central clinic for two full-time dentists. It provides subsidised fee-for-service general dental services to the *eligible* population of Derby and full fee-for-service dental care to the *non-eligible* population of Derby.

It also provides limited subsidised general dental services and school dental services to:
Derby Schools (Derby DHS, Holy Rosary et al)
Beagle Bay
Looma
Bidyadanga
Lombadina
One Arm Point
Kupungarri (Mt Barnett) and Ngallagunda (Gibb)
This part of the service operates in a caravan at the schools in Derby and in the community schools, with mobile dental equipment carried to the community sites.

This clinic also provides subsidised dental care to the *eligible* population of Broome in a dental caravan sited at the Broome Hospital, approximately a week every month.

Kununurra Dental Clinic

Private Dental Clinic (Principal: Lars Moir. Assistant Dentist: Maria Chan)

This is presently the only dental clinic in Kununurra. Dental care is provided by two full-time dentists to the population of Kununurra, on a full fee-for-service basis. It also provides limited subsidised dental services to the Kununurra population *eligible* for public dental care under a contractual agreement with the WA Health Department (Dental Health Services). This clinic also offers support and limited clinical sessions to the Kununurra Dental Therapy Unit.

Services are similarly provided to Wyndham Dental Clinic, sited in the Wyndham Hospital, for one day a fortnight. This arrangement will be suspended during the refurbishment of the hospital

(expected to be from the end of May 2007) due to health and safety issues. It is unknown if the service will be reinstated following hospital refurbishment.

In the recent past, a public dental service to Halls Creek Dental Clinic sited in the Halls Creek Hospital has been provided for one week in every six weeks, from the Kununurra Dental Clinic. This arrangement was a contractual agreement with the WA Health Department (Dental Health Services). This arrangement ceased May 2007.

Kununurra Dental Therapy Clinic
School Dental Service (Therapist: Linda Downie)

Provides limited routine and emergency dental care to students enrolled in school in Kununurra during the school term. Services are provided by one dental therapist. These services are provided out of a caravan sited at the following schools throughout the school year.
Kununurra District High School
St Joseph's Primary School Kununrra
Wyndham District High School
St Joseph's Primary School Wyndham
Warmun Community School
Halls Creek District High School
(including Red Hill Community School from this site)

Perth Based Dental Services to the Kimberley
Public Dental Service

In recent years, the WA State Health Department (Dental Health Services) equipped the remote communities of Kalumburu, Oombulgurri and Balgo with fixed clinics to improve delivery of dental services to these areas. At present these communities are serviced from Perth with a dental team flown from Perth to these communities to provide basic dental services. More complex dental treatment such as denture fabrication is not possible through these facilities. In 2007 the communities of Kalumburu and Oombulgurri are scheduled to receive 3 visits, each of 10 days duration, and Balgo will receive 2 visits of the same duration.

Fitzroy Crossing has been serviced sporadically from Perth. At present there is a dental caravan sited on the hospital grounds whilst the new hospital is built. There is also one sited at the school.
A dental therapist is stationed in Fitzroy Crossing for the whole of Term 2, 2007 to provide school dental services to the students of Fitzroy Crossing.
As yet, there are no scheduled visits to provide general dental services in the town of Fitzroy Crossing. The last visit by a dental team was September 2006 for six weeks.

Unstaffed Dental Facilities in the Kimberley

Fitzroy Crossing (Public) Dental Clinic

Whilst the hospital is under construction the existing dental clinic has been moved into an onsite caravan. The full time position for a dentist in this town (also to service remote communities of the Fitzroy Valley) is not occupied.

Halls Creek (Public) Dental Clinic

There is a fully equipped dental clinic in the Halls Creek Hospital and it is hoped that services will be provided from Perth on a fly-in fly-out basis. Visits have not yet been scheduled.

Kununurra (Public) Dental Clinic

A public dental clinic is under construction in Kununurra as part of the Kununurra Hospital.
Once construction is complete there will be a full-time position for a dentist to staff this clinic and to provide public services to Kununurra and surrounding communities.

Broome (Public) Dental Clinic

A public dental clinic in Broome is planned for construction in the next few years.

How can access to Dental Care in the Kimberley be improved?

Considering the difficulty in recruiting dentists to the Kimberley, the most effective way to improve access to dental care initially would be to improve access to those services presently available.

Barriers to providing and receiving dental treatment

Cost – in most areas where dental services are available subsidised treatment is available for the eligible population.

Transport – Physical geographical distance: The available dental services are widely spread across the Kimberley located in more central locations to the population. However, the patient has to have a way to physically travel from their place of residence to the nearest available dental service, and has to be able to cover the cost of that transport themselves in most circumstances.
Equipment - Providing even basic dental treatment requires certain basic equipment and environmental standards which makes providing treatment in ill equipped situations difficult.

Management of unco-operative people in need of dental care – access to general anaesthetic sessions or sedation.

Limitations of abilities of operators – there are procedures that the dentist /dental therapist is not able or does not feel comfortable performing and would recommend specialist treatment. For example, dental therapists are not permitted to extract permanent teeth -requiring a dentist to perform this procedure. A second example is surgical extraction of impacted wisdom teeth that the dentist is not able or comfortable to perform. Physical remoteness from these services requiring increased expertise is a major obstacle in accessing treatment and improving oral health of the population.