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Health care – what *is* available, and what *should be* available?

Health services available on Norfolk Island

Norfolk Island Hospital

2.1 Nearly all health services on Norfolk Island for both residents and visitors are delivered through the Norfolk Island Hospital which is the only hospital on the Island. The Norfolk Island Hospital Enterprise (NIHE), which manages the Hospital, was established under *The Norfolk Island Hospital Act 1985*.

2.2 The Hospital is a 24 bed facility which employs 30 full-time administrative, medical and domestic staff.[1] Until June 2001 there were two full-time government medical officers and a third doctor who took on a limited range of responsibilities four mornings a week. A decision in 2000 by the Minister for Health led to the employment of a third full-time doctor. A locum was engaged until the third doctor commenced in June 2001, giving a full time equivalent of 3.5 general practitioners. The local doctors and visiting specialists from the mainland provide all medical services from the Hospital. Although some extra beds are needed during specialists' visits, the occupancy level, at approximately eight beds per day, is very low.

2.3 As the only health facility on the Island the Norfolk Island Hospital must provide 24 hour service through its Outpatients Department and the general practitioners. It cannot refuse service to anyone, and consequently

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1 Norfolk Island Health Enterprise, Submissions, p. 44.

carries a considerable burden of bad debt. The Hospital operates with a perpetual deficit and depends on a large and increasing annual subsidy from the Norfolk Island Government. Concerns were expressed to the Committee in March 2001 that this subsidy might be reduced, but there has been no indication that the proposal by the Finance Committee, which triggered the concerns, will be adopted by the Assembly.

2.4 In its 1997 report, the Commonwealth Grants Commission (CGC) observed that the Hospital was of piecemeal design and construction. It was opened in 1953 using, in part, buildings erected during World War II. Extensions have been made at various times, and the layout, like that of many small, older hospitals on the mainland, is not conducive to efficient use of staff. The report concluded that, largely as a result of its age, the standard of buildings and equipment was below that found in small remote centres in mainland Australia, the effect of which was detrimental to the efficient operation of the Hospital.

2.5 The Committee was advised just prior to tabling this report that essential items of equipment, although regularly serviced, are so outdated that in some cases parts are no longer available. The X-ray machine, anaesthetic machine and autoclave all need replacing. The anaesthetic machine is over ten years old and parts and service for this model are no longer available. The estimated cost of a replacement is $43 000. A technician had to make a part for the autoclave during a recent major service. A replacement for this vital piece of equipment would cost $68 000. The Committee believes that it is imperative that funds be made available for the replacement of such items, and that future budget allocations allow for routine replacement of outdated equipment. The implications for the health service if any one of these crucial items were to fail during an emergency are obvious. Until this equipment is replaced the Committee considers that the welfare of those on the Island is at risk.

2.6 The Commonwealth Grants Commission noted that the Hospital building and equipment generally needed upgrading. The Committee made the same observations when it visited in November 1999 and March 2001. The Committee's impressions have been confirmed by several medical specialists. Professor Carol Gaston told the Committee via a teleconference hearing in June 2000 that she was stunned:

> because I was taken back 20 to 25 years when I went there. I was surprised that that component fell behind in what I thought was a

> community that did so well at so many other aspects of its economy and its services.[2]

2.7 In her submission, Professor Gaston commented on the age of the buildings, their unsuitable layout and inadequate signage, which caused poor internal traffic flow. She made further observations about the Hospital's inappropriate use as a nursing home, the impact of low utilisation on its budget, and the lack of education and development opportunities for staff. Her observations confirmed those of others, including hospital staff, who commented on infrastructure, staffing and organisational issues which need to be addressed.

2.8 The Hospital management, NIHE, is responsible for the maintenance of the Hospital. This arrangement differs from other Norfolk Island Government assets which are under the maintenance control of the Island's Works Department. Witnesses have commented that it appears that the Hospital 'makes do' with what is available, an approach which is consistent with a former medical officer's opinion that Norfolk Islanders have a strong tradition of self-reliance because of their extreme isolation in earlier times.[3] The advent of tourism in recent decades, and the dependence of the Island's economy on visitors, means that the traditional approach needs a close examination.

2.9 The Commonwealth Grants Commission noted in 1997 that visiting specialists left their own equipment at the Hospital and that there was a lack of storage space. Medical staff told the Committee in March 2001 that increasingly the Hospital was unable to provide the facilities required for the latest medical advances which people have come to expect. During that visit the Committee inspected living quarters in the Hospital grounds used by visiting specialists, and found them to be depressingly sub-standard.

2.10 The CGC report also noted that a replacement hospital would be needed in the next ten years. This had been estimated locally at $10 million, including aged care facilities, but no measures have yet been taken to build a replacement. Meanwhile the Department of Veterans' Affairs strongly advised against further spending on the present structures.

2.11 There are some parts of the Hospital which will require short-term spending just to continue functioning. The Hospital Director indicated during the Committee's visit in March 2001 that a minor extension, under the same roofline, was planned for the free-standing physiotherapy unit in order to accommodate extra equipment for both the new physiotherapist

2 Professor Carol Gaston, Transcript, p. 205.

3 Dr Michael Sexton, Submissions, p. 161.

and the visiting medical specialists who use these premises. The pathology laboratory within the main building, which is too small to allow for a much needed increase in staff and equipment, is another area which may need internal alteration in the short-term.

2.12 The Committee became aware on its second visit of the inadequate facilities for the safe disposal of waste. Hospital staff members recognise that the present arrangements for the disposal of waste, including diseased body tissue, sharps and post-mortem waste, are unsatisfactory. Surgical waste is bagged and disposed of by slow burn at the general tip. Until recently sharps have been burned at the local diesel incinerator and the remaining debris bagged and taken to the general tip for disposal. To reduce the risk of this method of disposal, sharps are at present being stockpiled, but this practice will continue to present a health risk. The solution, raised in the Waste Disposal Management Plan currently being considered by the Norfolk Island Government, would appear to be access to high temperature incineration.

Services provided

2.13 In its submission the Norfolk Island Government described the range of services the Hospital provides. This includes: outpatient consultations with doctors and nursing sisters, inpatient accommodation covering a range of conditions, including intensive care, limited pathology and x-ray facilities, maternity and baby health services, long-term geriatric care and respite care, as well as routine middle level surgery such as caesarean sections, repair of hernias and appendectomies.

Medical staff

2.14 Where practicable, patients are treated on the Island. The presence of at least two full time doctors means that surgery or procedures requiring anaesthesia can be performed. This arrangement, while providing a measure of medical security for residents, meant until recently that neither doctor was ever fully off duty while on-Island.

2.15 The two doctors were on call 24 hours a day throughout the year. Posts for government medical officers are normally for two years but the NIHE has had trouble attracting and keeping doctors with the right combination of skills for a remote practice. Doctor ‘burnout’ is a major problem which affects both the recruitment and retention of doctors.

2.16 Despite the employment of a part-time female doctor, who sees mainly women patients but has no responsibilities for in-patients, obstetrics, emergency cases or after-hours call-outs, Dr Fletcher advised that the load

on the two permanent doctors did not ease and that their clinics remained fully booked. These pressures led to the approval by the Minister for Health for the appointment of a third full-time doctor, to commence duty in mid-2001.

2.17 Most emergency or complicated cases are evacuated to mainland hospitals, using scheduled flights where possible or private medivac services or RAAF Hercules.

2.18 During the Committee's first inspection in 1999 Dr Davie commented that the lack of diagnostic equipment such as an ultrasound machine and image intensifier meant that the doctors were limited predominantly to emergency surgery.[4] There are also no facilities for laparoscopic surgery, which on the mainland increasingly replaces open surgery with its higher risk of complications and longer recovery period. No orthopaedic surgery is conducted on the Island, necessitating a medical evacuation in two of the most common emergency situations, a fall by an elderly person or a road accident.

2.19 The Hospital Director confirmed in her March 2001 submission the impression given by a number of witnesses that health services staff, particularly nurses, were not adequately renumerated or encouraged to undertake further training:

> Another issue that impacts on health service delivery is the outdated and inappropriate salary structure in health in Norfolk Island. Staff have no incremental scales and therefore no opportunity to advance salary wise, even after undertaking increased study in certain areas of interest. Whilst salaries are tax free the current system is both inadequate and inappropriate for the level of service expected of isolated staff.[5]

Visiting Specialists

2.20 In order to reduce the number of offshore referrals, many specialists visit the Island on a regular basis, usually once or twice a year. Among those who provide services are a gynaecologist, dermatologist, psychiatrist, endocrinologist, rheumatologist, urologist, gastroenterologist, general surgeon, ENT and orthopaedic surgeons, chiropractor and podiatrist.

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4 A new ultrasound was provided by private donation in December 2000. Subsequently, the same donors funded complementary equipment necessary to maximise its value in diagnostics. Staff acquisition and maintenance of skills in operating the equipment will continue to be problematic.

5 Ms Christine Sullivan, Submissions, p. 197.

However, follow-up consultations may require patients to travel to the mainland.

2.21 All specialists come to the Island with the right of private practice. An amount is then given to the NIHE for the use of the Hospital's facilities. Service clubs such as Rotary and Lions contribute significantly to their airfares and accommodation expenses.

2.22 The Committee was advised at a meeting of Hospital staff on its return visit in March 2001 that as the number of mainland referrals continues to increase, the incentive for specialists to visit the Island decreases. Hospital staff expressed concern that technological advances and the increased risk of litigation were also putting the visiting specialists program at risk.

Pathology

2.23 Some pathology tests are available through the Hospital's laboratory, mainly in microbiology and haematology. Most pathology tests, however, are sent to the mainland for results. This has the disadvantage of delays as the turnaround time can be a number of weeks. It is also expensive, costing around $300 for each courier service. Patients meet pathology expenses on a full cost recovery basis.[6]

2.24 In March 2001 the Committee was informed by Mr Peter Young, the sole laboratory scientist, that for at least ten years the Pathology Department had been seriously understaffed, and restricted by obsolete equipment and a lack of computerisation. The position required him to be always on-call and able to reach the Hospital within 10-15 minutes. There was no allowance for continuing education to keep abreast of new, more effective tests and methods.

2.25 Mr Young predicted an increase in pathology requests as a result of the appointment of a third doctor. The laboratory is too small to accommodate an urgently required pathology assistant, yet the demand for services has been rapidly increasing due to the increasing number of visitors to the Island. In order to cope with the workload, Mr Young has reduced specimen collecting hours as well as unpaid overtime, resulting in longer turnaround times. He said, 'I do not see this as providing the best possible pathology care to the Doctors and people on Norfolk Island, but I am not superman either.'[7]

6 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 85.

7 Mr Peter Young, Submissions, p. 200.

Post-mortem and funeral services

2.26 On its second visit the Committee inspected the Island's only morgue, a small, dilapidated outbuilding in the Hospital grounds. It has an ageing refrigeration unit with storage capacity for two bodies, a table for autopsies and a small waiting area, and is otherwise almost devoid of facilities. There are no facilities for embalming, nor is there the equipment or forensic training required for a thorough autopsy. The Hospital has received complaints about the facilities from many sources, including the police, doctors, other staff and relatives of the deceased. The Hospital Director told the Committee that the condition of the morgue presents a major health risk to staff as well as being inadequate for the deceased and their relatives. The nursing staff who prepare bodies for burial are not necessarily trained in the risks associated with the deceased, and the facilities under which they work are inadequate, both to ensure basic hygiene and to prevent the spread of infectious diseases.

2.27 Protocols as well as facilities for post-mortem examinations appear to be completely inadequate. Situations which would automatically involve an autopsy on the mainland, such as a post-operative death, do not necessarily lead to an autopsy on Norfolk Island. In the two year period to April 2001 there have been only three autopsies requested by the Island coroner and performed by the general practitioners.

2.28 The Hospital provides the only funeral services on the Island. The Committee believes that this is most unusual and less than desirable. Communities of comparable size on the mainland normally support a commercial funeral parlour with the services of a professional funeral director available as needed.

Radiology

2.29 The Hospital has adequate facilities for X-rays but the X-ray machine will soon need replacing. It is difficult for a radiologist to get sufficient experience to maintain skills in a small hospital. A new ultrasound has been donated as well as additional equipment to enable its potential to be realised. However, lack of training, the small number of cases available to develop experience and the lack of opportunities to refer results for expert interpretation are major drawbacks in this area. Staff advised the Committee that training in the use of the ultrasound for obstetric purposes does not assist with its use for diagnosis in many other areas, such as detecting cancers.

Physiotherapy

2.30 The physiotherapy unit, complete with hydrotherapy pool, is a separate building that was financed by the Rotary club. It was not used for physiotherapy for over four years. The Hospital Director interviewed applicants for the position of physiotherapist in March 2001, with the successful applicant commencing full-time in June 2001. The Committee noted that the salary package, although tax free, was considerably less than offered for a comparable position in a remote part of the mainland. The salary for the first year will be met by the Department of Veterans' Affairs, with a contribution from the Norfolk Island Government for airfares, removal expenses and an accommodation allowance.

Dental services

2.31 A full-time dentist and dental nurse provide dental services from the Hospital including a free school dental service up to Year 12. An orthodontist visits every six weeks to supplement the dental services. The Committee was informed in June 2001 that the Island's dentist had resigned in March and that a replacement was proving difficult to find.

Optometry and audiology

2.32 There is a resident optometrist with a fully equipped consulting room and an optical workshop for assembly and repair of spectacles.[8] The optometrist refers patients to mainland ophthalmologists and cares for post-operative patients. A hearing testing and hearing aid fitting service is provided by a practitioner based on the mainland. Support is provided by service clubs for this as well as for the ophthalmology service.

Pharmacy

2.33 A qualified pharmacist manages the only pharmacy on the Island, which is within the Hospital, supplying prescription and non-prescription medicines. It is open from 8.30 a.m. to 5.00 p.m. on weekdays, and Saturday mornings. The Commonwealth Grants Commission noted in 1997 that drugs were dispensed at full cost, with a substantial mark-up added to many items, allowing the pharmacy to contribute to reducing the Hospital's overall budget deficit. There is no pharmaceutical benefits scheme, although pensioners are covered by the Hospital and Medical Assistance scheme (HMA) which pays all, or the majority of, their medical

8 Norfolk Optical, Submissions, p. 49.

expenses.[9] Cardholding veterans and war widows pay $3.50 for all prescriptions, as they do on the mainland.

Maternity and early childhood

2.34 Dr Davie and other staff stressed to the Committee on its second visit the enormous importance on the Island, as in any small community, of retaining control of the birth process. A birthing room has been created in recent years. The Hospital has a humidicrib and trained maternity staff, and the three general practitioners are RACOG members. When serious complications can be predicted the mother is sent to the mainland prior to delivery if possible. There have been recent renovations to the Early Childhood Centre (formerly the Baby Health Clinic) which is open three days a week and provides antenatal classes as well as postnatal and baby health checks.

Child immunisation

2.35 Child immunisation is available, following the New South Wales health recommendations, but at present parents must meet the full cost. Figures provided by Mr David Glackin and Ms Janice Webber indicate that this amounts to $359.50 for a child prior to school entry.[10] This situation may change with the introduction of a subsidy promised by the Norfolk Island Government.[11] Given the importance of universal child immunisation there is a strong case for all essential childhood immunisation to be provided free through the NIHE.

Diabetes clinic

2.36 A weekly diabetes clinic is in operation, conducted by nurses who underwent diabetes training in 2000. This will be particularly valuable in light of the preliminary findings of the Griffith University School of Health Science in September 2000 that there is a number of undiagnosed or high risk diabetic cases on the Island. The Hospital Director indicated, however, that at present there were no plans for community screening for diabetes, due to limited resources.

Domiciliary nursing

2.37 Domiciliary nursing is provided by a hospital domiciliary nurse, on behalf of a private trust, the Emily Channer Trust. The service operates only three

9 Government of Norfolk Island, Submissions, p. 9.

10 David Glackin and Janice Webber, Submissions, p. 1.

11 Government of Norfolk Island, Submissions, p. 147.

half days per week, which the medical staff do not consider adequate. It is provided on a fee-for-service basis but the Hospital Trust subsidises the service.

Red Cross

2.38 The Australian Red Cross operates a blood bank from the Hospital on two consecutive days a month,[12] to ensure that all 175 registered donors are checked to enable them to be called in a local emergency. As the age profile of the Registered Nurses trained to take blood is increasing, a blood donor trainer was brought from NSW early in 2000 to train interested volunteers. The Red Cross runs first aid classes and, on a daily basis, telephones people who live alone. The Red Cross also uses the Hospital to store Home Nursing loan equipment as well as equipment to set up a ten bed emergency hospital.

Ambulance services

2.39 St John Ambulance[13] provides ambulance services through a roster of volunteers, and experiences difficulty, as does Red Cross with volunteers who cannot persuade their employers to allow them time off to attend emergency practices, even without wages. Skills drills conducted by St John members accredited on the mainland are held every two weeks. In November 1999 there were ten ambulance volunteers but only three could attend cases during work hours without losing wages. It is difficult to recruit ambulance volunteers, partly because of the fear within such a small community that the patient may be a relative or friend. In 2001 there were only five active volunteers, all of whom were under considerable duress.

2.40 The local division paid for its own modern ambulance with an interest-free loan from St John (now repaid), a donation from the Norfolk Island Government, and from fund raising. The Norfolk Island Division pays for uniforms, insurance and changes to the ambulance, as well as first aid and training equipment and pagers. Its only income for essential equipment and expenses is from teaching first aid and from donations. It provides a free service for residents and charges $30 for tourists. The NIHE pays for fuel and maintenance of the vehicle. There is no backup vehicle if the ambulance is out of service for any reason.

2.41 The ambulance is garaged at the back of the Hospital premises. The only access is through the car park adjacent to the main entrance. Volunteer

12 Australian Red Cross, Submissions, p. 51.

13 St. John Ambulance Australia, Submissions, p. 29.

officers must drive their own vehicles through the car park and pedestrian access, then drive the ambulance out the same way. The Hospital Director told the Committee that direct access to the main road for the ambulance was necessary both to reduce the response time in emergencies and to alleviate the risk to other Hospital users.

2.42 There is a need for guaranteed recurrent funding of both equipment and training to ensure the sustainability of this essential service. It is unrealistic for such a service to be continued on a purely voluntary basis, especially in view of the demands made by increasing numbers of mainly elderly tourists.

Aged care

2.43 The only residential aged care facilities on the Island are located in the Hospital. Accommodation for each elderly person is a cubicle curtained off from a thoroughfare. Facilities and staffing levels are widely acknowledged to be less than desirable, and the Committee has been told that many elderly people choose to move to the mainland in their final years rather than end up in the Hospital. There is very limited support for elderly people who try to live independently in their own homes.

2.44 The Department of Veterans' Affairs (DVA) has assisted the Returned and Services League sub-branch to establish a Day Care Club, not restricted to veterans, which now has sixty members. The Department has provided training for the volunteers who run the club, the only day program for the elderly on the island. Through a program called HomeFront it assessed veterans' and war widows' homes for physical risks and installed safety features such as grab rails, sensor lights and contrast step edges which reduce the risks of falls.

2.45 The DVA hopes that aged services such as these will continue to be funded by the NIHE for the broader community. DVA has allocated funding, with conditions attached, for one year for a physiotherapist and a geriatric nurse supervisor (aged care clinical nurse consultant) whose role would include coordinating the provision of aged care services. Interviewing of applicants for both these positions was held in April 2001, with successful applicants commencing duty in mid 2001. It is the Department's policy that resources it provides to the Island for veterans also benefit the broader community.[14] The issue of aged care in general, and the impact of DVA initiatives on aged care, is explored further in Chapter 5.

14 Mr Barry Telford, Department of Veterans' Affairs, Transcript, p. 148.

Community based health care

2.46 The Norfolk Island Government advised the Committee that there are community based health services such as weight control groups, Alcoholics Anonymous, access to Lifeline and religious ministers for counselling, as well as service clubs that raise funds for medical equipment and diabetic and glaucoma screening services.

2.47 The Community Health Awareness Team (CHAT) argued in its submission that the range of community services was very small and poorly used, because of lack of proper coordination and an accessible environment. It identified a great need for an extensive and well coordinated community health scheme, a considered proposal for which was incorporated in CHAT's submission and is described below in the section 'What *should* be available?', at 2.58 below.

2.48 The Committee received a submission from Rev Ian Hadfield of the Church of England, describing the lack of professional counselling services and awareness campaigns on the Island. He was not aware of anyone who would conduct marriage or other personal counselling of a long-term nature in a situation where the religious ministers felt out of their depth.[15] CHAT advised that although there are two professional counsellors on the Island, one is a full-time teacher and her extra-curricular work is voluntary. There is no advertised counselling service. In a letter to *The Norfolk Islander* newspaper, attached to CHAT's submission, it was noted that CHAT had tried contacting the Lifeline counselling number, a mainland number, six times in a week, without success.[16]

2.49 It is evident that in the absence of a coordinated community health centre, the medical officers are the first point of contact for almost every health issue.

2.50 Various submissions observed that health care on Norfolk was focused on curative treatment, rather than on educational or early intervention measures that could prevent many conditions from occurring or becoming serious. According to Professor Gaston, the existing model of health care delivery on Norfolk Island is one which disappeared in mainland Australia in the 1980s with government investment in community health centres.[17]

2.51 The Commonwealth Grants Commission reported in 1997 that the range of public and community services was narrow. There had been no

15 Reverend Ian Hadfield, Submissions, p. 159.

16 The Community Health Awareness Team (CHAT), Submissions, p. 25.

17 Professor Carol Gaston, Submissions, p. 60.

noticeable change at the time of the Committee's visit in November 1999, and public dissatisfaction appears to be growing among both Islanders and mainland visitors as community expectations inevitably increase.

2.52 The Committee was pleased to note that a group called the Substance Abuse Working Group, representing government, school, clergy and police, was formed in January 2001 to address the issue of alcohol and drug abuse on the Island. The Legislative Assembly accepted all eight recommendations of this group the following month. A well-attended public meeting of a group called Men Against Abuse, conducted by a religious group, was held in December 2000.

2.53 The Committee applauds such initiatives and encourages measures designed both to coordinate and to guarantee funding for their continuance. Substance abuse and domestic violence form the basis of much of the Island's police work, as well as being a major concern for community health.

Health services provided on the mainland

2.54 If the Island's doctors decide that a required treatment is not possible locally, medical evacuations to the mainland are arranged. Depending on the degree of urgency, these are by commercial flights, chartered aircraft or the RAAF (RNZAF for evacuation of New Zealand citizens to New Zealand). Only the Air Force's flights are free of charge, both to individuals and the Norfolk Island Government. Difficulties with the current situation and possible alternatives for medical evacuations are discussed in more detail in Chapter 6.

2.55 The preferred evacuation destination for Norfolk Island residents who are Australian citizens is Sydney, because the Norfolk Island Government has entered arrangements with the NSW Health Department for a Norfolk Island rate to be charged for various services. This rate was set on the basis of cost to the provider and is less than the 'ineligible for Medicare' rate but more than the private patient rate. Norfolk Island residents who are Australian citizens may also be referred to other states if there are compelling reasons such as available air travel or family connections.

2.56 Patients seeking treatment on the mainland require a referral from an Island doctor if their expenses are to be met by the Island's medical insurance scheme, Healthcare. The guidelines for referrals, prepared by the Minister for Health and in place since 1982, have attracted considerable criticism from patients.

2.57 There is some very limited legitimate access to the Medicare system available to residents. For example, those who move from the mainland to Norfolk Island remain eligible for treatment under Medicare on the mainland for five years. In addition, full time study on the mainland entitles a student to a Medicare card. Residents who require protracted and expensive treatment can exercise their right to move to and reside on the mainland. They would have to establish that they are resident through various documents such as payment of rates or rent in order to obtain a Medicare card. However, having chosen to take this course, a resident who returned to Norfolk Island would then face a waiting period of five years before any expenses related to the condition would be claimable under the Island's Healthcare scheme.

What *should be* available?

2.58 The Committee is aware that the Norfolk Island Government has plans to make changes to the health system. A review of health was called for in the Norfolk Island Strategic Plan 1998-2003. In 1999 the then Minister for Health, Mr Geoffrey Gardner MLA, initiated a comprehensive review, incorporating an island-wide health study undertaken by a team from Griffith University's School of Health Science, which began with baseline health studies in the first half of 2000. Mr Gardner told the Committee in November 1999 that part of the purpose of the review was to identify the services that should be available and to prioritise them, examine the resource implications and design a new health strategy specific to Norfolk Island's needs. He expected that the Griffith University team would coordinate community consultation on health matters and utilise the skills of health planners.[18] Mr Gardner resigned as Minister for Health in March 2001, explaining in an interview in *The Norfolk Islander* that one of the reasons for his resignation was:

> Frustration. The frustration occurs with my colleagues in the Assembly when you incessantly drive to achieve to set a direction, get a programme rolling, only to find when you appeal to them for comment, assistance, some guidance on issues, there's just nothing forthcoming.[19]

2.59 It is hoped that the present period of review will continue, providing both the impetus and guidance needed to update the Norfolk Island health system. Professor Gaston remarked that:

18 Mr Geoffrey Gardner MLA, Transcript, p. 3.

19 Mr Geoffrey Gardner MLA, Interview in *The Norfolk Islander*, 24 March 2001.

> Norfolk Island just has not had that jerk to bring it into the next generation of health care and that move away from constantly just focusing on the treatment end.[20]

2.60 The process of gathering evidence for this inquiry brought forward countless suggestions for services that should be available to Norfolk Island residents as well as proposals for delivering them. The Committee is conscious that no small, remote community expects to have the same facilities that are available in a large city with teaching hospitals. However, there were some suggestions for changes which had almost universal support. These included:

- the provision of a coordinated community health service with emphasis on preventive measures;
- appropriate care for the aged;
- a dependable and affordable emergency medical evacuation service;
- replacement of the Hospital;
- reducing the burden on the doctors;
- making the system more affordable for low and average income earners; and
- ensuring the sustainability of the visiting specialists program.

2.61 These seven issues are outlined below. Addressing them in further detail forms the substance of Chapters 4, 5 and 6. The major issue of adequate, affordable health insurance is discussed separately in Chapter 8.

1. Provision of a coordinated community health service with emphasis on preventive measures

2.62 Dr John Davie, one of the medical officers on Norfolk Island, expressed concern that:

> despite a world wide movement towards primary health care initiatives, we are seeing a situation in Norfolk Island where the focus is primarily on curative care.[21]

2.63 The submission from the new Hospital Director commented that:

> There are very limited prevention and promotion services and no designated budget funds for those services … Increased

20 Professor Carol Gaston, Transcript, p. 205.

21 Dr John Davie, Transcript, p. 31.

> significance must be placed on prevention and promotion and the need to maintain healthier lifestyles.[22]

2.64 Various witnesses commented on the difficulty that both Norfolk Islanders and visitors have in accessing national health programs and funding.

2.65 Members of the Community Health Awareness Team are trying to get a primary health care service started on Norfolk Island. Their submission to this inquiry contained a proposal which appeared already to have strong support within the community.

2.66 Their aim is to establish a primary health care centre and employ a professional community health coordinator who, with the aid of volunteers, would establish and coordinate a wide range of community health services. An important part of the role of the first coordinator would be the training of a local person to take on this complex and demanding role.

2.67 CHAT plans to make its proposed community health centre a drop-in centre for the public, open five days a week, with free services. Such an initiative would go a long way to providing the community health services required on Norfolk Island.

2. Provision of appropriate aged care

2.68 Another issue which prompted comment from many witnesses was the need to provide appropriate aged care on the Island. Various alternatives, such as increasing home nursing and domestic assistance to enable people to remain in their homes as long as possible, and establishing a purpose-designed, separate facility within or near the Hospital grounds, are discussed in Chapter 5.

2.69 The Committee is aware of aged care initiatives undertaken by the Department of Veterans' Affairs on the Island, through its 1998 report and through updates provided both in the Department's submission and the evidence given at the public hearing in Canberra in April 2000.

2.70 The DVA has provided specific, one-off funding for an aged care clinical nurse consultant (geriatric nurse supervisor) and a physiotherapist for one year. The DVA intention was that the physiotherapist would find private work as well, which would enable him or her to stay on the island beyond the expiry of the grant, and continue to provide a much needed service for all residents. A third grant has been made for the purchase of a vehicle

22 Ms Christine Sullivan, Submissions, pp. 195, 197.

large enough to transport veterans and others to and from treatment and day care.

2.71 Many of the recommendations made in the 1998 DVA Report by the Richard Tate Health Consulting Group continue to be relevant, cost-neutral or inexpensive, and potentially very valuable to the whole community. Some of these are examined in closer detail in the chapter on aged care.

3. Provision of a dependable, affordable medical evacuation service

2.72 The availability of medivac services to the mainland is considered an essential component of the provision of health services on Norfolk Island. In evidence presented to the Inquiry, the issue of a dependable and affordable medivac service emerged as one of the biggest areas of concern. Traditional reliance on the RAAF is no longer appropriate, and urgent steps must be taken to ensure a reliable, affordable service is available at all times to anyone on the Island who experiences a medical emergency. This issue is discussed in greater detail in Chapter 6 of this report.

4. Replacement of the Hospital

2.73 Whilst there is patently a need for a new hospital, many witnesses have cautioned against hasty action before a planning study and projection of future needs over the next ten to twenty years is done. It is hoped that the study being conducted by Griffith University will provide the Norfolk Island Government with the statistical information it needs for forward planning.

2.74 Several witnesses have advised that a Multi-Purpose Service model (MPS) would be suitable for Norfolk Island. This model draws together the delivery of acute, aged and community services, pooling the funds available to each, thus enabling a small community to provide a mix of services suited to its needs. This model has been applied in rural and remote areas throughout Australia where the population is too small to support a range of stand-alone units. Professor Gaston referred in her evidence to remote communities in the Northern Territory which are trialing alternative models. The MPS model can reduce overheads, as well as fill gaps and prevent unnecessary duplication of health services.

2.75 There could be a role for private enterprise in providing both a new hospital and an attractive ‘retirement village’. With a great deal to gain, attracting potential investors would become an important task for the Norfolk Island Hospital Enterprise or a delegate with appropriate experience and enthusiasm.

5. Reducing the burden on the doctors

2.76 There seems to be universal agreement that there is, and always has been, an enormous burden on doctors who work on Norfolk Island, due mainly to the isolation and to a lack of alternative sources of health advice on the Island. The doctors provide most of the primary health care available, as well as the acute care.

2.77 Various witnesses called for the employment of a third full-time doctor qualified to do anaesthetics and surgery to relieve the constant demand for services on the two full-time medical officers. The Norfolk Island Government conceded in 2000 that an additional full-time doctor was needed and the selected candidate commenced duty in June 2001. However, simply employing a third doctor may not solve the problem of excessive demand which appears to stem from the present focus on the curative, rather than on the preventive, the absence of ancillary services, as well as the expectations of patients.

2.78 The Committee believes that there are many reasons why the doctors are overburdened and that the underlying causes must be clearly identified and addressed urgently. This issue is examined in Chapter 4.

2.79 The Department of Veterans' Affairs identified two health care professionals whose services were urgently required; namely a physiotherapist and an aged care clinical nurse consultant. With DVA funding already approved there was some delay by the Norfolk Island Government in fulfilling its part of the joint arrangement for these two positions. Both positions were finally filled in April 2001, with the successful applicants commencing in mid-year.

2.80 The other position identified as urgent by many witnesses is that of a community health coordinator, preferably one with qualifications in mental health counselling. The addition of experienced professionals in these essential areas will contribute significantly to the standard of health care available on the island as well as provide support for the general practitioners. The Hospital Director has indicated her intention to add costings for the position of a health promotion officer to the 2002-2003 budget, as well as to examine other funding options for this important position.[23]

23 Ms Christine Sullivan, Hospital Director, supplementary information provided on request, Correspondence, 6 April 2001.

6. Making the system more affordable

2.81 Many witnesses informed the Committee that the present health care system is a major cost for most Islanders who are low or average income earners. Factors which have been identified as major causes of the cost burden are: the threshold of $2 500 of allowable expenses that each family must reach each year before being entitled to any medical benefits under Healthcare, the compulsory payment of the $500 per year health levy for every adult irrespective of income, the high cost of medicines, including vaccines, the lack of a pharmaceutical benefits scheme to offset this expense, and the inevitable high costs for travel to, and accommodation on, the mainland for medical treatment unavailable on the Island.

2.82 The Committee believes that the Norfolk Island Government needs to review its health care funding situation so as to develop a system that spreads the burden of paying for a quality, comprehensive health system more equitably across the population, with the unemployed and underemployed receiving free health care. Further details of the present cost burden and possibilities for easing this are examined in Chapter 4, and the general issue of funding is discussed in Chapter 9.

7. Ensuring the sustainability of the visiting specialists program

2.83 Visiting specialists have traditionally been the major providers of continuing education, exposure to new trends and professional support for the on-Island doctors. A former doctor on the Island, Dr Michael Sexton, told the Committee that:

> you have an intellectual concept of isolation, and that in itself provides you with a feeling of isolation, from both education and keeping up with trends. That was one of the reasons why we managed to get a good visiting list of specialists coming to the Island. You would buttonhole them all the time and utilise their expertise to educate you. I would make certain they all spoke to and lectured the staff on different subjects at the time.[24]

2.84 As more referrals for off-Island treatment are made, the incentive for specialists to visit the Island is decreasing. Other issues which are putting the visiting specialists program at risk include advances in surgery, the technology for which is not available on-Island, the increased risk of litigation and the need to maintain a specified caseload for accreditation in various specialities.

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24 Dr Michael Sexton, Transcript, p. 221.