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JOINT COMMITTEE ON THE NATIONAL CAPITAL AND EXTERNAL TERRITORIES

Reference: Health services on Norfolk Island

TUESDAY, 16 NOVEMBER 1999

NORFOLK ISLAND

BY AUTHORITY OF THE PARLIAMENT

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JOINT COMMITTEE ON THE NATIONAL CAPITAL AND EXTERNAL TERRITORIES

Tuesday, 16 November 1999

Members: Senator Watson *(Chair)*, Senator Crossin, the Deputy President and Chairman of Committees, the Deputy Speaker, Senators Greig, Lightfoot and Lundy and Mr Cameron, Ms Ellis, Mr Neville, Mr Snowdon and Mr Somlyay

Senators and members in attendance: Senators Crossin, Lightfoot and Watson and Ms Ellis, Mr Nehl and Mr Neville

Terms of reference for the inquiry:

To inquire into, and report upon:

The effectiveness of, and access to, the current Norfolk Island health system, and in particular

(i) what range of health and ancillary services is currently, or should, be available to residents (a) locally and (b) on the mainland;

(ii) what range of health and ancillary services is currently, or should, be available to visitors to the Territory;

(iii) measures that could be taken to assist access to a comprehensive level of health and ancillary care on Norfolk Island, taking into account the constraints of isolation and finances;

(iv) whether the Medicare system, in whole or part, should be available to residents of the Territory and, if so, under what terms;

(v) the appropriateness of current administrative and operational procedures for medical evacuations of persons on Norfolk Island requiring critical care on the mainland;

(vi) access to, and the utility of, telemedicine facilities between Norfolk Island and the mainland;

(vii) the availability of community health services, including residential or domiciliary care for frail aged residents of Norfolk Island;

(viii) the anticipated health infrastructure needs of the Island, the capacity of the Island community to meet necessary capital costs, and other possible avenues of funding; and

(ix) any other matters incidental thereto.

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Committee met at 9.05 a.m.

CHAIR—I declare open this public hearing of the Joint Standing Committee on the National Capital and External Territories, inquiring into the provision of health services on Norfolk Island. The matter was referred to the committee by the Minister for Regional Services, Territories and Local Government on 21 October 1999 and announced in the *Norfolk Islander* two days later.

The committee recognises that the short time since the announcement of the inquiry has given interested people very little time to prepare submissions prior to this hearing. The committee was scheduled to visit Norfolk Island and this did provide us an opportunity to take evidence at an early stage.

The purpose of the inquiry is to ascertain the range of health and ancillary services that are available to residents and to visitors. It is also to determine the measures that might be taken to assist access to a comprehensive range of services. The committee will also be looking at the utility of telecommunications methods and facilities and anticipated health infrastructure needs of the Island.

The committee prefers that evidence be taken in public, but if you wish to give confidential evidence to the committee you may request that the hearings be held in camera and the committee will consider your particular requests.

I remind you that all witnesses are protected by parliamentary privilege as such. I understand it is the custom in your local House to suggest that gentlemen may like to take off their coats. Those who wish to remove their coats should feel free to do so. I might set the example, because I think it sets a good working tone.

Witnesses will have the opportunity to take questions on notice and to provide additional information if they so require, or to correct the evidence. The record will be taken down by *Hansard* and witnesses will be given a copy of the transcript. If they wish to make any particular corrections subsequently, they may do so.

[9.08 a.m.]

CHRISTIAN, Mr John, Director, Norfolk Island Hospital

DONALDSON, Mr Graeme Peter, Acting Program Manager, Community Services, Administration of Norfolk Island

EDWARD, Mrs Kim Narelle, Healthcare Manager, Norfolk Island Administration

GARDNER, Mr Geoffrey Robert, Minister for Health, Norfolk Island Government

CHAIR—Welcome. Mr Gardner, it is my pleasure to invite you speak first. I ask you to present your evidence.

Mr Gardner—Thank you, Mr Chairman, and good morning. I guess it is appropriate to welcome you all to Norfolk Island. I hope you have had a very pleasant time whilst you have been here and enjoy the rest of your stay with us. I understand that you will be leaving in the morning at rather short notice, due to an unfortunate incident in Australia. The Norfolk Island government sends its regrets to the affected party.

Members of the committee may wish to address questions to my companions, as participants in the Norfolk Island government's submission. If so, I will ask them to come to the table to answer. I understand that you met Mr Christian yesterday at the hospital.

CHAIR—We welcome you all, and also the president of the Hospital Board.

Mr Gardner—The chairman of the Norfolk Island Hospital Board is Mr John Hughes. Mr Chairman, as you have pointed out, there was a short time frame to this inquiry, which prevents us from being able to provide a comprehensive written submission. However, this oral submission that I am presenting is for the committee's benefit and for me to try and impress upon you, its members, the serious weight that the Norfolk Island government places on health issues and the initiatives being taken to improve and increase that level of service to all on Norfolk.

I am approaching my first anniversary as Minister for Health. Early in my term I recognised the continuing need to review health services on Norfolk Island—it needed to be broad based—and evidence of that makes up the basis of this preliminary submission. As you alluded to earlier, Mr Chairman, I am quite happy to take questions on notice so that at a later date, hopefully in my soon to be first trip to Canberra, I may be able to reconvene with the committee to address some of those questions. I turn now to the terms of reference.

CHAIR—I would like to commend the hospital staff on their professionalism and dedication to the sick and toward the profession. I think we were all very impressed by that commitment. Perhaps, if you would not mind, you would pass that on to all the staff.

Mr Gardner—Thank you, Mr Chairman. The first point concerns what range of health and ancillary services is currently or should be available to residents, both locally and on the mainland. Our current services available locally and in Australia are outlined in the written

Norfolk Island government submission. No doubt they will be expanded upon in the submission by the Norfolk Island Hospital enterprise to the committee later today and, I hope, by others that will be making submissions to you.

The Grants Commission finding, to which I refer you, is that hospital, public health and community health services are comparable with mainland standards. I refer, for your information, to table 6.11 of the Commonwealth Grants Commission report into Norfolk Island in 1997, on page 140, under the heading 'Services on Norfolk Island relative to mainland standard'. I draw your attention to the right hand list, which refers to services comparable with mainland standard, and then the second listing in that column, 'Hospital, public health and community health services'.

In Australia, services are available depending on the locale that one is visiting and on paying the appropriate fee for service. Attached to the Norfolk Island government submission is a document that outlines the special arrangements that we have with the Department of Health in New South Wales. The question of what should be available is the big question, and I think it is a question that is asked everywhere. Everyone's expectations are different. The answer is based on the priority and what can reasonably be expected for a community of this size to support. Obviously, procedures such as open-heart surgery and other complex surgery, CAT scans and MRI procedures are out of the question on Norfolk Island. This is part of the purpose of the current health review, to identify the services that should be available and to prioritise, resource and implement them.

To assist the process, approaches were made in the first instance to the department of territories back in January of this year, with the assistance of Mr Vivan Morwinnie from the territories office. He was able to make introduction to a Ms Kathy Meleady from the New South Wales Department of Health, who I understand is the project development officer with the Department of Health in New South Wales and who kindly offered to assist us in the development of our preliminary strategy for the implementation of the health plan for Norfolk Island. However, for a number of reasons—one of which I am led to believe and understand was the fact that the Minister for Health in New South Wales decided he wanted to click in his own health review to try and deal with some of the problems that New South Wales is facing at the moment; of course that has left them somewhat short on the ground—as yet we have not had any positive response from the Department of Health in New South Wales.

However, always having options on stand-by, I have made recent approaches to Griffith University school of health sciences to secure support for qualified assistants to assist us to undertake a comprehensive island-wide health study, which is taking place from January next year for a period of three months, to coordinate community consultation on health matters and to utilise the skills of health planners to develop a health strategy specific to Norfolk Island. This would include the 'should be available' services, the resourcing implications of those services and the design of a new health complex specific to Norfolk Island and its needs.

There has been quite a history of plans that have been developed for a new health complex on the island from, I guess, the type of hospital that you would expect in inner Sydney to some types of remote hospitals, but the base work as far as the preparation of

those plans is concerned has never been done—that is, looking at the demographics and all the other needs that are required.

I understand the community health awareness team, which is a team of concerned community individuals who have a very strong interest in health matters on the island, will be making a submission to you later this morning. They have made a submission to the Norfolk Island government and, accordingly, a formal motion in the House to address their concerns as part of the health review received support from all members of the Legislative Assembly.

The second term of reference is what range of health and ancillary services are currently or should be available to visitors to the territory. I refer there to the written passage in the Norfolk Island government's submission. To clarify the differential in pricing, that relates specifically to hospital services on the island. Any other service is available at the same cost or price as any other local resident would have to incur. Indeed, pricing differentials occur throughout Australia's health service, as evidenced by the attached circular from the New South Wales Department of Health dealing with accommodation rates. It includes public patient rates, private patient rates, ineligible patient rates, which Norfolk Island falls under, whether you are metropolitan with a referral, metropolitan without a referral, non-metropolitan, psychiatric and other. It is certainly interesting to note that charges to Norfolk Island are the same as patients admitted to a public hospital under the Asylum Seekers Assistance Scheme. There may well be some irony in there.

Back to the point, the current services are all available to visitors. They are as outlined previously in the submission and as you will hear later on today. What should be available? Arguably, those offered in a similar sized community in Australia of the same population base should be. There is a large variation in the provision of services across Australia at present and those are being dealt with by the federal department of health in conjunction with the various regional government ministers.

What is the ideal model and where is it? That is the question we ask. What is realistic, being conscious of the funds and resourcing? Certainly, there has been a worthwhile vision provided in the document called *Healthy horizons: A framework for improving the health of rural, regional and remote Australians*. It is a long-term plan in 1999-2003 and that document was a joint development of the National Rural Health Policy Forum and the National Rural Health Alliance for the Australian health ministers conference earlier this year. It is certainly a worthwhile vision, but from my reading of it, it seems to lack the detail of what should be available for differing population bases across Australia. It is very generalised.

There is an issue that does spring up from time to time. It is a question that is often posed to me and it is probably worthwhile for the committee's consideration. The question that has been put to me on numerous occasions by not only residents but visitors to the island is: is it possible to extend the Commonwealth health care act to cover Australian visitors at Medicare schedule rates? Many of the visitors to the island are unaware of our political situation, quite clearly. To them, we are just another state or territory. Some have become trapped, unfortunately, because of being unaware of the situation. This provides

some argument to entertain the notion of a quasi-reciprocal health care agreement for visitor purposes.

If it is not thought appropriate, it is difficult to argue for maintaining a comparable level of health services in a foreign destination when the services on Norfolk Island are far advanced of many foreign, Pacific and Third World destinations for Australian travellers.

CHAIR—What was that term you used for an arrangement to cover the visitors?

Mr Gardner—A quasi-reciprocal health care agreement. As you would be aware, there are a number of reciprocal health care arrangements in place with various nations around the world.

For the aforementioned reasons, is visitors' ignorance of the situation justification for imposing enormous financial burden on them in the event of emergency medical evacuation from Norfolk Island? I will address this issue a little later, but affordable medical evacuation should certainly be available to visitors to Norfolk Island.

The third point relates to measures that could be taken to assist access to a comprehensive level of health and ancillary care on Norfolk Island, taking into account the constraints of isolation and finances. The first question is to determine exactly what is a comprehensive level of service. That is not easy. There is a general model—and I alluded to that previously—of core services that we have here on the island and which are available broadly across Australia. We need to consider other influences when determining that question. For example, the impact the climate has—the humidity, the effect that that has on skin disorders; whether we are from a tropical or from a cold climate; whether we need to cater for frostbite or mosquito-borne diseases; and the effects of climate on cases such as asthma and things like that. We also need to study demographics—the make-up of the population, the age, where we are going, how old the population is. Is it is ageing? To what extent is it ageing? Have we got a baby boom going on? There are those types of questions.

We need to consider the isolation of Norfolk Island—its distance from mainland centres. We also need to study the social environment, the workplace, whether we are in a city or in a rural situation and the stresses and other things that go with that—the stresses that are recognised now in the rural community in Australia with problems with farmers; the stresses of the inner city workplace; and the stresses that Norfolk Island produces in its own right. And there are stresses, Mr Chairman.

We also need to consider lifestyle, including nutrition, the population mix and whether there are any genetic factors that may have an influence on the requirement for health services on the island. All of these influence specific requirements over and above that core level of services that is provided. Mr Chairman, I put it to you that Norfolk Island could not be set up in a similar way to Thursday Island. They have a different range of influencing factors. One of my colleagues in the House recently referred to Borroloola, in the Northern Territory. It has no doctors. Certainly, we are different from Macquarie Street in Sydney and our needs are different from what is available in Macquarie Street in Sydney.

To determine the level of services for any place, realistically, a specific study of influences must be undertaken, otherwise the potential exists for underservicing. We are undertaking our study in collaboration with Griffith University in the first three months of next year. Attached to that team will be a nutritionist to develop suitable menus for hospital patients and to determine the effects of the seasonal supply of fresh fruit and vegetables on the island. We are awaiting also the confirmation of the inclusion of a health planner for the duration of that study.

The review currently under way, in conjunction with the health study and its results and the utilisation of qualified health planning services with input from this community, will work to improve upon the measures already in place and outlined in the written submission, including improving the visiting medical specialist program, improving the referral to mainland hospitals, improving the recruitment and retention of suitably trained doctors and staff, and improving access to off-island training for medical staff. That will be in conjunction with attempting to forge closer links with specific mainland service providers, similar to the arrangement that we now have with the New South Wales hospital system for accommodation of patients from Norfolk Island and, in particular, securing close working relationships with future providers of improved tele-health services—and I will deal with that matter shortly.

We are now working in close association with the Department of Veterans' Affairs to plan and implement home safety and falls prevention. The day club has recently been established on the island and provides an outlet for our elderly citizens on the island. It is not just restricted to recipients of Department of Veterans' Affairs pensions. We are also working with them to develop long-term aged care and residential accommodation. We are working with them to develop initiatives in youth-aged interaction—in other words, trying to encourage the youth on the island to interact more fully with aged people on the island. We are also working with them on geriatric staff resourcing and ongoing training for those staff.

I certainly also hope to discuss with Dr Wooldridge, the federal Minister for Health and Aged Care, the current status of telemedicine and its applications and to try to establish a cooperative approach, in tandem with a health complex redevelopment on the island, on the possible development of Norfolk Island as a training facility for remote medicine—I think I outlined that to some of the members yesterday or on the evening of your arrival—or maybe the attachment of Norfolk Island to such a facility.

In that regard, I believe that Norfolk Island is ideal, due firstly to our isolation. We have got no road ambulance service. I believe it would encourage people to hone their skills, knowing that that other type of evacuation is not readily available. We are unable to call a road ambulance so people are going to have to think a little bit harder about how they apply their skills.

Another ideal aspect of it is the number of tourists that we have coming to the island. With that is the element of the unexpected. Also, unfortunately, there is Norfolk Island's potential as a boat people destination. We have legislation in other areas being developed to contain that, but that is a real possibility and I guess adds significantly to the value of doctors training here. If they were to come across that type of thing, they would be

adequately prepared for it, and the associated problems that come with boat people. I think it has been experienced in Christmas Island at the moment, as you are fully aware.

Some of the Commonwealth benefits from taking that strategy in the development of this training facility would be to assist the Commonwealth with established medical services as part of a long-term defence strategy. As we are all aware, recent events in East Timor seem to suggest that spending will be increased substantially on defence strategies for Australia.

It would also provide a unique training experience for rural and remote doctors due to the aforementioned mix of reasons. On top of that, there is also potential cost benefits due to our tax arrangements. Some potential Norfolk Island benefits from such an arrangement would be the provision of on-island specialist skills and corresponding reduction in offshore referrals. It would also provide improved training access for local medical staff, and there would also be flow-on benefits to local businesses.

I would like to move on to point (iv) of my submission: 'Whether the Medicare system in whole or in part should be available to the residents of the Territory and, if so, under what terms'. The written submission outlines the current standing of Medicare as it relates to Norfolk and the discussions initiated at the August intergovernmental meeting. This arose as a result of the review of health services on Norfolk, including the question, 'Can the health care scheme be improved?'

As with Medicare itself, our scheme is seen by some to be imperfect, hence the need for us to try to explore the options available. One of those options was the complete privatisation of health insurance on the island—in other words, reverting to a degree back to the case that existed prior to 1989 when the Commonwealth withdrew the extension of the Health Care Act to Norfolk Island. That was when we had an insurer out of New Zealand, known as Southern Cross, that provided a level of comprehensive health cover to people on Norfolk Island. That was mainly for New Zealand citizens who were living here on the island. As you are aware, Australian citizens were, at that time, covered by Medicare.

The other option to pursue was Medicare as purely a commercial option. Currently, a review is being undertaken of our scheme by our insurance assessor, who was instrumental in the establishment of our own health care scheme on the island. We have not as yet received that, but we are expecting it very shortly. It is looking at the problems that have arisen with our scheme over time and the strategies needed to be able to address some of those problems. I think I need to make it quite clear here that the Norfolk Island government is not seeking a handout for its residents. We are pursuing the Medicare option purely on a commercial basis.

As pointed out in the Nimmo royal commission into Norfolk Island affairs, and subsequent advice received prior to the removal of the Commonwealth Health Care Act to Norfolk Island, the reality is the major imbalances in the taxes raised for the services that would be rendered to Norfolk Island—a severe imbalance. Furthermore, economic rationalists in the federal health and finance departments argued in 1989 that, if Medicare were to be continued, there would be substantial cost to Australia. As I have said, this was brought up at the intergovernmental meeting held on the island here in August. We are

exploring the options of our health care scheme, and, tied up with that, is the option of Medicare.

I would like to refer you to paragraph 7, page 210 of the Grants Commission report, which deals with the issue of health insurance. It says:

> Health insurance has some special aspects. We believe that it is being provided at well below mainland standards. We also note the lack of reciprocity between Norfolk and the Commonwealth and the problems this causes for both Norfolk residents visiting the mainland and mainlanders visiting Norfolk. In 1998-99, there were discussions between the two governments to overcome the deficiencies, but these came to nothing. We believe that negotiations should recommence as a matter of urgency. They should consider how the service can be improved, which government is best placed to provide it (either itself or under contract with the other government) and how the costs should be shared.

That is what we are attempting to do but, I must emphasise, on a commercial basis.

As yet, we have received no response from Senator Macdonald's office on these questions raised at the intergovernmental meeting. It has been three months, and I do know that discussions have been held between his office and the department of health.

It may be pointed out to you today that at the intergovernmental meeting I quoted a figure of $4,000 to $5,000 for the commercial option of purchasing Medicare from mainland Australia—and that is per adult. That was roughly estimated by calculating the average income in Australia and the 1½ per cent levy that is attached to the average income in Australia and a realisation that 13 per cent of Medicare costs are covered by the levy, which leaves something like 87 per cent that is not covered by the Medicare levy in Australia.

A bit of simple mathematics: by multiplying the levy raised by eight, which would give close enough to 100 per cent of the cost of Medicare in Australia, we arrived at a true cost—without the cost of infrastructure and everything else being attached—of between $4,000 and $5,000 per year per average income earner. That is the true cost of the provision of Medicare in Australia. I can assure you that at that time that raised some eyebrows and gave food for thought, and of course those figures do not include benefits received under the Pharmaceutical Benefits Scheme and remote assistance allowance packages for travel, et cetera, to mainland centres. There are a lot of questions requiring answers and we await these. Medicare, as an option, may not be suitable for Norfolk Island.

It has recently been brought to my attention that, possibly, part of the reason for reference to this committee of a health inquiry into Norfolk Island may have been rumours that the Medicare scheme has been abused by some residents on Norfolk Island. To date I am aware of only one case where a claim was forthcoming from a person resident on Norfolk Island who, prior to receiving a health care benefit, had received full Medicare benefit. Yes, the Norfolk Island health care scheme does cover over and above Medicare scheduled services. I certainly do not want to get into the identity of that person, but certainly that person is not a long-term resident of the island. I would be quite happy to discuss that with the committee in camera at a later date.

CHAIR—We have heard of that.

Mr Gardner—Again, this is not unique to Norfolk Island. Australians living abroad often return to Australia to utilise Medicare benefits. Norfolk Island is but a very small drop in a very large ocean.

I turn to the fifth point of the terms of reference, ‘The appropriateness of current administrative and operational procedures for medical evacuations of persons on Norfolk Island requiring critical care on the mainland’. For the benefit of others in this room who do not have a copy of the Norfolk Island government brief written submission, I would like to read aloud our response to that particular point.

Currently there is some uncertainty as to whether or not an RAAF Medivac will be made available in an emergency and the procedures to confirm availability are complex and lengthy. At the Intergovernmental Meeting in August this year the issue of RAAF Medivacs was raised and certain undertakings were given by the Federal Minister to investigate the matter with his colleagues and arrange for meetings between the Norfolk Government and other appropriate Federal Ministers and their Departments. To date this has not happened.

Mr NEVILLE—When you say ‘the minister’ was that defence, health or territories?

Mr Gardner—The minister that we discussed the issue with at the intergovernmental meeting was Senator Macdonald, minister for territories. The letter goes on:

To date this is not happening.

There are several options available

. continue with RAAF evacuations where no practical alternative available funded by:

. the Commonwealth

. the Norfolk Island Government

. jointly

. Utilise private air ambulance service, funded by:

. a NI Govt scheme

. the patient

. other, eg travel insurance

During the 12 months ended 30 June 1999 there were:

19 medical evacuations using regular passenger transport

1 medical evacuation using private air ambulance

and there have been three since, I understand, and—

6 medical evacuations using RAAF Hercules

These figures were extracted from the July 1999 Norfolk Island Hospital Enterprise monthly report. The submission goes on:

The above figures relate to evacuations for emergency treatment and excludes preplanned visits to medical providers on the mainland.

It is hoped to continue discussions with the Federal Minister and the appropriate Commonwealth Departments so that arrangements can be made firming up procedures for access to RAAF Medivacs. Currently RAAF Medivacs are only available when it is impractical to utilise other means and delays are incurred whilst the impracticability of other means is being established.

At this point I would like to point out that the Norfolk Island people are indebted to the RAAF for their tremendous support to local residents and their families when faced with the trauma of a catastrophic event that has required medical evacuation.

The changes to policy when they affect long-established arrangements are difficult to accept and understand, especially with regard to such a vital matter that has provided, until recently, certainty and peace of mind. As a result, we have turned our minds to the options. Are we able to improve and cement in place current arrangements? How can we ensure services for local residents and visitors in the event of current services not being continued or being unavailable? What funding alternatives are available?

Firstly, as with the Grants Commission recommendation on the Medicare matter and the reason for the issue having been raised at the August intergovernmental meeting, the required negotiations should consider how the service can be improved, which government is best placed to provide it and how costs should be apportioned. I am awaiting, again, a response from Senator Macdonald, although I am aware of a document entitled *Norfolk Island medivac: possible principles*. That document may be with the Administrator's office. It is certainly another example of the long problem that we have had with a logjam experienced in intergovernmental relations. Interestingly enough, this document, that I have secured by independent means just in very recent days, covers in point 1 part of the problem that we have in securing Medivacs. That point 1 is: reduce the number of players to the absolute essential. Example: why is the Administrator in the loop? I understand that this document was prepared by the territories department.

Secondly, with regard to exploring the options of insurances, I have had recent discussions with Careflight, which are based in New South Wales, as to their ability to provide an agreed price structure for medical evacuations from the island. I have in recent days received a response to that, and their fixed costs are about the $25,000 mark. It is interesting to note that it has also been rumoured that the same operators have provided quotes to evacuate private citizens out of Australia all the way back to the United States, with staff, for the sum of $20,000. There seems to be some disparity in their pricing structure; however we are exploring that option.

The question is: how do we fund that? I will come back to that shortly. Part of the option is developing an approach to the Royal Flying Doctor Service for a number of reasons: they are experienced, they service similar isolated communities throughout Australia and, as we spoke about yesterday, they fly to Christmas Island and to the Cocos (Keeling) Islands as well. Maybe there is a possibility of providing an annual subjunction to the Royal Flying

Doctor Service for that service. At the intergovernmental meeting in August I indicated, somewhat tongue in cheek, that the annual budget of the Royal Flying Doctor Service was some $18 million, which equates to roughly $1 per head of population in Australia, and suggested that, because of our population of roughly 2,000, maybe a $2,000 subjunction to the Royal Flying Doctor Service would be appropriate. The other options, as far as insurances are concerned, are making approaches to other medical air ambulance services.

To go back to the funding of insurances, the government submission lists Medivacs for the year ended June 1999. There were 19 regular passenger transport evacuations. We are now running into difficulties with those evacuations for a number of reasons. There are major difficulties with aircraft configuration: as the aircraft have been upgraded, their configuration does not allow easy access of stretchers to and from the aircraft. That particular point has been taken up with both Flight West and Air New Zealand. Flight West, I know, are looking into the possibility of being able to reconfigure their aircraft as they are now the most regular service provider to Norfolk Island. We still await a response from them. At times, passengers are required to take up up to eight seats when they are stretchered off on a regular passenger flight, and usually the full fare is required for those eight seats on top of the cost for doctors, nurses and equipment. Our health care scheme at the moment provides $200 in assistance for transport off the island. Some of those scenarios can cost in excess of $8,000. I also note here that Medicare does not provide any cover for transport costs.

The problem with staff having to travel offshore with the patient—that is, the doctor and the nurse—and also the equipment that is sometimes required on those regular passenger transport flights is that it can leave the island short of vital staff and equipment. If we had a major incident here on the island we would be understaffed and we certainly would not have the equipment to be able to deal properly with it. There was one commercial evacuation and the cost attaching there was in the vicinity of $25,000. As I have said, there have been three more of those since the end of June. There were six RAAF evacuations to the end of June 1999, and the costs have been estimated at over $70,000 each. I put it to you that maybe it is possible, as indicated in the submission, to credit monthly exercise flights to Norfolk Island.

If all 26 were private, using commercial evacuation—in other words, due to the reconfiguration of the regular passenger transport services and the unavailability of the RAAF service—then a simple exercise would result in an annual cost of around $620,000 for medical evacuations from the island. If that were to be attached to our current health care levy, it would equate to an increase in the levy of approximately $600 per year per member of the scheme, more than doubling the existing levy for a single health service. As I mentioned yesterday to members of the committee, already almost 10 per cent of members of the health care scheme are having difficulty in meeting payment of the levy. At the moment it is set at $500 per member per year.

Commercial insurances are non-existent, save for one. It is a specific type of insurance policy available on the island. To my knowledge, it is only available to four or five people on the island. The company provides the service so long as all of their other insurance policies are held by that company. There is a very strict qualifying regime to be able to secure that. It has an annual cost of about $1,000 per year which would cover for medical

evacuations and has been used in the past. However, any other commercial insurances that may be out there would also be subject to qualification and would need to take into account pre-existing conditions of patients. So we could not secure a commercial insurance policy for the evacuation of people from Norfolk Island. But that does not mean to say we are not going to continue to examine it. We need to, and that is what we are doing.

Thirdly, with respect to the other funding options that I mentioned, there is the financial capacity of Norfolk Island that was mentioned in the Grants Commission report. We need to explore and develop new revenue raising measures, and that is what is being done. We are doing that by the proposed redefining of our tax base and our tax system. The government is researching at the moment the implementation of a localised broad-based consumption tax for the island. There are also new government business initiatives under way, including the exploring of the establishment of an offshore finance centre on the island and, as members would be aware, the establishment of international gaming activities from the island. One or a combination of the three points may provide the answers and relief we are seeking.

CHAIR—There are some social costs associated with gambling, as we found out in Tasmania.

Mr Gardner—We understand that, Mr Chairman. It is probably opportune at the moment to give an indication to members of some of the other things that are often raised with me by members of the community and visitors to the island—not by great numbers of people; some people are not keen to come out and express themselves, especially when faced with a government minister, a member of the Legislative Assembly. Certainly, you do hear things from time to time around the island, and I think it is important for their benefit to provide the committee with some of the comments that I hear around the place from time to time. Certainly, these comments are not sanctioned by the Norfolk Island government and they are not intended to be taken that way. This is just prior to moving on to the next issue.

With respect to the question of taxes paid by Norfolk Island residents and visitors, and particularly visitors, and their application to the debate on the constitutional status of Norfolk Island, the question that is often asked is: are we an integral part of Australia or not? The Commonwealth, I think, in correspondence has made it quite clear that, yes, we are an integral part of Australia.

Likewise, there is the issue of the duty of care to Australian citizens, be they visitors or residents, or wherever they might be in the world. We look at the service that was provided in securing the release of Mr Steve Pratt and Mr Wallace in Serbia—the costs associated with that evacuation from Serbia, the political lobbying that took place and the costs that were involved in that.

My attention has also been drawn on numerous occasions to the multimillion dollars spent on the retrieval of non-Australian nationals. Even though I recognise that Australia is a signatory to many international agreements, the example given there is the saving of Ms Autissier on two occasions in the Great Southern Ocean and the costs that were attached to that. That ran into many millions of dollars on each occasion.

There is also another interesting one that was brought up with me just recently, just in the law few days, regarding the massive levels of foreign aid that are provided by Australia around the world and at times abused and misspent by the recipients of those funds. For example, and in particular, there is the aid that is being provided to Indonesia where there have been threats to kill Australians, and yet the aid continues. And just yesterday I noted on the Australian news that the new president of Indonesia is currently in the United States receiving health treatment.

I will now move onto point (vi), 'access to, and the utility of, tele-medicine facilities between Norfolk Island and the mainland.' Telemedicine and telehealth I put into the same basket: those facilities that assist via telecommunications systems in the delivery of health services. We utilise telephone services here at the moment for urgent medical referral and specialist advice. Quality and access is excellent as per the Norfolk Island Hospital Enterprise submission to this committee's inquiry into communications in May 1998.

Teleconferencing is available as needed, and the Legislative Assembly has made use of that facility in discussions with Senator Macdonald on occasions, and it is available to the wider public.

Fax services are available. That is used at present to provide pathology test results, electrocardiogram results, and for specialist diagnoses offshore. In other words, the results that are obtained here are sent offshore for diagnosis, and there is usually a fairly quick response to that. We also have Lifeline access via the telephone. We also have a pager system, which has its difficulties, but most of these technologies do. There is also a trunking radio system which assists in the provision of communications in emergency situations. Arguably, it is a bulky type arrangement, but it is also a consideration in our new communications infrastructure strategy.

There have been some advances in telemedicine on Norfolk Island since this committee was last on the island in relation to the communications inquiry. I think the GMO of the day, Dr Jeffrey Ayton from the Norfolk Island Hospital Enterprise, commented on the potential value of email and Internet access if that had been available at the hospital. That is now available at the hospital. There have been advances.

As to the future use of telemedicine and telehealth facilities, there is obviously enormous potential in the areas of teleradiology—which deal with x-ray and ultrasound—teleopthamology, teleconsulting, telepsychiatry, tele-education, videoconferencing, telepathology and teledermatology. In other words, there is a seemingly endless list of 'teleologies.'

There are limiting factors, Mr Chairman: the first one being the imagination. Secondly, there is the infrastructure that is required. That relates particularly to bandwidth, minimum capacities and data transmission speeds. Another limiting factor is the lack of current appropriate standards and codes nationally in Australia for the delivery of those services, the current costs of those applications and infrastructure, and the relative infancy of application of technological advances.

May I draw your attention to the document *Health on line: a report on health information management and telemedicine*, the October 1997 report of the House of Representatives Standing Committee on Family and Community Affairs. I refer to paragraph 381 of that document and a commentary given by Professor Kidd, who is the Professor of General Practice at Sydney University. Welcoming the inquiry as being 'very important and timely', he went on to say that he wished to impress upon the committee that:

> . . . we are still very much in the infancy of the information age and we can compare where we are now, if you like, to the early days of flying machines: we are not exactly sure where this Information Technology is going to take us or how it is going to take us there, but we have very vague notions of where we want to go. Those notions will become clearer as time goes on, but at the moment we are still very much in the early days.

Paragraph 382 of that report goes on to state:

> It is accepted that Telehealth and Health Informatics are in the early stage of evolution. Despite their early evolutionary phase, it is the Committee's view that any activities in the area should be planned and focussed and should not be driven primarily by the technology itself.

We are moving into an exciting time on Norfolk Island. New ultrasound technology has been budgeted for in this year's Norfolk Island government budget. We have a difficulty with it, though, in that our arranged trainer for our radiographer at the hospital to provide the necessary training for remote operators of the new equipment was, unfortunately, recently killed in an air crash in Fiji and we have not yet been able to identify a suitable replacement trainer. That has held up the purchase of the new improved ultrasound technology for the Norfolk Island Hospital.

There are also valued moves afoot by community members for the purchase of mammogram infrastructure for the island. It is a costly exercise. It has particularly costly resourcing implications as far as staff and training are concerned. But those are two definite areas where the telemedicine side of things could be of great assistance to Norfolk Island, by enabling the transmission the results of mammograms and ultrasonics to the mainland for express diagnostics from specialists on the mainland. There are at the moment, however, limiting factors associated with problems with resolution, of using the current telecommunications infrastructure we have in being able to send those adequately to the mainland for diagnostic purposes.

We currently have in our Internet service what is called the 64k system. I think that Telstra was mentioned in the *Health on line: a report on health information management and telemedicine* as saying that a minimum requirement just for videoconferencing, for example, which does not provide the clarity or the necessary resolution for these other applications, would be to double that capacity. For the resolution that is required for the transmittal of ultrasound and mammography applications, a minimum of two megs is required, which is fairly substantial.

I have referred to just some of the factors outlined. Many of those things were addressed in the report on health information management and telemedicine. I have referred the committee to that report and Ms Ellis, having served as a member of that committee, would know the content well. However, unfortunately we do not, to date, have any access to any information that shows any example of the standardisation and there is no availability of a

proved, standardised, off-the-shelf application for telehealth or telemedicine. There are plenty of pilot projects, lots of them. Unfortunately, there is very little federal government coordination.

Norfolk Island, like every remote settlement in Australia, does not possess or have access to the necessary resources at this stage to research and develop improved, customised, comprehensive telemedicine programs and infrastructure. I certainly believe this is the Achilles heel in the migration towards improved telemedicine services. We seek assistance from this committee in advising on the status of recommendation 21 of *Island to islands: communications with Australia's external territories*, the March 1999 report of this committee, which reads:

> The Committee recommends the Department of Communications, Information, Technology and the Arts, the Department of Transport and Regional Services and the Department of Health and Aged Care jointly develop plans and a timetable for the phased introduction of tele-medicine and tele-conferencing into the External Territories, through the provision of suitable infrastructure, equipment and training.

Again the approach, though lacking much required detail in the recommendation—for example, for standards requirements, et cetera—is, as far as my research suggests, the only proposal to date that suggests a coordinated approach to advancing improvements, in any meaningful way, in telemedicine.

It is all too easy for politicians to pay lip-service to things, and I guess this is one area where there has been some lip-service. There are all sorts of wonderful frameworks and bits and pieces, but really it is the coordination that is required for this to have a major impact across Australia in the health services field.

The Norfolk Island government is keen to pursue solutions. From the Norfolk Island perspective, cooperation is vital in developing our strategy, be it with the New South Wales Department of Health, universities, foreign consultants or institutions. We are attempting to be proactive on the implementation of improved telemedicine services to Norfolk Island.

I move on to point 7: the availability of community health services including residential or domiciliary care for frail aged residents of Norfolk Island. That wonderful document *Healthy horizons: a framework for improving the health of rural and regional and remote Australians 1999 to 2003*, which I referred the committee to earlier this morning, defines community health services as follows:

> Community health services consist of teams of health care professionals of different disciplines . . . Their aim is to protect and promote the health of the communities, provide primary health care and manage ongoing health problems. . . . The types of services offered by community health services include: women's and men's health programs; mental health support for groups and individuals; counselling and support for domestic violence and child abuse; condition specific support eg diabetes and asthma care; and targeted prevention programs eg smoking cessation, hypertension care and sun care.

This reference to types of services offered is not all-inclusive. As I mentioned earlier this morning, the submission to the Norfolk Island government by the community health awareness team from Norfolk Island expands on the type of services and yet still that list is not exhaustive. Some of the current services available include various counselling services

provided by ministers of religion, through the school, through private practice, across Lifeline connections and in other areas.

There is a weight control group. We have a private practice optometrist here on the island. It may be interesting if members were to be able to make available to themselves a copy of the recent edition of the *Norfolk Islander*, which addresses some of the improvements that that private practice has made and the improved service that they are now able to provide to the community of Norfolk Island.

We also have a recently established medical support foundation which I understand provides specific assistance to terminally ill patients. We also have an Alcoholics Anonymous. We have youth groups on the island. We also have a wonderful service club system here that provides enormous support to our health infrastructure. I am not used to talking so much, Mr Chairman.

CHAIR—Would you like to have a break for some questions?

Mr Gardner—If there are some questions, yes.

CHAIR—Have any of our colleagues got any particular questions?

Mr NEVILLE—I have plenty but we will not have time.

CHAIR—We have until 11.00 o'clock.

Senator CROSSIN—A little bit earlier you referred to a one-page document you pulled out of the yellow manila folder that you believe to have been written by the department of territories. Is that available for tabling so that we can know what you were referring to?

Mr Gardner—I am quite happy to do that. I can get copies for you if you wish.

Senator CROSSIN—Another question that perhaps does not go to too much detail or reference is: what is the bandwidth of your Internet access? Does anyone of your support people know that?

Mr Gardner—Senator, you are directing that question at somebody without adequate experience or knowledge in that field.

Senator CROSSIN—Is it different from what is in the *Island to island* report? Has it been upgraded or improved since then?

Mr Gardner—No.

CHAIR—Just before we proceed to the next question I would like to take this opportunity of welcoming the Chief Minister and to thank him for his attendance today. We look forward to discussions, Chief Minister, over lunch and at dinner this evening. I refer to the Hon. George Smith MLA. Thank you very much for coming. If you would like to submit

something in writing later on, you would be welcome. I would also like to acknowledge the presence of the Hon. Tony Messner, the Administrator. Tony, welcome.

Mr NEHL—I am interested in just what is involved. You have already answered the question by not answering it because, like me, you are not technically adept. Does anybody know what is required, in terms of the type of equipment and the cost, to provide the electronic infrastructure for ultrasound and for X-rays to be sent to the mainland?

Mr Gardner—Thank you for that, Mr Nehl. Probably the person best placed to answer that question would be your colleague, Ms Ellis. Certainly, she has had quite a deal more to do with telemedicine and the applications involved and would certainly be in a far better position to be able to provide indicative costs of the establishment of that type of infrastructure on the island.

Ms ELLIS—I am not in a position to give the costs. I was a member of both of the committees that did the reports to which you refer. Like you, Minister, I am not a technocrat in terms of telecommunications but, in your written submission, you mention the fact that a review of the island's future communications needs is currently being undertaken and the emerging results indicate that an upgrade is needed and imminent. I would like to know if you could tell us to what degree that upgrade is going to reach in terms of technical connection in the communication sphere? If a review is under way and an upgrade is planned, then the authorities here must have an idea to what degree it is going to be upgraded.

Mr Gardner—There have been discussions with Telstra in recent times where we have been given a far clearer indication of exactly what capacity is available through our current cable infrastructure in connections with Australia. At the moment, we have a 64K Internet link. They talk about minimum requirements and bit and pieces in that report of being two meg. In actual fact, there is a super group now—I understand that is the technical wording for this type of connection—that provides two meg now between Australia and Norfolk Island, but that is not part of the Internet access so I understand. Telstra have indicated that there is the potential for somewhere between 30 and 70 of these super groups between Norfolk Island and Australia through the existing cable infrastructure.

There have been discussions in recent times that maybe the cable is going to become redundant and is not going to be repaired with the introduction of the new Southern Cross cable. It would be phased out over time, and the costs of maintaining it were rather excessive. The latest advice received now from Telstra seemed to indicate that Telstra is quite prepared to continue to maintain that cable. Yes, there is capacity there at the moment.

However, at the same time that we were pursuing options, especially for the offshore finance centre, looking at the telecommunications capacity required to develop a niche type offshore finance centre here on the island and with the information that maybe this cable was going to be made redundant, there was certainly a need to start looking towards satellite communications for the island. In regard to that, there have been approaches made through the RTIF fund to assist Norfolk Island in the development of that type of communications infrastructure and the attached capacity that would be required for the advancement of telehealth and telemedicine activities on the island.

Ms ELLIS—Garry, I do not want to interrupt you needlessly here, but if I can just ask—

Mr NEHL—Interrupt away.

Ms ELLIS—The report into telemedicine, which is now two years old, really showed the limitless potential but, as you have said, it takes several components. The most important point is that limitation is only by the communication network available. During that inquiry, we saw examples in front of us of the transmission of three-dimensional X-ray. You can do anything with it. On your trip to Canberra in the near future, I strongly urge that you get the advice of this committee and, through this committee, the family and community affairs committee. If you have the time, then I would strongly suggest that you see some examples of what can be done, given the different limitation of communication link. That will give you, if you have not already seen it first-hand, a very good idea of what you actually need to pitch to here and the affordability from both the NI point of view and that of the Australian government and Telstra. It really needs to be seen to understand what exactly is required for certain levels of communication.

Mr Gardner—I certainly would very much appreciate that, Ms Ellis, and thank you.

Ms ELLIS—I am sure the two committees in collaboration could equip you to do that. It would be a very worthwhile exercise.

Mr Gardner—The hesitancy that exists at the moment is more in relation to the standards and codes and bits and pieces. For example, we all know that the video machines that you get in the United States will not play our Australian video tape. It is really making sure that these standards are global across Australia so that if we are sending something through that system there is a machine at the other end that is able to read it and not just throw it into gobbledygook, a bit like trying to get Windows 95 to talk to Windows 97 or Windows 99. Sometimes when you send emails, the emails go through but they cannot be read because they are all question marks and exclamation marks. We need to try to avoid that.

Particularly for us, the type of hardware that is required is not necessarily cheap. It might be cheap in the federal sphere but to a community the size of Norfolk Island, $20,000 to $30,000 worth of equipment is significant. We do not want to have to turn around next year and replace it because it is now out of date or it does not comply with standards that have been developed. There is an air of caution as to just how quickly we should embrace this type of thing. Certainly, I very much appreciate seeing it first hand.

Mr NEHL—Can I point out to you that the Antarctic Division, based at Kingston in Hobart, is involved in telemedicine through its Antarctic bases. In fact, the division is doing work for NASA, because Antarctica is the closest thing to being up there. It would be worthwhile talking to them about what they are doing, because they are doing telemedicine things as well.

A couple of questions I have relate to the actual provision of services. How many families or individuals are not able to afford the levy of $500 per person, or $1,000 per family a year?

Mr Gardner—It is difficult to determine what a person is not able to afford. It is affordable.

Mr NEHL—I mean those who do not pay. We will not discuss their financial status as to whether they can afford it or not, but how many are there who do not pay for whatever reason, whether they are broke or they do not want to?

Mr Gardner—Most of them end up paying but, as I said yesterday, it is about 10 per cent of total membership. It is somewhere between 90 and 100 persons on the island.

Mr NEHL—It was stated at our visit to the hospital yesterday that some people cannot afford the pharmaceuticals because there is no Pharmaceutical Benefits Scheme, as there is in Australia, and the cost of drugs can be very high indeed. It was suggested in those informal discussions that there were people who needed drugs, whether for diabetes or heart conditions, but that they did not take them because they could not afford them, and that some mothers with children who needed medication were not getting the medication because they could not afford it. Can you give us some detail on that?

Mr Gardner—It is probably more appropriate that the director of the hospital, Mr John Christian, reply to that.

Mr Christian—Some of the comments made yesterday by the doctor concerned were a little inaccurate. In general, most of the pharmaceuticals supplied through the pharmacy at the hospital are priced to come in at about the Medicare levy. As you know, the price in Australia is heavily subsidised under the Medicare levy. There are some drugs that are higher than that, but they tend to be the ones that are less used.

One particular instance that was quoted yesterday was cholesterol controlling drugs. The price here on Norfolk is considerably cheaper than the price in Australia. That particular drug he was talking about has not been put on the Medicare levy yet.

Mr NEVILLE—Are you talking about the Pharmaceutical Benefits Scheme as distinct from Medicare?

Mr Christian—Yes, sorry. In general, the pricing of the drugs is either equivalent to or slightly below or above—

Mr NEVILLE—Can I just interpose here? When you say they are cheaper, are you saying that the cost of the drug is less than the $20 that the average person would pay on the mainland? As you know, people on the mainland pay the Pharmaceutical Benefits Scheme levy at two levels. If they are employed ordinary citizens, they pay $20. If they are pensioners or welfare recipients, they pay $3.20. How would those drugs that Mr Nehl was asking you about compare with those two levels? For all practical purpose, no matter what the cost is to the particular pharmacy, that is the cost to the patient. How does the cost of those drugs here compare with what Mr Nehl asked you?

Mr Christian—What I am referring to is the price that is listed in Australia under the Medicare levy benefit. The pharmacist who runs our pharmacy tries to keep prices within

those limits. There are the odd exceptions such as the drug that was quoted yesterday which is actually not available on benefits; you have to apply.

Mr NEVILLE—What would you pay for that, in round figures?

Mr Christian—On Norfolk Island it is about $90 per month.

Mr NEVILLE—That is a lot more than the $20 for the average Australian.

Mr Christian—Sorry, that particular drug is not available in Australia; it is not listed on the Medicare levy benefit.

Mr NEVILLE—It is not yet on the PBS?

Mr Christian—No.

Mr NEVILLE—I see.

Mr Christian—That is where the confusion arose yesterday, with the doctor not being aware that in Australia that is not available under the benefits.

Mr NEHL—I will return to the thrust of my question, although I acknowledge what you are saying about prices. Are there individuals and families who are not getting the medication that they need for themselves or for their children because of cost?

Mr Christian—The particular doctor who raised that subject yesterday has only been on the island for about two months and was not aware of some of the welfare that is available on the island. We had discussions with the appropriate welfare person last week and said that if there is anybody who cannot meet the cost of those drugs, they do have the ability to apply for a special benefit through the welfare officer.

Mr NEHL—So what you are really saying is that there is nobody on the island who is missing out on taking medication that they need because of cost. Is that correct?

Mr Christian—Correct.

Mr NEHL—I will finish on issues raised at our informal talks at the hospital yesterday. I understand you have only a part-time radiographer. Can you tell the committee what the situation is with radiography?

Mr Christian—Certainly. The radiographer is employed for 25 hours per week, but she is on call outside those hours. If anything happens outside those hours, she is available. The reason why she is only on 25 hours is because there is generally insufficient work for her to be there for a 40-hour week.

Mr NEHL—But she is on call for 24 hours a day?

Mr Christian—Correct.

Mr NEHL—What happens if she breaks a leg?

Mr Christian—The two doctors do have some experience with the X-ray machine, and they can operate that if needed.

Mr NEHL—I want to revert very quickly to the pharmaceuticals matter. If you have passed the $2,500 expenditure per individual per annum on health care, and thereafter you get a refund or you get it for nothing, does that apply to pharmaceuticals too?

Mr Christian—Yes.

Mr NEHL—So before you get a benefit on pharmaceuticals, you have to have spent $2,500 first, plus your $500 levy. Is that correct?

Mr Gardner—Yes.

CHAIR—Because Senator Crossin has another appointment, I will ask her to ask a couple more questions before I move to my other colleagues.

Senator CROSSIN—Thank you. One question goes to the ambulance. Mr Gardner, you said that there was no road ambulance, but we have some background papers—

Mr Gardner—I am sorry, Senator Crossin, we do have a road ambulance. That reference I made about the road ambulance was with regard to our isolation and the establishment of a training facility here on the island—in other words, to attempt to hone the skills of rural and remote doctors because of the absence of a road ambulance being available between here and a mainland centre. It would be a way to hone skills, because it would not just be easy to say, 'I cannot deal with this here, call in the road ambo,' and it would shoot off down to Lismore, or wherever it may have to go to.

Senator CROSSIN—I see. The other issue I want to talk to you about is the levy of $500 or so a year that people are required to pay. How is that structured? Can they pay that monthly? Must they pay that every six months?

Mr Gardner—I can give a more detailed response but, basically, at the moment it is paid every six months—$250 every six months—and arrangements are made by some people to pay that off monthly in that six-month period.

Senator CROSSIN—Do people get a bill every six months that is due to be paid within, what, seven days, 14 days?

Mr Gardner—They get a levy notice. It may be best if Mrs Kim Edward addressed that issue specifically.

Mrs Edward—They are billed on 1 March and 1 September and they have 30 days from the date of the levy period to pay. Otherwise, they can complete a form advising the administration they wish to pay it off by instalment.

Senator CROSSIN—From our background notes, my reading of it is that it is structured on similar calculations to the Medicare levy based on the average weekly wage in Australia. I am aware that you have people who earn far in excess of that, so they are paying less. What about those people who are earning far less than that? Are there no exemptions, like there are for people in australia who would be on, say, a full or part pension?

Mrs Edward—They would be.

Senator CROSSIN—How do you go about getting that exemption and how is it calculated?

Mrs Edward—There is a notice that goes in the paper every levy period which states that you can apply for a suspension if you have alternate health cover with MBF, Commercial Union or any private health insurance, or if the income of a husband and wife is less than $7,000 within the previous six months they can apply for an exemption of the levy. They are covered, they are just exempted from paying the levy.

Senator CROSSIN—The $7,000 is a combined income?

Mrs Edward—Combined income.

Senator CROSSIN—Whereas on the mainland it would be $10,500 combined income or $5,700 each?

Mrs Edward—I am sorry, I do not know what it would be in Australia. It is $7,000 combined income or $3,500 per person.

Senator CROSSIN—So how did you strike this $7,000? If you have calculated your levy on an average weekly wage like Medicare, why are the exemptions not comparable to what would be the Australian standards? How did you arrive at $7,000 for the combined income exemption? And what is it for a single pensioner?

Mrs Edward—For a single person or a single pensioner?

Senator CROSSIN—A single exemption figure.

Mrs Edward—Three and a half thousand dollars.

Senator CROSSIN—How did you arrive at that?

Mr Donaldson—Senator, as well as being the Acting Program Manager for Community Services I am the authorised officer for social services. On your question relating to how the levy was struck, historically, when the health care scheme was first costed about 10 years ago, there was a costing done on what the scheme was going to cost the community and what the number of the people in the community was, and a simple division was done. It turned out to be about $100 or $120 per person per six months for the levy. As far as I am aware, there has never been any correlation between it and the Medicare levy—the 1¼ or 1½ per cent; that nexus does not exist. In subsequent years the health scheme has made a deficit

and the levy was increased to compensate for that deficit. It is now at $250 per person per six months.

On the second part of your question with regard to pensioners, Kim referred to an income level exemption based on income of $3,500 for the six months prior to the levy period. In calculating that income of $3,500 the pension amount is excluded, so automatically that excludes most of the pensioners from paying the levy on the grounds of income. It is only if pensioners' other income exceeds the $3,500 that they would have to incur the levy. That can happen if they have substantial interests, a house they rent out or part-time work, but generally the pensioners on Norfolk Island are exempted from the levy. We know from our pension records what their other income is and we automatically exempt them before the levy forms go out, so the elderly people on the island are generally not sent a levy notice so they do not have to concern themselves with it.

Mr NEHL—Do you ever have to take people to court to get them to pay?

Mr Donaldson—We have a system here of default summonses. Maybe Kim could better answer that one.

Mrs Edward—Just recently our Court of Petty Sessions Act has changed. We used to summons them for the debt, and half the time the debt was finally written off, but since our Court of Petty Sessions Act has changed they do go to court and discuss their financial situation. That has just happened recently. In fact, when they were summonsed to court they paid it prior to appearing in court.

Mr NEHL—Is it very widespread? Are many people in that situation, or likely to be?

Mrs Edward—We charge the health care levy to approximately 1,500 people and 90 to 100 would get to summonsing stage and actually be served.

Mr NEHL—What is the next step?

Mrs Edward—Once they are served they go and pay at the registry office by instalment. I cannot recall any steps going further, for warrants of execution or anything like that.

Mr NEHL—So generally, having gone to court on it, they then pay?

Mrs Edward—Most of them do, yes.

Senator LIGHTFOOT—Mr Gardner, you mentioned the disparity between medical health services on the island and those on the mainland. The mainland comes under a different tax regime, and obviously you have considered that. You have obviously considered for about a millisecond also coming under the Australian tax regime and rejected it, I imagine.

Mr Gardner—About that, Senator, yes.

Senator LIGHTFOOT—I bet it was even less than that. How do we come to some equity with respect to the tax that Australians are subject to and the comparatively low tax regime that Norfolk Islanders are subject to, and then say to the Australian taxpayers that we should bring Norfolk Islanders under precisely the same health scheme and services that we get on the mainland?

Mr Gardner—I do not think that is something that we are asking about. We are asking that—

Senator LIGHTFOOT—If I can interrupt, how do we then say that we should get the RFDS to fly to the island? I think that is an excellent suggestion. I have grown up in remote parts of Australia and I still live and work in some of those areas, as far afield as Derby, Halls Creek and Fitzroy Crossing. Some of those names you have probably never heard of, but they are very remote. In fact, they are as far away from Perth as Norfolk Island is from Sydney. I think it is a good idea, but we have fundraising for the RFDS in Australia. Would your government be prepared to impose some kind of levy, some kind of personal tax—I am not saying personal income tax, that is prohibitive, but a kind of personal tax—in order to fund something like the RFDS coming to the island on emergencies?

Mr Gardner—As I outlined in my submission, that is indeed one of the options that are available to us as we explore the avenues for funding. The easiest way—as I think is the movement in Australia towards the goods and services tax, basically—is to try and make that not felt. The levy at the moment is felt because it hits you right in the face every six months. I would much prefer it if we migrated to a broadbased consumption tax or something of our own here; maybe the costs of that could be built into that so it is not felt but on every item that you purchase you are contributing somewhere down the line, rather than having that hit-you-in-the-face, six-monthly type levy. They all have resourcing implications. I cannot speak for the rest of the government on that, but certainly we would very much like to be more compassionate in funding that type of thing. If we can do it by building it into some of our current tax arrangements or in our revised planning for tax arrangements, or even by supplementary revenue that may be received as part of the new government business initiatives, we have to explore those. We are doing that.

Senator LIGHTFOOT—What of the RFDS? Has there been any contact made with the Royal Flying Doctor Service of Australia on the mainland?

Mr Gardner—Yes, I have. I spoke on exactly this matter in our own House last month, saying that I am preparing a submission to the RFDS. It is basically the same type of approach as I have taken to Careflight: to be able to quote the cost and to see whether there is aircraft available for that haul out of Brisbane, Dubbo or wherever it needs to come from. That is the first big hurdle: to make sure there is adequate aircraft for it, and I am progressing that at the moment. But certainly there is nothing final on that yet.

Senator LIGHTFOOT—When I first became aware of the RFDS, they were flying very small aircraft. They then graduated to Beechcraft Barons; a lot of the aircraft now are King Airs or even bigger, and they are ideally suited to evacuations. But, on your comment that there are eight seats plus the medicos on the scheduled flights to the island, it seems to me that, if you transfer the cost of those eight seats plus the seats for the medicos, the RFDS

may be very interested in it. Are they aware of the alternatives to that so that they can create in their minds some sort of incentive to come here?

Mr Gardner—Not as yet, Senator. As I said, it is only early days with the RFDS at the moment. But we are pursuing it.

Senator LIGHTFOOT—The other question is with respect to medical evacuations from the island. Do you impose some obligation, or have you asked the federal government about it? We have, as I recall, remote area medical evacuations where they are obliged to set aside a couple of seats—although not eight. Do you have something similar to that with the commercial flights that land here?

Mr Gardner—I cannot accurately answer that one, but most of the airlines that service the island are fairly compassionate. If we need to get somebody off, usually room is made for them—certainly in the situations I have been aware of.

Mr NEVILLE—At what cost?

Senator LIGHTFOOT—What is the cost to the patient or to your medical—

Mr NEVILLE—What is the cost or the charge, either to the government or to the patient?

Mr Gardner—It is the room that is taken up in the aircraft, whether it be one seat or eight seats.

Senator LIGHTFOOT—Then you cannot request, or have not requested, that the landing rights incorporate a statutory obligation to evacuate patients for emergency treatment?

Mr Gardner—Not that I am aware of. But I will take that on notice and undertake to give you a comprehensive report on that when I visit Canberra. I will certainly be able to shed some light on those arrangements.

Senator LIGHTFOOT—We would appreciate that, and also I am sure that the committee could give you assistance with respect to the RFDS. Has there been any undue delay in the evacuation of people with life threatening medical conditions—melanoma, open-heart surgery, critical brain tumour operations, peritonitis, et cetera—that have caused their premature demise?

Mr Gardner—Not that I am aware of. It could be argued that there have been some very close calls because of perceived delays in securing our evacuation services. Again I could have expanded on that, but I believed it would be expanded on by the doctors who were going to give a submission to you later. They would certainly be in a better position to advise on that, both of them having served in the past on the Island in relation to RAAF and other evacuations.

Senator LIGHTFOOT—What, then, of those people on the Island—I do not know in what category they would be, but undoubtedly they would exist—who do not have health cover but need to be evacuated, when there is no guaranteed resource from which expenses can be either partially or totally repaid? What happens to people like that, and who assumes responsibility for the payment?

Mr Gardner—That scenario has not arisen. We have evacuated everybody that has required evacuation.

Senator LIGHTFOOT—And they have all been paid for by the Australian health system, the health system existing here or private insurance. Is that correct?

Mr Gardner—Private insurance, the health system here and the compassion of the Royal Australian Air Force.

Senator LIGHTFOOT—So you do not set aside any budgetary item as a contingency for people who need to be evacuated but are not covered by insurance of any kind?

Mr Gardner—The difficulties that we are experiencing at the moment are only recent. As I explained in my submission, the regular passenger transport evacuation services had been fine to date. Basically the configuration allowed passengers to be able to be evacuated and, because of the regularity of those services, nine times out of 10 it was easier to evacuate them on a regular passenger transport plane than to bring in the RAAF or a private carrier. In other words, within a couple of hours or three hours, there is usually a regular passenger transport service on the ground.

By the time the doctors have made the necessary diagnosis to be able to say, 'These blokes need to be away,' when they have made contact with the specialists in Australia and the specialists have said, 'You really need to get them off the Island,' normally somewhere there has been a window of opportunity to evacuate them. Only in very serious life threatening situations when there has not been a regular passenger transport service available have the RAAF and private medical retrieval services been called upon.

Senator LIGHTFOOT—So, in terms of costs to the Australian government, it would appear to me—at least from a cursory examination of the facts—that the RFDS would be a more viable alternative for single or double medical evacuations than the RAAF, with its high cost. Is that assumption correct?

Mr Gardner—Yes, you could probably say that would be correct. I did also mention in my submission that there are the monthly regular training flights that come through here. You would probably find other people today that say that the crews of the RAAF really love to actually go and pick up a real body, rather than just be on a training exercise.

Senator LIGHTFOOT—A real live body?

Mr Gardner—Yes, a real live one. I guess that training exercises become fairly mundane after a while. It is a bit like playing golf by hitting buckets and buckets of golf balls and not getting anywhere. You would be rather out there in the action. So, yes and no.

Senator LIGHTFOOT—The hospital, which I have visited on a couple of occasions, looks to my inexperienced eye to be clad in asbestos. Do you know whether that is correct?

Mr Gardner—I certainly hope not.

Senator LIGHTFOOT—Can you assure the committee that it is not?

CHAIR—You might like to take that on notice.

Senator LIGHTFOOT—If you would, you can take it on notice.

CHAIR—We are starting to run a little bit short of time.

Mr Gardner—I would be horrified if it was, but certainly we will find that out for you.

Senator LIGHTFOOT—But you cannot give the committee an assurance that it is not.

Ms ELLIS—I have a couple of brief questions. Minister, you mentioned that the RFDS fly to Christmas/Cocos (Keeling). Are you aware of the arrangements under which that operates?

Mr Gardner—No, I am not.

Ms ELLIS—We had better find out, I think. Mr Chair, I want to move on to a subject that has not quite been covered in the paper from the minister: the aged care facility. Is it appropriate to talk about that now? It is on page 5 of the government's submission.

Mr Gardner—When I was beginning to choke and took the break, I was in the middle of addressing that so, maybe with the chair's permission I can continue with that submission. I could address that and maybe then redirect the questions, if that is all right.

Ms ELLIS—All right—just briefly.

CHAIR—We are starting to run out of time. In deference to the other witnesses would you prefer to take it on notice?

Ms ELLIS—I have got two or three questions that are pretty relevant. Either we can get the further briefing or I can just ask the questions.

Mr Gardner—I am just wondering, Ms Ellis, if it is possible to complete addressing point 7 and maybe take the opportunity to reconvene later this afternoon. I think it is important that some of my final comments need to be aired publicly.

Mr NEHL—Mr Chairman, I would just like to endorse that. I think we do need to have the minister to be able to complete his submission.

CHAIR—Okay.

Mr Gardner—Thank you. I get back to where I was. I was discussing the types of services offered on Norfolk Island, including residential or domiciliary care for frail aged residents of Norfolk Island. I was dealing mainly with the community health services and it got to the point where I was discussing service club initiatives and the value of our service clubs on the Island in providing support for ophthalmology services, hearing and speech impairment services. In the current Rotary bowel scan project, I understand that eight kits out of 250 were brought to the Island. So there is value in the service clubs providing those services. They also provide diabetic screening services and glaucoma screening services to the Island which, in relation to Ms Ellis's concern, relates very much to the aged and frail on the Island.

There is also condition specific support provided via the hospital for things like diabetes and asthma. The Red Cross undertakes a daily phone check on aged singles on the Island, checking on the state of health of, usually, those that are alone and making sure that they are all right and do not need assistance. District nursing services are provided in conjunction with the hospital for home visits and there school medical and free dental services, the maternal and infant health facilities and the child and adult immunisation programs. The service clubs had provided that assistance until just recently, and as part of the proposal of budget review I will be taking to the government the picking up of the costs of immunisations for pre-school-aged children on Norfolk Island. I understand that a youth counsellor is shortly to be introduced into the Island through one of the churches established here. That is yet to be confirmed but there seems to be a need for youth counselling services on the Island.

There has also been a lot said, and probably a lot will be said today, about health educational and health promotion material. It is recognised by the government that there is great value in that at an appropriate level of service. Rather than bogging people down with thousands and thousands of different types of brochures, we want to try and introduce that over a period of time, make sure it is done properly and try and avoid some of the supplementary issues that raise themselves from time to time in relation to some of the health information that is available to people.

One of those, I suggest, is in relation to anorexia and bulimia. I had asked the previous director of the hospital to get in touch with the New South Wales Department of Health to see if they had a package that was available on that subject for distribution and discussion at the school. It was felt that one needed to be very, very careful on just how that information was projected to school children, who was actually providing the information. One should be very careful generally with the package, because it could have the opposite effect from the one intended. In other words, children could pick it up and say, 'It's great to be thin,' or 'I want to be thin.' They could use that sort of information in a way that detrimental to their health, rather than taking the warning about the benefits of making sure that they get regular check-ups and talk to people if they have problems. Certainly anorexia has caused a problem here on the island in two or three instances in recent times. So I just needed to point out the caution over the use of some of the education material. We need expert assistance to make sure it is delivered properly.

Alternative or complementary health care practices also contribute meaningfully to the very broadbased services that are available. On Norfolk Island these include hospital based

practices such as acupuncture and chiropractic services through the services of a visiting specialist. Private service delivery included homoeopathy and therapeutic massage. Again I refer the committee's attention to the recent addition of the *Norfolk Islander*, which includes an article on a recently opened business dealing with the Bowen technique and the alternative health advantages that that may provide.

Residential or domiciliary care for frail aged residents on Norfolk Island has been highlighted. It is obviously a health service that will require an increasing level of support due to the ageing trend of Norfolk Island's population. There is definitely a need for appropriate care at home and in residence. Maybe I will take this opportunity to refer again to the Grants Commission report. On page 87, in paragraph 57, that report states:

A related infrastructure issue concerns facilities for the care of the aged. Given the ageing trend of Norfolk Island's population, it has been recognised by the Island government that the provision of aged care facilities should be part of its strategic plan. However, these facilities are not a priority at present because enough beds were available in hospital for long-term aged care patients.

That has changed. The provision of aged care facilities is part of our strategic planning process. We believe now that the numbers that are in the hospital in the aged care section are increasing beyond the limits of what is thought to be the best-case scenario for the care of geriatric patients on Norfolk Island.

Domiciliary nursing services are provided through the Emily Channer Trust, which is a private trust, with patients who are not social security recipients paying a fee for each visit. There is a fee attached to that, but the social welfare side of the Norfolk Island government picks up that cost as part of pension entitlements. Residential care is provided exclusively by the Norfolk Island Hospital Enterprise and currently has four rostered staff covering geriatric care. There is a joint approach between the Department of Veterans' Affairs, as I alluded to earlier, and the Norfolk Island government to develop the necessary strategies to improve domiciliary and residential care for the aged on Norfolk Island.

The initiatives will provide, via seeding funding from the Department of Veterans' Affairs for entitled veterans and the Norfolk Island government for other pensioners on the island, budget considerations for the employment of a supplementary full-time qualified geriatric nurse and trainer, and a full-time physiotherapist. The spin-off benefit will negate the current need to refer other patients offshore. The physio unit is currently fully equipped and utilisation of visiting physios suggests virtual self-funding, also a speedier recovery of patients, including those hospitalised, and a corresponding reduction in patient health costs.

The Norfolk Island government is also considering the extension of home assessment and fall prevention as part of the health strategy. There have been recent discussions with the Return Servicemen's League on the island and the hospital board representatives to provide facilities for a quiet room and purpose built private rooms for long-term nursing care patients. We are awaiting at this stage a detailed proposal.

The Department of Veterans' Affairs have kindly offered advisory services in design and service implementation for such improvements, in particular relating to the redevelopment of the Norfolk Island Hospital as a whole. The strong inherent social and community values evident in Norfolk Island preclude consideration of elderly people in need of residential

support or full-time nursing care having to move offshore. We do not want to see that happening.

In many remote locations in Australia that are short of necessary facilities for the aged, we find that people are forced to move to larger towns that do have those facilities, away from their homes, friends and family. Due to the size and location, our health services and strategy for the future will in all likelihood mirror the Commonwealth's multipurpose service program, basically expanding on the current practice that we have here on Norfolk Island with some minor administrative change. That program allows communities to combine resources from the hospital, community health services, domiciliary care services and residential aged care services into a single pool. Service delivery priorities are determined and the resources distributed efficiently and sensibly by sharing skills, workload, administration resources and facilities. Stand alone, purpose built specific entities are simply not practical when considering the limited population and financial resources. This approach within Australia is gathering significant momentum in other remote communities.

That brings me to the end of point 7. Being conscious of time, I wish to seek to reconvene later this afternoon, if that is possible, to complete my submission.

Mr NEVILLE—I have some questions but I do not think we should hold up the agenda at this stage.

CHAIR—We do have another opportunity at five o'clock.

Ms ELLIS—I am happy to hold my questions on this section till then, but I do want to get them attended to.

Mr NEVILLE—I think they are very important. I would rather us extend this afternoon than not ask them.

CHAIR—Okay. That will give your voice a chance to recover. Thank you very much for appearing before the committee.

Is it the wish of the committee that the submissions tabled by the government of Norfolk Island and the Norfolk Island Hospital Enterprise Board of Management be accepted as evidence to the committee and authorised for publication? There being no objection, it is so ordered.

[11.03 a.m.]

DAVIE, Dr John, Medical Officer, Norfolk Island Hospital

CHAIR—Welcome, and thank you very much for the help that you gave the committee yesterday.

Dr Davie—Thank you for the opportunity to discuss some matters of concern with you today. We have two doctors on the island. My colleague is the senior medical officer. I have been here for four months on this occasion; I was previously here for four years in the mid-1980s. I have a background in general medical practice and have specialist training in public health and epidemiology. I worked in rural and remote Australia and in various overseas and developing countries in several capacities, primarily with an interest in public health medicine and in primary health care initiatives.

I would like to submit some of my concerns to the committee. They do not relate particularly to the terms of reference stated in your agenda but more to conceptual matters with regard to health care and health service delivery on the island. My primary concern is that, despite a worldwide movement towards primary health care initiatives, we are seeing a situation in Norfolk Island where the focus is primarily on curative care. I note, particularly in the four months that I have been here on this occasion, a paucity of preventive and promotional health matters on the island.

This, to me, is of major concern, because the health budget, like health budgets everywhere, is spiralling, and the movement towards primary health care seems to have been very slowly adopted here on this island. This pertains, in particular, to diseases of lifestyle, for example, which are at least as common, if not more common, on Norfolk Island as they seem to be on the mainland of Australia. I mention, specifically, items such obesity, tobacco related diseases, alcohol consumption and hypertension—all diseases which, I am sure you are aware, involve an incalculable cost to any community and particularly to health care on Norfolk Island when they get out of control, as they always do.

Coupled with this and the lack of preventive initiatives in this regard, I am particularly concerned that our greatest assets here are people, and yet it is very difficult for a medical practitioner to understand why we do not have simple legislation to make the wearing of seat belts compulsory. We have had a legislative assembly for 20 years, and I almost feel that it is an abrogation of their responsibility not to have incorporated this into law on this island. Therefore, one wonders if public health care and primary health care are treated with some degree of contempt on the island. I do not say that in a derogatory sense, because there certainly are other priorities which are of major concern here. But, with regard to public health initiatives, I do not think it would take very much to put into operation a plan which is both effective and will result in significant cost savings as it has been shown to do throughout the entire Western world, and yet we seem to be sorely lacking in this regard.

I caught the end of the minister's submission a few minutes ago, and I note that he mentioned that there are initiatives in the offing. I think most of these initiatives are possibly service club driven, and I commend them for that, but I see very little from a government perspective in this regard. For example, whereas we would have a very active immunisation

program in Australia, we have a very ad hoc appearance of that particular initiative here. I am not saying it does not happen, but the incentive to produce better results does not seem to be the same here as it would be on the mainland. That is just one example. The seat belts initiative is another one.

I think the school does a remarkable job trying to promote health initiatives, but it is a difficult thing to incorporate into curricula. As Geoff very sensibly mentioned with regard to items such as bulimia and anorexia, that in itself is a difficult philosophy to incorporate into the minds of young people and can be misinterpreted. Therefore, I would like very much to see, from a health perspective, a more community health driven, a more primary health care driven health care system available on the island. It has been incorporated in all health plans throughout the world. Health sector reform has welcomingly embraced primary health care initiatives. We do not really seem to have that happening here at the moment. The emphasis seems to be a single-minded focus on curative aspects, which is gobbling up the health dollar. There seems to be very little left over for preventive medicine and health.

I would also like to address the concern with regard to aero-medical evacuations. I personally have no doubt that the RAAF would never let us down, were we to need an evacuation of a seriously ill patient. However, there seems to have been an enormous amount of controversy about this in my four months on the island. I think the ad hoc arrangement that seems to exist—or we have the perception exists—with the RAAF is something that is not a tenable thing. We need to know for the security of the population on this island that we have a guaranteed system whereby they can be evacuated in the event of an emergency. Various alternatives can—and I would like to believe that those alternatives could—be incorporated into preventive health programs. I do not see, for example, what would be deleterious to this government were we not to increase the price of cigarettes by a couple of bucks a packet and incorporate that money into the provision of a sinking fund or something that might be relevant to all of this island.

I think also, from a tourist perspective, we should be making far more obvious to tourists to this island that there are inherent problems with regard to health here. We cannot cope with very much in an emergency. Therefore, we must encourage them all to take out travel insurance, for example, when they come. This should be made available proactively—not retroactively.

Those issues are beyond the scope of a medical practitioner, but I really would like to see some very strong initiative taken. At my home in Queensland, I have to take out ambulance insurance. We need a similar sort of arrangement here for aero-medical evacuation. It has to be addressed and I believe it is a considerable priority.

There are a lot of other contentious things I would like to bring up, but I think my offsider and senior medical officers are going to bring those up in significantly more detail. Those are the two issues that I really would like to address. Time is short, I know, and I certainly do not want to hold anybody up. I am available for questions at this stage rather than continuing with a lot of what you have already heard, according to the minister's submission.

Mr NEVILLE—I note that in the health minister's submission there were 26 medical evacuations for the last financial year. So there is roughly one per fortnight. You are not aware of the cost of those? We know what the cost of the private medical evacuation was, but what is the average? Do you get to see that, or does Mr Christian get to see the cost?

Dr Davie—I am sure Mr Christian would have better detail than I do.

Mr NEVILLE—They say that it can take up to eight seats to put a stretcher on a plane, so what do eight seats to the mainland cost?

Dr Davie—Between about $3,000 and $4,000. Unfortunately, with the aircraft we have here, three days advance notice is required to put a stretcher on the Flight West aircraft; the other two aircraft are not available at all for stretcher retrievals. When I was here before in the mid-eighties, I think there was a tacit understanding—as I was led to believe then, and I am sure it was not formalised to any degree—that one of the conditions of letting an airline service Norfolk Island was that it would make provision for stretcher-borne aero-medical evacuations. That does not seem to exist at the moment. I do not think it is an airline problem. I think it is related to the aircraft that are servicing the island now—for example, to remove bulkheads to put in a stretcher apparently is very difficult for the current airlines operating here.

Mr NEVILLE—You talk about preventive medicine. You mentioned a number of matters—lifestyle issues. What is the regime here for community screening? There is no mammography unit here?

Dr Davie—We have no mammography unit here, but in recent weeks I have seen a group on the island selling raffle tickets for a mammography unit. This is of particular concern to me, because I think there is a lot of fragmentation. My predecessors may well have initiated this idea of a mammography unit here. It is certainly a wonderful thing, but it does not stop at the provision of a piece of hardware.

Mr NEVILLE—It has to be a community screening thing.

Dr Davie—There has to be not only community screening but also the expertise to in fact read the mammograms.

Mr NEVILLE—But that is not uncommon on the mainland. For example, all the film for all of Central Queensland goes to Rockhampton for reading. To send the films from Norfolk to the mainland would not be any different from anywhere else in Australia. It does not mean you have to have a specialist on the island reading—

Dr Davie—I am not saying that, but you need a radiographer who is competent to do the screening. It is technically quite a difficult screening operation to do. Very often, at the time, you have to follow that up with an ultrasound investigation. We are investigating getting a new ultrasound machine. The combination of the two would certainly be beneficial. Then, of course, there are the additional costs of maintaining and servicing that equipment. I am not saying that it is out of keeping with what we require. It certainly would be of great advantage here. There is no doubt about that.

Mr NEVILLE—I would like to return briefly to the matter of the Pharmaceutical Benefits Scheme and the comparative costs. I accept the evidence that the raw cost of the medicine, or the drugs, on the island may be less than they are on the mainland. But, in terms of getting them to the islander patients, it would seem to me that the cost is considerably higher, bearing in mind that no-one on the mainland pays more than $20 for a PBS drug and a pensioner pays no more than $3.20. What is your comment on that?

Dr Davie—Certainly I find the cost of pharmaceutical items absolutely horrendous and beyond the means of many people, particularly the elderly people on the Island. By the time they get to 70, most Australians would on average be on six or seven preparations. To consider the aspect of lowering cholesterol by using a very basic preparation: one would be paying $100 a month on Norfolk Island for that pill alone. If you added a high blood pressure medication, it would be in the region of $70 to $80 per month for the same. You are talking maybe $300 or $400 or $500 a month that some of these patients are paying to try and maintain a reasonable standard of health.

Mr NEVILLE—Whereas there is a ceiling on the mainland of $600.

Dr Davie—Indeed. It is certainly of major concern, not only to those who are on a borderline financially. It is perhaps of even greater consequence, however, as a public health issue. I relate specifically to a case I had last week of genital herpes; the person could not afford the medication to treat their genital herpes. I am certain that that person is now freely available to spread that disease around this Island because they could not afford to pay for the medication. It has certainly been made aware to me that a welfare system exists and assistance does exist here on the Island, possibly to cope with that, but perhaps that is the thin end of the wedge, in a sense. I do worry about that sort of thing. If we had, for example, a tuberculosis outbreak and people could not afford to pay for decent prophylactic medication, we might subsequently have a major problem.

Mr NEVILLE—Could I interrupt you at that point. I am not anticipating my colleagues; we will obviously come down with findings and recommendations to the federal minister. But the question I ask is this: we talked about immunisation. It seems to me that a lot of people move between Australia and this place, and it is inconceivable that any part of the Commonwealth should have a lesser immunisation program than anywhere else—

Dr Davie—Indeed.

Mr NEVILLE—for the sake of public health of the whole, rather than for any other reason. The second consideration is sexually transmitted disease, again for the sake of the whole Commonwealth community—be it on Norfolk Island, in the Northern Territory, in Queensland or wherever. Again we have a big exchange of visitors and, as you say, it is spread not only within the Island but elsewhere. Is there a case that certain activities, like immunisation and the provision of certain drugs that have a Commonwealth implication, should be free or at a PBS level?

Dr Davie—Absolutely. I would concur and welcome such an initiative.

Ms ELLIS—I have just a couple of quick questions. We have been told this morning that there is no road ambulance on the Island. Is that problematic?

Dr Davie—We certainly have an ambulance—a very good one.

Ms ELLIS—I thought the minister was saying that there was none on the Island itself. I am sorry if I misunderstood. So you do have an ambulance?

Dr Davie—We have an ambulance. It is exceptionally well provided for and exceptionally well run by a very talented and dedicated team of volunteers from St John. They have got to be complimented.

Ms ELLIS—Thank you. I misunderstood an earlier comment. In relation to primary health care services: yesterday at the hospital we saw a couple of people on dialysis; there is a question of screening and education in relation to diabetes—there is a range of such services, isn't there, including nutrition for both young people and older.

Dr Davie—Yes.

Ms ELLIS—You were fairly critical, in your comments earlier, of the lack of a primary health care approach generally. Is there anything else you want to say in relation to that? I have visited a number of very remote communities on the mainland in the last 12 or 18 months, and in fact almost the sole purpose for existence of medical services in those places, for obvious reasons, is that primary health care service. Do you want to elaborate any further, particularly in relation to cardiovascular conditions and diabetes?

Dr Davie—I would like to take this opportunity to say—this is the area of my expertise, in a sense—that the long-term gains from effective, accountable, enthusiastically applied preventative health programs are absolutely immense. I do not know of a country in the world which has not taken a quantum leap from curative health to preventive health. The short-term gains are very difficult to compute, but the long-term gains are absolutely immense.

It does require a degree of expertise to implement them, and the prime expertise needed must emerge from the community. One has got to enable the community, one has got to empower the community to almost take responsibility for themselves. It is a movement which expands, and it grows like wildfire once it takes root. But it does take, certainly, direction and political will to make it succeed. Norfolk Island is the most ideal set-up to incorporate preventive health because you have a captured audience, as it were.

Ms ELLIS—In terms of preventative health, could I just take a different angle in relation to young people, youth. There are some rather exciting innovative programs now happening on the mainland in high schools, secondary colleges particularly, and in the senior primary area. The idea is not at all to tell young girls how not to become anorexic, and it is not at all to say, 'Don't commit suicide at 15.' It is actually the other way around: teaching and encouraging good health and wellbeing, and mentoring and a teacher's open door approach. So youth suicide or anorexia, for argument's sake, are not even mentioned. Do

you have a view on that? There are some packages at that level that I know would be available. It is a very positive, proactive approach to youth health.

Dr Davie—I think those would be of extreme value. Ivan Illych spoke many, many years ago about 'illth' as being an industry. Certainly, to focus on the negatives rather than the positives is psychologically the erroneous way to go about the whole issue. One has got to focus on good 'health' as opposed to 'illth'.

Ms ELLIS—I suggest that the NI government and the minister might to look into the programs to which I refer, if they are not already available. There are some in my electorate in the ACT, and I might take the opportunity of making sure the minister is made aware of them on his visit. One very last very quick question: what is the position in relation to dental health here?

Dr Davie—Hardware-wise we have a very good dental unit, and we have a very good dentist. Again my perception, without being accurate with regard to figures, is that it is difficult to access because of cost. Possibly the particular group you want to access finds it hard to sustain the cost of good dental hygiene and dental care.

Ms ELLIS—So there is a dentist here?

Dr Davie—Yes, we have a full-time dentist on the island.

Mr NEVILLE—Is he in private practice?

Dr Davie—No, he is likewise employed by the hospital board.

Mr NEVILLE—Who sets the charges?

Dr Davie—It is set basically on a Medicare rate, but my perception—Mr Christian will be able to amplify this—is that the cost is above the normal Medicare rate. We have a list of costs here. For example, the current fee for an initial examination here is $25, the Australian Dental Association rate is $34, and I think the fee was proposed to rise to $28. So it is a little bit less when one considers that.

Ms ELLIS—Is there any program in the schools in relation to dental health and screening for young children?

Dr Davie—Yes. The dentist visits the school on a regular basis, and students from the school visit the dentist on a regular basis. So an exercise almost similar to that conducted by school dental nurses in Australia is conducted here by the dentist and his dental nurse.

Mr NEVILLE—Are pensioners exempt, or what are they charged?

Dr Davie—I am not sure if pensioners are exempt. This could be clarified by some of my colleagues.

Mr Donaldson—I could answer that question on behalf of Dr Davie regarding pensioners' dental. All pensioners on Norfolk Island receive what we call HMA, hospital and medical assistance. It basically provides the same cover as health care provides, but more. It starts from zero base and they do not have to contribute anything, except that if they are what we might a better-off pensioner they might have to pay five, 10 or 15 per cent of their total costs. It covers pharmaceuticals, optical, all dental services including false teeth, and all medical and hospital bills. So generally the pensioners are pretty well covered.

Mr NEVILLE—And, as they have a supplementary income, they pay five, 10 or 15 per cent—a sliding scale. It is a sliding means-tested scale.

Dr Davie—It is a means-tested scale but it cuts out when they get to $2½ thousand worth of prescribed expenses and then the health care scheme takes over and they get 100 per cent cover.

Mr NEHL—Doctor, are there any HIV-AIDS difficulties here?

Dr Davie—Not to my knowledge. Certainly I am not aware of any positive tests that exist here on the island at the present time.

Mr NEHL—Thank you. What about usage of illegal substances? Are drugs a problem?

Dr Davie—My personal impression is that there is a lot of rumour-mongering with regard to the use of drugs beyond marijuana. I think there is a very significant use of marijuana on the island, and there are often rumours that perhaps there are more exotic preparations floating around and being used. My personal experience is almost zero—certainly in the four-month period. I think it would be very difficult for people to be using prescription drugs illegally, because things are very easy to monitor here on the island. Of course, people may have access to drugs on the mainland and there is very easy access to and fro.

With regard to heavy drugs, I have often thought that perhaps if someone were visiting Sydney or Brisbane or somewhere remote and getting access to heavier drugs it would be very difficult to maintain a supply here. That is why I do not really see the addictions to drugs on the island that one could anticipate. Certainly we have a few people resident on the island who have confirmed heroin addictions and who have gone through detoxification, et cetera, on the mainland. We have a few hepatitis C cases here as a result of injecting, but I do not believe that has been happening here; it has happened elsewhere. They have done their time over there, or had their treatment over there, and then have come back to roost on the island in a sense.

Mr NEHL—You mentioned the difficulties that would be associated with an outbreak of tuberculosis. Is there any TB on the island?

Dr Davie—There was in the mid-1980s when I was here. We had two confirmed cases of tuberculosis. It was an unusual form of tuberculosis, an avian and bovine tuberculosis, certainly not one that would lead to an epidemic.

Senator LIGHTFOOT—Was that from the local cattle?

Dr Davie—Yes. But with regard to human tuberculosis, I am not aware of any current cases. Certainly we do screen patients, not on a full-time screening capacity, but we are certainly aware—because we have a lot of residents who come from places remote from Australia and New Zealand—of the possibility of it being introduced. So we x-ray people and have a degree of vigilance which probably exceeds that which we would have in a major centre in Australia.

Mr NEHL—Accepting that the level of service here has some limitations because of the size of the population, size of hospital and numbers of staff, can you tell the committee whether there are any specific equipment items or anything else that you need to provide the services that are within the expected limitations?

Dr Davie—With regard to specific items, yes. A physiotherapy service is urgently needed. I think that is not just a curative service but a proactive service to keep the elderly mobile, flexible and avoiding injuries. Somebody mentioned earlier the necessity for things like an avoiding falls program—things like that we really need to be incorporating.

I would like very much to see an expansion of our domestic nursing service, which at the moment is limited to one domiciliary visiting nurse. It is run privately through the Emily Channer Trust. We have now over 10 per cent of our population over 70 years of age—that is a lot of people. They need to be seen on a regular basis and monitored carefully to avoid the fractures of neck or femurs, for example, which are common, and they can only be treated elsewhere.

We need to have better ultrasound—diagnostic ultrasound equipment. It is one of the things that my colleague and I really feel would be of great advantage in assessing people and certainly managing them better here, should they require surgery. We would also be able to diagnose something specifically and have a timely evacuation were it necessary.

Certainly there is always a need for an improvement in laboratory standards and with a lot of the new chemicals and reagents we should always be upgrading those. But those are very small items and something we can deal with in-house.

Perhaps the most pressing entity is the great need to look long range at our needs for the care of the elderly, and I am talking about accommodation. That really is an issue that we have to address quite strongly in the very near future, because the numbers that are going to present for accommodation in the existing facility will rise exponentially in early phases of the new millennium.

Mr NEHL—Finally, are you aware of any island residents who are not taking medication they need because they cannot afford it?

Dr Davie—Certainly I have had one case that I can mention specifically, a case of genital herpes. I also feel that things like follow-up for patients with hypertension, for example—and that may transmit to the diabetics and the obese—are certainly not presenting as frequently as they were in the mid-1980s. The cost, to me, is certainly prohibitive. I really

would love to do an epidemiological study of health care now, compared to the mid-1980s. I think we would find that overall health care was less satisfactory now than it was in the mid-1980s. I feel that is related to costs but it may well be also related to, for example, expectations.

In the mid-1980s we may have got away with somebody having a rectal bleed and thinking it was just haemorrhoids. Nowadays, nobody would go without having a colonoscopy. We do not do that here. Something else that I think we should introduce is a colonoscopy service.

It is all very well and good having a service organisation driven program for health, for bowel screening, for example. The thing is, you are now going to get 95 per cent of those results that turn up positive being false positives. For instance, the bleeding that you are detecting in the scan might come from haemorrhoids. We can examine for that here and say, 'Yes, he has got haemorrhoids.' But can you say that is all there is? Perhaps there is a bowel cancer a foot up there. You have got to now send him off for a colonoscopy.

So although the intent of having a bowel screen is wonderful, the cost that comes from it is immense, because every one of those patients has to go away for a colonoscopy. It is almost as though the dignity of risk is being abrogated somewhere and it becomes difficult.

Mr NEVILLE—You have colleagues competent to do colonoscopies?

Dr Davie—Certainly I have done many colonoscopies and certainly the training to do colonoscopies is not particularly difficult. Bearing in mind we would really stop at the diagnostic phase and the few that we might find with a carcinoma would have to be referred. But it would reduce the number of referrals very significantly—whereas we have 30 cases coming up with a positive bowel scan at the moment, all of whom have to go away. There is no alternative.

Mr NEVILLE—What does a scope and the associated sterilising equipment cost today ?

Dr Davie—Probably a maximum of $10,000.

Mr NEVILLE—Is that all?

Dr Davie—Yes.

CHAIR—Thank you. I now call Dr Lloyd Fletcher.

[11.33 a.m.]

FLETCHER, Dr Lloyd Douglas, Government Medical Officer, Norfolk Island Hospital

CHAIR—I now welcome Dr Lloyd Fletcher, the Government Medical Officer. I think you are aware of the previous comments I made in relation to committee hearings. Would you like to make some opening comments in relation to these health services on the island?

Dr Fletcher—I read the Joint Standing Committee letter from Senator Macdonald and basically made some comments on it. I heard half of Dr Davie's statements and agree with most of them. I guess everything is summed up there. I just seem to be asking for wheelbarrows full of money to solve all our problems.

As a summary, I would suggest that care, accommodation and hospital for the aged are getting to a critical point. That also involves improvements in district nursing care. With regards to diagnostic equipment, ultrasound is something that needs upgrading. A full-time physiotherapist is a position we need. We have a fully equipped physiotherapy department which has been unmanned for three years, and we really do need a physiotherapist. I would also like to suggest that a third full-time doctor is needed, and on top of that a new hospital.

Mr NEVILLE—Is that all?

Dr Fletcher—That's all!

Senator LIGHTFOOT—Dr Fletcher, with respect to amenities at the hospital, the trend in remote Australia, even regional Australia, is to bring the patient to the amenities rather than take the amenities to the patient because of the multiplicity and diversity of the remote areas in Australia. But we have a system in Australia that is at least underwritten by the Royal Australian College of Surgeons, and no doubt the AMA is involved in it too, where medical specialists—haematologists, ear, nose and throat specialists, gynaecologists, and those specialising in eye disease and so on—put in one or two and sometimes three weeks annually on a pro bono publico basis in remote areas. I mean really remote areas—Oombulgurri, Kalumburu, Balgo, Jigalong, Warakurna, Wingelinna, little settlements you have never heard of, but they are very prominent in Western Australia. Would it be practical to have you or your colleagues invoke that system to be used on Norfolk Island?

Dr Fletcher—I am from Western Australia and I have worked in Oombulgurri. I have worked on Elcho Island and with the Flying Doctor Service for five years in the central desert. I have worked at Cocos Island and here. So, I do know what you mean. As a matter of fact, all my medical career has basically been in remote areas. I have just come here from six months in Longreach.

All these remote areas do get visiting specialists, and we do too here on Norfolk. We have a visiting surgeon who comes each six months for a week. Each specialist comes for between three to five days. We have a visiting surgeon twice a year, an eye specialist twice a year, a rheumatologist twice a year, a gynaecologist twice a year, and then a psychiatrist, an orthopaedics specialist and an ENT specialist who all come once a year.

We do have visiting specialists, and they are well used, but waiting perhaps five months between a surgical visit, or 11½ months between an ENT visit, is a long time for recurrent or acute problems. Therefore, sometimes we have to send the person to Australia or New Zealand.

Senator LIGHTFOOT—To the mainland.

Dr Fletcher—Yes. People go to Sydney, Brisbane or Auckland from here, and we do not differentiate where they go. It depends on their background. People do go to specialists, and that does raise extra costs for airfares and accommodation at the other end. It is a while since I worked in remote areas in Western Australia, but there was a scheme then called IPTAAS. It is called PATS now.

Ms ELLIS—It still exists.

Dr Fletcher—People got assistance. Here people do not really get that assistance. They do have health care cover once they have paid their first $2,500 of medical bills in the 12 months period, but they are expected to find their accommodation and airfares. A minimal amount, $200, is allowed for some people for airfares. But, generally they have to go away at great cost.

That leads to another point which I might be a bit premature in mentioning, but which we might discuss later, and that is urgent medivacs. Perhaps we might leave that to later.

Senator LIGHTFOOT—There was some mention made of the frail aged and aged health care on the island. It would seem to me that there must have been a study of longevity on Norfolk Island compared to the mainland. Are you aware of any study that has been done with respect to life expectancy on the island, compared to Australia?

Dr Fletcher—No, I am not. I cannot say that people here seem to have greater longevity than elsewhere.

Senator LIGHTFOOT—Or lesser longevity, which is what—

Dr Fletcher—No, I cannot say that there is anything specific. There is no bus service or taxi service to speak of on the island, so elderly people who are alone, even though it may only be five miles from the centre of town, are generally pretty isolated. We have a district nursing service which operates for three half-days a week. I feel that is a bit inadequate. I guess that is to do with staff shortages and funding.

People seem to drift—it is a steady drift as they get elderly—towards the hospital. A couple of weeks ago we had something like 10 people in hospital, and now we only have eight, seven of whom are female patients who live in the hospital. That is a little bit sad. I am speaking about Norfolk. I know that it may be similar in remote areas in Australia, but it is a little bit sad to spend your days there, because you just have a partition dividing you and the patient next door. That then becomes your home in your declining years. That is why I mentioned we really do need upgraded services for the elderly.

Senator LIGHTFOOT—Has there been any definitive study completed with respect to the aged where they will need special care?

Dr Fletcher—No, not that I know of.

Senator LIGHTFOOT—Do you think it would be appropriate to undertake a study of that so that you are able to say with some positive figure what you will dealing with in, say, six months, two months, 10 years, five years?

Dr Fletcher—Yes, that is fair.

Senator LIGHTFOOT—Your colleague mentioned seat belts. I was not too sure whether seat belts were a legal requirement to be used here on the island or whether they were not. Do you have any information on the use of seatbelts?

Dr Fletcher—They are not compulsory to wear on the island.

Senator LIGHTFOOT—Are they the cause of road trauma? If so, how do you categorise that road trauma?

Dr Fletcher—As a general statement, seat belts are a good idea for everybody. However, I cannot say that I have much experience with major trauma on the island, particularly due to the lack of seat belts. In fairness, there is not a lot of road trauma here. The trauma that there is here is due to young males and the Friday-Saturday night scene associated with alcohol. I think that is a reasonable comment for at least 95 per cent of our cases of traffic trauma.

Senator LIGHTFOOT—Are those cases invariably treated at the hospital on the island, or are some of those evacuated to either New Zealand or the mainland?

Dr Fletcher—The more serious ones are evacuated. I have been here nearly six months in this second stint of mine and we have had one medivac off the island for road trauma.

Senator LIGHTFOOT—Is it your opinion that wearing seat belts would have prevented some of those traumas, or the degree of the trauma?

Dr Fletcher—Please do not take this the wrong way, but no, because the man we sent away had been on a motorbike. I do not mention that to be frivolous. Generally speaking, yes, I would have to agree with you. We are part of Australia and I think seat belts should be compulsory here too.

Senator LIGHTFOOT—I am not suggesting we should put a seat belt on a motorbike, Dr Fletcher, but did he have a helmet on? Is that compulsory here?

Dr Fletcher—They have become compulsory recently, yes. When I was here previously they were not.

Senator LIGHTFOOT—Okay. With respect to the third doctor, that takes the ratio down to one GP to about 600 people. Is that correct?

Dr Fletcher—Yes, it does.

Senator LIGHTFOOT—That is a fairly good rate compared to regional and rural Australia.

Dr Fletcher—Yes, it certainly is. I feel embarrassed saying that. I guess your figures are a fair comment—plus visitors. The visitors are quite a demand on medical service here because, as you may know, this island in the tourist trade is known as the island of the newlyweds or nearly deads—and only 10 per cent would be newlyweds. So there is a big demand by tourists.

However, it is more a demand on the doctors. Two doctors are on call all day every day for anaesthetics and surgery. We have got a surgical case pending today, hence my bleeper and radio are with me; I am waiting for some lab results. The same will happen tonight when we go out. I might be on call tonight. John is off, but he has to be aware, alert and available at all times, day and night.

When I was here previously, I was not even allowed to go fishing off the island. We were not even allowed to leave the island to go out in a boat. We had to be available at all times. Fortunately, the policy at the moment is a bit more sensible than that. There is a very big demand. There is a two- to three-day waiting list just to get a routine appointment to see the doctors. Casualty is therefore utilised every day by about 10 to 20 people. It does vary a bit. It is just the constant demand of being on call and never having a day off.

Senator LIGHTFOOT—You are saying that the third doctor is justified, even though, on the figures in Australia, it would appear not to be?

Dr Fletcher—To some extent, yes. The third doctor would allow one doctor to feel that, emotionally, he was actually off for a day. The figures at the hospital reveal that every man, woman and child on this island, on a population basis, see the doctor six times a year. Everybody on this island sees the doctor six times a year. That is once every two months. As you, you, you and you do not see the doctor six times a year, you come once a year, that means you, you, you and you come weekly or fortnightly. There are many elderly people here. It is a very heavily utilised service. That is another question that we have pondered, but we do no know how to get around it. The demands are incredible here; the demands on casualty are incredible. People do not know what it is like to wait more than 20 minutes in casualty. I do not think they have ever been to Sydney. If people come in, they expect to see a doctor at the time. If they have to wait for 20 minutes, frequently there is a letter of complaint to the board about having to wait for 20 minutes. The island has been spoilt over many years, consequently the demands are extremely heavy.

Senator LIGHTFOOT—And the expectation is high.

Dr Fletcher—There is nothing wrong with expectations being high. Everybody here deserves the same as their fellow cousins in Australia. Hence, we have to send people away

for tests, scans, ultrasounds, colonoscopes et cetera. The demands are very high. I do not think I have worked in a practice that has these demands on your time.

Senator LIGHTFOOT—There has been mention of smoking on the island, and the relative cheapness of cigarettes. Given that anyone who smokes consistently, or anyone who smokes without qualification, is going to suffer an early and probably painful death, what educational program—and I am really talking about preventative medicine here—is there on the island to alert people to the problems associated with cigarette smoking?

Dr Fletcher—There is a little warning on every packet that says 'smoking kills'.

Senator LIGHTFOOT—And that is it?

Dr Fletcher—That is about it. That is a good point. John alluded to primary health care. These sorts of topics are something that need time devoted to them for education—education at school, education of the public. Alcohol and tobacco are a problem on the island because of the low cost, and it is probably associated with other factors, too. Using it as a weak excuse, the doctors maybe do not devote enough time to it, because all we do is just see patients all day.

Ms ELLIS—What about the position of a health educator instead of a doctor having to do that sort of work?

Dr Fletcher—That may be a viable alternative.

Ms ELLIS—Would that could fit in, a qualified health educator at community health education level?

Dr Fletcher—Yes, but there is a group of people at the moment forming what they call CHATS, community health awareness team, and they are hoping to introduce topics and education programs like this to the public and into the schools. A health educator may be a good alternative.

Ms ELLIS—I will leave it at that, thank you.

Mr NEHL—Doctor, I took particular note of what you were saying about being on call. I am glad you are able to catch a fish occasionally now. That also applies to other people associated with the health services, I guess—to the pathologist and radiologist.

Dr Fletcher—They are on call 24 hours a day.

Mr NEHL—They have to be on call 24 hours a day.

Dr Fletcher—They are on call 365 days a year, because there is only one of each of them. Their services are not utilised as heavily as ours, partly because we are aware of the costs every time we call them in. We try not to call them in, because of the demands on their time. But they are on call 24 hours a day.

Mr NEHL—They are in a similar situation. Whether or not they are called in all that often, they have got to be prepared to be called in.

Dr Fletcher—That is right.

Mr NEHL—For anybody who has been in that on-call situation, it is a very demanding situation in terms of personal life and family.

Dr Fletcher—Yes, that is correct. You may say, 'So what, the same thing happens in Australia'—and it does. Quite often Australian communities might have three or four doctors in the community. When I was in Longreach, this was so, but it meant that at least you did get some time off when you knew you were off. I cannot say much more than that, other than this is a small island and the hospital here is very heavily utilised. There is nowhere else to go for advice, so people go there day and night.

Mr NEHL—How do salaries compare with the mainland for doctors and other health professionals like radiologists and pathologists.

Dr Fletcher—The last team of doctors here achieved a pay rise for us, which is quite good. I think it is quite satisfactory considering it is a tax-free island. I cannot comment too much on the radiographer and the laboratory people, but I think they are paid a very borderline sort of wage. The physiotherapist who was here left because of a money dispute, and subsequently we have not been able to get a replacement.

Mr NEHL—Does that mean it is difficult to recruit medical and paramedical staff?

Dr Fletcher—Yes, I think that is true. Basically, you need skills to cope with everything. You have to do anaesthetic surgery, deliver babies, caesareans, throw on a plaster and maybe do some screwing together of a few bones. You basically do have to do everything here. I think medical training is such these days that it is getting more and more difficult to recruit people with these skills, because medicine is geared to specialisation. I have been to the Antarctic in the past—that is where I went when I left here last time.

Mr NEHL—Where were you based?

Dr Fletcher—I have been to all the bases. The last one I was at was Macquarie Island in 1998. I have a very keen interest in the Antarctic and this particularly—

Mr NEHL—I share that interest with you; I have been twice.

Dr Fletcher—Oh, have you? Where did you go?

Mr NEHL—Casey, Davis, Mawson and Heard Island.

Dr Fletcher—I might have met you there. What years were you there?

Mr NEHL—In 1986, in May.

Dr Fletcher—In 1986 at Casey.

Mr NEHL—That is right.

Dr Fletcher—That is right; I met you there. I have this great interest in the Antarctic. At the moment, the Australians have four bases and all they can get is two doctors for the subsequent year, so they are taking another doctor to do a second year consecutively, and they are trying to find someone to fill in for five months over summer, and then someone to do a winter job. Why do I mention that? I mention that, because it was nice to meet you, and I mention it also because I see it as similar. Where do you get doctors? More to the point, where do you get young doctors? Where do you get young doctors who can do babies, anaesthetics and surgery? And I think that applies to remote Australia to some extent.

Mr NEVILLE—It is a big problem now.

Dr Fletcher—And it is going to get worse, not better.

Ms ELLIS—This is very relevant to another inquiry on another committee that I am involved with at the minute. Do you have a view on how you could consider rural remote GP services not becoming a speciality in themselves, because that could bring its own problems, but being an area of speciality or another category within the training of GPs? Do you have a view that you could share?

Dr Fletcher—First of all, I would do away with the Royal Australian College of General Practitioners and I would do away with the fellowship qualification of the Royal Australian College of General Practitioners. I would get doctors out there who wanted to be general practitioners and put them through six to 12 months training in specialties and subspecialties, where you get your diploma in anaesthetics and child health and obstetrics and do some bread and butter real stuff and become a general practitioner, but the emphasis being on general, not a specialist general practitioner, as it seems to be heading towards today.

Ms ELLIS—It is relevant to this inquiry because you have just told us of the difficulties in getting people to come to places like this. What about, in your instance, if you had not gone from remote to remote to remote to remote but had actually attempted a period of remote medicine and then re-entered the mainstream in the mainland somewhere—it has been put to us many times that that is very difficult.

Dr Fletcher—It is very difficult. I am trapped now because when this VR came in, in 1991 or so, I was at Cocos Island and, although it was offered to me, I was a salaried doctor and I was not allowed to have it. Subsequently, I am still not allowed to have it, so anywhere I go I am treated as a second-class general practitioner, and patients have to pay more money to see me because I am very 'second rate', even though my qualifications may be more than those of some of the colleagues I am working with. Medicine has sold us down the creek.

Ms ELLIS—So we also need, not only in the training part of GPs but in the recycling or reappointment, to somehow put a stripe on the arm of the person like yourself who obviously has ability far and beyond, in my view, the GP you would find in suburban Sydney or

Melbourne, who has probably never caesarean delivered a baby in their lives. Because of your remote service, it is very difficult for you to get back into that mainstream should you wish to do so, even though you have all that wonderful experience.

Dr Fletcher—Exactly. Just about every advertisement I see in the paper these days asks for VR GP. Very few ask for non-VR. So when I go back to Australia, it does not matter where I have worked, everyone will say, 'Oh, you haven't got that bit of paper that says you know how to counsel a mother who has a child that is crying at night,' or something.

I want to bring up the situation of medivacs from the island. I alluded to this yesterday at the hospital. If we have medivacs that require urgent shipment to Australia for medical treatment, we have a great problem getting them off the island. The best service is from the private medical companies, but they require $25,000 cash up-front. That is on Sunday night, Friday morning, whenever. Fortunately, a few of our tourists have insurance and can go by this method. Locals do not have this, and then we have to debate with the Air Force for a Hercules for $104,000. The Air Force are under instructions not to come to our aid for this unless circumstances are such that we cannot get any other transport or there is some dire circumstance that warrants getting in the Air Force.

Mr NEVILLE—It would be a catastrophic or a high emergency?

Dr Fletcher—Recently, by speaking to the Air Force, we did have them come over here for that motorbike accident—I think it was that one. The Air Force said, 'You're lucky you caught us. We've just got a plane come in, otherwise we wouldn't be able to do it. And, in any case, we would not have been able to do it for the previous three weeks because of the Timor incidents.' The Air Force do not always have other priorities, but they did recently and they may in future. But it is a general debate, spending several hours ringing up and arguing with people, trying to get approval granted by the Minister of Defence in Australia for the Air Force to come here. I am not saying that is the way to go. I personally think the private way is the way to go—they are a far more speedy, efficient service, and the Air Force agrees with me on that.

Mr NEVILLE—Does that $25,000 include the retrieval team or is that just purely the stretcherer, a pilot and an attendant?

Dr Fletcher—That is the team and the plane—everything.

Mr NEVILLE—Does that include a doctor?

Dr Fletcher—Yes. The most recent one was $23,650.

Mr NEHL—This is not a question to you, it is rather a comment on something I am aware of which may be of interest to you and also to the minister. Currently ,the University of Newcastle Medical School, under the leadership of Professor Sanson-Fisher, is looking at having a system of sending their students to do internships at Kempsey in my electorate, in Armidale and, I think, in Tamworth. In fact, he was meeting with Michael Wooldridge about it in Canberra last night. The thought occurred to me during our discussion that, if we get it

off the ground, it could be very useful to Norfolk too. So, if you like, I will keep you informed of what is happening with that.

Dr Fletcher—Yes, thank you. We do have medical students come here from Australia and New Zealand, and they come often. The next one is coming at the end of this month, the 29th or something—I am not sure, but John may tell you. Medical students are here for half the time, approximately, though at fifth- or sixth-year level their skills are often limited—you have still got to come if you are going to teach them to suture or—

Senator LIGHTFOOT—That is not as interns, though, is it?

Dr Fletcher—That is not as interns, no, that is as a medical students.

Mr NEVILLE—Have you ever had qualified interns?

Dr Fletcher—No.

CHAIR—Thank you very much, Dr Fletcher.

Dr Fletcher—Thank you.

[12.01 p.m.]

DUKE, Dr John, Member, Norfolk Island Hospital Board

HUGHES, Mr John Robert, Chairman, Norfolk Island Hospital Board of Management

CHAIR—Welcome.

Mr Hughes—To start off, I must say that everything that has been said today is basically what we have been saying; we agree with it almost 100 per cent. I have given to each of you a copy of our submission and, because time is getting short, I will not read the submission out as such. There are such fairly boring things perhaps as statistics and there is no point reading those out, but there is one thing I would like to mention. In the statistical section we say it is a 24-bed hospital. I notice in other documents that you have got it says 27. That is not because we have not got our act together. It is just that it has recently been reconfigured; it may go back to a 27-bed hospital—I think they are just utilising space in other ways.

Also in that statistical section we talk about the facilities we have at the hospital and the pharmacy is mentioned. It has not been mentioned to date but we have just employed a fully qualified pharmacist and she is coming to take over that role late this month—it says December but she is coming a week earlier. So that is something we hope can improve the facilities and service to the island.

With regard to your question 1, on the range of health and ancillary services, there was one thing that was mentioned to me while Dr Davie was speaking. He spoke of the need to go to Australia for colonoscopy. That is the case, but we do have a man who comes twice a year—though, as Dr Davie said on his way out, if he needed one he would want it straightaway and he would not wait.

Ms ELLIS—Exactly.

Mr Hughes—I just thought I should mention that. There is another community health service that has not been mentioned to date. We do participate in the Royal Far West Children's Health Scheme. That gives assistance with children who have to go to Australia for medical treatment, and their mothers or carers who go with them. I do not think it is used terribly much, but it is a nice facility that we can enjoy.

I have explained the continuing health care system where we pay $1,000 per family per annum—up to the first $2,500 of medical care is paid for by that family and then the health care system takes over.

Mr NEHL—Per family, not per individual?

Mr Hughes—Per family, yes—per nuclear family I think is the term they use.

Mr NEHL—So if you are an unmarried person you still pay two and a half thousand?

Mr Hughes—Yes, but you only pay $500 instead of the $1000 per annum. All those services are available to visitors, but, of course, they have to pay the appropriate fee for them.

I go down to point (iii), 'Measures that could be taken to assist access to a comprehensive level of health and ancillary care'. We feel that the current access to island services is relatively affordable with the exception of some pharmaceutical charges—other speakers have spoken about that—and medical evacuations. The visiting specialists have a disciplined schedule and are generally well used. However, some of those special services come at a cost, and there are some people on the island who find that that is a bit of an ask to meet those services.

We do have a particularly good relationship with some Australian hospitals in return of services, particularly the Prince of Wales. They help us very much with X-ray readings and pathology. We have a pathology arrangement where tests not done here are sent away. They do it for a fee, but it is a very reasonable fee and it is a pretty satisfactory sort of service. The only thing, of course, as we have all said, is that off-island treatment incurs costly fares, and it would be desirable if we could work out some form of financial or residential assistance for carers or for those people whilst they are in Australia.

Medicare would be welcomed but, again, it has been difficult. As you know, there are no income returns lodged on Norfolk Island, so the fixed fee would be appropriate. The minister for health has explained that in great detail. We all feel that the over $4,000 per person is unrealistic and not attainable. It is obviously a hard sort of figure to come out with, but it would seem to me that the costs of providing health services on Norfolk Island would be less per person than per person in Australia, assuming that all the infrastructure involved in Australia is included in that per capita cost of $4,000 to $5,000. That would not happen here because of the simpler services that we can provide.

On Dr Fletcher's comment about medical evacuation, we all feel very strongly about that, and the board is quite definite that procedures for medivac are cumbersome and time consuming, quite often to the extent of putting patients at risk. There is a great need for a formulated and simple approach that can deliver the service in a reasonable time frame. We hark back to the routine training flights that the RAAF do. I understand they do something like three practice medical evacuations a month. As it has been said before, it would be nice if we could factor our necessary evacuations into that, and perhaps some brownie points scheme would be worth considering.

As a matter of interest, the time that is taken in getting these—be it a private medivac or the RAAF medivac—is incredible. It can take three to nine hours before we get permission for an aircraft to leave the tarmac, and then you have the flying time from Australia to here. So you can see that the best part of a day is taken before something can happen. Whilst that is happening, the time of the doctor and other people involved is taken up, probably—or possibly—to the detriment of patients and certainly to the detriment of the good doctor and staff concerned because they then have to catch up on their backlog of work. It creates a problem.

With regard to access to the utility of telemedicine facilities, it would be absolutely desirable, and we feel that it would be invaluable in diagnostic and teaching roles. However, as has been discussed fairly fully, the facilities are not universally available. We have put a question to the committee here. Could you provide us with some information on facilities? But, from what I have heard this morning, that is going to be a little difficult at this stage.

Senator LIGHTFOOT—Is that a yes or a no, Mr Hughes?

Mr Hughes—Yes.

Senator LIGHTFOOT—It was a yes, you can supply?

Mr Hughes—No, could you supply us? Really, we are just asking for some assistance from you, should you know of any facility that we can look at that we may be able to use in the future. I understand that the technical facilities are not available but the Telecom people say that that is coming. So, hopefully, we can tune into that in due course.

Frail and aged care is a great problem because, as the previous speakers have said, it is increasing. The community health service is a thing that has been talked about a lot. We need all of those things. The community health service is available as listed. However, a more coordinated service would be desirable. The hospital is responsible by default for aged care, and in recent years the geriatric ward conditions and level of care have increased significantly. But a hospital environment is not suitable as a rest home, and dedicated facilities are now needed, as is increased staffing. Of course, this all comes down to money.

I move on to point (viii), ‘Anticipated health infrastructure needs of the island, the capacity of the island community to meet the necessary costs, and other possible avenues of funding’. The island definitely requires a new hospital and aged care facility, but the community is ill equipped to meet the costs associated. Possible funding avenues are a federal grant, and that is nice.

ACTING CHAIR (Mr Neville)—Do you have an asking figure, Mr Hughes?

Mr Hughes—Actually, not an official one. I see that the Grants Commission mentioned a figure of $10 million. That was a figure that was not agreed with by a company that was over here doing some work. They were project managers for one of the hotels here. We asked them to have a talk to us, and they did a fair bit of groundwork on it. They came back with a figure more like $5 million. That was not to fully equip the hospital; that was for the building of the hospital and the aged care.

ACTING CHAIR—Did that include aged care units?

Mr Hughes—Yes. But, once again, it was a fairly rubbery figure, because we did not have a brief for them.

Mr NEHL—Mr Hughes, on that aged care facility that you are talking about, I would have to say, having had a very substantial amount of contact with aged care facilities in my own electorate and elsewhere throughout the mainland, that what you have up there is totally

unacceptable in terms of privacy, on every level. You are not the only one to speak about the need for a dedicated aged care facility. Do you have any plans for one or is it still on the wish list? Have any steps been taken?

Mr Hughes—Officially, no; unofficially, yes. One of the universities in Queensland had a design project for the Norfolk Island Hospital. But it was completely unofficial. It was done, and they did not have any really definite figures. It is a bit rubbery, I suppose, but that is a start.

Mr NEHL—So, at this stage, apart from the acknowledgment that there is a need, there is no planning—no forward plan?

Mr Hughes—No. But some years ago a previous board raised $50,000-odd from the community to put towards a nest egg to start a hospital. At that stage, the board was dismissed—not for any nasty reasons but it was government policy—and nothing ever happened. That money is held in trust and is now available to the current board in its attempts to build a new hospital. But that money must be used for building a new hospital or for preparation for building a new hospital. That is as far as it has gone.

Mr NEHL—You make reference to a coordinated community health service. I get the impression from evidence we have had that you have a lot of community activity. Some people are doing this, and the RSL is doing White Oak—I think it is. There is no overall coordination; it is sort of ad hoc.

Mr Hughes—No. We do not have a facility or a person that is the coordinator or the dispatcher of those particular services. At the moment those services that are listed are there. They are published in the paper at regular intervals so that the community is aware of them if they need them, but there is nobody—

Mr NEHL—I have seen one of the advertisements.

Mr Hughes—to whom you can go to sit down with and be guided to the appropriate department. On the other hand, if anyone is in trouble, they have only to talk to the doctors or someone at the hospital who will direct them.

Mr NEHL—You do not have a form of neighbourhood centre which is a coordinating voluntary service?

Mr Hughes—No. There have been moves in the last 12 months by a group of concerned residents who would like to see this set up, and hopefully something like this will happen.

Mr NEHL—I notice in your submission—and it is the only place where I have seen it—that the hospital also provides funeral services.

Mr Hughes—Yes.

Mr NEHL—You have many hats to wear, haven't you?

Mr Hughes—Yes. The director is the funeral director, I must confess—a director in two ways. That is just limited to providing the casket and the hearse, which was donated by one of the service clubs, I think.

Mr NEHL—The final thing I would like to raise with Mr Hughes is the question of salaries for the professional people, whether they be doctors or paramedical staff. Dr Fletcher said that—and I think he was referring to the radiologist—the salary paid was only borderline. What is the policy of the hospital regarding the pharmacist that is starting very soon, the pathologist, the radiologist and the doctors? Do you have a policy that says that they shall be paid the mainland equivalent?

Mr Hughes—The adjusted mainland equivalent. It is a difficult thing to assume how much tax a person is going to pay, but we make ourselves aware of the mainland figure—

Mr NEHL—You take the tax off and then you pay the difference?

Mr Hughes—Yes. Basically, that is how it works. It is not perfect, but it is tolerable.

Mr NEHL—How much do you pay as an allowance for the people who are on call?

Mr Hughes—It has only just happened. It was different. At one stage the pathologist was getting three hours at time and a half, whereas the radiographer was getting two hours or one hour at time and a half. But that has changed and they both get a minimum of three hours now.

Senator LIGHTFOOT—That is for call-out?

Mr Hughes—Yes.

CHAIR—Did you say that certain of your hospital staff are discriminated against vis-a-vis, say, teachers? Are they paid on the same basis? Are they paid the equivalent of Australian dollars after tax?

Mr Hughes—I understand the teachers are paid the equivalent of the Australian rate.

CHAIR—Gross or net?

Mr Hughes—Their gross pay is the same as the Australian pay, but they do not pay the Australian tax; whereas our people are discriminated against in that light, because they are paid perhaps—

CHAIR—Does that discrimination apply to all levels of medical staff- doctors, radiologists, pathologists and pharmacists?

Mr Hughes—Yes, it does.

CHAIR—What is the reaction?

Mr Hughes—I understand Dr Fletcher said that he was happy with his arrangement, and I think generally speaking that is accepted as being relatively fair.

CHAIR—I was just wondering if there might be any inter-professional jealousies as a result of that sort of discrimination?

Mr Hughes—I am not aware of it, I must confess.

Ms ELLIS—Mr Hughes, in your written submission, where you refer to aged care, you mention the Mawson Units, which are stand-alone, low-cost, self-care accommodation. Can you tell me what they are, where they are and how people get into them?

Mr Hughes—Yes, I think there are five units. As you go into the hospital grounds, they are on the right-hand side. They are very low units which you probably would not notice. They were donated by local residents, Mr and Mrs Mawson, some years ago and were there to provide low-cost accommodation for aged people. At the moment there is only resident you could determine as an aged person, and the other residents are enjoying low-cost accommodation.

Ms ELLIS—What do they comprise?

Mr Hughes—Basically, it is a small motel type bed-sitter unit. There is a small bathroom and a bedroom-living room in one area.

Mr NEHL—Can we look at that when we do our tour tomorrow?

Mr Hughes—Yes, I imagine that would not be a problem.

Ms ELLIS—And they have their own kitchen facilities?

Mr Hughes—Yes, but very minor.

Ms ELLIS—How do they get into them; what do they pay to get into these units?

Mr Hughes—They pay no money to access them. They pay $50 a week, which includes electricity.

Ms ELLIS—Do the people in any of the five units access any domestic nursing services, meals on wheels or such?

Mr Hughes—No, not that I am aware of. I do not know whether or not Meals on Wheels would be available to them, but they do not access anything. They are self-caring at this stage. When that facility was first established there was the facility for them to go and have their meals at the hospital, but that seems to have fallen away just through lack of demand.

Ms ELLIS—Even though there is only one of the five being used for what you would call the aged care need, is that group of units the only aged care self-contained accommodation on the island?

Mr Hughes—Yes, it is.

Ms ELLIS—So if other people with needs in the aged care category come up and could be ideally suited to one of those units, would one of the four remaining units become available? I take it that the four units being used for low-cost accommodation, not aged care requirements, are the only low-cost accommodation available on the island.

Mr Hughes—Yes, I would imagine so. As it happens, that question has never arisen, because there is a vacant unit there at the moment and there always has been in my term on the board.

Mr NEVILLE—If you were asking for money for an aged care facility that might have, based on the people we saw yesterday, four hostel-type beds and four nursing home type beds—or something of that nature—you could understand that if the independent living was not being taken up, the Commonwealth would probably scrutinise that very carefully and would want to know that the people who were going into hostel type of accommodation were in genuine need of hostel care. I think you have to set a standard on the island if you are asking the Commonwealth to dig into their pocket, have you not?

Mr Hughes—Yes, that is fair comment.

Mr NEVILLE—If you have five aged care units and you are renting them out to other people, you could understand a certain level of suspicion in the federal bureaucracy at pouring some money into a hostel.

Mr Hughes—Yes, but at this stage there has not been any demand for those extra two units or whatever that have available there.

Mr NEVILLE—Do all those units have call buttons or intercoms to the hospital?

Mr Hughes—No, they have not.

Mr NEVILLE—But isn't it the general thing that when you have those sorts of aged care units you have an intercom or a call button to the hospital?

Mr Hughes—That would certainly be desirable. These were built quite some years ago, and they are very elementary.

Mr NEVILLE—You and I both know Childers well. The Childers independent units are clustered around the hospital, with call buttons into the hospital. Surely the independent units should be the first step and the hostel type accommodation the second step, and the third step might be three or four nursing home beds.

Mr Hughes—Yes, that is a possibility. The call button is certainly a good idea—and I know there has been some investigation into remote controlled wearable units—but of course that particular facility was not really designed with that in mind. But it is a good point.

Ms ELLIS—Imagining they are being used in one instance—but let us not care in how many instances—for aged care need, what is the qualifier to obtain residence in one of those units?

Mr Hughes—I must confess I am not aware of a set of requirements. Perhaps I could call on Dr Duke. He is a member of the board and has been on the board a long time. He may be able to help me on that one.

Dr Duke—As Mr Hughes said, the accommodation in those units has not been taken up by the types of people they were originally designed for. I was the hospital chairman prior to John taking up that position, and in our time—and I assume prior to that—there have been no written guidelines as to who would be accommodated there. They could be made into very nice units, and they could be connected with the hospital services.

One of the great difficulties at the moment is that one of the people there creates noise and fear. I think that is one of the reasons why some of those accommodation units are not taken up by people who might otherwise do so. They have been allowed to deteriorate, and that will be another reason why people do not take them up. We have a complicated situation where it is a grant and no-one will feel it is their responsibility to put the money into upgrading them. That is not an unaccomplishable task. We just have not had the person with the mind to do it.

CHAIR—Excuse me, could you could just tell us now in what capacity you appear?

Dr Duke—I am a retired consultant physician and cardiologist. I worked at the hospital here until Easter this year and have now retired part time.

Ms ELLIS—If we, as a committee, are going to consider aged care requirements, it is really useful to understand what is here and how they are used. Whilst not wishing to suggest over-bureaucratisation is required to set things in place, by the same token, there is an understanding required. The other part of that qualifier I was asking was in terms financial. In other words, do I assume that the current residents will all be pensioner income people, or are there other financially situated people who are or could gain access under the current usage arrangements?

Dr Duke—I am not quite clear that I get your question. I do not think you would have to be a pensioner to access the Mawson units.

Ms ELLIS—Subsequent to that, is it $50 a week rent?

Dr Duke—Yes.

Ms ELLIS—Would that need to be re-examined if a non-pensioner gained access and they were upgraded?

Dr Duke—Not that I know of. I think they would be charged $50 a week.

Ms ELLIS—Thank you.

Dr Duke—I think when Mr and Mrs Mawson introduced those units there were no financial restrictions. They were there to provide accommodation in the vicinity of the hospital for people who needed that independent of their income.

Mr NEVILLE—Picking up on where Annette has been, you do not have a Commonwealth subsidised home and community care scheme?

Dr Duke—No, we have no assistance.

Mr NEVILLE—Of the sort of people the district nurse sees, how many of those are requiring some form of medical assistance—injections, washing and all those sorts of things? How many are just receiving a visit and check-up to see that they are all right? There would obviously be two levels of care in there. Do you have any statistics?

Dr Duke—I can partly answer that, because I have seen the district nurse's little schedule as she looked after patients of mine. I know she would take blood pressure for 59 per cent. She would treat them for minor abrasions or things. It would not be just a chat. Our present person does as much as she can in the time to provide that sort of thing. If it is related she will provide it. I think it would be a reasonable number.

Mr NEVILLE—About fifty-fifty?

Dr Duke—At least, I would think, from what I saw nine months ago when I had a particular patient who we were following carefully.

Mr NEVILLE—You have 10 per cent of the population over 70. You say that there is a crisis coming up in a few years time in terms of how you are going to handle them unless there is a lot more care in the home. Is that the inference I got from the two doctors?

Mr Hughes—That would certainly seem to be the case.

Mr NEVILLE—Do you have any other backup facilities that occur on the mainland that are perhaps delivered by the Blue Nurses or St Vincent de Paul nursing service or the people who go around and sweep out houses and do a few minor jobs? Do you have a service like that?

Mr Hughes—No, we do not, but recently the Department of Veterans' Affairs came over and did a study. They are particularly keen to look after their aged veterans in a home situation. They had a group come over and assess their homes for safety and practicability. I know they have upgraded grab rails and that sort of thing. They are very conscious of that. But that is about the only other facility that we enjoy.

Mr NEVILLE—Do DVA recipients receive full mainland benefits?

Mr Hughes—Yes, I think they do.

Mr NEVILLE—A gold card?

Mr Hughes—Yes, a gold card.

Mr NEVILLE—And does the Commonwealth reimburse the Norfolk Island government for the pharmacy and so forth for that?

Mr Hughes—Yes.

Mr NEVILLE—Thank you.

CHAIR—Thank you very much, Mr Hughes and Dr Duke.

Proceedings suspended from 12.32 p.m. to 1.32 p.m.

COCHRANE, Mrs Joy Evelyn, President, Norfolk Island Hospital Staff Association

CONNOLLY, Mrs Patricia Helen, Director of Nursing, Norfolk Island Hospital

NOBBS, Mrs Janine Mary, Secretary, Norfolk Island Hospital Staff Association

CHAIR—Welcome. Is it the wish of the committee that the submission from the Norfolk Island Hospital Staff Association be accepted as evidence to the inquiry and authorised for publication? There being no objection, it is so ordered. Would you like to speak to your submission?

Mrs Cochrane—Yes. Our submission tries to address some of the questions that were given to us. Unfortunately, for us to go into complete detail would take a *Hansard* sized book. We had to cut it right back to the minimum. Would you like me to go through the format as it is in the submission for the benefit of the people behind?

CHAIR—We would like you just to give us an overview because we have the detail here. Perhaps each of you could give us an overview from your own specialised point of view.

Mrs Cochrane—Certainly.

CHAIR—We are really trying to find some solutions. If you have some solutions to the problems, or suggested solutions, they would be most welcome.

Mrs Cochrane—One of the main concerns on the island is our catastrophic and emergency evacuations, and that is mentioned in the submission. One of the areas that perhaps is not in the submission that would make it more user friendly is that our health administration has to readdress their letter of referral that goes out. We have a problem of a $2,500 limit that we go to, which is covered by Southern Cross here. Unfortunately, some people on the island, when they have a catastrophic accident, are not at that $2,500 limit. So they literally have to step off the island without that coverage by the health care system here. Perhaps one way of solving the problem is to change the wording of it in a letter, so that all bills are sent directly to the island, and then another letter could deal with a waiver system, so that when we come back to the island that $2,500 is then billed to the person.

Another problem area is the employment of only two medical officers here. It seems that our two medical officers are working in excess of 120 hours per week. These two medical officers are on call 24 hours a day—all the time. So our two medical officers, if I can coin the phrase, could suffer from burnout. They cannot completely relax or enjoy time off with their family, because at any time the combined skills of the two medical officers can be called upon. The combination of the skills is anaesthetic and surgery. A third doctor would relieve that situation.

I refer to the present situation regarding wages, and you also asked about the Medicare system, in whole or part, being introduced to the island. I suppose that would be a very good situation to have, but then again, the island does not want to become a burden to the Australian taxpayer. Our wage structure here is tax free. The seconded officers who come

here receive the full Australian wage without taxation on the island. The wage structure is done on the island and is not as high as for Australian counterparts. So a single registered nurse earns an hourly rate of $13.50. Yes, we do get penalty ratings. Some nurses are on call and they get paid an on-call allowance for that. But any one nurse is on call at any time if a catastrophe or an emergency happens.

Nurses here do not have the same wage structure as occurs on the mainland. I think a lot of people seem to think, 'Right, the nurses here are on a wage structure equal to their Australian counterparts.' It is not. It starts off at a $13.50 hourly rate, and the increments come in after that.

Mrs Nobbs—I am trying to think what we have put in the submission. I think the hospital really needs a physiotherapist, as well as looking at the staffing of the whole hospital, from the doctors to the office, which needs another staff member. We are always working short staffed in the nursing area. It is an overall picture having regard to the whole hospital. The hospital itself does need upgrading. There has been talk of a new hospital for at least 10 years that I am aware of, and it just goes on and on. Either we refurbish the one we have or we look at building a new one in the pretty near future.

CHAIR—On an adjacent site?

Mrs Cochrane—The same site; it is possible.

Mrs Nobbs—I think the site is a good site where it is. It is quite central for the island.

Mrs Cochrane—There is actually a lovely building site towards the back of the hospital that overlooks the valley, into the mountain and out to sea. The site at the moment is central. Not only is it central; if there is a catastrophe at the airport, the present site is easily accessible. They have investigated other sites for the hospital. It is my belief that the hospital, or the administration of the hospital, owns the grounds that the building is now sitting on. So why spend more money to buy another one to build a new hospital?

Mrs Connolly—I agree with that. The only thing that I might add to that is the need for a separate aged care facility where there can be secure places for people who are not easily handled—the geriatrics.

CHAIR—Very close to the hospital?

Mrs Connolly—Yes. It needs to be close, but I think it needs to be a separate unit if possible, because this is just a hospital that has been turned into something to care for aged people, and it is just not suitable.

CHAIR—Are the nurses full time?

Mrs Connolly—Yes.

CHAIR—All of them?

Mrs Connolly—Not all of them. We have got about three relievers, but it gets very thin because you do not have a lot of people to draw from.

CHAIR—Is it true that the nursing rates are about 85c per hour more than, say, for somebody in the hospitality industry?

Mrs Nobbs—Are you looking for a comparison of wages?

CHAIR—Yes.

Mrs Cochrane—I can give you a comparison because I moonlight as a tour guide—for which I have still got my badge on—which is unskilled and I do it out of hours. My hourly rate as a tour guide is $12 per hour.

CHAIR—And as a nurse you get how much?

Mrs Cochrane—As a single registered nurse it is $13.50 per hour. With respect to the tour guide rates, you do not work night shift, although you may work until 10 o'clock at night. If, after 10 o'clock at night, as a tour guide you are still on the buses, it is double time. There are benefits in working at the hospital. We do get superannuation, which has just started, sick leave, which we are allowed to accrue, and five weeks annual leave. There is also long service leave which is now happening at the hospital.

Senator CROSSIN—How do you negotiate any increases in your salaries?

Mrs Cochrane—Because the hospital is classified as the Norfolk Island Hospital Enterprise—it has been changed from the former situation—it is now a private enterprise. Our main way of negotiating wage increments now is to approach the Norfolk Island Hospital board of management. We approach them as to whether or not we can have a wage increment. If they are not agreeable, or do not come to the party, or are not giving us access to a wage rise, we can then access the Justice Morling tribunal settings. Justice Morling has just been to the island and the nurses did not appear—the staff at the hospital did not appear.

I will give an example of one of the problems we had with trying to negotiate a wage increment and an improvement for the nurses. It was a long, hard and bitter fight to get penalty ratings. We took that to the tribunal for somebody to make a decision and say, 'Is this part of your wage allowance? Can you all do it?' He ruled on that and we got the penalty ratings then. Our penalty ratings at the moment are 15 per cent for night duty, 10 per cent for afternoon and weekend, and double time on public holidays. The double timing is throughout the island.

Senator CROSSIN—So when people like ourselves are told that people on Norfolk Island actually get a salary that is tax free, can you explain exactly what that means. I must admit that I thought if a registered nurse was getting around $30,000 a year on the mainland, she would then pay tax and the Medicare levy, and I honestly thought people who worked here probably got the $30,000, not the component which is left after tax. Can you explain for us exactly what is meant by, 'We don't pay tax'?

Mrs Cochrane—From what I can gather, we do not pay tax as such. We do not pay tax as such to the Australian mainland. However, on Norfolk Island we do pay levies. Am I on the right track here?

Senator CROSSIN—Yes, and I also want you to cover what your $13.50 an hour is based on.

Mrs Cochrane—That is easy. We do pay levies; we call them hidden levies. We have a food taxation levy. Any goods that you buy at the supermarket are already on it. Everybody pays the same on that one with any goods that you buy here. That is what we call a hidden tax.

We also pay a health care levy which is $250 per head of family, the parents. After the age of 18 years, a child has to pay the $250 for himself or herself, unless they can prove they are still at school and being educated. Per year you are looking at $500 per nuclear family. On top of that is the Southern Cross, which is $98 per month for the nuclear family, that you can claim to pick up the gap of the $2,500.

We have a rather exorbitant telecommunications system here. The price of international phone calls in and out of Norfolk Island is twice what you would pay on the mainland. Is that what you are wanting to hear?

Senator CROSSIN—Yes.

Mrs Cochrane—Any aircraft landing on the airport now pay a landing fee to the administration. The health care levy that we have here, from my understanding, is supposed to go straight into the health care fund that is here on the island. If we were on the mainland and working in the same system, we would be paying into your Medicare system over there. I do not think anybody would really worry about it. It is just that, if you are going to introduce the Medicare system here on the island, the baseline point for finance is not as high as your hourly rate on the mainland. I have not got the figures right with me at the moment for the hourly rate on the mainland, but the last time I was looking the rate for the average registered single certificate nurse was $32 per hour.

Mr NEVILLE—Casual or permanent?

Mrs Cochrane—Permanent.

Senator CROSSIN—So the $13.50 is based on an hourly rate of, say, a comparable net salary in Australia as opposed to gross salary?

Mrs Cochrane—It is supposed to be based on that but is way below that.

Senator CROSSIN—Yes. Do you know if tax plus a Medicare levy deducted is factored in that?

Mrs Cochrane—On the mainland?

Senator CROSSIN—Yes.

Mrs Cochrane—When they make up their pay packet over there, they make it up at that $30 per hour, and then all the taxation is taken out of the gross at the end of that week or fortnight. It is taken out and then paid. They are not taking a whole $30 per hour home. All the taxation is taken out of the wages before they get it.

Mr NEHL—That $32 an hour of a 40-hour week is the equivalent of $1,280 a week salary. I doubt that registered nurses earn nearly $1,300 a week.

Mrs Cochrane—No, they are not taking that amount home.

Mr NEVILLE—They are not getting that much gross. It would be about two-thirds of that.

Mrs Cochrane—I have not got the figures with me, but I am saying to you that the hourly rate put out by the Nurses Registration Board is around double what we are giving here.

Mr NEVILLE—It sounds more like the casual rate on the mainland to me.

Senator CROSSIN—Are all of the nurses employed at the hospital local people or have some been brought from, say, New South Wales?

Mrs Cochrane—No, there are some nurses here who are local and some who are employed from overseas. Mrs Connolly will be able to answer that one better for you.

Senator CROSSIN—And they are all paid the $13.50 an hour?

Mrs Connolly—The midwives are paid more, the single certificates just a little bit less, but it is not a big difference. It is about 35c difference.

Mr NEVILLE—I would like to explore a couple of things with you. Yesterday in our inspection one of the things that concerned the hospital administration was the paucity of young Norfolk Islanders doing nursing. Do we need something like we have in Australia for doctors, what we call the John Flynn scholarships, to get young people in rural areas to do medicine on the presumption that, if they come from the country, they will probably go back to the country, and they are bonded to spend some years in the country when they finish medicine? Do we perhaps need something like that here to encourage young Norfolk Islanders, one or two a year, to go to the mainland to do nursing so that the skills can be brought back? Where did you all do your training—on the island or on the mainland?

Mrs Nobbs—We are all New South Wales registered nurses. All the nurses at the hospital are qualified. We also have assistants in nursing and enrolled nurses, but there is always a qualified nurse on duty at any time.

Mr NEVILLE—Do you train enrolled nurses here?

Mrs Nobbs—No. We are not capable of training.

Mr NEVILLE—Everything is done on the mainland?

Mrs Nobbs—Yes.

Mr NEVILLE—What happens in the future if no young girls, or lads for that matter, are going over to do nursing?

Mrs Nobbs—That is what is happening now. We cannot cover the hospital with a staff of local nurses like we have been able to, but I think at all times there have been one or two girls from the mainland that have come over. People do ring and show interest in coming to the island and I think that is the main way that girls come here to work.

Mrs Cochrane—We do have at the moment a young lass who is home on holidays who has just finished her nursing training. She is an islander. There is another island lass away at the moment who has finished her training and is now working in a hospital in Australia, and she is also going to America to train. I believe we also have a young lassie who is in her second year of medicine and another young lassie who is doing biomedicine. So we do have young ones going out and training. But if they do it they do it without saying they will come back and work here at the hospital for some length of time.

Mr NEVILLE—Whereas if they were on a scholarship they would be bonded to come back for two, three or four years or whatever.

Mrs Cochrane—Most of the popular young ones who go away to train, do train and stay overseas for a little while to gain more experience and bring it back.

Mr NEVILLE—There is another area I would like to explore with you. We were talking in evidence this morning about the Mawson Units as independent living, and then you mentioned that there are some difficult patients. What is your estimate of how many hostel type units and how many nursing home type beds would be required, based on what you have got in the hospital at present and what you know of from seeing other people coming into the hospital for treatment? Four of each type of bed or six?

Mrs Connolly—You would need more.

Mrs Cochrane—We have eight permanent geriatric patients at the moment—

Mr NEVILLE—Do you know the one to eight rating on the mainland? Are you familiar with that?

Mrs Cochrane—No.

Mrs Connolly—No.

Mr NEVILLE—It works downwards: categories 8 to 5 are hostel type patients—people who can look after themselves, bathe themselves, but require minimal nursing and generally

have a bedsitter type unit; then 4 to 1 are the nursing home type patients who are semi or permanently bedridden. What is your estimate of each group?

Mrs Nobbs—Male and female?

Mr NEVILLE—No, each of those two groups, hostel and nursing home. Just give us a bit of a feel for how many. If we were to make a recommendation that the Commonwealth make a special grant available, we would want to know what the estimate was of those likely to require nursing home care, say, in the next three, four or five years.

Mrs Nobbs—I would say that there should really be at least 12 beds available for nursing care patients. Two of our patients at the moment could probably cope in a hostel type situation, but there just are not those facilities available. They need a little bit of assistance. They are not quite capable of living in the Mawson Units, but the hospital is not really a place for them to be either.

Mr NEVILLE—You would see this as a unit near the hospital, perhaps using the same kitchen, but with a separate staff—is that the idea?

Mrs Cochrane—Yes.

Mrs Connolly—Yes.

Mrs Nobbs—Yes. We only have one chef at any time at the hospital kitchen so you would have to look at improving what is happening in the kitchen as well, at the need for more staff in there.

Mr NEVILLE—On the mainland, if you go into a hostel you negotiate a fee which is paid to the administration of the hostel, or the state government agency or church or whatever it might be, and then you draw down on that. Somewhere between $40,000 and $70,000 is most common, and you draw down on that for $2,600 a year. If the person dies or moves out of the hostel, the remainder is remitted to the family. On that sort of basis, what would people here be capable of paying? Would most people who get to the stage of moving into a hostel be capable of paying $30,000 or $40,000 or $50,000?

Mrs Connolly—No.

Mr NEVILLE—If they sold their homes?

Mrs Connolly—Maybe if they sold their homes, yes. That is not a thing that people on Norfolk think about.

Senator LIGHTFOOT—It is reality.

Mrs Connolly—It is reality, yes, I realise that.

Mr NEVILLE—If people like to stay in their homes on the island, is there a need for something like the HACC scheme we have on the mainland—the Home and Community Care scheme?

Mrs Cochrane—That would keep a lot more people in their homes here—the HACC situation of home and community care would do that quite well. That is with the district nursing as well. We have local support groups here, like the Lions Club, and they do help some of the people stay in their homes, and the clubs here help some of the people, but Health and Community Care would advance that even further.

Mr NEVILLE—It would need some formal type of structure.

Mrs Cochrane—Yes.

Mr NEVILLE—In the community, from the hospital, under one of the churches—how would you do it?

Mrs Cochrane—It would possibly be best done from the hospital because of the employment of the district nurse.

Mr NEVILLE—Thank you.

Mr NEHL—Could I ask one very basic question: what is the population aged 70 years and over of resident people?

Mrs Cochrane—There are no two ways about it; we have an ageing community here.

Mr NEHL—I realise that. Does anybody, even in the audience, know what the population is? The reason I ask the question is—

Mrs Cochrane—Aged 70 and over?

Mr NEHL—Aged 70 and over.

Mrs Cochrane—I could not tell you that without going back and finding out.

Mr NEHL—The Commonwealth has a ratio of 100 aged care places per thousand people aged 70 and over. If it were known what your population aged 70 and over was, you could then use that ratio to see how many beds you need. Mr Chairman, we have an offer from the audience.

CHAIR—We cannot take evidence from back there. The person will be presenting evidence later, so they might like to introduce that as part of their introductory comment.

Mrs Cochrane—I routinely tell visitors that at our latest census there were 1,800 people on the island, but that is the young ones and the older ones too. I really could not give you an accurate figure without going back to the census.

Mr NEHL—The reason I was asking that was to try and get some sort of estimation of what the needs are. If you assume the needs are the same as on the mainland, that 100 per 1,000 of those aged 70 and over is allocated on the basis of so many high care or nursing home and low care or hostel, and others are community aged care packages which are home cares.

Ms ELLIS—This is a bit of a favourite topic of mine—the need for an aged care facility. What happens at the moment with an aged person in the facility or in the community who suffers any form of dementia?

Mrs Connolly—They are admitted to hospital. There is nowhere else to put them.

Ms ELLIS—Do they go into that aged care area we saw yesterday?

Mrs Connolly—Yes, that is it. That is where they go and that is where they stay.

Ms ELLIS—That is totally insecure, so how do you cope?

Mrs Connolly—It is very difficult. But we do. We just have to have more people there, which we have done in the last few months, to look after those that wander around down there. That is all we can do.

Ms ELLIS—Has it ever been the situation, to your knowledge, that someone with dementia or Alzheimer's disease has needed to be sent to the mainland because of lack of facilities here?

Mrs Connolly—Yes, one.

Ms ELLIS—You know of one? They had family here?

Mrs Connolly—Yes.

Ms ELLIS—What happened in that instance with the remaining family here?

Mrs Connolly—They are still here.

Ms ELLIS—So there was a complete breaking up of the family unit?

Mrs Connolly—Yes. It was very traumatic for them.

Ms ELLIS—Roughly how long ago was that?

Mrs Connolly—Roughly 18 months to two years.

Ms ELLIS—Is that person on the mainland still living?

Mrs Connolly—No.

Ms ELLIS—Just anecdotally for us, can you explain to me the family make-up here? I get the impression that in some families here children stay on into their adult lives, but in some families that is not the case and they go to the mainland for their own career and life and so on. What is your feeling of the proportionality of that?

Mrs Connolly—I do not think that happens nearly as much now. People go. One of our greatest exports I think is the young people.

Ms ELLIS—So you are saying that more now go to the mainland than was the case? The reason for asking that is, obviously, that then you have got a growing number of incidences of elderly people with their family distant from here. Would that be your reading of it?

Mrs Connolly—Yes.

Ms ELLIS—Do you all agree with that?

Mrs Cochrane—Yes. The children go away and do their formal training, and they may stay off-island for quite some number of years and come back afterwards. And sometimes they do not return, unfortunately, until the parents have passed away, which is a great sorrow.

Ms ELLIS—Just one more quick one. In relation to the aged specific facility, suppose we have just passed you a magic wand and you can have down there at the hospital grounds what you want. Considering dementia and Alzheimer's, and considering distance of family remote from the elderly parents—not just bed numbers—how do you actually perceive that that facility would be constructed, in terms of facility, staffing and so on? What would be your ideal, do you think, for the community needs here, without being outrageous—a wish list with a little 'w', not a big 'W'?

Mrs Nobbs—One of the really important issues of need up there, something we have asked for for a long time, is a secure outside fenced area so that they can go outside but cannot get into the car park or other areas of the hospital. It needs to be separate because it is a hospital—we do get acute patients and you need to be able to just keep the two areas separate.

Mrs Cochrane—If I had a wish list for what could be built down there, it would include married quarters for couples who are in dementia to be together. That would be one of the things that I would have on a wish list—that they could have shared accommodation in private rooms for them, to preserve their dignity and wellbeing. I would like also to have perhaps semi-detached units for ones who are able to, let us say, make a sandwich and eat that but just need constant supervision to make sure they have not fallen over or harmed themselves or forgotten they have turned the gas on and left it on. It would be good to have that sort of situation, semi-detached, and to have staffing for those people in that unit or that particular area of living, so that our dementia patients or the residents who are not able to live at home can still have the dignity of being a person and not just a member of the hospital patients.

My wish list would be to separate the geriatric wing completely from the acute part of the hospital. That way they could have their own pets for therapy; they could have their own visitors coming in. They could have a room where their visitors could come in at any time of the day or night, and sit and talk to them. But the way it is structured at the moment, it is first and foremost a hospital for acute patients or surgery. It is not a geriatric home. Until that geriatric home or situation is separated and they are given their own things from the hospital, we will always have problems.

Mr NEVILLE—Would you have separate staffing?

Mrs Cochrane—Separate staffing, yes.

Ms ELLIS—We are talking here about specialist geriatric care nurses or staff, are we not?

Mrs Cochrane—Occupational therapists—

Ms ELLIS—Exactly, especially with Alzheimer's/dementia people. Would that have to be part of their training regime or staff intake planning?

Mrs Cochrane—Yes. Literally, it all boils down to finance.

Ms ELLIS—Thank you very much. I was very keen to hear your views on that.

Mr NEHL—Mr Chairman, I would like to pursue the point I started to make before I was interrupted.

CHAIR—We have to think about time.

Mr NEHL—I will be very brief, if I have your call.

Mrs Connolly—We can come back if you want us to.

Mr NEHL—The point I want to make is a very important one. Everybody says, 'Yes, what we have got at the hospital is inadequate. It is unacceptable.' Everybody says, 'We need a dedicated aged care facility with its own separate staff.' Has anybody done any planning or thinking about it? So far, what has been put forward to us in evidence is something that would be totally unviable in the ordinary mainland context. In my electorate I had one 18-bed hostel—totally unviable. It has now got 24 beds, and 24 is really on the borderline. For an aged care facility to be viable, it has got to have at least 30 and preferably 40. I just wonder: has there been any detailed planning or thinking about it, or is it just that small 'w' wish list of Annette's?

Mrs Cochrane—There was talk here at one stage of building a retirement village cum that sort of situation where they could have this 30-unit facility. Talk of that was started by a Mr Peter Middleton, who has unfortunately passed away. There has been some form of proposal but we were not part of that. It was coming from the private sector. But from the hospital point of view, we just know that the way it is at the moment for the treatment of

our geriatrics and their care, and for our residents and visitors here, what is happening at the moment is not satisfactory.

CHAIR—Thank you for giving us evidence. It is very interesting and I thank you for appearing before the committee.

[2.09 p.m.]

DAVIE, Mrs Sallie, Member, Community Health Awareness Team

EVANS, Mrs Colleen, Chairperson, Community Health Awareness Team

NOBBS, Mrs Janine Mary, Member, Community Health Awareness Team

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mrs Davie—I am here as a member of CHAT, and also I have worked a little in community health on the mainland.

CHAIR—Would you like to present evidence to the committee?

Mrs Evans—We are the community health awareness team which we started here to try to get a primary health care service up and running on Norfolk Island. We do not have such things as drug awareness programs or safe sex education programs. We do not have cancer support groups, diabetes support groups or things like that. Our main aim is to try to get what little primary health we have in the hospital out of the hospital and into a community health centre.

Mr NEVILLE—What would that centre look like? It is the sort of question that my colleague asked the last witnesses. What is your vision of it? Is it attached to the hospital or is it a separate area?

Mrs Evans—We would like it under the umbrella of the hospital. There is a small building in the hospital grounds at the moment which is called the baby health clinic.

Mr NEVILLE—Would it be a bit like the ones on the mainland where, in some centres, all the Pap smears are done, or would it be purely advisory?

Mrs Evans—We do not see it as that, because the doctors work out of the hospital. We want to start small and get drug programs and safe sex programs running, along with support groups for cancer victims and so forth.

Mr NEVILLE—There was evidence this morning that the community health regime is not real flash on the island, say, in the area of nutrition.

Mrs Evans—That is right. All those sorts of things we feel could come under the umbrella of a community health service. Our aim is to get a community health coordinator to run these services.

Mr NEVILLE—One paid professional?

Mrs Evans—Yes.

Mr NEVILLE—And how do you plan to fund that? Are you going to ask the Commonwealth to do that or would it be a joint thing between the Commonwealth and the island administration or what?

Mrs Evans—I am sure that Geoffrey told you this morning that we have had quite a few discussions with him and his ministry to try to get a community health coordinator funded. At this present stage, they have not got the money or facilities to do that. We are hoping that we might be able to get some sort of backing from Australia to get it up and going.

We have Janine, who is the baby health nurse; she is quite happy about it and Sallie, who has worked in community health in Australia quite a lot, is prepared to give voluntary time to start it off. Janine and I are prepared to put work into it voluntarily to get it up and running. But long term, there is no way volunteers can stay forever. You have to have somebody full time coordinating these services and that is our aim.

Senator LIGHTFOOT—Mrs Evans, is the medical problem here amplified not just because of your isolation necessarily, but because your isolation is as a single island in a fairly big area of water? Is that the problem? It appears to me that what you need here and what you want here is a medical facility that we would have in some of our cities or our major towns, but not in comparable towns around Australia. What is it? Is it that isolation to the mainland that makes you feel so vulnerable?

Mrs Evans—We are vulnerable because of that. We do not have the support network that you have in Australia. You can connect to other bigger hospitals and things like that. We do not have anything like that. We rely solely on our two GMOs to do all doctoring on Norfolk Island. Otherwise you are flown out, of course, if it is anything very serious. You cannot expect these two doctors to do all primary, secondary and tertiary hospitalling on Norfolk Island.

Senator LIGHTFOOT—With respect, is that not a problem though for your local government?

Mrs Evans—Quite possibly, yes. But the reason we are here today to talk to you is because we want to lift some of that load and get a community health service running. We have nothing like that. We have no education programs for better health so that people are not going through into secondary services and things like that. That is the aim of the community health awareness team.

Senator LIGHTFOOT—How do you see the figures of the two doctors working 120 hours a week? That is equivalent to four doctors working 60 hours, of course. That is a fairly high ratio, given the number of people here. Why is it that the doctors need to work 120 hours a week? That sort of ratio is something that rural and regional Australia would be very happy with.

Mrs Evans—I do not know that they do work 120 hours a week, but what I do know is that it is a small local friendly community and we all know the doctors. The first thing you do is call on them if you have any problem and they are very happy and obliging to help you—as much as they probably do not want to sometimes.

Senator LIGHTFOOT—Are the doctors involved beyond medical problems because of the close proximity?

Mrs Evans—They help you with emotional problems and things like that as well.

Senator LIGHTFOOT—If you could ask for something here to enhance the health system here for the islanders—say, one major item of equipment—what would that be? There is not going to be a consensus about it but what would it be?

Mrs Evans—Personally?

Senator LIGHTFOOT—Yes.

Mrs Evans—My personal opinion would be telecommunication networking to help with diagnosis.

Senator LIGHTFOOT—Telehealth communications?

Mrs Evans—Yes. That is my opinion.

Senator LIGHTFOOT—And do you know what is inhibiting that contact with the mainland?

Mrs Evans—No.

Senator LIGHTFOOT—You are not aware of what is inhibiting that?

Mrs Evans—No.

Senator LIGHTFOOT—That is not a particularly big budget item and I am sure that that is something that the committee would give some serious consideration to. The other area is that of your aged people, and we have a problem similar to that. In fact, the world is going grey, if I could put it that way.

Mr NEVILLE—Speak for yourself.

Senator LIGHTFOOT—This is not a grey rinse that I have either. But do you think it is feasible to divorce the two issues of health and assistance for the aged? In other words, the scheme in Australia that operates—I think it is the HACC scheme—where people are able to stay in their own homes and get assistance is not only better for the people to stay there, but it is better on the government coffers as well. Is that something that you have given consideration to here?

Mrs Evans—We personally at the CHAT team have not, because our aim has been to get the primary health service out. But if you are asking my opinion then we have a great volunteer network that works with people that stay in their home here. Most aged people do not go into the only facility we have, which is up at the hospital, unless they are totally incapacitated and cannot do anything for themselves. Otherwise most voluntary committees

here, such as Red Cross and Meals-on-Wheels, work around and we have an Emily Channer nurse who goes to the houses of the aged every day. We are already doing that now.

Veterans Affairs have started a group as well which picks up the aged every week and takes them into a local hall and they meet and play games and all that sort of thing. I think we have a fairly good network of that happening here now.

Senator LIGHTFOOT—I empathise with what you are saying, because I come from a very isolated area of Australia and lived there most of my life but do you think the major part of the finance should be a Commonwealth government responsibility or should it come from your local government?

Mrs Evans—Are you talking just on aged care or on all health?

Senator LIGHTFOOT—I am talking on health care generally. You can differentiate between aged care if you wish.

Mrs Evans—No. I believe that we cannot do without Australia and we need Australia's support. If we get money from you it is going to make it much easier for us to facilitate these services and get them up and running.

With local government, the money is everybody's money and we rely on the tourist trade for our dollar. That is only so much and you can only do so much with what you have, so we need assistance. This is my opinion of course.

Senator LIGHTFOOT—What if the Australian people were to say—if they had a say and they probably will not—'Look, we are paying a 10 per cent goods and services tax. Should we divert that to Norfolk Island, when it does not have a goods and services tax?'

Mrs Evans—I could be really naughty and say I lived and worked in Australia for 15 years and paid tax. I feel that you could give me a bit of money.

Senator LIGHTFOOT—I think we do divert a bit of money here. You do not agree with a goods and services tax. If you have an opinion, it is a curly one. You might be kind enough to frame an answer. You would not agree with a 10 per cent goods and services tax? You get 40,000 tourists a week through here.

Senator CROSSIN—Members on the committee would not agree with that, Senator Lightfoot, so be careful.

Mrs Evans—I really do not want to say anything. You say it.

Mrs Nobbs—You would have to look at the whole wage structure, not just putting a 10 per cent tax on one particular thing.

Senator LIGHTFOOT—You do not want to tax the tourists who come in here?

Mrs Nobbs—Absolutely not. We do not want you to tax our wage, we do not get paid enough now.

Senator LIGHTFOOT—It is okay to put the tax up in Australia.

Mrs Nobbs—Yes.

Senator LIGHTFOOT—How do we explain that in terms of equity to our Australian mainland constituents?

Mrs Nobbs—Senator Lightfoot, you mentioned the small population and the hours that the doctors work. As you are aware, we also have a very large tourist population. They mostly do come to the hospital because most of the visitors who come to the island are aged.

Senator LIGHTFOOT—Do you have any idea of the percentages that are outside the community?

Mrs Nobbs—Visitors who come to the island?

Senator LIGHTFOOT—No, to the hospital.

Mrs Nobbs—No, I do not.

Senator LIGHTFOOT—Do you have a guess?

Mrs Nobbs—A guess? Every day?

Senator LIGHTFOOT—In a percentage term or fractions?

Mrs Nobbs—No.

Senator LIGHTFOOT—A quarter?

Mrs Nobbs—I would say a quarter of the patients who come to the hospital every day are visitors.

Senator LIGHTFOOT—How is that reimbursed to the hospital?

Mrs Nobbs—They are charged more than local people are.

Mrs Evans—Because hopefully most of them have travel insurance, anyway.

Senator LIGHTFOOT—Thank you for that.

Senator CROSSIN—Are you saying that perhaps nurses or the hospital staff provide people in the community with advice about diabetes or asthma?

Mrs Davie—In theory that is supposed to happen but it does not. The top of the submission has a list of services advertised every week as being available, but they are not available as they should be. The clinics run on the mainland that provide advice and education on diabetes, alcohol, drug abuse and those kinds of things do not happen here. What we are after is for that to happen because that is preventative medicine. If we can do that kind of work in the community we are going to help the doctors with their load.

Senator CROSSIN—I understand that. At this point in time, would people on the island who want that information write to Asthma Australia or Diabetes Australia in Australia?

Mrs Davie—They would probably come and see the doctor. There are nurses in the hospital who are trained to do diabetes education and that kind of thing but there is not a regular clinic. If you are in the community and you want this kind of thing, you have to do a lot of questioning to find out how to get the help, and usually you do that by coming to see the doctor.

Senator CROSSIN—Has the proposal ever been put to the hospital board or has the local legislative assembly ever come up with the idea of funding a community based nurse or community based education service?

Mrs Evans—No, we have been trying to get that since about June. We had a couple of public meetings. It is in the proposal. We gathered over 350 signatures and we presented the proposal twice to the hospital board. Our health minister has it as well. Our health minister is trying very hard, but he is looking at a broad spectrum of the whole health issue, whereas we are looking at just one thing. He is very aware of it and I am sure he is very for it. As far as funding goes, I do not know how or what.

Senator CROSSIN—What access to advice do teenagers in high schools or young adolescents get in this community on a whole range of preventative and educative areas in terms of their health?

Mrs Nobbs—Earlier in the year we were asked by the school whether we could go and do some educational talk on sexually transmitted diseases. Dr Davie and I did one session with year 10 and that is all that we have done this year.

Mrs Evans—There were to be a couple of drug programs, but they have not happened yet, as far as I understand. The lady who was going to be here but had to be at school is the executive high school teacher. She is on our team. She feels very much they are in a lifeboat with no support. A lot of these things just are not happening. Our kids know very little about safe sex and sexually transmitted diseases. We never used to have the television like we do now. We have satellite TV. It does not have the ads like the commercial television in Australia with your antismoking campaigns and so forth. Our kids do not view anything like that. The programs are very limited in the school itself.

Mrs Davie—I think they depend on whether we get invited to do them.

Senator CROSSIN—Is the baby health clinic operated as part of the services that the midwife undertakes?

Mrs Nobbs—It is part of the hospital. It is a child health clinic. It is open three days a week—Monday, Tuesday and Wednesday. We do antenatal classes and see postnatal mothers and babies.

Senator CROSSIN—Is there an ongoing program that is monthly or six-monthly? Who does the routine checks on young children under the age of four and the immunisation program?

Mrs Nobbs—We follow the New South Wales health recommendations for immunisation. The children are followed through to school. As a child health nurse, I go to the school and do immunisations up until they leave school.

Mrs Evans—But there are no regular checks. They are only when they are babies, aren't they?

Mrs Nobbs—That is a personal choice. You cannot force people to come. But those are there if they want to come.

Senator CROSSIN—Is there an immunisation program on the island in terms of expectations on the mainland?

Mrs Nobbs—There is no incentive for immunisation, because you have to pay here.

Mrs Evans—We do it purely by want.

Mrs Nobbs—I keep the immunisation records. Just three weeks ago, I got a list of under five-year-olds from administration. There are three children on the island that are not immunised up to the date that they are supposed to be, and that is by choice.

Senator CROSSIN—If you choose to have your child fully immunised, is it at a full cost to you, or is it a public health cost?

Mrs Evans—We pay the lot.

Mrs Nobbs—Parents pay for immunisations.

Mrs Evans—If you are a mother like me, you have every immunisation known to man.

Mrs Davie—We would like to see services where the child health centre is extended to embrace some of these needs of the community so that we go into more educative and preventative help at the same centre.

Mrs Evans—We do not want a new building or anything like that.

Mrs Davie—We are looking to make a proper position for someone part time perhaps to start.

Mrs Evans—To build up to full time.

Mrs Davie—To make it a proper ongoing thing. There has been a lot of talk about having a counsellor, which I believe came up this morning. We feel that should be part of it.

Senator CROSSIN—So your standard polio and triple A immunisation of a young baby—

Mrs Nobbs—At two, four and six months.

Senator CROSSIN—Is paid for by the consumer?

Mrs Evans—All of them are paid by us.

Senator CROSSIN—At a cost of?

Mrs Nobbs—For two months alone, you have an HIB injection. You also have a triple antigen or Infanrix. The HIB is $14.50. The triple antigen is $13.00. Infanrix is similar, which is $43.00, but the side effects are less. The parents have the choice. The sabin is $1.00 per dose. You have that at two, four and six months. A measles, mumps and rubella injection at 12 months is $24.00, I think. That is repeated at 18 months and prior to commencing school.

Mrs Evans—A lot of us put our kids through the hepatitis injections and the meningitis injections as well. We pay for all of those as well.

Senator LIGHTFOOT—Is that full cost recovery, or is it subsidised?

Mrs Evans—No, we pay for it.

Senator LIGHTFOOT—It is full cost?

Mrs Evans—Yes.

Mr NEVILLE—If this position could be created, would you see that person also coordinating community scan programs—say, mammography, bowel cancer scanning, glucose testing and all those sorts of things?

Mrs Davie—Yes, everything, and they should probably also be involved with the district nurse in your aged care problems as well.

Mr NEVILLE—Do you, as people in the nursing industry, or on the fringes of it anyhow, see the need in this community for a health scan for the community?

Mrs Davie—Yes, I think that would be good because that is part of your preventative-type medicine, and at the same time you are educating people about what to look for and how to look after themselves.

Mr NEVILLE—What is your comment on the aged care unit that was spoken about earlier?

Mrs Davie—I think it is definitely needed.

Mrs Evans—It is definitely needed. There is nowhere besides the verandah at the hospital for old people to end up on and that is pretty sad. I would hate to end up my life on that verandah. As much as the nurses are wonderful and all the rest of that jazz, ideally, I would like to see something built where it is pretty, where they can sit out and enjoy the rest of their life. That would be fantastic.

Mrs Davie—With proper care.

Mrs Evans—With proper care, that is right. That is just how I would like to see my life end.

CHAIR—Thank you, ladies, for your presentation. If there are any subsequent thoughts please feel free to put in a supplementary submission.

Resolved (on motion by **Ms Ellis**):

That the submission from the Community Health Awareness Team concerning the need for a community health service and Medivac be received as evidence and be authorised for publication.

[2.33 p.m.]

BEADMAN, Mr Russell Harold (Private capacity)

CHAIR—Mr Beadman, thank you very much for coming before the committee. We welcome you and we invite you to give evidence. These proceedings, of course, are legal proceedings of the parliament. You are protected by parliamentary privilege.

Mr Beadman—I am appearing in a private capacity. I wish to speak about the health funds in Australia, and also the problems of being an Australian taxpayer living on this island and not being able to be issued with a Medicare card. Could I read this to you?

CHAIR—Yes.

Mr Beadman—This is just to give a few details about myself. I was taken to Canberra in 1923 and served practically all my working life with the Department of Housing and Construction in Canberra. I retired in 1982, and my wife and I came to this island in 1988. I do receive a superannuation pension from the Commonwealth of Australia or the government of Australia, and that superannuation pension is taxed. Possibly I would be one of a handful of people on this island who pay tax to the Commonwealth of Australia. This year I was granted a veterans gold card which I was most grateful for, and my wife is covered now with private insurance in Australia.

When we settled here in 1986 we had Medibank Private health cover and the use of the Medicare card. After being here about nine months—we were in Medibank Private at the time—Medibank Private wrote to us and told us that, due to the government restrictions, we could no longer remain a member of that fund, so we transferred to a fund in Sydney. In 1992, Dr Blewett, the then minister for health, decided that the Medicare system as it was would no longer apply to this island and therefore anybody with a Medicare card was not entitled to the normal things that go under the requirements of a Medicare card.

If we are having hospitalisation in Australia we are entitled to claim for the hospitalisation, not for the medical side of the business. For example, in 1996 my wife had a big heart operation in Sydney, five by-passes. Hospital costs were $18,000, which was paid for by the fund, and the doctors' bills, and there were 10 doctors involved, cost $10,000. This was paid for by the local fund on this island, because not only do we belong to the private fund but we also pay for the health levy on this island.

Towards the end of last year we did hear that the fund would no longer pay for hospitalisation on this island. Therefore I sat down and wrote them a letter requesting them to indicate whether this was so. I will read you the reply we got back. 'Dear Mr Beadman, I am writing in regards to your letter sent to Manchester Unity in regard to your membership with us and what you are covered for in Norfolk Island. I have been trying to contact you by telephone but have been unable to get through.' I do not know what was wrong with them, because it is pretty easy to ring through to Norfolk Island. 'Your current cover with Manchester Unity is private shared hospital cover with health cover plus ambulance exempt. We will pay some benefits towards hospital cover for you, but it would be best if you could

contact us with the hospital you are going into and the item number of the procedure you are having done and we can do a hospital benefit quote for you.'

I would hate to have been having a heart attack, because it would have been a bit impossible for me to contact the fund and ask them what they were going to pay for that. In that respect, the reply means to me that they may and they may not; but we are still paying into that fund in Australia.

As an Australian citizen paying taxes, of which a portion goes to the general health of the budget, I think we are entitled to the Medicare card and I am quite willing to pay the Medicare levy to obtain the card. As you people would know, the government of Australia—my government, too—instituted a health rebate stream. I am unable to claim for that health rebate.

I would like to continue in respect of residents of this island proceeding to Australia. People who live on this island and who grew up on this island, who have lived and worked here for quite a number of years, can proceed to Australia. Immediately they arrive in Australia they are allowed to enrol for the Medicare card: they have never paid a bit of tax in their life, but they are able to claim Medicare—and that also includes students proceeding to Australia for tertiary education. I have got nothing against them receiving this benefit—good luck to them!—but, as I said, I would like the thing reciprocated to me.

As far as I am concerned, the local health care is very good, and the staff are really wonderful. I believe the doctors are quite often stretched to the limit. A case in point concerned my wife last week. She had an appointment with the doctor on the Wednesday. At around about half past eleven in the morning she received a call from the receptionist stating that the doctor had not come in—but I do not believe that was right; I believe he was involved in something else which was very important—and she explained to my wife that she could not see a doctor until the following Monday. That is, to my way of thinking, an indication that something is wrong with respect to the system with the doctors here.

I would also like to comment on the medivac services provided by the Commonwealth of Australia and the Australian taxpayer, who foots the bill for the medivac services that are provided by the Commonwealth to this island. Over the years, it has cost an enormous amount of money, and the island does not in any way contribute to that service. I think that the island should be asked to contribute in some way for the evacuation of people from it. That is all I have to offer, Mr Chairman, and I thank you very much for listening to me.

CHAIR—Does the committee have any questions?

Senator CROSSIN—Could you just clarify for me, Mr Beadman, the issue you raised about not being entitled to the Medicare rebate?

Mr Beadman—If you read the taxation form, it states very clearly that you must hold a Medicare card and have a control number to claim the rebate. Just to go back a little bit, I did hold a Medicare card until about 1996. But, when my wife was very sick over there, I was asked if I had a Medicare card. I said I did. They said, 'Why don't you use it?' I said, 'Under the laws, I am not entitled to use it.' The comment came back, 'After all, you could

be lost in the system anyhow, and nobody would pick up the cost.' As far as I was concerned, it was not in my nature to utilise something you are not entitled to use.

Senator CROSSIN—Is this in comparison to the similar sort of medical levy you pay here on Norfolk Island and not being entitled to any rebate from hospital fees that you pay here? Is that the comparison that you are trying to make?

Mr Beadman—No. All I am stating in this respect is that I consider that, as an Australian citizen and a taxpayer, I am entitled to a Medicare card if I pay the Medicare levy.

Mr NEVILLE—I, like Senator Crossin, am not quite across what you are saying. I thought you were arguing earlier that, if you were a member of a health insurance fund like Manchester Unity or a medical benefits fund and you paid tax to the Australian government, you felt entitled to the health insurance rebate.

Mr Beadman—No, I do not. I was not arguing that way. As far as I am concerned, I belong to the fund in Australia, but I cannot utilise part of the fund. That is the medical side of the business, which is the doctor's side.

Mr NEVILLE—That is paid through Medicare.

Mr Beadman—I understand that. But if you have not got a Medicare card you cannot claim it.

Mr NEVILLE—I see. So you fall between two chairs: that is what you are saying.

Mr Beadman—That is right.

Mr NEVILLE—But do you get the health insurance rebate?

Mr Beadman—No, I do not, because you must have a Medicare card number.

Mr NEVILLE—In conjunction with a health fund number, as well.

Mr Beadman—Yes, to claim the rebate.

Mr NEVILLE—I see. To your knowledge, have any negotiations taken place to correct that anomaly that applies to Australian born citizens as distinct from Norfolk Island born citizens?

Mr Beadman—I have taken it up with the then member for Canberra. I think he may have taken it up with the Health Insurance Commission. The answer came back as no. I believe he took it up with the health fund also, and the answer was no. I think it even went as far as an ombudsman—is there one?—for the health funds.

Ms ELLIS—I think it is the Health Complaints Commissioner.

Mr Beadman—He told me quite frankly the position and that I was not entitled to it.

Mr NEVILLE—Do you earn any supplementary income on the island?

Mr Beadman—No, I do not.

Mr NEVILLE—So your total income comes from the mainland and you pay total tax back to the mainland?

Mr Beadman—That is right.

Mr NEVILLE—You pay a full medical benefits subscription to a health fund and you get no rebate and no access to Medicare?

Mr Beadman—I do pay it, and the only rebate we get from the health fund is if we go to Australia and go to hospital there, and then the fund takes care of the hospitalisation.

Mr NEVILLE—You do not get the 30 per cent rebate?

Mr Beadman—No.

Mr NEVILLE—It seems unfair to me, Chairman. We should take that up with the minister.

CHAIR—Yes.

Senator LIGHTFOOT—Mr Beadman, what happens on Norfolk Island when you or your spouse become ill and you require some medical advice or treatment? To whom do you go?

Mr Beadman—We attend the hospital.

Senator LIGHTFOOT—Do you attend that very often?

Mr Beadman—In the last few years, it has been quite a lot—because, as the years go on, you tend to require more attention than normal.

Senator LIGHTFOOT—What does that cost you here, every time you attend?

Mr Beadman—Here I think the fee to go to the doctor is $28.15—something like that. That is for a normal call. For a longer consultation, the charge is $50.

Senator LIGHTFOOT—And that is not refundable or rebateable because you do not have a Medicare card: is that correct?

Mr Beadman—That is right.

Senator LIGHTFOOT—What do other full citizens of Norfolk Island pay?

Mr Beadman—They are in the same position. They pay the same thing.

Senator LIGHTFOOT—Is that a full cost fee, do you know, to the hospital—or is it a partially subsidised fee?

Mr Beadman—The hospital is subsidised by the Norfolk Island government. Last year, if my figures are right, it was subsidised to the tune of about half a million dollars.

Senator LIGHTFOOT—You do not pay any form of taxation here on Norfolk?

Mr Beadman—You have duties that are payable to Customs for everything that is imported onto this island.

Senator LIGHTFOOT—That is about 10 per cent, isn't it?

Mr Beadman—It varies, I believe, from possibly eight per cent for foodstuffs, up to—I may be wrong in these figures—16 per cent or 17 per cent for other items. I did hear at one stage that it is about 180 per cent for cigarettes—a levy which I heartily approve of.

Senator LIGHTFOOT—You approve of it because you probably do not smoke.

Mr Beadman—And I am glad I do not.

Senator LIGHTFOOT—Yes, indeed. What I am getting at is that there is some advantage for you living here on Norfolk Island, when you do not contribute in a monetary sense or even in a physical sense, I suppose. I do not know: I guess you are probably retired. You are very much entitled to be, if you wish to be, incidentally—I am not taking issue with that.

Mr Beadman—I think I do contribute to this island. We buy practically everything that we require on this island. We do contribute to the health levy on this island.

Mr NEVILLE—You pay the levy as well?

Mr Beadman—Yes, we do.

Mr NEVILLE—How much do you pay?

Mr Beadman—It is $500 a year for my wife. If I had not have been entitled to the gold card, it would have been $1,000 per year.

Senator LIGHTFOOT—So you pay the $500 levy, plus you pay the hospital consultation fee, which is $28 or thereabouts, plus you pay the 1½ per cent Australian Medicare levy—

Mr Beadman—No.

Senator LIGHTFOOT—You do not pay that?

Mr Beadman—No.

Ms ELLIS—No. He pays private health insurance.

Senator LIGHTFOOT—So you have private insurance, but that does not cover you for doctors: is that correct?

Mr Beadman—That is right. If I had not received the gold card at the beginning of this year, we would be paying—including the $1,000, because I would have been paying the $500 levy also—about $4,500 for medical insurance.

Senator LIGHTFOOT—Are there any other expatriates that are in the same position as you, or in similar positions?

Mr Beadman—There possibly are. We do talk amongst ourselves about it, but I thought this time I would take the opportunity of putting my case to you people and finding out whether you can do something about my getting a Medicare card if I am willing to pay the levy.

Senator LIGHTFOOT—Do you know of anyone who lives on the island, expatriate or otherwise, who does have a Medicare card?

Mr Beadman—I believe there are people on this island living here with a Medicare card. I have no doubt that, when they proceed to Australia on holidays and things like that, the Medicare card is used. As I said before, I have never used the Medicare card since coming to live on this island. It is a beautiful island to live on.

Senator LIGHTFOOT—It is indeed, Mr Beadman. Thank you very much.

CHAIR—I presume those people who use the Medicare card would have obviously given the organisation the address of the mainland rather than Norfolk Island.

Mr Beadman—I believe that some of the cards have a Norfolk Island address and they are still used and accepted.

Mr NEVILLE—So your situation would not be unique. It would apply to any other Commonwealth public servant or, for that matter, any other Australian born superannuant who was living on the island and paying tax on the island would be in a similar position.

Mr Beadman—They would be.

Mr NEVILLE—Do you know how many of you are in that situation?

Mr Beadman—No. I would not like to hazard a guess. In passing, there are three ways you pay Commonwealth tax on this island. I pay tax on the pension I receive. Some residents of this island who finished their time on this island working for the Commonwealth of Australia pay no tax.

Mr NEVILLE—Why?

Mr Beadman—The New South Wales commissioner of taxation ruled, way back in the mid-1980s, that was the position. There are quite a few on this island who receive superannuation pensions and pay no tax on that pension. The third lot are the ones who come into work on this island. They can be here for two to three years and they pay no tax either. That includes the present administrator of this island.

Mr NEVILLE—So you say the deputy commissioner in New South Wales has granted exemptions to some people, and yet others who have come from Canberra and other parts of Australia have not been granted the exemption.

Mr Beadman—That is right. I hope that what I have said does not put any load on their shoulders, if the taxation commissioner decides that they should pay.

Mr NEVILLE—They certainly should not be subject to a double indemnity, that is for sure.

Ms ELLIS—Mr Beadman, what is your residency status here? Are you a permanent resident here?

Mr Beadman—Yes, I am. If you want to know how I arrived here to live: in 1950, 1951, 1952 I came over to this island for the then department that I worked for and I met a very lovely lady on this island. She came across to Canberra in 1952 and we were married in Canberra in November 1952. Her name was Marie Christian. We came back here for a holiday in 1987 and on the way back I said, 'Would you like to come back here to live?' She said, 'If you don't mind'. By February 1988 we were here on the island.

CHAIR—I think that is a very nice point on which to finish your evidence. Thank you very much. It is certainly a different slant from what we have heard earlier, and we appreciate that.

[3.09 p.m.]

BUFFETT, Mr Boyd Charles, President, Returned Services League Sub-Branch, Norfolk Island

CHAIR—Welcome. Is it the wish of the committee that the submission tabled by Mr Buffett on behalf of the RSL be accepted as evidence to the committee and authorised for publication? There being no objection, it is so ordered.

Mr Buffett—My main area of concern has been in the aged health care of the veterans. To that end, in 1998 we expressed our concern, through the office of the Administrator, to the Department of Veterans' Affairs, who granted us a sum of money to commission a report on aged care on Norfolk Island. That is the report that I have tabled. It was produced in December 1998 and since then we have endeavoured to address a certain amount of the issues presented in that report. In addressing those issues in consultation with the Department of Veterans' Affairs and also with the local government—Mr Gardner, the Minister for Health—our main areas of concern were in home safety of the veterans. The Department of Veterans' Affairs sent across a team to look at home safety and falls prevention and conducted a program on the island for that for the veterans community. Since then the RSL have set up a day care club for the aged community.

Even though we commissioned the report from the veterans' point of view, they could not do the report just on the veterans of the island, so it covers aged care generally on the island—even though it is titled for veterans they covered the whole range, and a lot of the figures that you were asking about earlier are in that report. There was a concern about geriatric training and staffing, and staffing of physiotherapy here on the island. Those areas are presently being addressed by the Department of Veterans' Affairs. We have put a submission through to the department from a committee formed here of the Minister for Health, the manager of the Hospital Enterprise and myself. They are currently addressing those issues and, hopefully, they will be resolved. So they are ongoing issues.

There was also a great concern about the nursing home area. The RSL were concerned about that area. That is currently being addressed; it is not an issue that has died. The hospital management at the moment are looking at alternative, mid-term solutions to that problem. I know the minister has a long-term plan for a new hospital and that those areas will be addressed in that. We are confident that the minister, on his trip to Canberra, will address that nursing home area and, as I said, the hospital board management team are also looking at short-term proposals to solve that as well. Overall, from that report, we are confident that areas are being addressed.

CHAIR—It seems to be a very comprehensive report.

Mr Buffett—Yes, we were very happy with the report.

CHAIR—I would say you got some professional help in putting it together.

Mr Buffett—We received a grant from DVA and we engaged a professional consultant from New South Wales.

CHAIR—I am sure we will find that very helpful.

Mr NEVILLE—Mr Buffett, are you an ex-serviceman?

Mr Buffett—Yes, I am.

Mr NEVILLE—Which war?

Mr Buffett—I served after 1972, at the end of Vietnam.

Mr NEVILLE—Looking at the honour board here, I would say that, relative to population, you had a very high proportion of people here who served in the Second World War.

Mr Buffett—Yes.

Mr NEVILLE—So you have a big problem coming up in the next few years?

Mr Buffett—Yes, we have, as far as the ageing veteran population is concerned.

Mr NEVILLE—Have you spoken to the department or Mr Scott about DVA contributing to a multipurpose aged care unit?

Mr Buffett—These discussions are ongoing at the moment.

Mr NEVILLE—I have not had the advantage of reading this report so that, if I go over territory we might see later, I apologise. Based on this report and your own observations, in your view—if you had an aged care facility—how many hostel type beds and nursing home type beds would be required, in round figures?

Mr Buffett—I would say, on the grounds that we are looking at an ageing community and it is getting larger, we would need up to 20 beds. We would probably need 10 immediately.

Mr NEVILLE—Do you see them being attached to a hospital or a separate unit, or do you see them close to the hospital and utilising, say, the same kitchen services?

Mr Buffett—I would like to see them in close proximity to the hospital.

Mr NEVILLE—But separate from the hospital?

Mr Buffett—Yes, with a separate identity. Geriatric care, I feel, is separate from hospital care.

Mr NEVILLE—But utilising common services where possible?

Mr Buffett—Yes.

Mr NEVILLE—Do you have an asking figure on that facility? Have you got any feel for what it might cost?

Mr Buffett—No, I have not. I would only be guessing because, as an RSL, we rely on the Department of Veterans' Affairs. We would look for assistance in that area.

Mr NEVILLE—What proportion of those 20 beds would be for ex-servicemen? I am just wanting an estimate: would it be for a third, a half, a quarter?

Mr Buffett—I would say it would be more for a quarter.

Mr NEVILLE—A quarter of the 20 beds would be for ex-servicemen?

Mr Buffett—Yes.

Ms ELLIS—I have a question also on that point, Mr Buffett: would you agree that it would be wise, if we go down the path of considering the construction or the development of such a facility, that it be done hand in hand with development of home and community care type package arrangements as well? I do not know if you are familiar with the HACC program on the mainland, but it is basically to maintain services—as long as choice allows it—for people to stay in their own home with supportive care.

Mr Buffett—I think the island community would like to see that. That is from my point of view. The islanders are a very independent sort of people. The longer they could stay in their home, the happier they would be. Going into a facility would be the last resort.

Ms ELLIS—I just want to make the comment—and it is not a criticism, it is just a comment—that we have a district nurse that works three half days a week, and we have no strong or really almost no community health program per se. I am a very strong supporter of the need for an aged facility here, but I think it needs to be in conjunction with a holistic program saying, 'Okay, what do we need in terms of estimation and in terms of fullness of program and service delivery?' In other words, in the home, maybe there is a need for respite to some degree: short breaks where they get support which makes things easier. That is one part of it. The other part of it would then be the two- or three-stage accommodation development. Would you agree with that?

Mr Buffett—I would agree with that. During the preliminary discussions that the RSL have had with representatives from DVA and our Minister for Health, they were the sorts of lines we were looking at and are following on with.

Mr NEHL—I am very pleased to have had the opportunity to have a very quick glance at that report. I did not know it existed until the lunchbreak. I was promised a copy from the minister who I was speaking to then. Just looking at it, a figure provides that the number of people who are 70 years and over—which is the relevant point when determining the numbers of places and facilities—is a little under 150. If you apply the formula right now on the current population, according to that report you would be entitled to 15 aged care places, meaning low care, high care and CACPs, which is the acronym for home care.

Obviously, if you were going to provide a facility, you would not want to do it just for the current population because of the ageing. I have to tell you that that is what happens back there. One of my problems with Social Security is that they always use the previous census figures which, for my area on the North Coast of New South Wales, are always out of date—but that is an aside. There is a need obviously there.

I intend, when the minister comes back before us, to talk to him about multipurpose centres. There is one in my electorate where we have hostel low care, hostel high care and nursing home facilities and a hospital as well. It is in a small community. I would suggest that the difficulty, which we are all aware of, is that your population base is very small. It means that the assembly, the government, with the best wishes in the world to provide facilities, are inhibited by the fact that their funding base is basically pretty tiny. I just want to mention in passing that, in spite of the need or the desire to have a totally separate aged care facility, quite frankly—I have to be fair dinkum—I do not think you have the chance of a snowflake in hell in getting a multipurpose centre type facility, because you do not have the population to justify it. But if you take the alternative tack—and I advance it just as a possibility for consideration—you may be able to get something. Thank you for that report.

Senator CROSSIN—Are there any recommendations in that report that the current assembly or the hospital board are picking up and looking at implementing or are there any that they have implemented?

Mr Buffett—There are. They are some of the ones that I have outlined; they are in geriatric training, staffing and physiotherapy. There were a lot of areas of joint ventures between the Department of Veterans' Affairs and government, and those issues are being addressed at the moment. Some areas, like day care clubs, which came back to the RSL, have been implemented.

Mr NEHL—Is one of these the White Oaks Club?

Mr Buffett—Yes.

Senator CROSSIN—So will the population in Norfolk Island—and, in fact, the need for a dedicated aged care facility—increase, according to the figures produced in that report?

Mr Buffett—Yes. Those figures were taken off the 1996 census. They have passed.

Senator LIGHTFOOT—Of the 149 veterans that were registered here a year or so ago, what percentage of those are from the mainland and what fraction originally come from Norfolk Island? Do have you any idea?

Mr Buffett—I do not have any idea on that. We consider them all the same, as far as the treatment of veterans goes.

Senator LIGHTFOOT—Yes. I think that is admirable and it is something that I endorse. But I was trying to work out what assistance there is for mainland citizens on Norfolk Island that may not be available for veterans from Norfolk Island, similar to other expatriates that are here.

Mr Buffett—They are all entitled veterans under the Veterans' Entitlements Act, so they would all receive the same entitlements.

Senator LIGHTFOOT—What about in the case of major medical attention? How do you get your members to the mainland?

Mr Buffett—They would be granted a warrant to fly to whichever medical centre that they had to go to.

Senator LIGHTFOOT—Are those travel warrants easy enough to get?

Mr Buffett—There is a process you have to go through.

Senator LIGHTFOOT—Do they have to be signed by a doctor, a JP or you?

Mr Buffett—They have to go through the doctor. I am not completely up to date on the actual process that they have to go through. That is done mainly by our welfare officer.

Mr NEVILLE—They would have to be authorised.

Senator LIGHTFOOT—But is the set of circumstances that enables your veteran to obtain these travel warrants to get to the mainland for treatment reasonably simple?

Mr Buffett—Yes.

Senator LIGHTFOOT—Do you see any problems with that? Is that adequate? Could it be improved?

Mr Buffett—There have been areas of concern, referrals and areas like that. But I think the system works fairly well.

Senator LIGHTFOOT—So the system works fairly well. Do you get a fairly good deal from the Department of Veterans' Affairs?

Mr Buffett—Yes, we are happy with the way the department operates.

Senator LIGHTFOOT—Has the minister ever visited Norfolk Island?

Mr Buffett—Yes, Minister Scott was here not long ago.

Senator LIGHTFOOT—That's very good.

Mr Buffett—We have actually discussed this report with him. That was the reason for his visit. As I said, he is endeavouring to address a lot of the issues that are in that report

Senator LIGHTFOOT—As a former national serviceman, I find him very easy to get on with. What I have done, because of my membership of the organisation in Western Australia, is present various cheques, et cetera, for different additions or attributes to enhance

the life of veterans. That runs from trailers with camping gear and barbecue equipment in it to buses that will take 14 or 15 people and so on. Do you get any assistance like that here for the veterans?

Mr Buffett—Not really, no.

Mr NEVILLE—There is an outreach program for that.

Mr Buffett—Yes.

Mr NEVILLE—It is a very good program.

Mr Buffett—We have only recently been made more aware of the programs that are available to us. We are following up on some of those at the moment.

Senator LIGHTFOOT—Over the years I have noticed the therapeutic value of these is quite excellent with respect to veterans. The change in their demeanour once they get out on a trip or get in a bus and get together is great. I think it is money that is well spent. If I or the committee can help you in regards to information, you should contact us.

I have one other question. What is it that veterans who are retired do here? How does the RSL sub-branch here enhance their lifestyle?

Mr Buffett—We do not do a great deal because most of the islanders are pretty independent sorts of people. They have independent minds. The most we do at the moment is the daycare club, the White Oak Club—that has been organised. Other than that, we have the facility at the RSL that they can visit if they want to.

Senator LIGHTFOOT—Is that your own club?

Mr Buffett—Yes. But other than that, most of them are quite independent and happy. They either enjoy their outings or they enjoy their own privacy.

CHAIR—An earlier witness spoke about certain taxation anomalies. What is the position of service pensions on Norfolk Island? Do you pay tax on the mainland?

Mr Buffett—Most of them do not. My understanding is that they do not pay tax because of the double taxation ruling. The FIL of the island was counted as a tax. Therefore, Australian taxation was not applied.

Mr NEHL—Unless they had additional income, their pensions would not be taxable anyway.

CHAIR—But if you have additional income that comes over the threshold—

Mr NEVILLE—Do many of the veterans have supplementary incomes?

Mr Buffett—Some of them may, yes.

Mr NEVILLE—So you do not have any trouble getting your people to the mainland. Where do they go—to Greenslopes or Concord or where?

Mr Buffett—If they have a preference for Brisbane or Sydney—

Mr NEVILLE—They go to veterans' hospitals there.

Mr Buffett—Yes.

Mr NEVILLE—Would most choose to have medical treatment at a veterans' hospital?

Mr Buffett—It is up to the individual.

Mr NEVILLE—What is the arrangement between the two governments in respect of DVA pensioners who are gold card people who are treated on the island?

Mr Buffett—There is an arrangement with the hospital management and they are billed.

Mr NEVILLE—They bill the DVA?

Mr Buffett—Yes.

Mr NEVILLE—Are there many Vietnam veterans on the island?

Mr Buffett—There are around six or seven on the island.

Mr NEVILLE—Were the Vietnam veterans on the island required to do compulsory national service?

Mr Buffett—I am not aware of that.

Mr NEVILLE—You went over voluntarily?

Mr Buffett—I joined at the end of the Vietnam War. I did not actually go to Vietnam itself.

Mr NEVILLE—But the ones who went from here: were they called up or did they volunteer?

Mr Buffett—I think most of them were working in Australia. Some of them were called up from here. In those days, some of them did receive call up papers.

Mr NEVILLE—In my electorate I have two groups of people who have been pretty heavily knocked around psychologically and they now have a program of counselling and a gym program. Like Senator Lightfoot, I have noticed an enormous improvement in their demeanour and their outlook since that started. Is there a need for anything like that in the health field here?

Mr Buffett—Not that is immediately evident. There may be underlying problems that I am not aware of. I cannot honestly say, 'No, there isn't'. There may be problems there that we are not aware of.

CHAIR—Thank you very much, Mr Buffett, for appearing before the committee today. We will certainly read that report with a great deal of interest.

Mr Buffett—Thank you.

[3.32 p.m.]

MAGRI, Mr Gregory Andrew Christian (Private capacity)

QUINTAL, Ms Denise Marie, Founder, ECO Norfolk

CHAIR—Welcome. Mr Magri, in what capacity are you appearing today?

Mr Magri—I am representing the youth on Norfolk Island.

CHAIR—Ms Quintal, have you any written evidence that you want to place before the committee?

Ms Quintal—I would like to present that later, if that is all right? In the meantime I would like to assist Greg.

CHAIR—Fine.

Ms Quintal—The first reference that Greg used was the Commonwealth Grants Commission report into Norfolk Island in 1997. On page 88 it is stated, under item 65, that there are no programs that assess youth health. He would like to deal with that today, the youth health situation on Norfolk Island.

Mr Magri—Teenagers and people aged up to 25 years old very rarely use the hospital, unless it is an emergency. Why? The over 18-year-olds pay $500 per year per person, two payments of $250, as medical payments to the Norfolk Island government. Could the government look at ensuring that every time young people pay that levy they get a free medical or nutritional check? It is not to be compulsory, but free.

Ms Quintal—We would like to emphasise the word ‘free’, so that it could be looked upon that they were getting something for free instead of it being compulsory, and they might then take up that offer.

Mr Magri—At the moment they are paying this $500 a year, and those that are not going to the hospital are starting to think, ‘Oh, well, I am not going to pay the $500 because I am not getting anything out of it.’ It just gives them a bit of an incentive, I feel, to go up to the hospital, because we have some real problems with our teenagers on the island.

CHAIR—Could you tell us about those problems?

Mr Magri—Norfolk Island has had a number of cases of teenagers with sexually transmitted diseases. Solution: could the government look at putting condom vending machines into the clubs’ and hotels’ toilets and other well-frequented public toilets on the island, not at the airport, due to Australia’s non-acceptance of exploitation of sex and our own views of non-acceptable sexual behaviour?

Ms Quintal—What Greg is saying is that he feels the solution to the incidence of teenagers and young people having sexually transmitted diseases on Norfolk is offering

condom vending machines in public areas which might give them an opportunity to seek those out. He feels that at the moment a number of youths are not going to the hospital with sexually transmitted diseases because they are embarrassed, and that by giving them an offer of somewhere they can go to take up these condoms they may have a little more freedom to do so. They do not like to go into Foodlands mall to purchase them under the public eye.

Mr Magri—I work at Foodlands, the supermarket, at the checkouts. In the past six months at my checkout three packets of condoms, containing 12 condoms, have been sold, and that is for the majority of the island, not just the youth. People do not look at using condoms over here.

CHAIR—Where do you suggest they be placed?

Mr Magri—One in the RSL, one in the brewery, in the local pubs and the clubs, and maybe in Foodlands mall, so that people can go in there if they want to, instead of having to come to Foodlands. A lot of the kids do not want to have to go through their auntie's checkout and get auntie to buy a packet of condoms.

Ms ELLIS—Fair enough.

Mr Magri—Whether they should put them in the toilets in Foodlands I am not sure.

Ms Quintal—On health insurance, on page 89, item 70, Greg refers to the contribution to the scheme which was set in 1997 at $130 every six months and has increased by approximately 100 per cent as it is now $250 every six months.

Mr Magri—I believe that a low income on Norfolk Island is perceived as $3,500 per six months per single person. Medical benefit payments have increased, but I do not believe that there has been a subsequent increase in wages of nearly 100 per cent, as in the price of the contribution to $250 per six months, to meet the price increase and demand on low income workers. Solution: could the government look at giving low income workers their free medical and nutritional check every time they pay the $250? These issues need to be addressed as this is a serious matter of concern.

Ms Quintal—What Greg is suggesting is that the low income worker be offered a free medical and nutritional check every six months when he pays this amount of money, since the wages do not seem to have aligned themselves with the 100 per cent increase in the medical benefits increase in the last two years on the island. Also, Greg and I would both like to state that we support the concept of self-government on Norfolk Island.

Mr Magri—One of the issues is housing and homelessness.

Ms Quintal—Yes, we would like to refer to page 102 on housing. Item 131 mentions existing services and says that there is no public housing on Norfolk Island and no provision of rent relief for low income earners. Further down in 136, it says that, accepting that there are no homeless people on Norfolk Island, there is little or no need for the provision of government owned housing. I also would like to submit a number of letters—that Greg has

collated—to 15 youth on Norfolk Island who are having problems at the moment with housing.

Mr NEVILLE—Are these 15 or 16 young people whose parents have died or moved to the mainland, or are they 15 or 16 kids who want to go into a flat and live together?

Mr Magri—A lot of the 15 or 16 kids are living at home at moment. They would prefer to move out. There are three or four cases where the parents have moved away from home. The problem over here is that the real estate people refuse to rent to ages between 16 and 25 and, while they refuse to rent to that age group, there is a problem.

Mr NEVILLE—In a community like this, the role of either the Norfolk Island government or the Australian government should not be to set up people in independent accommodation. Surely, it should be to strengthen the family unit on the island.

Ms Quintal—I totally agree. I believe the culture of Norfolk Island has changed over the last 30 years that I have been here.

Mr NEVILLE—Homelessness generated by other things is a different issue—for example, the parents moving to the mainland, parents dying or inability of young married couples to get a home. Many people on our mainland would argue that a lot of the social problems we are going through now are the result of encouraging that sort of program 10 years ago. That may or may not be true. Some would argue with me on that, but it is a well held view on the mainland that that is part of the social problems. I know there were cases of abuse and things like that that require kids to be away from homes. Is there any of that sort of thing on the island—for instance, physical or sexual abuse?

Mr Magri—There is actual physical abuse on Norfolk. I am not sure about sexual abuse. I would not say it is on the rise, but it is getting more and more known around the island. There was one case recently where a young island girl was in a very bad relationship. Her boyfriend was taken off the island because he was not a local. He applied to Canberra. They withheld the statements from the government here. He is now allowed to stay here. Hence, that girl has had to leave the island because she feels unsafe living here. She is a Norfolk Islander who was born on the island and who has lived here all of her life.

Mr NEVILLE—Where would she live if she were on the island?

Mr Magri—At the moment, she is between families, because she cannot live in her own house safely.

Senator CROSSIN—Ms Quintal, could you just clarify something for me? If there are a couple of 20-year-olds who want to live together on this island, as opposed to living with their families, can they not do that at the moment?

Ms Quintal—What Greg has researched and come to me to discuss is that he believes that there are a number of homes here that are owned by the government of Norfolk Island. Unfortunately, at the moment these homes are full of people who have other places that they are renting and they are staying in these government homes. That means the youth who need

these homes are not able to access them. It is a situation that Greg felt strongly about and wanted to bring to your attention.

Senator CROSSIN—Is it generally the situation on Norfolk Island that even if you are not going into a government home, or subsidised accommodation in some way or another, the general private rental market will not rent to an under 25-year-old? Is that right?

Ms Quintal—That is what I have been led to believe. Greg has a number of times come to me—

Senator CROSSIN—So if you want to move out and live in a flat or a house by yourself as a 21-year-old, you cannot do it, you have to stay at home with your mother and father until you are 25. Is that correct?

Mr Magri—No, it is until you can prove yourself. The main problem on the island is that there is a lot of alcohol abuse among our teenagers, and that is because of boredom. There have been cases where the kids have rented places, trashed them, and then they wonder why they cannot get another one. That is their fault. I am not trying to help them; I am trying to help the ones who have not rented at all. They have not rented through the real estate people and yet the real estate people refuse to rent them places. They are going on hearsay. They have been told, 'That person is a problem person.'

Ms ELLIS—Your statement about real estate really puzzled me and I would like the record that we are taking here to be really clear. Are you saying that there is an unwritten rule here—a gentlemen's agreement or whatever you want to call it—that says the real estate industry will not rent anything to anybody aged under 25?

Mr Magri—Yes, I am.

Ms ELLIS—So, it is not a case of the real estate industry discriminating and saying, 'We like you and so you can have a house, but we don't like you and so you can't'; you are saying that across the board, nobody under 25 can rent through a real estate agency. Is that correct, or is there discrimination?

Mr Magri—Yes, there is discrimination.

Ms ELLIS—So the real estate agency makes a choice, which is purely discriminatory, based on their own judgment, nobody else's, of who can and cannot rent?

Mr Magri—Yes, that's right.

Ms ELLIS—Okay.

Ms Quintal—For a lot of the younger ones who would like to start their first home, there is a lack of low rental accommodation available. So, they have got nowhere to go. They do stay with family or friends. Greg has a few staying with him.

I also had an incident the other night where I had a mother with five children who had been bashed and who wanted a safe house to go to. It was the second time she has rung me to be put away for the evening so her husband could not attack her. I do not believe at this stage we have any facility for any of these people to go to on the island. The reason she chose to drive around until her children were asleep and then take the opportunity to stay at the house was because the last time she did go somewhere the children were awake and told the father where to find her. Because it is such a small, accessible island, it is so easy to find a person who might be in hiding.

Senator CROSSIN—Isn't there a refuge or shelter here for DV victims?

Ms Quintal—No, nowhere for a family. She had spoken to a private psychologist on the island who had suggested that she leave the island and seek help on the mainland.

Returning to the housing problem, Greg had a solution to the housing situation on the island that he felt the government might be able to look at.

Senator LIGHTFOOT—When you talk about the government, do you mean the Norfolk Island government?

Ms Quintal—Yes. Because we believe in the concept of self-government, we felt that giving solutions to the problems was essential. We want to give a solution and not just complain. We want to try to assist the government make a better island for all of us.

Mr Magri—Is it a fact that the Department of Civil Aviation homes are partly owned, if not fully owned, by the government of Norfolk Island? They have eight houses around there; yet there are three families living in these government homes that already have homes and there is tourist accommodation which is rented to others on the island at exorbitant prices and they then pay less in government owned homes.

Could the government look at putting homeless youth into these homes immediately? The youth could rent a home at $50 per person per week, and that would give the youth a chance. It may stop the pessimism the real estate people seem to have about them. The youth have a real problem with the real estate people. I rang the real estate people and one of the ladies there said to me, 'Greg, I will blatantly refuse to rent to that age group.' There is a problem.

Ms Quintal—There are a couple of other concerns that Greg would like to bring up. They are concerns he has found within the community. Because of his job at Foodlands mall he actually meets a lot of people within the community. These concerns have been expressed to him and he would like to bring them to your attention today.

Mr Magri—What is happening with the RAAF medivacs on Norfolk Island? Members of the community have said that they have been asked at 2.00 a.m. to find approximately $25,000 to have a medivac brought into the island. The stress associated with doctors requesting that type of money at 2.00 a.m. of a member of the family can be enormous. We have to pay $25,000 to take this Careflight but we only get a $100 reimbursement on our

health care. Why at other times does the RAAF fly to the island and the government pays? Are there two types of flights? Are some being asked to pay and others not?

Ms Quintal—We have an example here. Elaine Nobbs, who could not attend today, could explain to you in more detail the situation that occurred when her daughter convulsed at 2.00 a.m. at the hospital in April this year.

Mr Magri—Turning to the ambulance fees, if a member of the community has to incur an ambulance fee from Richmond Base to Royal Prince Alfred Hospital, it could be as much as $2,700. Our health care scheme only allows $200 each financial year to be reimbursed. Could some better arrangement be made for these costs to be recovered?

Ms Quintal—I would like to pass on to you some photographs that have been taken on the island. These are of burn-offs that have occurred here. We have photos of bad days and good days alongside one another, and also some other photographs of burn-offs on Norfolk Island.

CHAIR—Is it a forestry burn-off?

Ms Quintal—I am not quite sure what this burn-off is, but it occurs at the airport.

CHAIR—How often?

Ms Quintal—From my home I have sighted it twice in the last four months.

Mr Magri—It is practice for a plane accident at the airport. They have a burn-off practice at the airport, and that involves the hospital, police and the ambulance.

Mr NEVILLE—Are you objecting to that?

Mr Magri—No, I am not objecting to it at all.

Ms Quintal—My purpose is to address the health risks associated with environmental hazards on a small island and the burn-off at the airport that can be associated with the smog going through town, which is a kilometre away from the actual burn-off site.

If we are talking about preventive medicine and long-term effects on our island, the fact is that we have had over 8,000 cars and vehicles imported into this island since the beginning of time. Registered and unregistered vehicles come to around about 3,334. We have trashed around 4,067 cars. If you refer to page 106, item 165, you will notice that, every 10,000 kilometres, vehicles have new tyres placed on them. If you multiply the number of tyres by 80,000 kilometres, you are looking at about 160,000 tyres that have been either burnt or trashed on this island since the beginning of time.

Senator LIGHTFOOT—Where are they disposed of other than burning?

Ms Quintal—Well, I am asking you that; I do not know.

Senator LIGHTFOOT—I am a relative stranger here, so I beg your pardon.

Ms Quintal—Senator Lightfoot, I would like to know where they are and I would also like to know if it is affecting our environment and our health.

Senator LIGHTFOOT—I will have to take the stand in a minute, but right now I am going to ask you some questions.

Ms Quintal—That is not a problem at all.

Senator LIGHTFOOT—So you do not know where the tyres go?

Ms Quintal—No, I am not quite sure where the tyres go; I do not know if they have been burnt. And if they have been burnt, what risk factor would that be to health, to prostate and breast cancer, on Norfolk Island? I do not know whether a study has been done on the population associated with these cancers and whether they are affecting us. If we are talking about preventative medicine today, I think our environment has to be closely looked at.

Senator LIGHTFOOT—With respect, I think that question is probably better addressed to your local government here.

Senator CROSSIN—Ms Quintal, do you know if the Norfolk Island Legislative Assembly has an environmental waste management or control plan that might specify or answer these questions for you? Or are you suggesting to us that they do not have one and that we should know about that?

Ms Quintal—I am not suggesting that they do not have one and that you should know about it. I am bringing it to your attention, because I am a concerned resident of this island. As far as the waste management program goes, I believe Mr Gardner is working on that. He has been working on it for the last three years of his term and the three-year term finishes around February. At this stage, I do not believe the waste management program has been placed into use. I hope that one of the things they are considering is the number of vehicles and tyres and the situation of how we get rid of these things.

Senator CROSSIN—So what happens with the disposal of rubbish on the island then?

Ms Quintal—At the moment, it is taken to an area of the sea and most of it is burnt prior to it being thrown over into the sea. I believe the government is working on a better facility. But I do not know how we will be able to afford a number of these things. It is quite concerning when one lives here, and has decided to retire here, to find that it might not be possible to maintain these facilities—the infrastructure and the economic growth of Norfolk Island—to satisfy the population, to give us a good grounding for the future, for our families and children.

Mr NEVILLE—Why do you change tyres at 10,000? From my experience, people would be complaining to the manufacturer that they were getting a rough deal if they did not get 35,000.

Ms Quintal—The Commonwealth Grants Commission actually stated that they change every 10,000 due to the potholes and the rough areas of the road here. It was from that that I did the calculations. The Commonwealth Grants Commission mentioned that, every 10,000 kilometres, the tyres need to be changed on a car. And I built my belief on the fact that most cars go for 80,000 kilometres in their lifetime. So I would say that there have been over 160,000 tyres and around 4,067 cars trashed on the island since the beginning of time.

I am just wondering whether the health risks associated with this form of environmental waste could be causing a number of diseases. The land mass is only five miles by three and the radius of the burn-offs can only be that far away. In Australia, you might have a situation where you would have a burn-off, but it might be in a zoned area which would not be close to a home. For instance, when they are burning off at the back of the airport, less than 500 metres away is a home, which you can see in those photos, in which three children live.

Mr NEVILLE—Are they burning off tyres?

Ms Quintal—I do not know what they are burning off. That is why I am suggesting it is serious and should be addressed. If it is tyres, and if tyres cause carcinogens, it could be causing a number of serious illnesses. We know that, by the year 2005, there are going to be more people over the age of 55 than under the age of 16. We already have 161 people over the age of 70 and that will be growing. I suggest that we consider how many people are going to live on the land mass before we make any decisions about our future.

Mr Magri—The majority of the tyres that are burnt here are burnt at the Headstone tip. There are tyres burnt where those photos are taken to help the effect of the fire with the emergency plan on Norfolk. Right in the middle of town just behind Borry's Rental Cars, there is a burning pit where they burn tyres as well. Most of the tyres get burnt.

Ms Quintal—I would also like to mention a solution that could be considered with the aged. The island has changed since the time that I have been here. Based on the fact that most people will be living with family or friends on the mainland by 2005, maybe the local islanders who own homes could consider selling their homes to youth on the island on a pay-back scheme. The money that they pay the person for the home could be used in the aged care facility. So, eventually instead of building more homes here, we could be distributing the home to a young family and the aged person could then move into the hostel and they would be paid money—just like a mortgage—that could actually be used to pay for their aged care. It would keep the homes within the family units of Norfolk Island, so we would not be selling them off to other people.

I had an experience with my Medicare card when I went to Australia. I had been here for three years and I still owned my company in Australia. I went over to use the card. I was also a Manchester Unity member and I have been with ANA prior to them for something like 18 years. I went over and did all my girly things, that came to about $1,300. I went to Medicare to pick up my difference. I was told that I was living on Norfolk Island and I was not entitled to Medicare. I then went to Manchester Unity and they told me that, if Medicare would not pay me, they could not then reimburse me. So I left Australia very disillusioned at the fact that I could not use my Medicare card and that I could not use, or get any rebate,

from the money that I had given to the health care fund over there. I have consequently ceased the fund with them and have gone onto the local Medicare facility here. That does disturb me, because I feel that it does not cover me for private, unless I take up a private health care fund. If you are on a low income, it is very difficult for you to have both. I had the experience of visiting a public hospital on the mainland with a friend. If you are not with a private health care fund, the facilities on the mainland for a public hospital are quite scary.

Mr Magri—Before we finish I would just like to go back to the question of wages. The administration has just put in an across the board wage rise for the admin workers. This does not affect the private sector. I have been working at Foodlands for two years. I am getting $8.75 an hour. On that sort of wage you find it very hard to be able to live as well as pay these amounts without some form of compensation. That is a general feeling with the younger kids and they refuse to go up there because it just costs too much to go to the hospital. I would like to make that point.

CHAIR—Thank you very much for appearing before us this afternoon. We appreciate the evidence you have given.

Is it the wish of the committee that the submission tabled by Mr Greg Magri and Ms Denise Quintal be accepted as evidence to the committee and be authorised for publication? There being no objection, it is so ordered.

Is it the wish of the committee that the documents tabled by our last witnesses be accepted as an exhibit and received as evidence to the inquiry? There being no objection, it is so ordered.

[4.07 p.m.]

BUTLER, Ms Pauline, Vice-President, Greenwich University

LATTER, Dr Melanie Robin, Academic Dean, Greenwich University

QUANTRILL, Ms Sian, Registrar, Greenwich University

WALSH of BRANNAGH, Dr John, Chancellor, Greenwich University

CHAIR—Welcome. I invite you to give evidence to the committee.

Dr Walsh of Brannagh—I will just speak very briefly as an introduction. Greenwich University is a private university, and the first and only university on the island. We are appearing before the committee to suggest a complement to complementary medicine and community health care on the island. The university is setting up and has set up a number of facilities for educational purposes. We have students from around the world, we have faculty from around the world, most of them in the United States, and we have access to a vast database not only of information and knowledge but also of people. We have some of the leading health care people in the world attached to the university as faculty and we have students working on subjects that could be of use not only to the island but also to the world community.

I gave evidence before this commission a year ago in relation to communications, and I will just refer to something from your own report, Mr Chairman, the *Island to Islands* report, where the committee said that the most significant new technology and one that was difficult to access in the external territories was the Internet. The availability and cost of the Internet were raised repeatedly during the inquiry. It offered a means to improve the delivery of health and education, to improve business opportunities and thereby provide much needed employment.

We use the Internet very heavily as a communication device. We can successfully manage a university from Norfolk Island that was successfully managed before in the United States, and it was suggested by our staff and the staff members who are present here today that the university could offer its services to the community, and they asked for the opportunity to present those ideas to the committee. I will hand over to the other members of my team.

Ms Quantrill—Firstly, I would like to thank you for coming to Norfolk and listening to us discuss the health issues that we have. As I said, I am the registrar at Greenwich University, and part of my job involves coordinating with various community groups that wish to use our conference room and other facilities. Recently, as you would be aware now, there has been a great deal of discussion on the island in relation to the community health, and we at Greenwich feel that we are in an ideal position to provide assistance in the area of communication and provision of information. If we are talking about preventative medicine, I think that education and information are key areas which should be explored. We feel that we can assist in that area.

We have a large conference room which is often used by groups on the island and which we would like to further promote as an ideal venue for public discussions, educational seminars and various health issues. As a distance education provider, our office is well equipped with the latest information technology, and we are online full time—online as in the Internet.

We are very willing to let community health groups and the hospital use our online time and our computer set-ups to assist them in the transfer and acquisition of information. We are currently awaiting availability to access videoconferencing on the island, and I see this as an area where we could really assist the community. We will have video cameras on each computer and the necessary videoconferencing software. With our permanent online connection we will then be in an ideal position to offer the doctors at the hospital the facilities needed to confer with their overseas colleagues on a face-to-face basis.

Taken one step further, I can see videoconferencing helping those on the island undergoing counselling. At the moment I believe that a psychiatrist visits the island every six months. With access to videoconferencing provided by Greenwich, patients could feasibly have counselling sessions weekly if needed. The problem which must be overcome in order for this to become a reality is the current restriction to our bandwidth on Norfolk Island. At the moment we are unable to access the full Internet potential due to restrictions which severely limit our Internet speed. Perhaps you could consider this concern which, while not directly related to the health area, is an area which, if improved, could benefit the overall health education and health awareness of our community. I thank you for your attention.

Dr Latter—I work as the academic dean at Greenwich. I am a vet surgeon by profession and I have a PhD in veterinary pathology. I want, firstly, to endorse the comments provided by our chancellor and registrar regarding the potential for Greenwich's facilities to assist the hospital and community health services by enhanced communications with the mainland, videoconferencing, access to health education and community health awareness.

Although the need for increased Internet bandwidth is basically a communications issue, once this technology has become available, the benefits, I think, will be felt across all sectors of the community, not least the area of health care. I am sure it has already been explained to you today that increased bandwidth would enable faster transmission of X-rays to the mainland for specialist opinion. This would benefit the doctors and the vets.

At Greenwich we would like to see our videoconferencing facilities used by doctors and health care workers to confer with colleagues and specialists and to seek second opinions and referrals. It is conceivable that in some cases referrals could even be conducted remotely, thereby avoiding airfare and travelling expenses which are not insignificant when you live here, along with the additional cost when you get the mainland of the medical expenses. As our registrar has already said, there is particular potential benefit in the area of mental health care, because at present we lack ongoing access to qualified counsellors, psychologists and psychiatrists.

CHAIR—When you say 'we', you are referring to the island?

Dr Latter—The island, yes—we at Norfolk. We do have six-monthly visits by psychiatrists but, for those of us who require ongoing assessment or continued advice, that is a long time between visits. The only way at present to access that sort of counselling is to return to the mainland, which is expensive on one hand and also requires separation from family and the support network. So I believe this videoconferencing service could be used very effectively to conduct follow-up sessions with specialists who visit Norfolk Island once patients return to the mainland.

Just to summarise what we have already really said: we have the facilities and expertise available to offer the community conference facilities for information nights, such as talks by visiting specialists or health educators, as well as the potential for access to some mainland health services through the Internet and videocommunications.

Ms Butler—I would like to speak about the use of the Internet on the island, especially for the provision of information about community health and integrated health and various sorts of complementary medicine. We have heard a lot here today about the need for some sort of a community facility that will look in general at the general health of the community.

Greg spoke to the last submission and I would like to congratulate him, because I think he touched on a few issues that none of us want to talk about these days, the problems with some of the youth. Those same problems are pervasive in the community at all levels but, because we do not have any real counselling for youth outside the school situation, we have to provide something for them which they can use when they want to use it.

People on the island are becoming very literate on computers and I think that, as a community, we are very foolish if we do not tap into that resource. To go to a web site you simply tap into it; nobody knows what you are reading; nobody knows what your concerns are or the information that you are seeking. And when you live in a small community like this—and some of you have said today that you also came from small communities—you would realise that nothing is a secret. I think Greg's story about the young people not wanting to buy condoms and paying their aunties at the check-out is just typical of what goes on.

At Greenwich we have just developed a very fine web site which is an international database. We are willing to develop one especially for Norfolk Island. We are willing to do it free of charge and to make it available to the community. We have the resources, the expertise on our staff, and access to incredible people who are world experts in community health.

We have heard lots of people today coming together to talk about what we need, but what we also need is education into what we can get and what is available. There are thousands of web sites around the world which we can make available to the people of Norfolk Island and certainly to the wider community. We have become very concerned with the community health issue on Norfolk Island, as Sian has said, because people have been coming to use our room and when they come in they tell us what their problems are.

We are willing to develop this web site. We have the facilities to use it. People in their homes have the facility to use it but it is still too expensive for them to use it until we start increasing the bandwidth and we can get access to the web at a cheaper rate.

At the moment the locals are paying $3.50 an hour, which is very expensive. We adults can afford to pay that sort of money but the young people cannot. As Greg said, he is earning $8.50 an hour. You cannot afford to pay half of the money you are earning just to sit down and surf around the web when you have got to pay for food, clothes and shelter.

What we would like to do is to provide this opportunity for our young people, and also people in the community, to have access to the wealth of information to answer the needs the community has—for example, grief counselling—and there are many web sites that cater for such services. All we need is the support of Telecom—or someone like that—to make this service available. We will do the entire thing at our own cost. You can go back to Australia and say that there is a program that is going to be on Norfolk Island which will be of great benefit to everybody and it is not going to cost either the Australian government or the Norfolk Island government one single cent.

If the people in the community had access to information such as we will be able to provide, we are willing to provide training for them to learn how to use it, to hone in and get the exact information which is relevant to their own problems. It will give them a basis whereby they can start their own networks. Through using these web sites you can create your own network anyway on the World Wide Web. We believe that if the people on the island here have access to what is available in complementary medicine they will be able to plan better for the sorts of medical facilities that they think they want on the island. We all have the same problems and the same aspirations because we all live in the same community. How we approach those things is very different.

Back in Australia you have special weeks. You have your diabetes week, heart foundation weeks and cancer week. We have those from time to time, too, but we usually get the information about two months later, because somebody sent it on a ship without an air mail sticker on it. So we do not get the opportunity to really benefit from those times of publication for community awareness. What we really need is access to those things when they are covered by the media in Australia. We see them on the news, on the current affairs shows with Foxtel—many people here have Foxtel—but they just do not have the same impact. It is like buying the Sunday paper on Wednesday: you do not want to read it anymore. It is the same thing with the special editions of various health things.

We have a lot of problems with diabetes and health and cancer on this island, huge problems. Probably they are no more common than you have in Australia but we are conscious of them, because we know these people who are sick. So these sorts of things are very prominent in our community and we all would like to do something to address them. We do not have the money to introduce huge programs at the moment for the community at large, but we do have the resources within Greenwich to offer those sorts of things to the community to help them get a little bit of confidence in where they are going and an understanding of what it is that we can do, either with some help from the government or just from help among ourselves and within our own networks.

You have all heard the saying ‘Rome wasn’t built in a day’. I would like to say that today has been a very special day for all of us because it is not an easy task to get up when you live in a small community and, more or less, hang your dirty washing out. A lot of people have done it today because they really love Norfolk. They love the people who work on Norfolk. Instead of having Rome being built in a day, I would really like to go away from here today thinking that what we have all come together for will really produce something worthwhile.

We came along to this conference a year ago, not as members of Greenwich but as members of the community, and we all had a very interesting day. We went away. We got a great report and not a lot of things happened from the report. What we would like today is to go away thinking something is going to happen. The problems we talked about 12 months ago are now 12 months worse. We are all 12 months older and those of us who are getting greyer are getting 12 months sicker. It is about time we set ourselves some sort of a target and started doing something.

Ladies and gentlemen, you are in a very powerful position today. You have come over here to make an investigation of what is going on on the island. I am sure what you saw one year ago has been reinforced even further today. If we all go away and we all produce something positive, if we all do one single positive thing, we may be able to assist one person solve a grief situation, maybe even save a life. By not doing it, we may be assisting that person to lose a life.

I would like to leave you with that thought today. Thank you very much for listening to us and we hope that you will come back again in 12 months. We will all come back and sit here and tell you how marvellous the world is because we have solved all our problems.

Ms ELLIS—Is today the first time that Greenwich has made the generous offers that you are making?

Ms Butler—No.

Ms ELLIS—Where and when have they been made in terms of cooperation with the community? I do not know to whom I am directing that.

Ms Butler—They have been made to many different organisations on the island and they are using it. What we are saying today is we want the bandwidth increased. That is all we want from you—to go away and look at the communication that comes to the island and increase the bandwidth so that we can all have access to better use of the Internet.

Ms ELLIS—So the community use of your facilities and your meeting and conference rooms and all of that is happening already?

Ms Butler—It is all going on now.

Ms ELLIS—Okay, by whom and in what way?

Ms Butler—We have many groups that use the conference room.

Ms ELLIS—In relation to our inquiry into health, how are they being used?

Ms Qantrill—By CHAT. They have used our room several times. Various other groups in the community. We do not ask them really for a description of what they are using the room for. They just phone up and book it. The Country Women's Association use it regularly and the school has booked it for a future engagement.

Dr Walsh of Brannagh—If I could add something to that, individuals come in and say, 'We understand that you have got access to Internet facilities. We understand you've got access to medical information. Can we use your facilities?' And we say yes. What we want to do is to improve that. We gave evidence a year ago and we asked for certain things to be done. You wrote a very good report and you suggested four things be done: all letters should be carried by air to and from Norfolk Island—your committee recommended that to the Commonwealth government; Australia Post should ensure that all express post articles are delivered by air to Norfolk Island; the Norfolk Island government should explore with Australia Post the possibility of reinstating an airmail service for Australia Post; and not downgrade international airmail destined for Norfolk Island through the Sydney exchange.

Not one of those recommendations you made to the Commonwealth government was honoured. Our airmail is still coming by boat. I had an important letter sent to me by the Commonwealth government in Canberra; it took seven weeks to get here. I had some documents sent by the Commonwealth government in Canberra. The documents arrived soaking wet, because the air carriers in Sydney left it out on the tarmac when it rained and the express air delivery is still coming by ordinary mail. The United States post office, which downgraded Norfolk Island because of the inability of Australia Post to handle airmail from the United States to Norfolk Island, has not reinstated.

Ms ELLIS—I do not know whether you are aware—and I am not speaking for the whole committee, but for myself—that the report made some excellent recommendations. Our visit here 15 months ago was very useful. The government response to that report has not been made and we are aware of that. We do not wish that to be seen as a downgrading of the work of the committee. I am not suggesting that you are referring to that, but I just want to say that.

Dr Walsh of Brannagh—I congratulate the committee, but it is a year. The committee does excellent work and we can improve what we can offer the island and the community if we have an increase in bandwidth.

Ms ELLIS—I do not wish to sound cynical—and I apologise if I do, because that is not my intent. Nothing in this world is given for free by anybody today. You have made some very generous overtures and offers. They are genuine ones—I am not decrying that for a moment—but what is in it for Greenwich?

Dr Walsh of Brannagh—Satisfaction.

Ms ELLIS—Increased business if you get the wider band?

Dr Walsh of Brannagh—No.

Ms Butler—We do not need that. We have enough—

Dr Walsh of Brannagh—We are a small graduate school. We have a limit to how many students we can take anyway and we certainly did not move to Norfolk Island because we would make more money out of it.

Senator LIGHTFOOT—How many students do you have?

Dr Walsh of Brannagh—Around 500.

Senator LIGHTFOOT—Are there some correspondence students? They are not all on campus here?

Dr Walsh of Brannagh—No, there is no-one on the campus here. We are distance learning. They are mainly from the North American continent. They are mainly United States citizens, Canadians, New Zealand and people from England.

Senator LIGHTFOOT—What about the UK? What about the Australian mainland?

Dr Walsh of Brannagh—A very small number from Australia.

Senator LIGHTFOOT—What about outlying islands of Cook Islands or Noumea?

Dr Walsh of Brannagh—The next major group are from countries in the South Pacific area.

Senator LIGHTFOOT—Are they full fee paying students?

Dr Walsh of Brannagh—Yes, they are.

Senator LIGHTFOOT—You survive solely by the fees that—

Dr Walsh of Brannagh—We do not receive nor would we ever accept any money from the government, as part of the university philosophy. We refused government money in the United States and we have told the Commonwealth government that if they ever offer us any money we will graciously send it back to them. We do not want any. I know you do not own communications in Australia anymore. You privatised Telecom and you turned it into Telstra—

Senator LIGHTFOOT—But it is still majority government owned.

Dr Walsh of Brannagh—Yes. There is something you could suggest to Telstra if they wanted to do something for the community and for Norfolk Island and for the Australian community. I asked Telstra when I was in Australia why we could not get these wonderful facilities that they offered us if the university transferred to the Australian mainland. They said, ‘We can give you two megabytes but there is a blockage in the Pacific cable.’ I said, ‘What does that mean?’ and they said, ‘We cannot transmit it to the island.’ They could not

give me a satisfactory reason. I would ask the committee to suggest to the Commonwealth government that they could say to Telstra that they could do something very worth while—

Ms ELLIS—And unblock it.

Dr Walsh of Brannagh—Unblock it, at no cost to themselves. Once you have got a facility like a running stream, it does not cost you anything to open the dam.

Senator LIGHTFOOT—Do you think that that aspect of your statement is partly based, if not all, on the fact that Telstra does not have a lot of equity in the Norfolk Island?

Dr Walsh of Brannagh—Telstra has no equity in communications here. Notwithstanding the views of the committee, the Prime Minister or anyone else, I think Australian Telstra does not regard Norfolk Island as part of Australia. That was borne out when I asked Telstra for some of their disks that they make available to potential customers on their Big Pond system. They said they would gladly give me everything I wanted until I said that the university was on Norfolk Island and the postcode was 2899. They said, 'We are terribly sorry. We do not supply these things to foreign countries.'

Senator LIGHTFOOT—We will do whatever we can to let Australian Telstra know that this is part of Australia. It has a different government from other parts of Australia and its territories but it is an integral part of Australia from that point of view, and we will carry on from there. Where did Greenwich—

Mr NEHL—Excuse me, Senator, Norfolk Island has a separate telecommunications company—

Senator LIGHTFOOT—Yes, I am aware of that.

Mr NEHL—which is not part of Telstra.

Senator LIGHTFOOT—That is what I was saying.

Mr NEHL—Telstra has no mandate to do anything; it is not allowed to.

Ms Butler—Can I say something here? The web that I am talking about would have to be accessed at night when most people were not at school or working. That is the time when it is very difficult to get on it. That is what I am saying.

Senator LIGHTFOOT—I think we have got the answer that we wanted. Thank you for that, Ms Butler. We got the answer that we wanted that with Telstra it is lack of equity in the telecommunications in Norfolk that induces it to downgrade. It does not have a priority at all. I personally agree with what you are saying. It is part of Australia and it should be treated accordingly. As for someone ignorant enough to say that it was not, we hope that that gets back to that person that he or she is ignorant.

What about enrolments here? How do you obtain your enrolments, and why isn't Australia part of that enrolment system?

CHAIR—I do not think that is relevant. We are talking about health issues.

Senator LIGHTFOOT—We are, but I see it as relevant if the health issues are here that Australian students could—perhaps if you just answer that question it might be quicker.

Ms Butler—We were not interested in doing a web for students. We were interested in doing it just for the community here as part of the work that the group has been talking about today—that is all. It is different from our normal web page. It is something different that we would add on to it.

Mr NEVILLE—What faculties does the university have?

CHAIR—Only in terms of health issues.

Ms Quantrill—We have a college of social science and health which addresses a large number of traditional and non-traditional health areas, and these are expanding all the time.

Mr NEVILLE—Working towards what sort of degree?

Ms Quantrill—Mainly postgraduate, so there are masters and PhD programs offered in various disciplines.

Senator LIGHTFOOT—We are over time. How many faculties do you have here? I know they are not all associated with health. We have got to know so we get some idea.

Ms Quantrill—Just in health areas?

Senator LIGHTFOOT—No, in all, right across your spectrum.

Ms Butler—The faculty members you mean, sir? Just on 400 around the world. They are not all in the health area. Four faculties but faculty members I am talking about.

Ms ELLIS—There are four faculties?

Ms Butler—Four faculties, yes.

Ms Quantrill—Ms Ellis, could I just answer personally your question as to why we would do such a thing as to provide a free service of little benefit to us. I am originally Canadian. I have lived on Norfolk Island for 13 years now. I have a six-year-old son. I am proud he is a Norfolk Islander and I feel that this is my home. I think I can speak for all of us at the table—we are all members of the Norfolk Island community. We have family and friends here. The issues that affect the community affect us and if we can provide assistance in any little way, through education, it benefits all of us and that is what we get out of it.

Ms ELLIS—Good, thank you for the answer.

Dr Latter—Could I also say something?

CHAIR—Just briefly—we are over time.

Dr Latter—Okay. I would just like to add that when you are living in Australia you have Sara Henderson coming on TV advertisements telling you if you are over 50 to get a mammogram. You have antismoking campaigns. You are almost bombarded with them. This is great, because it is subliminal brainwashing not to smoke and to regulate your drinking as well as the safe sex campaign and all those things. But we do not have that here. There is a real lack of awareness, I think, about issues. We have only just recently started the bowel scan scheme but I think until now those things have not been really public knowledge here. I think we can do a lot towards helping that situation by having guest speakers on diabetes, different disorders and other community health issues and hosting them at Greenwich. I think that could go a long way towards helping the community.

Ms ELLIS—Sure. We actually discussed this morning even the role of a health educator.

Dr Latter—Good. We could work with them, yes.

CHAIR—Just in closing I would like to point out that I come from the state of Tasmania and we also have bandwidth problems over there. Thank you very much for appearing before the committee.

[4.38 p.m.]

QUINTAL, Sister Bonnie Anne, MBE, Superintendent, St John Ambulance Australia, Norfolk Island Division

CHAIR—I welcome Sister Bonnie Quintal. Is it the committee that the submission that you have just presented as tabled be accepted as evidence to the committee and authorised for publication? There being no objection, it is so ordered.

Sister Quintal—I started at St John Ambulance 13 years ago. Unlike in Australia, we man the ambulance. St John in Australia goes to sporting venues only to give first aid, but we are ambulance officers. My officers train with studies sent over from Canberra. We have a division doctor who keeps us up to scratch, and I also keep them up to scratch. They work very hard. They are on call 24 hours a day, but there are some members who cannot get off in the daytime because their employers will not let them go or else they will lose their wages if they do go. So those who cannot get off in the daytime we roster on at night, which makes it a bit tough for them.

As usual, of course, we are asking for money. We have bought an ambulance since we started with a $10,000 loan from the headquarters in Canberra. We have since paid that back. We have fully manned the ambulance, which we have given to the hospital. We have bought stretchers, Oxyvivas and things like that. At the same time, we teach first aid to the general public, and we have bought all the equipment connected with teaching. We need a new Resusci Anne. The officers have first aid kits in their cars, although they need more sophisticated ones now. If they are driving to the hospital to get the ambulance to a case and they pass the case, they do not just want to pass and not do something. They have some first aid gear in their cars so they can do some attending while somebody else goes and gets the ambulance for them.

I do not know that there is a great deal more that I want to tell you, except that we need extra life saving equipment. The ambulance has to be reconstructed from time to time with the extra equipment that we get, and there is always a problem with money. Our main income is from our training classes. We also have a walkathon, which is a walk for health, sponsored once a year, and we have a Government House open day once a year. Between the two, they bring in about $2,000, which does not go very far in buying a lot of the stuff we need. We provide all officers with uniforms; they do not have to pay for them. The only thing is that, if they leave the division, they hand back their uniforms.

Quite a number of our officers are local, but we do not have island people because it is very hard for them. If it is a very personal sort of case that they have to go out on, they do not want to have to pick up a dead granny, or someone like that. We train a lot of people who are on temporary entry permits, who are very good and who work hard. Then they go to the mainland and send us a letter saying, 'We've joined St John here. We have become ambulance officers. Thanks for training us'. So we are becoming an Australian training course. I do not have anything else to say. Do you want to ask me any questions?

CHAIR—Thank you very much and congratulations on your initiative and the work that you do. There is much to be commended.

Sister Quintal—I think it is my officers who need the commendation. They work very hard.

CHAIR—You and your officers.

Ms ELLIS—To what level are the officers who attend with the ambulance qualified?

Sister Quintal—As far as the Australian ambulance service is concerned, I would say they are qualified to an advanced stage. They do not do injections. They do not do intravenous, but they can set everything up so it is ready to hand over to the doctor straightaway.

Ms ELLIS—What level is the equipment that you have in the ambulance? What sort of cases can you handle?

Sister Quintal—We can handle everything that comes up before us. We can do resuscitation; we do not have a defibrillator at this stage.

Ms ELLIS—I was just going to ask that actually.

Sister Quintal—This is what we are working on.

Ms ELLIS—What do they cost?

Sister Quintal—They cost between $4,500 and $5,000, with a training piece of equipment as well. I had a look at one when I was in Sydney. It talks, so it is a very safe piece of equipment. They can put it on to a patient, but it will not defibrillate unless there is absolutely no heartbeat at all. So it is perfectly safe. It will tell them when to start defibrillating, when to start resuscitation and things like that.

Ms ELLIS—So that is the next thing you would like?

Sister Quintal—Yes.

Ms ELLIS—Thank you, that is all.

Senator LIGHTFOOT—What did the ambulance cost? The $10,000 from Canberra, whilst welcome, would not have gone very far with a new ambulance. I think you said it was a new ambulance.

Sister Quintal—It was. We got a Toyota Army Cruiser, a troop cruise carrier, and we had the whole inside changed.

Senator LIGHTFOOT—Is it a four-wheel drive.

Sister Quintal—We have to have a four-wheel drive because not all accidents are on nice roads; they are down valleys and things like that.

Senator LIGHTFOOT—What is it that you would like, apart from the defibrillator, as part of your standard equipment? Is there something else?

Sister Quintal—We would like more training. We need another Resusci-Anne, but we do need a lot more training equipment that we can get through on.

Senator LIGHTFOOT—You need training facilities? What do you mean by training equipment?

Sister Quintal—Modules that the officers can work on, rather than working on each other. There are a lot of things you cannot do. You cannot resuscitate a normal person. It is very dangerous. That is why we need more Resusci-Annes.

Senator LIGHTFOOT—Mouth-to-mouth resuscitation is a bit hard on the island, I suppose.

Sister Quintal—Yes, it depends who it is.

Ms ELLIS—A dramatic way to see if you can do it is to knock someone off.

Sister Quintal—We need models of bodies that they can see.

Senator LIGHTFOOT—I think Dr Latter is a pathologist. She may supply them!

Sister Quintal—Models whereby they can look at bodies.

Senator LIGHTFOOT—But you do not need anything that is considered to be standard equipment, given the size of the population and the environment—you have got that?

Sister Quintal—At the present time, but there is new equipment coming out all the time, of course, and every time I go over to Sydney I have a look.

Senator LIGHTFOOT—What about assistance with St John from Canberra with teaching some senior officer or officers? Would they be of assistance here?

Sister Quintal—We always welcome anybody that comes over. When we first started, we did have people come over from Sydney St John, but they seem to have relaxed now and decided we can manage ourselves.

Senator LIGHTFOOT—The squeaky hinge gets the oil. If you wrote letters and continued to do so, I am sure they would start.

Sister Quintal—Yes, I do, I write a lot of letters.

Senator LIGHTFOOT—I can see that by your signature; it looks like you have done that a few times. That is all I have to ask. Thank you very much.

Mr NEVILLE—What sort of money are we looking at for these items—Resusci-Anne?

Sister Quintal—The Resusci-Anne would be $1,500 to $2,000 unless I can talk the airline into bringing it over. They are very good like that.

Mr NEVILLE—What about first aid bags?

Sister Quintal—They are $100 each.

Mr NEVILLE—And the extra lifesaving equipment is the defibrillator?

Sister Quintal—We are looking at the defibrillators.

Mr NEVILLE—So we are looking at about $7½ thousand?

Sister Quintal—Yes, and of course with any spare money we would buy uniforms.

Mr NEVILLE—Are you considered a separate division from the other states?

Sister Quintal—Yes, we are under Canberra.

Mr NEVILLE—Directly answerable to Canberra?

Sister Quintal—Yes, and I do not have a section above me. Over in Australia, they have divisions and sections and it spreads out. But we are an isolated division and answerable to Canberra.

Mr NEVILLE—Does the Norfolk Island government provide you with indemnity insurance?

Sister Quintal—Yes, they do to a certain extent, but we have our own insurance too. Each officer is insured, and when anybody in the public does first aid and I send over for their certificates they are automatically insured with Canberra. So, unless they hit the patient on the head or do something really stupid, Canberra will cover them.

Mr NEVILLE—Will the level of insurance rise when you start using things like defibrillators?

Sister Quintal—It probably will. Yes, I will be looking into that.

Mr NEHL—Do you get any support from the Norfolk Island government?

Sister Quintal—Not really.

Mr NEHL—The reason I ask the question is that—

Sister Quintal—We are asking for help now.

Mr NEHL—To my knowledge, certainly everywhere in the rest of Australia and in most parts of the world, it is just axiomatic that an ambulance service is provided by government.

Sister Quintal—We get a certain amount per patient, which is a very small amount. The hospital does pay for our petrol, but any change we want to make in the ambulance up to date we have done ourselves. We are now asking the government to help us.

Mr NEVILLE—How often do you get called out?

Sister Quintal—It varies. They can be out twice a night, they could be out three times a month, or six or seven times a week. It just varies.

Mr NEVILLE—How many calls a year then?

Sister Quintal—Probably we would make close to about 500 or 600 a year.

Mr NEVILLE—About 10 a week.

Sister Quintal—It could average about that, yes, and this is increasing now. We are getting a lot of elderly tourists.

Mr NEVILLE—What are the major types of call-outs—road accidents, heart attacks, or what?

Sister Quintal—Road accidents, medical, health and, I am afraid, tourists who die—DOAs, dead on delivery. It happens at a rather alarming rate.

CHAIR—Thank you very much, Sister, for appearing before the committee today. We will see what we can do to help you.

Sister Quintal—Thank you.

CHAIR—We now have a request from a Mr Rex Barrett to come before us. You can perhaps give us a quarter of an hour before we call the minister again. The minister has made a very generous offer to the effect that as he has been on he is prepared to allow at least some of his time for somebody in the room who would like to make a five-minute address. Is there anyone in the room who would like to present further evidence to the committee? I know we are catching you on the hop a little bit but obviously you may have heard some things today and you might like to make a comment, so we will give you this opportunity and thank you very much, Minister, for that generous offer.

[4.53 p.m.]

WYNDHAM, Reverend Dr Robert Harry (Private capacity)

CHAIR—Welcome. In what capacity do you appear before the committee today?

Rev. Wyndham—I am the Uniting Church minister, and, in that category, I am a temporary entry permit person. I just want to make a simple kind of contribution. Because we are here for a limited period of time, we have been able to make an arrangement with our medical benefits fund in Australia to cover us for any hospital considerations.

I do not know what has happened earlier in the day or in other submissions, but it has occurred to me that, as tourists come, as there are temporary entry permit people, there are probably folk like us who are paying an amount of taxation in Australia which would normally cover us for Medicare and yet when we come across the water we are no longer covered. It seems to me this is something that you folk could take on board and consider in your deliberations. It may well be that, because of the very small number of total residents on the island, this could be a challenge to the committee and the Australian government to give this kind of care and consideration so that Norfolk Island gets the benefits of Medicare coverage.

I really cannot say much more, because I am just speaking as an individual. I think I would perhaps be similar to other folk in at TEP, but it just seems to me there is perhaps an anomaly that once we fly back and hit Sydney, we go to a doctor there, we are covered, but we get in a plane and come over here and we are not covered.

Mr NEVILLE—You are talking about people on transfer that may or may not have much say in a posting here?

Rev. Wyndham—Yes.

CHAIR—Thank you very much. The matter has been raised earlier today. The committee has taken note of it. I think it is an important issue that you have raised.

Rev. Wyndham—It is just a simple thing, but I would want it to be the thin edge of the wedge to think about all residents on the island.

Ms ELLIS—You are paying Australian tax while you are here?

Rev. Wyndham—Yes—not for income derived on the island.

Mr NEVILLE—You have a supplementary fund on the mainland.

Rev. Wyndham—Very limited.

Ms ELLIS—For which you pay tax?

Rev. Wyndham—Yes.

CHAIR—Thank you very much for that offer. It was useful evidence.

[4.55 p.m.]

GARDNER, Mr Geoffrey Robert, Minister for Health, Norfolk Island Government

CHAIR—I think you have still got one or two more things to tell us.

Mr Gardner—Thank you for giving me this further opportunity to be able to address the committee. I would like to pick up where I left off this morning. I had completed term of reference No. 7 in my earlier presentation. I now move on to point No. 8, which is the anticipated health infrastructure needs of the island, the capacity of the island community to meet the necessary capital costs and other possible areas of funding.

The anticipated health infrastructure needs of the island would possibly include, and we have heard today, a new hospital, health service, aged care complex. I outlined that earlier in my submission in relation to the multipurpose type units. Mr Nehl was responding to that earlier in relation to a separate submission. There is also a requirement for ongoing equipment replacement, upgrading and new equipment to be found in relation to the applications of new technology—for example, telemedicine, which I addressed earlier this morning—and the ongoing maintenance of the current hospital and health facilities, that we have to comply with necessary standards or acceptable standards as far as facilities required for the delivery of health services and how they would be applied in Australia.

I will deal with the options for each of those three areas that I have outlined—firstly, the new hospital health service, aged care complex. I have been toying with the idea in recent months of the option of including a health complex in the delivery of health services as part of the complete privatisation package. I mentioned that with Senator Macdonald at our intergovernmental meeting in August. That would basically be tied into a long-term operating agreement with the Norfolk Island government in the provision of health services so that we still had some sort of overview of the level of services and the type of service provided to the community.

It is probably not a new thought in that I understand there are private hospital system providers both in Australia and New Zealand that basically walk in and privatise a hospital. They have a long-term agreement or a contractual situation that may extend up to 20 years so that they are able to recoup their capital costs and the moneys that they have spent on the development of such a facility; they operate it and provide the necessary services to the community that they are operating in; they make a profit and go away happy. The community is happy—they are getting the services that are required. That has the potential to take away any long-term staffing problems, access to equipment, access to new infrastructure and technologies because usually these privatised hospital systems or groups of hospitals have a very large pool of staff that they can draw from, expertise that they can draw from, equipment and technology that they are able to draw from. It is a consideration, and certainly in my mind well worth exploring further down the line.

We can also look at direct Norfolk Island government funding and how we are going to do that. As I mentioned earlier this morning, the Norfolk Island government are looking at various ways to change the way we raise taxes and revenue for the island—as I mentioned, the broad based consumption tax-type arrangement specific to Norfolk Island.

As I mentioned this morning, there is the development of new revenue initiatives—for example, the gaming and offshore finance centre in particular. There is always the option of special purpose foreign aid grants, so to speak—not necessarily from Australia as they could come from anywhere, and certainly it has been indicated to me that there are a number of programs that we may well be able to tap into in relation to that type of thing. There is also—

Senator LIGHTFOOT—Could you name some of those programs that you could tap into?

Mr Gardner—I do not have that information with me, but I will certainly provide it to you if you wish.

Senator LIGHTFOOT—Very good.

Mr Gardner—There is also evidence of a number of bequests that have been made to various funds on the island with the long-term goal of establishing a new health complex on the island. That is slowly building over time. Hopefully we will be able to utilise that in the not too distant future.

Mr NEVILLE—How much have you got in the kitty?

Mr Gardner—We have in excess of $60,000 as a firm commitment. We also have another offer that may extend that up to about another $200,000.

CHAIR—You have also got a $50,000 trust that was referred to this morning, or was that part of the $60,000?

Mr Gardner—No, I did not refer to a trust this morning other than the Emily Channer Trust.

CHAIR—That is part of the $60,000?

Mr Gardner—Yes. We could utilise a combination of some or all of the above of those to achieve the goals that we are looking at.

The equipment replacement upgrading and new equipment as far as technological change is concerned has been catered for historically by specific Norfolk Island government capital funding through our budget process. For example, you would probably be aware that in the 1998-99 financial year there was a new x-ray machine funded for the hospital. In this year's budget there is the new ultrasound machine that has been budgeted for. The budgeting for that includes the attached training for that.

There is also the historical involvement of service clubs and other community organisations in the provision of equipment and upgrading. I understand the Rotary Club were involved in the building and the fitting out of the physio unit that we have up there, and also the baby clinic that is up there at present. Different community organisations have funded emergency Thomas packs that we now have at the hospital for use in emergency

situations that may need people to have to climb down cliff faces, et cetera. It is virtually a hospital in a backpack that doctors are able to take with them. It has all the necessary equipment to be able to provide on-the-spot type treatment.

One of the other service clubs has undertaken to fund the purchase of an ultrasonic cleaner this year for the hospital. I guess it gets away from the old processes that we used. The autoclave process for sterilisation I think has been demonstrated not to have been the perfect system, so now there is a move to these ultrasonic cleaners, which seem to give a far better result.

Of course, as I mentioned earlier this morning, there are moves afoot within the community for the purchase of a mammogram unit. The fundraising has already begun for that and is actually well advanced. I understand that there will shortly be a proposal made to the Norfolk Island government to assist in the funding of that so that we can get it sooner rather than later.

But, as I mentioned in my presentation earlier this morning, there are a number of issues in relation to the purchase of that that we need to get over and address and make sure that everything is properly in place, and that includes the necessary technological advances for the results of those to be able to be transmitted to Australia for diagnosis if they are unable to be done here; various training issues; resourcing issues as far as where we are going to put it, where we are going to set it up, basically, have we got room to do that, and those types of issues. But certainly we are looking forward to receiving that proposal.

Of course, in the future, it is proposed that any telemedicine-type applications by the Norfolk Island government will be funded as part of our overall telecommunications strategy, which is under way at the moment, which is about developing the infrastructure for telecommunications. As I alluded to this morning, we have a proposal that has been developed as part of the RTIF funding program. There is potential there in the future to tap into any future Norfolk Island government entrepreneurial initiatives—in other words, new revenue fundraising measures other than those that I have alluded to earlier in my presentation—and the possible inclusion of communication partnerships between our own Telecom and other carriers, particularly in relation to the development of the offshore finance centre and the business that that may attract to our communications system. So we may well be jumping into bed with Telstra or Optus or one of those providers, and we may be able through those types of partnerships to fund the necessary infrastructure for telemedicine. So we have got a number of options that we have available to us.

The ongoing maintenance of facilities that I mentioned to comply with standards again is provided by a combination of operating costs of the Norfolk Island Hospital Enterprise, the revenue that is generated there, and the Norfolk Island government subsidy, which is on an annual basis. I guess at the end of the day that is a damned good reason to look at a new facility when you take into account the costs of maintaining an old building, an outdated building, and its associated infrastructure against the costs of maintaining new, easy care, easy maintenance-type infrastructure.

The question gets asked, and asked often: does Norfolk Island have the financial capacity in its own right? I have lost my Grants Commission report. I was going to refer to the

Grants Commission report, because that does identify that Norfolk Island has the financial capacity to meet all its service obligations. I do not actually have the report with me at the moment, but there is a useful quote there from page 213 of that Grants Commission report, paragraphs 19 and 20. It is the section dealing with the capacity to meet infrastructure requirements. Paragraph 19 reads:

19. Based on our analysis of the Island's economy and potential for increasing revenues, we believe that the Norfolk Island Government has the capacity to fund its existing and foreseeable infrastructure requirements. The total revenue raising effort required would still be below mainland levels.

It goes on to say in 20—

Mr NEVILLE—What are they referring to there—any particular item or just in general?

Mr Gardner—I am just about to address that, Mr Neville, if I may. It goes on in paragraph 20 to identify the most important infrastructure needs, and those were better harbour facilities, better road building equipment, new airport terminal and, as you are all aware, you came through our magnificent new terminal the other night on your arrival here. The waste disposal system is another area that is being addressed right at this moment. Street lighting and footpaths are another—as you are aware; you saw that in town. Upgraded government assets such as plant and equipment, workshops and computers are all under way this year as part of the budget process.

This is probably the important bit from paragraph 20:

In addition, it will be necessary in the longer term to spend large amounts on community facilities such as the school, the hospital and aged care facilities. These costs also seem to be within the financial capacity of the Norfolk Island Government.

I have finished that matter. I will be happy now to answer any questions in relation to that particular point.

CHAIR—Maybe you would might just like to go on. I think you have got one more item.

Mr Gardner—Yes, matters incidental. The Norfolk Island Government's submission does not address the point of matters incidental. However, I have a few points I need to make for the public record.

The first one is staffing issues. There are some difficulties with staffing, and we recognise that at the hospital. We recognise the need to be able to look at the conditions that people are working under. As was identified by some this morning, there are the excess hours that some of the doctors may be working and the impact that that has on their personal lives.

It is not just the doctors who we are worrying about, and you heard from the nurses this morning. We recognise that, we appreciate that, and we will endeavour through negotiation with them to try to sort out the best arrangement that we possibly can. I am also aware that we need to discuss issues with others, whether it be the pathologist or the radiographer or

whoever, and not just take things for granted. We need to address those, and I am quite happy to do that.

As was mentioned earlier, there are initiatives in place to be able to employ a full-time physiotherapist at the hospital. And as was pointed out by me earlier this morning, and by the RSL in their submission today, there are joint initiatives with DVA to provide for geriatric nursing and nurse training here on the island. As far as the doctors are concerned, the need for supplementary doctoring services on the island is under consideration at this moment, and just how we are going to structure that.

We have completed a cost analysis of services at the hospital, and that is a document that has been a long time in coming. We have just recently completed that, with the assistance of John Christian from the hospital. Basically, it is a document that will assist not only this government but also future governments in the budget process. It is looking at the level of subsidies that should be provided to the hospital and health care system. It is a very important document, a very useful document.

As far as health planning issues are concerned, that takes a bit of a leap forward this week. Unfortunately, my time has been distracted because of this inquiry. I do not hold that against you, Mr Chairman, but we have workshops going on this week to develop the frameworks for improved service delivery. That is not exclusive to the health area on Norfolk Island; it is very broad ranging and is occurring as a result of the Commonwealth Grants Commission's visit to Norfolk Island a couple of years back.

The system is working. But pressures exist in any system and there is not a perfect system that I have ever seen. I am sure all of you would be very aware of that. You would all have irate service recipients in your electorates, I am sure. And the criticism of the system is not unique to the Norfolk Island system. We all require health services, regardless of our political persuasions.

What we are about is a well coordinated community driven approach by the Norfolk Island government, health professionals, ancillary service providers and community organisations and individuals to determine health service priorities, and then to deliver them. Cooperation and compassion are required in the interim as we seek the necessary solutions to the problems that we have. We ask no more than that.

To assist the process we are seeking closer links with the federal Department of Health and Aged Care, participation in and information from relevant state and territory health forums, particularly in relation to rural and remote health issues, and we are trying and avoid the current bottleneck in communications via the Office of the Administrator. I will expand on that a little bit later.

I think it is important to refer again to the Commonwealth Grants Commission report, page 205, paragraph 107, points 1 and 2. I would like to read these out for the public record, Mr Chairman. It says:

107 *Commonwealth Government issues.*

(i) The Territories Office and other Commonwealth agencies need to make greater efforts to ensure that the Island is informed of relevant developments in the provision of services on the mainland, and of proposals for legislation which may be relevant.

(ii) Past inadequacies in communication between the Commonwealth and Norfolk Island Governments have resulted in mistrust on both sides and a better climate needs to be established, including through improved communication.

Concerning point (ii), on a personal level I have had very good communications and very great assistance from the territories department, and from Bruce Scott's Department of Veterans' Affairs. We have had a very good, cooperative working relationship with those two departments.

Concerning point (i), the most recent example of that which just got rammed home to me was when an invitation turned up last Friday from the Attorney-General's Department inviting me to the joint meeting of Attorneys-General to be held in Canberra some time last week. It took something like seven or eight weeks for that notification to come through. With faxes and emails and other bits and pieces, it certainly would have been possible to have it with me earlier than that. I do not think I would have been able to attend, but it would have been nice to have known that it was on and so be kept up to date with developments offshore.

In conclusion, let me say that I am passionate about my portfolio and I am happy to have been able to address your committee. We have a health system that we have tailored to our requirements, and we will continue to do so. We were given little choice about this. However, we took that upon ourselves and we have achieved something. The Commonwealth pulled Medicare from Norfolk, and they pulled the memorandum of understanding that one of my colleagues was trying to develop for agreement between Norfolk Island and the federal government for the purposes of health delivery and services. Accordingly, we have come up with our own system—and it has been very successful for 10 years—but we recognise the shortfalls and we are attempting to address them.

However, Mr Chairman, I wish to pass on some remarks on how the reference to your committee was made. I would like, as a matter of course, to table the first formal communication from Senator Macdonald and draw your attention to the opening remarks. I do not have sufficient copies for all members of the committee, although I have a couple here.

That first formal communication with the Norfolk Island government in regard to this inquiry is dated 22 October 1999, and the opening remark that I am referring to is:

Following your recent discussions with the Administrator. . .

Mr Chairman, it raises the question: what is the constitutional role of the Administrator, in particular to items listed in schedule 2 of the Norfolk Island Act?

I put it to you that the proper role of the Administrator is to act in accordance with the advice of the Executive Council of Norfolk Island. His role is similar to the role of the Governor of New South Wales who acts in accordance with the advice of the New South Wales government. In matters other than in schedule 2, he may act not in accordance with

the advice of the Executive Council. There are different criteria covering those. This is a schedule 2 matter and quite clearly in the executive authority of the Norfolk Island government. The same confusion recently arose over the firearms issue—a matter not in my portfolio responsibilities, but clearly a schedule 2 matter all the same. That issue has now successfully been resolved.

On this health inquiry, there has been no formal or informal advice to the Administrator, yet clearly his office initiated the development of the terms of reference of this inquiry with full knowledge of the review under way by the Norfolk Island government and without any consultation whatsoever with the Executive Council of Norfolk Island. This is more than just coincidence. I refer committee members to the transcript of the recent inquiry into the Norfolk Island Act and its amendments that are before the Australian federal parliament at the moment. Senator Tierney alluded to the same difficulties and the problems that had been caused there. I wish to have recorded in *Hansard* for the public record the Norfolk Island government's dissatisfaction with the improper role played in this matter by His Honour the Administrator.

CHAIR—That is pretty tough language.

Mr Gardner—I note that, Mr Chairman. Somewhat surprising is the apparent haste of the establishment of this inquiry considering that the Senate, so I understand—

Mr NEVILLE—With great respect, Mr Chairman, I do not know whether we are competent to hear this part of the evidence. This is a dispute between the two governments. We are here to respond to a term of reference given to us by the minister. I am not trying to cut you short if you want to protest but, as to Senator MacDonald's interpretation of what the administration may or may not have been said, it could have been an innocent remark. I said to the Norfolk Island health minister, 'I think it is about time you got a term of reference out on health.' It could have been as innocent as that. But they are not things for this committee to probe.

I have seven or eight questions I still want to ask you about the problems you have with health. I do not want to cut the minister short, but I do not know whether we, as a committee, are competent to look into the intergovernmental aspects of this or indeed to allow this port to be used to chastise the Administrator. I would move that the comment about the Administrator be struck from the record. I think it is inappropriate.

CHAIR—We always have a difficulty striking anything from the record, but I take my colleague's point. I am not sure this is the appropriate forum in terms of a dispute with the government. We have been given a reference and we are proceeding with that reference. We have received some pretty good information today. The discussions I have had with others who have been present have been fruitful. It might be more fruitful in terms of where we are going if this other issue of intergovernmental relations could be dealt with in a different forum. Are you happy with that?

Mr Gardner—I have no problem with that, Mr Chairman. It was just a matter of noting it for the record in relation to the establishment of the terms of reference of this inquiry.

CHAIR—What bothers me is that it has the potential to sour, at the end of a good day, some pretty useful information. It also raises the question of the status of our report. It might be unfortunate if it got locked up in an argument about intergovernmental relations.

Mr Gardner—I understand.

CHAIR—Undoubtedly, these are sensitive issues. I do not want to diminish that. At the same time, we have some responsibility to support our Administrator. Perhaps these issues should be conducted through other channels. Are you happy with that?

Mr Gardner—Absolutely. I had finished my comments on that but we will certainly be keen to pursue those through other channels.

CHAIR—Unfortunately, Mr Neville, I cannot order that any remarks be struck from the record, because it is on the record.

Mr NEVILLE—Like you, I do not want to see something soured that I thought was developing very fruitfully. I had some ideas to put to you on where we might be able to ameliorate some of your concerns. Clearly there are some injustices or anomalies whose resolution could not only help the people involved here on the island but could also take a lot of strain off your own hospital. Rather than bog down in an intergovernmental debate which, as the Chairman said, could sour—

CHAIR—I think the minister has agreed—

Mr Gardner—We will leave it at that?

Senator LIGHTFOOT—Perhaps with your cooperation, Mr Chairman, and the minister's, we could move to questions.

Mr Gardner—I have almost finished. I only had a couple of comments to make.

CHAIR—In relation to health issues?

Mr Gardner—Certainly, it does relate, especially to the senators who sit before me. I was commenting on the apparent haste of the establishment of this inquiry, considering that I understand from what I heard on ABC radio the other day that the Senate had rejected the proposal for an inquiry into Australia's public health system, with all its inherent problems. I certainly hope that Senator Macdonald was not supportive of rejecting the review. I am also still awaiting the courtesy of a reply to my letter to him relating to this inquiry, a copy of which I table for the committee's information.

Mr NEVILLE—Listening to the evidence today on the relative cost of getting people to the mainland, I am bemused as to why you have not purchased a colonoscope at this stage. If one of them costs $10,000, including all the sterilising and cleaning equipment that is required, and—as the doctor said—they could at least make a preliminary diagnosis. If, as a result of the diagnosis, the problem was not imminently dangerous, a person could go on a normal flight to the mainland. Given the difference between a normal flight to the mainland

and, say, $25,000 in a private aircraft or $100,000 for the RAAF, it seems that a $10,000 colonoscope could greatly increase the efficiency and effectiveness of the hospital and save a lot of transfers as well.

Mr Gardner—As you are aware, I am not a trained physician. I do not have any medical experience. One of the things I did, having dealt with my first budget regarding health matters on the island, was to approach the hospital board and the doctors at the hospital at the time to ask them to prioritise for me their requirements.

Mr NEVILLE—Did that include a colonoscope or not?

Mr Gardner—It did not.

Mr NEVILLE—A mammography unit?

Mr Gardner—No.

Mr NEVILLE—Neither?

Mr Gardner—No.

Mr NEVILLE—You surprise me. It seems to me, listening to the evidence today, that there are three areas where there are anomalies. One is in the treatment of AIDS, hepatitis B and C, TB, sexually transmitted diseases and the related matter of immunisation. My view is that perhaps the Commonwealth should be looking at this globally rather than state by state or territory by territory if the costs associated with those were removed from your budget. That was one area. The second issue was the former Commonwealth public servants—or, for that matter, other superannuants who won their superannuation on the mainland and who are paying taxation back to the mainland on those superannuation policies—being allowed to receive some form of Medicare payment, bearing in mind that they are still paying tax to the mainland.

As the Uniting Church minister—whose name escapes me—said today, the third group is the temporary residents who are here on compulsory or semi-compulsory transfer. If those three groups were removed from the system, would that be beneficial to the island in terms of cost reduction? There are anomalies in those three areas that could easily be addressed with the Commonwealth, with Dr Wooldridge. Would they reduce the burden on the health system here?

Mr Gardner—They may well do. I would have to sit down with my team and drag the figures out. Certainly I would be happy to provide a more comprehensive answer when we reconvene in Canberra, with some luck.

Mr NEVILLE—The other thing that disturbed me is that you are not a member of the Health Ministers Forum.

Mr Gardner—Not that I am aware.

Mr NEVILLE—You do not get invited to ministerial council meetings?

Mr Gardner—I have not received an invitation, no.

Mr NEVILLE—Have your predecessors been invited to the ministerial council meetings on health?

Mr Gardner—It may well have been the case in the past, but certainly I am not aware of it.

Mr NEVILLE—Do you think a lot of the tension that develops with the Commonwealth might be lack of communication rather than anyone trying to get at the other one?

Mr Gardner—Absolutely. I firmly believe that. That has been identified in the Grants Commission report, the statement that I read from it.

Mr NEVILLE—You are the Minister for Housing, I understand?

Mr Gardner—No.

Mr NEVILLE—Who is that? Mr Robinson?

Mr Gardner—We are talking about government housing?

Mr NEVILLE—Yes.

Mr Gardner—That would be the Chief Minister, being responsible for government enterprises.

Mr NEVILLE—Is it the government's broad view that people can rent government owned housing when they have other premises available and then rent the other premises to tourists? Is that considered acceptable conduct, or is it just something that has slipped through the net?

Mr Gardner—Under current policy, as far as I am aware, the letting of government owned property is on a free market basis. In other words, anybody is able to rent it. It is basically first in, best dressed.

Mr NEVILLE—Do they put up for tender, or anything like that?

Mr Gardner—No, I understand there are rental rates set and if somebody wants to make an application for them, they do. If a vacancy comes up, they are able to be slotted in.

Mr NEVILLE—Do newly married couples get any preferential treatment?

Mr Gardner—Not that I am aware, no.

Mr NEVILLE—Is there a health and environmental policy in relation to the disposal of used tyres?

Mr Gardner—At the moment, no.

Mr NEVILLE—Have you sought any help from the Commonwealth? This is a big issue in each of the states at present.

Mr Gardner—Part of my other portfolio responsibilities include waste management. I do not know if the committee is aware, but we have completed a waste management strategy for the island. That makes a submission to the Heritage Trust Fund to assist in some of the costs associated with the development of a long-term waste management strategy for the island. We have had many and varied discussions, including participation of the Administrator in the preparation of that strategy. I think it was His Honour who outlined to me practices in South Australia at some time with the use of tyres for creating artificial reefs at sea. I do not know whether those practices continue.

Mr NEVILLE—They are used on the mainland now, and for marron ponds and red claw ponds as well, a thousand tyres per pond. I just wondered if there was a policy as to their disposal.

Mr Gardner—Not as yet, but we expect that the advice we receive back from our application to the Natural Heritage Trust, whether it is successful or not, will provide some of the directions and proposals that were made as part of our application to the trust in those areas.

CHAIR—Have you considered the encouragement of the establishment of a retail pharmacy that may release some funds from the employment by the hospital of a pharmacist and also may help the doctors because pharmacists provide a lot of health issues that may not necessarily need referral to a doctor?

Mr Gardner—At the moment it is not a matter that is being pursued as part of the health review. My knowledge in the past—and certainly when I first came to Norfolk Island some 20-odd years ago—was that there was a separate stand-alone pharmacy on the island. For what reasons that closed down I am not aware. That was run by a qualified pharmacist.

Ms ELLIS—I have looked in the documentation I have and I do not seem to be able to find it. In relation to your health review, do you have figures like current population, projected ageing rates and projected birth rates—in other words, a population study that gives us an idea of what we are attempting to plan for when we look at forward health requirements? Are those figures available as a base line?

Mr Gardner—Yes, those figures would be available. Certainly the idea of compiling those into hard databases would be tied in with the health study that has been undertaken from January through until April of next year.

Ms ELLIS—Is there any set of figures available that we could get from you on notice before then that gives us generally that breakdown?

Mr Gardner—Yes, absolutely.

Ms ELLIS—We have talked a lot about the aged care facility at the hospital today. Are you aware of any non-aged—if I can use that term—people who require similar hostel and nursing home care through, maybe, a brain injury, accident damage or birth defect who are living on the island? If there are any, what are those people doing for services?

Mr Gardner—I may be wrong but I am not aware of anybody who falls into that bracket at the moment.

Ms ELLIS—That is good if that is the case.

Mr Gardner—I will try to give you some more detailed information on that on my impending visit to Canberra.

Ms ELLIS—In a number of communities it is a problem dealing with non-aged people with those sorts of requirements. In the short term, can you tell me if anything is planned to improve the current aged facility at the hospital in its general service to its clients? There is very little, if any, privacy. I am not having a go at the hospital per se and definitely not at the staff. They are working in difficult circumstances. We all sit around and hypothesise or theorise about the construction of aged facilities in the future, but what are we doing in the meantime, if anything, to improve what there is now?

Mr Gardner—In my submission earlier this morning in relation to the provision of domiciliary and residential care for aged and frail people on the island, I mentioned that I had discussed with a member of the RSL, who is a representative on the hospital board, with the RSL themselves and also with other members of the hospital board the development of a proposal to try to provide some better type of private accommodations for those elderly patients at the hospital. This kicked off when the long-term aged patients at the hospital got above the figure of eight who were being accommodated there. Unfortunately, we have had a couple of recent deaths amongst the elderly population which have reduced the number but there is potential for more if those people were to come into the hospital. Certainly the pressure has come on the system for us to have to sit down and think long and hard about exactly what we are going to do.

Part of the proposal suggests that maybe we build an attachment to the hospital, a transportable type thing so that, in the event a new development takes place, we are able to pick that up, shift it away and use it for something else—as an ancillary building to a new hospital system—and in the meantime use this for private type accommodation for the aged people. I think the nurses may have touched on the provision of a private room or quiet room for families going through the hospital. They just want to go and sit somewhere with the family or the patient and get taken out of the hospital environment, the clinical environment, and into something with a few nice lounge chairs and a video or TV or something like that. They want to be able to spend some valued time with the family. That is part of this proposal that these people have agreed to try and put together, taking into account the long-term intentions of the hospital and just how we can fit it in and make it work.

Ms ELLIS—I understand the wisdom of not spending enormous amounts of money whilst this planning is going on, but I have to admit my concern for the lack of privacy and the sparseness of accommodation that is there now. If those plans take two or three years to come to some point, in the meantime the status quo remains. That is what I was really getting at.

Mr Gardner—This is proposed to be very short term, and hopefully it will be within the next week or so that I will get some response back on that.

Ms ELLIS—Forgive me if we have been told this, but what are the current staffing levels in that aged care area? Could you get them for us? What are the numbers and qualifications of the people? Are they nursing sisters or are they carers?

Mr Gardner—I will be able to take it on notice and give you the details as far as their qualifications are concerned. There were some concerns in recent weeks about the level of staffing over the weekends. Certainly some criticism has been directed at the hospital board in relation to the use of volunteer helpers to staff over the weekend in those areas. I had a bit of difficulty with that and had some complaints from some of the families that had relatives in the aged care part of the hospital. I spoke to the director immediately about that to try and overcome the problem, to see if he could work around it by re-rostering the staff that we used during the week to cover the weekends. I understand that has now taken place and there are four staffing members, nursing members at the hospital, with various levels of qualifications—from fully qualified geriatric nurses to nursing sisters—and bits and pieces that are being rostered to cover it. But still that does not give us what could be expected or required to be a full 24-hour aged care nursing cover. That is an issue that needs to be dealt with as part of the review that is under way.

Mr NEHL—I have two questions and one, I am sure, will be very simple. I will leave it to last. The other one may be simple as well. Do you, as the Norfolk Island government, have any difficulty with workers compensation for hospital staff? I ask the question because of my awareness of the situation with nursing homes and other aged care facilities in my own area where some of them are fearful of being put out of business because of incredible leaps in workers compensation premiums. What is the situation here?

Mr Gardner—I am unable to give you a definitive answer on that. I will turn to my chairman of the hospital board to assure me that we are adequately covered in that area.

Mr Hughes—We are covered by the government workers compensation, as is everybody else.

Mr Gardner—We have our own stand-alone government workers compensation scheme on the island. The chairman indicated that that extends right through to the hospital.

Mr NEHL—You are very lucky to have your own scheme because, as I said, I have knowledge of workers compensation premiums for a nursing home jumping to $180,000 from about $60,000 in one year. The simple question is this: I noticed on the door of the pharmacy in the hospital two brief mentions of ‘Southern Cross’. I have made an

assumption—I do not know whether I am right or not—that Southern Cross is a New Zealand health care fund. Is that correct?

Mr Gardner—Yes, it is. Basically, it acts differently to Medicare in that with Medicare you have insurance policies that you can take out for the gap after you have incurred a lot of expense. The Southern Cross policy that is available here is gap insurance from zero to $2,500. A lot of people take it out, especially temporary entry permit holders. If my memory serves me right, I think they are compelled to take it out. That provides them with insurance for that first $2,500 of hospital costs. That is open to anybody that is on the island.

Mr NEHL—Is it widely accepted?

Mr Gardner—I think so. I think some people have some difficulty with it. The premiums per family are about $100 a month—in other words, $1,200 a year to give you a cover of $2,500. But, really, that is a matter for each individual to determine as to whether they want to take out that insurance.

Senator CROSSIN—When are you expecting the review of your health system to be concluded—the review that the NI Assembly is conducting?

Mr Gardner—I certainly hope that it will be concluded by about the middle of next year. The reason I say that is that a lot of the valuable information that is required for it will be as a result of the health study being undertaken by Griffith University and the provision of their nutritionists and health planning staff.

Senator CROSSIN—Have you given any thought as to whether any recommendations from this committee might fit into that?

Mr Gardner—I certainly hope they will complement it.

Senator CROSSIN—Do you feel somewhat compromised by the fact that we are here prior to your study being completed?

Mr Gardner—Yes and no. As was alluded to earlier, there are always some minor political difficulties in investigations by the Commonwealth into what Norfolk Island is trying to do. I tend to believe that the positives will bear reality out of it. Certainly, people in this community will tell me I am being somewhat naive to expect that. However, I live with that. I am an eternal optimist.

CHAIR—The states have similar sorts of problems.

Senator CROSSIN—My final question is this: have you, as minister, ever thought about providing free immunisation for children under the age of five on this island community?

Mr Gardner—I understand that that was a point of discussion on probably a couple of occasions earlier today—the lack of an immunisation program for pre-school age children. For a number of years, I believe the Lions Club of Arthurs Vale—and there may have also been a couple of other service clubs on the island—have subsidised the provision of an

immunisation program for children on Norfolk Island. It was recently brought to my attention that that funding option has now been withdrawn. In a proposal I made two or three weeks ago to the executive government of Norfolk Island and which I proposed to take to budget review this year—that is, early next month—I put forward the option of providing subsidised or a full free immunisation program for all children on Norfolk Island, recognising that it is standard practice in both Australia and New Zealand.

Senator LIGHTFOOT—Mr Gardner, what is the gross revenue of the government in Norfolk Island?

Mr Gardner—That is a good question.

CHAIR—Do you want to take that question on notice?

Mr Gardner—I am certainly happy to take that on notice.

Senator LIGHTFOOT—What is your health budget revenue? What portion of that budget do you take in dollar or percentage terms?

Mr Gardner—My finance minister always likes to remind me that I probably have control over the biggest portion of—

Senator LIGHTFOOT—Which is, in dollar terms?

Mr Gardner—Again, it is a matter that I would need to take on notice, simply because it covers so many areas. It is hospital, medical assistance, social welfare assistance, subsidies to the health care scheme—

Senator LIGHTFOOT—I have a feeling that it is fairly close to your heart, as someone with a passionate interest in his portfolio.

Mr Gardner—It certainly is, yes.

Senator LIGHTFOOT—How old is the hospital here?

Mr Gardner—My understanding is that it was built during the war years.

Senator LIGHTFOOT—It was built during the Second World War?

Mr Gardner—Yes.

Senator LIGHTFOOT—Who owns Southern Cross gap insurance? Is it a subsidiary of a major New Zealand company?

Mr Gardner—Southern Cross Health Insurance from New Zealand, yes.

Senator LIGHTFOOT—Is it a large insurer of health, or is it a small subsidiary of a large insurer?

Mr Gardner—It is a large insurer of health in New Zealand. I am not sure about the company structure, but they are also a provider of private hospital systems in New Zealand.

Senator LIGHTFOOT—Who allowed Southern Cross to become the gap insurer, or the prime insurer—if not the only one on the island?

Mr Gardner—I think that was residual from when Medicare was pulled from Norfolk Island back in 1989, or thereabouts. They were at the time, as I said earlier, insuring New Zealand residents who had come up here. At that time I was one of them. I had Southern Cross Insurance when I first came here. I think it is just a vestige of those days that, when we clicked into our scheme, they offered the gap insurance.

Senator LIGHTFOOT—Do you welcome other insurers here to offer some competition to Southern Cross?

Mr Gardner—I would certainly be interested to see any proposals from them, yes.

Senator LIGHTFOOT—What about the staff? How many staff are there, on average, at the hospital?

Mr Gardner—At any time?

Senator LIGHTFOOT—Give me an average.

Mr Gardner—Thirty or thereabouts throughout the year.

Senator LIGHTFOOT—That includes part time?

Mr Gardner—Yes.

Senator LIGHTFOOT—I think your report says '41', with part-time staff.

Mr Gardner—It is equivalent to about 30 at any one time.

CHAIR—Thank you very much, Minister, for appearing before the committee. Your evidence has been most useful. I would also like to state that all witnesses who have appeared today will receive a transcript of today's proceedings to be checked for accuracy.

With the leave of the committee, I refer to an earlier comment in explanation of a ruling that I made earlier. It is not really Australian parliamentary practice to delete evidence that has been given, or statements made. However, as chairman of the committee, I would like to state that not only is Mr Messner, the Administrator, a personal friend—and I say this from the point of view of providing some balance, which I think is important for the record—but also, knowing the man, I can assure all of his upmost integrity. He is a man who, I believe, is putting forward the best interests of Norfolk Island and has those best interests in mind at all times.

[5.53 p.m.]

BARRETT, Mr Rex Samuel (Private capacity)

CHAIR—Welcome. Would you like to make an opening statement?

Mr Barrett—I am speaking as a relative of two people that are in the aged care section of the hospital—both my parents—who in the last few weeks have become full-time residents of that area of the hospital.

I do not have my notes here so I have to improvise a little. One of the things that I would like to say is that the DVA report that was tabled earlier makes some excellent recommendations from the perspective of some of the relatives. We meet reasonably frequently amongst ourselves and less frequently with the hospital director. We meet some of the staff and some of the hospital board members from time to time to sort out various issues that need to be attended to at different times. The DVA report and the work that was done by the consultants have caused a substantial increase in staffing for the aged care area at the hospital. Substantial improvements have been made in that area in the last 18 months.

Today many issues have been addressed in this area that perhaps have been clouded as to the direction that the community may have been going. I think that the committee coming here has definitely helped precipitate some of these matters getting out in the open a little more freely, including increasing some of the staffing elements in that area in the hospital, because that was a bit of an issue. Weekends were just not being covered at all in that area. That has been corrected in the last week. It may be coincidental. I think both doctors appear to have addressed what they saw a substantial need.

The greatest concern—and I felt it was brought to the surface by Ms Ellis—was when some of these improvements were going to take place. Things have been bad for a long time through neglect. The aged people of the community, just like the young people on this island, are poorly served in terms of the value they get for the dollar that is spent. In 1996 a report was done by the relatives of those that were in the hospital. At that stage there were no dedicated staff for the number of people that were in the hospital. When I spoke to the minister, Nadia Cuthbertson, who was in charge of that area, she was the first one to instigate some improvement in the staffing levels and that initial improvement involved four hours a day, five days a week.

Once the DVA had visited, we had a substantial improvement in the number of hours. That has progressively increased over the last year to the point where, as of this last week, we now have to cover from seven in the morning, with a bit of an overlap in the middle of the day, through to 8 o'clock at night. That is a very substantial improvement and probably the part that could be attended to instantly. There was a view that perhaps there was not the funding there to pay for it. On the mainland you have an Aged Care Act that was brought in in 1997. In some of the papers that I have read to do with that on the mainland they expressly said that it should have people involved that had an expressed concern for the aged area and not have overlaps that ran elsewhere so their gender crossed over.

There is a big problem on Norfolk in that there is not a body that actually goes to bat for the aged care area. It is blended into the rest of the hospital. In fairness to the hospital board, they are obviously doing the best they can. I think one of the recommendations in the DVA report was that the aged carer should be being treated as a cost centre. That is now coming to pass. As that comes to pass we seem to be seeing that there is better value coming into the area. There may be some questions you want to ask as I am trooping along.

Ms ELLIS—I do not wish to get personal in the questions, but it is really interesting for me to know that your parents are in the hospital.

Mr Barrett—Yes.

Ms ELLIS—What were the circumstances that led them to move there? Were they in their own home?

Mr Barrett—Yes.

Ms ELLIS—For how long?

Mr Barrett—My father is blind and he went totally blind four years ago. I took him to New Zealand at that time to have an operation and it gave him the restitution of sight in one eye for a period of time, but that did not last. He has had a progressive series of strokes. He required increased nursing care and attention through that period while he was at home. That put a lot more strain on my mother. That resulted in her getting two compound fractures of the spine through osteoporosis advancing. She has also had a couple of strokes this year. In fact, she had one on the very first day of the year and she was in hospital right at the very beginning of the year.

Ms ELLIS—How old are they both?

Mr Barrett—My mother is coming up to 80 and my father is 79.

Ms ELLIS—So he is the one gentleman living there?

Mr Barrett—He is the one gentleman living there.

Ms ELLIS—We did not meet him, but we noticed him there. Other than the staffing situation, what is your feeling about the privacy, or lack thereof? Your dad is okay because he is the only bloke at one end. Well, he is not okay, but he is in an area on his own.

Mr Barrett—He is isolated in a sense too.

Ms ELLIS—He is isolated, so it is bad in another sense.

Mr Barrett—He is okay, but you have to go through two doors to get to him. But there is good reason why those doors are there, and we are happier with them there than not there. I think your description of the circumstances is quite adequate—the comments that you made earlier on—as are the comments that are made in the DVA report. But, of course, it has been

this way for a long period of time. Fortunately, the demographics of the island are putting pressure on the whole system, and so everybody is starting to talk about the same subject area where previously it was swept under the carpet. So we have a chance of seeing improvements and, in fairness to all parties involved, there have been substantial improvements in the last 18 months in terms of the level of physical care given to the various ones who are up there.

Ms ELLIS—Are they both pensioners?

Mr Barrett—They are now, yes.

Ms ELLIS—So what is the arrangement? Does their pension, bar a certain amount, go to their care there?

Mr Barrett—Yes. There is a formula: 80 per cent of their income goes to the hospital.

Ms ELLIS—Yes, very similar to the mainland. That is all I wanted to ask. Thank you for coming forward and talking about it.

Mr Barrett—That is all right.

Mr NEVILLE—My first question is: if the option had been available some years ago for your parents to buy a unit in the hospital grounds which would, when they passed on, revert back to your family—albeit with either some method similar to the bond system that is existence in Australia or a system that is used in a number of retirement villages where you buy into a unit and then you are guaranteed a certain figure when you go out of it—what would your personal reaction have been? Secondly, do you think a system like that, if it were Commonwealth subsidised, would find acceptance given the very strong family ties here on the island?

Mr Barrett—I will address the latter part first. When you use the word Commonwealth subsidy, and depending on what the size of that was, you obviously increase the incentive as to whether that is an acceptable thing. I think the government, through one or several ministers, floated the concept of this type of accommodation within the community and doing it privately, et cetera. It did not seem to run very far. A number of years ago it was brought up and it did not run very far then either—the largest problem being the total funding and who was going to sit over the top of the financial requirements. It is the same reason why the hospital has not been upgraded and why the aged care area is, in a sense, in as bad a shape as it is right now.

Mr NEVILLE—There is a certain amount of resistance on the mainland to this too, and it sometimes comes from the children of the people. You have a strong cultural thing here where you do not have a lot of houses. I imagine a lot of houses are handed down to the children. There is some resistance on the mainland to this sort of scheme because it really brings the family estate to a point of distribution well ahead of the parent's death.

Mr Barrett—Somebody has got to talk about death well in advance of the end.

Mr NEVILLE—Also, once they go into one of those units, it takes the control out of the hands of the family—until such time as they die anyhow—and that is not well accepted in some areas of Australia. I just wondered what you thought the cultural feeling would be here on the island, having lived through this experience yourself?

Mr Barrett—It is hard to know. I think it comes down to the same reason why the hospital is in the shape it is at the moment—funding. If somebody came along and said, 'There's $5 million here; let's see what is the best we can do with it,' I am sure—

Mr NEVILLE—I am not trying to preach to you.

Mr Barrett—I know.

Mr NEVILLE—Whether it is in Norfolk Island, the Northern Territory, Queensland or anywhere else, we have an ageing population in Australia, and the time is going to come when governments are not going to be able to shell out money to build nursing homes and hostels unless there is some contribution from the public, from the people who are going to use them. I am just trying to elicit from you what model might work on Norfolk as distinct from the mainland, or whether the general models that are working on the mainland might be able to be translated or tweaked to suit a Norfolk circumstance.

Mr Barrett—When the concept was being floated in the community in the last year or 18 months a Seventh Day Adventist minister spoke to me about it when it came up in conversation. I think the SDA church runs a system on the mainland where they guarantee people that, once they vacate the unit that they have used, they get a 90 per cent rebate of the value. So you are talking fixed returns and known numbers. I could see a system like that working very well because everybody knows exactly what they are going to get back out of it. If they go in a certain way, they can come back out knowing exactly what the numbers are.

Mr NEVILLE—So there if there were a certainty in it, you think it might be accepted on the island?

Mr Barrett—Certainty is always more acceptable to most people, isn't it?

Mr NEVILLE—Yes.

Mr Barrett—Then there is a perceived cost for whatever the time may. I am led to believe that 10 per cent works extremely well within that organisation on the mainland.

CHAIR—Thank you very much for appearing. It was very useful evidence. The committee has received a late, brief submission from Norfolk Optical. Is it the wish of the committee that this submission as tabled by Norfolk Optical be accepted as evidence to the inquiry and authorised for publication? There being no objection, it is so ordered. I thank the witnesses who have appeared before us today. The committee stands adjourned until a date to be announced.

Committee adjourned at 6.07 p.m.