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JOINT COMMITTEE ON THE NATIONAL CAPITAL AND EXTERNAL TERRITORIES

Reference: The provision of health services on Norfolk Island

MONDAY, 19 JUNE 2000

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JOINT COMMITTEE ON THE NATIONAL CAPITAL AND EXTERNAL TERRITORIES

Monday, 19 June 2000

Members: Senator Lightfoot *(Chair)*, Senators Crossin, Greig, Lundy and Watson and Mr Cameron, Ms Ellis, Mr Nehl, Mr Neville, Mr Snowdon and Mr Somlyay

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

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.

WITNESSES

Committee met at 9.15 a.m.

GASTON, Professor Carol Frances (Private capacity)

CHAIRMAN—Good morning, Professor Gaston. I apologise on behalf of the committee and the secretariat for our late start this morning. Many of our members are either fogbound or tied up in other committees that require some small measure of urgency and thus a priority in attendance. I welcome you and I apologise once again. I advise in opening this informal hearing of the Joint Standing Committee on National Capital and External Territories that this committee at the moment is not covered by parliamentary privilege. Not that I expect any breach of that particular order, but I thought it appropriate to advise you of that. We would anticipate having a proper quorum and a proper constitution of this committee where we can speak more freely and openly as soon as the fog clears and planes land and others organise themselves away from their committees. I do not want you to take that as a sign that you should be restricted in any way, other than with respect to privilege. Having said that, may I say good morning again and welcome.

Prof. Gaston—Good morning.

CHAIRMAN—Professor, we are going to ask you some questions and you can expand on them as you wish. We are going to ask questions that are well within your particular sphere of influence. I have read what is quite a formidable CV in terms of your experience with respect to hospitals all over those particularly remote parts of South Australia and the Northern Territory. I will perhaps lead off with the first question and that is how current is your knowledge of the developments in health in Norfolk Island?

Prof. Gaston—As I indicated in my covering letter, I only spent eight days on Norfolk Island and that was in December 1999.

CHAIRMAN—Are you aware of the report that was undertaken and compiled by a team of health specialists from the Griffith University?

Prof. Gaston—I am aware of it being done and of its existence but I have not familiarised myself with it at all.

CHAIRMAN—We will make that report available to you, Professor, and perhaps you might be kind enough to familiarise yourself with that. However, that does not impinge in a negative sense on our inquiry this morning. Would you be kind enough to explain to the committee how the kind of multipurpose service models mentioned in your submission could be set up in an isolated community—not just Norfolk, but any isolated community?

Prof. Gaston—The primary purpose of these multipurpose centres was actually to cash out the funds from the various funding streams that are applied in health settings. As you are aware, the health industry is in some ways burdened, I suppose, by multiple funding streams from state governments and from the Commonwealth. The Commonwealth, in particular, has funding streams from GPs, aged care and, I suppose, pharmaceuticals. The primary intention of

multipurpose centres is to bring all that funding together so that there is one package of funds that can then be aligned to the determined need for that community. So rather than having multifoci, you have multipurpose. The funding arrangements, of course, on Norfolk Island are very different, but the actual concept of multipurpose and therefore integrated services could certainly be applied to Norfolk Island.

CHAIRMAN—So whilst you see quite a difference with respect to Norfolk and other parts of the mainland, is there a similarity between Norfolk and what you are aware of on, say, Christmas Island or Cocos (Keeling) Islands, Australia's other external territories? In other words, does Norfolk Island stand alone in its requirement, in your experience, or are there some similarities to use on a model to judge Norfolk Island?

Prof. Gaston—I do not believe that Norfolk Island stands alone. However, I do not actually describe Norfolk Island as a remote centre in my mind. As a consequence of that, I was very surprised at the fact that it was still focusing very much on hospital services. Even in our rural remote areas in South Australia and in the Northern Territory, we do not do that any more and have not for many years. The focus has turned to one of, first of all, integration of services but, more importantly, primary health care services. I saw really no evidence, other than GP practice, of primary health care services on Norfolk Island.

CHAIRMAN—When you say 'primary health care services', how does that differ from, say, acute services or community and preventive medicine that is initiated and undertaken in remote areas?

Prof. Gaston—Primary health care services fall into that category of community services. It is non-hospital, it is non-acute and it focuses very much on health promotion, prevention, early screening and also community support. Our major focus these days, I suppose, is in the areas of mental health, maternal and child care, and adolescent services where that focus is at the primary end—that is, at early intervention and prevention—rather than at the response and treatment end.

CHAIRMAN—Does that primary service also include aged care?

Prof. Gaston—Aged care, strangely enough, still covers the continuum of care. There are aspects of aged care which are primary—that is, they still need to understand their own health and assist in their own wellbeing—but they also have acute illness episodes and require ongoing or chronically related care. So theirs is the full continuum: it can be primary care, it can be the acute setting and it can be ongoing chronic care.

CHAIRMAN—So they are well and truly represented in the loop; they not left out of the loop?

Prof. Gaston—By all means no, which is one of the reasons why they are always to the fore. It is not just because they are a large proportion of the population but because their needs do cover the full spectrum.

CHAIRMAN—So this model that you propose or promote could be easily adapted to Norfolk Island if it was not already in existence there now?

Prof. Gaston—Yes, it certainly could be. I can only reiterate that I was most surprised at the focus on the acute component. That particularly related to the aged facilities which were in the hospital, with less than ideal circumstances for the aged and very little privacy, yet there had been an attempt to provide hostel related services on campus. There had been little support for it, as I saw it, and I suspect it is mainly not because of lack of will but more due to lack of understanding and knowledge about these things.

CHAIRMAN—You only had a relatively brief visit to Norfolk. One can pick up, nonetheless, with respect to health services, a reasonable amount of information with respect to anomalies and the conditions of hospitals and their needs in a generic sense. Given that, do you see that Norfolk has fallen behind compared to some of the other isolated areas that you have had experience with in South Australia and the Northern Territory?

Prof. Gaston—I will just refer to Tennant Creek. I was there last week and they have a much larger hospital than Norfolk Island. I think Norfolk Island has about 27 or 30 beds and Tennant Creek has about 50. It has a very integrated service and I would say it probably focuses 70 per cent of its energies on the community, the community's needs and primary health care. Of course, they have been given a very good and overt reason for doing that and that is the particular needs of the indigenous population there. That is very much in their face all the time and makes it very evident to them that they need to focus on primary health care. Norfolk Island just has not had that jerk to bring it into the next generation of health care and that move away from constantly just focusing on the treatment end.

I think I made my summary quite clear in my submission. I was almost, you could say, stunned because I was taken back 20 to 25 years when I went there. I was surprised that that component fell behind in what I thought was a community that did so well at so many other aspects of its economy and its services.

CHAIRMAN—So your submission is very unambiguous when it comes to the attention that is needed on Norfolk Island. That is that attention could be described as urgent in some areas. Is that correct?

Prof. Gaston—I suspect that is a fair comment in that I always believe it is urgent to address the needs of communities before they reach the acute stage. I understand that the hospital has difficulty in keeping to budget, which is for a whole range of reasons, but that could be addressed in part by alternative care for the aged. It is very expensive to look after the aged in a hospital setting. It could also be addressed by preventing people from needing to enter the hospital. What I think is needed, and I am not sure whether Griffith addressed this, is to get an understanding of the health needs of that population. That includes the permanent population and the common recurring needs of that transient tourist population.

CHAIRMAN—Do you think the relative difference between, say, Tennant Creek and Norfolk Island may be based on the misnomer that Norfolk is not a part of Australia in the sense

that Tennant Creek is—and I do not mean in a geographical sense or in a terrestrial sense? Do you think that is somewhat misleading?

Prof. Gaston—I am not sure I am really in a position to comment on that. My observation was that the funding arrangements certainly impacted, and I suspect its ability to develop the capacity within the board and the staff to have a more contemporary approach to the delivery of health care. I am not sure it is the mentality of not being part of Australia, but rather both the intellectual capacity and the financial capacity.

CHAIRMAN—You did not see a culture on Norfolk Island that is apparently significantly different from that on mainland Australia? I am trying to cover this '25 years behind' that you see Norfolk as being in its health services. Do you see a cultural difference as well?

Prof. Gaston—In the broad sense, no, I did not see a cultural difference. I saw a culture there that was different—that is, the islanders. They put a great emphasis on that cultural difference that they have, meaning their history and their language, but that is not displayed in their business interactions. In a business sense, in a tourist sense, it is, to me, like part of Australia. I will tell you an interesting story: I thought it was so much part of Australia that I arrived at Sydney airport without my passport.

CHAIRMAN—Professor Gaston, it is part of Australia. It is a different part of Australia. I think this division that is perceived by other Australians at all levels, particularly in our political lives, perhaps detracts from what would otherwise be supplied to areas such as Tennant Creek; that it is not supplied to areas like Norfolk, where it is perceived that we are almost giving them aid rather than carrying out what is the responsibility of the Australian government in establishing health services commensurate with those on mainland Australia. This mentality that Norfolk is not only separated from Australia by part of the Tasman Sea but, in fact, separated from Australia in a legal sense should not be promoted. I think once we get over that then perhaps augmenting what is a reasonable health system on Norfolk Island might be easier. Could you comment on that?

Prof. Gaston—I suppose I could only go back to the comment I made before, and that is that I believe they lack the intellectual and financial capacity to move forward. I believe that is provided to Australians by Australia. If you are saying that Norfolk Island, although different, is part of Australia, then it should be assisted to develop its intellectual and financial capacity as other areas like Tennant Creek are. Certainly, the Commonwealth is right now putting extra effort into providing better health services to remote areas in Australia. It is not for me to say within the legal and constitutional bounds what is the role of Australia, but I do not think there is any doubt that just from proximity, association and—it is an awful word to use—benevolence we should provide them with the capacity they need.

CHAIRMAN—But living in Darwin you would be aware of the multimillion dollar hospital that has been built on Christmas Island. I understand that they pay no tax like Norfolk Island. I hasten to say that there is a difference in a constitutional sense between Christmas Island and Norfolk Island. I am not wishing to draw a superimposition there. I understand that the hospital, which I am visiting next month, on Christmas Island is something that all Australians will be very proud of. We do not have the same facilities existing on Norfolk, so there does need to be a

cultural change. How about expertise on Norfolk Island? Do you see an economic necessity for calling for expertise from outside Norfolk Island from Australia and in some cases from New Zealand, or do you think that the expertise ought to be domiciled on Norfolk Island, notwithstanding the population is about 1,800 people?

Prof. Gaston—I think you must first focus on the population's needs and then determine how that can be best provided. Your answer then will be in a mixed way. You will have the capacity within the island within the staff and governance to some degree, but you may need to access additional facilities. That can be done in many ways. It might be on a visiting basis or, as has been mentioned, through the use of telecommunications. This particular medium can be used very successfully in health. Daily we are seeing advances such that real-time diagnosis and real-time assisted surgery can occur. The only barrier now is in our own heads. It is certainly not the technology. It is our own ability to engage it and accept that it is yet another technological tool that we can use to enhance the provision of our health services to our local people. I mentioned in my submission that I was surprised that there was no evidence of the use at the hospital and yet just round the corner there was the Greenwich University that had quite good teleconference facilities that could have been used just for education purposes.

CHAIRMAN—What about that expertise? Do you think that the health services on Norfolk Island could be lifted appreciably if it was augmented with a nurse practitioner, given that both the doctors there seemed to work extraordinarily long hours. If there were eight days in the week I am sure they would be working eight days in the week as well.

Prof. Gaston—I am a little biased here. My adjunct professorship is in nursing. I chaired the ministerial advisory committee in South Australia for the formation of the nurse practitioner role in South Australia.

CHAIRMAN—Was that a state ministerial role, Professor?

Prof. Gaston—That is correct and I was an adviser to the committee here in the Northern Territory, so I am a great proponent of the role of the nurse practitioner, particularly in rural and remote areas. I do not confine it to those areas, but they are particularly valuable there. I make reference to that in my submission because they can provide a large amount of the primary health care services that are needed in a place like Norfolk Island and it would supplement the work of the doctors there. It is not about doing doctors' work; it is actually supplementing that work and working in collaboration. I did not speak to the doctors there, but I got enough of a feel to believe that they were not happy with the current focus on acute care and that, if they had the time, they, in fact, would want to invest more energy in primary health care. The use of nurse practitioners in collaboration with the doctors on the island would go a long way to moving that health service to one that is far more focused on health than on illness.

CHAIRMAN—So whilst the nurse practitioner would not be doing work that doctors would do, or should do, would it be fair to say that doctors are doing work that a nurse practitioner could do?

Prof. Gaston—Absolutely. There is a slight overlap because the role of the nurse practitioner can be adapted to the circumstance. We have nurse practitioners in remote areas where there are

no doctors and so they do have diagnostic and prescribing rights, but they are given only for that location. The role can be adapted and it is adapted according to the extent to which the medical service is provided or is not provided.

CHAIRMAN—What extra training or other education would a nurse practitioner need if she or he was to come from an appropriately qualified nursing post?

Prof. Gaston—It would vary because the nurse practitioner status would be awarded in order to practise, say, on Norfolk Island, so in that practice it would mean that you would want a nurse who is credentialled to work in primary health care and to work in a remote circumstance and who would provide general health screening and health promotion and intervention programs. That nurse practitioner would be very different from a nurse practitioner whom you wanted to provide simply mental health care in a rural region, for example. So you would look for the skills that you needed and then try and attract a nurse who could be credentialled to work as a nurse practitioner with those skills. It is the nurse registering body in South Australia—I am not sure about New South Wales—who actually authorises the nurses to practise and then they are credentialled by the authority in the region where they work.

CHAIRMAN—So there is not a tertiary curriculum that a nurse has to undertake prior to becoming a nurse practitioner?

Prof. Gaston—Not at the moment because it is such a varied role, and, because the systems are not in place in the higher education sector, the facility to be authorised and credentialled on assessed current experience has been provided.

CHAIRMAN—So it is possible or even probable that the proposed position could be recruited from a nurse with experience from Norfolk Island?

Prof. Gaston—It could be, but they would have to go through the authorisation and credentialling process.

CHAIRMAN—Did you manage to speak to the community health awareness team on Norfolk when you were there?

Prof. Gaston—No, I did not.

CHAIRMAN—That is a pity. I would like this recorded in *Hansard* so we can see whether it is appropriate that, on a visit by this committee in future, you are able to accompany us there, if that were at all possible. From your knowledge of the facilities on Norfolk Island and the inevitable financial constraints on any small or remote community—you have considerable experience in this area—do you think an older citizens village or an area that is discrete from the hospital is possible or even desirable?

Prof. Gaston—I think it both desirable and possible. It does not have to be distant from the hospital. In fact, it probably is advantageous for it to be reasonably close by—but, then, nowhere is far on Norfolk Island. As to its possibility, I suspect that there would be private sector aged care companies which could be interested. By attracting a private aged care

company you could get their investment in the facility—you could get a partnership arrangement or it could be entirely provided by a private organisation. Norfolk Island is a place that has certain attractions to people and that, plus the likelihood of at least minimal profit, could be quite attractive.

CHAIRMAN—After this question I am going to pass over to one of my colleagues because I have to go to another committee meeting. I would like them to participate for these last few minutes. I am going to pass over to Ms Annette Ellis, MP from the House of Representatives. Would private sector surgeries, consulting rooms or other medical facilities be appropriate on Norfolk? Is that the best way to go?

Prof. Gaston—Norfolk Island provides an opportunity to look at all options. This is where I have been alluding to the lack of broader knowledge and experience in the industry that has kept the hospital a little behind—that is, they have not had the opportunity to think about the various options available to them. You do not know how the private sector are going to respond until you have discussions with them. We have seen that right throughout Australia in the health industry where the responses to calls for tender for the provision of various services have ranged dramatically from almost no response to overwhelming response. You do not know what the response is going to be until you test it. When I was on Norfolk Island I was, on the one hand, saddened to see a service so far behind but, on the other hand, really energised at the opportunity to set up something that was very unique and targeted to that particular population, because we have now got so much more knowledge, technology and capacity.

CHAIRMAN—I very much appreciate your answers this morning, Professor Gaston. We will make sure you get that Griffith University study ASAP and I look forward to your presence on Norfolk Island, given your expertise in the subject.

Prof. Gaston—Thank you very much.

Ms ELLIS—Professor Gaston, I am a member of this committee and the member for Canberra in the House of Representatives. I preface my comments by apologising that I came into this teleconference during its course, so forgive me if I attempt to cover some ground that we may have already mentioned.

I understand that earlier this morning you may have mentioned Greenwich University and the discussions around telehealth. I have a very strong interest in this area from being on another committee of this parliament which in the last parliament did an inquiry and a report into telemedicine—a report which you may or may not be aware of. Can you expand a bit further for us on your comments in relation to telehealth? Given the telecommunications difficulties that Norfolk currently has, how do you see the development of telehealth and where do you see that fitting into the picture of things? What emphasis would you give that in terms of priorities, particularly when we would need to upgrade much of the communications to Norfolk to enable that to be carried out to its fullest extent?

Prof. Gaston—And you have given me three minutes?

Ms ELLIS—You can go on for as long as you wish because I think this is a very important issue.

Prof. Gaston—So do I. I am not familiar with the telecommunications infrastructure for Norfolk Island or who the carrier is or what the arrangements are. I do not know about that so I cannot comment on that. All I can do is comment on what is possible in terms of the technology that I know is available generally that we use very successfully in parts of Australia. My belief always is that you crawl before you walk. The use of telecommunications through telehealth is pretty scary for a lot of practitioners to begin with. It amuses me because doctors use technology every day but I think they get the impression that telehealth is going to do them out of a job or an opportunity to fly to a remote area or whatever. It has to be complementary. Telehealth is not a solution; it is a tool and a means.

I think you start off with education. You use it for educational purposes and as a management tool in meetings. You can get the medical and nursing staff engaged in conferences and meetings with their professional groups just to get them attuned to it. The next thing is for consultation. A very good case for Norfolk Island which led the way in South Australia was mental health. Mental health really lends itself to telehealth. In South Australia now we have over 25 telehealth mental health centres in rural areas. That has provided an enormous learning curve for practitioners but also for the community. We have certainly found in the Northern Territory and Central Australia that the Aboriginal community have engaged it. They do not care about the means for communicating; they just want to communicate. To get it as a consultation process would be the second stage.

Then you move to diagnostics. As your telecommunications become more sophisticated and your lines thicker or your satellite bigger, then you can use it for transferring images, particularly with radiology and with pathology. Then there is the ultimate, I suppose—and I think the first occurrence of this was in the Antarctic in 1969—of actual remote surgery. This is not a remote idea because the US military have done this from their military hospital in the US. They have led general surgical teams in quite sophisticated surgery in places like Rwanda and Yugoslavia.

Ms ELLIS—Taking the discussion a teeny bit further, where would you put the ability for telemedicine or telehealth on the list of priorities for Norfolk Island? If you and I were just sitting here saying, 'Money is not going to be an element of it really. We will just draw up our list of what we think needs to be done,' where would you put that? I am asking that, keeping in mind the enormous benefit of the diagnostic aspect—even though it was a little down on your list of advantages—the money savings and the human savings that would occur with needless medivacs and so on. When we are talking about Norfolk in relation to medivac, that is one of the problematic things we are dealing with, so where would you actually sit telehealth in your priorities?

Prof. Gaston—I would actually put it up very high because of the process needed to actually develop people's familiarity with it and in recognition of the great advantages. As I said, you start with the education, and I am not sure why one could not start by using the Greenwich facility just to familiarise staff and get them using the technology. I would put it up quite high. First of all, there is that facility there and there is a stepped approach to it. Secondly, the

consultation, which is that second step, could also facilitate the medivac issue. I know that here in the Northern Territory, just by having this facility available out of a couple of remote areas in the Tanami region, it does prevent medivacs from taking place. We had one early last year where it was thought that this person had some dreadful brain tumour; in fact, they had an abscess on their tooth and it was easily dealt with locally, of course. The third thing is that I believe it could also assist the staff and the board in developing their understanding of what is possible. I did not see any evidence of their knowing what is possible.

Ms ELLIS—Thank you very much for the contribution you have just given me in relation to telehealth, Professor Gaston. That was terrific. I am just going to pass across to my colleague Warren Snowdon.

Mr SNOWDON—I am the member for the Northern Territory and was previously the parliamentary secretary responsible for external territories, so I am well acquainted with the situation on Norfolk Island and in the Northern Territory. For a period outside parliament I worked with the Tanami Network, so I am across those telecommunications issues and the ability to use this medium for telehealth. I am actually interested in asking you questions about management. What is your view about the best way to manage health services on Norfolk Island?

Prof. Gaston—I was there for only eight days, remember, and management is a very broad issue. Are you talking about governance or are you talking about management?

Mr SNOWDON—I am talking about governance, about whether you need a multipurpose service based on a community model, about whether you need a hospital at all, about whether you need a multipurpose facility, about who should be the governing board, about what their skills should be and about who should pay for it.

Prof. Gaston—There is no doubt that a multipurpose centre is required there. I would move away from the emphasis on 'hospital' and focus on 'multipurpose centre', of which the acute area is but one component. In terms of governance, it is important that local communities have the responsibility and the accountability for governance. I have been through a lot of debate over this issue in South Australia with the large number of rural boards. Whilst they can be very political—but that is their right as citizens—they provide that local community focus. If you can educate them they can educate the rest of the community. They can save you a lot of time and energy because you can focus on developing their knowledge and understanding and they will go out to their morning coffees or dinners or barbecues at the local footie game and hand on that information. They are a very useful tool, so to speak.

However, they do need a great deal of assistance to understand their role in relation to management and that separation of powers between a governing body and management. I know that that is extremely difficult in small communities. I do a lot of work with the boards of small hospitals in South Australia. We can, and have, successfully assisted them to make that change, but it takes a bit of time. I would support a multipurpose centre. I would support local governance with the capacity building that is required.

I would have to stay away from the funding issue because I have not done sufficient reading or research on the current arrangements to be able to comment. But in general terms, I believe that when you are managing a multipurpose service for a small community you need to bundle up the money so that it is one bundle of money that can be distributed according to needs, and as needs change can be redistributed.

Mr SNOWDON—Are you aware of the coordinated care trials that have been taking place in the Northern Territory?

Prof. Gaston—Yes—at Katherine and on Tiwi Island.

Mr SNOWDON—Would you see that as a way to secure the funds?

Prof. Gaston—It is certainly a way that communities on the mainland can secure funds. Whether that is open to Norfolk Island or not, I do not know.

Mr SNOWDON—I do not think it is, but I want to explore the idea.

Prof. Gaston—I did not think it was. Coordinated care trials were an extension of the multipurpose funding scheme, but looked at larger populations. In the case of the Tiwi Island, the funds were given to the community and it is the budget holder, which is quite unique. It had its problems initially because of the learning curve that these communities have to go through, but that is ultimately where we want to go.

Mr SNOWDON—Thank you.

CHAIRMAN—Thank you very much, Professor Gaston for your appearance here today—I will not say attendance. If there are any matters on which we might need additional information, the secretary will write to you. You will be sent a copy of the transcript of your evidence to which you can make editorial corrections and forward back to the secretariat. Once again, on behalf of the committee and the secretariat I thank you for your most informative answers this morning.

Prof. Gaston—Thank you. I have enjoyed it. I am glad I could do it from sunny Darwin and not have to go to fog-bound Canberra.

[10.05 a.m.]

SEXTON, Dr Michael Frederick Halcomb (Private capacity)

CHAIRMAN—Welcome. In what capacity do you appear before the committee?

Dr Sexton—I appear in the capacity of someone who was a government medical officer for two terms on Norfolk Island. The initial term started in 1975 for five years and another episode was of two to three years starting in the mid-1980s. It is some 15 years since I practised on the island.

CHAIRMAN—Although the committee does not require witnesses to give evidence under oath, you should understand that these hearings are legal proceedings of parliament and warrant the same respect as the proceedings of parliament itself. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Are there any corrections or amendments you would like to make to your submission?

Dr Sexton—No.

CHAIRMAN—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 request. Dr Sexton, before we ask you some questions, do you wish to make an opening statement?

Dr Sexton—Yes, I would like to do so. One of the things that comes up is whether I am current in my knowledge of Norfolk Island. I think I have kept up-to-date for two reasons. One is that my first wife lives on the island and has married one of the indigenous islanders. We have children. She is a medical practitioner and we communicate about medical matters. Secondly, I have retired from general practice now. Part of my retirement is that I want to write up some still pertinent morbidity studies on disease patterns on the island, both as a general study and on the Pitcairn Island inhabitants. So I have to keep up-to-date with things on the island.

There are a few things I would like to say about Norfolk Island as an opening statement. One is that I was most impressed by Professor Gaston's presentation. To me, it demonstrates very clearly where telecommunication comes in. I spent some time down at the Antarctic and also saw it in action down there. It is a most impressive tool as long as you are not too beguiled by it.

Norfolk Island, despite what Professor Gaston said, still can be considered a remote area. It is an isolated area. It has its specific problems and that is why we are discussing the health problems of Norfolk Island here. One of the things about the island that makes it different is the tourist potential. It has its own industry. The tourists that go there are of increasing age. Their expectations, of course, are of medical outcomes for the area they have come from. They are very demanding in that field.

I agree entirely with Professor Gaston that the focus has been on acute medical services on the island. I guess I felt responsible for that when I heard her talking because I was instrumental in coming out of private general practice from Kalgoorlie and being the first of the private practitioners to go over there. Prior to that, the practitioners working on the island had been Commonwealth medical officers. I guess the medical services at the time were not good. Their focus was initially on providing a very good acute medical service on the island.

The two current GMOs are Lloyd Fletcher and John Davie. John Davie worked with me in my second stint on the island, and he is very focused on health care as well as on acute medical services. His wife, Sally Davie, is a member of what they called the CHAT, which is the community awareness group over there, and she is also focused. So it is a very good pair to have over there. If you want to keep going on the ongoing requirement to acute medical care, they are the individuals to ask, because they are competent and a very good pair to work with on the island.

Their problem, of course, if they bring up new ultrasounds, new radiology techniques or new instruments, is the limitation of the individual who is using them. If they are not good, the use of those instruments will not be good or the use of those techniques will not be good. Therefore education—and I see telecommunications as a magnificent tool for education over there—is an absolutely integral part of the progress of medical services on Norfolk Island. Aeromedical evacuation is an essential part of any acute medical services, and I guess we have the RFDS over here at the present moment. I actually worked with the Royal Flying Doctor Service in Kalgoorlie and had a lot of work with it there and also on the island, and it is a marvellous out to have when you have a problem.

I have always believed that medical services ought to be kept to a simple level, that you do not go above a certain level of expertise. If you do, you get into strife; and if you get into strife, that is not acceptable to the patient, to the community or to the legal courts. You just should not extend yourself above that level. So aeromedical evacuation, from whatever source it comes, is absolutely integral to the island medical services. I have always felt that some ambulance insurance, however it applies—I am not an expert on financial affairs—has to be made available. It has to be made readily useful, readily acceptable and able to be readily committed to the people.

The hospital—I use the term ‘hospital’ loosely—has grown like Topsy on the island. There is no forward planning and it is inefficient. I think it takes up a great proportion of the medical budget on the island to run an inefficient establishment. But that is the way it went: it was what was available and has just stayed there. A case can be made for a new centre and for integrating acute services into that centre, together with extensions of the acute services—and Professor Gaston has intimated that. They would be pathology services, X-ray facilities, preadmission assessment clinics, day surgeries and also community health services, which are integral to the island. I see the acute services as part of a hospital structure. You can call them whatever you like, you can call them purpose directed establishments or whatever you like, but the acute services are a part of that.

Equally, you can make a case for not building a hospital. It works fairly well, but it takes more money. I would probably favour the building of a more integrated establishment at the

present moment. Certainly one of the problems you have is attracting medical staff at all levels to the island, and I think if you had something like that you would certainly attract people more easily.

One thing that has been brought up is the employment of a third medical officer. I think a more appropriate thing would be to put in nurse educators and nurse practitioners so that medical practitioners can have some relief from the work. You really do work very hard. I recall working there as a solo medical officer. In those days we actually trained the staff so that if I had to take an appendix out, for instance, I would introduce the anaesthetic and then go around and do the surgery, but I would have one of the nursing staff trained to maintain the anaesthetic.

Now that is not a good way to practise surgery. But the point I make is that we train nursing staff to actually undertake anaesthetic skills and maintain an anaesthetic, and they can do that just as well as the medic. As long as they have someone listening all the time it can be done, has been done, and needs to be done in the future. Certainly you will not concentrate on removing an appendix 100 per cent of the time if you are listening to the click of the monitors all the time so nursing staff can look after an anaesthetic.

Probably the College of General Practitioners have a remote area training service for registrars. I think it would be more pertinent for perhaps a senior registrar to go in there as a relieving medic for locum work or to relieve the medics over there. Two years is a long stint to be in a place like that on call all the time. The problem with that, of course, is that the College of General Practitioners require supervision of those registrars. I do not know the status as regards to fellowships of the two medics over there at the time, but that is a requirement and that could be a limitation of that utilisation of individuals.

Preventive care, of course, is an absolutely essential focus that should be applied on the island. It needs implementation and coordination of community groups. I can tell the story of how we put morbidity surveys into work in community health care. Remember the old medical sheets, a bit of four-by-eight cardboard, and you would write on it laboriously? After 18 months or two years I actually changed the health system on Norfolk Island to the college health system and in the process of changing from those four-by-eight sheets to the A4 size we transferred the data onto computer records which came then to the old Department of Health and we got a print-out on all the statistics of health over a two-year period and prior to that on the island, which was absolutely important. And that is part of the study I will be writing up.

It showed a high incidence of diarrhoea and enteric diseases on the island that was well outside the range of the whole of the Pacific and, as a result of that, we did an epidemiological survey. We isolated viral studies out of the ground water—which was done through Westmead. What was happening was that the septic systems were just contaminating the ground water and people were drinking their own sewage. As a result of that survey it was a very easy thing to say, ‘Let us put in a water supply system and a sewerage system.’ That is a simple application of morbidity and epidemiological surveys which can then direct the future of community needs and medical requirements on the island, and that make the spending of the medical dollar on Norfolk Island much more efficient and effective—certainly reducing hospital numbers.

I know you are going to ask me about Lyn Griffith and the study she is doing on the island. It should be mentioned because she is actually doing a genetic study and she is trying to sample blood from the whole of the island community. So far she has removed blood from 600 out of a population of 1,800—a third of the population. She is taking the blood and doing studies on disease factors, taking body measurements and blood pressure measurements and dietary components. And on the blood she is doing genetic studies to see what the cardiovascular risks are and she is doing biochemistry studies on the sera in the blood.

I had rather hoped that this would be used in combination as a paired study with blood that was taken off by Professor Clem Boughton of Prince of Wales Hospital in Sydney in about 1978-79. He was doing arbovirus studies—which is the spread of mosquito borne diseases. We actually took blood from 93 per cent of the island community at that stage—I hopefully had control of the blood and Clem was going to use that to do his arbovirus studies—and I was hoping that blood would be used in parallel with Lyn Griffith's study, so that you could actually get paired studies and you would see disease trends occurring on the island which, once again, are imperative to the changes.

I think a study like that needs to be taken up. It is a very directed study and it is absolutely imperative that it is taken up, perhaps by a community health officer. It would assist health promotion on the island. The problems occur with pharmaceuticals. They are too expensive; they need to be made more available and less costly. They are an integral part of Western medicine. Aged care was brought up. There are absolutely imperative changes that are occurring worldwide and in Australia. It is the same on Norfolk Island. The Department of Veterans' Affairs did a study over there which showed that 60 to 70 per cent of their veterans are over the age of 70. Ten per cent of the community, if not more, are now aged and planning needs to be done, probably with a simple study and extrapolation to future needs. The planning needs to be done for community care at home, which is the prime thing—perhaps for some sort of aged village complex which Professor Gaston mentioned. Certainly, where you need supervision, there should be supervised care units—semi-dependent and dependent. Those are absolutely essential things to be considered and are all aspects of preventative care. There could be an incorporation of the private and public sector, involving their work together, and perhaps combining it to provide health care, health education and recreation for the aged.

One of the changes which you may not be aware of is that the health care networks in Australia now have to work under the legal requirement of corporate governance—a terrible term. What corporate governance means is that if a health care network appoints a medical officer, he is legally responsible for the outcome of his work. But now so are the health care network and the chief executive officer. This has occurred in obstetric care, particularly in some of the southern parts of New South Wales, where litigation has been directed at not only the medic but also the health care network, which is a new consideration within the appointment of medical officers and health services to the island. It applies to tourists. Tourists are the ones who will provide the funds and judge the outcomes of medical care. Therefore, if they are dissatisfied with a service that does not meet the requirements of where they come from, there is likely to be a legal outcome from that. The full-time inhabitants of the island are much more tolerant towards that attitude. They are proud of their area. I think that is going to change. That is part of the evolution of their remoteness. But the Norfolk Island hospital board, as it exists at present, has to work within that framework. The concept of their role should be one of

innovation and perhaps leadership. That is all I want to say. That is perhaps a lengthy opening statement.

ACTING CHAIR (Ms Ellis)—Thank you very much, Dr Sexton. We will throw to questions. You have covered a broad range of subjects, some of which I know we will want to talk about. I will ask my colleague Mr Snowdon if he would like to lead off with any particular points.

Mr SNOWDON—Given your history on the island and your knowledge of contemporary health issues generally, how would you characterise the health service delivery model on Norfolk Island against what is currently being provided elsewhere in Australia?

Dr Sexton—What currently is on Norfolk Island?

Mr SNOWDON—Or as you know it on Norfolk Island.

Dr Sexton—As I know it on Norfolk Island, it is related entirely to acute services, which I do not believe is a good way to go. With the change in contemporary medicine, that has to extend into the realm of preventive care. Professor Gaston brought up the subject of primary care. I think that is absolutely essential. It is a worldwide trend. John Davie, who is one of the medical officers on the island, is very well aware of that. That is the reason why he went back to the island—to try to promote that attitude. He has done a lot of work on it. He is very keen on it. He is enthusiastic about it. He and Lloyd Fletcher should be given the opportunity to do that. Of course, their problem is funding.

I think that is an essential change. It incorporates perhaps all of the things that I have said. Some of the things like AMEs are in the acute care, but I do think that the preventive care is the important component, of which acute care, in a hospital structure—and you might not call it a hospital but you have to centralise services on Norfolk Island—

Mr SNOWDON—Sure. Would you then be sympathetic to the idea of multipurpose services of the type described by Professor Gaston?

Dr Sexton—I think so. Acute care is part of a broad medical umbrella. It is the way that it had to go. It is the way medical services have developed over many years, particularly in remote areas. I think you can describe Norfolk Island as basically a clearing station for acute care. You can do what you can on a simple base but the rest has to be cleared out. Preventive care has to start somewhere but it gradually picks up and reduces, hopefully, the acute care problems.

Mr SNOWDON—I am conscious of your disclaimer about you not being a financial manager, or whatever term you used. Do you have any observations to make about the ability of the Norfolk Island community to pay for its health service?

Dr Sexton—There are more millionaires on Norfolk Island per square centimetre than perhaps the rest of the world. There are a lot of generous donations made on the island. That is one area you can certainly look at. With regard to the average Norfolk Islander, I do not think they are well off. That is the sort of general population.

With regards to funding on the island, it is very dependent on funds from Australia. I can talk about that only in general terms, and that is what I have done. But I do think if you take aged care, being a very close community for families and a matriarchal society, if the money was needed, say, in a village for a member to come out of the home and needed some supervised care, I am quite certain money could be found. I think there are unplumbed depths of finance on Norfolk Island that none of us really know about.

Mr SNOWDON—We should look at that!

Dr Sexton—I guess that is eight or nine years of experience saying that. It is interesting to find where money comes from when it is really needed. I guess we are all responsible for that. We can all do that. Then again, it might come from banks or whatever.

Mr SNOWDON—Your comments about the community would infer that community based health care models should work very effectively on Norfolk Island.

Dr Sexton—Yes, I think community health care where you have a mixture, an amalgam, between private and public funding will work. I am quite certain it will because of the bias of the island families. They are very family oriented. I am quite certain it is well worth while trying. For whatever reasons at the time, we had to incorporate the care of the aged into the hospital structure. So we have this false number of inpatients that are to do with elderly people being inpatients in the hospital. That is a terrible thing to do. But it was force of circumstance at the time. I still get a bit irritated when I see that it has not changed. Nothing has been done to incorporate change for preventive medicine on the island. I find that not logical and not acceptable.

Mr SNOWDON—I guess that is what I was getting at when I asked my initial question about how you see the health service and health service delivery on Norfolk Island against contemporary trends.

Dr Sexton—It just has not progressed. I am at a bit of a loss as to why that has occurred. One of the problems—not that I am being critical of it—has been the appointment of medics. You have only got medics there for a two-year term. You do not in any way attract some individual there for the long term or anyone who is going to install contemporary trends or ideas and maintain them. The hospital board should—that is a role of the hospital board. I think we have always had trouble attracting onto the hospital board on Norfolk enough expertise and interest to really do it. It has tended to be left to the medic to do it, and that is not necessarily a good thing.

A hospital board now has to provide leadership, innovation and a means of doing it. If you can get that you can go a long way as a medical officer to do it. You can appoint people like health educators and nursing assistants to do that. The Flying Doctor Service runs with nurse practitioners all the time. I remember in Leonora and Laverton we used to run a hospital on that basis and it worked extremely well. You knew you had a very competent person there; you knew you had to go and fly the plane if she said, ‘Come.’

Mr SNOWDON—Thank you.

Mr NEHL—First, let me apologise for being late, and to the committee as well. I was very interested in what you had to—

Mr SNOWDON—Caravans?

Mr NEHL—No, the Coffs Harbour Primary School suddenly appeared. I was very interested in what you had to say about the nurses on Norfolk. I think it is fair to say for the whole committee that we were very impressed with the nurses we met at the hospital. We spoke to them and learnt what they were doing. Just as an aside, it is better to have one of those nurses on Norfolk than the cook down at Casey or Mawson, which is the other option. Is there anything that should be done to provide more specific training and better qualifications for the nurses to enable them to back up the doctors even more?

Dr Sexton—Yes. I think you saw it today and that is an excellent method. I do not know what the problems are in the carriers providing telecommunications services or teleservices to the island, but that is absolutely a great thing to put into place over there. It is a wonderful way to start it because, as you say, you have to crawl before you walk. I think that is a marvellous way of putting in nursing education.

What we tried to do on the island when I was there was to provide funds for one of the nurses to go off every year and do a training course in some area of her choice and her expertise and then she had to put it in place on the island. That principle should still apply on the island, but that is a function of the hospital board. The hospital board should be innovative, and the funding for that perhaps comes via the Norfolk Island administration. That is the problem of getting the expertise and the intellectual exercise to do that. Any small community has that problem and you have to attract people to put it into place. It is basically education to help them with their particular interest. I cannot think of any other way, other than providing new areas to work in. If you provide a facility for, say, community health promotion and community education in, say, mental health or sexually transmitted diseases or whatever, there would be one of the nurses over there that could run that.

Mr NEHL—I was also interested to hear what you were saying about aged care and the fact that we have those people living in the hospital as internal patients. It is not very different to what it is in most of Australia. In fact, in my electorate every hospital has high band aged care facilities, nursing home patients. That is certainly the case in Coffs Harbour and Maxwell and wherever you would like to go. Warren Snowdon mentioned a multipurpose centre. In effect, it is already a multipurpose centre. One of the first ones to be established in Australia was in my electorate at Dorrigo, where we had a small hospital that has been transformed. It has hostel capacity and a nursing home plus some simple hospital facilities as well but ships people off to Coffs Harbour for something that is very desperate. I just return to that question that Warren asked: do you think if sufficient money could be made available for the hospital to regenerate, rebuild and get a modern facility—in other words, put a fire stack on the old one and start from scratch—that multipurpose model would be a satisfactory way of going for Norfolk?

Dr Sexton—Can you define a multipurpose model for me before I answer that?

Mr NEHL—I can do it from my personal knowledge.

Dr Sexton—I have a concept of it but I do not know whether it is the same as what we are talking about.

Mr NEHL—The model that I have in my mind is the one at Dorrigo. You had an old wooden hospital that had been completely refurbished. Added to it has been an area for nursing home beds and six or eight units of hostel type accommodation, plus you still have a hospital nursing corps which will do simple things. Anything that is really acute is put on the ambulance and goes down to Coffs Harbour. An addition that may not be appropriate for Norfolk Island is an area within the hospital that acts as a link for all state government services and Centrelink and other federal government services. So it is a providing not just the accommodation, aged care accommodation and primary basic health care but also a data source and a link to other services.

Dr Sexton—Does your preventive care come out of that hospital as well, like a community health centre?

Mr NEHL—No, I do not think so. With the area health service for the mid-north coast, I don't know. I have to be very careful. I should know.

Dr Sexton—On Norfolk you have to have just that sort of facility. That is the case against knocking the hospital down and building a new one. There is a good case for not knocking that hospital down and just remodifying what is there. It can be done and it works pretty well. It depends on the economic priorities of where you are going to put the dollars. The way the aged are looked after in the hospital at the present moment when it comes to supervised care—

Mr NEHL—Loving care.

Dr Sexton—is just unacceptable. I would not want any of my aged parents under those conditions where they have no privacy and none of their personal things. It is quite unacceptable and that has to change. You can build a unit onto the hospital where it is separated from the running of the acute services of the hospital or you can build a separate unit somewhere that is in close proximity, so you that you have the streams of an aged care village for the aged, and can provide acute health services, recreation facilities and education facilities in that centre. Then that progresses on to dependent, semi-dependent living sources. Whatever way you do it, what the model should be is dependent on how much money you are going to spend.

The Mawson units at the present moment are a series of about four or five units which were donated by a family who used to own one of the hotels on Norfolk Island. That was built as just semi-dependent units. It was meant to progress on to where we could have nurses to go down there and assess that all the time. It just has not done that. I do not think it is good. It has not changed.

That is the emphasis of what happens on Norfolk Island. There is no change there, and I think that has to be addressed because change is absolutely essential to the island. It is an Australian responsibility, I think. I might be putting my foot into a can of worms here, but Norfolk is basically the responsibility of the Australian government, no matter what the islanders say. They hold forth about their Pitcairn base and their Pitcairn families, but over the years, with the advent of changing communications, their bias towards Pitcairn and Norfolk Islanders has

changed. They are part of a cosmopolitan structure of Australia, whether they like it or not. I think their culture is a bit different, and certainly for tourism it has to be different for them to maintain a tourist destination. But, basically, they are Australians and I think Australia does have a responsibility. I do not want to go into the government structure on Norfolk Island, which is perhaps a top-heavy subject on its own.

Mr NEHL—I think that most of us on the committee would agree that they are Australians, and some of us, at least, would suggest that they should pay the same taxation as Australians. However, that is a different issue.

Dr Sexton—They would fire a few cannons across your bow there, I think. If they want subsidised medical services, it is quite obvious that they have to pay some form of taxation. It cannot be handed to them on a plate. They have to pay for that, and whether it is a part subsidy or whatever, I think the equation has to be decided on what they will do. But if they want adequate medical services in which they want to participate, they cannot expect to have bucket loads of dollars given to them, donated to them, from Australia without their meeting some of their own responsibilities in their consumption of that.

Mr NEHL—There is no argument from me on that. I have another question—and it is because of a particular interest I have in iodine deficiency disorders. I think it is probably most unlikely, but are there any incidences of IDD on Norfolk?

Dr Sexton—No, but one of the interesting things that Lyn Griffith is doing is thyroid function tests on all the island communities. We had very few cases of thyroid problems there. I think there are no problems there with it. The incidence of thyroid disease was exactly the same as probably the rest of Australia. But it is interesting; amongst the biochemistry surveillance that Lyn Griffith is doing is thyroid function. She is also doing hormonal studies and looking at cholesterol, triglycerides and blood sugar levels. Blood sugar levels are more pertinent. Insulin levels are more pertinent to the island than, perhaps, iodine problems.

Mr NEHL—As I said, I have a particular interest in that; that is why I asked the question. I think you made some reference to generations of medical officers there feeling isolated and out of touch and lacking peer communication and education. Can you comment on that?

Dr Sexton—Yes, I felt that over on the island because I was there for, perhaps, a two-year stint—the first time, for three years by myself. I think that when you are in a remote area by yourself, no matter what Professor Gaston says it is a remote place and it is made even more so by intellectual isolation when you see the water all around the place. So, as well as being isolated, you have an intellectual concept of isolation, and that in itself provides you with a feeling of isolation, from both education and keeping up with trends. That was one of the reasons why we managed to get a good visiting list of specialists coming to the island. You would buttonhole them all the time and utilise their expertise to educate you. I would make certain they all spoke to and lectured the staff on different subjects at the time. I think that was an important part of that. As I said before, this is where television and its facilities are great in providing education for that.

Senator Lightfoot talked about the right of private practice, and whether that is a model on the island. One thing I would like to say is that the visiting specialists all come over there with the right of private practice. That is the way they work on the island. Usually the Rotary Club or the Lions Club provide them with accommodation; they provide them with airfares. But all the people they see they charge the right of private practice. It certainly was in my time and I do not see that it has changed. They do have the right of private practice on the island. The problem is, if you have got Norfolk Islanders there with no Medicare, they do not get any subsidisation for that. If you do a hysterectomy or something like that you then have a big charge to the individual.

Mr NEHL—The question of remote and isolated medicine is one that is very much to the forefront for Australians because of not just Norfolk Island but other places as well. I was interested—and this is just as an aside—late last year I led a parliamentary delegation to Tonga and the Cook Islands. In the process we visited the island of Aitutaki where there is a hospital and two doctors—husband and wife, Burmese, been in the Cooks for 15 years. They had been on Aitutaki about eight years or something like that. When they went there the only X-ray was one left over from the Americans in World War II. A visiting Austrian doctor arranged for them to buy a second-hand but fairly new machine, which Air New Zealand flew out for them, but unfortunately they have not been able to use it because it has blown a fuse, or a little thing has gone, and there is just no technical back-up to do it. To carry it to absurdity, they have not been able to use their automatic washing machine for over a year because it needs some simple service. The reason I mentioned this is that, okay, Norfolk is isolated, but nothing like that. What about the technical back-up for medical services?

Dr Sexton—It is very surprising the technical ability of individuals present on the island. There is an amazing resource there. All you would have to do is find it and you will get it. Time and time again one comes to specialised machinery. We had the same problem when I went first to Norfolk Island. We had a machine there that was out of the First World War. When you X-rayed someone you irradiated the whole island. It was an amazing machine. We could not find the expertise on the island for us to get and install a new machine. We had to bring the people that we bought it from over with the machine. People in Australia like to do that because it is a remote area. It is a great area to live in. By and large, there is quite surprising expertise on the island. Also, the other thing you get is visiting tourists. When I was on the island, Customs would automatically let you know that there was another medic, a surgeon, an obstetrician or engineers coming. They would let me know and, if we had a problem on the island, we would utilise that resource.

Mr NEHL—It is a good intelligence service.

Dr Sexton—It is good commonsense. It is equivalent to what should happen in any remote area in Australia. Norfolk Island is no different from those remote areas in Australia, and you have got models all over Australia that you can apply to Norfolk Island.

Senator WATSON—Before I ask my questions I would like to indicate that they reflect in no way the dedication of anybody associated with the care of people on Norfolk Island. I would like to state that because I think there is a tremendous commitment by the existing people. But I see a role for this committee to speed up change in terms of aged care, preventative care,

evacuation and specialist services including telemedicine. We are subsidising medical care and we will continue that. You are concerned at the slowness of change. Do you think that bringing in some outside influence—for example, having a representative on the hospital board or some other area coming from mainland Australia—would speed up the concept of change; say, have an outside chair or an outside specialist who could influence the speed of change in these five areas that I have mentioned?

Dr Sexton—Lord Howe Island has an outside chairman who comes to the island, and there is a comparison there. I think the Norfolk Island community, and in particular the Norfolk Island Hospital board, would view that as criticism of themselves. They would also view it as not enough competence present on the island because they are a bit insular about that, but there is no doubt that there would be a lot of merit in that; it is a question of acceptance. How would you anticipate that he or she visited? Would you anticipate someone like Professor Gaston as an adviser to the hospital board, or as a—

Senator WATSON—You would actually have to go across there, say four times a year or however often they meet, and actually sit with the representatives during their committee meetings.

Dr Sexton—Yes, you would have to make certain that advice and information given was implemented because they are a fairly critical bunch over there and they are liable to do their own thing. But I think there is a lot of merit in that.

Senator WATSON—In terms of corporate governance and follow up and communications—

Dr Sexton—Corporate governance is the big thing of change in the future. But there is a great deal of merit in that and something like that should be implemented, whether it is at the hospital board level or whatever. The level would be very pertinent as to whether it works.

Senator WATSON—It comes back to this basic unsatisfactory system of funding health care in terms of preventive medicine. You mentioned the unplumbed depths of financial funding. That is not a very satisfactory method for Joe Blow who might not be a Pitcairn or else be someone who has only recently arrived on the Island and who has got to be airlifted out. How do you see a more viable system of funding, rather than the piecemeal approach that we are adopting at the present time? Have you got a plan for funding this? How are we going to finance this?

Dr Sexton—Senator Watson, I have always been on the receiving end of funding, I have never been in the area of determining funding and I am not an expert at it, but I do know that if there was the need on Norfolk Island, a way would be found. We had an individual over there who was levering logs up one day, and they have a thing called a cant hook. Do you know what a cant hook is? It is a thing with a big V on the end of it and you get underneath a log and you put the hook underneath and then you pull it back. The log rolled back on this hook and the whole thing hit this individual in the abdomen and he had a perforated abdomen. I had to judge that we were not able to deal with that case on the island at the time and so he was flown off.

He was flown off on the Norfolk Island Airline plane. That plane was chartered and paid for by one of the poorest families on the island. I do not know where those funds came from but that happens time and time again. I am quite certain that if you were over there and the same thing happened to you, your family would probably be able to find the resources to do that for you, but it depends on how much they valued you.

Senator WATSON—But, in terms of equity, is that a very viable and sensible way of funding a health care system in this 20th century compared with the rest of Australia? It is part of Australia.

Dr Sexton—I am not saying it as a form of funding a health care system. I am saying it as a means that the islanders have to be able to facilitate care that may be necessary to a member of their family. I would hope that one of the outcomes of this inquiry will be perhaps that that system is somehow going to be subsidised from sources other than from that source, and that must be one of the outcomes of this. I do not think it is a form of funding for a health care system.

Senator WATSON—We hear of the cases where finance is arranged to get people off the island, but we also met people who in their latter years voluntarily want to move off the island because of their fear of becoming ill and not being able to meet these sorts of costs. How many cases are you aware of where money just was not available to take people off the island and they just had to live with their problems or die with their problems?

Dr Sexton—During my time there, I cannot think of one case on the island in which there was an essential requirement when the requirement was not met from some source. Medical costs have changed since then, but at that stage there was huge community involvement. The money might have come from a service club; it might have come from other members of the family, but it would come out of the community somewhere to meet that requirement.

Senator WATSON—Telemedicine: I do not think that is practised in the hospital, is it?

Dr Sexton—No, I am not aware that it is.

Senator WATSON—Isn't that strange given its isolation?

Dr Sexton—Yes. I think it is a huge advance that should be incorporated into the Norfolk Island performer of medical—

Senator WATSON—Some sort of a priority. Could you identify the priority areas in terms of health care. Obviously, telemedicine is going to be rated fairly high. Could you prioritise that list for us?

Dr Sexton—I think an upgrading of acute services is well down the list because there are quite adequate services there. There will be things that need to change, like general ultrasound services and perhaps pathology services, and attracting individuals to it. High priorities are perhaps an integrated medical service in the hospital so that you do not centralise everything but

it is all under the same umbrella. I think telemedicine is high on the list. I think aged care is a most important requirement.

Probably my highest priority is to put in place preventive medicine. The preventive medicine area that I would look at is to put in morbidity surveys and health surveys so that you can isolate what the requirements are and then adapt future medical needs to the cold, hard facts of those surveys. You then apply from that community education, health educators and nursing. Those are my priorities.

I think something has to be done with aeromedical evacuations. When you have a problem on your hands and you have got an unconscious patient, most of the aeromedical evacuations relate to trauma cases on the island. They do not have seat belts on the island. There are 2.6 cars per family on the island. Most aeromedical evacuation problems we had were trauma cases. When you need it, your resources on the island just cannot cope with it, and you have to be able to get hold of some form of transport for the acutely ill patient. If you have got a closed head injury and an unconscious patient who is on a respirator, that person cannot go out on a commercial flight. We always used the RAAF Hercules, and it was a great moment when you heard in the distance the Hercules coming in with a whole team. I think that is an essential backup both to the government medical officers and also to the whole community, be they indigenous people or tourists.

The tourists are the ones who require the aeromedical evacuations. When something is wrong and they have got a trauma, they want the outcome on Norfolk Island to be exactly the same as it is in greater Sydney. That requires a readily available service that you can ring up and it will be there in 2½ hours. You can stabilise the individual and if there is surgery to be done, they might bring an anaesthetist with them or whatever, and then they go back. That is a prime requirement.

Senator WATSON—During your presentation, I am not sure whether you mentioned it but reference was made to a top-heavy administration on the island. Does that apply to health services or is it just general administration? Would you like to comment on it?

Dr Sexton—I do not know that I want to go further into that, Senator Watson. I did not mention top-heavy administration. I mentioned a government that was perhaps inappropriate for the island.

Senator WATSON—How does that manifest itself in a less than adequate health care system?

Dr Sexton—In my time there we had an administrator. It was a bit like the commissioner system in Victoria where the councils were removed and commissioners were put in place so that you were running a council area with three commissioners. Three commissioners are much easier to deal with than perhaps a composite of 10 individuals on a council. I think that is the general premise that you can put towards the application of the government of Norfolk Island.

CHAIRMAN—Are you aware of the reasons pharmaceuticals are more expensive on the island? That being a fact, could you suggest any ways that they may be brought down to comparable prices on the mainland?

Dr Sexton—I think the costs of pharmaceuticals on the island are related to the way they are purchased, so the purchase costs are high. There is no subsidisation for pharmaceuticals on the island. The way we used to get over that when I was on the island was if I prescribed to you penicillin, for instance, I would prescribe a pack of 25 penicillin capsules, which you would then take four times a day for six days. If I felt that the disease you had on Norfolk Island only needed the use of five or four days of penicillin, I would prescribe 18 or 16 tablets, which brought the cost down a lot. That is the extent you have got to go to to at least make certain that the individuals take pharmaceuticals.

CHAIRMAN—So you are saying it is a natural increase in price given the tyranny of distance from the mainland and it is not exploitation by wholesalers or dealers or pharmaceutical dispensers?

Dr Sexton—It could be that as well, but I am not aware of whether that is the case.

Mr NEHL—Could it be the absence of the Pharmaceutical Benefits Scheme is the main cause?

Dr Sexton—There are no pharmaceutical benefit schemes over there at all. I think that is the main problem, that there is no subsidisation of pharmaceuticals on the island. Time and time again, you might get someone with a sexually transmitted disease that needs Vibramycin or something and you prescribe it, they will not get it and they continue to have intercourse around the community, and hence you have got a community problem on your hands simply because you have not treated—you think you have, but you have not because the person cannot afford it. That is not a good outcome.

CHAIRMAN—In terms of rectifying that problem that is not existent to the same degree in Australia, at least on a per capita basis, would you recommend that that anomaly should have some urgency?

Dr Sexton—Yes.

CHAIRMAN—On behalf of the committee and the secretariat, thank you very much for your appearance before the committee today. If there are any matters on which we might need additional information, the secretary will write to you.

Dr Sexton—Thank you.

[11.03 a.m.]

THOMSON, Mr Clyde Spence, Executive Director and Company Secretary, Southeastern Section, Royal Flying Doctor Service of Australia

SANDERSON, Dr Russell Bruce, Chief Medical Officer, Royal Flying Doctor Service of Australia

CHAIRMAN—Welcome. Although the committee does not require witnesses to give evidence under oath, you should understand that these hearings are legal proceedings of parliament and warrant the same respect as proceedings of parliament itself. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Are there any corrections or amendments you would like to make to your submission?

Mr Thomson—No.

CHAIRMAN—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 request. Before we ask you some questions, do you wish to make an opening statement?

Mr Thomson—If it pleases the committee, I would like to give you an overview, Dr Sanderson can follow up and then we could perhaps answer some your questions.

CHAIRMAN—Please proceed.

Mr Thomson—I would like to give you a bit of an overview of how the Flying Doctor Service operates in Australia. It now operates through four operational sections: one in Western Australia; one in the central section, which is South Australia and the bottom end of the Northern Territory; Queensland; and the south-east section—which we are involved in—which is New South Wales, Victoria and Tasmania. We also contract some of our operations. For instance, in South Australia, we contract to the Moomba oilfields to provide on-ground medical services and, in Victoria and Tasmania, the operations we have there are a contract with government. So we do contract out services.

In the past the RFDS used to be quite a focused medical service. It has now moved from working in isolation, as we used to because there were no other medical services, to a primary health model where we work in an integrated way with other health service providers but while we remain an independent identity. We have moved now to develop formal links with the University of Sydney—through rural training colleges and through Aboriginal health services which we provide medical services to on a contracted basis—with the Commonwealth government and with the state governments in those places. So we are an integrated provider in these areas. One of the things that we utilise in there is telemedicine. I was very pleased to see that mentioned today as being a useful tool for providing services in isolation.

When it comes to Norfolk Island, I think you have to remember that we are talking from an imperfect basis of knowledge on Norfolk Island. I went there some years ago. It does fit some of the models that we deal with on mainland Australia where you have isolated communities. They are surrounded by land; Norfolk Island is surrounded by water. We see that we could provide if necessary some services that would enable those services to be developed on Norfolk Island. We can be an integrated provider in there, providing on-ground services and evacuation services that are required. So we would be prepared to answer questions on those matters.

One of the issues is that we also use telemedicine. Looking at what we heard today I would have to concur with some of the evidence today on the basis that the primary health model is the most economic model to use. If you go to the curative health model, which is where people present into a hospital for access to cure, then that is more expensive. Also, the least effective model is a model which relies totally on evacuation. That is a very expensive use of resources and really should be used as a last resort. We believe that the linkages with universities, colleges and formal providers of health services developing a primary health care model is a very efficient model to use, but it also embodies the use of emergency medicine.

Dr Sanderson—I would just like to talk about the model that we use in Broken Hill and the services that we were able to deliver from Broken Hill. We basically have two arms: one is a primary health care arm which delivers general practice services, early childhood and women's health services and dental services, and then we have an aeromedical service which does interhospital transfers and primary evacuations. The thing that links those two together is what we call remote consultations. Remote consultations, which we have been doing for 70 years on the radio to begin with, and now on telephone and with video conferencing and email, is I suppose what telehealth is about. We have got a lot of expertise in using the telephone to deliver health care to isolated communities and now we are using telehealth video conferencing. We have been using acute consultations in Wilcannia for some time now as part of the New South Wales outback telehealth project. We are also trialing emailing digital pictures from Moomba and are finding that quite a successful way of transmitting images. That is just a quick overview of the sorts of things that we do from Broken Hill.

Senator CROSSIN—Don't you have an aircraft that will take you across to Norfolk Island and back without refuelling?

Mr Thomson—We can do that from Brisbane but we would prefer to charter a light jet from Sydney because most of our aircraft are committed and episodes of evacuations from Norfolk Island are occasional. It is a better response. For instance, the Flying Doctor Service of Western Australia usually charters to evacuate from Christmas Island because that range requires what I would call more expensive hardware than we normally operate.

Senator CROSSIN—The Indian Ocean's territory health services have said in one of their submissions to us that they are often not able to secure aircraft. I am assuming that is in relation to the Royal Flying Doctor Service and they have to wait for a commercial flight or to secure a craft through Jakarta or Singapore. Why are they not able to secure a craft to Christmas or Cocos Islands and would that be a problem if you have a service going out to Norfolk Island?

Mr Thomson—They have not formalised the arrangements between themselves and their charter organisation. We would have a formal arrangement where we would be able to provide a response within three hours.

Senator CROSSIN—Could you explain to me how it works in terms of how you end up getting paid for the service you provide?

Mr Thomson—The one we provide now mainly in Australia?

Senator CROSSIN—Not so much that. If you took on a contract to go across to Norfolk Island, would you just expand your services?

Mr Thomson—We would not just expand. We would expect to be paid for it.

Senator CROSSIN—Just as you have contracted out to the government in Victoria, you would contract to the Commonwealth?

Mr Thomson—That is right. We have a contract with the Commonwealth now to provide our services and we could see this being an appendage to that contract. That contract is specific in the range, quality and price of services.

Senator CROSSIN—You have done medivacs from Norfolk Island in the past?

Mr Thomson—No, we have not.

Senator CROSSIN—Not at all?

Mr Thomson—Not at all. We have never been called on to do them.

Senator CROSSIN—Is that just a historical use of the Hercules?

Mr Thomson—I think it is a historical thing. If you go back to the time when Dr Sexton was first there, Norfolk Island airlines always had a KingAir on the ground on Norfolk Island and they used to use that with the staff at Norfolk Island to evacuate people to Brisbane. The RAAF became involved and it was easier to make a phone call to the RAAF rather than look around and see what alternatives were available.

Mr NEHL—You cannot do anything without the money. I think from your submission the current non-capital operational funding from the Commonwealth is $16 million?

Mr Thomson—Yes.

Mr NEHL—You need $20 million for operational?

Mr Thomson—That is right.

Mr NEHL—I have got the feeling at the back of my mind that you used to get $20 million from the Commonwealth in operational funding but about five or six years ago it was reduced in the budget from $20 million to $16 million? Is that correct?

Mr Thomson—The Commonwealth withdrew from capital and put the capital funding into the operational side of it on the basis that the Commonwealth would give us half our operating costs and the state would give us the other half and then we would find our own capital. That has been half successful because the Commonwealth has in part met their obligations but the state has said that they were not party to the agreement and have not been asked. We are negotiating our way through that at the moment.

Mr NEHL—Why should you be different from anybody else?

Mr Thomson—That is right. There is a degree of politics in it.

Mr NEHL—There always is.

Mr Thomson—I am just stating the obvious.

Mr NEHL—Do you need more money from the Commonwealth? I know the answer is yes but give me a sensible answer.

Mr Thomson—We are negotiating with the Commonwealth to receive more money but in a specific sense for specialist outreach services where the money was identified and also to maintain a high level of GP services to our remote towns. We are doing that but it is not an ambit claim, 'Give us more money.' We are identifying that money for services. That is a proper way to deal with it. However, I might say it is with little success at the moment but we hope to have future success.

Mr NEHL—I certainly hope you do too because, along with the rest of Australia, I have enormous admiration for the work you do—even on a personal basis, because you took my wife out of Normanton to Mount Isa once when she was very ill indeed. We thank you.

Mr Thomson—Thank you.

Mr NEHL—Just following on from Senator Crossin's questioning, you have not done medivacs to Norfolk but you have done them to Christmas?

Mr Thomson—Yes, and across Western Australia.

Mr NEHL—And you would have to charter an aircraft to do that?

Mr Thomson—Yes. They can do it in their present aeroplane, but it means that they go up the coast and then across. It is far easier to take the extra cost, get an aeroplane that can do that with reserves, which is a light jet, and make sure that you can have an appropriate response time.

Mr NEHL—And the additional cost of chartering to do that compared with your normal per kilometre charge?

Mr Thomson—It is about double, because you are paying for the capital on their aircraft as well as yours.

Mr NEHL—If the costs were not the factor and if you had your own aircraft or you could easily charter one to handle medivacs from Norfolk, are you aware of any problems that would stand in the way of doing it?

Mr Thomson—No.

Mr NEHL—Would you be happy to do that?

Mr Thomson—Yes. I think that is an extension of our service, which can be reliable, and we can do that. What works best is that we have a formal arrangement. What does not work best—and where the Western Australian thing falls between the planks—is when there is no formal arrangement about response times, level of service and price. Every one is negotiated as a new occasion, whereas what we are saying is that if you come to us and say, 'We would like you to do approximately 16 evacuations to Norfolk Island per year, we would like them done to this standard and this is the response,' we could respond to that. We would meet it, and then we would run a quality assurance program over that to make sure that we were responding within the parameters that we said we would. You have a range of expertise required. You can arrange for a neonatal emergency service down to emergency medicine, and neurologists and so forth can go in that service.

We do provide an outreach service out of Sydney which goes to Coffs Harbour with specialists. We are finding more and more that, as the specialists decrease in rural Australia, we are having to support the general practitioners in those areas with fly-in services. That is part of an extension that we could also give to Norfolk Island. Videoconferencing can quite often break those distances down considerably.

Mr NEHL—I am aware of that because of my interest in Antarctica. Having been to Antarctica a couple of times, I am aware of what is happening there in remote medicine and in the work they are doing for NASA as well.

Mr Thomson—NASA is well ahead on this.

Mr NEHL—How well equipped are your aircraft? Are they par for the course for medical evacuations or are they better than the average? How do you compare them with any other service that might be available from Australia in terms of the outfit and the capacity?

Mr Thomson—In talking about Norfolk Island, we would be chartering that aircraft. We would then be taking on board equipment which would be exactly the same as the equipment that we have in our own aircraft. We are an accredited organisation and aircraft are appropriately equipped.

Mr NEHL—Can you perform surgery in the air if need be? I know you would not want to. I would not want to be the patient either.

Dr Sanderson—It is not the basis of a medical retrieval to anticipate that you would have to do surgery in the air. The idea of a medical retrieval is to have the patient stable before you leave.

Mr Thomson—There have been babies delivered on the aircraft. That is always an embarrassing situation, because the child should be delivered before you leave or when you get there. But people have coped.

Mr NEHL—It happens in taxis too, doesn't it?

Mr Thomson—Yes.

Mr NEHL—Thank you very much.

CHAIRMAN—Are you aware of any reasons why the RFDS has not flown to Norfolk—other than not being called, of course?

Mr Thomson—Not to my knowledge, no.

CHAIRMAN—Why do you think that the RFDS has not been used, given the distances it flies in Australia—and I cite, in Western Australia, Kalumburu, Wyndham, Kununurra and down to Perth, which is probably greater than the distance from Brisbane to Norfolk or from Sydney to Norfolk. Why haven't the RFDS been called?

Mr Thomson—I think that the arrangements they had with the Air Force worked pretty well for the people on Norfolk and there was no need, because there was no cost impost to them, to change them.

CHAIRMAN—Is there a culture of relying on the RAAF; is that the main reason why the RFDS has not been called?

Mr Thomson—I could not answer that question.

CHAIRMAN—Is there any reason why the RFDS would not fly to Norfolk? Is there some apprehension about pilots flying over a large distance of water?

Mr Thomson—No. If it was an ad hoc arrangement we would probably then be reluctant because you have one arrangement coming in and you do not know whether you are catering for it or not. You suddenly get something that is outside your normal scope of operations. But we would have no difficulty at all with a formal arrangement.

CHAIRMAN—Do you have a suitable aircraft available that could fly to Norfolk?

Mr Thomson—We have access to a suitable aircraft. It can fly to Norfolk Island in two hours and 40 minutes.

CHAIRMAN—Is that a prop jet?

Mr Thomson—It is a jet. It is what is usually called a 'business jet'.

CHAIRMAN—Does that have flying hours that would allow you to do, say, one trip a fortnight, one trip a week or one trip a month?

Mr Thomson—Yes. There are two of them available.

CHAIRMAN—So there is no need to replace an aircraft with one suitable to go to Norfolk Island?

Mr Thomson—No.

CHAIRMAN—Health costs are the responsibility of the Norfolk Island government and residents do not pay Commonwealth taxes. Given that the RFDS is locally funded, do you see that as an impediment to the RFDS flying to Norfolk, remembering that recouping those costs may be difficult?

Mr Thomson—It would have to depend on what cost arrangements we were in. We would be reluctant to get into an arrangement that put us in the position of having to charge the Norfolk Island resident before we carried out the evacuation. We would like to see some formal arrangement made for the cost of those flights or the cost of any on ground services we provided in Norfolk.

CHAIRMAN—You fly to remote areas in Australia, including to Balgo, the Warburton Ranges, Jamison, Wingelinna, Warracunna, Docker River, Hermannsburg and so on. Are those costs recouped?

Mr Thomson—They are recouped. The cost for primary evacuations where it is not referred by a hospital are paid for by the Commonwealth, and the cost for transfers from a recognised hospital are then paid for by the state.

CHAIRMAN—What if you fly out of Alice to Warracunna just over the border in Western Australia? Who pays for those costs of the aircraft, for instance?

Mr Thomson—There is an ongoing argument there but normally we do it on a knock for knock basis. Quite often some of the people from Wingelinna go then to Kalgoorlie and then the two level out.

CHAIRMAN—So the RFDS is quite happy that it is a contra arrangement that just happens to balance out?

Mr Thomson—Yes.

CHAIRMAN—Is that just the aircraft costs or is that the medical costs?

Mr Thomson—That is the full cost.

CHAIRMAN—What about Groote Eylandt where you are doing something similar? Who pays for medivacs from Groote Eylandt?

Mr Thomson—They are arrangements half between the state government in Queensland and half between the Commonwealth.

CHAIRMAN—Why aren't the same arrangements made with Norfolk?

Mr Thomson—I do not think anyone has applied themselves to the problem.

CHAIRMAN—Do you see any differentiation between an evacuation from Norfolk, using one of your aircraft—and not the RAAF on this occasion—and the evacuation from Groote Eylandt to Brisbane or Darwin?

Mr Thomson—No. I do not see any difference from us carrying out an evacuation from Tasmania back to Melbourne. We do that all the time.

Senator CROSSIN—Is the evacuation from Groote Eylandt met by territory health services?

Mr Thomson—Off the top end there that is the Northern Territory aeromedical service.

CHAIRMAN—What about liaison with the RAAF? Is the RFDS, as a matter of course, in contact with the RAAF in case they are duplicating a flight with respect to evacuations?

Mr Thomson—Yes, if we had arrangements—for instance, if the RAAF promise us a four-hour response in a major disaster for people in places like Moomba, where it is a critical location with gas fields. In one case they did an evacuation for us from Broken Hill with a condition that needed the RAAF, so we have an arrangement there with them.

CHAIRMAN—Given the cost of flying aircraft, particularly expensive jet aircraft, what is the closest appropriate point between mainland and Norfolk Island?

Mr Thomson—There is very little difference between accessing Norfolk Island from Sydney or Brisbane.

CHAIRMAN—What about landing charges and other peripheral costs? What is the most appropriate economic point for a base to service Norfolk Island?

Mr Thomson—In the majority of cases it may depend on where the patient is resident. For instance, if that person had a Brisbane address, it would be appropriate to take that person to Brisbane.

CHAIRMAN—That is a matter of convenience though, isn't it?

Mr Thomson—Yes, that is a matter of convenience.

CHAIRMAN—What about the economic cost of it?

Mr Thomson—I think it is slightly cheaper to go from Brisbane rather than from Sydney.

CHAIRMAN—And there is no other retrograde reason why a base should not be established in Brisbane then?

Mr Thomson—No. Our preference would be for Sydney.

Ms ELLIS—Can I just ask quickly why you said your preference was Sydney?

Mr Thomson—We have got a main operational base there. We can certainly do it out of Brisbane, it is just there seems to be more traffic between Sydney and Norfolk than Brisbane and Norfolk.

Ms ELLIS—So no other reason?

Mr Thomson—No.

CHAIRMAN—Dr Bruce Anderson and Captain Clyde Thomson, I thank you both for your attendance here. If there are any matters on which we need additional information, the secretary will write to you. You will be sent a copy of the transcript of your evidence to which you can make some editorial comment. Once again, on behalf of the committee and the secretariat, I thank you.

[11.27 a.m.]

BADHAM, Mr Ian, Executive Director, NRMA CareFlight

CARRUTHERS, Ms Catherine, Business Development Manager, NRMA CareFlight

CHAIRMAN—Is it the wish of the committee that submission No. 36 be accepted? There being no objection, it is so ordered. Although the committee does not require witnesses to give evidence under oath, you should understand that these hearings are legal proceedings of parliament and warrant the same respect as proceedings of the parliament itself. Giving false or misleading evidence is a serious matter and may be regarded as contempt of parliament. Are there any corrections or amendments you would like to make to your submission?

Mr Badham—No.

CHAIRMAN—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 request. Before I ask you some questions, do you wish to make an opening statement and perhaps tell us something of your organisation?

Mr Badham—We would like to do that, if we could, Mr Chairman.

CHAIRMAN—Please proceed.

Mr Badham—The focus that CareFlight puts before you is on the provision of acute care and medical services for those very small and infrequent number of patients who need to be transported to the mainland for ongoing medical care that is not available to them within the capability of the clinical staff on the island. I am talking on the basis of first-hand, having accompanied our teams to do evacuations from the South Pacific, in particular having been to Norfolk Island a number of times when we have conducted medical evacuations from the island.

CHAIRMAN—That is with RAAF?

Mr Badham—Negative, as CareFlight. Our written submission does that to some extent. Most people are aware of CareFlight as a rescue helicopter organisation—for example, weekend coverage on television and in the press focused on rescues in the Blue Mountains. The reality is that CareFlight is far more than a rescue helicopter operation. Our CareFlight service operates a state-wide service throughout New South Wales from Sydney and we are currently establishing a separate helicopter in the central west of the state from Orange, and there is also a CareFlight under our affiliation operating in south-eastern Queensland from the Gold Coast.

CareFlight is a charitable organisation, a not-for-profit organisation, which is classified as a public benevolent institution. It was established in 1986 to provide both medical retrieval and

emergency helicopter services. Our principal location is within the grounds of Westmead Hospital in Sydney. CareFlight, under arrangements, provides services to state and federal authorities, particularly police, ambulance and groups such as the Australian Maritime Safety Authority for search and rescue activities such as the Sydney to Hobart yacht race rescues that we participated in.

Since CareFlight was established in 1986 as an extension of the old rescue helicopter concept, it has looked after more than 8,000 critically ill and injured patients of all ages. Our own teams travel by road ambulance, by fixed-wing air ambulance and jet air ambulance, as well as by helicopter. The principle that we are about is to take the teaching hospital standard of medicine with the specialists that we employ, or the registrars that we employ under our affiliation with the medical colleges, out to the accident site, out to the smaller hospitals. The principal difference between CareFlight and any other emergency helicopter service in Australia is that CareFlight actually employs their own doctors.

The other difference between CareFlight and other air medical services is that CareFlight also holds teaching accreditation with three medical colleges covering the fields of anaesthetics, intensive care and emergency medicine. We have particular interest in the clinical side. We do not have one of our medical staff available today but we can provide that information either in written or other form to you if that was required.

The services of CareFlight are met under arrangements with state governments. Unlike our colleagues from the Flying Doctor Service, we do not receive any federal government subsidy and the New South Wales government, for our operation in New South Wales, meets about 42 per cent of the cost of running the service; the rest comes in the form of donations and corporate support.

CHAIRMAN—From whom, mainly?

Mr Badham—Largely from the community and sponsors. Some focus in this inquiry has been on the provision of services to Norfolk Island by the RAAF and we have quite intimate knowledge of that. We have had a number of discussions with the RAAF, who recognised the lack of specialists available to them within the Air Force Reserve and within recent times we have had discussions. The RAAF were very interested in coming to an arrangement with us for the provision of doctors, however the only way they wished to do that was if some of the specialists employed by CareFlight joined the RAAF Reserve. While several of our doctors are in the Army Reserve and have undertaken duties in Timor, Bougainville, Somalia, et cetera, none of them in recent times has been interested in joining the Air Force Reserve, and the RAAF has not been interested in pursuing an arrangement whereby our doctors in our uniform would travel on their aircraft under their arrangements—although we have carried out a number of evacuations from South Pacific areas on behalf of the RAAF and a number of times we have made arrangements for some of the Army Reserve doctors with us to fly in the RAAF when they have not been able to get their own doctors. That has not been a permanent arrangement and there are a number of interservice difficulties with the Army reservists flying with the Air Force which makes it an impractical arrangement.

CHAIRMAN—There is no legal impediment to your members joining the RAAF Reserve, is there?

Mr Badham—If they wish to, that is their choice, and to date they have not wished to. Of the doctors who wish to be involved in the defence forces, most these days have chosen to do that through the Army Reserve, which is perhaps more immediate to their clinical needs.

With respect to the way in which evacuations have been carried out from Norfolk, apart from by Careflight, the more routine in the last few decades have been with the RAAF. That arrangement, as I understand it, has been largely because those services are provided free of charge to the people on the island by the RAAF. It has been an expensive exercise for the RAAF. I believe that a submission was made by them to you. The last evacuation from the island that the RAAF did, using one of the Careflight doctors who at the time was in the Air Force Reserve, involved the Hercules flying from Sydney to Newcastle to pick up one RAAF doctor, then up to Brisbane to collect the second doctor, then to Norfolk Island to collect the patient, who was transferred to Sydney. The Hercules then flew the first doctor back to Newcastle, to Williamtown, and the second doctor back to Brisbane. Unfortunately, they could not find a taxi chit to get the doctor from Brisbane to his home on the Sunshine Coast, so they had to fly the Hercules to Maroochydore to drop the doctor off and then the Hercules had to fly back to Richmond. So it becomes an expensive exercise for Australian taxpayers to pick up in that sort of situation.

Careflight does have specialist doctors; we have the equipment and the integration with our teams and arrangements to make them available for services such as those to Norfolk Island. Cathy Carruthers, after her formal submission, will be available to answer questions on that.

Ms Carruthers—I would like to expand a little on Careflight's international medical retrievals. That part of our operation is a business that is run by me. I have been with Careflight for nearly five years. Careflight commenced international medical retrievals more than 10 years ago as a logical extension of its work domestically. We undertake medical retrievals worldwide, both to and from Australia, using regular commercial aircraft, such as a normal Qantas aircraft.

CHAIRMAN—Is it a worldwide organisation?

Ms Carruthers—No, that is where we go; that is where we might move patients. For example, a list that I compiled some years ago identified probably more than 40 countries where we have actually transported patients to or from, worldwide. We use commercial aircraft such as Qantas and the usual airlines, if possible—it is obviously more economic—or we charter air ambulance aircraft. It is dependent on the needs of the patient, factoring in medical requirements and cost.

The medical retrievals that we undertake range from low intervention transports where a nurse only may be required, to urgent critical care medical evacuations. But I think it is fair to say that our real expertise, where we are often called upon, lies in the urgent critical care medical evacuations. Our clients include insurance companies, governments, employers and families—whoever needs our services. We have referrals from Australian embassies overseas

when travellers get into trouble and perhaps do not have insurance. We have acted on behalf of government departments here. We have a wide range of clients who we assist.

When we have been asked to undertake urgent medical evacuations in the South Pacific, we have used chartered aircraft out of Sydney on a rapid response basis. We are regularly asked to conduct medical evacuations in this region from places such as Vanuatu, Fiji, New Caledonia, Solomon Islands, Tuvalu and Norfolk Island, for example. So it is usual for us at any time to get a phone call and a request for assistance. From the time that we are activated, our target is to have a critical care team on board a chartered air ambulance within, say, 2½ to three hours at the outside. We do not guarantee that but our experience over the past 10 years generally shows that that is what we are able to achieve.

Ian Badham has mentioned the details in respect of the doctors that we employ. We have access to about 25 experienced retrieval specialists—specialists in anaesthesia, intensive care and emergency medicine—or advanced trainees in those specialities who have conducted critical care retrievals. Most of them have done at least 50 to 100 and some of them have conducted up to about 500 critical care retrievals. I think figures from some years ago indicated that about 75 per cent of our patients are ventilated patients so a lot of our experience is at the high end of transport. It is important to have those sorts of depths of numbers to call upon because when you are asked to provide an urgent response you need a sufficient depth to be able to find a medical team with the appropriate skills at very short notice. Two and a half hours to be up in the air in Sydney is a very short time. Quite frankly, a lot of that time is actually getting across to the airport with the way city traffic is.

We have a system in place where we have dedicated international equipment totally separate to our domestic response to enable us to do two critical care transports at any time, plus a number of more low intervention transports. We have our own stretcher bridge, which our doctors designed, which has built-in intensive care equipment. It is all packaged to enable a very fast response. It is dedicated to this work; it is not used for any of our other work. It is these types of systems that you have to have in place to enable a fast response. We have a medical director who is responsible for all our international missions. He is assisted by a deputy medical director. At least one of those gentlemen will monitor and supervise all of our international medical evacuations and he will also be able to assist with early advice until we are able to get there.

With respect to Norfolk Island, as I mentioned, we can generally have an aircraft with a critical team on board in the air within 2½ hours of activation. The aircraft that we use are generally used as business charter aircraft out of Sydney. Careflight has been involved over the years with assisting the operators and owners of those aircraft to fit them with the medical fit-out that is required. There is a quick process to adapt the aircraft to the needs of a critical care patient. We work closely with these operators. We have a very close relationship with them which enables us to source these available aircraft quickly, as you can imagine, in the short timeframe that we set ourselves.

The ballpark flight time is approximately 2 hours 25 minutes from Sydney to Norfolk and about 2 hours and 40 minutes back. Of course it varies depending on the winds, time of year, et cetera. Those are very average flight time figures from one of the aircraft that we use.

In terms of medical evacuations that we have conducted out of Norfolk Island back to Sydney—we are a Sydney based organisation—obviously this is where the medical resources are that we put on the aircraft. The aircraft we use are in Sydney. There are a great number of available aircraft actually in Sydney. So often it is a logical base for us to fly Sydney to Norfolk and bring the patient back to Sydney for teaching hospital standard of care here.

I looked at our records as far back as August 1998 to see how often we have been tasked to Norfolk Island. During that time we have conducted four medical evacuations out of Norfolk. One we did was on behalf of the Norfolk Island administration—and I do recall that one because the call came at 3 a.m. on 1 January. I did think there was probably a very good chance of finding people who were awake at that time of the morning given that it was following New Year's Eve.

CHAIRMAN—New Year's Day.

Ms Carruthers—Yes, New Year's Day then at that point. But we were able to quickly mobilise an aircraft and an appropriate critical care team and respond to that. The other three medical evacuations undertaken since August 1998 were on: 4 September 1999 an insured patient and so we were tasked through an assistance company; 11 July 1999 was an Australian citizen, a private medical evacuation—the family here in Sydney paid for the medical evacuation; and 23 August 1998 was an insured patient. To the best of my knowledge each time we have been asked to undertake a medical evacuation out of Norfolk Island we have been able to provide the assistance.

The process in terms of tasking us is simple, we have a dedicated international retrieval telephone number which will divert to the duty officer. Most times it is myself or Mr Ian Badham, and we have the authority to be able to make decisions as to what we do. We have available excellent medical advice from Dr Rod Bishop, who is our director for internationals, and he is assisted by Dr Steve Walker. We are able to, within that 2½ hour to three hours, put together an appropriate response should it be required. We are also happy at any time to provide any type of preliminary information and any type of support that is required. Sometimes a medical evacuation may not be required, but they might like to have some advice.

CHAIRMAN—Perhaps you would like to provide some answers later, given the limitation of time, Ms Carruthers.

Ms ELLIS—I know Careflight is a wonderful organisation. I see you doing things like rescuing people off cliff tops and heaven knows what else. You are a Sydney based organisation. On your mainland operation, how far do you extend?

Mr Badham—We provide our teams to go out by road ambulance, normally in and around Sydney, sometimes a bit further, and by helicopter from Sydney through to the mid part of the state. Our teams are also available to go on the New South Wales Air Ambulance aircraft throughout the rest of the state. For the international or interstate evacuations we use charter aircraft or regular public aircraft.

Ms ELLIS—So the charter aircraft that you use for Norfolk are similar to the ones you use for interstate transfers?

Mr Badham—Yes.

Ms ELLIS—How are they costed, the interstate ones?

Mr Badham—Within the domestic setting under our arrangement with the New South Wales Department of Health, Careflight does not charge our patients for our work and we have financial arrangements with state health, which is about just over 40 per cent of the cost of running our service, the rest comes from sponsors and from the community. For international or interstate evacuations it is a fee for service, with our service being available under arrangements which Cathy administers, with insurance companies, or governments or for insurance companies, private people or governments.

Ms ELLIS—So if someone is evacuated from anywhere on the mainland to Sydney, out of New South Wales I am talking about, the fee charged is on the same basis upon which the fee is operating for Norfolk Island?

Mr Badham—Correct.

Ms ELLIS—Forgive me if I am being a bit pedantic, but I find it difficult that we are using the term 'international' when we relate it to Norfolk Island because it is part of Australia. Is there any consideration within your operations about that anomaly?

Ms Carruthers—We have our New South Wales work under contract to New South Wales Health, and so this may be a slight misuse of the term. We do not do very much interstate work, but if you take out Norfolk Island, we distinguish between our work within New South Wales and all of our other medical retrievals that we do worldwide. We do not do very many interstate within Australia. As you can see, we have only done four to Norfolk Island since August 1998. We do a lot more than that worldwide—to the United States, Switzerland, France, Austria, Greece, England, Germany, Lebanon, Iran, Nepal, Indonesia, the Philippines, India, Thailand—

Ms ELLIS—I get the message. Maybe, Mr Chairman, we need to attach Norfolk Island to a state like New South Wales. It is attached, in fact, to my electorate in Canberra.

Ms Carruthers—Is that right?

CHAIRMAN—Some people think we should attach it to Australia!

Mr Badham—Perhaps the ACT government may wish to pick up the tab for the evacs out of there.

Ms ELLIS—They would be thrilled with that suggestion, Mr Badham!

Ms Carruthers—It creates confusion for travellers who may not appropriately insure before they go there because they do not realise that they are not travelling within Australia.

Ms ELLIS—For the purpose for which we are speaking?

Ms Carruthers—Yes.

Senator CROSSIN—Can you clarify for me how you then recover costs. You are contracted to New South Wales Health?

Mr Badham—For the work we do using our helicopter and medical teams out of Sydney and our arrangement with New South Wales Health, that is an arrangement we have with New South Wales Health. For work outside that with New South Wales Health, it is a commercial arrangement with individuals, insurance companies, assistance companies or governments.

Senator CROSSIN—So the evacuations from Norfolk Island have been a range of those?

Mr Badham—Yes.

Ms Carruthers—We are required on a one-off basis to charter air ambulance aircraft and, of course, we incur a significant cost for that. It is work that we do that is separate from our domestic duty roster. We take our doctors separate from our duty roster. We are chartering an aircraft on a one off basis and obviously incurring substantial costs.

CHAIRMAN—Can I ask a couple of brief questions. It is administered from Westmead Hospital?

Mr Badham—From our base in the grounds of Westmead Hospital. We are not part of Westmead Hospital. We are independent of Westmead Hospital.

CHAIRMAN—You are totally separate from the funds of Westmead Hospital?

Mr Badham—Correct.

CHAIRMAN—Does Westmead Hospital, given the frequency of flights in and out of Westmead Hospital, take an inordinate number of your Medicare evacuees?

Mr Badham—We are looking after approximately 1,000 critical patients each year. Those patients are taken back into whatever hospital is appropriate for that patient. Burns patients, for example, would tend to go to Concord; spinal injury patients would go to Prince of Wales or Royal North Shore. The patient goes to the appropriate hospital, even though our base is located within the grounds of Westmead Hospital. Having an air medical retrieval service based at a hospital affords a number of advantages to a clinically directed service with respect to teaching and integration within the medical system. It also allows us to have very quick access to blood transfusion products. Particularly going out to accident sites on a rapid response basis, being able to uplift blood to allow transfusions to be conducted quickly is an advantage, as it would be in responding to Norfolk Island in the same way.

CHAIRMAN—That was my next question. Do you think that, in responding to Norfolk Island, it is an ideal place, given the multitude of problems that are associated with evacuees from that place? Notwithstanding that it is an ideal place, most would go there?

Mr Badham—There were questions directed to the previous witnesses. As far as the ideal place to stage a retrieval to Norfolk Island is concerned, it is a matter of having access to the right aircraft. There are more of those available in Sydney than anywhere else. It is a matter of access to the appropriate clinical teams and equipment that are required.

CHAIRMAN—The airport itself may be a bit of an impediment, or can you get fast-track clearance?

Mr Badham—If necessary, to save time, we can fly our team into the airport by helicopter. Otherwise, the team normally responds by road to the airport, which is where the charter jets operate. We have made arrangements with those people, having regard to the work that we do for them, to allow us to take our intensive care mobile and equipment. Sydney is, for us, an ideal strategic place for departure because of transport arrangements, proximity to our doctors and to our medical equipment and the rest of our clinical staff. Also, there is the matter of the number of teaching hospitals in and around Sydney and the fact that it has all the various clinical requirements that the patient may require, whatever the particular nature may be. So Sydney certainly does provide that logical springboard.

CHAIRMAN—You mentioned the Sydney to Hobart yacht race and the tragedies that occurred there. I wanted the opportunity to say how much I appreciated the effort made by both the medics and the rescue pilots. I do not think I have ever seen anything as brave or as trying as the graphic television footage of that.

Mr Badham—While our teams had a particular involvement with search and rescue over a 2½-day period, we were not the only helicopter group involved. In fact, there were nine helicopters and 35 fixed wing aircraft from the civilian resources within Australia.

CHAIRMAN—Including the RAAF.

Mr Badham—Yes, in addition to the RAAF with an aircraft and the Navy with aircraft. I think it is quite remarkable that something in the order of 55 sailors were rescued during that period. The total cost of that to the Australian taxpayers, with the subsidy that is available to the operators of those rotary and fixed wing aircraft, was in the order of just over $600,000, which I think is remarkably cheap for the expertise which was available. I appreciate the comments directed not only to our teams that were heavily involved but also to the other rescue helicopter teams that did a wonderful job.

CHAIRMAN—It was an extraordinary rescue and it deserves the highest commendation. With respect to costs, are you aware of the hourly cost of having a Hercules in the air compared with having one of your planes that would fly to—

Mr Badham—I think you would need to refer that to the RAAF to see what costing they put on theirs.

CHAIRMAN—Do you have a generic cost we can go on?

Mr Badham—No, I do not.

CHAIRMAN—We will find that out, I think. We have had evidence given with respect to Hercules costs. If we can find out the cost of the Hercules, would you be kind enough to give the committee the cost per hour of an appropriate plane that you would use or have used to fly to Norfolk?

Ms Carruthers—I think the cost of our services has probably been referred to in a number of other people's submissions earlier in this inquiry. A little more than six months ago I did provide the Norfolk Island administration with some fixed prices for aircraft. I did negotiate with some of our aircraft suppliers—

CHAIRMAN—Could you give the committee that information?

Ms Carruthers—I would have to look that up and come back to you.

CHAIRMAN—Would you take that on notice?

Ms Carruthers—Yes.

CHAIRMAN—Providing it is appropriate for you to do that.

Ms Carruthers—I asked for our suppliers to give us a fixed price for any tasking within a six-month period, and in this way, depending on which aircraft was available—

CHAIRMAN—Is that an hourly cost or a total cost to leave and retrieve and return?

Ms Carruthers—The total cost of providing critical care—aircraft, personnel, medical personnel, medical equipment; everything.

CHAIRMAN—That would be great. From previous evidence, we have had a cost of $131,000 per evacuation.

Mr Badham—I think that was for the RAAF.

CHAIRMAN—Yes, that was for the RAAF.

Ms Carruthers—We are somewhat cheaper.

CHAIRMAN—This is my last question. By world standards, 2½ to three hours still seems to be a long time to scramble a team.

Mr Badham—You are looking at an infrequent activation—in three years, four calls to Norfolk Island, for example. Within that time frame, there is the framework of negotiating on an

individual, a one-off basis, the payment guarantee side of things. So there are a number of inhibiting factors which bring it to the time that Cathy has referred to it.

CHAIRMAN—Yes. I was going to finish my question by asking: is there some training that can be provided to lower that scramble time or is there some assistance that you believe the government can give to lower that scramble time?

Mr Badham—Prior arrangement would certainly reduce the time necessary.

CHAIRMAN—You would like to get a crystal ball, wouldn't you, Mr Badham?

Mr Badham—Yes.

CHAIRMAN—So, your answer is, no, you do not think you can reduce that scramble time?

Mr Badham—We can reduce that time, slightly.

CHAIRMAN—How could you reduce that time—through training, through assistance, through government assistance, through your own means?

Ms Carruthers—Prior arrangement with the Norfolk Island administration, for example, or such other body so that there was no need for any negotiation on a job-by-job basis as to a price for the job, getting it accepted in a written format and authorised. The authorisation process, for example—

CHAIRMAN—Is it customary for the Norfolk Island government to notify you to that you may be needed? Would that lower the scramble time if they did that?

Ms Carruthers—Early notification could allow us to—

CHAIRMAN—What about a 'may be needed'? I am not talking about a notification; I am talking about a 'may be needed'.

Ms Carruthers—Yes, early notification that we may be needed would certainly enable us to start our planning at an earlier stage.

CHAIRMAN—Could you respond quickly if you were notified by the Norfolk Island government, say, that it is possible that you may be needed within the next 12 hours; something of that nature?

Mr Badham—The way we operate within the New South Wales health environment is that very often we are placed on notice that we may be required for a response. Even though we respond normally on a seven-minute call-out, if you are notified in advance then, in that situation, you have the team sitting there, the equipment there, ready to go on a particular mission with the particular clinical needs of that patient taken care of. For situations such as Norfolk, with a lead-up advice it is certainly possible and would be preferable for us to be able

to then have the aircraft on stand-by, have the conversion work done to take it from its VIP role to the air ambulance role and have our teams ready to go up to the point of activation That would substantially reduce the time. It is part of a normal arrangement that would be put in place if a set arrangement was there. In most of these situations, whether it is to a trauma on the island or an ongoing illness, there is a lead-up notification. The better the notification, the quicker the final response.

Senator WATSON—Congratulations on the standard of the presentation—it has been first class. It does seem unfortunate that you have got to do some negotiating as to cost recovery, that there cannot be some sort of arrangement. Indeed, I think this committee should be looking at that aspect, that there has to be some negotiation. Do you ever find yourself in a position where there could be competing interests, that maybe you have just got a plane ready and they have got somebody else to do the job ahead of you because it costs the Norfolk Island administration less money to use them than to use you? Do you ever find yourself in that position, as a fall-back?

Mr Badham—In regard to Norfolk in particular, because there have been so few there has not been that conflict. If our team is engaged, then our team is available to go. Because we have such a large number of doctors on our books we have the capacity to stage multiple retrievals at any one time, both on the domestic setting and on the international setting.

Senator WATSON—My question is really directed to whether the people of Norfolk Island use you as a fall-back and perhaps do not execute the contract because somebody else, such as the RAAF, might be cheaper?

Mr Badham—I think you would have to ask them that.

Ms Carruthers—We can only say we have been called.

Senator WATSON—You do not find that you have inquiries and then there is no follow-up?

Mr Badham—No.

Senator WATSON—Thank you. Do most hospitals provide helicopter landing facilities in the grounds of the hospital?

Mr Badham—These days, yes.

Senator WATSON—How many hospitals, for example, in New South Wales would provide helicopter landing facilities within the hospital grounds?

Mr Badham—We would have to go through our directory to give you the exact number, but the majority of hospitals do have the facilities.

Senator WATSON—We seem to have some problems in Tasmania, some objections because of the possibility of accidents affecting other people. There seems to be a reluctance to allow

helicopters to land close by or in hospital grounds and I was just interested whether we might be out of step. Would you take that on notice?

Mr Badham—Certainly.

CHAIRMAN—Is it true that payment in full is usually, if not invariably, required before you will dispatch an aircraft?

Ms Carruthers—For non-regular clients. Quite a number of our clients we invoice because, as they are regular clients, we have an arrangement with them. However, as you can understand—

CHAIRMAN—What qualifies as a regular client? What is the interpretation, please?

Ms Carruthers—Someone that we have come to an arrangement with. It might be an insurance company or an assistance company that will regularly use our services. Unfortunately, because of the substantial costs involved for which we have no funding to do and because our focus is on providing a high level of medical care, we are not in the business of being debt collectors, so we are not in a position to simply dispatch aircraft at significant cost and then find ourselves in a position where we are not able to pay.

CHAIRMAN—So, hyperbole aside, you will not dispatch an aircraft until payment is guaranteed in full, either by the insurance company or by the recipient?

Mr Badham—Or by prior arrangement.

CHAIRMAN—For some prior arrangement, you need to be satisfied that the aircraft that you will dispatch and the other ancillary costs will be paid for in full?

Ms Carruthers—Yes, that is correct.

Ms ELLIS—I have a question about the scramble time. In relation to what you said before about medical staff, the doctors in particular, I do not want to make this sound flippant but I am sure there would be a difference if it was three o'clock in the morning compared to 10 o'clock in the morning?

Ms Carruthers—Surprisingly not. Sometimes traffic is lighter in Sydney and we might be a little bit faster.

Ms ELLIS—During the day?

Ms Carruthers—You are talking about 3 a.m?

Ms ELLIS—Exactly. It could be easier at 3 a.m. That is what I am getting at.

Ms Carruthers—Yes.

Ms ELLIS—Do those staff get to the airport under an emergency traffic arrangement?

Mr Badham—No.

Ms ELLIS—Why not?

Mr Badham—We do not have one.

Ms ELLIS—Has there been consideration of getting one?

Mr Badham—If it is required, we would do that. To date it has not been.

Ms ELLIS—The reason I am asking the question is: would that not facilitate a quicker scramble time?

Mr Badham—It certainly would.

Ms ELLIS—Whether it was required or not, the requirement of getting there is the reason that I would suggest it would be worth considering putting something like that together. Surely if it is urgent enough that someone has to scramble to get to an aircraft to fly somewhere to bring back someone who is dangerously ill, that would in itself constitute an emergency situation. Therefore, should there not be a useful consideration of emergency traffic procedure? I guess I am just trying to help the scramble time.

Mr Badham—Yes. For most of the work we do from overseas there has been quite a lengthy lead-up time with negotiating—

Ms ELLIS—I understand. It is different to the Norfolk Island situation.

Mr Badham—That is right. If we were to have a regular or a formalised arrangement for the retrieval of patients from Norfolk Island, we would put in place arrangements that would certainly reduce the response time to a minimum, and that would be one of the arrangements.

Ms ELLIS—Okay.

CHAIRMAN—On behalf of the committee and the secretariat, thank you, Mr Badham and Ms Carruthers, for your appearance here today. If there are any matters on which we might need additional information, the secretary will write to you.

Mr Badham—Thank you, Mr Chairman, for your interest.

Resolved (on motion by **Senator Crossin**):

That the committee authorises publication of the evidence given before it at public hearing this day.

Committee adjourned at 12.07 p.m.