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JOINT COMMITTEE ON THE NATIONAL CAPITAL AND EXTERNAL TERRITORIES

Reference: The provision of health services on Norfolk Island

FRIDAY, 7 APRIL 2000

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JOINT COMMITTEE ON THE NATIONAL CAPITAL AND EXTERNAL TERRITORIES

Friday, 7 April 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 Greig, Lightfoot and West and Mr Neville

Terms of reference for the inquiry:

To inquire into, and report upon:

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

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

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

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

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

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

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

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

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

(ix) any other matters incidental thereto.

WITNESSES

Committee met at 9.03 a.m.

ANDERSON, Ms Janet, Director, Health, Department of Veterans Affairs, New South Wales Office

TELFORD, Mr Barry, Branch Head, Department of Veterans Affairs

CHAIRMAN—I now open this second public hearing of the Joint Standing Committee on the National Capital and External Territories inquiry into the provision of health services on Norfolk Island. The purpose of the inquiry is to ascertain the range of health and ancillary services that are currently available to Norfolk Island residents and to the 37,000 tourists and holiday-makers who visit Norfolk Island each year. The committee has also been asked to determine what services should be available. However, as the committee has discovered, everyone's expectations are different. Many of those expectations were put to the committee in a day of gathering evidence on Norfolk Island. On that occasion, the committee heard a wide range of views from the government and residents of Norfolk Island.

Today the committee will be taking evidence from four Commonwealth departments which have responsibility for some aspect of health on Norfolk Island. I welcome Ms Janet Anderson and Mr Barry Telford from the Department of Veterans' Affairs—DVA. 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. The committee prefers that evidence is 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. Are there any corrections or amendments you would like to make to your submissions?

Ms Anderson—No.

CHAIRMAN—Ms Anderson, before I ask you some questions, do you wish to make an opening statement?

Ms Anderson—Yes, if I may. With your concurrence I would like to give a brief background on the way the Department of Veterans' Affairs operates, because it is material to our discussion of what we are doing for the Norfolk Islanders. By way of introduction, I want to explain that the department operates under the Veterans' Entitlements Act which empowers the commission, of which the department is delegate, to enable veterans to achieve timely and convenient access to appropriate high quality health services, which are both clinically effective and represent value for money. We have a particular brief under the act, and that is the way in which we operate. There are a couple of other things I should also mention. We define health as a broader concept than just the absence of illness or disease but take on board the WHO definition, which also mentions the presence of physical, emotional and social wellbeing. As you would have seen by my comments earlier, we also place particular emphasis on equitable access to services. This makes us focus particularly on the veterans in rural and remote areas and what steps we have to

take to ensure that they access the full range of services wherever possible that they might require to sustain them in their homes and allow them to lead full lives.

The department has a treatment population of entitled veterans and war widows under the act of about 352,000 and their average age is 74 years. In effect, you could argue that we are really an aged care purchaser inasmuch as we are looking at a population which is by and large fairly aged. Seventy-nine per cent of our treatment population is aged 70 years or over, and that becomes material when we consider what we are doing on Norfolk Island.

The health care conditions of our treatment population in its entirety are those that you would find in an aged population. They include chronic degenerative diseases. I raise that because it is material to what we are doing on Norfolk Island. Their health care needs are those you would expect of an elderly population. They range from services in the home, which allow older people to stay in the home for as long as possible, through to acute services in hospital facilities and, beyond that, into residential care facilities for hostel and nursing home type care. The purchasing model that the Department of Veterans' Affairs uses is based on accessing mainstream health services wherever possible. These are both in the public and private not-for-profit and private for profit sectors. We enter into fee-for-service contracts with local providers who can satisfy our requirements in terms of accreditation, quality standards and cost as well. Where the health needs of the veterans in a locality cannot be met by mainstream services, because either the services are unavailable or they are inappropriate to the veterans' needs, then we make some other choices as a purchasing authority. We commission special services in that locality. One example I could offer is the Vietnam Veterans Counselling Service. It is a special service set up by the department because we could not find something which was sufficient to meet the special needs of Vietnam veterans. Or we pay the cost of veterans' travel to another locality to access appropriate services. We buy or commission something special in situ or we pay for them to travel to that service elsewhere. The decisions we make around that are guided by issues of quality, timely access, convenience, cost and the appropriateness of the services.

I will move now to talk about what we are doing on Norfolk Island. As we indicated in our submission, the characteristics of that veteran population are very similar in many ways to those of the veteran population on the mainland. They are in the main older in age and certainly a large number of them—85 per cent of the gold card holders on the island—are over the age of 70. I will pause here briefly to explain gold card, which is a terminology we use in the department. Gold card holders are entitled veterans and war widows who have access to DVA-funded health care across the full spectrum of services. The other form of card holding is white card holders who have restricted entitlement based on an accepted disability, which is a disability sustained in war.

As indicated in our submission, there are 148 veterans and war widows on Norfolk Island of whom 54—it was 55, but one has died since the submission—are entitled to health care benefits. So 54 of those 148 are gold or white card holders. As I said, approximately 60 per cent of the people on the island in the veteran community are over the age of 70. I would also make the observation, and I am sure it has already been shared with the committee, that the general population of Norfolk Island is somewhat older in average terms than the mainland population. Norfolk Island has a higher proportion of older people in that population. Veterans are a significant part of that.

The Norfolk Island sub-branch of the RSL commissioned a report in 1998, which the Department of Veterans' Affairs funded, to look at the range of health care services and, more particularly, aged care services on the island, with a view to identifying gaps and developing a strategy which might fill some of those gaps. This report was provided as an attachment to our submission to the committee. As you would have seen, this report identified a number of gaps, and some of them were quite significant. I will quickly go through some of those, because again they point the direction for the department's intervention.

The island lacks an aged care assessment team. It lacks a purpose-built facility for residential aged care, which is only available on the mainland. So what happens is that older people on the island generally hold on for as long as possible—probably for too long—in their homes because often the alternative, if they want a purpose-built facility, is to transfer to the mainland. The older you get, the less inclined you are to make that sort of substantial shift in your living circumstances. So they hold on for a long time in their homes. The problem with that is there are not adequate community support services on the island to allow them to stay in the home safely. So there is a double jeopardy there: on the one hand, they need to move off the island and, on the other hand, they have difficulty staying at home.

There is also a dearth of formal programs of community based health and support services. There is a district nursing service, but there are no formal programs of home help or personal care or community transport. The aged care residential service that they do have on the island is actually accommodated in an old public ward of the Norfolk Island Hospital Enterprise, which is relatively unsuitable for aged care facilities, particularly for those people with dementia who require a secure and safe environment. It is not designed for that purpose. So there is no doubt that it is a relatively poor physical stock for the purposes for which it is currently being used.

The report also identified that there was an issue with staffing levels in that aged care facility and also with the knowledge and skills of the staff working there. The hospital tends to give priority to acute cases and places less importance on the work it does in aged care, and that shows in the way they staff the facility. I might add that this is not news to them; they were concurrent with every aspect of this report. At the stage that this report was undertaken, the island lacked a day care or day therapy program.

So this report was very influential for the Department of Veterans' Affairs in considering what action it might take to support the veterans and war widows on the island. It became clear to us that they were being relatively disadvantaged because of where they lived in terms of accessing health and aged care services. What we decided to do was negotiate a block funding agreement with the Norfolk Island Hospital Enterprise which, as you may well be aware by now, is the single provider of health services on the island as a government funded organisation. This block funding agreement covers in-patient, outpatient and community health services. I should hasten to add that for many of the community health services we are reliant on practitioners coming across from the mainland to do clinics on the island because they are not resident on the island, which of course incurs additional costs. In terms of critical mass in the population, it is probably difficult to justify residing there. Certainly they could not earn a decent living if they wanted to practise full time.

Just by way of outline, for the period March 1999 to March 2000 we paid approximately $160,000 for health care services to veterans on the island and about 40 per cent of that was for the accommodation and care of nursing home type patients in the hospital. Another 20 per cent was for acute services in the hospital and another 20 per cent again was for pharmaceuticals. So we had four-fifths of that payment being hospital based—this is nursing home type patients in acute care and drugs—and the remaining fifth for community nursing, GP consultations, specialist services and diagnostics. That gives you some sense of the weighting of the finances going into the island for health care services for veterans and war widows.

In addition to that we paid an amount of money, some $36,000, for travel to and from Norfolk Island by veterans and war widows seeking medical treatment on the mainland and that includes travel allowances as well. The travel was mainly to Sydney and for a range of services, including neurology, neurosurgery, general surgery and so on, but included in that amount, and it is a fairly substantial figure, was $25,100 for a medical evacuation from Norfolk Island to Concord Hospital for a veteran who had suffered a fractured neck of femur. As you can see that proportion is over two-thirds of that total sum and it is a substantial amount of money for a single evacuation. I am aware from the terms of reference of this committee that medical evacuation is one of the areas you are considering. There is no doubt that in an ageing population the risk of falls increases and you could assume therefore that the likelihood of requiring evacuation from the island would increase.

We understand—and I have not checked this personally—that commercial airlines servicing the island are not able to take stretcher cases and that the RAAF is in a position to accept stretcher cases only where the condition is life threatening. We surmise that there may well be a case where an individual—and indeed a veteran for our interest—sustains an injury which might render them less mobile and possibly even stretcher bound, but as their condition is not life threatening they would have to be evacuated from the island by boat, which would be a rather traumatic experience. We have some concerns about that and would share those with the committee. It is undoubtedly a very costly enterprise and I am sure that there may be cheaper ways, but I am sure that none of us would appreciate having a substantial injury and leaving the island by boat.

In addition to the block funding payment, we have more recently entered into an agreement to extend that block funding agreement with a series of one-off payments. These arise directly from the review undertaken by the Norfolk Island RSL sub-branch. We describe them as service development incentive payments and there are three areas in which we have decided to invest funding in order to bring up the infrastructure on the island to provide an enhanced level of aged care services for that community and specifically for the veterans and war widows on that island.

As indicated in our submission one area in which we are providing funding is for a geriatric nurse supervisor. This is a one-off funding grant of $38,000 for 12 months only, and this individual, when recruited, would be in charge of the aged care services both in the hospital and the community. Our intention here is to give aged care a more prominent focus within the hospital and within the health and aged care services generally on the island. We feel that it needs a bit of a higher profile in order to attract some attention and get some further support.

We are looking to this individual to provide a point of contact with the other forms of services on the island in relation to aged care matters. We are also looking to him or her to provide some in-service training for other staff in the hospital, particularly to increase their awareness of aged care issues and provide them with some specialised skills in caring for elderly people, particularly people with dementia.

We have provided another one-off grant of some $40,000 for the island to recruit a physiotherapist for 12 months. During that period we expect the island and the physio to look at means of sustaining the employment of that position beyond the 12 months by establishing an income structure outside DVA funding. We believe that there is an opportunity for a physio on the island to engage in private work and to attract funding for that from local residents, which would allow them to operate on the island. Ours is a seeding grant to attract somebody to the island who can hopefully stay on beyond the expiry of our grant and continue to provide services for all residents on the island.

Thirdly, we have also provided some funding for a community and patient transport vehicle, which is a larger vehicle than just the two- or three-seater. This would allow veterans and other folk on the island to be transported to and from treatment, day care and so on.

Moving quickly to final initiatives we have undertaken on the island to underpin the existing services, we have facilitated the establishment of a Day Care Club by the RSL sub-branch. Indeed, that commenced on 25 August last year. We provided an establishment grant of $15,000 under our joint ventures scheme for that. That Day Care Club now has 60 members. It is run by volunteers along the lines of the model which is used widely in New South Wales. We have provided training for those volunteers. As it is the only seniors day program on the island it is obviously very popular. We are very pleased with the way it is going.

Lastly, the Department of Veterans Affairs has a program called HomeFront, which is designed to assess veterans and war widows' homes for physical risk and to take action for a modest amount of money to ameliorate those risks. We sent a group across to the island last year. One of their tasks was to offer home assessment to veterans and war widows on the island. They undertook around 40 of those. As a result of those home assessments we were able to fund the installation of things like grab rails in bathrooms, sensor lights, contrast step edges, handrails and so on, which reduced the risk of falls and increased the safety of the home environment. All of this, of course, is designed to support the veterans and war widows in their homes for as long as possible.

The other point I would make is that we are also exploring the use of digital videotape as a means of allowing people in situ to gather evidence which can be judged remotely. In this circumstance—we have not used it yet on Norfolk but it has been used in other parts of New South Wales in remote communities—we have asked a local service provider who might be an occupational therapist, a physiotherapist, even a nurse, to take a digital videotape of a veteran's home, in particular looking at risk areas such as the entryway, bathroom and so on, and to send that videotape via electronic means to one of the departmental occupational therapists for assessment. That departmental occupational therapist who has the appropriate training can make judgments about need which may not be able to be made by the individual on the site. This is one of the technologies we are exploring more fully which allows us to ensure that there is no

inequity in access for those living in remote areas. I will close by saying that the programs of funding I have outlined are all subject to evaluation. We have built into our funding agreements with the island certain performance criteria against which their work will be measured. Thank you.

CHAIRMAN—Mr Telford, do you have any statements you wish to make?

Mr Telford—No, thank you.

Mr NEVILLE—Could you just refresh our memory on the number of gold cards and white cards?

Ms Anderson—Yes. There are 46 gold cardholders and eight white cardholders. One of the individuals died recently.

Mr NEVILLE—That means that most of the 46 served overseas.

Ms Anderson—Yes.

Mr NEVILLE—By and large, nearly your whole cohort are gold cards, bar a few.

Ms Anderson—Correct—who have the full entitlement.

Mr NEVILLE—I suppose it is very hard to compare with the Australian health system. It is horses for courses in Norfolk Island; you have to work with the system that is there.

Ms Anderson—Yes.

Mr NEVILLE—I for one am not convinced that you achieve anything by just Australianising the system, so to speak, except making the whole community more dependent on Australia rather than selectively doing what you have been doing and that is trying to find the hot spots and fixing those. With reference to the geriatric nurse, who would fund that program after the first year? How would it become self-sustaining? Have you worked that through?

Ms Anderson—That is a good question. We have had discussions with the hospital administrator on that matter. We are hopeful that they will be able to find funding from their own resources to sustain that position. We believe that it will become evident very quickly after they recruit the individual that it will be a core position, particularly if they are prepared to pursue, as they appear to be, the notion of coordinating services. There are two issues there. First of all, there is a dearth of services, and, secondly, the services which do exist are poorly coordinated. We believe that this geriatric nurse can provide a point of coordination, and we think that the benefits of that will become apparent very quickly. So our hope is that the islanders will find some way of sustaining that position themselves.

Mr NEVILLE—If there are only 54 people involved in a population of about 3,000, it makes it very hard to justify a dementia wing, does it not?

Ms Anderson—First of all, there is the proportion of the veteran and war widow population who would have dementia, but then there are those within the larger group of island residents. In all of these initiatives, as you would have appreciated very clearly, we are providing a resource to the island, and the beneficiaries of that extend beyond the veteran community.

Mr NEVILLE—That is the point I was coming to, yes.

Ms Anderson—We see that very clearly because there is a diseconomy of scale. We would not provide 0.2 of a geriatric nurse because that would be a nonsense. So, on a number of occasions in these remote areas we actually recognise the benefits which flow from our initiative into the broader community and accept that that is part of what we do. We are very pleased by that but, at the same time, we know that if we were not to invest, it would not happen. So if we are to look after the 54, then the flow-on effect means that the others get some benefit from that too.

Mr NEVILLE—And that $38,000 is the total cost, is it?

Ms Anderson—For the geriatric nurse, yes. The island is making a contribution towards that as well, as they are for each of these programs. There is a recognised additional cost for each of these which the island will be picking up.

Mr NEVILLE—You mentioned the evacuation. What was the cost of that?

Ms Anderson—It was $25,000 for a single evacuation.

Mr NEVILLE—Does the Department of Veterans' Affairs make any donations, direct or indirect, to the Royal Flying Doctor Service?

Ms Anderson—No, not donations.

Mr NEVILLE—Do you have an arrangement with them?

Ms Anderson—I believe we do. I cannot speak to the detail of that, but my understanding is they certainly provide aeromedical evacuation for us from remote areas of New South Wales.

Mr NEVILLE—It seems to me—and I expressed this earlier when we were on the island—that we have got this vast expanse of ocean that has to be crossed. Given the types of aircraft that the commuter airlines are using, I can well understand that they cannot pull seats out because they are not big enough to be able to do that on a regular basis. Obviously, the RAAF does not want to have to go there every other day. The third option is a commercial evacuation, which no doubt that one was.

Ms Anderson—I believe that was a RAAF evacuation.

Mr NEVILLE—Okay, but whether it was the RAAF or someone else, I think we were quoted figures when we visited the island of even more expensive evacuations. It occurred to me that if we want to have an ongoing umbrella over the island there might be some merit in the various government departments which are involved in the island's health facilities coming to some

permanent arrangement with the Royal Flying Doctor Service through Sydney or Brisbane. How that would be achieved I am not quite sure. I suppose one option would be that the next time the Commonwealth adjusted grants to the Royal Flying Doctor Service it would adjust to Queensland or New South Wales an amount to do so many evacuations a year, if required.

Ms Anderson—I am not aware of the total number. Has the committee been advised of that, in terms of the number of evacuations required?

Mr NEVILLE—Yes, we were, but it is not in my consciousness at this minute.

Ms Anderson—I do not know what the incidence is.

Mr NEVILLE—While we were over there we noticed that no-one really has a solution to it, and I think we have got to find the solution, whether it is for veterans or for the community at large, or for that matter for a tourist who gets into difficulties. We need to have some basis where we are not jumping around the place all the time. There were 19 medical evacuations using regular passenger transport, the RPT, there was one using the private air ambulance, and there were six with the RAAF. That is 26 evacuations to 30 June 1999.

Senator WEST—But only seven with the five special aircraft; the rest were RPTs—able to be put on the scheduled flights. You are not going to start wanting to give them a special flight, are you?

Mr NEVILLE—No, I would not think that at all. What I notice in Queensland, where I have had some association with the aerial ambulance, though not so much with the Royal Flying Doctor, is that they tend to try to integrate their services. If someone is being taken out to or brought back from emergency treatment and there is another person who perhaps requires eye care or something else, quite often they make a seat available to them so there is not another trip. I would like your reaction to the idea that the various government departments, or the government at large, might do something with respect to the Royal Flying Doctor Service.

Mr Telford—It is very hard to comment on the broader issues because, as you say, we have such a small number of veterans in the community and also in terms of the costs associated with taking one or two people, which Ms Anderson has spoken about. Our response has been to look more at the prevention side and to put in the comprehensive assessment of the home environment. We know that this particular case that we have referred to was a result of a fall—a broken neck of femur. By the placement of grab rails, non-slip on the floors and all of the HomeFront initiatives and other activities, we are getting in ahead of those things. So we believe our most appropriate immediate response is one of prevention and of integration with the current arrangements over there.

It is just not possible, as Ms Anderson said, to have a total service just related to veterans, but the seeding funds for some of those other on-island services can be extremely effective. In fact, some years ago we did the same thing with podiatrists. We funded a podiatrist to get started on the island. That person was able to pick up a number of clients from the rest of the community—non-veterans—and then become self-funding and continue to service the island, veterans as well as non-veterans. What we are trying to do in our strategic directions is to focus both on

prevention and on putting in place mechanisms which we are happy to kick-start but which we realise must have some sustainability, rather than necessarily looking at some of the far more expensive and reactive chronic solutions.

Mr NEVILLE—I did not want to put you in a spot in terms of policy but, obviously, with so small a population, if there was some sort of unanimity of opinion in the various departments involved that would give the committee some guidance on what we might recommend to government.

Senator GREIG—My question might be more policy related too, but I will try and be careful. Ms Anderson, did I hear you correctly when you said earlier that more than 50 per cent of the island's population were older than 70, or was that veterans only?

Ms Anderson—No, that is relating to the veteran community on the island. The figure is more in the range of 10 or 12 per cent of the island population. That is still a slightly higher figure in terms of proportions than you would find on the mainland, so there is a slightly more aged profile on the island than on the mainland.

Senator GREIG—We are looking at approximately 50 veterans—is that right?

Ms Anderson—Yes, just slightly over that.

Senator GREIG—Presumably, then, the department would be concerned about their health and possible frailty in the next five to 10 years.

Ms Anderson—Indeed.

Senator GREIG—Is there a particular policy through which the department must work in terms of how to address that as more serious health issues may arise in the next few years? Specifically, will facilities and resources be available for those people to continue living as best they can on the island or must they come to the mainland?

Ms Anderson—That is obviously a key concern for us. Our preference would always be to support ageing in place, wherever that is appropriate. The dilemma we face, as highlighted by the report undertaken two years ago, is that the infrastructure support to allow that to occur is relatively poor. What we have tried to do in these funding initiatives is to underpin that, slightly at least, so as to wherever possible maintain veterans in their homes on the island.

We are working fairly closely with the hospital director to try to upgrade not just their approach to the physical stock but, indeed, their whole approach to aged care services. We are very pleased by the response we are getting. There is certainly a very strong willingness and enthusiasm to try to reshape some of their thinking and their service delivery patterns to accommodate these increasing needs. Of course they see as clearly as we do that we are not just talking about veterans, that the whole population is ageing and therefore they have a much bigger problem on their hands, if you like. We are particularly concerned about the potential need for older people who become very frail to have to move to the mainland. That sort of dislocation when you are 70 or 80 years old is extraordinarily difficult to accommodate well. I am sure we

see some increased morbidity and possibly even mortality as a result of those sorts of moves, and that is an anathema. There must be a better way of doing it. We are somewhat limited, as Mr Telford has indicated, in what we can do, because our contribution, relatively speaking, is fairly modest. We will continue to work with the island as much as we can, first and foremost to look after the interests of the veterans and war widows on the island, but also, as I said previously, hopefully to provide resources more generally where appropriate to support the island in general.

Senator GREIG—In the RSL commissioned report there was reference to a need or a perception that there was a requirement for greater access to the department's health promotional and carer support programs. Can you paint us a picture of what kinds of things are involved there and how practically they can be implemented on the island?

Ms Anderson—Yes, and that is an interesting area. I have one particular member of staff who is very enthusiastic about that, and it is great to see. She has already been in contact with the hospital director and the executive of the RSL sub-branch to talk about the various resource material we have and the sorts of programs which could be mounted fairly modestly by locals on the island to improve their level of fitness and their level of health generally. We have a fairly extensive range of literature on various issues in relation to health promotion which we have already made available to the island, and they have taken that up with great enthusiasm. We will continue to work with them. The sorts of issues we are talking about for older populations are improving or maintaining fitness levels, diet and dentition—things like that which might not necessarily occur to everyone but which are vitally important in maintaining a level of wellness amongst an aging community. It is an area where we are keen to do some more work.

Mr Telford—The other important strategy in carer support being used there and elsewhere across Australia is in dementia management, in assisting our carers to better manage their spouse or whoever in the home. There is a range of literature and other support services we have available in that area. Again, it is a really important preventive strategy. If the carer can manage as long as possible in the home before removing the person to a residential care facility of some sort, that relieves some of the pressure to come to the mainland or on the current hospital arrangements for handling dementia.

Senator WEST—It seems to me from your submission and from your presentation here today that you have looked at how to provide a service and be innovative about it. What requests are coming to you from the Norfolk Island health service on initiatives that they think would be appropriate? It seems to me that it has been a bit of a one-way street here: you are leading rather than responding. Is that a correct assessment?

Ms Anderson—I will take the compliment, but I think it is actually more a collaborative approach than that might first indicate. The undertaking of the review a couple of years ago was in fact very much a partnership. The consultant and the DVA representatives worked very closely with various officers and government officials on the island as the report was being prepared. So there was a very strong sense of working together to produce an analysis of the deficits on the island. In that process there was also a lot of learning on both sides being undertaken. As a result of that report certain things have flowed, and the initiatives I have outlined have been cast largely within that framework.

While it looks, on the one hand, as if we have been proactive—and I hope that we have been—I think that, equally, the Norfolk Islanders are very receptive to what we are saying and, indeed, in the work that we have done with them, are prepared to volunteer their own ideas. A small task force visited the island last year for a couple of days and in the course of that time had several community meetings and were very pleasantly surprised at the level of interest amongst the community in these sorts of initiatives. As is often the case, a little bit of interest from another party able to kick-start something—to use Mr Telford's words—is just the sort of catalyst which is required by these sorts of local communities to pick up their own game, as it were, and to start looking for ways that they can be innovative themselves and build on some of the early work which has been done. We are seeing that now in some of the ideas coming through in conjunction with the establishment of the Day Care Club. There are spin-offs from that which we have not suggested but which have come to the islanders as they become more used to these slightly different forms of care.

Mr Telford—It is fair to say that the RSL sub-branch came to us seeking help and saying, 'We do not really have the expertise and the knowledge of the frameworks, responses, and so forth, to aged care.' They sought our assistance in the development of that report. That was very much an initiative that they had because they just felt as though they were not in possession of a whole stack of that expert advice. We were not either and that is why we used an independent consultant who had been working on the mainland with those services.

Senator WEST—You say there is no ACAT team there, but for a population of 3,000 in most areas of Australia there would be some semblance of an ACAT team. Is there no ACAT team there because they have not thought about it or because they do not have the qualified skilled professionals there?

Ms Anderson—I am not entirely sure, but I believe it does come down to skills in some way. The fact that we are looking at recruiting a geriatric nurse and that they themselves have identified a deficit in their skill mix in the aged care area suggests to me that they probably are under-resourced in terms of special staff working the aged care field. The other point I would make is that, in line with your observation about interest or expertise, in many ways they are not dissimilar to other remote communities that make the best they can and probably sometimes with poor physical stock. We see numbers of examples, certainly across rural New South Wales—of which you would be aware—where people are late or slow coming to the idea that the needs of the local population are changing and, increasingly, the acute care beds are taken up by nursing home type patients.

Senator WEST—I guess it gets back to how much of a comprehension does Norfolk Island have along with those other communities in New South Wales, for example, that health care does not equal doctors and acute care beds?

Ms Anderson—I would say that they have a substantial and growing understanding of that.

Senator WEST—That is a move in the right direction. You expressed concern about evacuation by boat, but you would have to agree that there are a number of situations where that really is the only alternative. If you have someone who is severely demented and you have someone who is psychotic, no airline is going to take them, nor should they.

Ms Anderson—No, I agree with you. I certainly accept that point. The issue is problematic in itself and probably it is inevitable that there will be some evacuations by boat. The worst possible scenario would be where you had somebody with significant and life threatening trauma who was also dementing, or something like that, such that you had some behavioural issues overlaying some physical symptoms. I think the dilemma there would be an acute one because you have the issues of time in an emergency service versus the difficulties of managing that patient in transit. I do not envy them those choices because I think they are very difficult. You are right, I am sure there are some circumstances where an evacuation by boat would be the only option unless you were prepared to charter an entire plane and provide special medical attendants for that individual.

Senator WEST—You would need more than medical attendants for some of them. You talk about recruiting for the provision of a physiotherapist and physiotherapist services for 12 months because you said you could not employ a physio for 0.2 of a week. Why not?

Ms Anderson—Perhaps I was not entirely clear on that point. You can, and I think there are some cost inefficiencies if that person is travelling from the mainland regularly. But overlaying that, and possibly more importantly in relation to physio, is that a lot of their work is rehabilitation, as you would be aware. It must be a continuing service. It cannot be something which happens once a fortnight. If somebody needs access to physiotherapy often they need it more regularly than that. If somebody is coming into the island or possibly even wanting to practise or is only being able to afford to practise on a very part-time basis, then access to that service could compromise the individual's health. What we are trying to do is to put in place a physio on a full-time basis at least for that 12-month period to see whether we can come to some understanding or arrangement in relation to how they generate their income beyond that.

The other point to make is we are also looking to that physio to embark upon some of these health promotion programs I was discussing with Senator Greig and really become an innovator on the island to push along some of the health promotion issues we want to pursue, including care in the home, improvements in mobility and so on. It is a physio but it is a physio-plus. We are looking to that individual not just to provide routine physio services but to extend beyond that into the community and really take on health promotion with some enthusiasm.

Mr Telford—If the example I quoted before on podiatry comes to fruition, then it is a very good investment in the longer term to actually allow that person the opportunity to go wider than the veteran community to pick up additional needs and requirements of other non-veteran patients which they may be dealing with and, in the longer term, become, in effect, a fee-for-service arrangement.

Senator WEST—What contribution is going to come from the Norfolk Island Health Service for this? It strikes me that if you are going to use them for two days a week they are getting three days out of it and, if they are not going to pay a brass razoo, one wonders—

Ms Anderson—I believe there is some contribution from the island. I do not know what proportion of their time will be spent treating veterans but I think that the health promotion will also take up a fair amount of their time if it is done well. Health promotion can take up an

enormous amount of time. Let me just have a look here. No, it is not able to give it to me in the detail I am looking for.

Senator WEST—I am happy for you to take that on notice.

Ms Anderson—Yes, I would be pleased to.

Senator WEST—Can you give us some indication as to what the reciprocal obligation—contribution—from the Norfolk Islanders is going to be? We are into reciprocal obligations these days. If they are not making any contribution that is not particularly fair to DVA. You are providing a service but I am interested to know what they are doing in return as well.

Ms Anderson—If I may follow on from that, Senator, my understanding is that in the discussions with the island they are expecting that this physiotherapist, once recruited, will spend the lion's share of their time working on behalf of or for the veterans and war widows for that year, both in the direct care and in their liaison and health promotion work. So we do not believe that it is poor value for money for us.

Senator WEST— I will be interested to see how it works and see what happens after the end of the year when it comes up for review. You also say in your conclusion:

DVA welcomes this inquiry into the provisions of health services on Norfolk Island. Clarification of the Commonwealth Government responsibilities relating to Norfolk Island will influence decisions made by DVA regarding the nature and scope of our role in supporting the veteran community on the island.

Can you expand and actually say precisely in simple language what that means?

Ms Anderson—I suppose it was our way of saying, when this committee comes to a view about the nature of the government's responsibilities for Norfolk Islanders, we as a government department naturally will need to fall into line with that. We did not want to sound as if we were trying to pre-empt the outcomes of this review, and that was why I would not take it any further than veterans, because that is what we are authorised to discuss. In relation to veterans and war widows we take a fairly straightforward view on this. The island, typical of a number of other islands, made a substantial contribution to the war efforts in World War I, World War II and indeed the Korean and Vietnam wars. I understand that every single eligible male on the island volunteered for service in one of those conflicts. We believe they have an entitlement to the health care benefits available from the government and we have operated under the act to ensure that they get access to those entitlements.

Senator WEST—You use the words 'clarification' and 'responsibilities'. Is there some lack of clarity at present?

Mr Telford—There are always times when who is funding what and whose responsibility it is to fund what causes confusion. It is very easy for us to say what we can and cannot fund because it is a clear definition under the act of looking after veterans and so forth. You have raised how far we go in assisting to kick-start some particular service, what capacity the hospital has to contribute towards that, and the broader issues of the infrastructure which is available or is not available on the island and the ageing of the population. In all of those issues we have been

working with the people on the island and the RSL sub-branch in particular. We would all benefit from some clarification of where in the future these things are going to go. We have had some good experiences in terms of our past involvement with the island. We are very confident that our emphasis on prevention and health promotion and those other more interventionist programs at the lower level are going to be very beneficial. That is not to say, though, that we could not benefit from some clarification across the board on the island or elsewhere.

CHAIRMAN—We had a Department of Veterans' Affairs consultant, as well as other witnesses, tell us that a multipurpose service on the island would serve the island better. Given that it would appear that there are several government departments that either have a responsibility in a significant sense, or at least a peripheral responsibility, for health—such as the Department of Transport and Regional Services, which has an overall responsibility for services on the island—would that not be a better way to utilise and extract the best from the health dollar on the island?

Mr Telford—I guess what we attempted to do, and through the approach that was made by the RSL sub-branch, is to go down that sort of track. Our response would be that we are providing assistance to both the treatment of veterans at the individual level, to the RSL sub-branch and to the hospital enterprise itself. In terms of the coordination and integration of other services on the island, our view would be that we are leaving them to develop that as the local response.

CHAIRMAN—Who was 'them' specifically?

Mr Telford—The RSL sub-branch in particular and those people whom we have engaged in the various mechanisms which Ms Anderson has outlined. So we would not see ourselves coming in over the top and being a coordinator; we would be looking to provide assistance and resources for the local veteran community who understand the local requirements and the local situations so that they can assist with the coordination and integration at that level rather than having it come from our own department.

CHAIRMAN—But that is limited then to veterans, is it not?

Mr Telford—It may not be. While we see them as veterans, they see themselves as members of the broader community. The RSL sub-branch is a relatively influential group in the broader community, not just amongst veterans but amongst the wider community as well. So the role they would take would go beyond just the veteran community we talk about—and indeed into the non-card-holding community as well.

CHAIRMAN—Isn't that a little nebulous to rely on the RSL as the focal point for the delivery of all health systems and services?

Mr Telford—We are not relying on them entirely, no.

CHAIRMAN—As the DVA, who would you rely on outside the RSL sub-branch on the island?

Mr Telford—As Ms Anderson says, we have got an agreement now with the hospital which is providing those services and coordinating some of those things through the geriatric nurse or the physiotherapist. It is not just through the RSL. I was talking about the RSL sub-branch as being more a community group who were organising their own constituency, not necessarily just at the health level.

CHAIRMAN—If you could be more specific about my question with respect to the multipurpose service, wouldn't it be better if the RSL sub-branch contributed to the multipurpose service, as the evidence was given to this committee, rather than deliver a service to the veterans, or assist in delivering a service to the veterans and then perhaps catch up someone in the net outside that?

Mr Telford—I am not aware of any talk about the multipurpose service. I do not know if you are, Ms Anderson?

Ms Anderson—No, I am not either, although I make the observation that, as I indicated earlier, 40 per cent of our funding to the hospital for services it provides directly is actually for nursing home type patients. The multipurpose service model would lend itself well to addressing the needs of that group and it strikes me that there might be some benefit in pursuing it. So, for the purposes of our interest, I think it is an interesting idea. It has not been raised with us. If it were to be raised with us, I think we would consider it very carefully as being potentially something useful to pursue.

CHAIRMAN—Just on that, you said you had a small task force visit the island last year for a couple of days.

Ms Anderson—Yes.

CHAIRMAN—Could you enlarge on that? How big was the task force; of whom was it composed, in a professional sense; and what does 'a couple of days' mean?

Ms Anderson—The deputy commissioner of New South Wales led the task force.

CHAIRMAN—Deputy commissioner of DVA?

Ms Anderson—Yes, in New South Wales. She led the task force and she was there for two days, from memory. She was accompanied by a group of three people. One was our health promotion manager. The other two were the Day Care Club coordinator and the HomeFront assessor. So each of the people going in, in addition to the deputy commissioner, had a specific task to perform on the island.

CHAIRMAN—They were there for two days as well?

Ms Anderson—No. I was about to go on and say that the health promotion manager was there for, from memory, three days. The other two, the Day Care Club coordinator and the HomeFront assessor, were there for a longer period—if memory serves, it was about a week. They had

particular tasks to perform: in the first instance, to establish a Day Care Club and, in the latter instance, to undertake 40 home assessments of veterans and war widows living on the island.

CHAIRMAN—Was there a report delivered?

Ms Anderson—Yes, there was.

CHAIRMAN—Would you be happy for the committee to have access to that report?

Ms Anderson—Yes, there would be no difficulty with that at all. I would need to seek approvals from my bosses and so on, but, as far as I am concerned, the report is a useful reflection of what occurred on the island.

CHAIRMAN—You have read the report?

Ms Anderson—I have, yes.

CHAIRMAN—Were you happy that it was money well spent?

Ms Anderson—Definitely.

CHAIRMAN—Has there been any implementation as yet of the recommendations in the report?

Ms Anderson—Yes. The grants, the special incentive payments I have outlined, were confirmed in the process of that visit and, in fact, were embellished as a result of that visit—we added on additional expectations for the island to achieve as a result of the time we spent there.

CHAIRMAN—Obviously you are restricted because of your limitations in your department, but, if you step outside your positions in the DVA, do you think it delivers the best comprehensive health system to the island, considering islanders are different to the mainlanders? Mainlanders do not tend to think as a community as the islanders do, or at least not to that degree. Given that, do you think that you deliver the best for the Australian taxpayer's dollar on the island, or do you think that you do need some assistance outside that?

I know that you concentrate on veterans, and that is what you are supposed to do, but, as you have said and other witnesses have said, the Norfolk Island sub-branch of the RSL sweeps up a lot of people in the net regardless of whether in fact they are veterans or not. So in a sense you are not just delivering to the veterans on the island; you are either directly or indirectly delivering your sorts of health services to other areas of the island as well. Given all that, do you think that you do deliver the best possible health system to the island?

Mr Telford—Yes, I do believe we do, given all those constraints you have mentioned.

CHAIRMAN—Could that be improved and augmented by some assistance in the terms of that multipurpose service if we brought in, say, the Department of Health and Aged Care to deliver to

a single source on the island? In your view, notwithstanding the comprehensive nature of the delivery of your health service to the island, do you think that, with the advantage of the expertise that Health and Aged Care has, as well as the Department of Transport and Regional Services, that that would be a step forward?

Mr Telford—Senator, I guess it all turns on your comment about the comprehensive nature of our health care services, and we are restricted, whether it be Norfolk Island or any other rural and remote area, by what infrastructure and services are available there. So if the veterans or war widows have a need for a service and that service is comprehensive on the island, we would obviously make better use of that. So, if that improved, our services would also be able to improve. But I was responding in terms of we believe we deliver the best service given the constraints you outlined, and if that infrastructure improved, then consequently our level of service would improve also, I believe.

CHAIRMAN—So on that basis then, you infer at least that you would want to participate in a delivery to a single source of your particular expertise and the contributions that you make to the health system on the island. You could deliver that to a single source, together with the department of aged care, for instance, and the Department of Transport and Regional Services, and those three government bodies should deliver to a single source with respect to comprehensive health care on the island.

Mr Telford—Yes, that makes intrinsic sense. Of course, we are constrained by the legislation and what capacity we have to deliver in a different sort of model, and I do not know whether you are alluding to funds pooling or some arrangement of that nature.

CHAIRMAN—Yes.

Mr Telford—But we would need to consider that when we saw the detail of it because there may well be some legislative constraints associated with that.

CHAIRMAN—There is a duplication, for instance, of some executive staff. Your group travelled to the island last year, as you said, Ms Anderson, for a couple of days; other groups from Transport and Regional Services undoubtedly travelled there as well; this committee travelled there last year and so on. There is a duplication of travel alone that must amount to quite a significant cost. That could be reduced and that money then directed into the health system on the island. For instance, the hospital, without dispute, needs refurbishing: you would agree with that?

Ms Anderson—Yes.

CHAIRMAN—And this would be one way perhaps that it could be delivered.

Mr Telford—Yes, I accept what you are saying. I guess, though, that there are not a great number of visits to the island by Veterans' Affairs. One of the main purposes of the visit last year Ms Anderson referred to was to actually do the HomeFront assessments and to undertake that accident and falls prevention strategy. I would be surprised if there were people on the island—in fact, I know there weren't at the time we went—who could actually deliver that innovative

program because no other department in Australia actually delivers the sort of comprehensive home assessment and accident falls prevention which we do. So that was justified in its own right in that we could do them all in one fell swoop and put in place a whole range of reactions to those veterans' needs. Having a couple of people involved, where there is normally only one involved in a HomeFront prevention, in this case it was better value for money to look beyond just the accident falls prevention needs of the individual and look to social isolation and some other requirements as well. So, while your point I think I take as a fair one, in the case of last year's visit it was slightly different in that sense.

CHAIRMAN—Let me finish off with one last question. Maybe you would want to dissect the question. Australia has thousands of islands, few of which are inhabited, as part of its territory, external and otherwise. We have Christmas and Cocos (Keeling) islands, as well as Norfolk, that are assessed as external territories, and the Antarctic. Why is Norfolk somewhat different in its treatment of its health services? I know that it has its own government and it has a different history. It has got a different ethnic background, largely, to Cocos (Keeling) and Christmas, but we have other islands that are not assessed as external territories and nonetheless they are islands. There is Lord Howe, Thursday, Bathurst, Groote, Kangaroo Island and so on. They seem to have a far better delivery of health services, and a more rapid delivery of health services, than Norfolk. Taking out the tyranny of distance that Norfolk bears—in fact, Norfolk islanders may consider that tyranny of distance to be an advantage—what is it that makes Norfolk people second- class citizens when it comes to the delivery of health services?

Mr Telford—You are going beyond the capacity of our competence to answer that question. It is fair to say though that—

CHAIRMAN—You could perhaps answer for yourself, and I will ask Ms Anderson in a minute.

Mr Telford—I am over the top of the history of that arrangement. But what makes us focus particularly on Norfolk as opposed to Christmas or Cocos (Keeling) is indeed the percentage of veterans and war widows who are there and our capacity to be able to deliver in a much more condensed way for those numbers of veterans on that island than on Christmas, or Cocos, or the other ones you speak of.

Mr NEVILLE—Bearing in mind we have different levels of care between the mainland and Norfolk, what is your cost per client on Norfolk compared with your cost per client on the mainland?

Ms Anderson—I apologise that I did not actually do that calculation last night as I intended to. What I need to do is add to the figure that I had the additional funding that we were providing for this financial year, and I failed to do that.

CHAIRMAN—You could take that on notice.

Ms Anderson—I would be happy to.

Mr NEVILLE—Did I hear you say in earlier evidence that it was costing you about $160,000 or $170,000 a year on Norfolk?

Ms Anderson—There are a number of—

Mr Telford—Some are one-off items.

Mr NEVILLE—That was a one-off project? Obviously you have got greater economies of scale on the mainland.

Mr Telford—And I think also—

Mr NEVILLE—But you do not have the same costs on Norfolk either.

Mr Telford—It is a calculation which is fraught because—

Senator WEST—Can you compare apples with apples doing that?

Mr Telford—We will try and see what we can do.

Senator WEST—You might find they are apples and oranges.

Mr Telford—That's right. The $25,000 evacuation would skew the figures immediately.

Mr NEVILLE—Senator West's comment is quite correct—it is unquestionably apples and oranges—but it would be nice to know how much we invest in each client on the mainland in comparison with each client on Norfolk. That might give us a bit of a feel.

Mr Telford—We will take it on notice.

Ms Anderson—The figures I was looking at last night indicated that we were probably paying less for Norfolk veterans and war widows than we were for veterans and war widows on the mainland, which was interesting as a statistic because you might surmise the opposite. However, the conclusion which was drawn in the evaluation I read was that because of the limitations on access on Norfolk, people were more self-sufficient. They tended to make health care decisions for themselves which were not about accessing services.

Mr NEVILLE—I understand that. Do they get the same pension rates on the island as they do on the mainland?

Mr Telford—My understanding is yes.

Mr NEVILLE—Is that both pensions?

Mr Telford—Yes. There is no difference in terms of the pension rates irrespective of anywhere you live.

Senator WEST—That is DVA pensions?

Mr NEVILLE—The Department of Social Security pensions do not apply on the island.

Senator WEST—No.

Mr NEVILLE—So what component of the pension rate is paid by DVA in those cases? Does it depend on the category, whether they are TPI and so on?

Mr Telford—That is indeed right, and their level of assessed disability and so forth.

Senator WEST—Could one of the reasons why less money was spent on DVAs on Norfolk be the fact that when they get to the time of needing critical and expensive care they come to the mainland?

Ms Anderson—Yes. I would pleased to do the exact figuring and provide it to the committee because I do not know what was factored into that analysis. I need to address that specifically to make sure that we were doing a just comparison.

Mr Telford—We can probably look at the cost incurred on the mainland as well.

CHAIRMAN—The committee thanks you for your attendance here today, Ms Anderson and Mr Telford. If there are any matters on which you 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 corrections if necessary.

[10.12 a.m.]

ROBERTS, Group Captain Geoffrey James, Director, Battlespace Management, Aerospace, Royal Australian Air Force

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 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?

Group Capt. Roberts—None.

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 hearings be held in camera and the committee will consider your request. Before we ask you some questions, do you wish to make an opening statement?

Group Capt. Roberts—No, Senator.

Senator WEST—In your submission, which is brief, you outline that until several years ago RAAF provided Norfolk Island with medical evacuation support but that that has changed with the advent of civilian aeromedical retrievals. Are you able to give us some figures as to what number of retrievals you were doing before the change and what it is now?

Group Capt. Roberts—No, Senator. I can take that on notice.

Senator WEST—That would be very helpful. I am interested in the second paragraph where you say that that arrangement was a mutual benefit because it received an excellent service and the RAAF AME teams gained valuable training experience. But a couple of paragraphs later you say that the current evacuation methods are not providing any training benefit at all. Whenever I have asked questions in other places—and other senators as well—about evacuations and sudden urgent searches, we have always been told that it is coming out of the training budget and that it is good training experience. Why in this submission are you saying there is no training component and no training value?

Group Capt. Roberts—There are two issues. One is an aircrew training component, and the other is the aeromedical evacuation team training component. For the aircrew, there is no training aspect on the transit to the island, the landing, the sequence of events and the flight details to come back. For the AME team, for the doctors and nurses that go on this, there is benefit and training available. At the end of the day, it is the cost-effectiveness of that sort of training and the cost of actually providing that service to the military and the diversion of those resources into providing that emergency service.

Senator WEST—You say the cost of each flight is estimated to be $131,000.

Group Capt. Roberts—That is correct.

Senator WEST—Are you able to give us a breakdown of what that $131,000 might be?

Group Capt. Roberts—As best I can, the $131,000 is full cost recovery, as per policy, for the aircraft. About eight hours of aircraft and aircrew time are included in that. There are aspects such as capital depreciation, contract maintenance elements and those sorts of things, as well as the AME team itself. The crew on a C130 comprises five people, and the AME team will vary, depending on the type of situation that they are going into. On average, I am advised that it is about six people.

Senator WEST—You are saying the cost estimate is $131,000. What do you charge Norfolk Island health services or DVA or whoever for those retrievals?

Group Capt. Roberts—Again, I do not have the detail on the financial aspects of that. In an emergency situation where the air commander can approve those flights, to my knowledge recovery action from Air Command certainly is not taken against the island at $131,000. I will have to take that on notice and come back to you.

Senator WEST—I am happy for you to do that, because we just had DVA say that the last retrieval they had had cost them $25,100. They thought that might have been a RAAF one.

Group Capt. Roberts—My understanding is that on civilian medical evacuation the costs which have been provided by DOTRS I believe are around $23,000 to $25,000.

Senator WEST—What is the approval process? Can you run through how the decision is made and whether it will be a RAAF evacuation or a civilian evacuation and who or how?

Group Capt. Roberts—Yes. There is the basis of the defence policy that we run. We do this task under the policy of defence assistance to the civilian community.

Senator WEST—Yes, I know the category in the budget.

Group Capt. Roberts—Part of that is that we should not be using defence resources as a substitute for capabilities or other expertise that are available from other government agencies or from the private sector itself.

Senator WEST—Yes.

Group Capt. Roberts—However, where these are inadequate or not available at the time, then we obviously would do that in cases of emergency. The process would be a request going into our Headquarters Air Command. An assessment of the request would be made under a number of criteria, which is also covered in the policy document. In general, that criteria would take in considerations, that the air movement is considered necessary by a service medical authority—we have a senior medical officer at Air Command—to save life; that alternative means of transport, including civil air ambulance, are not available or would bring an unacceptable delay which would further jeopardise the patient's recovery. Under the service medical authority, the

assessment is the patient's condition, the aircraft, the equipment and the staff availability to actually go and do the mission and whether the AME, aeromedical evacuation, can be conducted successfully and that it is appropriate. With that advice given to the air commander, the air commander can then authorise the flight.

Senator WEST—So it is the air commander who authorises the flight?

Group Capt. Roberts—In those emergency situations where those criteria are met. The other one is that the flight is operationally feasible, that is, we can actually get an aircraft in there and back out. If it is international there are issues of diplomatic clearance because we are a state aircraft.

Senator WEST—This is for Noumea and places like that elsewhere in the South Pacific?

Group Capt. Roberts—Yes, but not for Norfolk.

Senator WEST—So it does not require ministerial approval?

Group Capt. Roberts—The only time it requires ministerial approval is when there is an alternative source of transportation available and the request has still come in to us. Then there would be a conflict in policy and ministerial approval will be required to actually go and do that. So what we would normally see there is emergency, or critical, cases where people's lives are in immediate danger and they have to be evacuated. We would generally not go up to the minister because they would have to be handled right now. They are handled by the air commander. What you would probably find, and I do not have the facts with me, is that in routine aeromedical evacuation—where people are coming back to Australia and their life is not in immediate danger—they are the types of requests where the air commander would say that there are alternative means of transport and therefore if we wish to pursue this further we need to get the minister's approval.

Senator WEST—What is the length of time it takes to assemble a crew, both your flight crew and your medical crew, and then get the aircraft in the air? What is the flight time to Norfolk Island?

Group Capt. Roberts—We do not purposely have crews on standby for this situation. What we routinely have is a C130 on 12-hour standby to meet national defence activity tasks and requirements, which basically means that from the time we are alerted to the time we actually get airborne and provide the service is 12 hours. We paint that as the worst-case scenario. To the credit of our airlift group personnel, who run the C130, they always manage to do it in much less time and are very responsive. That is for the aircraft and aircrew. We do not have any formal standby requirements for our aeromedical evacuation personnel, the medical personnel, doctors and nurses. In some cases we actually require specialist doctors to go with the flight of specialist personnel.

Senator WEST—Depending on the injury or the condition that they have to treat?

Group Capt. Roberts—Yes. What that means is that we need to bring reservists in, so there is the coordination of actually bringing in reservists. We do not have any formal standby for the medical team itself. Because of that there is a call-out roster rather than a standby commitment—if we have to go then we will get in contact with you and you will come. I understand that there have been cases where take-off has been delayed because the specialist reservist we require happens to be in the operating theatre and as soon as they get out they will come and fly. But generally we have been much more responsive in less than that 12-hour time. Basically if they can put a crew together—and it may not be the standby crew—in the time within the safe employment of those people in crew duty times, et cetera, then they will launch straight away.

Senator WEST—If someone is on standby what are the restrictions on their movements? Can they only move a certain distance from the base or do they have to stay on base?

Group Capt. Roberts—That is right, depending on the length of standby. A 12-hour standby enables us to actually employ people and aircraft on other activities and tasks, rather than have a dedicated aircraft sitting on the ground tying up resources and a dedicated aircrew on the ground. If you really want that 24-hour very quick response, you would probably have two crews tied up as well as tying up a medical team. We just do not have those sorts of resources. On a 12-hour standby, the aircraft may not be located at Richmond—it could be in Darwin, Tindal, Townsville or some other part of the country. Generally, they will try and use the aircraft within the local area, so that they can get it back on the ground, turn it around and be ready in the quickest response time they can. What I am getting at here is that, because it is not a core defence business or activity and we do not have dedicated standby people for that particular activity, we cannot guarantee that we will always be responsive in time or can actually provide the service. I think we have been reasonably fortunate that we have been able to do that.

Senator WEST—What is the flying time to Norfolk from Richmond?

Group Capt. Roberts—I would have to get back to you with the exact flying time.

Senator WEST—It depends on the weather and stuff, I know.

Group Capt. Roberts—I would say about three hours.

Senator WEST—Three hours there and three hours home?

Group Capt. Roberts—With turnaround times on the ground. Generally prior to launch there would be aircraft pre-flighting activity and that type of thing, because the aircraft also are not configured internally for aeromedical evacuation.

Senator WEST—I know what they are configured like internally, and they are not very comfortable for troop transport. Cargo is what you usually use them for.

Group Capt. Roberts—That is right. I am from a maritime background on P3s and they are much more comfortable.

Senator WEST—That is a different story.

Group Capt. Roberts—So there is that configuration aspect as well as the type of equipment that needs to go in there we do not routinely stock because it is not our prime business. But there may be some specialist equipment that we need to bring in for this particular case. There is that compatibility with the aircraft and I just draw an analogy to no mobile phone use on civilian aircraft. There is that sort of aspect with this role that we have to be careful of as well.

Senator WEST—Given that it is three hours there and three hours back, that is six hours minimum flying; you then have the preparation of the aircraft and time on the ground in Norfolk. If you had a crew bring the aircraft in from Darwin, for example—although I think it is more likely to be somewhere a bit closer than that—how do you go with flying hours?

Group Capt. Roberts—There are a number of hours set aside. We are realistic and we know that with defence aid to the civil community we will be called out at some stage during the year, whether it be for flood assistance or whatever. There are a number of hours which are allocated in support of national support.

Senator WEST—No. I am thinking of flying hours for the crews.

Group Capt. Roberts—For the crew that brings the aircraft back, we would have a look at their crew duty time. If it were to expire before the end of the mission, then we would put another crew into that aircraft. So, whilst the request would come in and while the aircraft is relocating and refuelling—and it may have to drop in somewhere to pick up specialist equipment, maybe in Sydney—they would be getting a crew together that could actually go out and do the task. Again, I come back to the point that we cannot guarantee the availability of that crew, because we may have all our crews and aircraft committed. At this time, within Air Force as well on the availability of these aircraft, we are changing over our C130 fleet. Of course, availability of aircraft becomes critical to meet all defence activities and demands as well. It is very close management. So we cannot guarantee that those assets would be available to actually provide that assistance.

Senator GREIG—To the best of my knowledge I do not think I have seen a C130.

Senator WEST—Yes, you have.

Senator GREIG—I do not know that I have. Could you give us a brief description of what kind of plane we are talking about here for my benefit?

Group Capt. Roberts—It is a transport aircraft, with high wing, four engines, turbo prop—propellers, but the propellers are driven by a jet engine. It is a cargo aircraft, purposely designed for military to take troops into battle for parachute drops; you can put dry vehicles into the back. It has a rear ramp so that you can load in and off there as well as through smaller cargo doors. It is designed to operate into unprepared airstrips. It can operate into some of the outback strips which are quite small. It has a short take-off and landing capability. It is designed for the tactical theatre. Air Force uses it for that but also for strategic airlift which is basically the high-level transit and movement of cargo which the C130J will primarily do. Our tactical squadron runs C130Hs which are the camouflaged aircraft and they do most of the tactical work. They are

airconditioned and pressurised, but there are limitations to that. It is an aircraft built to military standards, not civilian standards, and so there may be some issues with that as well.

Senator GREIG—So we are talking about a large aircraft?

Group Capt. Roberts—A very large aircraft.

Senator GREIG—In that sense, why is that aircraft chosen for these trips? Is it because of the greater speed or is it because of the internal space for medical facilities?

Group Capt. Roberts—We really do not have an aircraft with the space available, although there is more space in there than what is required to actually fulfil those types of roles. For instance, the Caribou is slow. It is another transport aircraft but it is slow. It is a shorter range aircraft not suitable to go to Norfolk and provide aeromedical evacuation.

Senator WEST—They are also being phased out, aren't they?

Group Capt. Roberts—Yes, that eventually will be the plan. There really are no other aircraft. You are looking from the C130 to a Boeing 707, which would be inappropriate. Also there are runway considerations at Norfolk which we need to come into. The other aircraft will be P3C, a maritime patrol aircraft which is not set up to take any litter patients or anything like that, so really the C130 is probably the most suitable. The chances are that there would be one at Richmond, which is the squadron's home base, that would be available to go and do this type of work.

Senator GREIG—Are there no bases in northern New South Wales or Southern Queensland that could cater for the C130?

Group Capt. Roberts—The C130 can operate out of all those bases but the home base is Richmond where all the maintenance facilities are. The squadrons actually reside there under a group named Air Lift Group which manages the 707 and the Caribou. We have our Nav trainers which are the 748s and we have got some light Beech aircraft there and the C130s.

Senator GREIG—You mentioned earlier that the department was changing over the C130s. By that did you mean you were getting newer ones or different models?

Group Capt. Roberts—We are getting different models; the same line of aircraft as the C130J that has a bigger capacity for cargo. Visually it has a lengthened fuselage and it is painted grey which is basically the difference.

Senator GREIG—I understand that ministerial approval is required for such trips where there is not an alternative flight available. Are you aware of any cases where that has been denied?

Group Capt. Roberts—No. I spent some time as Director Operations at Air Command and I was there for four years. There were some cases on international bases where there were alternatives and when it was put to the people requesting, they explored those alternatives and ended up utilising that service.

Senator GREIG—With respect to government policy in regard to Richmond air base, is it the government's intention to continue to maintain the site, if not upgrade it?

Group Capt. Roberts—I am not privy to the long-term plans of—

Senator WEST—Okay. Where is Richmond in the DRP list of short-, mid- and long-term surplus to needs?

Group Capt. Roberts—I think in the longer term that Air Lift Group will move out of Richmond.

Senator WEST—So that is the five- to 10-year time cycle going back to 1997?

Group Capt. Roberts—That is correct, but that time line seems to be continually slipping.

Senator WEST—It is moving, yes.

Group Capt. Roberts—So I would not see us moving out of there in the immediate future. But even with the C130 movement, it would most likely be an east coast base because of the type of activity that is involved. Most of our forces are on east coast base, most of the support infrastructure and most of our training activity in the short term, with larger exercises being conducted in the north. So, if it moves from Richmond, there are alternative bases under review such as Williamtown and Amberley near Brisbane, those types of things. But I cannot give you any definite timings or dates on the future of either of those bases.

Senator GREIG—You mentioned that it took a crew of six to organise one of these flights. Can you give us a rough breakdown on what that means in terms of a flight crew and medical staff?

Group Capt. Roberts—There is a total of 11. There are five flight crew staff, which comprises two pilots, because it is a two-pilot aircraft, a flight engineer, a navigator and a load master to make sure that things are correctly stowed, et cetera, and loaded down in the back of the aircraft. The composition of the AME team of, on average, six people is very dependent on the type of crisis which they are going to evacuate and whether there will be specialist people in there or not. So the figures that I have been given are that on average it will be about six and the composition of that will vary with the situation.

Senator GREIG—And is there a minimum requirement in terms of hierarchy of medical staff on these trips, in terms of a particular specialist or—

Group Capt. Roberts—Not that I am aware of. Generally you will have a doctor who will lead the team, and it will be an Air Force doctor or at times it may even be a reserve Air Force doctor.

Senator WEST—Would you use civilian doctors as well if you have not got a reservist or a permanent officer of that particular category that you needed?

Group Capt. Roberts—I think that would have to be done in consultation with our senior medical authority when they are discussing the support that is going to be required and the critical nature of the patient. They are of course talking to the medical people on Norfolk Island as well to assess. There have been occasions where medical staff from Norfolk Island have been brought back with the patient, but as to whether we actually go out and purposely seek specialist civilian staff, I do not think so, but I will have to take that on notice.

Senator WEST—Okay.

CHAIRMAN—I will just fill in for Mr Neville while he is on that urgent phone call, Group Captain. There has been some evidence given to the committee, I think it was on Norfolk Island when we sat there last year, that the private sector was able to do an evacuation quicker—that is, a Medivac quicker—and more efficiently and with more expertise, and cheaper, if that is not efficient as well. Would you agree with that?

Group Capt. Roberts—These—

CHAIRMAN—That is not to disparage the RAAF. I had a wonderful—

Group Capt. Roberts—I understand. The thing with the civilian aeromedical evacuation team is that they generally have purpose aircraft with the equipment required on board and they are configured for that. They also have people who, I guess on a daily basis, manage aeromedical evacuation which has some significant differences and expertise required other than just straight medical evacuation via other means. So they certainly do have expertise in that. I would agree that it would appear to be much cheaper to utilise the civilian aeromedical evacuation services. With the establishment of a number of these within the states, they have developed fairly efficient structures to be able handle this type of work.

CHAIRMAN—What is the payload of a C130, a Herc, in tonnes?

Group Capt. Roberts—I really could not give—

CHAIRMAN—They are heavy lift, aren't they?

Group Capt. Roberts—Very heavy lift—you are talking about taking trucks and—

CHAIRMAN—Fifty tonnes is not too far out of the question, is it—probably more?

Group Capt. Roberts—I would say it would be up around the 60-tonne mark, as an estimate, so it certainly has the capacity to lift.

CHAIRMAN—In a military configuration, how many personnel could it take, roughly?

Group Capt. Roberts—Normally, in a seated configuration, which is webbing and does not conform with civilian standards, it would be around 94 to 100 personnel.

CHAIRMAN—So we have an aircraft that takes 100 personnel plus the crew, and that could lift 60 tonnes, being sent on a three-hour journey one way and three hours coming back, so a six-hour journey, to pick up, often, just one person?

Group Capt. Roberts—That is right. The reason we do that is because there is no alternative and the patient's life is in jeopardy.

CHAIRMAN—I understand that necessity and that imperative, but it is rather ludicrous to send an aircraft like that. If I can give an analogy, there are some bus services throughout Australia that, instead of sending a bus on a scheduled night run when there is no evidence of any passengers, will send a taxi out if people want it. That is a crude analogy to what I am about to say, and that is: wouldn't it be better for your operations to contract with the Royal Flying Doctor Service with their aircraft that are smaller, that are cheaper, that can scramble much quicker than a C130, for obvious reasons, and for the RAAF to literally pay the Royal Flying Doctor Service out of their budget in these emergencies?

Group Capt. Roberts—I come back to an initial statement that I made, that this type of activity is not a Defence core activity or responsibility. However, we do react to assist the civilian community. What would be more appropriate, I believe, is that either the Flying Doctor corps or some other civilian or government organisation responsible for health care or provisions of services to the island goes down that path. My personal view—not Defence's—is that certainly overall, in a holistic government sense, it would be cheaper to take one of these expert aeromedical evacuation civilian teams to go and do that. Because it is not a core function of Defence, I certainly would not see Defence going into a contract arrangement with a civilian organisation to provide that.

CHAIRMAN—The point of my question was just to amplify the ludicrous situation of sending a heavy-lift aircraft that can take 100 personnel and 50 or 60 tonnes of heavy-lift equipment, such as trucks or tanks, to an island to pick up one person. The RFDS flies to most of the islands around Australia, including Cocos (Keeling), Christmas, Bathurst, Thursday, Groote, Kangaroo et cetera. Yet this is one exception because it is often not perceived by Australians—and I include some Defence personnel and some people in parliament—as being part of Australia; it is seen as being something that is disparate from Australia, and that is not true. I guess I am asking you for a personal opinion, and it is a valued opinion. Shouldn't the government look very seriously at including Norfolk Island in the loop of the RFDS and leave the Defence Force to defence, particularly with the limited amount of heavy-lift aircraft that we have?

Group Capt. Roberts—I totally agree.

Mr NEVILLE—What is the distance to Norfolk Island? Do you know that?

Group Capt. Roberts—No.

CHAIRMAN—It is about three hours.

Group Capt. Roberts—It is probably a little bit less than the three-hour mark. I can take that on notice.

Mr NEVILLE—I think when we went across on the Falcon it was a bit under two hours.

CHAIRMAN—That is a bit faster than a Herc.

Senator WEST—The Falcon is not exactly the slowest member of the fleet.

CHAIRMAN—It is a bit faster and a bit more comfortable than the Hercules.

Mr NEVILLE—Did you read the evidence from other witnesses?

Group Capt. Roberts—No.

Mr NEVILLE—Mr Hughes, who is the chairman of the hospital board on Norfolk Island, was somewhat critical of the procedures of the bureaucracy. He said that it can take three to nine hours for the RAAF or a commercial operator to get permission for an aircraft to leave the tarmac, and then you have the flying time from the mainland to the island. The best part of a day is taken before something can happen. Is that a reasonable summation? He is saying that it is three to nine hours before the plane even leaves Australia.

Group Capt. Roberts—That is correct. We do not keep an immediate stand-by aircraft committed to this type of activity. We normally keep C130s because of other defence requirements on a 12-hour stand-by. We see that as the worst case in that from notification we can redeploy an aircraft back into Richmond ready to go and organise a crew and a medical team in that time frame.

Mr NEVILLE—I get the impression from your submission—not you personally—that you would like to be rid of it, to put it bluntly.

Group Capt. Roberts—We believe there are more efficient alternatives to using a defence resource in this particular case, particularly given overall frequency of providing that sort of service and particularly, whilst we do fulfil and we have in the past met those requirements, we cannot guarantee 100 per cent because of the availability of aircraft and personnel.

Mr NEVILLE—Again—and I am not saying you personally, I am talking the RAAF in general—I found the statement that there was very little training value in a trip to Norfolk a bit hard to cop. Like the chairman I found it a bit difficult to comprehend, in that this is, with the exception of the Antarctic territories, our most distant outpost. It is a self-governing unit of the Commonwealth. In an extreme situation it might, at some time, be subjected to some sort of threat and it might be used as a diversionary thing for boat people or any number of other activities. I would have thought the RAAF's knowledge of that area and the ability to get there quickly and use it for training would have been an integral part of our outer defence.

Group Capt. Roberts—The training issue and the importance of Norfolk Island are on the strategic picture. The training issue for the crews in conducting an AME is basically take-off,

landing and transit training. They get sufficient of that within the Australian environment itself and the variety of areas in which they operate.

Mr NEVILLE—Where else do they go three hours over water?

Group Capt. Roberts—They will operate to places such as Cocos and Christmas at times and, also, in support of the RAAF detachment up at Butterworth. They will go on some US courier runs, bringing cargo to and from. The particular aspect is that they are at high level and they take off and land. It is really no different from—

Mr NEVILLE—I understand that. Senator West made a very good point. Whenever we go and rescue some visiting sailor or there is some incident off our shores somewhere, the government, the RAAF and the Navy are very quick to say that we should not be looking at this in terms of expense; this is a very important training exercise. I found a bit of a flavour of the disingenuous in this. Those sorts of things are taken as read when we do that sort of thing, our international obligations, yet it would appear we do less for citizens in our most remote areas. While I accept, if you tell me so, that there is no particular training value in that, Mr Hughes, or Mr Gardner, makes the comment from the island, and listening to the last witness, that there is no way of getting an ACAT team over there. If as part of a training flight, even if you were going over there on a quarterly basis for a training flight, an ACAT team went with you, wouldn't this be a very sensible marriage of resources of two Commonwealth departments?

Group Capt. Roberts—You raised a couple of issues on training value. For example, the Autissier-type rescue, severe weather, low level operations in all weather, is good training value. High level transit to and from an area is not. So, the comparison between Norfolk and those types of things are quite different in the types of environment in which you will be operating and the types of skills that you are going to need. In fact we are employing two different types of aircraft, in some cases, in these types of environments. There is a bit of apples and oranges in that comparison. The importance of Norfolk Island, its strategic value and whether we should be doing more as far as exercising and that in there is not for me to say. I really cannot answer that question. The other issue on those training flights that may go into Norfolk Island and whether we should take ACAT teams or not, I think comes back to the fundamental question as to whether it is a defence responsibility to provide aeromedical evacuation. I do not think it is. It comes under Defence assistance for civil community. Other agencies are more responsible for the medical and health care on that island than Defence. It is not a core Defence issue.

Mr NEVILLE—But not many have experience of three hours over water, even the RFDS.

Group Capt. Roberts—Cocos is a considerable distance and so is Christmas Island. With high level transit over water there is the navigation aspect to it and security. I believe they have demonstrated that clearly with their current operations.

Mr NEVILLE—Fair enough. Notwithstanding all the things you have said—and I do not think anyone wants to see the RAAF or any of the other armed services burdened with unnecessary tasks in the civilian community—your submission says that you do 20 AMEs per year on average around Australia. I found it extraordinary that, if you were doing that number of emergency medical lifts of one sort of another, and having regard for the size of the Hercules,

there is not a module that could immediately be put into the plane that would carry stretchers, cradles for drips and various things like that, a module that would be wheeled in and bolted in, or strapped in. Do we have to concoct that on every occasion and set that all up as a one-on-one, each item individually? We do not have a thing that is just rolled in ready to go?

Group Capt. Roberts—No, not to my knowledge. The aircraft is not permanently configured for AME, so when it is actually diverted onto that task, it will have to be configured to take stretchers. But to reconfigure it for stretchers does not take that long; in fact the aircraft has capability to do that with its passenger racks internally, within the aircraft itself.

Mr NEVILLE—Are there facilities there for drips if they are needed, and that sort of thing?

Group Capt. Roberts—The specialist medical equipment has to be brought in.

Mr NEVILLE—And special seats for doctors and nurses who need to be close to the patients and those sorts of things, are they readily available?

Group Capt. Roberts—I am not familiar with the configuration requirements within the aircraft, but I believe that special seats are not fitted. It is what is available in the aircraft. The equipment that is brought in is specialist medical equipment required for meeting the patient's needs on the transit.

Mr NEVILLE—Would you say your gut feeling is that a greater concentration on a civilian aeromedical group would be the best solution to Norfolk's problems?

Group Capt. Roberts—I concur with that.

Mr NEVILLE—Thanks, Group Captain.

Senator WEST—This is probably not a fair question to you and you may want to take it on notice. I had hoped the brigadier would have been here to answer it. What are the future plans for AME teams given this civilianisation of Defence medical and health services? I am after details of where they are likely to be situated if they are going to continue with an ADF AME, the numbers that you think you are going to need to continue with and where the locations of those would be?

Group Capt. Roberts—I am not involved with the review of the medical services, but I will take that question on notice.

Senator WEST—That is Brigadier Ramsey's area.

Group Capt. Roberts—It definitely is, but we would still need an in-house capability, an in-service capability, for AME for those particular combat zones and areas in which we need to bring people out of the forward areas into the safer support areas.

CHAIRMAN—You said that you were four years with operations in the Royal Australian Air Force. Is that a department within the RAAF, or a wing?

Group Capt. Roberts—That area is within Headquarters Air Command. They have an operations cell there which coordinates certain activities at a higher level rather than the detailed tasking.

CHAIRMAN—Aircraft movements?

Group Capt. Roberts—Yes, aircraft movements.

CHAIRMAN—Personnel movements?

Group Capt. Roberts—There is a section that looks after personnel within Headquarters Air Command in terms of filling positions and posting cycles. Personnel management in respect of aircrew qualifications is—

CHAIRMAN—Type of aircraft?

Group Capt. Roberts—done at what we call the Force Element Group level. The particular one relevant to our discussion is Air Lift Group. That is managed at a one star. They manage the training and the development of capability within that specific area. At Headquarters Air Command in operations we would handle these types of requests that come in. We have handled requests in the past, even from the Royal Flying Doctor Service, in situations where they do not have the capacity to meet the requirement. One that springs to mind was a very large gentleman in Broken Hill who just could not fit physically into the Royal Flying Doctor Service aircraft.

Senator WEST—Nor the commercial aircraft either.

Group Capt. Roberts—No. He had a serious heart problem and desperately needed to go to Adelaide, so it was a matter of using a forklift to get that individual into a C130 to transport him down. We handle those types of situations as well. But, yes, the operations area actually provides the higher level tasking for the F111s, the maritime P3s as well as our transport wings et cetera. We will provide them with the task. They will then allocate crews and aircraft and work out the best way of meeting that task, because they are the experts in that particular aircraft and in the role that it does.

CHAIRMAN—You mentioned some contact you had with the RFDS. Was there any time during your four-year tenure at operations that you had cause to call on the RFDS for medical evacuations from anywhere?

Group Capt. Roberts—No. There was one occasion when we had a RAAF person in Wagga Wagga who needed to be airlifted to Sydney.

CHAIRMAN—How was that arranged, to your memory?

Group Capt. Roberts—From an operational point of view I did not approve the use of the RAAF C130 to go down to Wagga Wagga, pick the individual up and fly them in.

CHAIRMAN—Why was that—because of cost?

Group Capt. Roberts—No, because at the time—and I am going back quite a few years now—with the operational demands being made and the stand-by configuration of the aircraft, we actually used the New South Wales Air Ambulance Service.

CHAIRMAN—It seems somewhat illogical from my view, taking the isometric view that I do on these sorts of situations where you have the Australian Defence Force's aircraft and the Royal Flying Doctor Service, which has built up an immense expertise over the years and a network Australia wide—they know dirt strips well, they have special medical officers and people such as nurses they can call on who volunteer their time—that there is no bilateral understanding between the RFDS and the Royal Australian Air Force with respect to evacuations from places like Norfolk Island. There could be a considerable reduction in cost and time. Would you agree that perhaps there needs to be a review of that to see whether the RAAF should not stand aside merely because it is part of the defence arm of Australia—a very important part and a revered arm I might say; nonetheless there is a perception that the RAAF is aloof from this, 'We are here to fight for you. We are not here to evacuate people from Thursday Island or from Norfolk Island'—and that there should be some liaison with the Royal Flying Doctor Service?

Group Capt. Roberts—I am not too sure whether on a medical ground there is liaison. I would imagine that medical staff know each other within those areas and that there may be. I do not know. Certainly, from an operational point of view, there is not that liaison, mainly because we are not into civilian aeromedical evacuation. It is not a designated task for the Defence Force, and so the expertise—

CHAIRMAN—But the fact is that you do it.

Group Capt. Roberts—We do it if the civilian organisation cannot handle it or is unavailable at the time.

CHAIRMAN—That was the point of my asking you about a permanent liaison with the RFDS. Don't you think there should be some closer contacts and links with respect to that? If you are given instructions or you are asked to provide a C130 to evacuate someone, not just from Norfolk but from any other outlying part of Australia—Groote, Thursday, Bathurst or any of those other outlying islands—and you have no liaison with the RFDS, do you assume that the RFDS has been contacted, that they cannot do it and that therefore you should consider supplying an aircraft?

Group Capt. Roberts—We go through the agency requesting that support to ensure that they have contacted the civilian agencies that provide that service. If that service cannot be provided, then why can't it be provided in the time frame?

CHAIRMAN—So you satisfy yourself that that service cannot be provided to, say, Norfolk Island on a telephone conversation?

Group Capt. Roberts—I would have to take that fully on notice because the senior medical authority may, in fact, have those liaisons established at a medical level on whether they can be done or not. I think that the liaison issue is much wider than just the Royal Flying Doctor Service. Because there are other agencies out there such as CareFlight and the individual state provision

of these types of flights—whilst they are helicopter—there is a bigger implication on the provision of that Australia wide. Specific to Norfolk Island there is, of course, the capability to actually get out there and come back. So I would have to take that on notice, but certainly from an operations level the senior medical authority would provide that advice to me. For the exact consultation that they go through, I would have to take on notice and provide that to you.

CHAIRMAN—Please do. It seems to me, though, that there is an inordinate lack of coordination between all of the civilian aircraft and organisations that are capable of supplying Medivac and the RAAF and that it may not be a case where the RAAF is the last source of call for an evacuation. How many aircraft—and I include in that the C130s—were left on the east coast of Australia when the East Timor emergency was at its peak? Were there any aircraft left here for purposes like that which could be used for Medivac from Norfolk Island?

Group Capt. Roberts—Yes. There were aircraft still available on the east coast. With Timor—I am trying to recollect from memory here—we probably had about eight or 10 aircraft tied up at its peak. As other nations contributed to the airlift, that dropped back. There were still aircraft being employed on the east coast on tasks other than Timor. This is where I come back to. They may not have been at Richmond at the time, but they would have been doing other tasks.

CHAIRMAN—So there was always an aircraft here that could have been used in an emergency such as an evacuation from Norfolk Island?

Group Capt. Roberts—Possibly. It depends on the exact availability of the crew, the crew time and that sort of thing whether it was appropriate to use it or not.

CHAIRMAN—That ambiguity suggests that there was not one here. You said there possibly was and there possibly was not as well.

Group Capt. Roberts—There is an aircraft, but whether we could have turned it around in the time frame to meet the critical nature of the aeromedical evacuation is what I am saying we cannot guarantee. We could have turned the aircraft around but, if it was going to take 12 hours, then that may not meet the critical nature of the aeromedical evacuation.

CHAIRMAN—Can I put it to you that it is possible that a suitable aircraft could not have been turned around in the maximum nine-hour period that it seems to take on other occasions for medical evacuations from Norfolk.

Group Capt. Roberts—That is a possibility. Although we have met the task previously, there is always that possibility.

CHAIRMAN—Thank you, Group Captain Geoffrey Roberts, for your attendance here today.

Group Capt. Roberts—Thank you.

[11.10 a.m.]

BURNESS, Mr Mark Alexander, Director, Medicare Eligibility Section, Financing and Analysis, Department of Health and Aged Care

MASKELL-KNIGHT, Mr Charles Andrew, Assistant Secretary, Financing and Analysis Branch, Department of Health and Aged Care

TAYLOR, Ms Tanya, Australian Public Service Officer, Medicare Eligibility Section, Financing and Analysis Branch, Department of Health and Aged Care

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 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 submissions?

Mr Maskell-Knight—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 hearing be held in camera and the committee will consider your particular request. Mr Charles Maskell-Knight, before we ask you some questions do you wish to make an opening statement?

Mr Maskell-Knight—I would like to briefly summarise our submission. It is addressed especially to the fourth term of reference for the inquiry relating to access to Medicare. Our submission provides a brief history of the position of Norfolk Island under Medicare. As you would be aware, the current position is that Norfolk Island is not covered by the Medicare arrangements. However some residents of Norfolk Island, who are Australian citizens and were resident in Australia, will be eligible for Medicare on return visits to Australia within five years of when they last resided in the country. The same access extends to all Australian residents who no longer reside here but who return within five years.

We have discussed a number of options to improve access to health services for Norfolk Islanders with the Norfolk Island Administrator and with the Department of Transport and Regional Services. These options are all based upon the Norfolk Island government accepting financial responsibility for the costs of these services. They include providing access to the Medicare payments system for Norfolk Islanders and purchasing a comprehensive health insurance product for the island population. As we said in the submission, we are ready to work with the island administration in developing these options and, as necessary, liaising with the Health Insurance Commission or providing advice on the design of suitable health insurance arrangements.

CHAIRMAN—Does anyone else wish to make an opening statement? If not, I will ask the first questions as everyone else seems to be a little preoccupied. Mr Maskell-Knight, you said

that Norfolk Island must accept responsibility for its health care and then you qualified some of those areas on which it should contribute if it was going to be part of the Medicare loop in Australia. But what of the other external territories of Australia, and I particularly talk about Christmas Island? There has been a modern, large, multimillion-dollar hospital built on Christmas. That was last year or the year before—it is quite new. Given the cost of that hospital and dividing that into the amount of people that reside on Christmas Island, doesn't that appear to be somewhat inequitable with respect to Norfolk, which does not have a multimillion-dollar modern hospital?

Mr Maskell-Knight—I think you are asking me for an expression of opinion, Senator. The fact is the government policy is that Medicare does not extend to Norfolk Island, as a self-governing territory. It has been the policy of this government and the previous one. I do not think I am in a position to canvass whether that is equitable with regard to policies that might apply elsewhere.

CHAIRMAN—What about the comparison with the Northern Territory, which is self-governing, or the Australian Capital Territory, which is self-governing? Can you offer a comment on that with respect to health care?

Mr Maskell-Knight—The Health Insurance Act, which is passed by this parliament, specifies that Medicare extends to the states and territories and it defines the two territories as being the Australian Capital Territory and the Northern Territory. It expressly states that it does not apply to external territories.

CHAIRMAN—So with respect to any new hospital or facilities to extend or refurbish the Norfolk Island Hospital, they are completely out of the loop? The act which you administer assiduously, by the sound of it, is not all-encompassing with respect to Norfolk, which is a 'special case'?

Mr Maskell-Knight—It is a special case, as are the other external territories. Medicare, as defined in the act, applies to mainland Australia and Tasmania, if we are going to talk about islands.

CHAIRMAN—I do not think you could describe Tasmania as an external territory. It is an integral part of Australia, the same as Norfolk Island is. It just happens to be one that is recited in our Constitution a little differently. So what is there that the health department could do with respect to Norfolk, to assist Norfolk in upgrading its health facilities, comparable to other parts of Australia?

Mr Maskell-Knight—I do not think, within the bounds of current government policy, that we can do much in the area of upgrading their facilities. I note that the Grants Commission inquiry into Norfolk Island concluded that the island had sufficient revenue capacity, were it utilised, to meet its own infrastructure needs. That information probably may have led to the government taking the policy it has.

CHAIRMAN—What of the emergency evacuation of the 37,000 people, a significant number of whom are Australian citizens? Is your department happy that all that can be done with respect to any perceived emergency is being done?

Mr Maskell-Knight—I might go back a step. The fact is that we, as you say, are here to administer the health insurance and health service provision regime that is constructed under Medicare. It is not part of our portfolio responsibilities to concern ourselves about the health care situation on Norfolk Island.

CHAIRMAN—Your responsibilities encompass financing and analysis. What does 'analysis' mean in this case? I do not want you to give me an English lesson, Mr Maskell-Knight—I know what 'analysis' means. What does it mean in your case?

Mr Maskell-Knight—Our branch is responsible for Medicare statistics, for hospital financing under the health care agreements, for Medicare eligibility. We also conduct policy work relating to how the health financing system within Australia works and how it could be bettered in various ways.

CHAIRMAN—You may have to take this on notice if you do not have it with you, but what are the statistics with respect to the cost of Medicare, of medical services delivered to Christmas Island on a per capita basis and Norfolk Island on a per capita basis?

Mr Maskell-Knight—We would have to take that on notice. I am not sure whether we would be able to provide anything on Christmas Island. In relation to Norfolk Island, we would not be able to provide any statistics. Medicare services are not payable to people on the island. I doubt it would be possible to identify people resident on the island who return to Australia within the five-year window and receive Medicare services, but I will investigate that.

CHAIRMAN—Let me see if I can assist you. Your responsibility as the Assistant Secretary to the department is for financing as well as the analysis branch. Maybe you could take this on notice as well. What was the cost of building the hospital on Christmas Island?

Mr Maskell-Knight—That is a matter I understand for the Transport and Regional Services portfolio. It was not funded from ours.

CHAIRMAN—It was not funded through the health department.

Mr Maskell-Knight—It was not funded through the health department.

Mr NEVILLE—You had no part of it?

Mr Maskell-Knight—No.

Senator WEST—Would it be true to say that the only hospitals you have any knowledge of—

CHAIRMAN—Perhaps I could just finish off, Senator West, and then I will come to you.

Senator WEST—I just wanted to follow up that particular line.

CHAIRMAN—What does your section undertake with respect to financing? Financing what specifically?

Mr Maskell-Knight—We are responsible for payments to the Health Insurance Commission that they then pay out in the form of Medicare benefits and are responsible for payments to the states under the health care agreements which they use as a contribution to funding the public hospitals.

CHAIRMAN—What about funding for the Northern Territory?

Mr Maskell-Knight—They are included in those arrangements. As a territory they have their own Australian health care agreement, as does the Australian Capital Territory.

CHAIRMAN—So that comes under financing for the Northern Territory or is it included in an amount—

Mr Maskell-Knight—The Northern Territory is treated exactly the same as the states in respect to hospital funding and Medicare funding.

CHAIRMAN—What about Cocos (Keeling) and Christmas?

Mr Maskell-Knight—In Cocos (Keeling) and Christmas Islands the provision of hospital services certainly is the responsibility of the Department of Transport and Regional Services. In relation to Medicare services, I will have to defer to Mr Burness.

Mr Burness—Services on those islands would be met through Medicare where they were identifiable as being provided there.

CHAIRMAN—As opposed to Norfolk which is not met through Medicare?

Mr Burness—Correct.

CHAIRMAN—What about Medicare card holders on Norfolk Island? Do you have statistics with respect to that?

Mr Maskell-Knight—I do not believe so. The criteria for being eligible for Medicare is that you are a resident of Australia and, for the purposes of the act, Norfolk Island is not included within that. There may be people resident on Norfolk Island who by some means or other have convinced a Health Insurance Commission officer that they are residing in Australia. That would technically be a breach of the Health Insurance Act.

CHAIRMAN—What about the statistics, Mr Burness, for those people that live as permanent residents of Cocos (Keeling) and Christmas with respect to your particular area of Medicare? Do you keep records of that discrete from other states?

Mr Burness—If they have a registered address in terms of the Medicare database, yes, they would be able to be identified.

CHAIRMAN—Could you identify those for the committee and come back to us if you need to take it on notice with respect to the amount that is spent through Medicare on both Christmas and Cocos (Keeling)?

Mr Burness—We can examine that for you.

CHAIRMAN—I do not want you to examine it for me, Mr Burness; I want you to give the committee the exact numbers, thank you. Do you understand what I mean?

Mr Burness—I certainly do.

CHAIRMAN—I just have one last question and that is with respect to the eligibility section of the Department of Health and Aged Care. What are the different criteria for Australian citizens that you could explain to the committee? In other words, are there some Australians that do not fit the model that allows them to access Medicare facilities? I speak specifically of Norfolk Islanders. Are there any other areas in Australia that are out of the loop in that regard, or is it peculiar only to Norfolk Island?

Mr Maskell-Knight—The basic criterion is that you are a permanent Australian resident. That includes Australian citizens who reside within Australia, it includes anyone from another country who has a permanent resident status within Australia and it also includes, at the margins, people who have applied for permanent residency and meet certain other criteria. Temporary residents, even long-term temporary residents, are not eligible. For example, an American citizen who is an employee of an American company who is posted to Australia for three years would not receive permanent residency status and would not be eligible.

CHAIRMAN—Do we have a reciprocal arrangement with any other nation equivalent to Medicare? In other words, can we reciprocate with Australians who need to facilitate Medicare overseas?

Mr Maskell-Knight—There are a number of reciprocal health care agreements and Mr Burness can give you the details of them.

CHAIRMAN—You will take that on notice?

Mr Maskell-Knight—I think we can do that now, can we not?

Mr Burness—We have the United Kingdom, Italy, Malta, Sweden, Finland, New Zealand, Netherlands and the Republic of Ireland.

CHAIRMAN—That is the limit of it. When you say, Mr Maskell-Knight, that you need to be an Australian citizen—I think that is fairly basic and it is fairly well understood—and you need to be resident in Australia, then is Australia defined as being its territories as well?

Mr Maskell-Knight—It is not in the Health Insurance Act.

CHAIRMAN—It is not with respect to the health act?

Mr Maskell-Knight—No.

CHAIRMAN—What defines Australia with respect to the health act?

Senator WEST—I want to be clear it is the Health Insurance Act.

CHAIRMAN—I do not want the full detailed definition of it. What defines Australia with respect to the health act in terms of its territories and in terms of its landmass?

Mr Maskell-Knight—Australia includes the territory of Cocos (Keeling) Islands and the territory of Christmas Island and elsewhere the definition of territories includes those but it does not include other territories.

CHAIRMAN—So it does not include the Antarctic or Norfolk Island?

Mr Maskell-Knight—No.

CHAIRMAN—They are the only two?

Mr Maskell-Knight—Yes.

Mr NEVILLE—Would you agree that Norfolk Island is in a unique situation?

Mr Maskell-Knight—I think, again, that that is asking for an expression of personal opinion.

Mr NEVILLE—Within the context of the Australian experience, in delivery of government services, it is unique in comparison with the other states and territories?

Mr Maskell-Knight—I suppose it is unique in many ways, yes.

Mr NEVILLE—It is not a trick question.

Mr Maskell-Knight—Norfolk is certainly different.

Mr NEVILLE—Do you have a good understanding of Norfolk Island, its general history and so on, because this is central to the other questions I want to ask you?

Mr Maskell-Knight—I am not sure how good an understanding I have. I have certainly studied 19th century Australian history, and Norfolk Island featured largely within that.

Mr NEVILLE—My understanding is that Norfolk Island is, generally speaking, about 80 per cent self-sufficient. Is that a fair summation of it? They are not, so to speak, a basket case. Can you tell me the cost per patient on Norfolk Island to the Commonwealth Department of Health?

Mr Maskell-Knight—With some difficulty. As I said before, we do not meet the cost of any services on the island. So on that basis the answer would be zero. To the extent to which some persons resident on Norfolk Island receive services on the mainland, there is some cost there.

Mr NEVILLE—Let me come at it another way. What does it cost per patient on the mainland or, if you like, the estate, in terms of health care? What is the average utilisation? You say that your division is responsible for Medicare statistics. Therefore, what is the average cost per patient on the mainland?

Mr Maskell-Knight—The cost per patient of Medicare benefits is around $330 at the moment, give or take a bit. The cost of pharmaceuticals is $160, roughly. The cost the Commonwealth puts into the public hospital system would be of the order of $320 per capita, and the states, broadly speaking, match that. The total health care system as a whole, counting the amounts of money people pay out of pocket and everything else, and the costs of dentists and physiotherapy and other things that are not covered by Medicare, averages about $2,500.

Mr NEVILLE—So we are looking at about $810 as the Commonwealth's contribution to the average patient on the mainland?

Mr Maskell-Knight—Yes.

Mr NEVILLE—What proportion of the total health cost is covered by Medicare?

Mr Maskell-Knight—Without meaning to be flippant, it comes down to what you mean by Medicare. If you mean—

Mr NEVILLE—I mean the Medicare contribution derived from the levy.

Mr Maskell-Knight—The Medicare contribution derived from the levy would be a very small number. The last time I looked it was about—

Mr NEVILLE—About one-fifth?

Mr Maskell-Knight—Are you saying the health care system as a whole, or just of the Commonwealth contribution to it?

Mr NEVILLE—Of the Commonwealth contribution.

Mr Maskell-Knight—The Commonwealth at the moment is spending about $23 billion on health and related services. That includes nursing homes and public population health. I would have to take the question on notice to give you a precise answer, but the Medicare levy covers about one-fifth.

Mr NEVILLE—Therefore, could we not argue that Norfolk Islanders make no contribution to the Medicare system, which after all only covers 20 per cent of the real health costs provided by the Commonwealth?

Mr Maskell-Knight—Nor do they make a contribution to the other 80 per cent.

Mr NEVILLE—That is the point I am coming to. They are 80 per cent self-sufficient. Wouldn't you think that 80 per cent of the remaining 80 per cent, or 64 per cent of what the Commonwealth would otherwise provide for the average Australian citizen, would be the entitlement of a Norfolk Islander?

Mr Maskell-Knight—The entitlement of the Norfolk Islander is spelt out in the Health Insurance Act.

Mr NEVILLE—I am not worried about the Health Insurance Act in that respect. What I want to know is: as a matter of equity coming from the base, Medicare only provides 20 per cent of the Commonwealth's contribution anywhere in Australia.

Mr Maskell-Knight—And the other 80 per cent comes from taxes.

Mr NEVILLE—Taxes, yes. You come to the point very readily. I am saying that Norfolk Islanders, in their semi-independence, do pay a tax contribution equivalent to about 80 per cent, given the services that they have that a mainlander pays. Therefore, the Australian on the mainland gets virtually 80 per cent of his health care—unless he is privately insured—from general revenue. If Norfolk Island takes 80 per cent of the burden of its own care—and I repeat the question to you—would you not think it were fair that the Norfolk Islanders should be able to claim up to about 65 per cent of the health care costs from the Commonwealth, if they are to be on a basis of equity with the mainland?

Mr Maskell-Knight—I think you are asking me for an opinion about what government policy is, and I cannot give that.

Mr NEVILLE—I was relying on you because you have the statistical grip, and you also advise the government on health financing systems policy. I think those were your words.

Mr Maskell-Knight—That is correct.

Mr NEVILLE—If I cannot talk to you about this, who in the bureaucracy could I talk to?

Mr Maskell-Knight—I think you are trying to get officials to comment about the equity or otherwise of government policy and certainly the guidelines of Senate committees preclude that.

Mr NEVILLE—This is a joint standing committee. I am trying to get a grip. We are conducting an inquiry into health services on Norfolk Island. Germane to that is an understanding of what contribution people make on the island as compared with the mainland, what taxation people pay on that island compared with the mainland and what rights to health might conceivably on a basis of equity come from those formulas. I see you as the Medicare statistician

and the person responsible for health finance systems policy. I wanted a comment from you, because, quite frankly, you are the person who comes to the point of those various items.

Mr Maskell-Knight—Maybe I can help you by referring to the Commonwealth Grants Commission report on Norfolk Island which essentially said that the revenue raising capacity of the island is such that it could provide all services at a mainland standard.

Mr NEVILLE—I think the general view of the committee might be somewhat different from that.

Senator WEST—Some of the members of the committee.

Mr Maskell-Knight—I should say that I have not made a study of Norfolk Island. I am not aware of the revenue raising capacity, or any other matters that are relevant there. As I understand the Grants Commission report, they were charged by the government to examine precisely those issues. The conclusion they reached is that Norfolk Island has sufficient resources to enable them to provide a mainland standard health service.

Mr NEVILLE—Just going on to the comparison with Cocos and Christmas, could you tell me what proportion of the population of Cocos and Christmas Islands contribute to the Medicare levy?

Mr Maskell-Knight—I cannot. I would not be able to answer that. I would have to seek that information from the tax office.

Mr NEVILLE—Would you take that on notice?

Mr Maskell-Knight—Yes.

Mr NEVILLE—I would like to know what proportion of people on Cocos and Christmas pay the Medicare levy.

Mr Maskell-Knight—I will approach the tax office and ask them. I am not sure. I do not know whether they would be able to answer that or not.

Mr NEVILLE—We were talking before about the entitlement to Medicare of people who were on the island. They have to convince the department of their bona fides. People go over there and spend time in some form of public service. For example, there are doctors and specialists who spend a long period of time on the island and provide services to the health system there. There is also a major construction going on there at present to do with a cliff on the island. When people are on some form of public service on Norfolk, are they covered by Medicare from Australia, or do they claim on Norfolk Island's health system and are reimbursed by Medicare? What is the methodology in those cases?

Mr Maskell-Knight—I cannot answer the question in terms of what it is, but I can tell you what it is not. Medicare does not pay for the services provided on Norfolk Island. I would imagine that if they were employees of a construction company, the construction company would

be responsible for their costs under some insurance arrangement. If they are long-term medical officers posted to the island, I imagine they would be covered by the island's own health care arrangements.

Mr NEVILLE—Could you check that through for me and could you take that one on notice as well?

Mr Maskell-Knight—Again, Mr Neville, that is something I would have to ask another department, but I am happy to do that.

Mr NEVILLE—Thank you very much.

Senator WEST—In your submission, and certainly in the transcripts of the previous hearings when the committee has made a visit to Norfolk, the island health minister indicated that they were looking to pursue discussions with the department about access to Medicare and other issues relating to Medicare arrangements. At the time of writing this submission, the department had had no contact, no correspondence and no dialogue with the Norfolk Island authorities. Has that changed in recent times?

Mr Maskell-Knight—We have had a number of meetings with the Administrator of Norfolk Island. I think we had two meetings with him, and we have had a number of discussions with the Department of Transport and Regional Services, but we have not directly spoken to the island administration, the health department on the island, so to speak.

Senator WEST—Is that because they have not pursued it or discussions and negotiations have not yet reached that particular appropriate stage?

Mr Maskell-Knight—We have had discussions with the Department of Transport and Regional Services and we are happy to work with them on fleshing out some of these options more, but they have not come back to us on that.

Senator WEST—The Norfolk Island authorities have not come to you with an option or with proposals?

Mr Maskell-Knight—No, Senator.

Senator WEST—So aged care gets no look in. The committee was told that some residents who are not entitled to Medicare benefits do have Medicare cards. Do you have any evidence of the Medicare scheme being abused by some residents of Norfolk Island? You talked about it depending on whether they are a permanent resident here or they come back here within the five years. How long do you have to be back to be able to keep your Medicare entitlements alive?

Mr Maskell-Knight—I will have a go at this, but Mark might need to fill it in. As I understand it, if you come back within five years after you last resided in Australia, you can access services instantly. Beyond the five years, you have to demonstrate an intention to reside here permanently.

Senator WEST—Yes. Mr Burness, do you have anything to add to the answer?

Mr Burness—No, not at this stage.

Senator WEST—I suppose what I am thinking of is a situation where somebody comes back for a week's holiday within every five years. Would that kick the five years out each time they come back?

Mr Burness—They would probably be queried. Within that five years, their Medicare renewal would come up. They would therefore probably come back without a Medicare card. They would then seek to obtain a Medicare card and would then have to establish that they were residing in Australia, which they could not.

Senator WEST—So you are not aware of any abuses that are taking place in relation to people on the island accessing Medicare?

Mr Burness—Not specifically. There has been some anecdotal commentary about that issue. We have sought from the Department of Territories, and I think it was from the island administration itself, a list of the residents of the island. We wanted their names, addresses and ages, and none of that has been provided to us. We have had some data provided to us of their age and sex profile to work out some of the data which is before this committee, but we have never been provided with the details of the territory population to make any really hard figured calculations.

Senator WEST—If somebody came back to Australia more than five years after they had ceased to reside here, how long would they have to wait before they could access a Medicare card? Could they actually go and prove they were going to stay here and access one immediately? There is no waiting period, is there?

Mr Burness—If they can establish that they are residing here by a number of pieces of evidence, which include all sorts of things like where they are on the electoral roll, where their children are, where their house is—all those factual issues—they would have immediate access. But I might add that if there were a delay in their capacity to access, their eligibility is not compromised in the sense that if they came in on day one and it took three months to establish it, there would be no quibble about the fact that they had an eligibility from day one once it was established and they would be able to retrospectively claim any of those Medicare benefits.

Senator WEST—We have heard that the aged care facilities on the island are not good—almost non-existent, it would appear—so, as people age and develop health problems, they may well come back to mainland Australia. Do you have any handle on what the numbers are that might be doing that?

Mr Maskell-Knight—I do not think we would, Senator. The Health Insurance Commission would be better placed but I doubt that they would collect that sort of information.

Senator WEST—Are you aware of any telemedicine pilots going from the island?

Mr Maskell-Knight—I am not personally aware. I understand there are some but I do not know about the detail.

Senator WEST—Has the department any involvement in those, or is that with the other department, the Department of Transport and Regional Services?

Mr Maskell-Knight—I would have to take that on notice. I do not believe so.

CHAIRMAN—Thank you for your attendance here today. If there are any other matters on which we might need additional information the secretary will write to you. You will be sent a copy of the transcript of the evidence to which you can make corrections.

[11.55 a.m.]

ALLEN, Ms Sarah, Policy Officer, Self-Governing Territories Section, Department of Transport and Regional Services

ELLIS, Ms Maureen Therese, Director, Self-Governing Territories Section, Territories and Regional Support Division, Department of Transport and Regional Services

KAVA, Ms Rosanne, First Assistant Secretary, Territories and Regional Support Division, Department of Transport and Regional Services

CHAIRMAN—I now welcome witnesses from the Department of Transport and Regional Services. 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?

Ms Ellis—No.

CHAIRMAN—The committee prefers that all evidence be taken in public, but if you wish to give confidential evidence to the committee you may request that the hearing be held in camera and the committee will consider your particular request. Ms Ellis, before we ask you some questions, do you wish to make an opening statement?

Ms Ellis—Ms Kava will make an opening statement.

Ms Kava—The Department of Transport and Regional Services, through its Territories and Regional Support Division, has carriage of the administration of Commonwealth responsibilities in relation to the self-governing territory of Norfolk Island. Under the Norfolk Island Act 1979, the Norfolk Island government has a range of powers and functions broadly comparable to the ACT and Northern Territory. They also have some powers that are exercised by the Commonwealth with regard to immigration, customs and quarantine. Health is a schedule 2 matter under this act, and by this I mean that schedule 2 matters are those over which the Norfolk Island government has sole responsibility. Commonwealth health legislation, including the Aged Care Act 1997 and the Health Insurance Act 1973, does not extend to Norfolk Island.

The department's interest in Norfolk Island health is twofold. Firstly, the department, under its regional services responsibilities, is of the view that people living in rural, regional and remote communities in Australia have a right of access to a level of services, including primary and secondary health care and health insurance, comparable with those of their fellow Australians. Secondly, where practical and appropriate, the department works with the office of the Norfolk Island Administrator and the Norfolk Island government to provide information and assistance and to facilitate liaison between Norfolk Island and relevant Commonwealth agencies that also have carriage for health responsibilities. As a self-governing territory, the Norfolk Island government is always at liberty to approach Commonwealth portfolio ministers and other state governments directly on matters of mutual concern.

Our submission was prepared in consultation with the administrator and the official secretary on Norfolk Island. It drew on a number of reports, complaints to the Minister for Regional Services, Territories and Local Government and other printed sources, and it was cleared with the Department of Defence, the Department of Health and Aged Care and the Department of Veterans' Affairs. The department made its submission to the committee on the basis of concerns held for some time in relation to access by residents and visitors to Norfolk Island to a comprehensive range of health services. Some of these concerns were highlighted in the Commonwealth Grants Commission report on Norfolk Island in 1997. It concluded that, in the area of health insurance and private health care, the standard of government services on Norfolk Island was below that provided on the mainland and that the below standard of service was of particular concern to the less well-off. It also stated that community health services provided on Norfolk Island were narrower than that available in small remote communities on the mainland.

The department's specific concerns against the committee's terms of reference included the lack of preventative health initiatives on the island that have implications for both residents and visitors, visitor ignorance of the health arrangements on Norfolk, the limitations of the Norfolk Island health care scheme, particularly in relation to low income earners, the standard of aged care facilities on Norfolk Island falling short of the standards required and provided on the mainland, access to and cost of health care on Norfolk Island in comparison to the mainland, lack of Norfolk Island residents' access to national health programs and the significant reliance of the Norfolk Island government on the RAAF for emergency medical evacuations, the lack of alternative health insurance coverage for emergency patient transport and the trauma to residents and visitors of the high cost, of the order of $23,000 or more, of evacuation at the time of the medical crisis.

Health is one of the issues discussed at the intergovernmental meetings held between the Commonwealth and Norfolk Island governments. The issue was discussed at some length at the last IGM, held on Norfolk Island in August 1999, in particular in relation to veterans' health, hospital and health insurance and medivacs. The Commonwealth, through the Department of Veterans' Affairs, has recently funded a consultancy assessing the aged care needs of veterans on Norfolk Island which resulted in the report on the visit to Norfolk Island by the New South Wales state Office of Veterans' Affairs, which was August 1998.

The main thrust of the recommendations of this report is to create a community oriented aged care services structure which explicitly attempts to provide all needed support to the aged to enable them to continue living in their own homes with dignity and independence for as long as possible. At the time of the IGM a further Department of Veterans' Affairs delegation visited the island to assess aged and community care needs, to initiate home front assessments and to establish a day care club on the island. The Minister for Regional Services, Territories and Local Government had also written to the Minister for Health and Aged Care in July 1999 seeking his support in exploring options for reviewing Norfolk's current hospital and health services, particularly in relation to health insurance and Medicare matters.

The department had had discussions at officer level with the Department of Health and Aged Care and was developing an options paper which would include data previously requested from the Norfolk Island government. I note that whilst a discussion paper was drafted the matter was put on hold pending this inquiry. The paper was used as the basis for our fairly lengthy

submission. Following the intergovernmental meeting, the Commonwealth undertook to facilitate communications between the Norfolk Island government and the Minister for Health and Aged Care, the Hon. Dr Michael Wooldridge. A meeting was arranged between the Norfolk Island Minister for Health, Mr Geoff Gardner MLA, and Dr Wooldridge for late November 1999. This meeting occurred.

In relation to medivacs, the administrator's office had, prior to the intergovernmental meeting, taken action to resolve some confusion surrounding procedures by publishing them in the local newsletter, the *Norfolk Islander*. While the Department of Defence has advised they will continue to provide assistance to Norfolk Island in times of genuine need, they have stated that aeromedical evacuation support for Norfolk Island should be the exception rather than the rule.

Officials also undertook to help develop a more expeditious method of handling medivacs. A draft protocol was prepared by this department and forwarded to the CEO of the Norfolk Island administration for discussion. I believe Minister Gardner referred to this document in his submission to the JSC public hearing on Norfolk in November. However, we have received no formal response from them on that document. Subsequently, a copy of the Department of Defence protocols for medical evacuations has been made available by the department to the Norfolk Island government through the Office of the Administrator.

General information concerning the Royal Flying Doctor Service and telemedicine facilities has also been provided to the Norfolk Island government through this channel. The department recently arranged a meeting with the Aged and Community Care Division of the Department of Health and Aged Care to explore the potential for the provision of some programs to Norfolk Island. This meeting revealed that, as the Aged Care Act does not extend to Norfolk Island, none of the initiatives provided for mainland residents for residential or home care are available to the elderly on Norfolk Island.

The department believes the application of Medicare services to Norfolk Island is a matter between the Norfolk Island government and the Commonwealth Department of Health and Aged Care. The Department of Transport and Regional Services has not progressed discussions on this matter with the department of health since the initiation of this inquiry so as not to anticipate any outcomes of this inquiry. There are a number of options under which Medicare services could be extended to Norfolk Island. An amendment to the Commonwealth Health Insurance Act 1973 could also provide for continuity of health care cover for mainland residents when visiting Norfolk Island.

The department acknowledges the good work of health professionals on Norfolk Island and the recent high priority placed on health issues by the Minister for Health, Mr Geoff Gardner MLA. The recent election of a new Norfolk Island government and the early indication of a preference to work with the federal government on priority areas have created an ideal opportunity to progress some important issues on Norfolk Island, including health. The health review initiated by Mr Gardner and commenced in January this year, with the assistance of Griffith University, is developing a health profile for Norfolk Island that will go a long way towards identifying the type and level of services required on the island. We are advised the team are in the final stages of their data collection.

To capitalise on this good work, it is important that the Norfolk Island government develop a detailed strategic plan for the development and management of health care on Norfolk Island. Health care, including hospital, medical and community services, on Norfolk Island must be coordinated to ensure better health care for residents and for visitors. Perhaps the biggest challenge facing the new Norfolk Island government is addressing their limited administrative and financial capacity to make progress on priority issues like health. We understand the Norfolk Island government is currently reviewing health, immigration, land and their revenue raising capacity. This department is only too happy to assist where possible and practical. However, the burden for progress on the health issue rests with the Norfolk Island government as a self-governing territory and with the Norfolk Island administration.

It is important that the island's positive relationship with the Department of Veterans' Affairs continues. A strong relationship between the Norfolk Island government and the Department of Health and Aged Care would also be appropriate to assist the Norfolk Island government in providing their residents and visitors with an acceptable standard of health care. In our view, liaison with the Department of Health and Aged Care is essential for the future possible application of Medicare services in some form to visitors and/or residents, the potential for reciprocal arrangements for Medicare services similar to that with New Zealand and the provision of advice and potential assistance to Norfolk Island in relation to the expansion of primary health care on the island.

Health is an issue for which the Norfolk Island government is responsible. The department trusts its contribution to this inquiry has identified areas of concern and provided some constructive options for assisting the Norfolk Island government with its review of health services and the provision of future high level standards of health services to the residents of and visitors to Norfolk Island.

Senator WEST—Mr Chairman, after this department has appeared before us, we might want to consider bringing the representatives of department of health back to answer a few questions that have arisen from this submission and from some of the answers that have been given already, so I would flag that.

Mr NEVILLE—To which I add, Senator, 'Hear! Hear!'

CHAIRMAN—I think that is an excellent suggestion. I am sure that the secretary will—

Senator WEST—I will flag that because you have talked in your submission about the need for close liaison, not just between you and Norfolk Island, but actually involving the other departments here on the mainland. I had thought that the aged care division was in the business of actually being a bit commercial and proactive in selling some of their resources and their knowledge on aged care; I wonder why they have not picked up Norfolk Island. Do you know why no full response has come back from the draft protocol for Medivacs that has gone to the CEO over there?

Ms Ellis—It may in fact have been overtaken by events in that the draft protocol was put together when there was a time of some confusion and some difficulties on the island. I think on the committee's visit to the island, it was raised that it can take up to nine hours for the plane.

Since then there have been discussions between the Norfolk Island government and Department of Defence. The Department of Defence have provided a clear list of their protocols and I think in fact that it clarified whether or not ministerial approval was also required and cut out a role of at least one of the particular parties. To our knowledge there have not been the same problems since.

Senator WEST—Right. So those problems to some extent have been overcome?

Ms Ellis—We will have the opportunity to clarify that with representatives from the Norfolk Island government. They are coming out in two weeks. It is our intention to clarify that in fact that is now resolved and that we do not have to pursue the draft protocols that we did discuss.

Senator WEST—Who from the island was out this week?

CHAIRMAN—The new chief administrator, the Hon. Ronald Nobbs.

Senator WEST—What is the progress in the negotiation of discussions with the RFDS in terms of Medivac? Can you give us some indication there?

Ms Ellis—That is in fact a matter for the Norfolk Island government. Because they are a self-governing territory, our role, as Ms Kava alluded to, is to facilitate discussions where we can. It is a balancing act to ensure that we do not step in where we are either not invited or not wanted. What we have done is pursue some information in relation to the RFDS and made that available to the Norfolk Island government through our office of the administrator. Being aware that the Norfolk Island government's capacity is a little limited, we do what we can to pick up that sort of thing. But as far as progressing discussions, I could not comment.

Senator WEST—Okay, that is fine. In terms of health there, do you know if there are any health demographic statistics and disease incidence statistics available that we can look at to compare with mainland Australia to see if the life expectancy is anything like ours, if rates of dementia for elderly people are the same and how incidences of certain diseases, such as lung cancer, diabetes and those sorts of things compare?

Ms Ellis—I am not aware of any recent studies. We could check the files and see if we have any old studies. The actual health inquiry that has been initiated by the Norfolk Island government with the assistance of the Griffith University kicked off in January on the island. They are in fact developing a health profile on Norfolk Island through interviewing residents, taking blood tests, getting medical histories et cetera, so we will hopefully in the near future have some very up-to-date data on that sort of thing. But as far as I know, the team are still on the island. I think they are winding up their data collection this week and next.

Ms Kava—I should just point out that the Norfolk Island government will have that information. We will not necessarily—

Senator WEST—I guess that is the next question. Does anybody have it? It must make it a little bit difficult for you to be able to carry out some of your administrative and facilitating roles if you are not able to have those statistics and gauge their accuracy. You have to know how the

statistics are collected if we are going to compare the incidence of, say, diabetes on Norfolk and in Australia. Unless you know that the statistics are being collected using the same methodology, they are not going to be of any use to anybody for comparative purposes, are they?

Ms Kava—Senator, we would have to go to the expert department in any case for that sort of information. We are not specifically skilled in the health area, as Maureen said previously. Because health is a schedule 2 matter it is the sole preserve of the Norfolk Island government. But they are at liberty to approach us or any other department for assistance and for information and we are certainly willing to assist them. I guess it is a matter of the Norfolk Island government wanting us to be involved and we cannot presume upon that relationship given the clear responsibility lines for health.

Senator WEST—If we are going to spend any money in Australia on health, giving it to the states under whatever agreements there are, we require those states to provide us with statistics and information. One of the problems that we have had in the past has been that with emerging programs and the information and statistics being collected, the methodology that is being used was not necessarily the same and you were measuring apples with oranges. I would be hesitant to say, 'Yes, these schemes and initiatives are great ideas and we can give this amount of money,' if we are not measuring apples with apples. I think that somebody should look at ensuring that the methodology used on Norfolk Island is the same as that being used here—and maybe I should have asked the department of health about that and that is one we can look at for the future. Would you be conscious of the need to ensure that the methodologies are similar between Norfolk Island and the mainland so that we can actually get an accurate comparison of the statistics and the incidence and things like that?

Ms Kava—Given that the study is actually being done by an Australian university, and I am only assuming therefore that it would bear some relationship with national standards in that regard, I would have to agree with your point that health is really the appropriate department to ask in terms of the consistency of that data.

Senator WEST—There does not seem to be a great deal of consultation taking place between health and Norfolk Island—is that correct or not?

Ms Ellis—It would appear so. We did arrange a meeting with the health minister from Norfolk Island, Mr Gardner, with Dr Wooldridge in late November last year. We are not aware of the actual outcome of that meeting. The department has had quite a bit of liaison with the department of health but with regards to the direct link between Norfolk Island and the department of health I am not aware that there has been extensive dialogue there.

Senator WEST—As the department that would have the overarching control and the consultative, liaising and facilitating role for Norfolk Island, you are unable to tell us what the outcome has been of the consultations or discussions with Dr Wooldridge and Dr Gardner?

Ms Kava—I am not aware that we have been advised. Minister Gardner will be coming to the Australian mainland in a couple of weeks time so we are quite happy to follow that up. But, again, it is a matter of health being a schedule 2 matter about which we cannot appear too intrusive, but we can certainly follow up with the department of health. They have not, as far as I

know, provided us with any information. We have no direct responsiblity—I am sorry to be repetitive on this point—for health matters, per se, because our minister has no responsibilities for health matters on Norfolk. Certainly we try to facilitate, in terms of talking to departments ourselves and arranging meetings, but we were not in attendance at that meeting. We are happy to pursue the issue both with Minister Gardner and the health department.

Senator WEST—I am just—I am not quite sure what the word is—

CHAIRMAN—Perplexed?

Senator WEST—That is probably a very good word—as to how you are able to operate, or what constraints that must place on you if a department within the Australian context does not get back to you and give you feedback on the results of some consultations that you actually initiated. Perhaps I need to think about that one some more.

Mr NEVILLE—May I first, Ms Kava, congratulate you and your colleagues on this submission. It is comprehensive and it is pertinent. Without exceeding the bounds of policy, you have made very clear-cut comments on equity and such matters. That gives the committee the ability to be able to proceed with some sense of confidence in what you have given us. I thank you very much for that.

I know it is very difficult—as you say, you are not in the delivery of health care—but I might start with the RFDS. As you say, we do not want to interfere in the prerogatives of the Norfolk Island government but, after all, it is an inquiry into the provision of health care services on Norfolk Island. The alternative to finding some mainland instrumentality to provide evacuations is the RAAF and other mainland based services. So I do not think we should be too precious in offering suggestions to the Norfolk Island government. My personal view, at least from the anecdotal evidence we have picked up now, is that there would be some merit in exploring the RFDS out of Sydney and/or Brisbane.

I was doing some rough calculations here earlier and it looks like the average trip of the RFDS in Australia is about 653 kilometres. The average cost is about $1,000. On this briefing note provided here by the secretariat, which I am sure they could make available to you from their last annual report, they had 22,000 evacuations across Australia for a total turnover of a bit over $20 million. So you can get a bit of a grip on what it is costing them per service. I know that is a fairly tenuous argument on its own; you would have to discount that for distance and other factors. But I think it gives us the flavour of what is possible compared with $131,000 suggested by the RAAF, even though they might be only charging the department—was it $25,000?

Ms Kava—It was $25,000.

Mr NEVILLE—It looks like they need about 25 trips a year of one sort or the other. I just wonder whether you would like to comment on the possibility of your department exploring that more fulsomely.

Ms Kava—I would just like to just clarify those numbers. As far as I am aware, the Department of Defence does not charge our department in any way for those trips. The cost is borne by the Department of Defence. I do not know whether that—

Mr NEVILLE—I thought you said there was a transfer of costs of $25,000.

Senator WEST—That was the DVA.

CHAIRMAN—There is no cost, Mr Neville, to Norfolk Island, but there is to the other territories.

Mr NEVILLE—Yes. There is a cost to the Commonwealth in one form or another. What is the best way to ameliorate those costs? Is it to leave it with commercial operators, with the RAAF or perhaps to explore the RFDS?

Ms Kava—It is certainly a difficult one. As has been mentioned, any evacuations from other territories are paid for directly. Indeed, in the Indian Ocean territories, for which we provide services, the arrangement is quite different because they are a non-self-governing territory. We actually fund those evacuations.

Mr NEVILLE—What are they costing you per trip?

Ms Kava—I would have to take that on notice, Mr Neville.

Ms Ellis—Having worked on the Cocos islands, I know a medical evacuation was $23,500 about three years ago. But the $25,000 mark is similar.

CHAIRMAN—Was that to Darwin?

Ms Ellis—No, to Perth.

Mr NEVILLE—Do you have any handle on what proportion of Cocos and Christmas residents are Medicare contributors?

Ms Ellis—No, we would not necessarily have that sort of data.

Mr NEVILLE—It is not your primary field of concern. Do you not have it from your experience as administrator either?

Ms Ellis—Obviously, all taxpayers are Medicare levy contributors. On Cocos you have the difficulty of a high proportion of unemployment and social service recipients.

Mr NEVILLE—It is the highest proportion in Australia, I understand.

Ms Ellis—Yes, it is, Mr Neville. Cocos would be quite different from Christmas Island whose population at the moment is running around 1,500. The unemployment statistics are much lower.

Mr NEVILLE—I will just interrupt my questioning. The chairman has to leave shortly and would like to ask some questions so I will wait for a while.

CHAIRMAN—I do appreciate my colleague deferring to me over my necessity to go back and see my family in Western Australia for at least a day before I come back here on Sunday. I am sure Senator West's heart is weeping for me. I thank you for your concern, Senator West.

I join my colleague, Mr Neville, in commending you for the high professional standard of your submission. It does make it much easier for us to see where you are coming from. If we can encourage you to keep up this high standard we are quite prepared to praise you and for you to read it in *Hansard* at some stage. It is an excellent report and I thank you again for it.

I want to ask you, Ms Ellis—I think you mentioned this—about the statement that you believe that health is really a problem to be solved between the Norfolk Island government and the Department of Health and Aged Care. Does that reflect roughly what you said or what was in your report?

Ms Kava—Yes, it does.

CHAIRMAN—Yes, thank you. We understood from the evidence we took this morning from the Department of Health and Aged Care here that they sort of washed their hands of responsibility for health care on Norfolk Island.

Mr NEVILLE—Who is responsible?

CHAIRMAN—There is some ambiguity there. Perhaps you could clear it up.

Ms Ellis—Basically, it is the Norfolk Island government. The Department of Health's legislation, which empowers them to do what they do on the mainland, does not extend to Norfolk Island; and neither does the Aged Care Act. The application of Commonwealth legislation in relation to the external territories automatically applies to the Indian Ocean territories unless expressed not to do so. In relation to Norfolk Island, it does not automatically extend; it has to be expressed to do so.

The Commonwealth health legislation did extend to Norfolk Island and was revoked in the late 1980s with the inception of the Medicare arrangements. Because of the fact that neither of those two acts extend, that department does not necessarily see a role. Our position that Medicare or health care cover is a matter between the Department of Health and the Norfolk Island government means that it is really the Norfolk Island government's responsibility if they see that Medicare in various options would be appropriate to extend to Norfolk Island.

CHAIRMAN—Pardon me interrupting you. You are saying that on the basis of a legal and constitutional responsibility that Norfolk Island has and not in any other respect. Is that correct?

Ms Ellis—Yes, that is what I am explaining.

CHAIRMAN—Please proceed.

Ms Ellis—If Norfolk Island wish to proceed with any options that relate to Medicare, the Norfolk Island government would appropriately liaise with the department of health in relation to the options available, whether that was possible, whether it would have implications for legislative amendments, et cetera cetera.

CHAIRMAN—It seems a little inequitable when we have, among other things, the Royal Flying Doctor Service. I spent most of my life in the bush and the outback, mostly in the outback, where you always had this feeling of security because you could get on the pedal set—although it was electrical by that time, but it was still called the pedal set—and you could call up the RFDS. They would be out to where we lived in an hour and a half in a Beechcraft Baron, they would pick you up, whether you had a broken leg or whatever, and take you back, so you did have some security. Norfolk Island people do not have that same security. Yet that RFDS service probably costs maybe $10 a year per capita in Australia to maintain. Do you think, in terms of equity—not in terms of the aggregate that they would collect from Norfolk Island—that if we extended the RFDS to Norfolk Island and they paid the same per capita amount that we pay in Australia—that is, $10 per annum, which nets $200 million—that would be a fair way? I think there is probably a constitutional argument that that could be one way of solving Medivac problems in Norfolk Island—that is, to have a permanent RFDS base there. What is your opinion about that?

Ms Kava—I do not know enough about the RFDS to comment in detail, but I would make the general comment that those living on Norfolk Island and visiting Norfolk Island do not have an equitable arrangement compared to other Australians and that we do need to find a solution. Whether or not per capita cost for those on Norfolk Island comparable with the mainland is the answer it certainly has some appeal in terms of equity. In relation to costs, given that it is a flight over water and that there are probably restrictions in terms of what types of planes can undertake that flight, the costs may be quite different. But I would agree that we need to come to some more permanent solution than exists currently, with people either being covered by their travel insurance and having to get some form of emergency flight, some small commercial flight, or relying on the RAAF being able to assist in time. That is clearly not a sustainable long-term solution.

CHAIRMAN—I think you are right. In terms of the economics of it, it is ludicrous that an aircraft that has a capacity to take 100 troops with their webbing equipment and their arms and to lift 50 or 60 tonnes of trucks or tanks at the same time should be sent for one medical evacuation. If it costs $130,000 per patient to get in the C130 Hercules, if you multiply that by six it is costing $700,000 or $800,000. It seems to me to be retrograde, in economic terms, not to consider having an RFDS base. It would certainly cost money, but it probably would not cost that amount of money.

Ms Kava—Could I add that it is very important that the Norfolk Island government, which is responsible for health, would need to be involved and contribute to any solution to do with Medivacs. It is very much of the view that it is their business and would want to be a main negotiator of any solution.

Mr NEVILLE—Could you arrange for the minister to meet with the committee when he is here next week?

Ms Kava—It is not next week, I think it is the week after. I could certainly take that on board.

CHAIRMAN—Yes, I appreciate your comments and I am glad that we have that on record now. I just used the RFDS because of my knowledge of it, and some in-depth knowledge of it as well, having used it on a couple of occasions. I have drawn the conclusion with respect to interdepartmental relations, where the health services cross over, that there is some recalcitrance between the departments to assist in preventing or minimising overlapping. The Department of Health and Aged Care might be one of those departments that is perhaps not as cooperative as it might be practical to be with, say, your Department of Transport and Regional Services. Is that a wrong perception?

Ms Kava—It would be true to say that relations between departments at different times—particularly for an area within our department that is looking at an issue like territories and contacting many different departments on many different issues—are helpful to a greater or lesser degree. I make no comment about Health and Aged Care. I am not as aware that we have had any particular difficulties there whatsoever, but obviously, at different times and on different issues, the ability to move quickly through issues varies.

CHAIRMAN—Does this committee need to facilitate better relations in terms of economics? I am not going to say that there is antipathy between government departments, but does this committee need to look at facilitating more cooperation to draw the best from the Department of Veterans' Affairs, your department, the Department of Transport and Regional Services, and, say, the Department of Health and Aged Care?

Ms Kava—I would emphasise that I see no antipathy between any of those departments.

CHAIRMAN—Yes, I tried to steer clear of that by saying it.

Ms Kava—Certainly, I think working constructively would be a very positive thing with the common aim in terms of improving the health status of Norfolk Island.

CHAIRMAN—Yes. On some of the evidence we have taken, it would appear, without analysing the minutiae of it, that there could be some benefit drawn from those particular three departments where there is overlapping health concerns, and particularly for Norfolk Island, if we were to try and draw the best out of the redoubtable contribution that each department could make.

On the issue of Norfolk Island being a self-governing territory, do you think that this committee could look at an education program where Norfolk Island was spelled out to the Australian public generally, and that would include government departments, that it is an integral part of Australia and not separate, that it is not independent. If it is not an integral part of Australia, then let it go, but if it is an integral part of Australia they deserve exactly the same sorts of health services that we have on mainland Australia, the same sorts of health services that they have with a multimillion dollar new hospital on Christmas Island, the same health services that we have in the mendicant territories, the ACT and the Northern Territory. Do you think the committee should do something about that?

Ms Kava—Any efforts that emphasise the fact that Norfolk Island is an integral part of Australia, which is something that is not as widely known as it should be by Australians, or even by parts of government departments, would be a very positive thing. Norfolk Island does have a slightly different status in terms of health. A matter that I understand was mentioned with the previous speakers was the fact that Norfolk Island residents do not pay tax. That makes it a little unusual and different in terms of getting that parity. But, certainly, any effort to clarify more generally—and it is an issue that we have looked at trying to address with government departments—would be extremely welcome.

CHAIRMAN—Thank you very much, and I apologise for having to leave.

Mr NEVILLE—I would just like to return to the cost matter. Ms Ellis, you might be able to tell us: do you know what the hospital cost is on the island territories?

Ms Ellis—No. I would happily take that on notice, but I do not know offhand, I am sorry.

Mr NEVILLE—Pursuing your option 2 as to what might happen, apparently there has been some modelling done, because the Department of Health and Aged Care says it will cost $2.2 million to bring Norfolk under the Medicare umbrella. That is my reading of your submission. I do not know what page it is on in yours, but in our papers it is on pages 35 and 36. I am sorry, that is the summary. You said there were three possible options for Medicare on Norfolk Island. Apparently there has been some modelling done. I imagine there would not be a lot of contributors, even on Norfolk, given the mean income on the island. If we assumed that it would cost $2.2 million to bring them under the Medicare umbrella, wouldn't it make more sense for the Commonwealth to top up their existing system than to just—I used the term in earlier evidence and got chastised by the chairman—Australianise the system, so to speak? If the island is already 80 per cent self-sufficient, do we do them a service by putting them under some regime that does not perhaps add a heck of a lot more to their quality of health care but bureaucratises a fairly simple system over there? Wouldn't it be better to have a top up? What is your view on that?

Ms Ellis—The difficulty with that, Mr Neville, may lie with the fact that the Commonwealth Grants Commission have identified that if the Norfolk Island government has the will to increase its revenue raising capacity, there is the scope there to raise it. So I suppose that is countering that argument with the justification of topping up.

Mr NEVILLE—But as the chairman said, all of us on the mainland, to some extent or the other, receive assistance from the Commonwealth well beyond our Medicare contribution. I think the witnesses from the health department said that the Medicare levy represented only about 20 per cent of the real cost of the Commonwealth contribution. I thought in the light of that, and in the light of the fact that they have been largely self-sufficient, it made better sense to build on what they have already got rather than to destroy that and have to pay the lot. That is my proposition.

Ms Ellis—Yes, given that the difference between the Medicare levy component and the rest is actually paid by the Australian taxpayer, that is a difficulty. Again, because Norfolk Island residents do not contribute in that tax sense, that is, if you like, the complicating factor in all of

this: how to find a solution that is fair and equitable to those on Norfolk Island and those visiting it but that is not disadvantaging mainland residents that pay tax.

Mr NEVILLE—Another way of looking at it would be: is it possible to have a system of highly focused and targeted one-off grants, for example—you make comment on it—for what purport to be retirement units that are allowed to fall into disrepair? Even when we were over there, one or two were rented. I do not know what the reason for that is, but I think that is appalling in one respect. Perhaps that was the model that was given to them—just a row of units. When I go into modern aged care facilities today, that is not the way it is done; it is done in cluster developments, where people have their room and en-suite and have some common living area. That might have worked better because they are a very family based community. To put people into individual little boxes might have been why that failed rather than to have a more inclusive type of model. What would you think of a couple of specialised one-off grants to upgrade the hospital and then perhaps try a different model of nursing home?

Just before you answer that, in Australia we allow 100 beds per 1,000 population over 70 years. So if we take, for round figures, 3,000 people on Norfolk and we say 10 per cent of those are above 70 years of age, they would be entitled to about 30 beds. The Department of Health and Aged Care's modelling is: 40 per cent go to hostels, 50 per cent to nursing homes and 10 per cent to home care packages. I might have that 40 per cent and 50 per cent back to front. On the basis of what we enjoy on the mainland in aged care, and on the basis of the formula we apply on the mainland, we would be providing about 30-odd beds: perhaps about 12 of one, 15 of the other and a few aged care packages. On that basis, would a one-off grant that moved towards that type of model not be an experiment worth trying, without trying to dismantle the whole Norfolk Island health care system?

Ms Kava—It is very difficult to comment without any particular expertise in health.

ACTING CHAIR (Mr Neville)—I know I am generalising. But with all this there is no starting point, is there?

Senator WEST—All the Commonwealth is providing at present in aged care basically is the recurrent funding. Your proposal would not address the issue of the recurrent funding. Whilst we give recurrent funding, there is also a significant contribution made by the resident, and I do not see how they could do that as well. I hate to poke a hole in your idea, but it strikes me initially from a quick think through that there is where a problem would arise.

Ms Ellis—One of the difficulties Norfolk Island has in accessing mainland grant type initiatives is whether or not the legislation extends. That is the problem with aged care. The legislation does not extend so they do not have access to those initiatives. There are other Commonwealth initiatives where the Norfolk Island government have had access to grants. They recently got an environmental grant for waste disposal and they have also recently got some NTN funding. It just depends on the vehicle and whether or not they can have access.

Senator WEST—NTN?

Ms Ellis—Networking the Nation for communications.

ACTING CHAIR—The area where we would really fall down is with health and aged care. That is my personal observation. There are a few other things, but I defer to my colleague, Senator West.

Senator WEST—You might want to take this on notice for the other party or department on the aeromedicals and aircraft type that can operate on that distance over water. That might also have an impact on whether the RFDS ideas that some of my colleagues are coming up with are feasible. I am aware that transport in the aviation area does certainly have some criteria as to what aircraft size can be used. I know the RFDS in New South Wales are basically flying Super King Airs. I do not know that the Super King Air range would meet that criteria.

Ms Ellis—The fuel capacity range is one of the major criteria.

Senator WEST—I would be interested if the other side of your department can provide us with some guidelines about aircraft type and distances looking at those smaller sized aircraft rather than a C130 option.

Ms Kava—We would be happy to provide that.

Senator WEST—Thank you. Thank you for your attendance. There may be some matters that we may need additional information on in which case the secretary will write to you. I think you took some questions on notice.

Resolved (on motion by **Senator West**, seconded by **Mr Neville**):

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

Committee adjourned at 12.49 p.m.