The Parliament of the Commonwealth of Australia

In the pink or in the red?

Inquiry into the provision of health services on Norfolk Island

Joint Standing Committee on the
National Capital and External Territories

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Foreword

Adequate and affordable health services are among the most essential requirements for any community, and it is the obligation of government to ensure that those services are available to its citizens.

Responsibility for health services was ceded entirely to the Norfolk Island Government by the Commonwealth under the *Norfolk Island Act 1979*. Commonwealth legislation covering health, aged care and health insurance does not extend to Norfolk Island, with the result that people on Norfolk Island, both residents and visitors, do not have access to the many national health programs and initiatives which assist other small remote communities in Australia.

However, Norfolk Island remains a part of the Commonwealth, and it is the Commonwealth which is ultimately responsible for the welfare of its citizens, whether on a remote self-governing island territory, in isolated outback communities, in regional centres or in the major metropolitan areas.

On 21 October 1999 the Minister for Regional Services, Territories and Local Government, Senator Ian Macdonald, wrote to the Committee, asking that it inquire into the effectiveness of, and access to, the Norfolk Island health system. The detailed terms of reference for the inquiry were both wide ranging and particular in their focus, including matters as fundamental as basic health infrastructure and aged care as well as others such as telemedicine, community health services and arrangements for medical evacuations by air to the mainland.

The Committee visited Norfolk Island in November 1999 for hearings and inspections, and held further hearings in Canberra in April and June 2000. As 2000 drew to a close it was becoming clear that significant developments were taking place, among them the completion of the first phase of a comprehensive review of health services on the Island, undertaken by a team from Griffith University's School of Health Science. A major purpose of this review, which was initiated in

1999 by the then Norfolk Island Health Minister, was to identify the services that should be available, to prioritise them, to examine the resource implications and to design a new health strategy specific to Norfolk Island's needs.

With the release of the preliminary findings of the Griffith University team's survey in late 2000, and with a visit to Norfolk Island already planned for another inquiry in March 2001, the Committee decided to conduct further inspections and meetings with health professionals on the Island, in order to review developments before concluding its inquiry. In the three months since that visit there have been further significant developments, and the Committee is pleased to note that progress has been made in some areas.

However, it remains indisputable that there are significant concerns to be addressed. Chief among them are the ageing and inadequate hospital facilities, which are well below the standard which residents and the many visitors from the mainland have a right to expect. Community health and health education programs are also well behind mainland practices, and the aged care situation could well be described as dire.

The Committee has made a number of general recommendations relating to the major issues raised by the inquiry, including the crucial issue of funding, and has also made recommendations relating to a range of more particular concerns, including many raised by Norfolk Islanders.

I would like to thank all those who assisted the Committee in this inquiry by making submissions, giving evidence at hearings and providing information in other ways, particularly, of course, the residents and medical staff on Norfolk Island. I would also like to thank those who helped with arrangements for hearings, and the committee secretariat for its assistance during the course of the inquiry.

The Committee was impressed by the commitment, and the achievements in often difficult circumstances, of the health professionals on the Island, and by the way in which Island residents have for so long coped with the challenges presented by their isolation. However, those qualities of professionalism and resourcefulness must now be fully supported by the provision of a full range of health infrastructure and programs by government.

Senator Ross Lightfoot
Chairman

Membership of the Committee

Chairman	Senator Ross Lightfoot (Chairman from 8 December 1999)
Deputy Chair	Senator Trish Crossin
Members	Senator Brian Greig
	Senator Kate Lundy
	Senator John Watson (Chair to 8 December 1999)
	Senator Sue West
	Mr Ross Cameron MP
	Ms Annette Ellis MP
	Mr Gary Nehl MP
	Mr Paul Neville MP
	Hon Warren Snowdon MP
	Hon Alex Somlyay MP

Committee Secretariat

Secretary	Mr Richard Selth (from January 2001)
	Ms Gillian Gould (to December 2000)
Inquiry Secretary	Ms Sue Irvine (from March 2000)
	Ms Nicole Robinson (to April 2000)
Research Officer	Ms Emma Herd
Administrative Officers	Ms Sarah Steele
	Ms Shari Rogers
	Mr Rohan Tyler
	Mr Vishal Pandey

Terms of reference

On 21 October 1999 the Minister for Regional Services, Territories and Local Government, Senator the Hon Ian Macdonald, wrote to the Joint Standing Committee on the National Capital and External Territories, requesting that it 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.

Executive summary

This inquiry was undertaken because health care has increasingly been a concern for both the Commonwealth and Norfolk Island governments. The *Norfolk Island Act 1979* gave the primary responsibility for the provision of health services to the Norfolk Island Government but the Commonwealth retains an overarching responsibility to ensure that all Australians have access to an adequate standard of health services. Commonwealth legislation covering health, aged care and health insurance does not extend to Norfolk Island, with the result that people on Norfolk Island, both residents and visitors, do not have access to the many national health programs and initiatives which assist other small remote communities in Australia.

Nearly all health services on the Island are provided through the Hospital, an inadequate building with outdated equipment. No one is refused treatment and hospital funding depends on a diminishing fee base as well as a variable subsidy from the Norfolk Island Government to balance its books each year. Without adequate funding or planning for replacement of the health infrastructure, the gap between the level of services which can be provided and the level that patients expect has been increasing each year.

The expansion of tourism, which is now the Island's main industry, has significantly increased demands on the under-resourced hospital and its staff. The lack of Medicare entitlement for visitors means that the cost, as well as the range and standard of health services, is a major consideration for this key industry. The ever present possibility of an expensive emergency medical evacuation poses a significant financial risk to the unwary tourist without full insurance cover.

The Committee believes that for the welfare of residents and visitors alike there is an urgent need for action by the Norfolk Island Government to provide appropriate levels of funding as well as forward planning for health services.

Evidence collected during the course of the inquiry led the Committee to focus on seven issues which were raised repeatedly by witnesses: the need for community health services and a refocus on preventive medicine, appropriate aged care choices, a dependable emergency medical evacuation service, a new hospital building, reducing the demand for doctors' services, reducing the cost of health services for lower income earners and ensuring the survival of the visiting specialist program.

The Committee was impressed by a proposal put forward by a group including health professionals called CHAT (Community Health Awareness Team), which already appears to have support within the community and the Assembly. This kind of initiative should be encouraged and supported through guaranteed, recurrent government funding, and appropriate coordination with existing and proposed action in the primary health field. Initiatives which have strong community support backed by government commitment are likely to succeed and bring widespread benefits.

The rapid increase in the number of elderly residents on Norfolk Island means that a new approach must be taken if people are to have the choice of remaining on the Island for their final years. Various measures which will assist people to remain in their own homes are needed, as well as a choice of facilities for those who need more care. There will continue to be a demand for nursing home accommodation, as well as a place for elderly people who need the company, stimulation, safety and support that comes from living in a small community designed to meet their changing needs. The Department of Veterans' Affairs has provided, and will continue to provide, expert assistance in some areas of aged care for veterans and indirectly for other older residents. Day care, home safety assessment, transport, and funding for a physiotherapist and an aged care clinical nurse consultant are some of the initiatives to date. The Committee believes that the possibility of including Norfolk Island under the Aged Care Act should be considered and explored by the Commonwealth and Norfolk Island governments.

A dependable, affordable medivac service is essential to an isolated community. As dependence on the Royal Australian Air Force becomes a less certain option, the situation must be examined carefully. Either a commercial medivac company or the Royal Flying Doctors Service would be prepared to negotiate a service contract with the Norfolk Island Government. The Norfolk Island Government has a responsibility to ensure that this service is available to any person on the Island who encounters a medical emergency, whether or not they have insurance to cover the very considerable expense.

Replacement of the hospital is another major expense for which the Norfolk Island Government will have to budget in the next few years. Without borrowing, or instigating new revenue raising strategies, the Norfolk Island Government is

unlikely to be able to fund this major project. The Committee believes that forward planning, including a serious investigation of funding options, must be undertaken in the very near future. A design incorporating the flexibility of the Multi-Purpose Service model should be tailored to provide a mix of acute, aged and community services suited to Norfolk Island's population profile, with its unusually high number of older people, both resident and transient. Design assistance available through the Department of Veterans' Affairs should be sought.

The issue of excessive demands on the Island's doctors needs to be examined and addressed. In addition to the burden imposed by isolation, other factors such as the lack of alternative sources of health advice and ancillary services, and the unrealistic expectations of some patients, have combined to place past and present medical practitioners under enormous, unrelenting pressure, which is potentially detrimental to all parties. The role that e-health can play in providing alternative sources of advice, access to mainland specialists and ongoing training for hospital staff is only just being recognised but its value could be realised almost immediately. The use of nurse practitioners and visiting health professionals such as mental health counsellors is another option which the Hospital Enterprise may wish to employ to redirect patients to other, often more appropriate, sources of professional advice.

Statistics indicate that Norfolk Island households spend fifty per cent more on health than those in New South Wales. For low income earners the burden is great. The cost of many pharmaceutical items is far higher than on the mainland, which leads to people avoiding taking essential medicines. The health levy of $500 per year for people over eighteen is unindexed and represents a severe impost on some. The Government's Healthcare scheme of medical insurance does not cover the first $2500 of expenses (or a figure considerably higher when non-allowable expenses are considered), and insurance to cover the 'gap' is expensive. The Committee believes that all aspects of health funding need to be examined by the Norfolk Island Government with a view to making it more equitable and affordable.

Staff at the Hospital believe that the visiting specialists program which has brought immeasurable benefit over several decades is now under threat. Increasingly, specialists cannot use their expertise in the latest medical procedures because the facilities are not available. Diminishing case loads, the increasing risk of litigation and poor accommodation are other factors which lessen the incentive for a specialist to leave a busy mainland practice.

The question of access to adequate health insurance appears complex and daunting. Many witnesses to the inquiry expressed the view that they would prefer to be part of the Medicare scheme if the Commonwealth and Norfolk Island

governments could negotiate an equitable and practicable way for the Norfolk Island Government to contribute to the scheme in the absence of a levy applied to declared income. The present Healthcare system is manifestly inadequate. It is essential that this issue and many others be debated extensively in the community since the outcomes will have a profound impact on access to health services for generations of Norfolk Islanders.

The Committee is reassured that many of the present shortcomings of the health system will be addressed in the planning documents, commissioned by the Norfolk Island Government, to be produced by the team from the Griffith University School of Health Science. An intensive community consultation process should follow both the release of this Committee's recommendations and the Health Strategy and Implementation Plan to be drawn up by the Griffith University team. With so many competing priorities, it is vital that widespread community debate be sought, following input from the Island's resident and visiting health professionals.

The Committee has observed signs of neglect and complacency alongside some very positive developments in the health field on Norfolk Island since this inquiry began. It is plain that informed change, new directions and professional leadership, coupled with realistic funding, are required. The Committee hopes that before the need for change becomes crisis driven, it will be embraced by an informed community and supported by commitment from those with control of the public purse.

List of recommendations

Chapter 3 Health care – how do visitors fare?

Recommendation 1

The Committee recommends that the Norfolk Island Hospital Enterprise reconsider the pricing structure for services to mainland visitors, so that the cost does not become a disincentive to tourism.

Recommendation 2

The Committee recommends that measures be taken by tourist companies, airlines and other tourism promoters to warn all potential travellers to Norfolk Island of the high cost of health care, the fact that any expenses incurred will not be claimable on Medicare and that private travel insurance covering medical evacuation is essential.

Recommendation 3

The Committee recommends that the Commonwealth and Norfolk Island Governments consider the desirability of amending the *Health Insurance Act 1973* in order to cover mainland visitors to Norfolk Island under Medicare.

Recommendation 4

The Committee recommends that the Norfolk Island Hospital Enterprise develop for the Norfolk Island Government a proposal for the implementation of a health levy on visitors, as a basis for providing, in the absence of Medicare, quality health services free to all visitors, including the cost of medical evacuation if necessary.

Chapter 4 Health care – how can a comprehensive level be provided?

Recommendation 5

The Committee recommends that the Norfolk Island Government enact or amend legislation:

- to make the wearing of seatbelts compulsory;
- to lower the legal blood alcohol limit for drivers to a level comparable with that of the mainland; and
- to forbid smoking in enclosed public places and provide enforceable penalties for non-compliance.

Recommendation 6

The Committee recommends that the Norfolk Island Government increase the price of alcohol and tobacco products and direct the revenue raised to community education programs that target lifestyle issues such as drink driving, substance abuse, domestic violence and nutrition.

Recommendation 7

The Committee recommends that the Norfolk Island Government give the highest priority to establishing and promoting a coordinated community health service, either by adopting the Community Health Awareness Team (CHAT) proposal for a coordinated community health service or by instituting a similar, professionally organised service.

The Committee also recommends that the Norfolk Island Government provide funding for the recruitment of an experienced, enthusiastic, full-time community health coordinator with extensive knowledge of contemporary community health issues.

Recommendation 8

The Committee recommends that the Norfolk Island Government:

- promote road safety measures such as the advantages of wearing seatbelts, not drinking when driving and nominating a ‘designated driver’;
- undertake a survey of all existing community resources in order that these may be coordinated, publicised and utilised widely;
- consider ways of accessing health education programs which are available on the mainland through various departments; and

■ appoint a qualified occupational health and safety officer to examine public areas for safety, and allocate adequate funds for the implementation of appropriate health and safety measures.

Recommendation 9

The Committee recommends that, in order to support existing health personnel and provide a wider range of community health services, the Norfolk Island Hospital Enterprise:

■ extend the hours of the baby / child health sister;

■ explore the possibilities of contracting a mainland practice consisting of a variety of health professionals to provide staff on a rotation basis;

■ consider employing, or training existing nurses to become, accredited nurse practitioners with skills identified as useful adjuncts to those already available within Norfolk Island's health system;

■ negotiate with the Royal Flying Doctor Service with a view to providing a remote, after-hours consultation service;

■ give serious consideration to the proposal of the Royal Flying Doctor Service to provide, on rotation, doctors with a primary health care and emergency evacuation focus, as well as registered nurses and allied health workers with community health experience; and

■ employ a part-time dietician with the right to private practice.

Recommendation 10

The Committee recommends that in order to replace the Hospital the Norfolk Island Government move urgently to:

■ complete a projection of future needs in the health care system, using all available sources, including a forecast of the numbers and needs of visitors to the island;

■ examine the funding options for a new multi-purpose health facility, taking into consideration a range of options such as borrowing (possibly through a low-interest Commonwealth loan), raising new taxes, attracting private investment and applying for a Commonwealth grant for part funding;

■ seek independent expert advice from consultants with proven experience in the field of multi-purpose health facility design, including taking advantage of any advisory assistance in this area offered by the Department of Veterans' Affairs; and

■ adopt a timetable for the replacement of the hospital which includes completion dates for the necessary stages such as planning, consultation and the tendering process.

Recommendation 11

The Committee recommends that, in order to maintain and increase the skills of its nursing staff, the Norfolk Island Health Enterprise allocate funds and provide time off for on-island training, and expand the present system of sending nurses to the mainland for specific area training.

Recommendation 12

The Committee recommends that the Hospital Director and medical officers continue to examine and make changes to the existing patient appointments policy and procedures in order to reduce the number of unreasonable demands on hospital staff.

Recommendation 13

The Committee recommends that, in order to make health services more affordable and hence accessible, the Norfolk Island Government and the Hospital Enterprise:

■ establish guidelines to allow low income earners access to free or subsidised hospital and medical services;

■ require, in the absence of a universal pharmaceutical benefits scheme, that essential, life sustaining medicines be supplied at cost, and inform the community of the existence of the special benefits currently available to those who cannot pay, in order that Islanders do not avoid seeking medical treatment

■ consider subsidising the cost of medicines prescribed for long-term use to maintain good health, such as those required to lower blood pressure and cholesterol levels;

■ proceed with the stated intention of subsidising the cost of child immunisation, give consideration to meeting the full cost for each child and implement an awareness campaign; and

■ increase the Healthcare allowance of $200 for travel to, and accommodation on, the mainland, to cover a return airfare and at least one night's accommodation for those who demonstrate that they cannot afford, or are not eligible for, private insurance which covers such expenses.

Recommendation 14

The Committee recommends that, as long as the compulsory Healthcare levy continues, the Norfolk Island Government make it more equitable by:

- devising a means of indexing it to income;
- raising the annual income below which an exemption from the compulsory Healthcare levy may be claimed, to a figure deemed to be a 'living wage'; and
- considering the provision of free medical and dental checkups to lower income earners as an incentive to pay the Healthcare levy.

Recommendation 15

The Committee recommends that the Norfolk Island Government proceed urgently with the Griffith University-designed strategic and operational plans, giving due attention to:

- promoting robust community awareness and consultation through the local media and well advertised public meetings;
- establishing and guaranteeing, at an early stage, a realistic budget based on a program of forward estimates; and
- supporting measures such as the funding of essential equipment, staff training and e-health facilities that will reduce the need for mainland referrals.

Recommendation 16

The Committee recommends that a scheme such as the Patient Assisted Travel Scheme be available on Norfolk Island, either through:

- an extension of the schemes presently available in the states and other territories; or
- a similar arrangement provided by the Norfolk Island Government.

Recommendation 17

The Committee recommends that, in reassessing the role and functions of the Board of Management of the Hospital Enterprise, the Norfolk Island Government:

- initiate a professional review of the role and responsibilities of the Hospital Board;
- make appropriate changes to the governing act;

- amend the principal selection criterion for the position of Hospital Director so that proven dynamic health administration experience is mandatory;

- guarantee clear authority to the Hospital Director, as the chief executive officer, to manage and execute changes within the framework of Norfolk Island Government policy;

- recruit to the Hospital Board a balance of people, including those with experience in contemporary health systems and people with business acumen; and

- institute clear accountability processes for the Norfolk Island Hospital Enterprise (which is a statutory authority), including annual reports.

Chapter 5 Aged care

Recommendation 18

The Committee recommends that the Commonwealth Government extend the Aged Care Act to cover Norfolk Island, to enable the Norfolk Island Government to access existing programs and initiatives designed to assist rural and remote communities.

Recommendation 19

The Committee recommends that, in order to enable elderly people to remain living in their homes for longer, the Norfolk Island Hospital Enterprise:

- increase the district nursing hours, and involve the district nurse where appropriate in the design, implementation and coordination of services necessary to maintain aged persons who are borderline independent in their homes;

- in consultation with appropriate staff, examine, prioritise and implement the generally low cost services recommended by Department of Veterans' Affairs, such as respite care and carer support, which would assist people to remain in their own homes;

- examine the feasibility of involving service clubs in Home and Community Care-type services, such as house cleaning and maintenance and shopping; and

- extend home assessment and accidental fall prevention services to all elderly Norfolk Island people.

Recommendation 20

The Committee recommends that responsibility for routine medical consultations for the aged residents in the hospital be devolved from the general practitioners to the aged care clinical nurse consultant or nurse practitioner.

Recommendation 21

The Committee recommends that the Norfolk Island Hospital Enterprise allocate sufficient funds to ensure that the existing physiotherapy and hydrotherapy facilities at the Hospital are maintained at optimal levels.

Recommendation 22

The Committee recommends that responsibility for liaison between the Norfolk Island Government and the Department of Veterans' Affairs be formalised, in order to take maximum advantage of the benefits available through relevant DVA programs.

Recommendation 23

The Committee recommends that, pending the construction of a new hospital or alternative aged care facility, the Norfolk Island Hospital Enterprise take immediate steps to improve the nursing home facilities within the Hospital by:

- establishing a separate cost centre and 24-hour staffing allocation, so that aged care does not lose out to the demands of acute care;
- enhancing the perceived status of caring for the nursing home patients, including increased staffing levels and training in geriatric care, in particular the special needs of dementia patients;
- improving security for dementia patients by fencing part of the hospital grounds; and
- providing privacy for residents, and an attractive and comfortable environment for aged care within the hospital.

Recommendation 24

The Committee recommends that the Hospital Enterprise consider for the future accommodation of elderly people with limited independence either:

- a suitable shared house, near the hospital; or
- purpose-built, dedicated nursing home and hostel places located within a Multi Purpose Service facility.

Recommendation 25

The Committee recommends that the Norfolk Island Government investigate the possibility of a fully or partly private sector funded retirement village to provide a variety of accommodation for people with differing levels of independence, as well as facilities for social and physical activities. Support for the idea of residents' investment should be canvassed.

Chapter 6 Emergency medical evacuations

Recommendation 26

The Committee recommends that the Norfolk Island Government provide universal cover for the cost of medivacs by:

- raising funds to pay for all medivacs;
- sourcing a private insurer, possibly through the use of incentives; and
- exploring the possibility of a cost-sharing arrangement with the Commonwealth for the provision of medical evacuations from Norfolk Island.

Recommendation 27

The Committee recommends that the Norfolk Island Government actively pursue negotiations with the Royal Flying Doctor Service for the provision of an emergency evacuation service under a formal arrangement.

Chapter 7 E-health – existing and future possibilities

Recommendation 28

The Committee recommends that the Norfolk Island Government investigate opportunities for expanding its e-health potential by:

- becoming involved in nation-wide collaborative consultations, such as *Health Online: A Health Information Action Plan for Australia*, regarding standards and guidelines for the implementation of e-health across Australia; and
- establishing links with a state-based e-health network.

Recommendation 29

The Committee recommends that the Norfolk Island Government, in conjunction with community groups on the Island such as the Community Health Awareness Team, make available computer facilities to allow residents on the Island to access information on health services.

Recommendation 30

The Committee recommends that all health staff at the Norfolk Island Hospital receive education and practical training in e-health technologies.

Chapter 8 Healthcare or Medicare?

Recommendation 31

The Committee recommends that the Norfolk Island Government and the Commonwealth continue discussions of the most practicable method of providing Norfolk Island residents with an affordable, comprehensive level of health insurance.

The Committee also recommends that the Norfolk Island Government organise a series of public meetings to offer information, and seek community input, on whether to pursue Medicare or another form of comprehensive health insurance as an alternative to Healthcare.

Recommendation 32

The Committee recommends that the Commonwealth Government extend Medicare cover to:

- those Australian citizens resident on Norfolk Island whose income is below the Australian taxable income limit of $13 550, so that they are entitled to the same access to Medicare as mainland residents who are not liable to pay the Medicare levy;
- retired residents of Norfolk Island aged 55 years and above, who have paid income tax on the mainland for a period of at least five years; and
- Temporary Entry Permit holders, resident on the Island for less than six months, who would be eligible for Medicare benefits elsewhere in Australia.

Recommendation 33

The Committee recommends that the Norfolk Island Government announce the findings of its review of the Healthcare Scheme in order that residents may consider them, and determine whether Healthcare is a feasible health insurance option for the community.

Chapter 9 Funding

Recommendation 34

The Committee recommends that the Norfolk Island Government:

- establish a program of forward estimates for health services and capital expenditure, in conjunction with the implementation plan developed in consultation with the Griffith University team; and
- establish a task force to investigate alternative sources of government funding including new taxes and charges.

Recommendation 35

The Committee recommends that the Norfolk Island Government give recognition to the valuable contribution to the health system of volunteers by providing:

- financial underpinning, coordination and direction to their efforts; and
- incentives to local employers to provide paid time off for volunteers.

Recommendation 36

The Committee recommends that the Norfolk Island Government encourage private philanthropy by inviting the Island's wealthy to fund:

- specific projects of their own choosing; and
- scholarships for training in health care designed to encourage young Islanders to return to the Island for part of their careers.

1

Introduction

The inquiry process

1.1 On 21 October 1999 the Minister for Regional Services, Territories and Local Government, Senator the Hon Ian Macdonald, wrote to the Committee requesting that it conduct an inquiry into the provision of health services on Norfolk Island.

1.2 In referring the inquiry, the Minister advised the Committee that the issue, particularly access by residents and visitors to a comprehensive range of health services, had been a major concern to the Government for some time. The Minister indicated that he was aware that health care was also of particular interest to the Norfolk Island Government.

1.3 The Committee had a long arranged plan to visit Norfolk Island in mid-November 1999 for general discussions and inspections and decided at short notice to expand this visit to include a public hearing for the new health inquiry. On 25 October 1999 an advertisement was placed in *The Norfolk Islander* newspaper, notifying Norfolk Island residents of the Committee's intention to visit and setting out the terms of reference for the inquiry. The advertisement invited people to make written submissions as well as oral submissions at the public hearing.

1.4 Advertisements inviting submissions were placed in nine national, state and territory newspapers on 29 January 2000. The Committee wrote to organisations with experience relevant to the issues raised in the terms of reference, inviting them to make a contribution. These measures generated further interest which resulted in additional submissions.

1.5 The inquiry received 42 written submissions, listed at Appendix A. Public hearings were held on Norfolk Island on 16 November 1999 and in

Canberra on 7 April and 19 June 2000.[1] In conjunction with the public hearing on Norfolk Island, Committee members inspected the facilities at the Norfolk Island Hospital and spoke to staff and patients.

1.6 The Committee made a return visit to the Hospital in March 2001 because there had been a number of developments in several important aspects of health care. The Committee inspected the Hospital, including various outbuildings on the premises, and a nearby property for sale which had potential as a residential aged care facility, accompanied by the new Hospital Director, Ms Christine Sullivan. This was followed by round-table discussions with the Director and other staff, and the provision of supplementary information requested by the Committee.

Brief history of Norfolk Island

1.7 Norfolk Island is located in the South Pacific Ocean, 1 676 kilometres north-east of Sydney. Measuring only 34.5 square kilometres, and fertile, it is the only inhabited island in a small, mid-ocean, volcanic outcrop. Even by present standards of transport and communication, Norfolk Island is very remote and isolated.

1.8 The population of the Island is approximately 3000, consisting of a permanent resident population of 1600, about 400 temporary residents and, on any day, approximately 1000 visitors.

1.9 The Island was claimed for the British Crown when it was discovered uninhabited by Captain Cook in 1774. In 1788 the first British penal settlement was established, consisting of both convicts and free settlers. This settlement was abandoned in 1814.

1.10 In 1825 Norfolk Island was re-established as a penal colony for intractable prisoners, and again abandoned in 1855, owing to changes in public attitudes to transportation and the oppressive nature of the convict system.

1.11 The colony of New South Wales controlled Norfolk Island in June 1856 when the Pitcairners arrived to commence the third settlement of the Island.

1.12 The Pitcairners were the descendants of *Bounty* mutineers who settled on Pitcairn Island in 1790. Drought and illness on Pitcairn forced the community to request the British Government to transfer them to some

1 All oral submissions are recorded in the transcripts which may be found on the Committee's web site at: http://www.aph.gov.au/house/committee/ncet/index.htm.

other appropriate place. In 1854 the Pitcairners were advised that they could relocate to Norfolk Island. Their descendants now form approximately 46 per cent of the permanent resident population.

Relationship with the Commonwealth

1.13 Norfolk Island has been an Australian territory since 1914, when, under section 122 of the Constitution, it was accepted as a territory under the authority of the Commonwealth of Australia.

1.14 Norfolk Island is now administered in accordance with the provisions of the *Norfolk Island Act 1979*. With this Act the Australian Parliament conferred a substantial measure of self-government on Norfolk Island as a territory under the authority of the Commonwealth. These powers are greater than those held by the states and territories.

1.15 Norfolk Island is not covered by Commonwealth legislation unless it is specifically mentioned in a particular Act. For the purposes of this report it is important to note that the *National Health Act 1953*, the *Health Insurance Act 1973* and the *Aged Care Act 1997* do not apply to Norfolk Island.

1.16 The Commonwealth Department of Transport and Regional Services (DOTRS) has a responsibility to ensure that the governance of Australia's territories meets local and national needs. Hence it plays an important role in overseeing affairs on Norfolk Island.

1.17 The Self-Governing Territories Section, located within the Department, oversees the Commonwealth's interests on Norfolk Island. According to its 1998-1999 annual report it:

> maintained and developed Commonwealth interests in Norfolk Island, and worked in partnership with local government to contribute to national social, environmental and economic performance.

1.18 The Administrator, appointed by the Governor-General and responsible to the Minister for Regional Services, Territories and Local Government, is the senior Commonwealth Government representative on Norfolk Island. The Administrator acts with the advice of the Norfolk Island Executive Council in relation to matters which are within the executive authority of the Norfolk Island Government. In all other matters the Administrator acts on the instructions of the Minister. The Self-Governing Territories Section meets the costs of the Office of the Administrator.

Governance on Norfolk Island

1.19 The *Norfolk Island Act 1979* provides the basis of the Island's legislative, administrative and judicial systems. Norfolk Island has a modified Westminster style parliamentary government consisting of a nine member Legislative Assembly which controls its own budget and raises revenue under its own system of laws. Members are elected for a three year term. The Executive Council is convened and presided over by the Administrator, whose role is similar to that of a state governor. The Executive Council consists of members of the Assembly who perform ministerial functions. Ministerial portfolios include finance, health, education, immigration and tourism.[2]

1.20 The Act states that the Legislative Assembly is empowered 'to make laws for the peace, order and good government of the Territory'. It cannot make laws to acquire property, raise defence forces or coin money.

1.21 The powers of the Norfolk Island Government incorporate the functions of both local and state governments in a manner similar to the Northern Territory or the Australian Capital Territory, but they also include a range of functions which are exclusively exercised by the Commonwealth in mainland Australia.

1.22 The Act divides the legislative functions and responsibilities of the Assembly into Schedules 2 and 3. Schedule 2 contains matters normally performed by state and local governments, including public health. Schedule 3 covers matters normally reserved for the Commonwealth, such as customs, quarantine, immigration and social security.

1.23 Laws passed by the Legislative Assembly are presented to the Administrator for assent. Depending on the subject matter, the Administrator may assent to, or withhold assent from, the proposed law, return it to the Assembly with recommended amendments or reserve it for the Governor-General's pleasure.[3]

1.24 The Administrator is required to act in accordance with the advice of Norfolk Island's Executive Council in relation to most scheduled matters, but the Commonwealth Minister for Territories retains the power to veto legislation on a Schedule 3 matter.

2 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 19.

3 *Norfolk Island Act 1979*, Section 21.

Responsibility for health care

1.25 The provision of health services on Norfolk Island is different from anywhere else in Australia or its territories. On the mainland, health is a state responsibility, with the states organising the delivery of health services. However, the Commonwealth makes specific purpose payments to the states to support those services. The Commonwealth also contributes to individuals' health costs through medical and pharmaceutical benefits. Similar arrangements exist between the Commonwealth and the two self-governing territories on the mainland.

1.26 Norfolk Island residents do not pay Commonwealth income tax or most other federal taxes including the Goods and Services Tax. Since 1989 most have not been eligible to receive Medicare benefits. However, the Commonwealth, through the Department of Veterans' Affairs, assists in providing comprehensive health services to eligible veterans on Norfolk Island, who account for sixty per cent of the population over age seventy, an age group which forms a significant proportion (ten per cent) of the total resident population of 1600.

1.27 Under the *Norfolk Island Act 1979* (Cth) the Norfolk Island Legislative Assembly has primary responsibility for the provision of health and ancillary services, including aged care, and the health infrastructure on Norfolk Island. Public health and social welfare are both matters which are specified in Schedule 2 of the Act. This gives the Norfolk Island Legislative Assembly the power to make laws concerning these matters. The Commonwealth Minister responsible for regional services has no power to veto Schedule 2 matters. The Department of Transport and Regional Services advised the Committee that the Norfolk Island Government has not sought Commonwealth assistance for health services since 1989.

1.28 There are indirect health advantages to mainland residents that are not provided directly through the Health budget. By comparison, most Norfolk Island residents experience a considerable disadvantage as a result of their isolation and the high cost and present state of their health system. DOTRS stated in its submission that:

> as a matter of principle, Norfolk Island residents have a right of access to health services and health insurance at a level comparable to mainland standards.[4]

4 Department of Transport and Regional Services, Submissions, p. 73.

1.29 DOTRS also noted as a major concern Norfolk Island residents' difficulties in accessing national health programs and funding:

> The fact that Commonwealth legislation – such as the Commonwealth's aged care legislation – does not extend to Norfolk Island hinders Norfolk Island residents' access to programs and initiatives aimed at assisting communities in rural, remote and regional Australia – of which Norfolk Island forms a part.[5]

1.30 The Commonwealth Grants Commission noted in 1997 that the Commonwealth has a responsibility to ensure that certain services are provided to Australians at appropriate levels. DOTRS observed that if the Norfolk Island Government could not provide services at an appropriate standard, the Commonwealth should consider ways in which it could assist the Island community by extending health services and funding eligibility to the same level available to other Australians.[6]

Related inquiries

1.31 The Committee acknowledges the work of a number of Commonwealth bodies which have previously conducted inquiries into various aspects of governance on Norfolk Island. These works were of great assistance in the conduct of the current inquiry.

1.32 The Commonwealth Grants Commission (CGC) released in June 1997 the report of its inquiry into Norfolk Island's economic capacity, financial and administrative arrangements and government services. The CGC examined a wide range of government services and infrastructure provided on the Island, including the Norfolk Island Government health insurance scheme and Norfolk Island's hospital services and infrastructure, public health services and community health services. The Committee found this to be a very thorough report which was useful in examining the provision of health services on Norfolk Island. Another very useful document was *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, a report commissioned in 1998 by the Returned and Services League of Australia's Norfolk Island sub-branch, funded by the Department of Veterans' Affairs and prepared by Richard Tate of the Health Consulting Group, Victoria.

5 Department of Transport and Regional Services, Submissions, p. 77.

6 Department of Transport and Regional Services, Submissions, p. 90.

1.33 The Committee examined Norfolk Island's communication system in its report of March 1999: *Island to Islands: Communications with Australia's External Territories.* That inquiry assisted in the analysis of issues related to e-health. The Committee has also made reference to the October 1997 report of the House of Representatives Standing Committee on Family and Community Affairs on telehealth entitled *Health on Line.*

2

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

Health services available on Norfolk Island

Norfolk Island Hospital

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 Professor Carol Gaston, Transcript, p. 205.

3 Dr Michael Sexton, Submissions, p. 161.

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

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

Services provided

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

Medical staff

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

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

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

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

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

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

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

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

Visiting Specialists

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

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

5 Ms Christine Sullivan, Submissions, p. 197.

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

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

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

Pathology

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

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

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

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

7 Mr Peter Young, Submissions, p. 200.

Post-mortem and funeral services

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

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

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

Radiology

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

Physiotherapy

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

Dental services

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

Optometry and audiology

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

Pharmacy

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

8 Norfolk Optical, Submissions, p. 49.

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

Maternity and early childhood

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

Child immunisation

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

Diabetes clinic

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

Domiciliary nursing

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

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

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

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

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

Red Cross

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

Ambulance services

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

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

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

12 Australian Red Cross, Submissions, p. 51.

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

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

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

Aged care

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

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

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

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

Community based health care

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

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

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

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

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

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

15 Reverend Ian Hadfield, Submissions, p. 159.

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

17 Professor Carol Gaston, Submissions, p. 60.

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

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

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

Health services provided on the mainland

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

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

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

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

What *should be* available?

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

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

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

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

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

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

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

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

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

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

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

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

2.63 The submission from the new Hospital Director commented that:

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

20 Professor Carol Gaston, Transcript, p. 205.

21 Dr John Davie, Transcript, p. 31.

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

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

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

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

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

2. Provision of appropriate aged care

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

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

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

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

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

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

3. Provision of a dependable, affordable medical evacuation service

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

4. Replacement of the Hospital

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

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

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

5. Reducing the burden on the doctors

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

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

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

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

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

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

6. Making the system more affordable

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

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

7. Ensuring the sustainability of the visiting specialists program

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

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

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

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24 Dr Michael Sexton, Transcript, p. 221.

3

Health care – how do visitors fare?

Who is visiting Norfolk Island?

3.1 In considering the provision of health services to visitors on Norfolk Island, the Committee focused mainly on tourists from mainland Australia, who constitute approximately eighty per cent of the 37,000 visitors Norfolk Island receives each year.[1] There are also approximately 400 non-residents living on the Island who must pay the local Healthcare levy as residents do, but who must also have private health insurance in order to remain.

3.2 While visitors to Norfolk Island generate large amounts of revenue, they also place heavy demands on the Island's health services. Norfolk Island is a tourist destination with high appeal to older people seeking a relaxing holiday. Advice from the Norfolk Island Tourist Bureau to the Department of Transport and Regional Services in November 1999 indicated that sixty per cent of visitors are over 56 years of age. Statistics in the *National Strategy for an Ageing Australia*[2] show that health expenditure for people over 65 is 3.8 times higher than for those under 65, and that older people are admitted to hospital more often and for longer periods of time. Hence, the very high proportion of elderly tourists visiting Norfolk Island is significant in terms of the extra demands placed on local health services.

3.3 The implications of such statistics become more significant when seen in light of the overwhelming importance of tourism to the Norfolk Island economy. Commonwealth Grants Commission figures indicate that

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1 Department of Transport and Regional Services, Submissions, p. 78.

2 Australian Institute of Health and Welfare, background paper, *National Strategy for an Ageing Australia*, section 5.3, p. 19.

tourism contributed between one quarter and one half of the total estimated Island economy of $80 million in 1995-1996. The CGC Report also observed that:

> Over time, taxation decisions have minimised taxes paid by residents and raised a higher than proportionate share of taxes from tourists. This was said not to be a deliberate policy and seems to have come about without any close analysis of what it might be doing to the single most important industry in the Territory.[3]

3.4 Similarly, questions arise about the long-term impact on the Island's economy of the much higher charges for health services imposed on visitors, most of which are double or more those for residents and not claimable under Medicare. (See table at 3.12, below.)

3.5 Mrs Janine Nobbs, a nurse at the Norfolk Island Hospital, estimated for the Committee in November 1999 that about a quarter of the patients visiting outpatients each day were visitors. The Department of Transport and Regional Services advised that 51 Australian residents were treated as in-patients at the hospital in 1998-1999. An examination by the Hospital Director in April 2001 of records of services provided at the Hospital indicated that approximately half were for tourists. Sister Bonnie Quintal, Superintendent of St John Ambulance, told the Committee that elderly tourists now make up a significant proportion of the 500-600 calls that the volunteer ambulance service attends each year.[4]

3.6 The Norfolk Island Government's submission stated that:

> Doctors in Australia estimate that there should be about 1 Doctor for each 1100 or 1200 head of population. From this point of view, Norfolk seems to appear as a cushy job for Doctors with a permanent population of only 1700. However, Norfolk Island had 37 000 tourists last year, and 'a large portion' of these were elderly and infirm. Subsequently, their numbers contributed in no small way to artificially boost our 'patient population'.[5]

3.7 Tourism statistics collected for 1995-1996 show that tourists constituted about a quarter of the total Island population compared with a mainland figure of only one per cent. In March 2001 this figure had risen to one third of the total number of people on Norfolk Island.[6] Dr Sexton observed that

3 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 202.

4 Sister Bonnie Anne Quintal, MBE, Superintendent, St John Ambulance Australia, Norfolk Island Division, Transcript, p. 118.

5 Government of Norfolk Island, Submissions, p. 179.

6 Statistics provided by the Norfolk Island Immigration Office show that for the week ending 29 March 2001, of the total number of 3118 on the Island 1053 were tourists. (The remainder was made up of residents, GEPs, TEPs and those with permits in process.)

tourists' expectations of medical outcomes are those of the area they have come from, and that they can be very demanding.[7]

3.8 In her March 2001 submission the new Hospital Director raised an interesting solution to the problem of providing a dependable, affordable health service for visitors in the absence of Medicare access. She proposed that the NIHE, as the sole provider of health services on Norfolk Island, could appropriately be the provider of health insurance for visitors. If all visitors were informed that, owing to the fact that Medicare is not available on Norfolk Island, they were required to take out Norfolk Island health and travel insurance, then the fees levied would ensure that services could be made available at no cost.

> Funds levied at 30,000 tourists per year would also provide the NIHE with a substantial amount of funding to seek capital improvements and address the issue of medivacs and the associated costs.[8]

3.9 As an example, a levy of $100 per visitor would generate over three million dollars per annum. With a guarantee of this level of funding the NIHE would be able to plan a replacement hospital in the short term, as well as address many other areas of need within the health system. However, it would be important that the imposition of such a levy demonstrated significant improvements to the level of services available to visitors, rather than as an additional impost on visitors to help provide improved services for residents. The cooperation of airlines and travel agents in collecting such a levy would have to be sought, and the means of incorporating it into a total package would have to be devised to avoid consumer irritation and reluctance to travel to Norfolk Island.

3.10 The Committee believes that such a system could be an effective and equitable short-term solution to the financial situation in which the Hospital Enterprise finds itself, given that part of the burden in recent times has been imposed by the increased demand from elderly visitors. It would, within a year, provide an injection of sorely needed funds which would help to solve problems such as staff shortages and the lack of training opportunities, which would rapidly translate into benefits for both visitors and Islanders. However, it is important that such a levy not be seen as a means for the Norfolk Island Government to avoid the major issues of revenue raising and appropriate levels of spending on health services.

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7 Dr Michael Sexton, Transcript, pp. 213-214.

8 Ms Christine Sullivan, Submissions, p. 196.

Services available to visitors

3.11 Submissions from the Norfolk Island Government and the Norfolk Island Hospital Enterprise advised that all health services available to residents on the Island are available to visitors. The Government submission noted there was a 'differential in pricing of services provided at the hospital for residents and non-residents'.[9]

3.12 Charges for services rendered to visitors are much higher than those for residents and some are considerably higher than charges for services on the mainland under Medicare. A standard consultation during business hours is double the Medicare schedule fee. The Department of Transport and Regional Services (DOTRS) provided the following examples of the two-tiered fee structure on Norfolk Island, based on information received from the NIHE in November 1999:

Service	Visitors	Locals
Consult during business hours	$57.50	$28.75
Consult out of business hours	$92.00	$57.50
Private ward per night	$477.50	$266.00
Shared accommodation	$430.00	$181.00
Intensive care per night	$937.50	$437.50

These figures remained the same in May 2001.

3.13 One submission to the inquiry described how a dressing change to a leg ulcer by a nurse at the hospital cost $75. The fee was the same for all subsequent visits. The submitter, Ms Margaret Clyde, observed that:

> I believe that the cost was too great, leading to a perception that tourists could be seen to be subsidising an ailing hospital system which has to cater for an aging population from a very small population to pay the medical levy.[10]

3.14 Some visitors, unaware of the higher costs and assuming that they are covered by Medicare on the Island, have encountered unexpected and disconcerting costs during their holiday. (The subject of eligibility for Medicare is dealt with in Chapter 8.) DOTRS advised that all prospective visitors should be given information in advance about the type and level

9 Government of Norfolk Island, Submissions, p. 7.

10 Ms Margaret Clyde, Submissions, p. 121.

of health care services available on the Island. This information should include the cost of services and details of any available health insurance options.[11] Until the issue of medivacs is satisfactorily resolved, visitors should be advised of the very high cost of a medical evacuation by a private company and urged to take out insurance which will cover the full cost in all situations.

Medicare and insurance for visitors

3.15 Norfolk Island has had its own health care system since 30 September 1989. Since 18 December 1990 mainland visitors have not been covered by Medicare for health services provided to them on the Island.

3.16 Evidence to this inquiry indicates that there is widespread ignorance among potential tourists of the fact that Norfolk Island is not covered by Medicare and that Australians visiting Norfolk Island must take out general insurance to cover medical expenses incurred there. Many believe that their existing private health insurance will cover them for treatment and the cost of medical evacuation. DOTRS commented that:

> This is not the case – which leaves individuals exposed and can, and does, result in hardship. Many of the elderly visitors to Norfolk Island may also have some difficulty in obtaining insurance coverage for pre-existing illnesses … as taxpayers, these people have and do contribute to Medicare through taxation on the mainland.[12]

3.17 The office of the Private Health Insurance Ombudsman described a complaint made by a health fund member who had to be hospitalised for an acute condition while on Norfolk Island. The patient's Australian health fund refused to pay benefits for hospitalisation because under its rules Norfolk Island is not considered to be part of Australia as a passport is required to travel there.[13]

3.18 The Committee does not believe that Australian citizens should need a passport to travel to and from Norfolk Island. The decision of this health fund is an instance of a penalty that the passport requirement can impose on the unwary visitor. If tourism, and hence the Norfolk Island economy, is to flourish, visitors will need guarantees that their visit will not impose hidden costs.

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11 Department of Transport and Regional Services, Submissions, p. 79.

12 Department of Transport and Regional Services, Submissions, pp. 78-79.

13 Private Health Insurance Ombudsman, Submissions, p. 135.

3.19 In compliance with Commonwealth law, domestic travel insurance policies do not provide cover for health services.[14] General insurers who provide travel cover for Australian citizens travelling to Norfolk Island issue a policy covering international benefits which includes health services cover. The Hunter Urban Network for Consumers of Healthcare noted in its submission that private health insurance is expensive, and that travellers over seventy years of age have to pay an additional premium of $50 even if they have been declared perfectly fit and well by their doctor.[15]

3.20 The Committee was told of an elderly couple's decision not to visit Norfolk Island as a heart condition precluded the husband from obtaining appropriate insurance coverage. The couple's own health fund did not cover health related expenses on the Island. The wife wrote to the Committee:

> However, we do think that as Norfolk Island is an Australian protectorate [sic], we should be able to go there and be covered for a short stay.[16]

3.21 Reverend Dr Robert Wyndham, a Uniting Church minister who has a Temporary Entry Permit, told the Committee about the situation for those on temporary entry visas, some of whom have little say about their transfer to Norfolk Island. Although he had personally been able to arrange hospital cover with his health fund, he felt it was an anomaly that:

> there are probably folk like us who are paying an amount of taxation in Australia which would normally cover us for Medicare and yet when we come across the water we are no longer covered.[17]

3.22 The Department of Transport and Regional Services advised that in order to provide for continuity of health care cover for tourists between Norfolk Island and the mainland under the Commonwealth *Health Insurance Act 1973,* the Commonwealth Government would need to bring Norfolk Island within the Act's definition of 'Australia'.[18] The Committee considers that this is an area which needs further examination by the Commonwealth and consultation with the Norfolk Island Government.

3.23 The Committee believes that it is important for the Norfolk Island Government to seek extensive community input on such important matters before entering discussions with the Commonwealth. Differences

14 Insurance Enquiries and Complaints Ltd, Submissions, p. 113.

15 Hunter Urban Network for Consumers of Healthcare, Submissions, p. 65.

16 Mrs M. Baguley, Submissions, p. 67.

17 Reverend Dr Robert Wyndham, Transcript, p. 119.

18 Department of Transport and Regional Services, Submissions, p. 79.

of perspective should not stand in the way of ensuring that Norfolk Island's valued visitors are eligible for the kind of comprehensive health insurance to which they are entitled on the mainland.

Other issues

3.24 Safety was raised as an area of concern for visitors, particularly for the elderly. It was suggested that more care could be taken on Norfolk Island to ensure that the likelihood of falls and other kinds of accidents occurring is minimised. A tour guide described how within a party of elderly tourists two experienced accidents. One person tripped over a tree stump hidden in grass and another tripped on a ramp. The doctor who treated both patients commented that there were a lot of unnecessary accidents on the Island. The Norfolk Island Government should consider implementing safety checks at all popular tourist sites, possibly along the lines of the inspections done by the Department of Veterans' Affairs. Such matters should be under the responsibility of a properly trained Occupational Health and Safety officer.

3.25 Issues of concern about medical evacuation are similar for both residents and visitors, particularly with regards to the cost. The Committee was told informally of an incident in which, in a life-threatening situation, a patient's relative had to arrange the transfer of $23 000 to a medivac company before an aircraft was despatched from the mainland. The patient's insurance company later refused to reimburse the expenses on the grounds that the condition was pre-existing. The witness expressed concern that this situation had befallen an Australian citizen in an Australian territory.

3.26 The Committee's concerns about past over-dependence on the RAAF for medical evacuations and the urgent need for a formal commercial arrangement to provide a guaranteed service for visitors as well as residents is documented in Chapter 6.

Recommendations

Recommendation 1

3.27 **The Committee recommends that the Norfolk Island Hospital Enterprise reconsider the pricing structure for services to mainland visitors, so that the cost does not become a disincentive to tourism.**

Recommendation 2

3.28 **The Committee recommends that measures be taken by tourist companies, airlines and other tourism promoters to warn all potential travellers to Norfolk Island of the high cost of health care, the fact that any expenses incurred will not be claimable on Medicare and that private travel insurance covering medical evacuation is essential.**

Recommendation 3

3.29 **The Committee recommends that the Commonwealth and Norfolk Island Governments consider the desirability of amending the *Health Insurance Act 1973* in order to cover mainland visitors to Norfolk Island under Medicare.**

Recommendation 4

3.30 **The Committee recommends that the Norfolk Island Hospital Enterprise develop for the Norfolk Island Government a proposal for the implementation of a health levy on visitors, as a basis for providing, in the absence of Medicare, quality health services free to all visitors, including the cost of medical evacuation if necessary.**

4

Health care – how can a comprehensive level be provided?

Overview

4.1 This chapter looks more closely at areas identified in Chapter 2 as urgently requiring attention, and examines measures that could be taken to help achieve a comprehensive level of health and ancillary care. The constraints of isolation and finances have been taken into consideration, as has the unique relationship of the Island with mainland Australia.

4.2 Aspects of the health system which have attracted closer examination include the provision of coordinated community health facilities to focus on preventive medicine, appropriate aged care facilities, a dependable and affordable medical evacuation service, replacement of the hospital, reducing the burden on doctors, making the system affordable and preserving the visiting specialists program. In addition to specific short-term and long-term measures that could be taken to provide these services and facilities, consideration is given to initiatives which would have a general benefit in all areas of health care.

4.3 Subsequent chapters deal in depth with three of the major issues of concern to both Islanders and this Committee. Chapter 5 examines the issue of aged care in more detail, Chapter 6 examines the subject of medical evacuations and Chapter 8 deals with the need for affordable, comprehensive medical insurance. The Committee believes that these are issues which require particular attention under the terms of reference of the inquiry.

4.4 Some of these issues have already been identified by the Norfolk Island Government. The review initiated by the former Minister for Health, Mr Gardner, is designed 'to identify the services that should be available

and to prioritise, resource and implement them'.[1] It is expected that the review, in conjunction with the findings of this inquiry, will provide the Norfolk Island Government with the advice, support and impetus required to undertake initiatives in the health area.

Issues of concern

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

4.5 When Dr John Davie, one of the full-time doctors on the Island, spoke to the Committee at the public hearing on Norfolk Island in November 1999, he was emphatic that:

> the long-term gains from effective, accountable, enthusiastically applied preventative health programs are absolutely immense.

He emphasised that a community must be empowered to take responsibility, that it requires political direction and will, but also:

> It is a movement which expands, and it grows like wildfire once it takes root.[2]

The Committee is aware that the Norfolk Island Government has already identified the need for action, but is concerned that the resignation of the then Health Minister in early 2001 may lead to a period of indecision and inactivity.

4.6 The Department of Transport and Regional Services observed in its submission that the advantages of preventive health care have been well demonstrated both nationally and internationally, and that the introduction of such initiatives on Norfolk Island would raise the overall health standard and, over time, reduce considerably the costs of curative health care.[3]

4.7 Evidence from the medical staff[4] and early findings of the Griffith University Health study indicate that, in common with most parts of Australia, lifestyle diseases such as obesity, smoking and alcohol related diseases and hypertension are common on the Island, yet there is a paucity of preventive and promotional work. If the tasks of early detection

1 Mr Geoffrey Gardner MLA, Transcript, p. 3.
2 Dr John Davie, Transcript, p. 35.
3 Department of Transport and Regional Services, Submissions, p. 74.
4 Dr John Davie, Transcript, p. 31.

and monitoring of such diseases devolve partly to qualified community health staff there are many advantages, not the least of which is a long-term reduction of suffering and of personal and public cost. It also shifts some of the work load from overworked general practitioners.

4.8 During its visit to the Norfolk Island police station the Committee was informed that most crimes on the island involve drink driving and domestic violence. Dr Lloyd Fletcher identified car accidents involving young males in drink driving incidents as a major source of hospital admissions. There is no legal requirement to wear a seat belt. Police advised that the legal blood alcohol limit is 0.08 which is significantly higher than on the mainland. Historically, this level has been set higher to allow people, in the absence of public transport or taxis, to drive home after social events where they have been drinking. There appears to be a need for a strong promotion of, among other things, the concept of the 'designated driver' who abstains, which has been adopted widely, even among young people, on the mainland.

4.9 DOTRS informed the Committee that government measures such as the introduction of new road traffic laws, including more up-to-date drink driving laws and the mandatory wearing of seat belts, had also been called for in the past.[5] Police and medical evidence indicates that these two measures would help reduce the far-reaching personal, social and financial costs of road accidents. Dr Davie commented that he was:

> particularly concerned that our greatest assets here are people, and yet it is very difficult for a medical practitioner to understand why we do not have simple legislation to make the wearing of seat belts compulsory.[6]

4.10 The CHAT submission to the inquiry referred to evidence given to it at a public meeting it held to promote a community health centre. At that meeting the police sergeant referred to the cost to the community of alcohol and drug abuse:

> In his opinion the Norfolk Island community was extremely tolerant of alcohol and drug abuse amongst its members … We have a society where in some families there are 3 generations of long term cannabis abuse with the accompanying social problems. We deserve a support group and educational programmes – for those affected by these problems.[7]

5 Department of Transport and Regional Services, Submissions, p. 80.

6 Dr John Davie, Transcript, p. 31.

7 CHAT, Submissions, p. 25.

4.11 Dr Fletcher also informed the Committee that he believed that marijuana use is a significant problem among young people on the Island, especially in the local high school. A high school teacher who was a member of CHAT likened the situation to being 'in a life boat with no support'. Mrs Colleen Evans, Chairperson of CHAT, commented on the absence of commercial television and hence of advertisements for anti-smoking campaigns.

> Our kids do not view anything like that. The programs are very limited in the school itself.[8]

4.12 In order to reduce the financial and social costs of these behaviours, issues such as drink driving, domestic violence and substance abuse need to be tackled with appropriate education campaigns, which logically would be initiated and promoted through an active community health service. Dr Fletcher expressed the hope that the CHAT team would undertake education programs about such issues for the schools and wider public.

4.13 In early 2001 the Substance Abuse Working Group, which was formed to address the issue of alcohol and drug abuse on the Island, made eight recommendations to the Legislative Assembly, all of which were accepted in principle. These recommendations proposed a community survey to quantify the incidence of drug and alcohol abuse, employment of a social worker for three months for needs assessment, the keeping of records relating to substance abuse and a community education program. The Group also recommended that the cost of education and rehabilitation related to alcohol abuse should be funded by the Liquor Bond, which is a major revenue earner for the Norfolk Island Government.

4.14 The Committee was advised in May 2001 that, as a result, an off-Island social worker / researcher had already been selected to conduct a needs analysis, and was due to commence a three month contract in July 2001. The full-time position is to be funded by the Norfolk Island Government. The appointee will work from an office in the Early Childhood Centre, which provides convenient access to, and opportunities for liaison with, hospital staff who would be involved in relevant community education programs.

4.15 The Substance Abuse Working Group is supported by the long experience of the Salvation Army in this field. A meeting of a group called Men Against Abuse was conducted by another religious group in an attempt to acknowledge and deal with the issue of domestic violence. While it is reassuring to note that these important issues are being acknowledged and tackled by some people within the community, the Committee

8 Mrs Colleen Evans, Transcript, p 76.

encourages the Norfolk Island Government to continue to demonstrate support for such initiatives by funding, and by placing responsibility for such programs under, an appropriate coordinating authority. This would ensure that such programs receive the financial and official support required for their continuation, coordination of various resources as well as accessibility for the whole community.

4.16 The Island doctors regard alcohol and tobacco consumption as a problem on the island, 'because of the low cost, and it is probably associated with other factors, too'.[9] The Griffith University Health Study found that over twenty per cent of the population were active smokers, most of whom have smoked in excess of ten years and consume on average 16-20 cigarettes a day. This group was 'likely to present as a burden to health services in the short to medium term due to smoking related disease (CVD, cancers, respiratory disease).'[10] The Hospital Director advised the Committee that smoking was not discouraged through No Smoking zones, and was permitted virtually anywhere. This situation means that the potential impact of passive smoking also needs to be considered.

4.17 The Committee believes that the Norfolk Island Government has an obligation to protect the health of people on the Island by introducing regulations forbidding smoking in public buildings and ensuring that such regulations are enforced.

4.18 Dr Davie thought that it would be a good idea for the Assembly to place a tax impost on cigarettes, perhaps by a couple of dollars a packet, with the money raised directed towards a purpose of benefit to all on the island.[11] During discussions with staff on the Committee's second visit to the Hospital, Dr Davie reiterated this point, claiming that cigarettes were so cheap on the Island that a tax of $3 or $4 per packet would not be unreasonable, and that alcohol could also be taxed to provide income for health services. He stressed that income raised in this way should not disappear into general revenue. Funds raised from an extra tax on alcohol and tobacco would have the dual advantage of restraining excessive consumption and providing a continuing source of funding for the community services budget.

4.19 Diet and the need for nutritional education is another lifestyle factor which needs to be addressed, particularly in light of the preliminary findings of the Griffith University Health Study. The study found that:

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9 Dr Lloyd Fletcher, Transcript, p. 44.

10 Norfolk Island Health Study, Preliminary Results and Analysis, Griffiths Hughes & Quinlan, Griffith University, September 2000, p. 1.

11 Dr John Davie, Transcript, p. 32.

> the prevalence of overweight and obesity amongst the Norfolk Island community mirrors and exceeds that observed in the Australian population. Overweight and obesity levels of this nature are accepted as being a major issue for population health with a predicted high burden on health service requirements over the next few decades.[12]

4.20 The Hospital Director observed in her submission to the Committee that:

> A community dietician would be a valuable addition to the services, for advice and support on weight control programs, antenatal care, menu selection, school canteens etc.[13]

She informed the Committee that as well as consulting with patients at the Hospital, there were opportunities for private work with restaurants and clubs, as well as providing advice to government on food handling guidelines and hygiene standards. A partly government-funded position that also offered the right to private practice, similar to that negotiated with the physiotherapist, would be of great benefit to the community.[14]

The Community Health Centre proposal

4.21 Members of the Community Health Awareness Team informed the Committee at the public hearing that they are trying to initiate a primary health care service on Norfolk Island. Their submission contained a proposal which already has strong support within the community, as well as from both the new (1999) and retiring medical officers and the Hospital Management Board. The then Norfolk Island Minister for Health informed the Committee that a formal motion in the Legislative Assembly to address the concerns of CHAT had received support from all members. However, in May 2001 no further action appeared to have been taken.

4.22 Mrs Evans, the chairperson of CHAT, told the Committee that their aim is to take the primary health care out of the secondary health care facility (the Hospital). While CHAT believed that the existing baby health clinic building would be a suitable, accessible location, the Committee was told in March 2001 that this small building is already fully utilised. CHAT also aims to hire a paid professional community health coordinator who, with the aid of volunteers, would:

> assess existing services, propose new ones, co-ordinate, organise and source funding for various projects. (For example grants

12 Norfolk Island Health Study, Preliminary Results and Analysis, Griffiths Hughes & Quinlan, Griffith University, September 2000, p. 1.

13 Ms Christine Sullivan, Submissions, p. 195.

14 Ms Christine Sullivan, supplementary information provided on request, Correspondence, 6 April 2001.

> programmes for specific projects). They would also be expected to train a local person to ensure the longevity of the project.[15]

4.23 CHAT hopes to provide preventive health care and education for the community in the areas of drug, alcohol and tobacco abuse, sex education and sexually transmitted diseases, diabetes, asthma, cancer support, parenting programs, counselling and mental health support, as well as reinforcing existing maternal and child health services. Presumably the service would undertake additional programs or services when a need is identified within the community.

4.24 CHAT plans to make services free at its proposed community health centre. It also intends that it becomes a drop-in centre for the public, open five days a week. Proposals for staffing the centre include immediately extending the hours of the existing Child Health sister to allow her to establish new programs and initiatives, utilising the services of health professionals within the community on either a voluntary or paid basis, and eventually employing a community health nurse and a mental health counsellor.

4.25 Anecdotal evidence suggests that because of the small size and nature of the community, a non-resident counsellor might be the only person an Island resident would approach for help in some situations. The 1998 report prepared for the Norfolk Island sub-branch of the RSL, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, suggested the idea of contracting a mainland group practice which would send counsellors and other health professionals to the island on rotation, for periods of approximately three months. Continuity would be ensured by close liaison between counsellors who are colleagues.[16] Counselling services available within a more broadly based community health centre would help to preserve the anonymity most people require when seeking counselling services.

4.26 CHAT has already been offered support and some funding from the Medical Support Foundation, and would seek donations from users of the centre. To ensure the success of a valuable community project such as this it would be important for it also to receive regular and realistic funding from the public purse, particularly in the area of staff recruitment and remuneration.

4.27 There is strong evidence that new health initiatives are most likely to succeed when they emerge from the community and maintain strong community support. The Committee believes that the CHAT proposal,

15 CHAT, Submissions, p. 25.

16 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 48.

with strong backing and guaranteed financial support from the Norfolk Island Government, would make a good starting point for the provision of comprehensive community health services on the Island. In April 2001 the Hospital Director rated the appointment of a full-time, skilled health promotion officer as a high priority, proposing to include funding for such a position in the 2002-2003 hospital budget.

Accessing national health programs and funding

4.28 The Department of Transport and Regional Services noted in its submission that Norfolk Island residents have difficulty in accessing national health programs and funding, including those aimed at assisting communities in rural, remote and regional Australia, of which Norfolk Island is a part. However, as has been noted, the Commonwealth legislation under which some of these initiatives are funded, does not extend to Norfolk Island.

4.29 The DOTRS submission noted the argument of some Norfolk Island residents and representatives that although they do not pay mainland income tax, some pay tax on investment, superannuation and other income earned from a mainland source, which should entitle them to Commonwealth funding. Many residents return to Norfolk Island after many years of earning and paying Commonwealth income tax, but they receive no benefit from Medicare or access to national health programs.[17] The Department commented that access to Commonwealth programs, however achieved, would help offset the limitations of Norfolk Island's health and aged care services.

4.30 DOTRS noted that the Island's increased liaison with mainland health care providers could also assist greatly with preventive health care initiatives such as child health, breast screening, mental health services, youth programs and public health programs, all of which would have major flow-on benefits for health care provision on the Island.[18]

Using existing resources

4.31 A person with qualifications in community services could examine existing resources and ensure that these were well utilised. This is particularly important on Norfolk Island where service clubs, and volunteers in general, play such a significant role.

4.32 Meals on Wheels and home assistance for elderly people were two important areas identified in the RSL report as significant in helping

17 Department of Transport and Regional Services, Submissions, p. 77.

18 Department of Transport and Regional Services, Submissions, p. 80.

people stay in their homes longer, yet there appears to be little awareness of, or demand for, either service from residents. The report commented that:

> this may be confusing the absence of need with a lack of knowledge of the availability of such services and structure for people to access the services.[19]

4.33 The service clubs have volunteers who could assist people with transport and home-based tasks. However, like Meals on Wheels, there appears to be little or no demand for the services. If, through the efforts of a community services coordinator / health promotion officer, these were actively promoted and more generally available:

> it would become more socially acceptable to use these services as a legitimate form of community support.[20]

4.34 Coordination of the revenue raising initiatives of community organisations for health services and equipment is essential to ensure consistency with the overall health strategy for Norfolk Island. For example, Dr Davie has advised that while a bowel screening initiative run by the local Lions Club was of tremendous value, it inadvertently created another need on the Island in that all thirty patients with a positive result required a colonoscopy – a service not currently provided on Norfolk Island. Dr Davie confirmed the unfortunate result of a lack of coordination in community services:

> So although the intent of having a bowel screen is wonderful, the cost that comes from it is immense, because every one of those patients has to go away for a colonoscopy.[21]

4.35 He advised the Committee that the equipment needed to perform colonoscopies on the Island would cost a maximum of $10 000 and that he was experienced with the procedure. The Hospital Director commented that all screening programs should be coordinated with the scheduled visit of an appropriate specialist, to avoid delays in diagnosis and resulting patient anxiety.

4.36 Another example of a service club driven initiative was fund raising for a mammography unit. Dr Davie, aware of the potential complications of an uncoordinated effort, said:

> This is of particular concern to me, because I think there is a lot of fragmentation … It is certainly a wonderful thing, but it does not

19 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 41.

20 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 41.

21 Dr John Davie, Transcript, p. 39.

> stop at the provision of a piece of hardware … of course, there are the additional costs of maintaining and servicing that equipment.[22]

Dr Davie pointed out that mammograms often have to be followed up with an ultrasound investigation.

4.37 Although the purchase of each of the major items of equipment identified during the inquiry, plus the cost of related staff training, would make an impact on the health budget in any one year, the financial benefits to Islanders who would be saved many unnecessary visits to the mainland would be significant, as would the benefits of early detection to their wellbeing. Borrowing should be considered for capital investment such as this because the health and financial benefits would far outweigh the burden of debt repayment.

2. Provision of appropriate aged care

4.38 This subject is examined in greater detail in Chapter 5. However, it is noted here to indicate the importance that witnesses to the inquiry have placed on tackling the issue with both urgency and informed decision making. Mr Gardner informed the Committee that aged care had become a higher priority for the Government in the last couple of years:

> The provision of aged care facilities is part of our strategic planning process.[23]

He referred to the joint approach between the Department of Veterans' Affairs and the Norfolk Island Government to develop the necessary strategies to improve domiciliary and residential care for the aged on Norfolk Island. The Committee is convinced of the continuing value of this relationship and encourages the establishment of similar co-operative links with the Department of Health and Aged Care.

4.39 There appears to be universal agreement that the present accommodation in former public wards of the Hospital is totally inadequate. Evidence suggests that there is an urgent need for both increased home nursing and other measures which will enable the elderly to remain in their own homes longer, as well as for purpose-built residential accommodation for those who can not be supported adequately at home. Dr Davie observed that:

> the numbers that are going to present for accommodation in the existing facility will rise exponentially in early phases of the new millennium.[24]

22 Dr John Davie, Transcript, p. 33.

23 Mr Geoffrey Gardner MLA, Transcript, p. 29.

4.40 Training in geriatric care, particularly for dealing with dementia patients, is needed for hospital nursing and domestic staff. This should soon be available through the employment of the aged care clinical nurse consultant. The employment of a physiotherapist full-time for a year, with fifty per cent of salary for a further two years, will contribute enormously to the well-being of the frail elderly. There is also an urgent need for measures which will ensure the privacy and dignity of the present occupants of the 'Verandah' until satisfactory alternative aged care accommodation is available.

4.41 'Ageing in place' and the provision of acceptable residential facilities are examined in detail in Chapter 5. The Committee's recommendations on aged care appear at the end of that chapter.

3. Provision of a dependable, affordable medical evacuation service

4.42 This issue is also examined in detail in Chapter 6. It is listed here as an indication of the level of concern expressed over present arrangements.

4.43 While Norfolk Islanders have great respect and gratitude towards the RAAF for the many emergency evacuations it has performed over the years, they are aware of the risk of depending on a source which may not always be available, and which, although free to Islanders in a crisis, is estimated to cost Australian taxpayers $130 000 per evacuation. Because an appropriate aircraft may not be based at Richmond at the time of a request for an aeromedical evacuation, and because Defence guidelines require that civilian alternatives should be sought first, the RAAF cannot guarantee that requests will be fulfilled.[25]

4.44 The difficulty that Islanders experience in obtaining affordable medical insurance which will cover them for evacuation expenses makes the use of private medivac companies complicated. Hire of a specially equipped aircraft and crew is expensive, up to $40 000 per evacuation. The need to guarantee payment before a flight is despatched can cause considerable anguish to patient, family and Island medical staff, as well as a potentially dangerous delay for a critical patient.

4.45 The possibility of involving the Royal Flying Doctor Service is examined in Chapter 6. The Committee's recommendations also appear in that chapter.

24 Dr John Davie, Transcript, p. 38.

25 Department of Defence, Submissions, p. 138.

4. Replacement of the hospital

4.46 As described in Chapter 2, the hospital is a World War II vintage building, with many extensions added in ad hoc fashion over the years. Its age, inefficient layout and low occupancy rate means that it is not cost efficient to staff or maintain. By default, it houses approximately eight frail elderly people who need full care.

4.47 The Norfolk Island Government is aware of the need to replace or drastically upgrade the hospital and aged care accommodation, but has competing demands with other essential infrastructure. Island witnesses have mentioned rough 'guesstimates' which have put the replacement cost variously at $5 million, $10 million and $15 million. The Department of Transport and Regional Services questioned the ability of the Norfolk Island Government to meet such costs without some form of assistance.[26]

4.48 There is a small hospital trust fund containing approximately $50 000 from Islanders' fundraising[27] but the Norfolk Island Government does not appear to have sufficient funds either at present or in the foreseeable future for a new facility. John Howard and Associates noted in their 1998 strategic review of the Norfolk Island Government that there was a lack of forward planning for replacing infrastructure:

> there is no forward planning to identify and schedule key capital works, either renewals or replacements. There is no framework for prioritizing between competing capital works projects. There is no mechanism to ensure and plan for the funding of future capital works commitments … urgent projects with significant multiyear costs find it difficult to obtain the necessary commitment.[28]

4.49 In May 2001 the Hospital Director advised that she had received 'sound advice' that a benefactor wished to make a significant bequest towards a replacement hospital. The size of the bequest, which the potential donor wished to make available in the near future rather than after his death, might be sufficient deposit for a loan for the full amount. The donor had already arranged to address the Board, and had expressed the belief that his actions might inspire similar philanthropy among others of the very wealthy who live on the Island. The Hospital Director said that the action of this benefactor had increased the chances of accelerating plans for a new hospital.

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26 Department of Transport and Regional Services, Submissions, p. 81.

27 Mr John Hughes, Transcript, p. 52.

28 John Howard and Associates, *Norfolk Island Administration – Strategic Review* (April 1998) p. 112.

4.50 Philanthropy on this scale must evince strong support and action from the Norfolk Island Government if the initiative is to be seized and maximised. The Department of Transport and Regional Services observed that if it is established that the Norfolk Island Government is unable to meet the costs of providing necessary capital equipment and infrastructure, consideration ought to be given to some form of Commonwealth assistance.[29] The issue of infrastructure funding is examined further in Chapter 9.

4.51 Whilst predicting an accelerated demand for acute services due to the ageing population, the Department of Veterans' Affairs believes it is important that before any physical redevelopment is undertaken, a planning study needs to be done that will:

> clearly define the acute health clinical needs of the likely catchment population for the next ten to twenty years. This will require a statistical projection of the likely future population numbers, age and sex composition having regard to the 1996 census data base, fertility and mortality rates, immigration etc. An audit will also be required of the hospitals available morbidity data and referrals offshore.[30]

4.52 The results of the Griffith University study should provide an age and health profile of the population, which, combined with analysis of tourist figures, should provide a basis for informed predictions about future hospital requirements.

4.53 The RSL report observed in December 1998 that the Norfolk Island population reflected an older age distribution than the mainland. Those over seventy accounted for ten per cent and those over 65 formed sixteen per cent of the Norfolk Island population.[31] Given the large numbers of people in the sub-70s age group and the tendency for younger people to move away from the Island to find work, the report predicted 'a significant and increasing demand for aged care services'. It also commented that the over-seventies age group:

> will be likely to have the typical multisystem problems of the aging adult – a combination of decreasing mobility, impaired mental functioning, chronic cardiovascular disease, cancer and other degenerative disorders.[32]

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29 Department of Transport and Regional Services, Submissions, p. 81.

30 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 47.

31 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 1.

32 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 5.

4.54 Witnesses who have commented on the need for a new hospital have generally spoken in terms of a multi-purpose facility which is the focal point for the delivery of many different health related services. The Multi-Purpose Service model (MPS) is a relatively new approach to the delivery of acute, aged and community services which is gaining popularity in rural and remote areas on the mainland. Mr Gardner told the Committee that he was aware of the value of the MPS model:

> Due to the size and location, our health services and strategy for the future will in all likelihood mirror the Commonwealth's multipurpose service program, basically expanding on the current practice that we have here on Norfolk Island with some minor administrative change.[33]

The necessary administrative changes will require professional expertise which the Committee would strongly advise the Norfolk Island Government to seek in regard to the application of the model in the unique Norfolk Island circumstances.

4.55 The MPS model can both fill gaps and prevent duplication of health services. Professor Carol Gaston, an expert in the redevelopment of many rural hospitals in South Australia and the Northern Territory, commented in her submission on the potential this would have to redirect funding to community services on Norfolk Island.

4.56 The RSL report also raised the potential of the MPS model for Norfolk Island, suggesting a possible mix of services for a new facility, including a roughly equal number of acute and nursing home beds, further hostel type places, as well as accident and emergency facilities, operating theatre, day care centre, community health services, meals on wheels etc.[34] Professor Gaston informed the Committee that it was desirable for an older citizens' village to be discrete from, though reasonably close to, the hospital.[35] The Community Health Awareness Team also said that it preferred a community health centre to be discrete from the hospital. As the focus of the health system changes, the Hospital should increasingly be seen as a place for a wide variety of functions, and not just a treatment centre for the ill.

4.57 Plans for a replacement facility should be informed by consultants with proven experience in designing multi-purpose medical facilities. A community consultation process should be undertaken to ascertain that community expectations and preferences are met. Mr Gardner advised the

33 Mr Geoffrey Gardner MLA, Transcript, p. 30.

34 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 45.

35 Professor Carol Gaston, Transcript, p. 208.

Committee that the Department of Veterans' Affairs has offered advisory services in design and service implementation for the development of the Norfolk Island hospital as a whole.[36]

4.58 The Committee believes that the DVA offer of assistance in designing a new hospital, as well as various other options outlined in the 1998 RSL report should be seized and acted upon enthusiastically while veterans still remain a large proportion of the aged population of Norfolk Island. Responsibility for identifying such assistance should be conferred on an appropriate person , possibly an RSL (Norfolk Island) member or a person capable of being an advocate for veterans.

4.59 Several witnesses raised the option of private sector funding for a new hospital. Richard Tate, author of the RSL report, promoted the option. He described a situation in which the operator of a privately financed, built and operated hospital enters into a contract with the government to provide specified public health care services for a finite period, perhaps fifteen to twenty years, after which the asset could revert to the government. He believed that such an arrangement might appeal to the innovative and independent spirit of Norfolk Island.[37]

4.60 Professor Gaston also raised the possibility of private sector funding, advocating testing the waters for alternative means of financing:

> You do not know how the private sector are going to respond until you have discussions with them.[38]

4.61 In the meantime, various witnesses have strongly advised that no further major refurbishment or extension to the hospital be undertaken. A proposal to add ensuite bathrooms, which would involve significant cost, would not be an appropriate use of funds at this stage. In contrast, plans to create a quiet room for the elderly patients need not involve much expense but would make a marked improvement in conditions for those who are confined to the building.

4.62 The Hospital Director advised the Committee that in recent years all proposed changes to the building have been assessed against the projected life of the building.[39] Some alterations had been made in the Baby Health building and the main reception / office area, and one of the isolation units in the grounds was converted to a self-contained flat for the frail, but independent aged. A small, under-roof extension to the physiotherapy

36 Mr Geoffrey Gardner MLA, Transcript, p. 29.

37 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 46.

38 Professor Carol Gaston, Transcript, p. 209.

39 Ms Christine Sullivan, supplementary information provided on request, Correspondence, 6 April 2001.

building was scheduled for mid-2001. However, the Hospital Director said in May 2001 that the advent of an enthusiastic benefactor to the scene meant that the situation may alter. If the prospect of a new hospital within the next several years became a reality, even the smallest changes would have to be examined very closely. For instance, the morgue urgently needs an injection of funds but even this extremely inadequate facility might have to be made to suffice.

4.63 The Committee supports the Director's decision to place further capital expenditure on the existing hospital structure on hold, apart from essential maintenance and minor improvements to enhance the safety, privacy and comfort of the permanent aged residents.

4.64 In conclusion, the Committee believes that there is an urgent need for a new hospital on Norfolk Island, the construction of which will require significant planning and the expertise of people with proven experience in the field of multi-purpose health facility design. Norfolk Island is part of Australia, and its residents, the majority of them Australian citizens, have the right to health care standards the equal of those which would be expected by the residents of any other remote community. The Committee is aware of isolated communities elsewhere in Australia which have hospitals of a standard vastly superior to that of the Norfolk Island Hospital.

4.65 The funding of a new hospital will be a critical issue. The Committee believes that the Norfolk Island Government must, as a matter of priority, examine the funding options for a new multi-purpose health facility, including options such as borrowing (possibly through a low-interest Commonwealth loan), raising new taxes and applying for a Commonwealth grant for part funding. It is also essential that the Norfolk Island Government, in consultation with those with the relevant expertise, adopt a timetable for the replacement of the existing hospital, which includes completion dates for the necessary stages such as consultation, planning and the tendering process.

5. Reducing the burden on doctors

4.66 Early in the inquiry many witnesses spoke to the Committee about the urgent need to alleviate the pressure placed on the two full-time doctors. The Committee is pleased to note the appointment of a third full-time doctor in 2001. The 2000 Norfolk Island annual report revealed that there were over 11 000 outpatient consultations in that year. Dr Fletcher commented to the Committee that:

> demands on casualty are incredible. People do not know what it is like to wait more than twenty minutes in casualty.[40]

4.67 The NSW state office of the Department of Veterans' Affairs noted that its meetings with Returned and Services League representatives, community groups, hospital staff and members of the Norfolk Island Government revealed a similar finding:

> There was concern about the load being placed upon the available doctors and a strong interest was evident in identifying ways of alleviating this by moving to a less medically-centred approach.[41]

4.68 There should be widespread acknowledgment that the doctors have been overburdened and that whenever such a situation arises it presents both a risk to patients and a threat to the long term viability of the medical service on the Island. This issue is examined below in the section 'Changing patients' expectations' (4.88).

4.69 Publicity and debate on the role and responsibilities of the general practitioners and the need for alternative sources of health information and care should be encouraged through the local newspaper and radio as well as at widely advertised community meetings. Community input into finding solutions to the problem is important in a situation where traditional community attitudes and practices form part of the problem.

4.70 The introduction of e-health measures has the potential to reduce the workload of the doctors, to ease their sense of professional isolation and to assist them with their professional development. Telehealth issues are examined in Chapter 7.

Transferring responsibility

4.71 There appear to be various ways that the present, unacceptable workload could be reduced. Current overuse of the doctors as the first point of call should reduce with the development of a coordinated community health service. Much of the responsibility for primary health care, particularly for personal, psychological and psychiatric problems, which can involve many, lengthy consultations, could be transferred to a mental health counsellor at a community health centre. Ultimately, the capacity for video conferencing with mental health professionals off-Island will help address this need.

4.72 Similarly, the newly appointed aged care clinical nurse consultant could take on many of the medical responsibilities for the aged. The fact that

40 Dr Lloyd Fletcher, Transcript, p. 43.

41 Department of Veterans' Affairs, NSW state office, *Report on the visit to Norfolk Island in August 1999*, Exhibit 14, p. 11.

there are elderly people living in the Hospital means that there are high expectations by nursing staff, patients and their relatives for regular visits by the doctors. According to Dr Fletcher:

> Doctors are called all too often and all too easily.[42]

4.73 Moving the aged away from the acute care section of the Hospital would reduce the demands on doctors. This could possibly be achieved before the construction of a new facility by redefining and separating the aged care space, staffing and funding from the acute care function of the Hospital. Increased staff training in geriatric care, which the aged care clinical nurse consultant should provide, should also assist in reducing the demand for a doctor's presence.

4.74 The Committee hopes that the employment of the third full-time doctor will allow the doctors sufficient time away from duty to discuss, consider and implement measures that would reduce the overwhelming demand for their services.

The role of nurse practitioners

4.75 Nurse practitioners with appropriate skills, who may prove easier to recruit than doctors, are becoming a feature of rural and remote health care on the mainland. Professor Gaston advised that:

> All other States and Territories are now either implementing or in the process of implementing this role. It is a role that is particularly useful in rural and remote areas where there is not the number and distribution of General Practitioners sufficient to support the primary health care needs of the population.[43]

4.76 She outlined the benefits of the role of nurse practitioner to remote communities:

> Health assessments, screening, care planning, management and coordination, limited diagnostic and prescribing rights provide the opportunity for these advance practice nurses to provide primary care in areas such as mental health, child and maternal care, women's health, palliative care and long term care of people with chronic illnesses such as diabetes, asthma and epilepsy.[44]

4.77 If a nurse practitioner credentialled to work in primary health care and in remote circumstances could be recruited to provide general health screening, health promotion and intervention programs, there would be a

42 Dr Fletcher's report to the Norfolk Island Minister for Health, Submissions, p. 180.

43 Professor Carol Gaston, Submissions, p. 61.

44 Professor Carol Gaston, Submissions, p. 61.

considerable reduction in this aspect of the doctors' work.[45] Dr Sexton advised the Committee that he thought employing nurse educators and nurse practitioners would be more appropriate than employing a third doctor. He commented that the Royal Flying Doctor Service uses nurse practitioners regularly:

> we used to run a hospital on that basis and it worked extremely well. You knew you had a very competent person there; you knew you had to go and fly the plane if she said, 'Come.'[46]

4.78 In relation to an area of particular concern to the present doctors, the requirement for two doctors to be available at all times in case of emergency surgery and anaesthesia, Dr Sexton said that:

> we train nursing staff to actually undertake anaesthetic skills and maintain an anaesthetic, and they can do that just as well as the medic.[47]

He commented on the potential for local nurses to be trained in various areas of need which he identified as community health promotion and community education in mental health and sexually transmitted diseases.

4.79 Dr Sexton was an enthusiastic supporter of the hospital's practice of providing funds for one of the nurses to go to the mainland each year to do a training course in an area of her choice and expertise, with the expectation that on her return she would 'put it in place on the island'.[48] This scheme has the potential for expansion, possibly targeting areas of need identified in the new health strategy. Dr Sexton also expressed the views of a number of witnesses when he commented on the potential of telecommunications to provide specific training for nurses. The RSL report referred to the possibilities of distance learning through various mainland institutions which offer courses in specialist nursing areas.

4.80 Professor Gaston explained that in the present absence of tertiary curricula, nurse practitioners are authorised and credentialled on assessed current experience by the nurse registering body in the region where they work.

Recruitment of doctors

4.81 In 1999 the then Health Minister, Mr Gardner, identified the recruitment and retention of suitably trained doctors as an area of concern to the

45 Professor Carol Gaston, Transcript, p. 208.

46 Dr Michael Sexton, Transcript, p. 218.

47 Dr Michael Sexton, Transcript, p. 215.

48 Dr Michael Sexton, Transcript, p. 219.

Norfolk Island Government.[49] Several other witnesses have commented on the difficulty of finding a suitably qualified doctor in a period of increasing specialisation. As Dr Fletcher commented:

> he would have to be a Doctor who was a capable all-rounder, able to do Surgery, Orthopaedics, Anaesthetics and Obstetrics. Such a bird would be hard to find in these days of ubiquitous medico-legal litigation and medical specialisation.[50]

4.82 The possibility of developing Norfolk Island as a training facility in remote medicine, suggested by the Minister for Health, has potential but should not impose further responsibilities for training and supervision on the existing medical officers unless there is a demonstrated, substantial reduction in their present workload. Dr Fletcher advised that he and Dr Davie already undertake responsibility for fifth or sixth year medical students from Australia and New Zealand, who regularly come to Norfolk Island for further training.

4.83 Most contracts are initially for a period of two years, with the possibility of an extension. The Hospital Director told the Committee that, considering the present lack of opportunities for continuing training for hospital staff, it was probably not in either the doctors' or the community's interests for doctors to remain too long in such an isolated posting. The exciting new possibilities for continuing education and engaging in regular on-line consultation with mainland experts, soon to be available through the Internet, may make the issue of keeping up-to-date less problematic.

4.84 The Hospital Director also noted that employing young doctors for a shorter period often had many advantages in that they brought with them enthusiasm and the benefits of their recent training. The six month engagement of Doctor Foong had led to a proposal for an effective, low cost entry into the realm of e-health. Dr Foong had used net-conferencing to assist with medical visits to remote communities in the Himalayas, transporting the relatively basic equipment on the backs of ponies. In the remotest places, he had visual contact and instant transfer of images to specialists in the USA. He was able to adapt his experience and knowledge of the technology to the Norfolk Island situation.

Royal Flying Doctor Service proposals

4.85 The Executive Director, South Eastern Section, New South Wales Operations of the Royal Flying Doctor Service (RFDS) outlined in a submission to this inquiry various services which the RFDS could provide,

49 Mr Geoffrey Gardner MLA, Transcript, p. 6.

50 Dr Lloyd Fletcher, Submissions, p. 183.

in addition to medical evacuations.[51] Several of these appear to have the potential to reduce dramatically the workload of the full-time doctors, as well as bring in new ideas and technologies. The RFDS can provide a remote, after-hours consultation service to relieve the medical officers from sleep disrupting, non-urgent consultations. Utilising such a service could make a significant reduction in the present number of night and weekend callouts, which is a major source of the overload and the resulting stress experienced by the doctors.

4.86 Another service proposed by the RFDS was the provision of medical officers with a primary health care and emergency medical transfer focus, as well as community based registered nurses and allied health workers, on three to six month rotations. Having access to a dependable source of appropriately trained medical personnel would be of benefit to the Norfolk Island Government, which at present encounters considerable difficulty and expense in locating and employing qualified staff. The RFDS proposal refers to its links with the Sydney University Department of Rural Health and the College of General Practice.

4.87 The RFDS indicated in 2000 that it was in the process of discussing and costing these proposals with the then Hospital Director. It would appear that no further progress has been made. The Committee strongly urges that the present Director examine the proposals, consult with the Hospital Board and re-establish contact with the RFDS with a view to exploring these options.

Changing patients' expectations

4.88 A change in the expectations of some patients needs to be achieved, and this may prove to be a considerable challenge. Dr Fletcher informed the Committee that over the years the people of Norfolk Island have come to expect instantaneous medical service, and the patients' demands for instant service are rewarded and reinforced by the system:

> many of them phone the Hospital daily to talk to the Doctor. These phone calls amount to 'freebie' consultations, and are time-consuming when the Outpatient Clinic is already fully booked out. There are also a number of patients who insist on phoning the Doctor at his home or at nights or at weekends … They know that they can go to the Hospital day or night, any day of the week, and a nurse will see them and immediately phone the Doctor … There are also many patients… [who] just turn up at Casualty whenever they want to see a Doctor. All patients have to be fitted in to

51 Royal Flying Doctor Service, Submissions, p. 179.

> already fully booked Clinics , and they get to see the Doctor regardless of how heavily booked his Clinic may already be.[52]

4.89 The RSL report observed that Norfolk Island, with a ratio of medical practitioners to population better than the Victorian state average, would appear to be well served in terms of GP numbers.[53] This ratio improved further with the appointment of a third doctor in mid-2001. However, there is abundant evidence from many different sources that the use of doctors' services is higher than on the mainland.

4.90 A re-examination of outpatient policy and procedures appears to be needed. Present administrative practices concerning appointments and access to the doctors when they are consulting, and after hours, need revision. Identifying and implementing changes would require discussion with and support from nursing and administrative staff, and would need the full support of the Hospital Board. A positive promotional campaign should be devised to launch any new procedures to help counteract the natural resistance to change. The Committee was pleased to note that, beginning in January 2001, the new Hospital Director writes an article for the local paper every six weeks, reporting on developments at the Hospital. Her first article dealt with the making and keeping of appointments, and the appropriate use of outpatient services.

4.91 There seems to be a need for an awareness campaign for Islanders, to promote understanding of how to get advice and whom to approach for assistance with different health and lifestyle problems, so that the doctors are not always the first point of contact for every health related issue. In the first instance this might have to be spearheaded by the doctors themselves. Alternatively, it could perhaps be done under the auspices of the fledgling Community Health Awareness Team which appears to include various qualified health professionals among its volunteers. Providing advice on who to contact is the kind of ongoing task that would become the responsibility of a community health coordinator.

6. Making the system more affordable

4.92 The Committee became aware during the course of the inquiry of the financial burden on Islanders trying to access health care. Comparisons with costs on the mainland indicate that a higher percentage of income is spent by Islanders on health than by other Australians. The Commonwealth Grants Commission reported that household expenditure surveys had shown that the average weekly expenditure on health and

52 Dr Fletcher's report to the Minister for Health, Submissions, pp. 180-181.

53 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 31.

medical costs on Norfolk Island was more than fifty per cent higher than that in New South Wales.[54] There are no free public hospital services, except to age pensioners, as a result of which there are many bad debts.

4.93 There are several major factors contributing to the high costs – the dependence on patients' fees for essential funding, the inequitable structure of the compulsory health levy, the inadequacy of the health insurance scheme, which is designed to cover only 'catastrophic' costs, and the inflated price of medicines, which provides a source of funding for the hospital.

Dependence on fees for funding

4.94 Underlying many of the difficulties is the fact that the Hospital, which is the focus of health care on the island, depends on fee recovery for the major part of its funding. The Hospital resorts to ever-increasing subsidies from the Island's government each year to remain solvent. It experiences a high level of bad debts. The Norfolk Island Government's submission to the CGC inquiry in 1997 stated that:

> The Enterprise's dependence on fee collection for the majority of its funding causes cash flow difficulties and makes accurate budgeting for equipment replacement and other capital asset acquisition difficult. Active debt collection procedures are necessary.

4.95 As the number of in-patients, and their length of stay, decreases, the Hospital's revenue inevitably declines. The Norfolk Island Government's submission also identified this fundamental flaw in the funding of the Hospital:

> The Enterprise faces conflicting goals in terms of its reliance on throughput to fund its activities and the overarching aim of a community health care system to promote practices that will decrease the utilisation of health services. The occupancy rate of the Norfolk Island Hospital Enterprise has decreased by an average 2 patients per day over the past two years. Calculated at $200 / day x 2 x 365, this is broadly equivalent to an income reduction of $146,000 per annum.

4.96 The dependence on fees for funding acts as a disincentive for the NIHE to review its fee structure, which appears high for a system without comprehensive health insurance coverage. Fees for visitors to the Island are approximately double those for residents. (See the fee comparison table in Chapter 3, at 3.12.)

54 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 94.

The health levy

4.97 The current Healthcare scheme, under which all Norfolk Island residents over the age of 18 pay the same compulsory levy of $500 per year, regardless of income (with some limited exceptions), appears inequitable. The flat rate of the levy means that a greater burden is placed on lower income earners. Witnesses have told the Committee that low income earners have difficulty meeting the compulsory health levy, which has increased by nearly 100 per cent since 1997, to $250 each six months. This impression was reinforced by DOTRS, which believes that at least ten per cent of members have difficulty paying the Healthcare fees.[55] Mr Gardner, the then Health Minister, confirmed this figure at the public hearing on Norfolk Island.[56]

4.98 The Committee was told that when the levy was first calculated about ten years ago, a costing of the health scheme was undertaken. The resulting figure was then simply divided by the number of people in the community. The levy was initially $260 per year per adult, payable in two six-monthly instalments, but as the health scheme continued to make a deficit, the amount was almost doubled in 1997 to $500 per year.[57]

4.99 The cause of this funding problem, which impacts more on low and average income earners, appears to be the original major miscalculation of the full cost of providing a complete health system. Figures from the last ten years now provide the Norfolk Island Government with a much better indication of the actual cost to the Island. It is unrealistic to expect that the large budget required could be raised through individual levies and the payment of patients' fees to the Hospital. The Hospital's continuous deficit, the level of bad debts and the Government's annual informal subsidy to the hospital are all clear indications that both the source and level of funding for the system need urgent review.

4.100 Mr Gardner informed the Committee that he personally wished that the funding of the Healthcare scheme could be more compassionate:

> The levy at the moment is felt because it hits you right in the face every six months.[58]

He indicated that the Government would look at other means of funding. However, the Committee is unaware of any progress on the health funding issue.

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55 Department of Transport and Regional Services, Submissions, p. 76.

56 Mr Geoffrey Gardner MLA, Transcript, p. 11.

57 Mr Graeme Donaldson, Transcript, p. 22.

58 Mr Geoffrey Gardner MLA, Transcript, p. 24.

4.101 Mr Gardner was aware of other problems with the Healthcare scheme. He said that he was expecting a review shortly by the insurance assessor who established the present scheme.[59] Considering the shortcomings of the original scheme, the Committee believes that an independent assessment should also be undertaken .

4.102 The income below which an exemption from paying the levy may be claimed is $7000 per year. A patient may have to spend up to fifty per cent more than the threshold of $2 500, due to non-allowable items, plus the $500 levy, before getting any financial relief.[60] The submission from DOTRS commented that:

> One could also reasonably argue that the current Healthcare scheme, where all Norfolk Island residents contribute the same amount regardless of income (with some limited exceptions), is inequitable.[61]

4.103 A scheme in which medical expenses could consume as much as half of a wage earner's annual income before any reimbursement is made obviously imposes a severe burden. Healthcare contributors on Norfolk Island who earn less than $33 500 per annum pay more than they would under Medicare levy provisions whereas those with higher incomes pay less than they would under Medicare.

4.104 One witness made the suggestion that low income earners be offered a free medical and nutritional check each six months as an incentive to pay the levy.[62] His evidence supports the doctors' opinion that low income earners, particularly the under 25s, avoid seeking medical treatment because of the cost. Dr Davie thought it was likely that the same group found it difficult to access good dental hygiene and treatment.[63]

4.105 Up to one hundred of the 1500 contributors do not pay the levy, and get a default summons. Until recently, up to half the debts were finally written off, but changes to the Court of Petty Sessions Act mean that the situation is now discussed first, and defaulters usually pay by instalments.[64]

4.106 Even in the absence of personal income tax, it should be possible to devise a contribution scheme that is more equitable. This could be achieved, for instance, by raising the low income threshold which at present exempts only the very lowest income earners, and by devising a way of indexing

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59 Mr Geoffrey Gardner MLA, Transcript, p. 7.

60 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 90.

61 Department of Transport and Regional Services, Submissions, p. 77.

62 Mr Gregory Magri, Transcript, p. 96.

63 Dr John Davie, Transcript, p. 36.

64 Mrs Kim Edward, Transcript, p. 23.

the levy so that those who have lower incomes pay less. The Norfolk Island Government's submission indicated that under its existing taxation arrangements it is not possible to apply a levy to residents' incomes:

> as many residents are not required to determine their taxable income or lodge income tax returns.[65]

4.107 Although residents are not required to declare their incomes, some might be very willing to supply proof of low income to entitle them to a rebate on the Island's compulsory levy and/or a reduction of the threshold for reimbursement of medical expenses.

Limitations of Healthcare

4.108 Since Healthcare was devised to cover 'catastrophic' costs, it does not cover Islanders for a 'normal' level of medical expense. In essence, due to the difficulty of obtaining private health insurance, some Islanders must meet all health related expenses they incur. As already noted, their average expenditure on health and medical costs is much higher than that of most mainland families.

4.109 Under the Healthcare scheme, which is described in Chapter 8, nothing is claimable until a $2 500 limit per family has been reached. The CGC noted that various limitations and non-allowable items in the scheme mean that in some cases, a resident may have to spend over $6 000 before reaching the barrier.[66] Islanders are not covered by a pharmaceutical benefits scheme. Full private health insurance is very expensive and difficult to obtain.

4.110 The Southern Cross Medical Care Society provides cover for expenses up to the Healthcare threshold at a cost of $48 per month for an individual or $96 a month for a family, regardless of the number of children. The Society advised that its plan covers 915 people for expenses up to $2500 incurred on Norfolk Island, in Australia or New Zealand or elsewhere.[67] The Committee does not regard a scheme in which a family pays over $1000 per year in premiums for $2500 worth of benefits as good value. The Healthcare system is discussed further in Chapter 8.

Avoiding treatment

4.111 The Department of Transport and Regional Services is aware of reports from previous and current medical practitioners that Island residents on lower incomes avoid seeking medical treatment because the costs are

65 Norfolk Island Government, Submissions, p. 7.

66 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 90.

67 Southern Cross Medical Care Society, Submissions, p. 132.

prohibitively expensive for them. These reports suggest that some people are not taking medication for chronic and acute conditions, because of the high cost. Dr Davie gave an illustration of a typical older patient who might need six or seven preparations which could cost between $300 and $500 per month.[68]

4.112 He told the Committee again in March 2001 that it was common for people to avoid taking medicines seen as not absolutely essential, such as those for high cholesterol and hypertension, because of the cost. He was aware of a situation in which a young TEP patient baulked at paying $200 for treatment for herpes, the patient preferring to wait until back on the mainland and covered by Medicare.

4.113 The Committee received a copy of a letter that one Islander wrote to the Director of the Hospital noting that he and members of his family had been 'refused life saving drugs in the absence of up-front payment' and questioning the hospital's policy on providing essential medicines.

Case Study – Mr Mike King [69]

Mr King described how he had been told by both the pharmacist and the accounts clerk at the hospital when he went to collect prescription medicine for his wife that they had been instructed not to provide it unless he paid in cash. When he said that he was not in a position to pay at the time, he was told, after 'a prolonged exchange (quiet but certainly not unobtrusive)', that he could have the drugs on a seven day account. Mr King advised that on at least two other occasions members of his family had been refused essential medicines in the absence of up-front payment.

Mr King sought to establish whether cash payment was required of everyone or only those with 'delinquent' accounts, and what criteria were used to determine the status of an account. He was concerned that details of his account status were not confidential.

He questioned the policy of refusing drugs, commenting on the implications for 'disadvantaged or impecunious' Islanders who deny themselves proper health care because of their financial situation. He believed that the prospect of humiliation and embarrassment at having to plead in public for medicines would act as a further disincentive.

Mr King's letter did not mention welfare assistance.

68 Dr John Davie, Transcript, p. 34.

69 Mr Mike King, Exhibit 6, letter dated 17 November 1999.

4.114 The then Hospital Director told the Committee in November 1999 that people who cannot meet the cost of drugs may apply for a special benefit through the welfare officer.[70] It is not known whether the correspondent did not know that such benefits were available or whether he and his family were not eligible.

4.115 The Commonwealth Grants Commission noted in its 1997 report that some common prescription medicines can cost six times mainland rates, although some expensive drugs are similar to mainland prices.[71] The pharmacist advised the Commission in 1997 that an asthma puffer costing $20 on the mainland cost $68 on Norfolk Island. Dr Davie said at the public hearing on the Island:

> Certainly I find the cost of pharmaceutical items absolutely horrendous and beyond the means of many people, particularly the elderly people on the Island …To consider the aspect of lowering cholesterol by using a very basic preparation: one would be paying $100 a month on Norfolk Island for that pill alone.[72]

Without a pharmaceutical benefits scheme, the cost of medicines for any chronic condition may become prohibitive.

4.116 The Committee reiterates the concern it expressed in its *Island to Islands*[73] report that anomalies in the Norfolk Island Act leave Norfolk Islanders disadvantaged in terms of consumer protection. The Australian Competition and Consumer Commission (ACCC) has no jurisdiction over complaints originating on Norfolk Island unless Norfolk Island is specifically mentioned as a 'Territory' under the relevant act.

4.117 The CGC explained that the cost of medicines to the Hospital is already high because of the procedures associated with the 'export' classification of the medicines and the high freight costs from the mainland. The Norfolk Island Government's submission to the CGC inquiry admitted that it 'proves to be very costly for chronic conditions requiring expensive medications on a permanent basis'.[74] However, the pharmacy continues to sell medicines with large mark-ups. The 1998-1999 annual report of the NIHE showed that the pharmacy contributed to the Hospital a surplus of $184 956 on sales of $466 447 in that year.

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70 Mr John Christian, Transcript, p. 20.

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

72 Dr John Davie, Transcript, p .34.

73 Joint Standing Committee on the National Capital and External Territories, *Island to Islands: Communication with Australia's External Territories*, March 1999, p. 43.

74 Norfolk Island Government's submission to the CGC inquiry, p. 40.

4.118 DOTRS echoed concerns held by Dr Davie that, where people were avoiding taking medication for contagious conditions such as sexually transmitted diseases, there might be serious public health risks, possibly with national implications. The Department's submission noted that:

> The lack of primary and public health care services on Norfolk Island has implications for the protection of Australians as a whole from transmittable diseases, particularly in light of the high visitor turnover and interchange of tourists and hospitality industry employees with the mainland.[75]

Communicable diseases known to be present on the island include Hepatitis B and C as well as various sexually transmitted diseases.[76] The presence of HIV and AIDS cannot be ruled out.

4.119 Although special benefits to cover the cost of pharmaceuticals are in some instances available through the Island's welfare officer, the likelihood of people applying for them in the case of sexually transmitted diseases seems remote. Evidence suggests that very few residents are aware of the welfare option.

4.120 The Committee is concerned about the possibility that any part of Australia should have a sub-standard immunisation program. There may be a case for the Commonwealth to subsidise immunisation and certain drugs that have a Commonwealth implication. Evidence suggests that the cost of child immunisation is a burden on most families. The Norfolk Island Government believes that compliance is high. However, DOTRS has anecdotal reports of low immunisation rates.[77] The then Norfolk Island Health Minister indicated that the Government has endorsed the re-introduction of a subsidised immunisation program for pre-school aged children in 2000, but the extent and date of introduction of the subsidy is not known.[78]

4.121 Specialists who provide services on the Island charge patients the full private practice rate. The NIHE conceded in its submission that some specialist services are beyond the affordable limits for a number of Islanders. This problem could be managed if the Healthcare scheme had a lower threshold, or if low income earners had access to medical insurance to cover the large 'gap'.

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75 Department of Transport and Regional Services, Submissions, p. 74.

76 Ms Christine Sullivan, supplementary information provided on request, Correspondence, 6 April 2001.

77 Department of Transport and Regional Services, Submissions, p. 74.

78 Norfolk Island Government Supplementary Submission, Submissions, p. 147.

4.122 Since most specialists visit only once or twice a year, and then for only a few days, complex medical conditions usually require travel to, and accommodation on, the mainland. As this may include several visits for an initial consultation, as well as for follow-up treatment, travel and accommodation expenses can be enormous. The allowance under Healthcare is a maximum of $200 per year per individual, which is less than a quarter of the cost of one return airfare.

4.123 Evidence suggests that the number of trips and the length of stays on the mainland could be reduced if higher levels of post-operative care were provided on the Island; for instance, through physiotherapy, increased home nursing and eventually through telehealth technology. The cost of equipment and professional training which would increase the number and quality of treatments available on the island should be examined against the costs at present incurred by patients who must seek treatment off the Island.

4.124 The Island's doctors told the Committee on its first visit that if the Hospital had diagnostic ultrasound and colonoscopy equipment, as well as appropriate levels of skills among staff, it would lead to a significant reduction in the number of patients who had to be referred off-island. The new ultrasound and related equipment acquired in 2000 will eventually allow the doctors to better assess and manage patients and, in the event of an evacuation, may allow extra time for this to be organised before a patient's condition deteriorates.

4.125 The presence of a physiotherapist after mid-2001 will reduce considerably the period of time some patients have to remain on the mainland, particularly after orthopaedic surgery and strokes.

4.126 The Commonwealth Grants Commission Report noted that the airlines give Island residents discounts of about 30 percent on their fares. In some cases the hospital will pay for a patient's air transport but add the cost to the patient's account, which effectively gives the airfare on credit. However, despite discounted airfares available to residents, travel will continue to be expensive. The Committee believes that the $200 reimbursement for travel under Norfolk Island's Healthcare should be increased for those who can demonstrate that they cannot afford private health insurance to cover travel and accommodation. Access to the Patient Assisted Transfer Scheme (PATS), available on Christmas and Cocos (Keeling) Islands, but not to Norfolk Islanders, would dramatically improve the lot of those who must have treatment on the mainland.[79]

79 Dr Lloyd Fletcher, Transcript, p. 41.

4.127 Dr Fletcher referred to the great cost of airfares and accommodation when people have to travel to the mainland for specialist treatment, and noted that on Norfolk Island people are not eligible for the financial assistance which is available for essential medical travel in remote parts of mainland Australia.[80]

4.128 The scheme Dr Fletcher referred to is available in each state, although the name varies. The Indian Ocean Territories are covered under the Patient Assisted Transfer Scheme (PATS). In NSW it is called the Isolated Patients Transfer Assistance Scheme (IPTAS). Under these schemes, patients from remote areas receive from their state government an amount equivalent to the cost of the cheapest appropriate mode of travel to regional or metropolitan health facilities for specialist medical attention not available locally or from visiting specialists. Norfolk Island residents are not presently eligible for this scheme and there is no Norfolk Island Government funded equivalent.

4.129 Norfolk Island pensioners are covered by Healthcare and the Health and Medical Assistance scheme for their total medical costs, including airfares.

4.130 The cost of an emergency medical evacuation by air, if not provided by the RAAF, is at least $25 000, a cost which may well be ruinous for the bulk of residents who have no private health insurance cover. The average number of medical evacuations per year, varying in urgency, over recent years is 26. If these all required an urgent, private medivac, the cost would be over $600 000, which the then Health Minister equated to an increase in the levy of $600 per year per member.[81] There are no satisfactory alternatives to aerial medical evacuations, which will always be an issue for the population of a remote island. Discussions with the Royal Flying Doctor Service and private medical evacuation companies, perhaps accompanied by incentives, may lead to lower costs. The Committee believes that finding a solution should be a high priority for the Norfolk Island Government.

7. Ensuring the sustainability of the visiting specialists program

4.131 The visiting specialists program has been responsible over the last few decades for bringing to Norfolk Island a level of health care otherwise unimaginable. In that time it must have saved an enormous number of visits to the mainland by patients, thereby sparing many individuals unnecessary pain, distress and cost. However, changes in medical practice,

80 Dr Lloyd Fletcher, Transcript, p. 41.

81 Mr Geoffrey Gardner MLA, Transcript, p. 11.

combined with other factors, have left the current on-Island medical staff fearful that the program is now under threat.

4.132 Rapid advances in the use of technology in both diagnosis and treatment mean that specialists increasingly cannot use the latest procedures, those with which they have developed their expertise, on Norfolk Island. For instance, more and more laparoscopic procedures are routinely performed as alternatives to invasive open surgery in mainland hospitals. The operating theatre at the Norfolk Island Hospital, though adequate for uncomplicated open surgery, is not equipped for laparoscopic surgery. Increasingly, visiting specialists are choosing to perform operations on the mainland.

4.133 Accompanying the rapid rise of 'high tech' medicine has been a rapid increase in litigation. While there has not been a history of litigation on the Island to date, the doctors are burdened by the ever-present risk. As Dr Michael Sexton told the Committee:

> Tourists are the ones who will provide the funds and judge the outcomes of medical care. Therefore, if they are dissatisfied with a service that does not meet the requirements of where they come from, there is likely to be a legal outcome from that. The full-time inhabitants of the island are much more tolerant towards that attitude. They are proud of their area. I think that is going to change. That is part of the evolution of their remoteness.[82]

4.134 If the cursory examination of hospital records in April 2001, which indicated that about half of all services are provided for visitors to the Island, is correct, then the fear of potential legal action by a dissatisfied visitor patient is quite legitimate. Dr Fletcher observed in an early response to this inquiry that:

> The Island offers all of its health services to tourists, who add a significant burden to the medical work load. And their demands and expectations are high as they come from bigger and better systems abroad.

He also predicted that 'Island' attitudes towards health outcomes would rapidly become more like those of visitors:

> Do please note that the Norfolk public expect – and demand – full services which are available to their mainland cousins these days. That is a fact of life which will never go away.[83]

82 Dr Michael Sexton, Transcript, p. 216.

83 Dr Lloyd Fletcher, Submissions, p. xxx.

4.135 Unfortunately, as a higher proportion of people are referred to the mainland for treatment, there are fewer patients for the specialists to see when they make their six or twelve month visits. This means that there is less incentive for specialists to leave their mainland practices, in some cases for up to a week. Apart from a financial disincentive, there is the prospect of diminishing caseloads. In some medical specialties the maintenance of a specified number of cases is required for continuing accreditation. There is the danger of a vicious cycle being established. As all the medical staff have acknowledged, the visiting specialists program has been invaluable in providing them with knowledge of new developments in medicine, training in new procedures and a bolster against their sense of professional isolation.

4.136 Optimistically, the advent of netconferencing may offer a partial solution satisfactory to all parties. As the transfer of data such as X-rays, ultrasounds, pathology slides etc becomes routine, the need for face-to-face consultations will diminish. However, the visiting specialist, who has all the advantages of knowledge and insight into the Norfolk Island situation, will continue to consult at a distance, will retain Norfolk patients on his / her books and quite possibly find that there is less need for expensive trips to the Island.

4.137 In addition to out-dated equipment and clinical facilities, the accommodation available on the Hospital premises for visiting specialists is a source of concern. It is substandard by almost any criteria. The Hospital Director told the Committee during its last visit that she feared that it was a considerable disincentive to specialists. The Committee believes that its use should be discontinued and that an arrangement should be sought with one of the Island's better hotels to provide discount accommodation for the specialists.

Measures which would assist in all areas

Development and implementation of health strategy

4.138 The Norfolk Island Government has commissioned the Griffith University School of Health Science to prepare a 'Health Strategy' and 'Implementation Plan for Future Health Services on Norfolk Island'. Funding was provided by the Norfolk Island Assembly for these projects in the *Supplementary Appropriation Act 2000*. The first stage was concluded in September 2000 with the Griffith University team's *Norfolk Island Health Study: Preliminary Results and Analysis* which summarised the current health status of the Norfolk Island community.

4.139 Having a strategy prepared by experts will be a great asset to a small community where those with responsibilities for health matters are fully stretched. Provided the ensuing implementation plan takes into account the Island's present and projected financial situation it will be an invaluable guide.

4.140 The Norfolk Island Government should proceed with the second stage of the Griffith University review as soon as practicable. The strategic and operational plans should be made available for public comment as soon as they are presented.

4.141 Any desire for changes that may be precipitated by the community consultation process, or from the release of this Committee's report, should be discussed with the Griffith University team and the strategy and implementation plans adjusted accordingly. The Norfolk Island Government should then organise its forward planning according to the stages of implementation detailed in the review.

Review of funding

4.142 As already noted, and discussed further in Chapter 9, the Norfolk Island Government needs to examine the funding basis of its health system, since it is obvious that it cannot depend on fees and levies alone. The value of raising loans and attracting private investment is examined, as is the desirability of broadening the range of the Island's taxes in order to increase substantially the funding available for health care.

Increase in independence and accountability of the Hospital Board

4.143 There is a need for strong financial management as well as for clarification of the role and powers of the statutory body which runs the Hospital. The Commonwealth Grants Commission found that the NIHE did not appear to have an acceptable degree of independence, judging by its budgeting processes and its lack of flexibility in financial management. [84] Since the Norfolk Island Hospital Enterprise will be a major player in changes to the health system, it will need to have access to strong business acumen supported by a degree of executive independence, as well as a good understanding of the basic requirements of modern health care.

4.144 The Hospital Board which manages the Hospital Enterprise has, at present, an unusual combination of responsibilities. Under the Norfolk Island Hospital Act 1985 it is charged with the following functions:

- to control, administer and manage the Hospital Enterprise;

84 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 201.

- to give directions to the Director in relation to the day to day administration of the Enterprise;
- to advise the executive member on issues related to future development of the Enterprise; and
- to advise the executive member on public health issues.

4.145 The Committee fails to see how an honorary board, comprised of six members of the public who meet monthly, can have the expertise or even the opportunity to give directions about the day to day running of the Hospital. In the past, it would appear from anecdotal evidence that its responsibility to advise the Minister for Health has been interpreted by some members as the opportunity to direct criticism at the Hospital Director. The lines of communication with the Director, who is also a member of the Board, should be frank, regular and positive, with any problems aired first at Board meetings, and conveyed formally to the Director if the issue cannot be resolved through amicable discussion.

4.146 The current Director has advised that the Board had been very supportive, sought explanations and resolved issues quickly, and generally refrained from intervening in daily affairs. The Director and the Board Chairman meet weekly.

4.147 The Committee is pleased to note that the current Hospital Director has 25 years of experience in the health care and health administration fields. However, at present the principal selection criterion for the Director's position stipulates either experience in health administration *or* other management skills. The Committee believes that recent, dynamic participation in health administration should be mandatory for such an important position.

4.148 The need for the Hospital Board to have greater independence from government is increased by the frequency of change of Legislative Assembly membership. As the CGC Report noted, this causes problems of discontinuity in the legislative process and the development of the community:

> After a typical election, around half the representatives have not served on the previous Assembly and on only two occasions has a sitting Executive Member been re-elected and re-appointed to the Executive.[85]

4.149 The CGC concluded that the problems associated with the frequent changes might be reduced if the Assembly were to adopt a longer term

85 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, pp. 187-188.

strategic focus, with planning going beyond the life of one Assembly.[86] The Committee hopes that the Griffith University team's Health Strategy and Implementation Plan will provide the current and future Norfolk Island Governments with the necessary long-term focus.

4.150 The CGC concluded that the impact of the use of statutory authorities (the hospital is one of two) on the accountability of the Assembly and Ministers to the community needs to be questioned.[87] It also concluded that:

> The present confusion in lines of authority and responsibility is likely to be reducing efficiency and accountability.[88]

4.151 For the successful implementation of the new Health Strategy it will be essential that adequate responsibility is given to the Hospital Director to make appropriate decisions to implement the agreed changes. The present Hospital Director indicated that she has not at this stage experienced difficulties, but the Committee is aware of anecdotal evidence that before his resignation the previous Director experienced considerable criticism and interference by members of the Hospital Board in the day-to-day running of the Hospital. The Grants Commission's observation that managers of government enterprises need to be given clear authority to manage within the framework of government policy is also relevant to the Director of the Norfolk Island Hospital Enterprise.[89]

4.152 Concomitantly, any extension of financial and decision making independence must be accompanied by strong, clearly identified accountability measures. The CGC Report noted that although the Hospital as a statutory authority has to provide a monthly financial statement to the Assembly and have its accounts audited annually, it is not required to produce any non-financial information. There is no requirement for an annual report, and no evident procedures for efficiency audits. The Report expressed concern about accountability:

> It is unclear what the oversight, direction and reporting arrangements are for these authorities in relation to the Public Service, the relevant Ministers and the Assembly.[90]

86 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 206.
87 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 207.
88 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 206.
89 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 207.
90 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 204.

Importance of expertise on the Hospital Board

4.153 Another issue which will need to be addressed if the Norfolk Island health system is to undergo an overhaul is that of the experience and expertise of the Hospital Board. Professor Gaston, who has worked with a large number of boards of small hospitals in South Australia, informed the Committee that leadership, change management and innovation must all start with the Board. She saw it as the Board's responsibility to set the strategic direction, and delegate responsibility for operational decisions to the chief executive officer. She observed that:

> they do need a great deal of assistance to understand their role in relation to management and that separation of powers between a governing body and management. I know that is extremely difficult in small communities …We can, and have, successfully assisted them to make that change, but it takes a bit of time.[91]

4.154 Professor Gaston had been told during a visit to Norfolk Island in 1999 that there was no-one on the Hospital Board who had any long-term knowledge or experience in the broader health system. While this information was not strictly valid, her observation is very relevant:

> Whilst it is important to have input from people with business, legal and financial [experience], it is even more important that there is some involvement at the governance level of people with contemporary health system knowledge and experience.[92]

4.155 The Hospital Director advised the Committee that in April 2001, of the six members of the then Board, three had some kind of experience in the health field, in addition to the Director herself.

4.156 The Norfolk Island Hospital Staff Association remarked in its submission that the function and authority of the Hospital Management Board and appointment of Board members needs to be reassessed.[93] The submission from DOTRS referred to two reviews that had recommended either that the Hospital Board be disbanded or be limited to an advisory role.[94] The Committee supports the John Howard and Associates' recommendation that the Board have only an advisory role. There seem to be sufficient

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91 Professor Carol Gaston, Transcript, p. 211.

92 Professor Carol Gaston, Submissions, p. 63.

93 Norfolk Island Hospital Staff Association, Submissions, p. 33.

94 Department of Transport and Regional Services, Submissions, p. 94. The Norfolk Island Government's 1992 review of the Norfolk Island health system recommended that the Hospital Board should be disbanded. The *Norfolk Island Administration – Strategic Review* (April 1998), by John Howard & Associates, recommended that the Hospital Board should only have an *advisory* role.

reasons for the Board's role to be opened to public discussion as part of the Griffith University's strategic plan development.

4.157 Professor Gaston spoke of the influence that members of a Board in a small community can have in promoting new ideas informally.

> If you can educate them they can educate the rest of the community. They can save you a lot of time and energy because you can focus on developing their knowledge and understanding and they will go out to their morning coffees or dinners or barbecues at the local footie game and hand on that information.[95]

4.158 Dr Sexton referred to the difficulty that was experienced in attracting people with enough expertise and interest onto the Hospital Board during his two periods of service on Norfolk Island in the 1970s and 1980s. He felt that there was 'a lot of merit' in the idea of bringing onto the Board an outside specialist who could speed up changes in the areas identified in the new health strategy.[96] Such an initiative might involve someone visiting the island regularly for board meetings. An outside appointee, sensitive to the unique situation on Norfolk Island, could assist in implementing the new health strategy as well as increase the understanding of other Board members, particularly those with no medical background, of contemporary trends in community health.

4.159 The Committee believes, however, that the strength of the present Director's background and skills should enable her both to initiate essential changes and to assist Board members without a health background to understand the extent of recent changes in health administration. An advertisement in *The Norfolk Islander* for new Board members in March 2001 stated that:

> the governance and structure of health services are currently under review and persons appointed need to be aware that the powers and functions of the Board may alter subject to review outcomes.

4.160 While it appears that at present there is informal communication between the hospital doctors and the Board, mainly via the Hospital Director, there would be value in establishing a means for regular dialogue between the various health professionals and the Hospital Board. Those involved on a daily basis with the present realities of the health system are often best placed to indicate where change is necessary, but without support from the Board, they are not in a position to effect it.

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95 Professor Carol Gaston, Transcript, p. 211.

96 Dr Michael Sexton, Transcript, p. 223.

Anticipating e-health

4.161 The Committee is aware that the Norfolk Island Government has recently secured two grants from 'Networking the Nation' to assist it in its endeavours to secure the technological infrastructure necessary to take advantage of the huge potential of e-health. The value of e-health for a remote isolated community can not be underestimated. There is much that can be done in preparation, particularly in the area of familiarising both medical staff and the population in general with the use of the Internet, in order to avoid possible problems of 'technophobia'.

4.162 The Greenwich University has facilities which it is willing to make available to others. Anecdotal evidence suggests that there are others on the island with private Internet facilities who are also willing to assist those who want access, although the present cost of connection, at $3.50 an hour, is not inconsiderable.[97] The main limitation at present is with the bandwidth, which makes Internet connection slow and expensive.

4.163 In May 2001 the Committee was informed that Dr Damien Foong, who was on a short-term contract at the Hospital, had developed a proposal for netconferencing which could bring forward the regular use of e-health with minimal outlay and professional involvement. Dr Foong demonstrated the ease of his proposal to members of the Legislative Assembly using his own equipment. Further details appear in Chapter 7.

Involving the next generation

4.164 Concern has been expressed about the lack of young Islanders entering nursing or other health related careers. The Committee has been told that most of the permanently resident nurses are mature aged. With the trend towards increased numbers of ageing people already identified in both the resident population and in the all-important tourism industry, qualifications in the many associated health areas would seem a desirable goal for those who wish to maintain their careers on Norfolk Island.

4.165 The Committee believes that the Norfolk Island Government should give consideration to measures which could be taken to attract young Islanders into training in nursing or other areas of medicine. Reference was made at the public hearing on Norfolk Island to the John Flynn Scholarship Scheme, which is designed to encourage young people from rural areas to study medicine. The scholarship imposes an obligation to return to the country for a period of service. Medical Rural Bonded Scholarships give students a grant of $20 000 a year on the condition that they agree to practise in rural areas for six years. There are people on the Island with

97 Ms Pauline Butler, Vice-President, Greenwich University, Transcript, p. 107.

both the philanthropic urge and private wealth needed to sponsor young Norfolk Islanders in training for various health careers.

Promoting the need for change

4.166 It is a well acknowledged fact that in every community there are those who feel threatened by, and therefore resist, change. However, there is abundant evidence that a great many Norfolk Islanders feel that improvements to their health system are overdue. Many have put forward their ideas to this Committee. Some have already taken action, such as the members of CHAT, who have developed a proposal for a community health service for which they have actively sought support at all levels.

4.167 The release of the health strategy to be written by the Griffith University team should mark the beginning of a period of intense interest in health issues. The contracted authors have already indicated that they will seek community input before and after a draft strategy is developed. The Hospital Director commented that:

> Those that work within the NIHE need to be involved in all areas from assessment, planning, implementation, monitoring and evaluation.[98]

4.168 There will need to be a 'critical mass' of popular support if the process of change is to be rapid. There would appear to be a very important role for the local newspaper and radio station during this period. There should also be a series of well-advertised public meetings at which concerned citizens can contribute ideas and suggestions, as well as hear from various health professionals.

98 Ms Christine Sullivan, Submissions, p. 197.

Recommendations

Recommendation 5

4.169 **The Committee recommends that the Norfolk Island Government enact or amend legislation:**

- **to make the wearing of seatbelts compulsory;**
- **to lower the legal blood alcohol limit for drivers to a level comparable with that of the mainland; and**
- **to forbid smoking in enclosed public places and provide enforceable penalties for non-compliance.**

Recommendation 6

4.170 **The Committee recommends that the Norfolk Island Government increase the price of alcohol and tobacco products and direct the revenue raised to community education programs that target lifestyle issues such as drink driving, substance abuse, domestic violence and nutrition.**

Recommendation 7

4.171 **The Committee recommends that the Norfolk Island Government give the highest priority to establishing and promoting a coordinated community health service, either by adopting the Community Health Awareness Team (CHAT) proposal for a coordinated community health service or by instituting a similar, professionally organised service.**

The Committee also recommends that the Norfolk Island Government provide funding for the recruitment of an experienced, enthusiastic, full-time community health coordinator with extensive knowledge of contemporary community health issues.

Recommendation 8

4.172 **The Committee recommends that the Norfolk Island Government:**

- **promote road safety measures such as the advantages of wearing seatbelts, not drinking when driving and nominating a 'designated driver';**
- **undertake a survey of all existing community resources in order that these may be coordinated, publicised and utilised widely;**
- **consider ways of accessing health education programs which are available on the mainland through various departments; and**
- **appoint a qualified occupational health and safety officer to examine public areas for safety, and allocate adequate funds for the implementation of appropriate health and safety measures.**

Recommendation 9

4.173 **The Committee recommends that, in order to support existing health personnel and provide a wider range of community health services, the Norfolk Island Hospital Enterprise:**

- **extend the hours of the baby/child health sister;**
- **explore the possibilities of contracting a mainland practice consisting of a variety of health professionals to provide staff on a rotation basis;**
- **consider employing, or training existing nurses to become, accredited nurse practitioners with skills identified as useful adjuncts to those already available within Norfolk Island's health system;**
- **negotiate with the Royal Flying Doctor Service with a view to providing a remote, after-hours consultation service;**
- **give serious consideration to the proposal of the Royal Flying Doctor Service to provide, on rotation, doctors with a primary health care and emergency evacuation focus, as well as registered nurses and allied health workers with community health experience; and**
- **employ a part-time dietician with the right to private practice.**

Recommendation 10

4.174 **The Committee recommends that in order to replace the Hospital the Norfolk Island Government move urgently to:**

- **complete a projection of future needs in the health care system, using all available sources, including a forecast of the numbers and needs of visitors to the island;**
- **examine the funding options for a new multi-purpose health facility, taking into consideration a range of options such as borrowing (possibly through a low-interest Commonwealth loan), raising new taxes, attracting private investment and applying for a Commonwealth grant for part funding;**
- **seek independent expert advice from consultants with proven experience in the field of multi-purpose health facility design, including taking advantage of any advisory assistance in this area offered by the Department of Veterans' Affairs; and**
- **adopt a timetable for the replacement of the hospital which includes completion dates for the necessary stages such as planning, consultation and the tendering process.**

Recommendation 11

4.175 **The Committee recommends that, in order to maintain and increase the skills of its nursing staff, the Norfolk Island Health Enterprise allocate funds and provide time off for on-island training, and expand the present system of sending nurses to the mainland for specific area training.**

Recommendation 12

4.176 **The Committee recommends that the Hospital Director and medical officers continue to examine and make changes to the existing patient appointments policy and procedures in order to reduce the number of unreasonable demands on hospital staff.**

Recommendation 13

4.177 **The Committee recommends that, in order to make health services more affordable and hence accessible, the Norfolk Island Government and the Hospital Enterprise:**

- **establish guidelines to allow low income earners access to free or subsidised hospital and medical services;**
- **require, in the absence of a universal pharmaceutical benefits scheme, that essential, life sustaining medicines be supplied at cost, and inform the community of the existence of the special benefits currently available to those who cannot pay, in order that Islanders do not avoid seeking medical treatment**
- **consider subsidising the cost of medicines prescribed for long-term use to maintain good health, such as those required to lower blood pressure and cholesterol levels;**
- **proceed with the stated intention of subsidising the cost of child immunisation, give consideration to meeting the full cost for each child and implement an awareness campaign; and**
- **increase the Healthcare allowance of $200 for travel to, and accommodation on, the mainland, to cover a return airfare and at least one night's accommodation for those who demonstrate that they cannot afford, or are not eligible for, private insurance which covers such expenses.**

Recommendation 14

4.178 **The Committee recommends that, as long as the compulsory Healthcare levy continues, the Norfolk Island Government make it more equitable by:**

- **devising a means of indexing it to income;**
- **raising the annual income below which an exemption from the compulsory Healthcare levy may be claimed, to a figure deemed to be a 'living wage'; and**
- **considering the provision of free medical and dental checkups to lower income earners as an incentive to pay the Healthcare levy.**

Recommendation 15

4.179 **The Committee recommends that the Norfolk Island Government proceed urgently with the Griffith University-designed strategic and operational plans, giving due attention to:**

- **promoting robust community awareness and consultation through the local media and well advertised public meetings;**
- **establishing and guaranteeing, at an early stage, a realistic budget based on a program of forward estimates; and**
- **supporting measures such as the funding of essential equipment, staff training and e-health facilities that will reduce the need for mainland referrals.**

Recommendation 16

4.180 **The Committee recommends that a scheme such as the Patient Assisted Travel Scheme be available on Norfolk Island, either through:**

- **an extension of the schemes presently available in the states and other territories; or**
- **a similar arrangement provided by the Norfolk Island Government.**

Recommendation 17

4.181 **The Committee recommends that, in reassessing the role and functions of the Board of Management of the Hospital Enterprise, the Norfolk Island Government:**

- **initiate a professional review of the role and responsibilities of the Hospital Board;**
- **make appropriate changes to the governing act;**
- **amend the principal selection criterion for the position of Hospital Director so that proven dynamic health administration experience is mandatory;**
- **guarantee clear authority to the Hospital Director, as the chief executive officer, to manage and execute changes within the framework of Norfolk Island Government policy;**
- **recruit to the Hospital Board a balance of people, including those with experience in contemporary health systems and people with business acumen; and**
- **institute clear accountability processes for the Norfolk Island Hospital Enterprise (which is a statutory authority), including annual reports.**

5

Aged care

The present situation

5.1 The population of Norfolk Island, in common with many small country towns on the mainland, is ageing more rapidly than most Australian communities. Already ten per cent of the population is over the age of seventy, and this percentage is likely to increase in the next few years. The Department of Veterans' Affairs report examined data from the 1991 and 1996 censuses, and concluded that the figures 'suggest a significant and increasing demand for aged care services in the years ahead on Norfolk Island.'[1]

5.2 In 1996 the Norfolk Island Government changed the rules for General Entry Permits, allowing them to be granted to people with sufficient means who wishe to retire on Norfolk Island.[2] Also, among the rapidly increasing number of tourists to the island the trend has been for older, often quite elderly, visitors. The impact of these trends is becoming more obvious each year, and the need for improved facilities for the care of the elderly has been acknowledged widely.

5.3 Evidence suggests that some people reluctantly leave the island as they age, in search of quality aged care, rather than end their days on the 'Verandah' at the Hospital.[3] The Committee was able to see first hand the unsuitability of the hospital environment for the frail elderly, some of

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1 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 21.

2 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 22.

3 Mrs Colleen Evans, CHAT, Submissions, p. 53.

whom had dementia. With just a curtain for privacy, with shabby, basic, hospital furniture and without the necessary physical security or full-time care by geriatric trained staff, it is not a destination of choice.

5.4 A witness to the inquiry described how the lack of home support services and alternatives to nursing home care contributed to both his parents being forced to become long-term patients in the hospital:

Case Study – Mr Rex Barrett [4]

Mr Barrett described the situation that led to both his parents being admitted as full-time residents of the hospital. His father became totally blind and suffered a series of strokes. His care put undue strain on Mr Barrett's mother, the main carer despite her age and advancing osteoporosis. Mrs Barrett eventually suffered two compound fractures of the spine as well as two strokes. Separate facilities for male and female patients meant that the elderly couple could not live together and Mr Barrett Snr, being the only male, was isolated.

Mr Barrett said that some of the longstanding concerns of elderly patients' relatives about staffing inadequacies had been addressed, with a substantial improvement in the last eighteen months, particularly since the DVA visit. However, he believed that 'the aged people of the community … are poorly served in terms of the value they get for the dollar that is spent.' Mr Barrett remarked that he and other relatives were impressed with the 'excellent recommendations' made in the RSL report on aged care on Norfolk Island, which focus largely on means to support the elderly to remain in their own homes.

Mr Barrett felt that a retirement village option, in which people buy a unit and a known percentage of the investment is returned to the family upon their death or departure, would be preferable to the situation his parents are in. A Commonwealth subsidy would increase the incentive.

5.5 The Norfolk Island Government noted in its submission to this inquiry that aged care was an area of growing need, and that it had commenced planning to meet the health needs of the elderly members of the community.

4 Mr Rex Barrett, Transcript, pp. 137-140

5.6 The *Aged Care Act 1997* (Cth) does not apply in Norfolk Island or to any other external territory. The Act provides the framework through which the Commonwealth gives financial support through payment of subsidies and grants for the provision of aged care and related matters. The Department of Transport and Regional Services observed in its submission that access to Commonwealth programs would help offset the limitations of Norfolk Island's health and aged care services.[5]

5.7 The Committee would encourage any changes to the Act that would allow the Norfolk Island community to access programs and initiatives designed to assist rural and remote communities in the provision of aged care, available on the mainland.

5.8 Recent involvement by the Department of Veterans' Affairs with projects for veterans has already been a catalyst for change within the local community. Ms Janet Anderson of the Department commented that the Norfolk Islanders were very receptive to DVA initiatives and were prepared to volunteer their own ideas. She believed that there was a very strong sense of working together during the analysis of the deficits in aged care on the island, with a considerable amount of learning on both sides.[6]

5.9 Cooperation with the Department of Veterans' Affairs has led to initiatives which have already made modest improvements in facilities for the aged, with scope and enthusiasm for further joint ventures.

5.10 The strong tradition of caring for the frail elderly at home has been affected by factors such as the increased participation in the workforce of mature women, traditionally carers of the aged, as well as the departure of many in the 20-40 age group to the mainland, pursuing further education and career opportunities.

5.11 Currently, the elderly who are too frail to look after themselves are cared for in the Norfolk Island Hospital as long term nursing care patients. They are attended during the day by one full-time nursing staff member and a part-time activities officer, but at night the aged care section is covered only by ward staff from the acute care section. The RSL report identified both a shortage of staff and a lack of knowledge and skills among the staff working with these patients. Elderly residents who are able to remain in their own homes are visited by the district nurse, although at present she is only employed for three half-days per week. There are no formal programs of home help, personal care or community transport.[7] Meals on wheels are available from the hospital kitchen but reports indicate that

5 Department of Transport and Regional Services, Submissions, p. 77.

6 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 151.

7 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 143.

'the wheels' must be provided by relatives of those being served, and that there is little demand for the service. The Red Cross runs a service, Telecross, telephoning people who live alone at a set time each morning.

5.12 The Department of Transport and Regional Services noted in its submission that the residential facilities, located in former public wards of the hospital, fall far short of the standards required and provided on the mainland. The DVA's observation was that there 'is no doubt that it is a relatively poor physical stock for the purposes for which it is currently being used'.[8] This situation does not appear to have been designed; rather, it has just evolved, with an increase in the number of elderly who cannot be cared for at home, the availability of surplus beds at the hospital and the fact that the only other option is to leave the island.

5.13 The accommodation lacks privacy and a homelike atmosphere as well as security for dementia patients. There have been none of the physiotherapy or occupational therapy services which are normally available to aged residents on the mainland, although this situation changed in mid-2001 with the appointment of a physiotherapist. Geriatric training is needed for both nursing and domestic staff at the hospital, and this should be addressed by the newly engaged aged care clinical nurse consultant. The Department of Veterans' Affairs believes that the hospital:

> tends to give priority to acute cases and places less importance on the work it does in aged care.[9]

5.14 Mr John Hughes of the Hospital Board advised the Committee in November 1999 that a prefabricated set of five units, the Mawson Units, was donated to the Norfolk Island Hospital some years ago for aged accommodation. Although located in the grounds of the Hospital this facility has not been used exclusively for aged accommodation and has been allowed to deteriorate. The RSL report recommended that the Norfolk Island Government should carefully consider the role and place of these one-bedroom, independent living units, as they represent aged and healthcare capital stock that is significantly under-utilised.[10]

5.15 Witnesses have said that some residents are noisy and have created a climate of fear. The Hospital Director advised in April 2001 that the five residents comprised five people with particular health needs. All had to negotiate a lease with the NIHE. One other unit for an elderly person has

8 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 143.

9 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 143.

10 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 60.

been created in the former isolation unit which is located very close to the main building.

Facilities for war veterans

5.16 The Department of Veterans' Affairs meets the cost of medical treatment for entitled members of the Norfolk Island veteran community treated locally and on the mainland. The Department's submission in February 2000 stated that there were 148 veterans on the Island. Of these, 89 were over the age of seventy, which constituted a quarter of the island's over-seventy population. Fifty-five were entitled to health care benefits, forty-six of whom held Gold Cards, which means that the Department pays for any treatment the veteran or war widow needs.

5.17 As the Norfolk Island population ages, the number of individuals who are covered by DVA entitlements and programs will also decrease. This will result in a larger proportion of elderly Norfolk Islanders being required to fund their own health care, rely on the Island's welfare system or seek care on the mainland. There is bound to be an increased cost to the Norfolk Island Government, which will need to make accurate forward estimates in order to cope with its ageing, non-veteran population.

5.18 In 1998 representatives of the Department of Veterans' Affairs visited the Island to assess the needs of veterans as part of a review of aged care services commissioned by the Norfolk Island RSL sub-branch. As a result of that visit there has been a joint approach by the Norfolk Island Government and the Department to upgrade all facets of care for the elderly. The Department's representative said at the public hearing in Canberra that:

> we are providing a resource to the island, and the beneficiaries of that extend beyond the veteran community …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.[11]

5.19 An advisory committee was formed, comprising the President of the local RSL sub-branch, the Minister for Health and the Director of the Hospital, to develop specific proposals by which the Department of Veterans' Affairs might assist in the development of better services for veterans on the Island. As this Committee no longer exists, it may be helpful if the new

11 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 147.

aged care clinical nurse consultant (ACCNC) and a representative of the RSL or an officer in the Administration are designated to assist in liaising with the Department, to ensure that valuable opportunities for joint aged care projects are not lost. There is a great need for continuity in this area.

5.20 The RSL report implied that there were other areas where funding could be provided, but it will be necessary for the Norfolk Island Government and the RSL to approach the Department. For example, DVA could be approached for funding support to set up a community based aged care and dementia services support program, using the CACP model (Community Aged Care Places). Although recurrent funding would not at present be provided, given the present high numbers of entitled veterans on the Island a case could be put by the Government and the RSL for consideration of this. Ongoing costs of such a program for non-entitled veterans and the general population would need to be met by a combination of service charges and / or government subsidy.[12]

5.21 Other programs which might attract capital or seeding grants include the Joint Projects Program (for projects designed to help veterans maintain and improve their independence and quality of life), the Community Care Seeding Grants Program (for new or existing projects in community care and respite care) and the Healthy Lifestyle Encouragement Grant. The Committee wishes to stress the continuing importance of the RSL report and the many valuable recommendations it makes.

5.22 As a result of the original advisory committee's proposals, the Department of Veterans' Affairs offered financial assistance for the employment of a geriatric nurse supervisor and a physiotherapist for twelve months, as well as the purchase of a suitable vehicle. The funding takes the form of a 'service development incentive payment' or seeding funding, made under a variation of the current agreement for the provision of hospital and other health services.

5.23 The Committee was advised in April 2001 that a geriatric nurse supervisor, or ACCNC, had been selected and was due to commence duty in May. The ACCNC was selected for the ability to take charge of the aged care services both in the hospital and the community. As the coordinator for aged care services the ACCNC should be able to identify, coordinate and promote existing facilities, as well as develop other facilities for which there is an obvious need. An important part of this role will be to provide specialist training in aged care nursing, especially in the care of patients with dementia. Close liaison with a future community health coordinator,

12 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 68.

medical staff and the district nurse will be essential to develop this important role fully. The Hospital Director advised that the ACCNC will be responsible for establishing an Aged Care Services Steering Committee.

5.24 A physiotherapist was also selected and was due to commence duty in June 2001. The physiotherapist was chosen for the ability to devise and conduct therapy programs for the aged in residential care as well as fitness programs to enhance the wellbeing and independence of the elderly who manage to live at home. Since the intention, demonstrated by DVA funding of fifty per cent of the salary for a further two years, was to attract a physiotherapist who would stay for several years, the selection process took into consideration the ability to establish a sustainable private practice using the existing facilities at the hospital and an interest in doing so.

5.25 The RSL recently established the White Oak Day Club for veterans and other elderly residents. The DVA informed the Committee of other initiatives that have been taken up with enthusiasm:

> 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 … 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.

5.26 The DVA also conducted extensive home safety assessment programs: HomeFront, and the Rehabilitation Appliance Program (RAP), over a period of two weeks.

5.27 Other main areas of need identified in the recommendations of the report commissioned by the RSL are:

- professionally staffed therapy services and programs (the appointment of an experienced and enthusiastic physiotherapist will assist greatly in this area);[13]
- access to DVA health promotion and carer support programs;
- improved quality of residential aged care services provided by the hospital,[14] and support at home by community-based care services (including respite, dementia care, carer support and day therapy)[15]; and

13 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, pp. 47-48.

- a Norfolk Island Government contract for home and community-based care services to a 'group with proven expertise'.[16]

5.28 The Department of Veterans' Affairs submitted that its ability to enable access by the veteran community on Norfolk Island to health and other care services was restricted by the realities of limited access to professional staff, and the resource constraints of the NIHE and the Norfolk Island Government. To meet its commitment to the veteran community, the DVA requires an enhanced and more integrated model of health and aged care services, both residential and community-based.

5.29 The RSL report identified the lack of any trained therapy staff on the island as a major deficit, given the major financial, social and therapeutic benefits of patients returning to their community as soon as possible after treatment.[17] Having qualified therapy staff on-site would mean that the periods of extended rehabilitation required for stroke, hip and knee replacement and cardiac patients would be reduced significantly. Rehabilitation on the mainland is much more expensive because of travel and accommodation costs, and can cause extended separation from family members.

5.30 Given that attracting suitably qualified staff is difficult, the RSL report proposed a solution based on working with a therapy services team from the mainland who could provide both post acute rehabilitation as well as aged services therapy. A team consisting of a counsellor, occupational therapist or physiotherapist could be contracted to provide services on rotation of one team member every three months, which would ensure some continuity through communication with team members who know each other. The cost savings from patients being returned from the mainland earlier could be used to offset the cost of the therapy service.[18]

5.31 The Department made it clear that it uses privately as well as publicly provided services for veterans. It has offered support in designing a suitable residential facility, and the RSL report emphasised the advantages of attracting private investment and involvement in both the construction of facilities and the provision of specialist geriatric services. Its policy is to access mainstream health services for veterans wherever possible:

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14 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 49.

15 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 57.

16 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 56.

17 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 47.

18 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 48.

> 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.[19]

5.32 The Department added that clarification by this Committee of the responsibilities of the Commonwealth Government will influence decisions made by the Department regarding the nature and scope of its role in supporting the veteran community on the Island.

5.33 The RSL report is an extremely useful document which should provide valuable assistance to the Norfolk Island community as it examines and develops its aged care services as part of the new health strategy. The Committee strongly recommends that ongoing responsibility for liaison with the Department should be formalised.

Ageing in place

5.34 This is a concept of aged care that is increasing in popularity. It reflects the wishes of most elderly people to remain in their own homes, within a community of people they know well. It is the Department of Veterans' Affairs' policy to support ageing in place for as long as possible, taking into consideration the needs of the home based carers. The dilemma on Norfolk Island is that the infrastructure support to allow that to occur is relatively poor.[20]

5.35 The RSL report recommended that the Norfolk Island Government should consider developing a range of community support services similar to HACC (Home and Community Care) services, to enable the frail elderly (and disabled people) to remain in their own homes.[21] As mentioned above, seeding funding may be available through the Department for a variety of initiatives. The Report noted that:

> The value of such services in keeping aged people in their own homes and out of institutions is widely recognised as a superior approach for the patient and family and more cost effective than institutional based care.[22]

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19 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 142.

20 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 149.

21 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 62.

22 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 63.

> Such programs need not cost the government very much at all as most potential users indicated that they would be happy to pay for services. They just need somewhere to be able to ask for this sort of assistance, a kind of one stop shop for such services.[23]

5.36 These services should be flexible and tailored to the needs of individuals. HACC services on the mainland include home cleaning, cooking, laundry, shopping, home maintenance and repair, respite care, assistance with showering and dressing, community nursing, food services, day care centres and other social support. The value of employing a community health services coordinator who would identify, promote and coordinate all services that already exist, particularly those offered by service clubs and volunteers, has already been discussed in Chapter 4. In the interim, these kinds of initiatives could possibly be examined and undertaken by the new aged care clinical nurse consultant, in conjunction with the proposed Aged Care Services Steering Committee.

5.37 The RSL report recommended that the hours of the district nurse be extended. This would allow the nurse to organise more health education and health promotions activities as well as help more of the elderly to remain independent in their homes.[24] There is an important role for the district nurse in the implementation of services necessary to maintain those with borderline independence in their homes. Dr Fletcher confirmed that the hours, three half days a week, were 'a bit inadequate'.[25]

5.38 Although Norfolk Island is small, transport for those without access to a private car is difficult. This can lead to social isolation and associated problems, especially for the aged. Dr Fletcher commented that:

> There is no bus service or taxi service to speak of on the island, so elderly people who are alone, even though it may only be five miles from the centre of town, are generally pretty isolated.[26]

5.39 For many people on the mainland, 'ageing in place' begins with a decision to move into a community such as a retirement village while they are still relatively young and active, with the energy to take up new interests and make new friendships. Such communities within a community can be an ideal place for people as they become less mobile, especially when accommodation for different levels of independence is an integral part of

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23 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 63.

24 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 62.

25 Dr Lloyd Fletcher, Transcript, p. 41.

26 Dr Lloyd Fletcher, Transcript, p. 41.

the design of the 'village'. People can move to an assisted lifestyle without moving away from friends and activities that they value.

Alternative residential facilities

5.40 There could be a role for private enterprise in providing aged care, either through an investment partnership or entirely provided by a private organisation. Professor Gaston felt that Norfolk Island was a place which could be quite attractive to investors, either local or off-shore. A quality older citizens' village with accommodation for different levels of independent living, built close to the hospital, could combine private and public health services:

> to enable residents "to age in place" within a communal environment, with medical, recreational, health promotion and emergency facilities within easy reach.[27]

5.41 Such facilities, which are designed with recreational facilities to attract the 'young elderly', may combine one or two bedroom units for fully independent living with hostel and nursing home-type accommodation within the same complex. As people age they have the option of moving to assisted living within the same community which removes much of the trauma of enforced relocation.

5.42 The Committee believes there could well be scope for a partly or fully privately funded initiative such as this. Evidence suggests that the motivation and means to build a privately funded older citizens village already exist on Norfolk Island. The Government Gazette No. 20, of 11 May 2001, indicated that plans for a private village, consisting of ten two-bedroom self-care units for residents had been submitted for approval to the Planning Board. However, there is no indication the proposal includes any communal or recreational facilities or facilities for assisted independent living.

5.43 Older property owners could be encouraged to sell their homes to younger islanders to raise the money required to invest in a place in an attractive community facility. Ms Denise Quintal made a proposal along similar lines when speaking to the Committee during its visit to Norfolk Island:

> maybe the local [elderly] islanders who own homes could consider selling their homes to youth on the island on a pay-back scheme.

27 Professor Carol Gaston, Submissions, p. 62.

> … we could be distributing the home to a young family and the aged person could then move into the hostel and they would be paid money – just like a mortgage – that could actually be used to pay for their aged care. It would keep the homes within the family units of Norfolk Island.[28]

5.44 Another option, suggested in the RSL report, was the acquisition of a suitable house near the hospital for a group of elderly people, with a personal care assistant. This could provide a home-like atmosphere, companionship, assistance with daily care as well as the security of ready access to medical backup:

> Provided that the house was not too far away and linked by telephone and call bell to nursing and medical assistance, it could be a good model of aged care services delivery.[29]

5.45 The opportunity to acquire a large house, easily adapted to accommodate six or more elderly people with a live-in assistant, presented in August 2000. This dwelling was located a few minutes walk from the main hospital building and had large, attractive gardens, views and many bedrooms, as well as large rooms suitable for communal use. The proposal to buy the house was supported by the Hospital Board but the Norfolk Island Government, although agreeing with the concept in principle, was not able to fund the purchase.

5.46 In May 2001 the house was still for sale. The Committee believes that the price and terms for this property represented good value as well as an opportunity to address the urgent problem of aged accommodation within the Hospital. However, such a decision is constrained by the present uncertainty about the timetable for replacing the Hospital.

Possibilities for short-term action

5.47 Even if immediate action were taken to plan and build a new aged care facility, the situation for those already living in the Hospital and those who are barely managing to cope in their own homes cannot wait. Urgent measures are needed to improve the quality of life of those already living in the hospital, as well as to assist people to continue living in their own homes rather than have to move to the mainland or into the Hospital.

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28 Ms Denise Quintal, Transcript, p. 102.

29 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 49.

5.48 There was a delay in implementing the three initiatives proposed by the Norfolk Island Advisory Committee and approved by DVA, namely, the proposed geriatric nursing supervisor, physiotherapist and the vehicle. Each of these initiatives, now activated, will make significant and immediate improvements in health services for the aged. The Committee hopes that future joint initiatives will not experience similar delays.

5.49 Expanding the hours and responsibility of the district nurse could be undertaken immediately, and could be seen as a logical place to start in the push to make ageing in place a reality. The acquisition of a new vehicle and its use to transport small groups of elderly people to the Day Care club, to appointments or even to the supermarket, will rapidly reduce their social isolation and increase their independence and wellbeing.

5.50 Ideally aged care and acute care should not be combined since aged care generally suffers when the two are in competition for staffing and funding. The RSL report documented that this has been the case in the Norfolk Island Hospital although recent staff rostering has endeavoured to keep one staff member on duty in the aged section by day. The DVA Report recommended that in order to recognise aged care as one of the core services of the NIHE, a separate cost centre should be established in the NIHE chart of accounts to reflect this.[30]

5.51 The Committee expects that the ACCNC will organise other improvements in aged care, such as staff training and an examination of underutilised existing facilities. It awaits future developments with interest.

Recommendations

Recommendation 18

5.52 **The Committee recommends that the Commonwealth Government extend the Aged Care Act to cover Norfolk Island, to enable the Norfolk Island Government to access existing programs and initiatives designed to assist rural and remote communities.**

30 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 50.

Recommendation 19

5.53 **The Committee recommends that, in order to enable elderly people to remain living in their homes for longer, the Norfolk Island Hospital Enterprise:**

- **increase the district nursing hours, and involve the district nurse where appropriate in the design, implementation and coordination of services necessary to maintain aged persons who are borderline independent in their homes;**
- **in consultation with appropriate staff, examine, prioritise and implement the generally low cost services recommended by Department of Veterans' Affairs, such as respite care and carer support, which would assist people to remain in their own homes;**
- **examine the feasibility of involving service clubs in Home and Community Care-type services, such as house cleaning and maintenance and shopping; and**
- **extend home assessment and accidental fall prevention services to all elderly Norfolk Island people.**

Recommendation 20

5.54 **The Committee recommends that responsibility for routine medical consultations for the aged residents in the hospital be devolved from the general practitioners to the aged care clinical nurse consultant or nurse practitioner.**

Recommendation 21

5.55 **The Committee recommends that the Norfolk Island Hospital Enterprise allocate sufficient funds to ensure that the existing physiotherapy and hydrotherapy facilities at the Hospital are maintained at optimal levels.**

Recommendation 22

5.56 **The Committee recommends that responsibility for liaison between the Norfolk Island Government and the Department of Veterans' Affairs be formalised, in order to take maximum advantage of the benefits available through relevant DVA programs.**

Recommendation 23

5.57 **The Committee recommends that, pending the construction of a new hospital or alternative aged care facility, the Norfolk Island Hospital Enterprise take immediate steps to improve the nursing home facilities within the Hospital by:**

- **establishing a separate cost centre and 24-hour staffing allocation, so that aged care does not lose out to the demands of acute care;**
- **enhancing the perceived status of caring for the nursing home patients, including increased staffing levels and training in geriatric care, in particular the special needs of dementia patients;**
- **improving security for dementia patients by fencing part of the hospital grounds; and**
- **providing privacy for residents, and an attractive and comfortable environment for aged care within the hospital.**

Recommendation 24

5.58 **The Committee recommends that the Hospital Enterprise consider for the future accommodation of elderly people with limited independence either:**

- **a suitable shared house, near the hospital; or**
- **purpose-built, dedicated nursing home and hostel places located within a Multi Purpose Service facility.**

Recommendation 25

5.59 **The Committee recommends that the Norfolk Island Government investigate the possibility of a fully or partly private sector funded retirement village to provide a variety of accommodation for people with differing levels of independence, as well as facilities for social and physical activities. Support for the idea of residents' investment should be canvassed.**

6

Emergency medical evacuations

Background

6.1 Because of the small population and the nature of the 'cottage hospital'[1] on Norfolk Island, only a limited range of medical services can be provided in the case of acute health problems. The nearest major hospital is over 1500 kilometres away. Several witnesses likened the hospital's role in a medical emergency to that of a clearing station where patients are stabilised until they can be transported back to the mainland for specialist treatment. Several generations ago people took their chances and lived or died according to the skill of the doctor and luck, but such a lifestyle has long passed, and patients expect appropriate specialist treatment in a life or death situation. Tourists, the economic lifeblood of the Island, have the same expectations.

6.2 The Defence Department submission advised that until several years ago the Royal Australian Air Force was the sole provider of aeromedical evacuation (AME) support for critical patients on Norfolk Island. The Air Force provided the service because no other aircraft operator had the capacity either to deliver a rapid response surgical team to the Island or to evacuate a stretcher patient who required in-flight care.[2] However, the Committee was advised that about twenty years ago:

> Norfolk Island airlines always had a KingAir on the ground on Norfolk Island and they used to use that with the staff at Norfolk Island to evacuate people to Brisbane. The RAAF became involved

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1 Department of Transport and Regional Services, Submissions, p. 86.

2 Department of Defence, Submissions, p. 138.

> and it was easier to make a phone call to the RAAF rather than look around and see what alternatives were available.[3]

6.3 Given Norfolk Island's remoteness and total isolation, a dependable, fast evacuation service can be seen as an essential service which should be available to anyone on the Island on a basis of medical need. A patient's ability to pay for the service should not be an important consideration. There is a need for universal cover for the cost of a medical evacuation.

The present situation

6.4 According to the Defence Department submission, the advent of civilian aeromedical retrieval services which have aircraft capable of operating into Norfolk Island has resulted in a significant reduction in the demand for RAAF AME services.[4] Private, chartered services with purpose designed aircraft are seen to be faster, cheaper and easier to arrange. However, the RAAF continues to provide the majority of emergency evacuations from Norfolk Island, free of charge. In 1999 there were three private medivacs, provided by Careflight, compared with six RAAF medivacs. In 2000 there were six emergency medivacs, three by the RAAF, and in the first half of 2001 five, none of them undertaken by the RAAF.

RAAF medivacs

6.5 The policy for using RAAF planes for aeromedical evacuations is covered by Defence Instruction (General) Operations 5-1: Defence Assistance to the Civil Community. It states that Defence Force aid should not be used as a substitute for capabilities available from other government agencies or the private sector, but may be provided where such resources are inadequate or not available. Defence policy is that it will continue to provide this kind of assistance to Norfolk Island in times of genuine need, but it should be seen as the exception rather than the rule. Defence supports any measures to provide alternatives through other government agencies and / or the private sector.[5]

6.6 Under RAAF AME procedures, if a civilian alternative is available, AME missions require formal authorisation from the Minister for Defence, or his delegate. The authorisation process can encounter considerable delay. The

3 Mr Clyde Thomson, Royal Flying Doctor Service, Transcript, p. 229.

4 Department of Defence, Submissions, p. 138.

5 Department of Transport and Regional Services, Submissions, p. 96.

Government Medical Officer at the Norfolk Island Hospital, Dr Fletcher, advised the Committee that the medical staff have great problems arranging emergency medivacs. For locals or visitors without insurance, it may take many hours to get approval granted by the Minister for Defence:

> and then we have to debate with the Air Force for a Hercules … The Air Force are under instructions not to come to our aid for this unless circumstances are such that we cannot get any other transport or there is some dire circumstance that warrants getting in the Air Force.[6]

6.7 The Defence Department advised that where there is no civilian alternative, the Air Commander Australia at Air Headquarters has the authority to order an AME mission.[7] While there are guidelines for the approval process, approval would always be given in a life or death situation and where evacuation by other means would cause unacceptable delay. Authorisation has also been given in the case of a resident or visitor who has no medical insurance or other means of paying for a commercial evacuation.

6.8 However, the necessity of proving the inability to pay causes potentially life threatening delays as well as unacceptable moral dilemmas and wasted time for medical staff trying to organise the evacuation. Witnesses have described the procedures for authorising a medical evacuation, either RAAF or civilian, as time consuming, disruptive and an extra burden on medical staff. Mr Hughes, Chairman of the Hospital Board said:

> we all feel very strongly about that, and the board is quite definite that procedures for medivac are cumbersome and time consuming, quite often to the extent of putting patients at risk. There is a great need for a formulated and simple approach that can deliver the service in a reasonable time frame.

6.9 He added that:

> It can take three to nine hours before we get permission for an aircraft to leave the tarmac, and then you have the flying time from Australia to here. … Whilst that is happening, the time of the doctor and other people is taken up, probably - or possibly - to the detriment of patients and certainly to the detriment of the good doctor and staff concerned because they then have to catch up on their backlog of work.[8]

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6 Dr Lloyd Fletcher, Transcript, p. 47.

7 Department of Defence, Submissions, p. 138.

8 Mr John Hughes, Transcript, p. 50.

6.10 The Department of Transport and Regional Services also advised the Committee of the concern that Norfolk Island medical staff have at being required to assess a patient's ability to pay in an emergency medical situation.[9] The Department recommended that the protocols for emergency medical evacuations be reviewed and agreed by all parties, and details circulated to all residents and visitors. The approval process for evacuations should be expeditious to avoid any risk to the patient associated with time delays.

6.11 Since providing assistance to civilians in an emergency is not a primary role for the Defence Forces, there is no dedicated aircraft or crew for this purpose. Hence, there is always some uncertainty as to whether an aircraft will be available in the case of an emergency. Dr Fletcher related an incident when he requested a RAAF medivac and was told:

> You're lucky you caught us. We've just got a plane come in, otherwise we wouldn't be able to do it. And, in any case, we would not have been able to do it for the previous three weeks because of the Timor incidents.[10]

6.12 Air crew are on twelve hour stand-by. The Defence witness advised that:

> 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.[11]

6.13 The implication is that it can take up to twelve hours for a plane to take off, especially if a reservist medical specialist is required and has to be called in. However, the RAAF prides itself on achieving a turnaround time considerably less than twelve hours, including the time taken to set up the aircraft as an ambulance.[12] Flying time to Norfolk Island is then between three and four hours.

6.14 The aircraft used for medical evacuations, the C130 (Hercules), is a heavy duty cargo craft built to military standards, with a capacity vastly larger than is necessary for a single patient AME. The interior, although air-conditioned and pressurised, is less than ideal for a critically ill patient. It is noisy to the extent that normal conversation is impossible, as well as very bumpy. However, the Defence witness told the Committee at the April 2000 public hearing that the Hercules is the only RAAF plane suitable for evacuations from Norfolk Island when factors such as

9 Department of Transport and Regional Services, Submissions, p. 87.

10 Dr Lloyd Fletcher, Transcript, p. 47.

11 Group Captain Roberts, RAAF, Transcript, p. 170.

12 Group Captain Roberts, RAAF, Transcript, p. 163.

distance, the length of the airstrip, time spent flying over ocean and the need to carry a stretcher, high tech medical equipment and personnel are considered.[13]

6.15 Based on the policy of full cost recovery, the cost to the RAAF for each flight is estimated at $131 000. This costing is based on about eight hours flying time for a Hercules aircraft, with an air crew of five plus a medical team of five or six, depending on the type of medivac. This figure includes a component for maintenance and depreciation of the aircraft. There is also the possibility that a relief aircrew must be sent if take-off occurs well into the shift of the first crew.[14]

6.16 The RAAF normally charge the State or Territory health authorities concerned a fee for an emergency medical evacuation. This is the case with medivacs from Australia's other inhabited External Territories but not with Norfolk Island. None of the cost is recovered from any outside source at present, nor do there appear to be any plans at present to charge in the immediate future.

6.17 However, the Norfolk Island Minister for Health, Mr Gardner, advised the Committee that at the Intergovernmental Meeting in August 1999 the Federal Minister for Territories had raised the issue of RAAF medivacs, leading to an impression that there might be a policy change. Mr Gardner said that:

> The changes to policy when they affect long-established arrangements are difficult to accept and understand, especially with regard to such a vital matter that has provided, until recently, certainty and peace of mind. As a result we have turned our minds to the options. Are we able to improve and cement in place current arrangements? How can we ensure services for local residents and visitors in the event of current services not being continued or being unavailable? What funding alternatives are available?[15]

6.18 The RAAF base at Richmond conducts on average twenty AMEs each year. In early 2000 there were six doctors, 23 nurses and 30 medical assistants based at Richmond. Missions to Norfolk Island represent approximately ten to fifteen per cent of all AMEs.

6.19 The Defence Department submission observed that the arrangement has, in the past, been of mutual benefit, as the Island has received an excellent aeromedical evacuation service and the RAAF medical teams have gained

13 Group Captain Roberts, RAAF, Transcript, p. 166.

14 Group Captain Roberts, RAAF, Transcript, p. 162.

15 Mr Geoffrey Gardner MLA, Transcript, p. 10.

valuable training experience.[16] There is minimal training benefit to the aircraft crew. The main disadvantages to Norfolk Islanders are that the RAAF cannot guarantee that an aircraft and trained medical team will be available at the squadron's home base at Richmond, NSW, when a request for an AME is received, and that each case must be negotiated, often a lengthy and stressful process. The disadvantage to Australia is the significant cost to taxpayers.

6.20 An example of the expense incurred was provided by a witness who advised of a recent RAAF evacuation which involved the Hercules plane flying from Sydney to Newcastle and Brisbane to pick up two doctors, then to Norfolk Island and back to Sydney with the patient, then on to Newcastle and the Sunshine Coast to return the two doctors to their homes and finally back to the Richmond base.[17] Such a flight plan might double the flying time and would almost certainly involve two separate flight crews.

6.21 DOTRS expressed concern at the 'significant reliance' of the Norfolk Island Government on the RAAF for emergency medical evacuations:

> particularly in light the Federal Government's move to 'user pays' principles; the lack of alternative health insurance coverage for emergency patient transport; and the trauma to Island residents and visitors when faced with the exorbitant cost of evacuation at the time of a medical crisis.[18]

Careflight medivacs

6.22 Careflight, a commercial medivac company which made submissions to the inquiry, undertook four medical evacuations between August 1998 and June 2000, two for insured patients, one at the Norfolk Island Government's expense and one at the patient's expense.[19] Careflight was established in 1986 to provide a helicopter rescue service out of Westmead Hospital in Sydney, but now also provides urgent medical support and evacuation in the South Pacific, using charter jet aircraft on rapid-response out of Sydney. It advised that its jet aircraft, with a critical care team on board, can be in the air within 2.5 hours of activation, and would then be able to reach Norfolk Island in 2 hours 25 minutes.[20]

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16 Department of Defence, Submissions, p. 138.

17 Mr Ian Badham, Careflight, Transcript, p. 238.

18 Department of Transport and Regional Services, Submissions, p. 86.

19 Ms Catharine Carruthers, Careflight, Transcript, p. 240.

20 Careflight, Submissions, p. 165.

6.23 Doctors employed by Careflight are sourced from a pool of more than 25 specialists or advanced trainees in anaesthesia, emergency medicine and intensive care. Most have completed at least 50-100 critical care retrievals and all practice in major teaching hospitals in Sydney. They are assisted by nurses with intensive care certification or by paramedics.

6.24 As a specialist medical retrieval service, Careflight believes its expertise lies in the depth of specialist knowledge available within its large group of retrieval specialists as well as systems it has developed to ensure access to an aircraft and to minimise response time. Careflight advised at the June 1999 public hearing that it has:

- sufficient numbers of retrieval specialists to ensure that a team with appropriate skills can be supplied at very short notice;
- dedicated equipment for international retrievals, including a purpose designed stretcher bridge with built-in intensive-care equipment which enables a very fast response;
- access to a large number of suitable aircraft through various operators to ensure that a plane can always be sourced and adapted rapidly;
- a dedicated international phone number that is diverted to the duty officer at all hours;
- medical specialists who provide preliminary advice and support by phone; and
- the advantages of being based within the grounds of a major teaching hospital, such as very rapid access to blood transfusion products.

6.25 Although Careflight is a registered charity, its international arm operates on a fee-for-service basis and receives no subsidy from the Commonwealth. It has provided the Norfolk Island Government with fixed prices for periods of six months in the past, although it is an infrequent client. Negotiating on a job-by-job basis increases both the cost and 'scramble' time. Non-regular clients must make arrangements for payment in full before an aircraft is dispatched. A prior arrangement with the Norfolk Island Government could enable it to be invoiced.[21]

6.26 Dr Fletcher told the Committee:

> I personally think the private way is the way to go – they are a far more speedy, efficient service, and the Air Force agrees with me on that.[22]

21 Ms Catharine Carruthers, Careflight, Transcript, pp. 245-246.

22 Dr Lloyd Fletcher, Transcript, p. 47.

6.27 The advantages of using a commercial medivac company include the dependability, the speed of response and access to highly specialised skills. The disadvantage, in the present situation, where few Islanders or visitors are covered by insurance, is the cost. If the Norfolk Island Government can find a solution to providing universal cover for medivacs this option would be invaluable in the event of critical emergencies.

The lack of insurance cover

6.28 Statistics indicate that so far the cost of a service provided by a private operator such as Careflight, estimated in mid-2000 at approximately $25 000, is prohibitive for the many residents and visitors who do not have private health insurance that covers medical evacuations by air. Evidence from the November 1999 hearing, as well as anecdotal evidence provided to the Committee, indicates that the requirement that payment be guaranteed at the outset has been the cause of serious distress to patients and families. At present, where a resident or a visitor without insurance cannot afford this amount, negotiations are begun with the RAAF to send a Hercules.

6.29 Norfolk Island's health insurance scheme, Healthcare, covers only $200 of the transport costs associated with medical treatment. Very few Island residents have private medical insurance that covers medical evacuation as it is almost impossible to obtain or prohibitively expensive. The Norfolk Island Minister for Health informed the Committee that probably only four or five people on the Island had insurance to cover the cost of a private medical evacuation. The company providing the service has a very strict qualifying regime, including holding all of a customer's insurance policies. The annual cost is about $1000.[23]

6.30 DOTRS advised that insurance companies will not provide acceptable global insurance to the Norfolk Island Government to cover medivacs from Norfolk Island. The premium that would be set would merely equate to the expected annual cost.[24]

6.31 The Department of Veterans' Affairs referred to a case in which the cost of a single private medivac for a fractured neck and femur equalled two thirds of the annual amount spent on veterans' and war widows' travel for medical treatment. As people age and the risk of accidental falls increases, the likelihood of an emergency evacuation increases.[25] The doctors

23 Mr Geoffrey Gardner MLA, Transcript, p. 11.

24 Department of Transport and Regional Services, Submissions, p. 86.

25 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 144.

advised the Committee during its inspection that orthopaedic surgery is not undertaken on the Island, primarily because of a lack of diagnostic equipment and post-operative care facilities.

6.32 The Norfolk Island Government has not in the past covered the cost of commercial evacuations, arguing that the community cannot afford to cover the costs. Imposing a 'medivac levy' in addition to the Healthcare levy is not deemed feasible.[26]

6.33 The Norfolk Island Government could exercise its revenue raising authority to impose a new tax, other than one based on expenditure, which would ensure it had the finances to fund satisfactorily one of its most essential services.

6.34 As noted in Chapter 3, in March 2001 the new Hospital Director proposed that if all visitors to Norfolk Island were required to take out health and travel insurance, the fees levied would provide the NIHE with a substantial amount of funding to seek capital improvements and address the issue of medivacs and the associated costs.[27]

Non-critical medivacs

6.35 Medivacs on commercial passenger flights are used for patients who can be monitored by a single doctor or nurse and who require minimal medical assistance. In 1999 nineteen patients were evacuated using regular passenger transport.[28] However, commercial flights are not always available and at present only one aircraft type can be reconfigured for stretcher retrievals. Dr Davie advised the Committee that if a stretcher has to be installed, notice must be given to the airline (Flight West) three days before the scheduled flight.[29] Commercial flights are not always scheduled on every week day.

6.36 The service, at a cost of $8 000, which is roughly equivalent to the cost of the eight seats that must be removed to install a stretcher and used to seat medical attendants, is still very expensive for patients who are not covered by insurance. A major disadvantage is that this arrangement can leave the Island short of medical personnel and essential equipment.

6.37 The suggestion has been made that a statutory obligation to transport patients in an emergency be made part of an airline's landing agreement.

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26 Department of Transport and Regional Services, Submissions, p. 86.

27 Ms Christine Sullivan, Submissions, p. 196.

28 Department of Transport and Regional Services, Submissions, p. 86.

29 Dr John Davie, Transcript, p. 33.

The Norfolk Island Government has informed the Committee that no such obligation exists at present.[30] It appears that even if an airline were willing to undertake an emergency stretcher evacuation without notice, there are not the facilities at Norfolk Island airport to carry out a seating reconfiguration.

The Royal Flying Doctor Service

6.38 The Royal Flying Doctor Service (RFDS) does not at present provide any form of health services, either emergency or primary health care, to Norfolk Island. However the RFDS attended the June 2000 public hearing for this inquiry and subsequently submitted to the Committee a proposal of services which it would be interested in providing to Norfolk Island. This proposal was forwarded to the Norfolk Island Government and discussions began between the Chief Medical Officer of the South Eastern Section, New South Wales Operations, and the Director of the Norfolk Island Hospital. The RFDS has provided preliminary costings for the various services.

6.39 When asked why the Flying Doctor had never conducted medical evacuations out of Norfolk Island Captain Clyde Thomson, Executive Director, South Eastern Section, replied:

> I think that the arrangements they had with the Air Force worked pretty well for the people on Norfolk and there was no need, because there was no cost impost to them, to change them.[31]

6.40 The RFDS, which provides aeromedical services through eighty per cent of Australia, also contracts its services and would be willing to enter into a formal arrangement with the Commonwealth or the Norfolk Island Government for the evacuation of patients from Norfolk Island. Like the commercial operators, the RFDS charters jet aircraft, and with one of its critical care teams on board can dispatch an emergency flight within 2.5 hours of activation. Flying time is the same as for commercial operators, which is up to an hour and a half less than the RAAF flying time.

6.41 In addition to an evacuation service the RFDS could provide other services such as:

- a medical officer with primary healthcare focus and emergency aeromedical transfer experience, on a six month rotation;

30 Government of Norfolk Island, Submissions, p. 146.

31 Mr Clyde Thomson, Royal Flying Doctor Service, Transcript, p. 232.

- a remote consultation service to relieve the Island medical officers from non-urgent consultations after hours;
- semi-urgent medical evacuations using the RFDS doctor and commercial aircraft (in addition to a Sydney-based retrieval team);
- community-based registered nurses and allied health workers on three to six month rotations;
- visiting specialists;
- links with the Sydney University Department of Rural Health and the College of General Practice; and
- expertise in the implementation and development of telemedicine.

6.42 The RFDS witnesses emphasised that the Flying Doctor has moved towards a primary health model, working in an integrated way with other health service providers. Captain Thomson said that forming linkages with universities, colleges and other providers of health services to develop a primary health care model embodying the use of emergency medicine was a very efficient approach. He added that:

> the least effective model is a model which relies totally on evacuation. That is a very expensive use of resources and really should be used as a last resort.[32]

6.43 He stressed the importance of a formal arrangement that specified the standard and range of services required:

> if you come to us and say, 'We would like you to do approximately 16 evacuations to Norfolk Island per year, we would like them done to this standard and this is the response,' we could respond to that. We would meet it, and then we would run a quality assurance program over that to make sure that we were responding within the parameters that we said we would. You have a range of expertise required. You can arrange for a neonatal emergency service down to emergency medicine, and neurologists and so forth can go in that service.[33]

6.44 The advantages of using the RFDS include dependability, long experience in the field, the offer of a package of useful services to support primary health care on the Island and the fact that its cost per emergency evacuation would be significantly cheaper than a commercial operator could offer. The RFDS receives Commonwealth and state government

32 Mr Clyde Thomson, Transcript, p. 228.

33 Mr Clyde Thomson, Royal Flying Doctor Service, Transcript, p. 231.

funding in addition to its own significant fundraising efforts. Another advantage of a formal arrangement with the RFDS is that it would be possible to provide emergency evacuations for tourists and bill the home state for the service in the same way as on the mainland.

6.45 The disadvantage to the Norfolk Island Government is that RFDS services, although less expensive than a commercial operator, would not be free like a RAAF medivac, but would attract a cost that would require a new source of funding.

6.46 The Indian Ocean Territories Health Service (IOHS) made a submission to the inquiry outlining the arrangements under which the RFDS flies to Christmas Island. Urgent medivacs may be undertaken either by commercial aircraft, if the flight schedule is appropriate and a stretcher can be installed in Perth, or by charter flight. The IOHS normally contacts the RFDS to ask for assistance in securing a charter flight. The RFDS contacts aircraft operators who may be able to assist since the RFDS does not own a suitable aircraft for this long-haul flight. If both these avenues fail the IOHS will try to secure an aircraft through Jakarta or Singapore which can cost up to $85 000. There is an average of six urgent medivacs a year from Christmas Island.

6.47 Captain Thomson of the RFDS explained that the reason why it is sometimes difficult for the RFDS to secure a plane to fly to Christmas Island or the Cocos (Keeling) Islands is that the arrangements about response times, level of service and price have not been formalised.[34] With a formal arrangement in place with Norfolk Island, the RFDS could provide a response within three hours.[35]

6.48 Dr Davie referred to 'an enormous amount of controversy' over the question of emergency evacuations. While he expressed his opinion that 'the RAAF would never let us down', he believed the ad hoc arrangement that seems to exist with the RAAF is not tenable:

> We need to know for the security of the population on this island that we have a guaranteed system.

He believed it was time for some strong initiative to be taken such as compulsory insurance for aero-medical evacuation. The situation:

> has to be addressed and I believe it is a considerable priority.[36]

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34 Mr Clyde Thomson, Royal Flying Doctor Service, Transcript, p. 231.

35 Mr Clyde Thomson, Royal Flying Doctor Service, Transcript, p. 229.

36 Dr John Davie, Transcript, p. 32.

6.49 Dr Davie also thought that Norfolk Island should be making it far more obvious to tourists that there could be problems with regard to health and that the Island Hospital cannot cope with many emergency situations:

> Therefore, we must encourage them all to take out travel insurance, for example, when they come. This should be made available proactively - not retroactively.[37]

Recommendations

Recommendation 26

6.50 **The Committee recommends that the Norfolk Island Government provide universal cover for the cost of medivacs by:**

- **raising funds to pay for all medivacs;**
- **sourcing a private insurer, possibly through the use of incentives; and**
- **exploring the possibility of a cost-sharing arrangement with the Commonwealth for the provision of medical evacuations from Norfolk Island.**

Recommendation 27

6.51 **The Committee recommends that the Norfolk Island Government actively pursue negotiations with the Royal Flying Doctor Service for the provision of an emergency evacuation service under a formal arrangement.**

37 Dr John Davie, Transcript, p. 32.

7

E-health – existing and future possibilities

The only barrier now is in our own heads. It is certainly not the technology. It is our own ability to engage it and accept that it is yet another technological tool that we can use to enhance the provision of our health services to our local people.[1]

What is e-health?

7.1 The term telemedicine, which is the basis of one of the terms of reference for this inquiry, is one of a growing number of expressions used in conjunction with telecommunications technology in the Australian health system. Telemedicine tends to emphasise the role of doctors in providing health care to distant patients. The term telehealth emphasises a wider range of applications involving a range of health professionals. In addition, discipline specific terms such as teleradiology, telepsychiatry and telepathology are becoming part of the lexicon of health.

7.2 The Commonwealth Government has released two documents on the subject in recent years: *Fragmentation to Integration: The Telemedicine Industry in Australia* in 1998, and *From Telehealth to E-Health: The Unstoppable Rise of E-Health* in 1999, both prepared by John Mitchell of John Mitchell & Associates. The latter report discusses the transition from telemedicine to e-health which is much broader than either telemedicine or telehealth.

7.3 The Committee's preference is for the term e-health which is defined in *From Telehealth to E-Health: The Unstoppable Rise of E-Health* as:

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1 Professor Carol Gaston, Transcript, p. 207.

> the use in the health sector of *digital data* – transmitted, stored and retrieved electronically – for clinical, educational and administrative purposes, both at the local site and at a distance. Hence e-health is the overall, umbrella field that encompasses telehealth.[2]

7.4 Many witnesses spoke enthusiastically, though in general terms, of the benefits of telemedicine or e-health to a remote community. Most conveyed the impression that it was a boon that was still some distance away in the future, especially given the present limitations of the telecommunications infrastructure on Norfolk Island.

7.5 However, the Committee was impressed to hear late in the inquiry of a proposal by one of the Island doctors for a netconferencing facility which could be implemented with minimal cost in the very near future. The appeal of the proposal, which has already been demonstrated to members of the Norfolk Island Legislative Assembly, was in its simplicity and its capacity to integrate with equipment and expertise that already exists on the Island. Based on the Internet, which is already widely used, netconferencing offers many advantages over teleconferencing, which requires professional expertise to set up and maintain and is therefore much more expensive.

7.6 Further details of this proposal may be found below in the section *The development of e-health on Norfolk Island*, at 7.15 below.

Communications infrastructure on Norfolk Island

7.7 The *Telecommunications Act 1997* (Cth) does not extend to Norfolk Island.[3] The Norfolk Island Government has the sole authority to establish, maintain and operate the domestic communications network within Norfolk Island, which it does under the *Norfolk Island Telecommunications Act 1992.* Norfolk Telecom was established to manage the local network. However, Norfolk Island has been the beneficiary of a number of Commonwealth grants for telecommunication purposes under the Networking the Nation scheme.

7.8 In 1994 the Norfolk Island Government established a commercial agreement with Telstra to provide an international telecommunications

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2 Mitchell J, *From Telehealth to E-Health: The Unstoppable Rise of E-Health*, Department of Communications, Information Technology and the Arts, Canberra, 1999, p. 6.

3 Nor does the Universal Service Obligation, which operates within the Christmas and Cocos (Keeling) Islands, extend to Norfolk Island.

network link using the ANZCAN[4] undersea cable as the carriage medium. The cable is expected to expire by 2005.[5]

7.9 An Internet Service Provider (ISP) on Norfolk Island, www.nf, was established by Norfolk Island Data Services (NIDS) in 1996. NIDS provides local customers with access to the Internet, on-line and e-mail services, and charges $5 an hour to use its ISP operations.

7.10 The Committee's 1999 report, *Island to Islands: Communications with Australia's External Territories*, noted NIDS' concerns that Norfolk Telecom rates of $98 000 per year for a 64 KBPS link on the ANZCAN cable, and restrictions imposed on line use, meant that NIDS could only provide channels with a limited data rate. An equivalent satellite line would give twice the performance for $1 000 per month. However, NIDS was restricted to the use of Norfolk Telecom, which precluded it from exploring a direct link with the cable network or from accessing a satellite as an alternative.[6]

7.11 In October 1997 the Norfolk Island Government negotiated with Telstra over the establishment of its own ISP network, NI.NET, to provide standard Internet access and e-mail services to rival NIDS' operations.

7.12 NI.NET was established in May 1998 and is serviced by a 64Kbps[7] line to Telstra Big Pond in Sydney. All local subscribers are connected by 33.6Kbps lines. NI.NET is a subsidiary of Norfolk Telecom and is wholly owned and operated by the Norfolk Island Government. It provides standard access to the Internet, e-mail and commercial web-hosting to its customers. Charges to the customer include a $40 initial connection fee and $4 per hour Internet access.[8]

7.13 The Norfolk Island Government has undertaken a review of its communications infrastructure and telecommunications and Internet service provisions. It received a grant of up to $80,000 from the Remote and Isolated Islands Fund (RITF) of the Networking the Nation program (NTN) in order to:

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4 Australia-New Zealand-Canada undersea telecommunications cable.

5 This agreement lasted from 1 May 1994 to 30 April 1999, and was subsequently extended until November 2000. It is anticipated that the agreement with Telstra will continue to be extended on an ad hoc basis until the Norfolk Island Government establishes alternate arrangements.

6 Joint Standing Committee on the National Capital and External Territories, *Island to Islands: Communications with Australia's External Territories*, pp. 42-43.

7 Kilo (1 000) bits per second data transfer rate.

8 The $4 per hour access rate includes unlimited downloads and connection times as well as a free private e-mail box.

> prepare documentation and conduct tenders to address the Island's need for mobile telephony, satellite services, a replacement exchange, and internet applications.[9]

7.14 This was to provide the basis for a further NTN application for funds to assist the Island in developing and implementing a strategic plan to enhance the existing communications infrastructure. The October 1997 report of the House of Representatives Standing Committee on Family and Community Affairs, *Health on Line: A Report on Health Information Management and Telemedicine*, recommended that all funding sought from RTIF:

> should cover a minimum requirement of 128 Kbps … so as to ensure adequate standards for Telehealth consultations and transmission of radiology and pathology images.[10]

7.15 In November 2000 funding of up to $750 000 was approved by the Networking the Nation Board for the establishment of a two-way satellite earth station on Norfolk Island to supplement and eventually replace the existing cable link. In March 2001 the Chief Minister announced that Telstra had been awarded the tender for this project. Further funding of just over $50 000 was also approved for the procurement of capital equipment, a service agreement and project management for the Island's first telehealth service. The deed of agreement between the Commonwealth and the Norfolk Island Government was still being drafted in May 2001.

The development of e-health on Norfolk Island

7.16 Among the primary benefits of e-health are the limitless possibilities and creative applications of telecommunications in the provision of health services. Despite limitations imposed by the available bandwidth, basic e-health facilities are, in fact, already established on the Island. For example, telephone and fax services are used for urgent off-Island medical referral and specialist advice, and for the provision of Lifeline services. E-mail and Internet access available at the Norfolk Island Hospital, although slow, provide medical staff with professional contact as well as access to the latest information.

7.17 The Department of Veterans' Affairs, as part of its *HomeFront* program, has been using a simple but very effective e-health service in remote parts

9 Under 'Networking the Nation Online – Successful Projects, 7th Round' at www.dcita.gov.au.

10 *Health on Line: A Report on Health Information Management and Telemedicine*, p. 25.

of New South Wales, the technology and expertise for which probably already exists on Norfolk Island. The service involves the use of a digital videotape of a veteran's home, focussing on risk areas such as bathrooms and stairways, made by a local service provider such as a physiotherapist.

7.18 The videotape is then sent via electronic means to one of the Department's occupational therapists for assessment which may not be able to be made by the individual on the site.[11] The application of a simple e-health measure such as this to the wider population of ageing people on Norfolk Island would have a positive impact on their ability to 'age in place'.

7.19 The Committee heard evidence from many different witnesses that the development of telehealth practices and facilities was expected to be of great benefit to the provision of health services on Norfolk Island.[12] A smaller number was aware that e-health had already arrived and was simply awaiting development and widespread acceptance.

7.20 Professor Gaston outlined a four-step approach for the development of telehealth which would be applicable to Norfolk Island:

> You start off with education. You use it for educational purposes and as a management tool in meetings. The next thing is for consultation. A very good case for Norfolk Island which led the way in South Australia was mental health. Mental health really lends itself to telehealth. That has provided an enormous learning curve for practitioners but also for the community. They do not care about the means for communicating; they just want to communicate.
>
> Then you move to diagnostics. As your telecommunications become more sophisticated and your lines thicker or your satellite bigger, then you can use it for transferring images, particularly radiology and pathology. Then there is the ultimate, I suppose … of actual remote surgery.[13]

7.21 The Committee found this framework particularly useful for the examination of e-health possibilities for Norfolk Island and the ways in which they could be successfully accessed and utilised. When asked where she would rank telehealth on a list of priorities for Norfolk Island, Professor Gaston replied:

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11 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 145.

12 Norfolk Island Hospital Staff Association, Submissions, p. 33; Norfolk Island Hospital Enterprise, Submissions, p. 47; Professor Carol Gaston, Submissions, pp. 62-63; DOTRS, Submissions, p. 87; Southern Cross Medical Care Society, Submissions, p. 133; Church of England on Norfolk Island, Submissions, p. 159; Ms Christine Sullivan, Submissions, p. 196; Mr Peter Young, Submissions, p. 200, and others.

13 Professor Carol Gaston, Transcript, p. 210.

> I would actually put it up very high because of the process needed to actually develop people's familiarity with it and in recognition of the great advantages … it does prevent medivacs from taking place … it could also assist the staff and the board in developing their understanding of what is possible. I did not see any evidence of their knowing what is possible.[14]

7.22 The Committee believes that the situation is changing rapidly, and that the medical staff are well aware of immediate applications as well as various potential advantages.

Netconferencing proposal

7.23 In May 2001 a proposal to establish netconferencing facilities at the Hospital was made, which has the potential to accelerate the widespread, routine use of e-health on Norfolk Island. When implemented, this proposal, now approved, will result in the application of e-health to the management of patients' care on a daily basis. The proposal, outlined below, was accompanied by a practical demonstration for medical staff, members of the Hospital Board and members of the Legislative Assembly.

7.24 Netconferencing as an alternative to teleconferencing offers a number of advantages in the Norfolk Island context. Teleconferencing, while providing a high quality audio-video image delivery between multiple points, requires professional expertise to set up and operate, is limited to a maximum of ten access points (the functional limitation is much less) and is very expensive both to set up and to maintain. In contrast, netconferencing offers multipoint video conferencing, the only limit being access to a computer and the Internet. It is easier to set up and to use, and has an almost infinite capacity for the addition of new applications through the relatively simple upgrading of software.

7.25 Dr Damien Foong, who developed the proposal, informed the Committee of several instances in which he had already used his own personal equipment to transfer data which had spared patients a trip to the mainland to see a specialist. He described how he had taken a high definition photograph of the spinal X-ray of a patient with severe back pain, had then scanned this image into his own computer and transmitted it by e-mail to a mainland chiropractor. The chiropractor was able to advise that an immediate consultation was not necessary, thereby avoiding the stress, and expense, to the patient of an urgent visit to the mainland.

14 Professor Carol Gaston, Transcript, p. 210.

7.26 A similar result was achieved through the electronic transmission to a specialist of a high definition image of a suspicious mole. Dr Foong estimated that up to $5 000 in airfares, accommodation and time off work may have been saved through the subsequent receipt of the specialist's opinion that it was safe to remove the mole on the Island. He predicted that the transfer of clinical data such as ultrasounds, X-rays, ECGs and pathology slides to one or more specialists on the mainland would rapidly become routine. He stressed that a doctor's 'duty of care' to patients would be better achieved using netconferencing.

7.27 While Dr Foong was able to achieve these results using the existing server capacity, he noted that the variety of applications would increase as soon as the anticipated new satellite coverage commenced. He also observed that by pursuing satellite telecommunication links, Norfolk Island would not find itself burdened with obsolete technology. It is anticipated that by 2005 the Teledesic project, with nearly 300 satellites in orbit, will provide complete, world-wide, telecommunication coverage. In the interim, Norfolk Island could access satellite link-up immediately using the Immarsat system; the main disadvantage would be the cost. Alternative satellite coverage should be available by October 2001.

7.28 Other advantages of the netconferencing proposal include access to continuing medical education, on-line conferences and courses, on-line real-time communication and real-time emergency assistance as well as rapid access to the Internet and multimedia libraries, and various time and labour saving administrative functions.

7.29 Dr Foong advised that the value of his own equipment used to demonstrate the possibilities of the proposal (laptop, scanner, software and SLR camera) would not have exceeded $10 000. He estimated that the cost for up-to-date equipment commensurate with hospital requirements would be between $50 000 and $70 000. This would include the cost for a server, a high-speed laptop computer, a colour laser printer, a scanner, two digital video cameras, a high definition SLR camera, four web-cameras, a digital screen projector and software.

7.30 The Hospital Director and Dr Foong have suggested that the Hospital could be used as a pilot to demonstrate the many applications and immediate benefits for other users both on-Island and possibly in other external territories.

7.31 Dr Foong's proposal recommended that the Hospital get its own account with a server such as Bigpond, which offers eighteen months service, including hardware, for $1100. He also referred to the possible advantages to Norfolk Island of Telstra's Special Digital Data Obligation for remote locations.

E-health for training and education

7.32 Two primary areas where e-health would be most effective for Norfolk Island include:

- continuing medical education for health practitioners; and
- health education and increased community awareness.

7.33 The provision of e-health services is heavily dependent upon the local health practitioners' familiarity and ability with the technology upon which e-health is based.

7.34 The National Health Information Management Advisory Council (NHIMAC), in its report *Health Online: A Health Information Action Plan for Australia*,[15] identifies the need for increased training as a key priority for health practitioners implementing e-health technologies. For Norfolk Island, technology training resources are limited. While the use of information technology mediums such as the Internet is increasing rapidly, further training and education for health practitioners on the Island will be necessary.

7.35 Funding sought by the Norfolk Island Government for the implementation of a new telecommunications network will, by necessity, include an allocation of funds for technical training for Island residents to operate and maintain the new infrastructure. One option might be to extend this funding to include training and education for health providers in the operation of new e-health communications technology.

7.36 A number of state and territory-based telehealth networks provide training in the use of health technologies as part of their e-health strategy. For example, Networking North Queensland provides training in e-mail and Internet use, including search strategies, techniques in advanced searching and evaluating information on the Internet.[16] The Queensland Telemedicine Network, in conjunction with Rural Health Training Units, also conducts regular videoconferencing training.

7.37 Once health professionals have increased their familiarity with the use of e-health technologies, the technology itself can be successfully used to provide further health-related training and education.

15 *Health Online: A Health Information Action Plan for Australia*, National Health Information Management Advisory Council, November 1999, p. 41.

16 www.health.qld.gov.au/qtn/nnq.

Continuing medical education for health practitioners

7.38 General practitioners and nursing staff in rural and remote communities often face obstacles to further professional training. E-health offers an excellent opportunity for health professionals to improve upon their skills and to access relevant, up-to-date information through the use of the Internet and videoconferencing. This could be achieved through both public and private networks already available and operating.

7.39 In evidence to the inquiry Dr Sexton stated that 'education – and I see telecommunications as a magnificent tool for education over there – is an absolutely integral part of the progress of medical services on Norfolk Island'.[17] The Norfolk Island Hospital Enterprise expressed a similar opinion in its submission, observing that telehealth 'would be invaluable in diagnostic and teaching roles'.[18]

7.40 CMENet, coordinated by the Queensland Rural Divisions Coordinating Unit, is an excellent example of an Internet site offering online, continuing medical education for health professionals. Doctors wishing to undertake clinical attachments to refresh skills, learn new skills and fulfil requirements for maintenance of clinical privileges can interrogate the CMENet database by discipline on a wide range of subjects.[19]

7.41 The Women's and Children's Hospital (WCH) in South Australia is a major teaching and research hospital which uses videoconferencing and related technology to provide a range of services to professionals and communities in rural and remote areas. In addition to health promotion consultation and clinical consultation services, the WCH provides teaching and education services as well as international research expertise in all areas of health and health promotion. Educational applications include specific training for professionals, delivery of higher education courses and development of professional networks.[20]

7.42 The Norfolk Island Hospital Enterprise could establish a working relationship for the facilitation of on-going training and education for medical staff on the Island with one or more of these kinds of facilities.

Health education and increased community awareness

7.43 Preventive health care has been identified as an area which could be considerably expanded by developments in e-health. The Island

17 Dr MichaelSexton, Transcript, p. 214.

18 Norfolk Island Hospital Enterprise, Submissions, p. 46.

19 www.cme.net.au

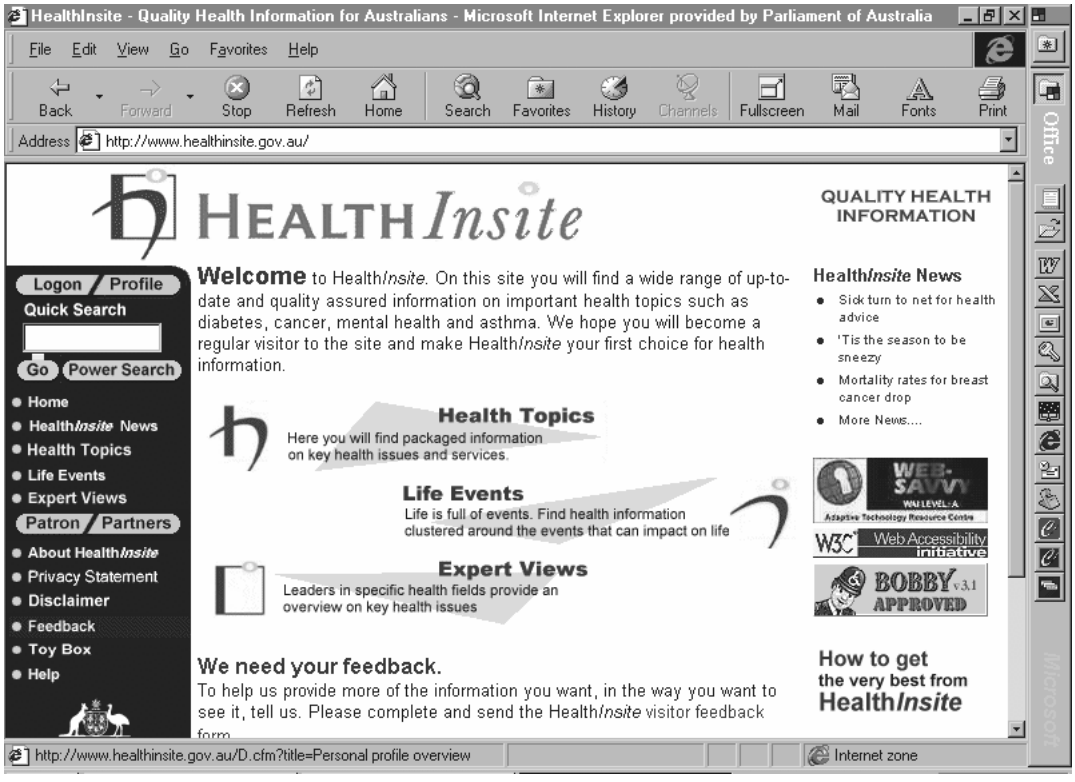
20 www.wch.sa.gov.au/tele

community's ability to access this information is also relatively unrestrained by ignorance of the technology. The Committee heard that:

> People on the Island are becoming very literate on computers and I think that, as a community, we are very foolish if we do not tap into that resource.[21]

7.44 There are a number of online resources established, both at the Commonwealth and at the state level, to facilitate improved community access to health awareness initiatives.

7.45 Health*Insite* is Australia's most comprehensive health information web site. It was established by the Commonwealth Government, and the Minister for Health and Aged Care, Dr Michael Wooldridge, is the site's patron. Health*Insite* currently has over fifty information partner sites, 'featuring information on vital health topics such as diabetes, cancer, heart disease, children's health, asthma and mental health'.



Home Page for www.healthinsite.gov.au – a Commonwealth online health information resource.

7.46 There are also issue-specific web sites which could provide Norfolk Islanders with readily available, up-to-date information about a potentially limitless variety of topics. [22]

21 Ms Pauline Butler, Transcript, p. 106.

7.47 Such sites would be especially effective for Islanders wishing to access information in a highly confidential manner. Ms Pauline Butler from Greenwich University commented that:

> To go to a web site you simply tap into it; nobody knows what you are reading; nobody knows what your concerns are or the information that you are seeking. And when you live in a small community like this … you would realise that nothing is a secret.[23]

7.48 Norfolk Islanders could readily access information to help deal with mental illness or to promote more effectively community awareness of the issues involved. For instance, *Headroom* is a web site established by the WCH in South Australia which focuses on young people's mental health. The stated intention of the web site is:

> To educate the broader community about mental health, because we all have our mental health to consider and there are many things we can do to promote and protect our mental health … Headroom aims to provide information to support young people and families through stressful times, providing food for thought about issues which affect all young people.[24]

7.49 If local residents are encouraged to seek health-related information for themselves through the medium of the Internet, the resulting community awareness and sense of ownership of health services will assist in shifting the emphasis from acute care to preventive care.

7.50 This could be facilitated by the provision of free access to the Internet for health related reasons, through the hospital or proposed community health centre. People could be encouraged to book time to access health information web sites through the Internet, in a similar manner to the Internet services available through public libraries for community use.

E-health and consultations

7.51 In evidence provided to the Committee the Royal Flying Doctor Service stated that it has expanded on its 'remote consultations' to include teleconsultations to the services it delivers from Broken Hill.

> We have got a lot of expertise in using the telephone to deliver health care to isolated communities and now we are using telehealth videoconferencing. We have been using acute

22 Some examples include the Australian Kidney Association: www.kidney.org.au; Osteoporosis Australia: www.osteoporosis.org.au; and Panic and Anxiety Hub: www.paems.com.au

23 Ms Pauline Butler, Transcript, p. 106.

24 www.headroom.net.au

> consultations in Wilcannia for some time now as part of the New South Wales outback telehealth project.[25]

7.52 One of the most successful applications of teleconsultations in Australia has been through the provision of telepsychiatry services to rural and remote areas. At the state / territory level, South Australia has had the most experience, and the most success, in working to provide telepsychiatry services to isolated areas.[26]

7.53 The Rural and Remote Mental Health Service of South Australia, through Glenside Hospital in Adelaide, has one such successful program. It currently has over 25 videoconferencing units located within rural South Australian hospitals, which operate on ISDN at a transmission speed of 128 Kbps.[27]

7.54 This service works to complement local health services and allows local health providers to retain ownership of the process and overall management of the patient's treatment, while ensuring best practice treatment.

> The local GP retains responsibility for clinical management of the patient. A given number of booking slots are available each week and rural practitioners ring a secretary to book the patient in. The patient sees the psychiatrist with the GP or mental health worker sitting at the patient's end. At the completion of the consultation the consultant telephones the GP to discuss with them, the diagnostic assessment and treatment recommendations. A letter summarising what has been discussed is then written and faxed through to all relevant carers.[28]

7.55 Norfolk Island already has a working program of visiting specialists. This form of teleconsultation could be used effectively to complement existing services in many areas such as cardiology, dermatology, ophthalmology and others, as well as in mental health. By allowing for follow-up consultations with the specialist on a more frequent and regular basis, a more effective patient-doctor relationship can be developed. This could be further boosted by a six-monthly on-Island consultation.

7.56 The ability to access teleconsultations with specialists is particularly effective in emergency situations where the only other option is an

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25 Dr Bruce Sanderson, Royal Flying Doctor Service, Transcript, p. 228.

26 These services are also provided to parts of the Northern Territory, including Alice Springs.

27 *Information Technology and Under-Served Communities*, www.telehealth.org.au / discussion_papers / info_tech, p. 11.

28 *Information Technology and Under-Served Communities*, www.telehealth.org.au / discussion_papers / info_tech, p. 11.

expensive and sometimes traumatic medivac. As Professor Gaston commented:

> Consultation, which is the second step, could also facilitate the medivac issue. I know that here in the Northern Territory, just by having the facility available out of a couple of remote areas in the Tanami region, it does prevent medivacs from taking place. We had one early last year where it was thought that this person had some dreadful brain tumour; in fact they had an abscess on their tooth and it was easily dealt with locally.[29]

7.57 The ability to consult with specialists from remote and isolated areas leads logically to the next stage in the process, which is the ability to provide diagnostics through the utilisation of e-health technologies.

E-health and diagnostics

7.58 The use of e-health technologies for diagnostics in remote areas can have significant ramifications in terms of improving the availability and cost-effectiveness of health services to the local community. This is especially true for isolated areas such as Norfolk Island, where the only other options are to send the test results, or to require the patient to travel, to the mainland for diagnosis, at considerable expense.

7.59 The transmission of medical images and data includes X-rays, ultrasound, CT scans, nuclear medicine investigations, echocardiograms, coronary arteriography, dermatology photographs, ophthalmology images, such as slit lamp images, fundoscopy, otoscopy, ECGs, cardio-respiratory indices, pathology images and other diagnostic information.[30]

7.60 Radiology and Pathology are areas where the transferral of diagnostic information via telecommunications networks could markedly and rapidly improve the health services available on Norfolk Island. If the netconferencing proposal is adopted by the Norfolk Island Government, health professionals on Norfolk Island may soon be transferring images on a regular basis, particularly in the fields of radiology and pathology. Advances in computer technology in pathology, in particular, appear long overdue.

7.61 Teleradiology, which involves the transmission of X-ray images, ultrasound or brain scans, is the largest single application of telemedicine

29 Professor Carol Gaston, Transcript, pp. 210-211.

30 Telehealth Development Unit, Health Department of Western Australia, information brochure, *Telehealth: A New Era.*

in Australia, with an estimated 150 sites around the country.[31] It generally requires 128 kbps of ISDN.

7.62 The use of teleradiology and telepathology would be especially effective for Norfolk Island, in the light of previously expressed dissatisfaction with the mail delivery system between the Island and the mainland. The Committee's *Island to Islands* report noted that:

> For the hospital, relying on mail services at present often delays patient diagnosis by weeks. This can pose difficulties in patient management and possible expense for the patient needing to travel to the specialist. The alternative would be to send the X-rays for specialist review by tele-medicine link. The Norfolk Island Hospital therefore supports the setting up of a tele-radiology link.[32]

Health informatics

7.63 Health informatics, which focuses on the management, storage and retrieval of health data, can improve the ability of health professionals to manage patient records and pharmaceutical dispensaries.

7.64 In December 1998 the Norfolk Island Hospital installed a dispensing computer system, on which the medical records and drug histories for every resident of Norfolk Island were entered. The system is also used for cataloguing all pharmaceuticals and over the counter medications.[33]

7.65 This system could be used to transfer patient and dispensary records between general practitioners and specialists for diagnostic consultations. It would also be useful when visitors to the Island require medical treatment.

7.66 In 1996 the PeCC project (Project Electronic Commerce and Communication) was established by the then Department of Industry, Science and Tourism, in collaboration with the Commonwealth Scientific and Industrial Research Organisation and pharmaceutical companies. The goal of the project was to rationalise clinical supply chains through the implementation of electronic commerce using Internet based technologies.[34]

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31 *Telemedicine in Australia: Industry Trends and Business Models*, www.jma.com.au/TelemedAus, p. 5.

32 *Island to Islands: Communications with Australia's External Territories*, p. 44.

33 Mrs Dale Hogden, Submissions, p. 36.

34 *Health Online: A Health Information Action Plan for Australia*, National Health Information Management Advisory Council, November 1999, pp. 68-69.

7.67 The project has been highly successful in increasing the efficiency of pharmaceutical supply chains through online ordering systems. With the introduction of the new computerised dispensary system to the hospital, Norfolk Island is in an excellent position to take advantage of projects such as PeCC.

The cost of e-health

7.68 Although e-health does require an initial outlay of capital for telecommunications and information technology, in the longer term it allows for much more efficient, cost effective management of health services, especially for rural and remote communities, where often the only alternative may be a medical evacuation.

7.69 There are Commonwealth funding schemes which Norfolk Island can access in order to supplement the cost of establishing an e-health capacity on the Island. As noted above, the Norfolk Island Government has already sought and received funding from the NTN scheme.

7.70 There is also the *Regional Solutions Program*, launched on 27 October 2000 by the Minister for Regional Services, Territories and Local Government and the Deputy Prime Minister and Minister for Transport and Regional Services.[35]

7.71 Schemes such as these, as well as investment by the Norfolk Island Government, will help to meet initial infrastructure costs. There is also a number of health service providers, both public and private, assisting in the implementation of e-health networks, infrastructure and practices for remote and rural communities. These may help to reduce the operational costs of an e-health network.

Access to e-health support

7.72 *Health Online: A Health Information Action Plan for Australia*, released in November 1999, was developed in response to calls for a national strategic approach to the application of e-health. With the aim of promoting new ways of delivering health services, it details e-health projects currently operating, as well as proposed future projects. It is a 'living document', which is monitored and updated by the National Health Information Management Advisory Council (NHIMAC) on a regular basis.[36]

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35 This provides funding for small and larger scale projects, with grants of between $1000 and $500 000 available. Projects might include community planning, local project implementation, community adjustment initiatives, regionally based or infrastructure projects, or the employment of community based development officers. Joint Media Release, 27 October 2000.

36 www.health.gov.au / healthonline

7.73 NHIMAC will use the information in the document to provide high-level advice to health ministers from the states and territories and the Commonwealth Government. This will serve to forge a national collaborative approach to the use of information technology in the provision of health, and to ensure consistency and coherence. Consultation with various stakeholders in the industry, and with local governments, will help to ensure that there is a coherent and universal understanding of the issues involved,[37] and the standards of service provision required.[38]

7.74 The Committee believes that the Norfolk Island Government should familiarise itself with *Health Online* and investigate the means of becoming a participant in this continuing strategic approach to e-health. A small, isolated community has much to gain, and to share, by tapping into the intellectual resources of similar mainland communities.

State and territory e-health providers

7.75 Each state and territory has established an e-network of health services for rural and remote areas, as well as implementing a number of e-health initiatives for the provision of more efficient and effective health services to isolated areas. New South Wales, Queensland and South Australia are three prominent examples of state-based e-health networks operating successfully in Australia.

7.76 The New South Wales Department of Health has implemented an extensive telehealth network which includes a number of telehealth services across the State. The NSW Health web site states that:

> The impact of telehealth on work practices include improved working relationships between staff at remote sites; greater integration of remote health services; support for isolated staff; identified training and support programs; improved access to supervision for staff.[39]

7.77 Queensland has also established an extensive telehealth network, the Queensland Telemedicine Network (QTN) which coordinates and supports the use of e-health in the state. There are currently over 160 videoconferencing sites with health facilities. The main areas currently utilising videoconferencing are mental health, paediatrics, and intensive

37 These issues include ensuring that the necessary legal, data protection and security frameworks to facilitate electronic transfers of health information are developed.

38 To this end the Health*Insite* was established.

39 'What is telehealth', at: www.health.nsw.gov.au/pmd/telehealth

care, with new developments in areas such as ophthalmology and cardiology.[40]

7.78 Queensland has also recently launched the Networking North Queensland project. This is a two-year project, funded by NTN, DOCITA and state and private health providers, which aims to improve health outcomes for people living in North Queensland by increasing access to technology.[41]

7.79 The South Australian Government has a number of e-health initiatives running in conjunction with universities and private hospitals. For instance, *HealthySA*, established by the South Australian Department of Human Resources, provides a comprehensive listing of health information web sites on the Internet, as well as information on a wide variety of health management issues.[42]

7.80 Western Australian services will potentially be available on Christmas Island. In a submission to this inquiry the Indian Ocean Territories Health Service (IOTHS) stated that:

> We are hoping to link up with the WA Health initiative, for remote areas in Tele-radiology through the radiology Department of Fremantle Hospital …there are discussions occurring in relation to projects under "Networking the Nation" in relation to tele-medicine, tele-centres and mobile phone access for the Indian Ocean Territories.[43]

7.81 With the Northern Territory connecting to South Australian initiatives, and Christmas and the Cocos (Keeling) Islands poised to link up with Western Australian services, it is clear that e-health enables health service providers to connect with telehealth networks regardless of their origins.

7.82 There are similar opportunities for Norfolk Island to link up with either the New South Wales or Queensland telehealth networks. This would reduce the need for the Norfolk Island Government, or the Hospital Enterprise, to 'research and develop improved, customised, comprehensive telemedicine programs and infrastructure'.[44]

7.83 Furthermore, the then Norfolk Island Minister for Health told the Committee that the Norfolk Island Government was keen to pursue solutions:

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40 www.health.qld.gov.au/qtn/network

41 www.health.qld.gov.au/qtn/nnq

42 www.healthysa.sa.gov.au

43 Indian Ocean Territories Health Service, Submissions, pp. 119-120.

44 Mr Geoffrey Gardner MLA, Transcript, p. 15.

> From the Norfolk Island perspective, cooperation is vital in developing our strategy, be it with the New South Wales Department of Health, universities, foreign consultants or institutions. We are attempting to be proactive on the implementation of improved Telemedicine services to Norfolk Island.[45]

Private e-health providers

7.84 There are a number of private companies which provide assistance in helping rural and remote communities move their health services online.

7.85 *Med-E-Serv*, formed in 1994, is an Internet healthcare community for healthcare professionals with over 22 000 Australasian health professionals and numerous colleges, societies and health organisations registered on its user base. It claims to have delivered over 200 successful programs to the online health community, including developing and implementing web-based solutions, distance professional education, web-enabled data collection and overall solutions for health care suppliers.[46]

7.86 There is also a wide variety of discipline specific 'tele' projects operating out of universities and colleges across Australia. A link between Norfolk Island and any one of these schemes would have the potential to enhance e-health services to the Island community. A combination of services could be used in conjunction with facilities and infrastructure already in operation on the Island.

7.87 The Royal Flying Doctor Service offers telemedicine facilities as part of its contractual agreement for the provision of health services to remote and rural areas.[47] The RFDS proposal for services to Norfolk Island, discussed in Chapter 6, includes implementation and development of telemedicine as well as the advantages of its strong links with the University Departments for Rural Health (UDRH), Colleges and tertiary hospitals.

7.88 The use of health information in the promotion of community awareness forms an important part of calls by Norfolk Island health professionals to shift the emphasis of health care on the Island away from acute care to preventative and primary care. Norfolk Islanders should be encouraged to take ownership of their health treatment by accessing the wide range of health related information services available through the Internet. In turn, the Norfolk Island Government should encourage its residents to become part of the e-revolution transforming the provision of health services.

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45 Mr Geoffrey Gardner MLA, Transcript, p. 15.

46 www.medeserv.com.au

47 Royal Flying Doctor Service, Submissions, p. 189.

Recommendations

Recommendation 28

7.89 **The Committee recommends that the Norfolk Island Government investigate opportunities for expanding its e-health potential by:**

- **becoming involved in nation-wide collaborative consultations, such as *Health Online: A Health Information Action Plan for Australia*, regarding standards and guidelines for the implementation of e-health across Australia; and**
- **establishing links with a state-based e-health network.**

Recommendation 29

7.90 **The Committee recommends that the Norfolk Island Government, in conjunction with community groups on the Island such as the Community Health Awareness Team, make available computer facilities to allow residents on the Island to access information on health services.**

Recommendation 30

7.91 **The Committee recommends that all health staff at the Norfolk Island Hospital receive education and practical training in e-health technologies.**

8

Healthcare or Medicare?

8.1 This chapter looks at the background to the move away from Medicare and the setting up of Healthcare by the Norfolk Island Government, in the context of its quest in the 1980s for full responsibility for public health matters. It describes the health insurance situation as it now exists and makes comparisons between health cover on Norfolk Island and the mainland. It also describes various options for an alternative system of providing health cover, including reintroducing Medicare in some form. Equity issues relating to Healthcare are discussed in Chapter 4.

The move away from Medicare

8.2 At the commencement of the *Norfolk Island Act 1979* health was a function retained by the Commonwealth. When Medicare began in 1984 the inhabitants of Norfolk Island were not eligible under the newly amended definition of 'Australian resident' in the *Health Insurance Act 1973*. However, an order under subsection 6(1) of the Act made visitors entitled to stay more than six months eligible for Medicare, which meant that most Norfolk Islanders were eligible for Medicare on the mainland. A new section of the Act meant that benefits were also payable for medical, although not hospital, services rendered overseas, which included Norfolk Island.

8.3 In the mid-1980s, as part of a drive towards self-government, the Norfolk Island Government sought further legislative and executive powers, including full responsibility for public health matters.

8.4 Subsequent negotiations between the Commonwealth and Norfolk Island Governments resulted in a Memorandum of Understanding, under which mainland visitors would be eligible for free hospital treatment on Norfolk Island, and Island residents would be eligible for free medical care on the mainland under Medicare.

8.5 However, as it was found that Norfolk Island residents made far greater use of Medicare than visitors did of the health care facilities on Norfolk Island, the proposal for reciprocal health care did not proceed. In March 1988 Commonwealth health authorities advised that an agreement for reciprocal health care could only be contemplated where there were negligible costs to the Budget, comparability of health care systems and equality of access.[1]

8.6 Later in that year changes were made to Medicare eligibility and entitlement. Norfolk Island was deemed not to be a part of Australia for the purpose of the *Health Insurance Act 1973*, which meant that residents of the Island would not be eligible for access to Medicare from as from 1 January 1989. Key amendments to the Act included:

- restricting access to Medicare to persons with a legal entitlement to reside permanently on the mainland, and who actually lived there;
- excluding from Medicare Australian citizens living abroad from January 1989 (except those from countries with reciprocal agreements); and
- withdrawing Medicare benefits for medical services rendered overseas (including Norfolk Island).

8.7 To allow time for the Norfolk Island Government to make arrangements for an alternative health insurance scheme, the Commonwealth agreed to delay the effect of the legislative change until 30 September 1989, effecting this through a temporary Ministerial Order under subsection 6(1) of the Act.

8.8 A package of Norfolk Island legislation to establish the Norfolk Island healthcare scheme was assented to on 19 December 1989. Since that time Norfolk Island has had its own health care system. It is not known how the original costing of providing a health service was calculated, but for the health insurance scheme, the predicted annual cost was simply divided by the number of people on the Island, to produce an annual levy of $260 per adult.

8.9 A referendum conducted in 1989 by the Norfolk Island Government on the question ‘Do you support the Healthcare scheme?’ had a seventy per cent affirmative vote. The Department of Transport and Regional Services informed the Committee that residents supporting the ‘yes’ case argued that there was a need for a scheme to cover catastrophic medical costs with no upper limit which private health insurance might impose. Residents supporting the ‘no’ case argued against the compulsory nature

1 Department of Transport and Regional Services, Submissions, p. 91.

of the scheme, the fact that elderly and infirm residents could not afford both their existing private cover and the compulsory scheme and that if the scheme failed or was discontinued they would be unable to obtain suitable private cover.

8.10 The House of Representatives Standing Committee on Legal and Constitutional Affairs recommended in its 1991 report, *Islands in the Sun – Legal Regimes of Australia's External Territories and the Jervis Bay Territory*, that the scheme be evaluated by the Commonwealth in the future to ensure the adequacy of health care provisions on Norfolk Island.

8.11 The Commonwealth Grants Commission inquiry concluded in 1997 that health insurance on Norfolk Island was being provided at well below mainland standards. It noted the lack of reciprocity between the Norfolk Island and Commonwealth Governments, the problems that this caused for both Norfolk Island residents visiting the mainland and mainlanders visiting Norfolk Island, and regretted that discussions between the two governments to overcome the deficiencies had come to nothing:

> We believe that negotiations should recommence as a matter of urgency. They should consider how the service can be improved, which government is best placed to provide it (either itself or under contract with the other government) and how the costs should be shared.[2]

8.12 The Grants Commission also commented on the advantages of national objectives for certain services which, on the mainland, ensure that the state governments address the provision of minimum standards of service for some groups in society, particularly the disadvantaged.[3]

The health insurance situation today

8.13 The annual Norfolk Island Healthcare levy is now $500 per person, with a maximum payment of $1000 per nuclear family. Membership is compulsory for all people over eighteen years of age, including those on Temporary Entry Permits who express an intention to reside on the Island for more than 120 days. Approximately 300 non-residents working or staying on Norfolk Island, while covered by the Healthcare scheme, must also provide Norfolk Island immigration authorities with evidence of adequate health cover under private health insurance or Medicare for expenses not covered by Healthcare. The only exemptions are for those who receive a Norfolk Island or Veterans' Affairs pension, those who can

2 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, pp. 210-211.

3 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 210.

show that they have sufficient private insurance and those who have earned less than $3500 in the six months preceding a levy payment date.

8.14 The Healthcare scheme is intended to meet 'catastrophic' medical costs. Reimbursement is only made when approved medical expenses exceed $2500 for a nuclear family in a financial year. The Commonwealth Grants Commission noted that, including the cost of non-allowable items, a family might spend more than twice this amount before being eligible for reimbursement. The DOTRS submission to this inquiry advised the Committee that the Norfolk Island Government's own projections in 1996 showed that Healthcare normally pays a maximum of $1800 out of every $3000 spent by a member on medical services.[4]

8.15 Approved costs include hospital, medical and outpatient treatment and diagnostic, laboratory and specialist services on Norfolk Island, hospital and medical treatment on the mainland or in New Zealand when referred by an Island doctor, pharmaceuticals, optometry, medical appliances, and various services such as physiotherapy up to a limit of $200 a year. There is no cover for dental costs, speech and occupational therapy and cosmetic surgery. In addition, the scheme does not cover treatment outside Norfolk Island without a referral from an Island doctor, accidents or illnesses that started outside Norfolk Island, and pre-existing conditions for five years after joining Healthcare. The scheme reimburses only $200 per year of the cost of travel to the mainland for treatment.

8.16 Submissions to the Commonwealth Grants Commission were critical of guidelines issued by the Executive Member on the circumstances in which the doctors should provide referrals for offshore treatment. The Commission argued that decisions should be the sole responsibility of the medical officer, that the guidelines were too restrictive and that their primary aim was to limit the expenses of the Healthcare scheme.[5]

8.17 The submission from the Norfolk Island Hospital Staff Association to this inquiry also commented that the system of providing referrals needed reviewing, including making it more 'user friendly'.[6] The Committee believes that all decisions should be made by medical staff, to allow for the best medical outcome for the patient. If this policy is not adhered to, the Norfolk Island Hospital Enterprise, and ultimately the Norfolk Island Government, will become vulnerable to legal action.

8.18 Medicare is available, legitimately, in several ways, which allows some of the financial burden of health service provision to be passed on to the

4 Department of Transport and Regional Services, Submissions, p. 76.

5 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 90.

6 Norfolk Island Hospital Staff Association, Submissions, p. 33.

Medicare system.[7] People who move to Norfolk Island to live remain eligible for treatment on the mainland for five years. Residents who undertake full-time study on the mainland are also eligible for a Medicare card. Residents who develop conditions requiring expensive or specialist treatment not available on Norfolk Island can legally access Medicare by exercising their right to reside on the mainland. To obtain a Medicare card they would have to establish residence through appropriate documentation.[8]

8.19 The Australian Taxation Office advised that for Medicare levy purposes, residents of Norfolk Island are not treated as residents of Australia. The *Income Tax Assessment Act 1936* provides that a Medicare levy shall be paid by an individual who is a resident of Australia at any time during the income year, based on their taxable income. An Australian citizen, resident on Norfolk Island, is not liable for the Medicare levy. The test for residency for Medicare levy purposes differs from the test for Medicare benefit entitlement, which is a matter for the Health Insurance Commission.[9]

8.20 DOTRS referred to anecdotal evidence that some Norfolk Island residents possess Medicare cards which they use to claim benefits for mainland medical services and pharmaceuticals to which they are not entitled.[10] Such evidence suggests that misuse is widespread. However, the Committee has neither the requirement nor the resources to quantify it.

8.21 The Department of Health and Aged Care noted that some residents of Norfolk Island who no longer reside in mainland Australia continue to have legitimate access to Medicare by virtue of a Ministerial Order (which ceases to have effect on 31 December 2003) under the Health Insurance Act. This allows Australian citizens who are absent from Australia to access Medicare for any return visits for up to five years from the date they were last resident for Medicare purposes. Residents eligible for Medicare under the Ministerial Order are generally not liable for the Medicare levy, regardless of their ability to access the Medicare arrangements or their level of income.[11]

8.22 Other witnesses raised concerns that Australian citizens may pay taxes on the mainland during their working lives and then not be able to access Medicare when they retire to Norfolk Island. This category of residents is likely to continue to expand since the rules for General Entry Permits were

7 Department of Transport and Regional Services, Submissions, p. 82.

8 Department of Transport and Regional Services, Submissions, p. 82.

9 Australian Taxation Office, Submissions, p. 141.

10 Department of Transport and Regional Services, Submissions, p. 82.

11 Department of Health and Aged Care, Submissions, p. 117.

modified in 1996 to allow people with sufficient financial backing to retire to Norfolk Island. The Legislative Assembly sets a variable quota, which in 2000 was 45 and in 2001 is ten.

8.23 Such a large increase in a generally older age bracket, if sustained, could have a profound impact on Norfolk Island's health system in the future, as well as result in an increasing number of former and continuing Commonwealth taxpayers who have no access to Medicare. The Norfolk Island Government estimated that the number of Temporary Entry Permit holders and General Entry Permit holders who may be eligible for Medicare benefits, having been absent from Australia for less than five years, would constitute twenty per cent of the community. A conservative estimate of Commonwealth superannuants on the Island and others contributing to the taxation system in Australia was 100 individuals, which equates to another five per cent.[12]

Case Study – Mr Russell Beadman [13]

Mr Beadman, a retired Commonwealth public servant who paid taxes and contributed to a government superannuation fund throughout his working life, has been a resident of Norfolk Island since 1986. Despite his many years of paying Commonwealth income tax (he still pays it on his superannuation pension), he and his wife are not eligible for Medicare benefits for any services either on the Island or the mainland.

If it were not for his recently acquired DVA Gold Card he would be liable for the Island's $500 Healthcare levy and all medical expenses up to $2500, which is the situation for his wife. Both also contribute to a private health insurance fund on the mainland that will no longer cover them fully for hospitalisation costs on Norfolk Island or for doctors' services on the mainland. Without the DVA entitlement, Mr Beadman and his wife would be paying about $4500 a year for less than adequate health insurance.

Mr Beadman believes that as a taxpayer he should be covered by Medicare, and also be able to claim the thirty per cent health rebate on mainland taxation for which a Medicare card number is needed. Although retired for nearly twenty years, Mr Beadman expressed his willingness to pay the 1.5 per cent Medicare levy if it would enable his wife to have access to Medicare.

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

13 Mr Russell Beadman, Transcript, pp. 80-86.

8.24 The experience of another witness demonstrates the possibly negative impact on the Island's main industry of the present health insurance situation. A mainland health fund would not provide cover for a visit to Norfolk Island, despite membership of approximately fifty years. When cover was sought with two other insurance companies one declined and the second offered limited cover excluding any pre-existing conditions. As a result the proposed seven day visit to Norfolk Island did not take place.[14] The inability to find travel insurance to cover pre-existing health conditions is a common experience for older tourists who, in the case of Norfolk Island, form by far the largest category.

Healthcare and Medicare – some comparisons

8.25 The Commonwealth Grants Commission made a useful comparison between conditions and cover provided by Medicare and the Pharmaceutical Benefits Scheme (PBS) and the Norfolk Island Healthcare Scheme. Under Healthcare:

- claims for reimbursement can only be made when approved medical costs exceed $2500. Under Medicare and PBS, no minimum expenditure threshold applies to claims;
- all residents 18 years and over must contribute to the scheme, unless they are pensioners, have sufficient private health insurance or earned less than $3500 in the six months before a levy day. The figure for a couple is $7000, notwithstanding that there may be only one income earner. Under Medicare, only taxpayers contribute to the scheme;
- the annual levy is a flat rate of $500. Medicare is indexed to income, with the levy generally 1.5 per cent on incomes over $13 550. On the mainland a person's taxable income would need to be approximately $33 000 a year before their Medicare levy equalled that imposed by the Norfolk Island scheme;
- residents who return to the Island and must rejoin the scheme are not covered for any pre-existing illness or injury for five years. Under Medicare, residents who return after being elsewhere for less than five years are immediately covered for pre-existing conditions. Those who return after *more* than five years overseas and state their intention to reside in mainland Australia are also immediately covered for pre-existing conditions.

14 Mrs M Baguley, Submissions, p. 67.

8.26 Medicare levy revenue covers only a small proportion of Commonwealth and State/Territory health expenditure, with income tax and other revenue contributing the rest.[15]

8.27 The Norfolk Island Minister for Health advised in November 1999 that a review was being undertaken of the Healthcare Scheme by the insurance assessor who was instrumental in establishing the scheme originally.[16] The review was to examine problems that have arisen and to propose strategies to address them. The Committee is not aware if the review has been finalised at this stage.

8.28 The Commonwealth Grants Commission calculated that the Healthcare levy represents a revenue raising effort above that on the mainland, primarily because nearly everyone is liable, even Temporary Entry Permit holders. People who receive Norfolk Island pensions are well catered for because their total medical costs, including airfares, are covered.[17] However, for other residents, the Commission concluded that the Healthcare scheme imposes a much greater proportion of total health costs on users than does Medicare.

8.29 Some residents take out private health insurance, particularly with the New Zealand insurer, Southern Cross, to cover the $2 500 gap, at a cost of $48 per person or $96 per family per month. DOTRS considered that if ten per cent of the population had trouble paying the Healthcare levy, it was reasonable to expect that a greater proportion would experience difficulty in also paying private health insurance premiums. The higher cost of living on Norfolk Island might also act as a disincentive.[18] Household expenditure surveys indicate that health and medical costs on the Island are approximately fifty per cent higher than in New South Wales.[19]

8.30 One witness advised that while his wife, Norfolk Island born and educated and an Australian taxpayer for over forty years, was able to access her Commonwealth age pension while living on Norfolk Island, the high cost of medical attention there, particularly medicines, had resulted in her living on the mainland where she is entitled to Medicare cover.[20]

8.31 The Commission reported that during its conferences on Norfolk Island many individuals had made statements that they would prefer to pay the mainland Medicare levy and receive Medicare benefits, rather than remain

15 Department of Health and Aged Care, Submissions, p. 117.

16 Mr Geoffrey Gardner MLA, Transcript, p. 7.

17 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 94.

18 Department of Transport and Regional Services, Submissions, p. 76.

19 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p.94.

20 Mr Ernie Friend, Submissions, pp. 55-57.

in the Norfolk Island Healthcare scheme.[21] The Committee also found that there were many people who would like to return to the protective umbrella of Medicare.

8.32 Dr Fletcher commented in an early submission to the inquiry:

> Another suggestion … is that Norfolk Islanders give up the idea of thinking that they can "go it alone", pay the standard 1.5% Medicare Levy per person to Australia, and get full public Medicare benefits like their Aussie cousins.[22]

8.33 The Hospital Director observed that there would be a number of benefits to being associated with Medicare that were not immediately obvious, including simple things such as access to standardised administrative forms. She observed that current health insurance schemes do not provide the health system with any associated benefits such as access to services such as a pharmaceutical benefits scheme or continuing medical education.

8.34 She said that there had never been any kind of health forum on Norfolk Island to gauge community opinion about access to Medicare.

> The Medicare system as such has not been fully debated at a community level. Until there is a fulsome discussion on the proposed options and its associated benefits then an educated response cannot be sought.[23]

8.35 The idea of a health insurance levy on all visitors which, in the absence of access to Medicare, would provide them with free, quality health services on Norfolk Island, was put to the Committee by hospital staff during a meeting in March 2001. It was also mentioned in the submission by the Hospital Director.[24] This suggestion is examined in Chapter 3.

Should Medicare be available to residents?

8.36 The Department of Transport and Regional Services advised that in response to representations from Norfolk Island residents and others in relation to perceived shortcomings of the public health services provided on Norfolk Island, the Minister for Regional Services, Territories and Local Government and the Minister for Health and Aged Care had agreed to encourage the exploration of options for extending Medicare benefits to

21 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 95.

22 Dr Lloyd Fletcher, Submissions, p. 205.

23 Ms Christine Sullivan, Submissions, p. 196.

24 Ms Christine Sullivan, Submissions, p. 196.

Norfolk Island. Members of both departments have been discussing the issues. There are also discussions between officers of DOTRS and the Norfolk Island Government.[25] Health issues were also discussed at the Commonwealth / Norfolk Island Inter-Governmental meetings in August 1999 and June 2000.

8.37 The Department of Health and Aged Care submission also referred to separate discussions with both the Administrator of Norfolk Island and representatives of DOTRS regarding the possibility of providing a Medicare-equivalent health service to Norfolk Island residents. Options identified range from full cost recovery by the Commonwealth for Medicare and PBS usage,[26] to the Norfolk Island Government purchasing an insurance policy from a private insurer for comprehensive private health cover for all residents.[27] The then Norfolk Island Minister for Health told the Committee that it was impossible to find a private insurer who would do this for an acceptable premium.[28]

8.38 An alternative might be found in Mr Gardner's suggestions for a commercial Medicare option. In this case the Commonwealth would take the role of a private insurer.

8.39 However, calculating costs would remain problematical without data on residents' incomes. Mr Gardner calculated a figure based roughly on estimates of the average income on the mainland, arriving at a cost of between $4000 and $5000 per year per average income earner. This figure was exclusive of infrastructure costs, PBS benefits, assisted travel and other benefits.[29] Although such a figure appears to be beyond the present means of the Norfolk Island Government, the concept is worth exploring. Many different factors would need to be taken into account which might result in quite different figures.

8.40 The Commonwealth Grants Commission anticipated such an option:

> The Commonwealth might be thought to have the expertise and resources to provide … health insurance more easily and cheaply than does the Norfolk Island Government … Some revenue

25 Department of Transport and Regional Services, Submissions, p. 95.

26 The Department of Health and Aged Care has sought to clarify the number and identity of residents on Norfolk Island who would require access to MBS and PBS, in order to assess the costs of the Medicare option. To date, the Department has not received adequate data from the Norfolk Island Government.

27 Department of Health and Aged Care, Submissions, p. 117.

28 Mr Geoffrey Gardner MLA, Transcript, p. 11.

29 Mr Geoffrey Gardner MLA, Transcript, p. 8.

> source, say departure tax, may need to accompany the transfer of them to the Commonwealth.[30]

8.41 An alternative option from the Grants Commission left more control in the hands of the Norfolk Island Government:

> it might be concluded that, while the services would be best delivered by the Commonwealth, Norfolk Island should maintain responsibility for them and contract with the Commonwealth for their delivery at appropriate standards. In that case, no revenue source would need to be transferred, but a reasonable contract price, based on marginal costing and recognising the joint interest of the Commonwealth and the Norfolk Island Government, would need to be negotiated. Such arrangements might require additional [Norfolk Island] taxation to finance them.[31]

8.42 In its submission to this inquiry DOTRS put forward the following three options for the provision of health insurance:

1. The Norfolk Island Government retains sole responsibility for providing health insurance.
2. The Commonwealth provides health services to Norfolk Island.
3. The Commonwealth charges the Norfolk Island Government for health services provided on the mainland to Norfolk Island residents.[32]

Options proposed by the Commonwealth

1. The Norfolk Island Government retains sole responsibility for providing health insurance.

8.43 Under this option the Norfolk Island Government would continue to provide health insurance cover through the Healthcare scheme, raising $750 000 a year from levies (i.e. $500 per member x 1500 members) and contributing an increasingly large annual subsidy from the Revenue Fund.

8.44 Even to sustain the current level of health services the Norfolk Island Government will have to increase its revenue-raising efforts, a fact acknowledged by the Minister for Health.[33] Measures that might be employed to achieve this are examined in Chapter 9.

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30 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 215.

31 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 215.

32 Department of Transport and Regional Services, Submissions, pp. 83-85.

33 Mr Geoffrey Gardner MLA, Transcript, p. 12.

8.45 The advantage of this option to the Norfolk Island Government is that it would retain responsibility for health without financial contributions from the Commonwealth.

8.46 The disadvantage is that Norfolk Island's health system would continue to differ from that on the mainland, visitors would still lack appropriate health cover for services rendered on the island and the inadequacies and inequalities of the current Healthcare Scheme might not be addressed.

2. The Commonwealth provides health services to Norfolk Island.

8.47 Under this option the Commonwealth Government would provide health care grants to the Norfolk Island Government, and Medicare cards to Norfolk Island residents for use on the Island and on the mainland. Grants which are currently provided to all mainland states and territories for public hospital services equate to approximately $300 per person. Australia's other inhabited external territories are included in the healthcare grants scheme, which deems them to be part of Western Australia. A different funding formula might be needed for Norfolk Island in the light of its small population.

8.48 Residents could contribute to Medicare by paying a levy to the Commonwealth instead of the current Healthcare Scheme. To avoid a shortfall, such a levy would need to be calculated to allow for the fact that significant Commonwealth funds raised from other taxes are also directed to the states and territories.

8.49 A potential obstacle to this course might be resistance from Islanders reluctant to disclose their income. However, an alternative would be for Medicare to be optional, and available for those willing to pay the levy. The Department of Health and Aged Care advised that the cost of this option to the Commonwealth would be approximately $2.2 million, based on the population profile revealed in the 1996 census.[34]

8.50 Norfolk Island could also negotiate reciprocal charging arrangements with the states and territories, allowing it to charge the home state of a tourist for services rendered on Norfolk Island, and in turn being billed by mainland states for treatment provided to Norfolk Island residents.

8.51 The advantage of this option would be that Norfolk Island would be provided with mainland equivalents of health services and health insurance. This option would benefit residents and tourists alike.

8.52 Anecdotal evidence suggests there are many residents who would prefer this option but are reluctant to speak openly in favour of it.

34 Department of Transport and Regional Services, Submissions, p. 85.

3. The Commonwealth charges the Norfolk Island Government for health services provided on the mainland to Norfolk Island residents.

8.53 Under this option the Commonwealth would provide flagged Medicare cards to all Australian Norfolk Island residents and then bill the Norfolk Island Government for health services provided by the Commonwealth. The Norfolk Island Government could recoup this money either by maintaining the Healthcare Scheme or by charging individuals for services rendered on the mainland.

8.54 As with option 2, Norfolk Island could also be included in mainland reciprocal charging arrangements. The Committee believes that New Zealand residents would be eligible for Medicare benefits, as they are on the mainland, due to the reciprocal arrangement that exists between the Australian and New Zealand Governments.

Options proposed by the Norfolk Island Government

8.55 Several options have been put forward by Norfolk Island Government. At the hearing on Norfolk Island, the then Norfolk Island Minister for Health, Mr Geoffrey Gardner MLA, commented that:

> As with Medicare itself, our scheme is seen by some to be imperfect, hence the need for us to try to explore the options available.[35]

8.56 One of those options was the complete privatisation of health insurance on the Island. In this way, Mr Gardner explained, Norfolk Island would revert to a similar arrangement to that which existed prior to 1989, when Southern Cross, a New Zealand insurance company, provided a level of comprehensive health cover to mainly New Zealand citizen residents. At that time, Australian citizens were covered by Medicare.

8.57 Mr Gardner outlined another option which was to pursue Medicare purely on a commercial basis. He said:

> I think I need to make it quite clear here that the Norfolk Island Government is not seeking a handout for its residents.[36]

8.58 The issue of inability to calculate residents' income was raised as significant in terms of formulating options for the provision of Medicare on Norfolk Island.

8.59 The Norfolk Island Government's submission referred to discussions at the 1999 Inter-Governmental meeting on the option of Norfolk Island

35 Mr Geoffrey Gardner MLA, Transcript, p. 7.

36 Mr Geoffrey Gardner MLA, Transcript, p. 7.

contributing an amount towards the cost of Medicare so that residents were eligible for Medicare cover for treatment on the mainland, as well as the possibility of mainland visitors being covered by Medicare for services received on Norfolk Island. Again, it commented that:

> it is not possible to apply the Medicare levy to residents income as many residents are not required to determine their taxable income or lodge income tax returns.[37]

8.60 The absence of such information makes much more difficult the task the Norfolk Island Government has ahead of it in identifying alternative sources of revenue as well as funding an acceptable form of public health insurance. The CGC Report commented that one benefit to Norfolk Island, if it were to increase revenue through a new tax structure, might be that it generated this kind of information through returns to the Norfolk Island Government.[38]

8.61 The Committee considers that the issue of health insurance is of such fundamental importance to the people of Norfolk Island that it should be raised and thoroughly discussed at well advertised public meetings on the Island. Input from people who work within the Hospital Enterprise as well as that of valued outsiders, such as the visiting specialists, should be sought in an effort to educate the community in order that an informed response to the many options is available. It is not an issue which can be left to the discretion of the Executive Member of the Assembly. The Committee concurs with the Commonwealth Grants Commission's 1997 finding that negotiations between the Norfolk Island Government and the Commonwealth over issues of service standards and provision, cost sharing and reciprocity should recommence as a matter of urgency.

37 Government of Norfolk Island, Submissions, p. 7.

38 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 212.

Recommendations

Recommendation 31

8.62 **The Committee recommends that the Norfolk Island Government and the Commonwealth continue discussions of the most practicable method of providing Norfolk Island residents with an affordable, comprehensive level of health insurance.**

The Committee also recommends that the Norfolk Island Government organise a series of public meetings to offer information, and seek community input, on whether to pursue Medicare or another form of comprehensive health insurance as an alternative to Healthcare.

Recommendation 32

8.63 **The Committee recommends that the Commonwealth Government extend Medicare cover to:**

- **those Australian citizens resident on Norfolk Island whose income is below the Australian taxable income limit of $13 550, so that they are entitled to the same access to Medicare as mainland residents who are not liable to pay the Medicare levy;**
- **retired residents of Norfolk Island aged 55 years and above, who have paid income tax on the mainland for a period of at least five years; and**
- **Temporary Entry Permit holders, resident on the Island for less than six months, who would be eligible for Medicare benefits elsewhere in Australia.**

Recommendation 33

8.64 **The Committee recommends that the Norfolk Island Government announce the findings of its review of the Healthcare Scheme in order that residents may consider them, and determine whether Healthcare is a feasible health insurance option for the community.**

9

Funding

The present situation

9.1 The Commonwealth Grants Commission concluded in 1997 that the Norfolk Island Government had the financial capacity to meet the obligations associated with its existing government functions, in terms of both service provision and infrastructure requirements. It noted, however, that some services were not being provided at appropriate levels and that some infrastructure was in poor condition:

> The Norfolk Island Government is not raising sufficient revenue to deal with these deficiencies, though the capacity to do so is clearly available.[1]

9.2 The Grants Commission's investigations led it to conclude that the Norfolk Island Government would have to increase its total revenue collection by at least sixty per cent before the Island's population would be contributing more to the provision of government services than people on the mainland. However, it could not achieve this unless:

> tax revenues (and charges) were increased and administrative capacity and efficiency improved. Community commitment would be required to achieve both objectives.[2]

9.3 The Grants Commission concluded that:

> Successive Norfolk Island Governments have kept the level of taxes low, resulting in low levels of services and expenditure on infrastructure.[3]

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1 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 218.
2 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 213.
3 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 174.

9.4 The low revenue performance is the result of the narrower range of taxes and charges imposed on the Island and the fact that a number of tax bases are not used at all. Where the Norfolk Island Government does impose taxes the rates are high. The CGC Report commented that 'the Norfolk Island Government accesses the financial capacity available to it at greater than mainland severity'.[4] However, with very limited taxation imposts on income and wealth, the tax regime is regressive.[5] The CGC calculated that the introduction of progressive income tax to replace the Customs Duty would result in many people on Norfolk Island paying less tax.[6]

9.5 The CGC report referred to suggestions by some Norfolk Islanders that the community prefers a lower level of government service provision and a large voluntary effort. The Commission concluded that it could not be sure there was a community preference for this 'voluntary taxation'.[7] The Committee has gained the impression throughout this inquiry that most Islanders would prefer a service as fundamental as health provision to be reliably and adequately funded by government. It is unreasonable and inequitable to expect a hard core of dedicated volunteers to provide essential services for the whole community.

9.6 The reliance on narrowly based indirect taxes and income from government business enterprises means that revenue growth depends on increased expenditure, primarily by tourists. This leaves the economy vulnerable to fluctuations in the tourist industry.[8]

9.7 The CGC expressed concern that some taxes are levied on an honesty basis, without any check to determine compliance. Taxes are generally more mobile than on the mainland. For instance, modern communication and banking enable Norfolk Island businesses to bank 'outside'. A 37 per cent fall in the level of transactions attracting the Island's Financial Institutions Levy accompanied a four fold increase in the levy in 1990.[9] The CGC concluded that most of the decline in this tax base must be assumed to be due to tax minimisation, and that 'it would be naïve to believe that other taxes were not being minimised or avoided'.[10]

9.8 The Norfolk Island Government is not at present raising sufficient income to pay for major capital works in the health area, such as a new hospital. The CGC found in 1997 that the hospital building and equipment were

4 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 156.
5 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 164.
6 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 163.
7 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 143.
8 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 163.
9 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 161.
10 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 162.

below standard, mainly because of their age, and that there was a narrower range of community health services, particularly health prevention programs, than in small remote communities on the mainland. It also found that the health insurance scheme operated by the Norfolk Island Government was at a much lower and 'inappropriate' level, which was of particular concern to the less well off.

9.9 The situation with regard to health services and infrastructure has changed little, and in the intervening years since the CGC Report was released Norfolk Island's health facilities have become more outdated, while people's health care expectations both on Norfolk Island and on the mainland have continued to rise. There is an increasing gap between the services that people on the mainland take for granted and those available on Norfolk Island.

9.10 Health care on the Island is provided through the Norfolk Island Hospital Enterprise, a statutory authority which operates at a loss. The Hospital Enterprise received a government subsidy of $495 000 in 1998-99, without which it would have faced a loss of $395 495 for that financial year. This operating result is more disturbing when the surplus of $184 956 contributed by the hospital pharmacy is taken into consideration.[11]

9.11 The Commonwealth Grants Commission reported that the Hospital does not refuse the provision of services to those in need, even if this results in bad debts:

> Because of the high medical costs involved and the low income of many of the locals, this policy has contributed to the accumulation of debts, which totalled over $300,000 early in 1997 but had been reduced to about $180,000 by July.[12]

Many of the long-term patients in the Hospital are veterans or Hospital and Medical Assistance (HMA) patients who receive free or subsidised health care.[13]

Forward planning

9.12 The Hospital's deficit requires increasing subsidies from the Island's government each year, and there does not appear to be any forward planning for the provision of funding for capital works. The Department of Transport and Regional Services referred in its submission to various

11 Department of Transport and Regional Services, Submissions, p. 81.

12 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 86.

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

independent studies, as well as Norfolk Island Assembly budget debates, that have identified a lack of forward planning for the replacement of Norfolk Island's infrastructure.[14]

9.13 The CGC Report noted that:

> The requirement of balanced budgets can cause the postponement of necessary capital expenditure until sufficient funds have been accumulated from recurrent revenue sources and dividends paid by GBEs (government business enterprises).[15]

The report's Main Findings section concluded that 'a system of forward estimates would facilitate long term planning of recurrent and capital needs and cash flows'.[16]

9.14 The report by John Howard and Associates in 1998 observed that:

> there is no forward planning to identify and schedule key capital works, either renewals or replacements. There is no framework for prioritising between competing future capital works projects. There is no mechanism to ensure and plan for the funding of future capital work commitments. The result is that popular and 'easy' options get funded, while urgent projects with significant multi-year costs find it difficult to obtain the necessary commitment.[17]

9.15 The RSL report commented on the implications of lack of long term planning at the Hospital, describing how limited funds had been spent creating a pleasant birthing/family support area which, based on 1996-1997 figures, would only be used for 70 days a year. It noted that demand for aged care can only increase and that most of the aged people in the 'less than optimal' accommodation at the hospital would be living there for the rest of their lives.

> So although the obstetric redevelopment is a worthy objective and achievement, perhaps in hindsight and with some appropriate health care planning and given a limited pool of funds, the money may have been better spent on the aged care section of the hospital.[18]

9.16 The development and launch of the implementation plan which the Norfolk Island Government has contracted with the Griffith University

14 Department of Transport and Regional Services, Submissions, p. 81.

15 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 203.

16 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. xvi.

17 John Howard & Associates, *Norfolk Island Administration – Strategic Review*, April 1998, p. 112.

18 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 34.

team should provide the necessary impetus to enable the Government to adopt the policy and practice of forward planning in the area of health.

9.17 The Grants Commission observed that while the Norfolk Island Government would have to spend large amounts on community facilities, including the hospital and aged care facilities, the costs would be within the financial capacity of the government. It also observed that:

> while it is probable that Norfolk could raise sufficient recurrent revenue to fund infrastructure requirements, the use of loans might, on occasions, be beneficial to more timely service provision and cash flow management.[19]

The use of private investment might provide a similar benefit.

Existing funding sources

1. Fee recovery and subsidies

9.18 The present system of funding for the Hospital depends mainly on patients' fees and an annual subsidy from the Norfolk Island Government. Profits from the sale of medicines, and private fundraising contribute smaller amounts. This arrangement, which requires an unpredictable subsidy from general revenue to cover the deficit, is inadequate, and fails to provide a basis for forward planning. Not surprisingly, indications are that the predicted increase in demand for services will require an increasing financial input from the Norfolk Island Government. The Grants Commission was of the view that the Norfolk Island Government would face increased expenditure in the future, even if there were no change in the standard of health service.[20]

9.19 The problems associated with the dependency on fee recovery for a major part of the hospital's funding are becoming increasingly obvious. Modern medical practice aims to reduce both the number of hospital admissions and lengthy stays. As the number of inpatients decreases, and the length-of-stay figures also decrease, the hospital's revenue will inevitably decline. The Grants Commission also noted that a fall in occupation rates in recent years due to the deaths of long-term elderly patients was reflected in the fall in fee income.[21]

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19 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 214.

20 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 168.

21 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 86.

9.20 Coupled with this decline in income is the fact that the hospital, which does not refuse service to anyone, experiences a high level of bad debts. The Norfolk Island Government's submission to the CGC inquiry in 1997 stated that:

> The Enterprise's dependence on fee collection for the majority of its funding causes cash flow difficulties and makes accurate budgeting for equipment replacement and other capital asset acquisition difficult. Active debt collection procedures are necessary.

9.21 The Committee believes that the Norfolk Island Government should extend its welfare system to allow designated low income earners access to free or subsidised hospital and medical services. This is more humane and ultimately cost effective than billing patients whose records demonstrate that they have genuine difficulty in paying, and then pursuing debt collecting procedures when they default.

9.22 The Government's submission to the CGC further clarified the fundamental flaw in the funding of the hospital:

> The Enterprise faces conflicting goals in terms of its reliance on throughput to fund its activities and the overarching aim of a community health care system to promote practices that will decrease the utilisation of health services. The occupancy rate of the Norfolk Island Hospital Enterprise has decreased by an average 2 patients per day over the past two years. Calculated at $200 / day x 2 x 365, this is broadly equivalent to an income reduction of $146,000 per annum.

2. Profits on medicines?

9.23 The practice of adding mark-ups to medicines already made more expensive by freight and customs charges, in order to make an income which then subsidises the hospital, appears to be an expedient born of a chronic shortage of funding. It acts as a deterrent to good health. The provision of pharmaceuticals on a basis of need, rather than ability to pay, underpins the Pharmaceutical Benefits Fund on the mainland. In the absence of such a scheme there appears an obligation to provide essential medicines at least at cost, if not subsidised. The Committee believes that this is an area of funding which must be examined from a social equity / health viewpoint and changed.

3. Volunteers and community fundraising

9.24 There is a strong tradition of community fundraising for new hospital or medical equipment, as well as of provision of services by volunteers on the Island. These praiseworthy practices were a necessity in former times when Norfolk Island had a subsistence economy, but it is not an appropriate method of funding a health service for a community with increasing expectations in health care and an economy significantly dependent on tourism. 'Voluntary taxation', referred to above, inevitably places a far greater burden of responsibility and obligation on some members of a community than on others.

9.25 Community fundraising efforts, a worthwhile activity in any community, need the coordination and long-term guarantee of projects that comes from government support. For example, approximately $50 000 worth of community fundraising effort for a new hospital lies untouched, awaiting a government decision on whether a new hospital should be part of its health strategy.

9.26 The report on the visit of the NSW state office of the Department of Veterans' Affairs commented that there was little capacity to raise additional funds this way. It also noted that the pool of volunteers was shrinking:

> There is a limited pool of community volunteers, many of whom are ageing, and an increasing demand for their services. The ability to expand the pool of volunteers is limited as many of those in the workforce have additional unpaid commitments, or a second or third job.[22]

9.27 Essential services such as the ambulance service are funded almost entirely through community efforts and operated by volunteers. The difficulty of finding volunteers who can work during business hours has already been noted, as has the impact on aged care of the rapidly increasing participation in the paid workforce of women, the traditional carers.

9.28 Martin Stewart-Weeks, a researcher and consultant on issues of civil society and voluntary association, made useful observations about volunteering in an article 'Nursing that public spirit':

> People respond to a clear task, to training and leadership, to having the proper resources to be effective and to get good feedback. They are willing to commit their time and skills if they

22 Department of Veterans' Affairs, NSW state office, *Report on the visit to Norfolk Island in August 1999*, Exhibit 14, p. 12.

> know what they have to achieve and get a sense of the larger result to which they are contributing.[23]

9.29 He argued that 2001, the International Year of the Volunteer, should be used as a springboard to improve support for volunteering, including internet access, providing greater training for volunteer managers and addressing the issue of Workcover. Governments should recognise the economic contribution of volunteers, and community groups must recruit, retain and reward volunteers far more effectively. In the Norfolk Island context such advice is timely.

9.30 The Committee believes that volunteer work should not be a substitute for government action. For the spirit of volunteering, which has always been such an important part of the Norfolk Island culture, to remain strong and purposeful there is a need for the Norfolk Island Government to acknowledge and support a clear distinction between basic services which government should provide and the added benefits of voluntary effort. Essential services such as the ambulance service are clearly a government responsibility.

Health insurance funding

9.31 The compulsory Healthcare levy is another area of concern. The Committee was told that when the levy was first calculated about ten years ago, a costing was undertaken on the expected cost of the health scheme, and the resulting figure was then simply divided by the number of people in the community. The levy was at first about $250 per year per adult, payable in two six-monthly instalments, but as the health scheme continued to make a deficit, the amount was doubled in 1997 to $500 per year.[24] The Health Care Fund received a government subsidy of $330 000 in 1998-99 without which it would have made a loss of $213 633.[25]

9.32 The levy is inadequate to cover the full cost of meeting claims and inequitable because it is not based on income. The present rate causes hardship to at least ten per cent of those compelled to pay it, and hence is unlikely to be increased it in its present form.[26] An indexed levy, compulsory even for those with private health insurance, would spread the burden more fairly. On a remote island, all residents and visitors are

23 Martin Stewart-Weeks, *The Australian*, 18 October 2000, p. 15.

24 Mr Graeme Donaldson, Transcript, p. 22.

25 Department of Transport and Regional Services, Submissions, p. 81.

26 Department of Transport and Regional Services, Submissions, p. 76.

potential users of the health service, no matter what other private health arrangements they may have.

9.33 Much of the cause of the funding problem, which impacts so heavily on low and average income earners, appears to be the original major miscalculation of the full cost of providing a complete health system. Figures from the last ten years now provide the Norfolk Island Government with a much better indication of the actual cost of health to the Island. The hospital's continuous deficit, the level of bad debts and the government's annual ad hoc subsidy of the hospital, are all strong indications that both the source and level of funding for the system need urgent review.

Alternative sources of funding

9.34 The Committee is aware that the Norfolk Island Government is exploring alternative sources of income. The likelihood of increased revenue from any of the sources known to be under investigation does not appear likely in the short-term. However, the completion of the first stage of the Griffith University study and the need to proceed as soon as practicable with an implementation plan must prompt an urgent examination of existing revenue raising opportunities. DOTRS commented in its submission that:

> any review of health services on Norfolk Island should be accompanied by a review of specific Norfolk Island Government revenue raising initiatives.[27]

9.35 There appears to be a need to consider seriously other options such as imposing new taxes, borrowing, seeking private investment or inviting private philanthropy from the group of very wealthy people who have made Norfolk Island their home. Tapping into existing Commonwealth schemes may also present opportunities for improving health services.

New taxes

9.36 The CGC Report observed that taxes presently levied on Norfolk Island are imposed at high rates by mainland standards, and that raising the rates further could be detrimental to the economy.[28] This would certainly appear to be the case in the health system where the unindexed levy for

27 Department of Transport and Regional Services, Submissions, p. 90.

28 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 212.

health insurance was recently doubled, causing hardship and a high rate of default. The health system places a heavier burden on residents than on their mainland counterparts, as well as placing an excessive burden on tourists, who represent the Island's main industry and source of income.

9.37 Little use is made of taxes on income and wealth, including land. Census data indicate that incomes for most of the population are not high, in comparison with the mainland. However, as the CGC Report pointed out:

> It is generally accepted that between 40 and 80 very wealthy people live on the Island.[29]

9.38 The CGC, in examining whether Norfolk Island's financial capacity could be used by increasing taxes, commented that any new tax structure should:

- not damage the tourist industry;
- not be detrimental to diversification of the economy;
- be equitable so that contributions increased as wealth increased (not the case with the present taxation regime); and
- be designed to keep avoidance to a minimum.

9.39 A consumption tax for instance, with which the Committee agrees, could be partly avoided by the more wealthy members of the community who make some of their purchases off-Island, and

> could also impose a greater percentage tax burden on those who can least afford it.[30]

9.40 Considering the evidence of the Islands' doctors and others on the huge social costs of excessive consumption of alcohol and tobacco, which are available cheaply on Norfolk Island, urgent consideration should be given to increasing their price. An extra charge levied at the point of sale and termed a 'health tax' might go some way towards reducing consumption and the associated health and social costs to the community, as well as providing a new source of income for the health system. It should be possible to devise a method of ensuring that only bona fide travellers have access to duty-free alcohol and tobacco at point of entry and exit.

29 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 25.

30 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 213.

The value of borrowing

9.41 As part of its forward planning the Norfolk Island Government should consider the advantages of modest borrowing. The CGC noted in 1997 that there were no outstanding loans and that borrowing for any purpose had been resisted:

> The balanced budget objective has sometimes been thought to be more important than whether the appropriate levels of services were being provided to the community.[31]

No. 28 of the report's Main Findings was that the 'Norfolk Island Government has an ability to borrow and can afford to do so'.[32]

9.42 The Norfolk Island Government's submission in May 1997 to the CGC made an insightful comment on the requirement of a balanced budget:

> While this is sometimes portrayed as sound economic management such an approach is obviously not without risks. Deferred capital projects and capital replacement can become urgent at inopportune times and economic management can become management by crisis.

9.43 The CGC Report commented on the reluctance of past Norfolk Island governments to borrow money:

> We see little real distinction between setting aside money in the budget for estimated capital expenditure and buying the asset and setting aside the same money as repayments. Deferring capital expenditure would generally result in some cost increases due to the effects of inflation on the price of the new asset and additional maintenance costs of the old one.[33]

9.44 'Traditional thinkers' who are uncomfortable with the idea of borrowing should be encouraged to consider the question of inter-generational equity:

> Borrowing ensures that the present and future populations, which receive the benefits of an asset, share the cost of it.[34]

31 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 202.
32 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. xv.
33 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 180.
34 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 181.

Attracting private investment

9.45 An alternative method of funding major infrastructure replacement is to use the private sector. For instance, the alternative exists of attracting private investment, either complete or partial, to replace the Hospital with a multi-purpose health centre and / or to build an attractive retirement village. This alternative should be mooted during the community consultation process of the new health strategy and implementation plan, in order to gauge local support for the idea. Many different models exist on the mainland, differing in size, design, range of facilities, degree of government control, and in the case of older citizens' facilities, target age groups and level of resident investment. The provision of telehealth facilities and expertise is another area which lends itself to private investment or a joint venture.

Philanthropy

9.46 A tradition of helping others is well established on Norfolk Island. The Committee is aware that in a small community there are numerous instances of private, often unacknowledged, philanthropy. Fostering this is an important task within a small community.

9.47 Philanthropy on a large scale is a feature of many societies. It should be possible to encourage philanthropy on a much larger scale among the group of very wealthy residents who have chosen to live on Norfolk Island. There are many opportunities for the wealthy to contribute voluntarily to the Island's welfare, to help ensure the long-term viability of its unique lifestyle. There is the possibility of endowing scholarships to attract young Islanders into health related careers which they could pursue on the Island. Bequests and legacies are invaluable and should be encouraged. With the anticipated health strategy and implementation plan in place it will become simpler to invite the wealthy to fund a particular project of their choosing, such as a room in the medical centre or a major item of medical equipment.

9.48 The Committee was informed in May 2001 of the possibility of a large bequest towards the cost of replacing the hospital, and trusts that such philanthropy will inspire other wealthy residents to contribute. As with other voluntary effort, it is important that such generosity is not seen as a substitute for funding commitment by the government. Rather, it should prove an impetus towards community action. It should be seen as a demonstration of support by the wealthy for the lifestyle that Norfolk Island offers them.

Commonwealth assistance

9.49 This report and the recommendations it contains have been made on the assumption that expenditure on health services and infrastructure on Norfolk Island will continue to be funded mainly by the Norfolk Island Government. This assumption was also made by the Commonwealth Grants Commission in 1997. It outlined the reasons why Norfolk Island receives much less revenue per capita from the Commonwealth than other Territories, including:

- the expectation of many, both on and off the Island, that Norfolk Island should be self sufficient;
- the degree to which past Norfolk Island Governments have sought independence from Australia rather than reliance on the Commonwealth; and
- the consequent wider powers that the Norfolk Island Government has to raise revenues.[35]

9.50 The Commission's conclusion on the Island's capacity to provide services at appropriate levels was unequivocal:

> Largely because of the wide revenue powers of the Norfolk Island Government, no Commonwealth assistance appears to be justified.[36]

9.51 The Grants Commission acknowledged that while it is ultimately for the Norfolk Island community to decide on the level of services it wants, it believed that:

> its Government's past pursuit of financial self sufficiency (and rejection of specific offers of Commonwealth assistance) has, in our opinion, resulted in lower standards of services and infrastructure than need be.[37]

9.52 The Grants Commission concluded that since the Commonwealth Government has a responsibility to ensure that services are provided to all Australians at appropriate levels, where this is not happening the Commonwealth could be forced to take responsibility for them and also for some revenue powers to pay for them:

> If the Norfolk Island Government were to do nothing to improve its administrative capacity and infrastructure, there would be a

35 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 178.
36 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 213.
37 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 178.

> risk of the Island economy declining, of revenue capacity falling and levels of services deteriorating. The Commonwealth could then be forced to take responsibility for a wider range of service provision and revenue raising for the Island. The level of independence of Norfolk Island would thereby be reduced.[38]

9.53 While acknowledging and commending the interest of the present Norfolk Island Government in improving the health service, the Department of Transport and Regional Services concluded its submission with the observation that:

> If the Norfolk Island Government were to do nothing or was unable to provide services at an appropriate standard, the Commonwealth should consider ways in which it can assist the Island community by extending health services and funding eligibility to the same level available to other Australians.[39]

9.54 The Department noted that the Norfolk Island Government had already expressed a willingness to work with Commonwealth authorities, including the Department of Veterans' Affairs and the Department of Health and Aged Care.[40] The Committee is aware of the enthusiastic reception of DVA expertise and assistance in the area of aged care, and the strong spirit of cooperation that developed between DVA officials and Island volunteers.

9.55 The Committee is hopeful that there will be scope for similar joint ventures with the Department of Health and Aged Care, and would encourage any changes to the determining acts that would allow the Norfolk Island community to access the many valuable health programs and initiatives designed to assist rural and remote communities and available through the Departments on the mainland.

9.56 The DOTRS submission also noted that although the Island is exempt from Commonwealth taxation a large number of current residents have lived and worked on the mainland for significant periods, paying Commonwealth taxes as a result.[41] Commonwealth funding is provided to the Norfolk Island community under a wide range of other programs, such as those operated under the Natural Heritage Trust, despite its exemption from Commonwealth taxation.[42]

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38 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 218.

39 Department of Transport and Regional Services, Submissions, p. 90.

40 Department of Transport and Regional Services, Submissions, p. 81.

41 Department of Transport and Regional Services, Submissions, p. 77.

42 Department of Transport and Regional Services, Submissions, p. 78.

9.57 DOTRS believes that Norfolk Islanders are disadvantaged because most Commonwealth legislation pertaining to health does not extend to Norfolk Island. This hinders them from accessing various 'programs and initiatives aimed at assisting communities in rural, remote and regional Australia – of which Norfolk Island is a part.' Access to Commonwealth programs would help offset the limitations of the Island's aged care services in particular. The Department noted that some of the services provided through the Commonwealth Aged Care Program operate outside the Act.[43]

9.58 The Committee does not see that an exact quid pro quo need be established in order for people living on or visiting Norfolk Island to be entitled to access the many and various advantages that a health system which services twenty million people can engender.

Recommendations

Recommendation 34

9.59 **The Committee recommends that the Norfolk Island Government:**

- **establish a program of forward estimates for health services and capital expenditure, in conjunction with the implementation plan developed in consultation with the Griffith University team; and**
- **establish a task force to investigate alternative sources of government funding including new taxes and charges.**

Recommendation 35

9.60 **The Committee recommends that the Norfolk Island Government give recognition to the valuable contribution to the health system of volunteers by providing:**

- **financial underpinning, coordination and direction to their efforts; and**
- **incentives to local employers to provide paid time off for volunteers.**

43 Department of Transport and Regional Services, Submissions, p. 77.

Recommendation 36

9.61 **The Committee recommends that the Norfolk Island Government encourage private philanthropy by inviting the Island's wealthy to fund:**

- **specific projects of their own choosing; and**
- **scholarships for training in health care designed to encourage young Islanders to return to the Island for part of their careers.**

Senator Ross Lightfoot
Chairman

A

Appendix A – List of submissions

1 Mr David Glackin

2 Government of Norfolk Island

3 Community Health Awareness Team

4 St John Ambulance Australia

5 Norfolk Island Hospital Staff Association

6 Mrs Dale Hogden

7 Norfolk Island Hospital Enterprise Board of Management

8 Norfolk Optical

9 Australian Red Cross

10 Community Health Awareness Team
(Supplementary Submission)

11 Mr Ernie Friend

12 Mr Ernie Friend
(Supplementary Submission)

13 Professor Carol Gaston

14 Hunter Urban Network for Consumers of Healthcare

15 Mrs M Baguley

16 Department of Veterans' Affairs (NSW State Office)

17 Department of Transport and Regional Services

18 Insurance Enquiries and Complaints Ltd

19 Department of Health and Aged Care

20 Indian Oceans Territories Health Service

21 Mrs Margaret Clyde

22 Southern Cross Healthcare

23 Private Health Insurance Ombudsman

24 Department of Defence

25 Royal Flying Doctor Service of Australia

26 Australian Taxation Office

27 Government of Norfolk Island
(Supplementary Submission)

28 Medical Benefits Fund of Australia Ltd

29 Rev Ian Hadfield

30 Dr Michael Sexton

31 Confidential

32 Department of Transport and Regional Services
(Supplementary Submission)

33 Department of Health and Aged Care
(Supplementary Submission)

34 Department of Veterans' Affairs (NSW State Office)
(Supplementary Submission)

35 Department of Transport and Regional Services
(Supplementary Submission)

36 NRMA Careflight

37 Government of Norfolk Island
(Supplementary Submission)

38 Royal Flying Doctor Service of Australia
(Supplementary Submission)

39 Mr Graeme Woolley

40 Ms Christine Sullivan

41 Mr Peter Young

42 Dr Lloyd Fletcher

B

Appendix B – List of exhibits

1. Mr Greg Magri: Personal letters relating to the accommodation difficulties experienced by young people on Norfolk Island
2. Ms Denise Quintal: Photographs of burning off on Norfolk Island
3. Mr Boyd Buffett: Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998
4. The Hon Mr Geoffrey Gardner MLA, Minister for Health, Government of Norfolk Island: 'Norfolk Island – Medivacs: Possible principles'
5. Mr Mike King: Letter from Mr King to the Director of the Norfolk Island Hospital Enterprise, Mr John Christian, dated 17 November 1999
6. Ms Merval Hall: Letter from Ms Hoare to the Committee, dated 15 November 1999
7. Ms Merval Hall: 'Another Rotary Service' and 'Norfolk Island Hospital Auxiliary President's Report', reported in *The Norfolk Islander*, Vol 34, No 31, 29 May 1999 and Vol 34, No 3, 23 August 1999
8. Ms Merval Hall: *Norfolk Island - A Revised and Enlarged History 1774-1998*, by Merval Hoare
9. Ms Yvonne Burns: Indian Ocean Territories Health Service, *Instructions to Patients who Qualify for Patient Assisted Travel Scheme (PATS)*
10. Ms Yvonne Burns: Indian Ocean Territories Health Service, *Medical Management Policy: 1/98 Patient Assisted Travel Scheme*
11. Mr Roger Bowie, Chief Executive, Southern Cross Health Care: pamphlet, *Your Island Your Health - Your Norfolk Island Health Insurance Plan*
12. Mr Roger Bowie, Chief Executive, Southern Cross Health Care: pamphlet, *Southern Cross Healthcare* - Travel Care

13. Mr Roger Bowie, Chief Executive, Southern Cross Health Care: Annual Report 1999, *Greater Access to Better Healthcare - Southern Cross Healthcare*

14. Ms Maria Mackell, Department of Veterans' Affairs, NSW State Office: *Report on the Visit to Norfolk Island by NSW State Office in August 1999*

15. Dr Damien Foong, Netconferencing proposal for Norfolk Island, 7 April 2001

C

Appendix C – List of hearings and witnesses

Tuesday, 16 November 1999 – Norfolk Island

Norfolk Island Administration

Mr Geoffrey Gardner, Minister for Health
Mr John Christian, Director, Norfolk Island Hospital
Mrs Kim Edward, Healthcare Manager, Norfolk Island Administration
Mr Graeme Donaldson, Acting Program Manager, Community Services

Dr John Davie, Medical Officer, Norfolk Island Hospital

Dr Lloyd Fletcher, Government Medical Officer

Norfolk Island Hospital Enterprise Board of Management

Mr John Hughes, Chairman
Dr John Duke, Member

Norfolk Island Hospital

Mrs Patricia Connolly, Director of Nursing
Mrs Joy Cochrane, President, Norfolk Island Hospital Staff Association
Mrs Janine Nobbs, Secretary, Norfolk Island Hospital Staff Association

Community Health Awareness Team

Mrs Colleen Evans, Chairperson
Mrs Sallie Davie, Member
Mrs Janine Nobbs, Member

Mr Russell Beadman

Returned Services League Sub-Branch, Norfolk Island

Mr Boyd Buffett, President

ECO Norfolk

Ms Denise Quintal, Founder

Mr Gregory Magri

Greenwich University

Dr John Walsh, Chancellor
Ms Pauline Butler, Vice-President
Dr Melanie Latter, Academic Dean
Ms Sian Quantrill, Registrar

St John Ambulance Australia

Sister Bonnie Quintal MBE, Superintendent

Reverend Dr Robert Wyndham

Mr Rex Barrett

Friday, 7 April 2000 – Canberra

Department of Veterans' Affairs

Mr Barry Telford, Branch Head
Ms Janet Anderson, Director, Health, NSW Office

Royal Australian Air Force

Group Captain Geoffrey Roberts, Director, Battlespace Management (Aerospace)

Department of Health and Aged Care

Mr Charles Maskell-Knight, Assistant Secretary, Financing and Analysis Branch
Mr Mark Burness, Director, Medicare Eligibility Section
Ms Tanya Taylor, Medicare Eligibility Section

Department of Transport and Regional Services

Ms Rosanne Kava, First Assistant Secretary, Territories and Regional Support Division
Ms Maureen Ellis, Director, Self-Governing Territories Section
Ms Sarah Allen, Policy Officer, Self-Governing Territories Section

Monday, 19 June 2000 – Canberra

Professor Carol Gaston

Dr Michael Sexton

NRMA Careflight

Mr Ian Badham, Executive Director
Ms Catherine Carruthers, Business Development Manager

Royal Flying Doctor Service of Australia

Dr Bruce Sanderson, Chief Medical Officer
Mr Clyde Thomson, Executive Director and Company Secretary, Southeastern Section