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.**