GENERAL PURPOSE STANDING COMMITTEE No. 2

Monday 4 September 2006

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 9.00 a.m.

MEMBERS

The Hon. P. Forsythe (Chair)

The Hon. J. C. Burnswoods
The Hon. A. Catanzariti
The Hon. Dr. A. Chesterfield-Evans
Ms. S. P. Hale
The Hon. R. M. Parker
The Hon. C. M. Robertson
The Hon. H. S. Tsang

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PRESENT

The Hon. J. Hatzistergos, *Minister for Health*

Department of Health
Ms R. Kruk, *Director General*
Dr R. Matthews, *Deputy Director General, Strategic Development*
Professor K. McGrath, *Deputy Director General, Health System Performance*
Mr R. McGregor AM, *Deputy Director General, Health System Support*
Dr D. Robinson, *Deputy Director General, Population Health and Chief Health Officer*
Mr K. Barber, *Chief Financial Officer*

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CHAIR: I declare open this hearing of budget estimates for Health, and open to the public. I welcome Minister Hatzistergos and accompanying officials to this hearing. At this hearing the Committee will examine the proposed expenditure for the portfolio of Health. Before we commence I will make some comments about procedural matters. Today's hearing will proceed without microphones due to the Public Service Association work bans on room set-up. I ask members and witnesses to speak in a clear voice, one at a time, and the audience to keep background noise to a minimum. I really want to stress that this room is not the best acoustically, and we really will have to ask people to speak up.

In accordance with the Legislative Council's *Guidelines for Broadcast of Proceedings*, only Committee members and witnesses may be filmed or recorded. People in the Public Gallery should not be the primary focus of any filming or photos. In reporting the proceedings of this Committee you must take responsibility for what you publish or the interpretation you place on anything that is said before the Committee. The *Guidelines for Broadcast of Proceedings* are available from the table by the door. In relation to the delivery of messages, any messages from attendees in the Public Gallery should be delivered through the Chamber and support staff or the Committee clerks. Minister, you and your officers who are accompanying you are reminded that you are free to pass notes and refer directly to your advisers while at the table.

I ask that Hansard be given access to material placed on the public record during hearings. This is the usual practice in the House and is intended to ensure the accuracy of the transcript. I ask that all mobile phones be turned off, please. By that I mean that they are not to go to silent mode but must be turned off because of interference with Hansard. In relation to the format of hearings, Minister, the Committee has agreed to the following format: we will do 20 minutes for the Opposition, 20 minutes for the crossbench and 20 minutes for the Government in rotation. There will be a 15-minute break at 11 a.m. When we get to the final sequence, I will simply divide the time to give a fair opportunity for each grouping to ask questions.

The Committee has previously resolved that the return date for answers to questions taken on notice will be 21 calendar days from the date on which they are sent to your office. Do you anticipate any problems with that?

The Hon. JOHN HATZISTERGOS: Not at this point. I will let you know if we do.

CHAIR: Proposed issues for questioning.

The Hon. JOHN HATZISTERGOS: We have been given only one list.

CHAIR: Thank you. You are familiar with that. We now move to the swearing in. Obviously, Minister, you do not need to be sworn in, but all witnesses from the department, statutory bodies or corporations will be sworn in prior to giving evidence. I think the easiest way will be for me to simply move across the table. I will ask each person to state your full name, job title and agency, and I will then ask you to take the oath or the affirmation. The words should be in front of you.

ROBYN KRUK, Director General, Department of Health, and

DENISE ROBINSON, Deputy Director General, Population Health and Chief Health Officer, Department of Health, and

RICHARD MATTHEWS, Deputy Director General, Strategic Development, Department of Health, affirmed and examined:

KATHERINE McGRATH, Deputy Director General, Health System Performance, Department of Health, and

ROBERT McGREGOR, Deputy Director General, Health System Support, Department of Health, and

KEN BARKER, Chief Financial Officer, Department of Health, sworn and examined:

CHAIR: I now declare the proposed expenditure for the portfolio of Health open. Minister, do you wish to make a brief opening statement?

The Hon. JOHN HATZISTERGOS: Thank you, Madam Chair. It is appropriate in a budget estimates hearing that I provide the Committee with a report on the state of the Health budget to provide some context for the discussion that will follow. I am pleased to report that the 2006-07 annual recurrent budget for the New South Wales health system has once again been increased—to a record $11.7 billion. In '06-'07, more than 27 per cent of the 2006-07 State budget is being allocated to Health. This year's State budget sees health expenditure increased by $828 million or 7.6 per cent compared to last year's budget.

Rural and regional communities of New South Wales will receive a major boost in health funding as part of this year's budget. As a major commitment to the health of rural and regional communities, recurrent budget spending on health services in 2006-07 will top $3.46 billion. This represents an increase of $307.8 million, or 9.8 per cent, on last year. One of the key budgetary achievements in the 2005-06 budget has been the implementation of the area health service restructure and the redirection of savings to key front-line services across the State. One of the key elements of these reforms was the amalgamation of 17 area health services into 8 area health services.

Additional savings have been delivered by reforms in mobile and voice telecommunications service contracts and more strategic procurement approaches. Local savings are being retained by area health services and redirected to front-line clinical services. I am pleased to outline to the Committee now where these savings have been redirected. In the Sydney West Area Health Service, $3.8 million in administrative savings in '05-'06 have been redirected to fund: cardiac services networking and early triage, $2.5 million; single use catheters initiative, $1 million; and the nurse practitioner initiative, $300,000.

In the Greater Western Area Health Service, $2.9 million in administrative savings have funded a large range of projects including ear, nose and throat and neurology remote clinics at $926,000; paediatric clinical nurse consultant at Broken Hill, $138,000; nurse practitioners $90,000; intensivist services at Orange Base Hospital $220,000; paediatrician at Bathurst Hospital $95,000; funding for nephrologists at Orange Base Hospital $80,000 and equipment upgrades of $410,000. In the Hunter New England Area Health Service, $4 million in savings has been allocated as follows: $2 million to enhance clinical services at Tamworth and Armidale and fund a number of specialist and registrar positions at Tamworth; $1 million for elective surgery medical infrastructures and additional registrars and nurses at Manning; $1 million to enhance mental health services in the northern part of the area health service.

In the North Coast Area Health Service, an extra $2.56 million has been invested in extra surgery at Tweed, Lismore and Coffs Harbour at $2.05 million; $206,000 enhancement of area-wide regional dialysis, including extra shifts at Ballina Renal Unit; additional supplies to support permanent dialysis at Brunswick-Byron, Richmond and Clarence districts and the employment of a second nephrologist at Lismore Base; enhanced cardiology services in Tweed at $300,000. The Northern

Sydney Central Coast Area Health Service over $5 million in savings has been redirected to increased resources for haematology and bone marrow transplants; clinical redesign initiatives in emergency departments, mental health and surgical services and the Wyong Paediatric Ambulatory Care Unit.

In the South Eastern Sydney and Illawarra Area Health Service, more than $8 million in savings resulted in a $2 million funding boost for the Sydney Children's Hospital; $400,000 for increased after-hours MRI services at the Prince of Wales Hospital; $1 million for enhanced maternity and obstetrics care, including the development of specialist Aboriginal and community midwifery projects and the appointment of an academic professor to oversee obstetric maternity and foetal medicine across the area; and $4.9 million in extra funding for the Illawarra and Shoalhaven, including $1 million to expand interventional cardiology services at Wollongong; $600,000 to create four new surgical positions, including two surgical registrars, one anaesthetic registrar and one neurosurgical registrar; $1 million to expand renal dialysis at Wollongong and Shoalhaven; $900,000 to enhance the acute geriatric service, including the establishment of a network service between Bulli and Wollongong hospitals; $400,000 for enhanced oncology services across the Illawarra Cancer Care Centre and Shoalhaven and Milton-Ulladulla hospitals; $200,000 to provide additional medical and nursing support for emergency departments at Shellharbour and Wollongong; $400,000 for enhanced gastroenterology services at Wollongong Hospital.

In Sydney's South West Area Health Service, more than $4.8 million in savings has been redirected to: enhanced radiotherapy services at Liverpool and Campbelltown hospitals, $2.22 million; increased insertion of defibrillators at Royal Prince Alfred and Liverpool hospitals, at $2.39 million; and the development of a paediatric assessment unit at Campbelltown Hospital at $250,000. In the Greater Southern Area Health Service, savings of $3.9 million were redirected to front-line services, including increased specialised services previously not available to those residents who had to travel to Sydney to access them.

That is our savings achievement for 2005-06: redirecting funds from administrative duplication and overlap to front-nine service delivery. While the Leader of the Opposition makes vague promises about cutting waste and mismanagement, we are getting on with genuine and sensible reform and achieving tangible savings without mass sackings of the kind promised by the Leader of the Opposition. In NSW Health, administrative job reductions of about 1,000 full-time equivalents have been achieved in consultation with unions, without recourse to forced redundancies. While the number of corporate administrative staff has fallen there has been a substantial growth in the number of medical, nursing, allied health and ambulance staff including: Between 30 June 2004 and 30 June 2005 there was an increase of 107 full-time equivalent medical staff, that is 1.7 per cent; 2,035 full-time equivalent nursing staff, that is 6.1 per cent; and 686 full-time equivalent allied health professionals, that is 2.7 per cent; and 78 full-time equivalent uniformed ambulance staff, an increase of 2.7 per cent.

That is an increase of 2,906 full-time equivalent front-line staff. It is anticipated that reform savings will rise to in excess of $70 million in 2006-07 and you can look forward to a report at next year's estimates on how the additional savings were used to improve patient care. In addition to presenting an outline of the 2006-07 Health budget and reporting on the department's progress in relation to structural reform, it is appropriate in setting the scene for budget estimates that I report to the Committee on major risks to the Health budget in 2006-07. Members would be aware of the increasing pressure on our system, particularly with our ageing population, because older are people presenting to emergency departments with increasingly complex medical problems. Members would be aware also of the impact on our hospitals and the ambulance service of the lack of affordable after-hours access to general practitioners—a Federal Government responsibility. Members may be aware also that the Australian Health Care Agreement is due for re negotiation next year and that the Federal health Minister has been making all kinds of threats in relation to funding for State public hospitals– and based on previous experience, those threats need to be taken seriously.

Members need to be aware also that recently a policy was announced that threatens to reverse the reforms that I have outlined and to reverse the flow of savings from the front line and return them to new layers of bureaucracy and waste. As I said at the outset, one of the central features of the major savings reforms we have implemented was the amalgamation of area health services from 17 to 8. The Opposition has promised to revert to local and district health boards. It has not given the Government the precise details of how many, but based on the structure that existed in 1993—before major reform

began—the Coalition's policy is expected to create in excess of 41 local and district health boards. That policy will reverse the savings that have been achieved as a result of the restructure, and will endanger the patient service enhancements that I have outlined.

The Coalition's policy will add layers and layers of unnecessary bureaucracy as administrative staff positions are duplicated, hospital by hospital, district by district. It is estimated it will cost millions, but it is not clear of course where the money will come from, which front-line services would be cut to pay for the re-establishment of that administration. It will eliminate the opportunity for rational planning and improved networking across the State, leading not only to waste, duplication and overlap but also to a situation where hospitals are pitted against each other and where communities are pitted against each other in the fight for a share of resources.

It is a risky strategy, made even more dangerous by the commitment of the Opposition to cut 29,000 jobs, which cannot be realistically achieved without impacting on essential front-nine services, the bulk of which are in the health work force. In conclusion, the 2006-07 budget is good news for the people of New South Wales. It delivers record levels of health spending and supports real reform aimed at delivering fewer administrators and more doctors, nurses and allied health professionals caring for patients.

CHAIR: Minister, have any matters relating to the governance of the Greater Southern Area Health Service been referred to be Independent Commission Against Corruption in the past 12 months?

The Hon. JOHN HATZISTERGOS: Not that I am aware of.

Ms KRUK: Not that I am aware of.

CHAIR: Have there been any anomalies in the handling of funds in the Greater Southern Area Health Service?

The Hon. JOHN HATZISTERGOS: I do not know what that question means. What do you mean by "anomalies"?

CHAIR: Obviously whether all funds have been accounted for?

The Hon. JOHN HATZISTERGOS: The Chief Medical Officer will answer.

Ms KRUK: I will call on Mr Barker to respond. That area health service is subject to the usual auditing provisions of the Public Finance and Audit Act. If you are aware of any concerns, I would appreciate you telling us.

Mr BARKER: My understanding is that all health services have submitted financial statements to the Auditor General. All health services are now going through a process of having those statements audited. The Auditor General normally will issue audit certificates around the end of September, or maybe in October, but that depends on how they go with the timing. I have had no feedback from the Auditor General's office that any of our accounts are subject to concerns over inappropriate financial practices over the public monies that health services have charged to them.

The Hon. ROBYN PARKER: How many motor vehicles does the Department of Health operate?

The Hon. JOHN HATZISTERGOS: I understand it is 9,874.

The Hon. ROBYN PARKER: How many motors vehicles does the Greater Southern Area Health Service operate?

The Hon. JOHN HATZISTERGOS: I do not know. I do not go around counting these things.

Ms KRUK: Ms Parker, do you want us to take that question on notice and get back to you during the course of this hearing?

The Hon. ROBYN PARKER: Certainly, that would be good.

The Hon. JOHN HATZISTERGOS: Are you talking about ambulances as well?

The Hon. ROBYN PARKER: I have been talking about motor vehicles.

The Hon. JOHN HATZISTERGOS: Ambulance officers drive motor vehicles.

The Hon. ROBYN PARKER: It would be fantastic if you could break it down into categories.

The Hon. JOHN HATZISTERGOS: We will give you what you want.

The Hon. ROBYN PARKER: At the same time we are particularly interested to know whether those vehicles are owned or leased?

Mr BARKER: There is a mixture across NSW Health. The majority of vehicles are leased in line with Treasury policy about our motor vehicle fleet. However, a number of vehicles are also owned, but that is a very small number. Treasury policy is that motor vehicles will be leased through a Treasury facility. However, in some instances vehicles are owned by the agency, which is permissible. That will vary from health service to health service.

The Hon. ROBYN PARKER: Referring in particular to the Greater Southern Area Health Service, are other forms of lease available to staff, such as through salary sacrifice?

Mr BARKER: Under our salary packaging policy an employee can have certain approved expenses charged to his or her salary packaging. That provision is approved by the Commonwealth to encourage the recruitment and retention of health workers within the work force. I will not go through the complications, but they are entitled to a $17,000 grossed-up fringe benefits tax exempt cap. Within those entitlements they can make arrangements to have the costs of their own motor vehicles, including how they have acquired those vehicles, charged back through their salary packaging arrangements. That is something they are entitled to, as are public health employees across the country.

The Hon. ROBYN PARKER: Would that be a no-voted lease?

Mr BARKER: It could be a no-voted lease, but the financing of that motor vehicle is purely between the employee and whoever else. They are not NSW Health vehicles if they are doing it under that type of salary packaging arrangement, unless their position allows them, as a condition of their employment, to have access to a government vehicle.

The Hon. ROBYN PARKER: Just to finish off on that leasing process, over the last two years have you had brought to your attention any anomalies in leasing arrangements for motor vehicles for staff?

Mr BARKER: What do you mean by anomalies?

The Hon. ROBYN PARKER: An anomaly is when something is not quite right, I would have thought.

The Hon. JOHN HATZISTERGOS: What exactly does that mean? What are you looking for?

The Hon. ROBYN PARKER: Have anything been raised with you that does not sit right—something that might be an issue?

CHAIR: Something that is outside the policy guidelines.

The Hon. JOHN HATZISTERGOS: That is a very vague question and it is difficult to respond to it. Normally I do not become involved in motor vehicles. If I did I think you would be questioning my priorities. If these issues are really that important and significant to you, identify the nature of the anomalies that concern you.

The Hon. ROBYN PARKER: Either there are issues or there are not.

Mr BARKER: I am not aware of any anomalies. If you have some facts that you would like to give us, we will certainly investigate them to see whether they are consistent with our policy.

The Hon. ROBYN PARKER: So nothing has been raised that you are aware of at this point?

Mr BARKER: Nothing has been raised.

CHAIR: Have more than 75 hotels been permitted a second smoking room during the smoking ban transition phase?

The Hon. JOHN HATZISTERGOS: I am not au fait with that.

Ms KRUK: I might ask the chief health officer to speak about some of the arrangements regarding hotels.

Dr ROBINSON: The department has received a number of applications for a second smoking room. They have all been subject to scrutiny by the department. There have been a number of instances where approvals have been given for a time-limited period for that additional area. Primarily, these are for hotels where there has not been the physical capacity to have the appropriate level of separation to enable them to fulfil their policy requirements. As I said, these are for a time-limited period. The changes that we are moving to will be that all indoor areas will be smoke-free by 4 July next year.

CHAIR: Are you able to provide a list of the hotels that have been permitted a second smoking room?

Dr ROBINSON: I would be you able to do that on notice, yes.

CHAIR: Could you provide a list of those that have had applications rejected?

Dr ROBINSON: I will.

The Hon. JOHN HATZISTERGOS: We will take that question on notice.

The Hon. ROBYN PARKER: Referring to staffing, how many jobs have been designated corporate administration?

The Hon. JOHN HATZISTERGOS: The annual report deals with that. If you would like to have a look at the annual report you will find the answer.

Ms KRUK: Ms Parker, do you want us to refer you to the section in the annual report?

The Hon. ROBYN PARKER: I think it is page 125.

The Hon. JOHN HATZISTERGOS: It is page 125. The interesting thing is that the number of front-line nursing allied health positions has been increasing over the last few years. It also increased last year. If you look at the annual report you will find that those levels have increased. It is dictated somewhere in a graph in the report. I am sure it is a document with which you are familiar, so I might just refer you to it. All the information is there.

The Hon. ROBYN PARKER: Referring to corporate administration jobs, how many of them have been abolished since the restructure of NSW Health?

The Hon. JOHN HATZISTERGOS: Since the amalgamations of the 17 area health services into one, over 1,000. We set a target of 1,000 but we abolished slightly more than that.

The Hon. ROBYN PARKER: How many nurse management jobs have been abolished since the restructure of NSW Health?

The Hon. JOHN HATZISTERGOS: I do not have the details of individual positions, but I can give you some information on it.

Ms KRUK: While the Minister is looking at his material I might ask Mr McGregor to respond. The focus of the 1,000 positions clearly was on corporate jobs and not front-line jobs. I think what you are referring to is the very real need to look at where an individual's time is spent, whether he or she is a corporate person or whether he or she is a front-line person. The other clear commitment that was made in the House was that those 1,000 jobs to which the Minister referred would be the subject of an independent audit. The Minister made reference in his opening statement to where the funding is allocated in relation to front-line services. A commitment was also made to independently audit that process. That also means identifying the positions I might ask Mr McGregor about nurse unit management.

Mr McGREGOR: As was indicated to you earlier, the corporate services reforms were around corporate staff employed by area health services, not by nurse management staff or other staff who may have a clear clinical role. At the end of June 2006, a total of 1,047 positions had been formally deleted from the corporate services areas, including payroll, supply and area support staff who were not needed in two places when we were merging two areas into one and, in one case, three areas into one. The levels of nurse unit manager are below those levels and in hospitals. From time to time those areas are subject to review by responsible area management. We have seen some examples of where there has been some consolidation of nursing services. The Northern Sydney-Central Coast area is an example of that. However, in relation to that change there was no reduction in nurse unit manager positions but there certainly were changes in roles.

The Hon. ROBYN PARKER: You would not then consider nurse managers to be classified corporate administration?

Mr McGREGOR: No. That is not included in how we define corporate services staff for the purposes of the amalgamations.

The Hon. JOHN HATZISTERGOS: We have abolished a variety of positions that are described as corporate administration. Incidentally, I noticed that every time there was something in the media about any of those positions going, Opposition members were out in the community championing those positions and arguing that they should be retained. They went out and promised that, at next election, they would reinstate a general manager exclusively for two hospitals. We deleted those positions to have shared management across campuses. One position is on the Central Coast and the other is down south.

Opposition members went out and said, "We will reinstate those positions." That is exactly what Opposition members have done all around the State. Whenever a position has been deleted and it has caused a slight murmur of public disquiet, Opposition members have gone out and said, "We will reinstate those positions." At the same time they are going around telling everyone that they will abolish 29,000 jobs. Opposition members have not told us where they are to come from. Presumably Health has its share; it certainly has not been exempted.

CHAIR: Mr McGregor, you used the Central Coast as an example of consolidation.

Ms KRUK: North Sydney.

CHAIR: Is that just an example or are there others as well?

Mr McGREGOR: I referred to North Sydney and to the Central Coast.

CHAIR: Are they the only two?

Mr McGREGOR: No. A review occurred in south-east Sydney and Illawarra. A review is occurring in the Greater Southern Area Health Service. Presently, a review is occurring in Sydney west. We expect those reviews to be ongoing.

CHAIR: Can you take it on notice to provide a list of all areas where that review is under way?

Mr McGREGOR: I think you will find that, at the end of the day, it will be virtually every area. Nevertheless, we will provide you with a list.

Ms KRUK: I think all members are aware of the fact that the area health services are working on their area health service plans. It is clear—and that was one of the underpinning things in relation to the restructure—that the networking of hospitals is a key component to providing quality services. Referring to the Minister's example of Wyong and Gosford, I know the massive support that the GM was given in that hospital but I also know that the staff whom I spoke to informally were appreciative of the significant clinical gains that have been made by greater networking between Wyong and Gosford. I think there are examples like that across the State. I stress Mr McGregor's comment that the corporate savings had to do with administrative positions. The consolidation of hospitals into networks actually has to do with good clinical services.

CHAIR: Director General, thank you for the explanation but can we still get that list?

Ms KRUK: We will make every endeavour to get it to you.

The Hon. JOHN HATZISTERGOS: Gosford was one example. The Leader of the Opposition went up there with the Hon. Michael Gallacher and the shadow Minister, who is sitting behind us, and they all promised that they would reinstate a general manager at Gosford Hospital. The people up there much prefer the paediatric ambulatory care unit that will be built at Wyong. That is the sort of thing you have to be careful about, particularly when you were talking about your 29,000.

The Hon. ROBYN PARKER: On corporate administration, what is the salary range?

The Hon. JOHN HATZISTERGOS: That is in the annual report. There is a breakdown, as there is in every annual report, of senior executive service salaries.

The Hon. ROBYN PARKER: Can you provide us with an average?

The Hon. JOHN HATZISTERGOS: No, that is in the annual report. We provide an annual report for every area health service and we provide one for the department. Our job is not to come here to answer questions about material that is on the public record. You have indicated some rules about these estimates but I can tell you one that reinforces what I have said at every estimates hearing: I am not a research service. The information is in the annual report and you can go and have a look at it.

The Hon. ROBYN PARKER: Minister, you are here to talk about the budget, which is on the public record.

The Hon. JOHN HATZISTERGOS: That information is in the annual report. If you have a look at it you will see a breakdown.

The Hon. ROBYN PARKER: We are here to question you about the budget.

The Hon. JOHN HATZISTERGOS: You can question me all you like.

CHAIR: Minister, we are entitled to ask you to answer questions notwithstanding whether the information is in the annual report.

The Hon. JOHN HATZISTERGOS: I am not a research service, Madam Chair. I have said that at estimates committee hearings time and time again. Opposition members have layers and layers of researchers and staff—I do not know where they put them all. They are all there. They all search around and put out ridiculous press releases. The information is in the annual report. Have a look at it.

CHAIR: Ms Parker has asked a question and I direct you to answer it.

The Hon. JOHN HATZISTERGOS: I have answered it.

The Hon. ROBYN PARKER: You answered it with your usual attitude.

The Hon. JOHN HATZISTERGOS: That is not true. I am very kind and courteous. I am trying to be helpful.

The Hon. ROBYN PARKER: The people of New South Wales would like to know some answers. There are 10,000 corporate administrative positions.

The Hon. JOHN HATZISTERGOS: There are not. That is wrong.

The Hon. ROBYN PARKER: How many are there? Are all their salaries in the annual report?

The Hon. JOHN HATZISTERGOS: No, they are not. If you have read the 2004-05 annual report you will see the proportions of different positions. I am giving you this information, by the way. It is out of the annual report but I will give it to you any way because I am a kind and generous person. Some 66 per cent are medical, nursing, allied health and uniformed ambulance; 18 per cent are hospital employees such as wards people, technical assistance and ancillary staff; 8 per cent are hotel services, cleaning and catering; 6 per cent are corporate administration; 1 per cent is maintenance and trade; and 1 per cent others. That is the breakdown.

The Hon. ROBYN PARKER: Will you provide us with the average salary of NSW Health employees and corporate administration jobs?

The Hon. JOHN HATZISTERGOS: I will provide you with any information that is not in the annual report.

Ms KRUK: If I may add to that, obviously the first tranche involved the reduction from 17 CEOs to eight. That is most senior positions. That has translated down to a reduction in the second tier employees—in effect, the crunching of two areas, and in some instances 2½ areas, into one. They are positions at all levels, commencing from CEO and working down. To restructures at the moment, from my understanding, we are at the fourth and fifth tier within an area health service restructure. As I have indicated, that is data that the Government has given a commitment to making public when we finish that process. It is clearly taking into account the most senior positions within the NSW Health bureaucracy.

The Hon. ROBYN PARKER: Minister, on 31 July you issued a press statement stating that the Coalition policy to report information about hospital-acquired infection rates for each hospital by clinical department and annual reports was already being done. That being the case, can you point out the page in the annual report or indicate any other publication or Internet site where that information can be found?

The Hon. JOHN HATZISTERGOS: That information is publicly available on the web site.

The Hon. ROBYN PARKER: Which web site?

The Hon. JOHN HATZISTERGOS: The NSW Health web site. I am surprised that you have not looked at it.

The Hon. ROBYN PARKER: I will get one of my many advisers to have a look at it.

The Hon. JOHN HATZISTERGOS: That is good—put them to use.

The Hon. ROBYN PARKER: The Clinical Excellence Commission advised on 21 August that there were 125,000 clinical incidents notified in New South Wales public hospitals in 2005-06. This did not include hospital-acquired infections despite that being identified as a key indicator of quality in hospital care by various bodies, including the Australian Council on Healthcare Standards. Why not?

The Hon. JOHN HATZISTERGOS: I am not aware of the 125,000 figure—

Ms KRUK: If I may add something, Ms Parker. I think you are referring to the release that Professor Cliff Hughes issued last week, which for the first time has made New South Wales the leading State, if not one of the leading health systems, in relation to reporting its quality and safety data. I may ask the Chief Health Officer who worked with Professor Lynne Gilbert, who was responsible for looking at the whole issue of MROs, to give some background and I think the Minister also wishes to make an additional comment.

The Hon. JOHN HATZISTERGOS: I can give you some information on this that will be comprehensive but, I think, cover the issues that you have raised properly as well as some additional issues. In 2005-06 the allocation for the Infection Control Program was $956,153. The initiatives funded by that allocation include the New South Wales Infection Control Resource Centre, the Sharps Safety Program, the collection, analysis—

CHAIR: Minister, I am sorry, could you please slow down and speak up? Hansard is having some difficulty.

The Hon. JOHN HATZISTERGOS: Yes, sure. It also included collection, analysis and aggregation of healthcare-associated infection data—

The Hon. ROBYN PARKER: I just want to know about the possible—

The Hon. JOHN HATZISTERGOS: That is included in what I am going to say. It included associated infection data by the Australian Council on Healthcare Standards, and resource development to support the Clinical Excellence Commission [CEC] Hand Hygiene Program. In 2006-07 the budget is $2.36 million, which represents a $1.4 million increase on the previous year. The 2006-07 allocation represents a significant increase in infection control expenditure since 1994-95, as the only dedicated expenditure at the time was a small allocation for the establishment of the Infection Control Resource Centre. This additional funding will provide for the following services: support for laboratory screening of patients to improve detection of multiple antibiotic-resistant organisms [MROs]; dedicated positions in each area to co-ordinate MRO control and prevention programs; the development and implementation of clinical improvement initiatives targeting healthcare-associated infections, particularly those caused by MROs and maintenance of the CEC Hand Hygiene Program.

NSW Health continues to maintain a comprehensive evidence-based infection control policy to support our area health services in protecting patients and staff. This policy is currently under review to ensure that contemporary infection control issues and their practical applications continue to be addressed. In response to community and health care workers' concerns, the department is also working with the State's leading experts and a range of stakeholders, including consumers, on multiple antibiotic-resistant organisms to improve the prevention and management of MROs in hospitals. An Infection Control Summit was held in Sydney on 6 October 2005 to provide consumers and clinicians with an opportunity to comment on the proposed recommendations of the expert group. Detecting and containing MROs is an issue for modern health systems across the world, as these bacteria are fast becoming a fact of life in hospitals.

CHAIR: Minister, I am sorry to interrupt but is that a lengthy statement?

The Hon. JOHN HATZISTERGOS: It is not that long—3½ pages.

CHAIR: The time for Opposition questions has concluded.

The Hon. JOHN HATZISTERGOS: That is all right. I will stay longer. I do not mind. This means that we need to have the most robust possible defences in place to protect patients and minimise the spread of infection through hospital wards. The CEC has already commenced a hand hygiene campaign in response to the preliminary recommendations of the expert group. The expert group has also identified the widespread adoption of contact infection control precautions and other patient isolation strategies, screening of selected high-risk patients, environmental cleaning, and information technology to enable better control of antibiotic use and surveillance, particularly targeting bloodstream infections, as key elements of an effective response to MROs in our hospitals.

A range of tools is available to support area health services with implementation of the policy and with assessing the quality of their infection control programs. A comprehensive policy on healthcare workers' screening and vaccination is in place to minimise risk of occupational acquisition or transmission of vaccine-preventable diseases. In 2006 the department has made available free of charge to areas the vaccines required to adequately protect healthcare workers against vaccine-preventable diseases, and a campaign is in development to increase the uptake of vaccination by healthcare workers.

The department has a comprehensive policy for reporting occupational exposures to blood and body fluids and post-exposure management. This includes the statewide needlestick injury hotline and 24-hour access for healthcare workers to clinical assessment and treatment if appropriate in all hospitals. Specific policies, procedures and educational resources relating to emerging infections, such as SARS, avian influenza and pandemic influenza are also either in place or in development in accordance with the pandemic action plan. New South Wales has in place a mandatory system in place for the standardised monitoring of healthcare associated infections. Data are collected on MRO infections, a range of surgical site infections, intravenous line-related infections and occupational exposures. This surveillance system covers every public healthcare facility that admits patients, including referral hospitals, community hospitals and state-managed nursing homes.

The department contracts the Australian Council on Healthcare Standards to analyse the data that is provided on a six-monthly basis. The surveillance program focuses on identifying infection control problem areas to assist hospitals to implement and evaluate improvements in quality of care. Data on healthcare-associated infections acquired in hospitals in New South Wales is published on the web site. These data show the rates of infection are broadly comparable with other Australian States and lower than comparable countries internationally. It is anticipated that data on infections acquired in 2005 will be available on the web site in a few months.

I am advised that hospitals are provided with reports detailing their local and aggregated State infection rates for specific indicators. The reports can be used to evaluate and, where, necessary, improve their own hospital infection control practise, programs and policies. With 45 indicators during 2003-04 and 54 from January 2005 the New South Wales infection control quality monitoring program is the most comprehensive of its type in Australia. It rivals that of other countries with well-developed systems of healthcare-associated infection monitoring. As there is no mandatory national method of collecting and reporting healthcare-associated infection rates, it is not possible to make any meaningful comparison on infection rates between different jurisdictions.

CHAIR: To assist Hansard would you table the document you have just read?

The Hon. JOHN HATZISTERGOS: Yes, I am always happy to help.

CHAIR: I will have questions from the cross bench.

Ms SYLVIA HALE: Minister, in relation to the Isolated Patients' Travel and Accommodation Assistance Scheme [IPTAAS] how much funding will be provided for the new amalgamated Transport for Health Program?

The Hon. JOHN HATZISTERGOS: Record funding.

Ms SYLVIA HALE: Would you be more specific?

The Hon. JOHN HATZISTERGOS: Did want Transport for Health or just IPTAAS?

Ms SYLVIA HALE: Transport for Health and then how much of that funding is earmarked for IPTAAS?

The Hon. JOHN HATZISTERGOS: I will provide an answer which I think covers most of what you ask. I have not isolated the specific parts of it but it covers the IPTAAS and goes beyond that. If you want to ask me anything further, you are welcome to do so. Ms Sylvia Hale was kind enough to provide a list of topics and this is what I have prepared for her. This year, the Government has provided record funding of $10.7 million to assist rural people in accessing specialist medical treatment through the IPTAAS program. This represents a significant 32 per cent increase on last year's budget. In addition, the Government's reforms to the scheme to help more country patients and their families came into effect on 1 July 2006. Those changes cut the eligibility distance for the IPTAAS from 200 kilometres to 100 kilometres. They increased the vehicle allowance from 12.7¢ per kilometre to 15¢ per kilometre and integrated five separate programs into a single program under a revised Transport for Health policy.

In previous years nearly 29,000 claims were approved under the IPTAAS for people living in rural and remote parts of the State who needed to travel to access specialised medical treatment in Sydney or major regional centres. Through those reforms it is expected that an extra 11,500 patients and their carers will benefit. Patients in country areas should not have to suffer the cost and tyranny of distance to access the specialist medical treatment they require. The Government has delivered a fairer deal for country patients. These compassionate reforms will help country patients and their families at a time when they need it most. The Government also subsidises patients for all required accommodation, and that initiative further eases the financial strain of travel costs. Where a person needs to travel with an escort or carer, the scheme can also assist in meeting those costs.

The total of these changes is estimated at $2.6 million per year. Area health services and NSW Health will contribute $2.1 million, while the Cancer Institute will provide $500,000 for cancer treatment patients. So this Government is introducing substantial, fully funded improvements when it comes to the IPTAAS, unlike the proposals that have been articulated by the Opposition. If I could just cover those briefly.

Ms SYLVIA HALE: I am not really interested in the Opposition's proposals at the moment.

The Hon. JOHN HATZISTERGOS: I think a lot of people are.

Ms SYLVIA HALE: I would like to ask you more information about the allocations to the IPTAAS. You said that an extra $2.6 million has been allocated per year. Will that provide the money that is required to meet costs incurred by changing the distance and fuel criteria?

The Hon. JOHN HATZISTERGOS: Yes.

Ms KRUK: If I could ask Dr. Mathews because what is also significant with the policy changes to the IPTAAS program is the work that is being undertaken at Area Health Service level with the Department of Transport to improve the on-ground co-ordination of various community based transport. I think if you have time it is worth asking Dr Mathews to comment briefly.

Ms SYLVIA HALE: Perhaps, later on. Will that $2.6 million be quarantined for use for that specific purpose?

The Hon. JOHN HATZISTERGOS: Yes. The overall funding for Transport for Health is actually more than the $10.7 million that I articulated. It is actually $15.9 million—$10.7 million is IPTAAS but we have other transport programs beyond IPTAAS.

Ms SYLVIA HALE: So that is $15.9 million so that is an extra $5.2 million for those other programs?

The Hon. JOHN HATZISTERGOS: Yes, but you are aware there were about five different programs that this Government reformed on 1 July: the Isolated Patients Travel Accommodation and

Assistance Scheme, the Statewide Infants Screening for Hearing Program [SWISH] travel which assisted families to take babies—

Ms SYLVIA HALE: I am not keen to pursue those matters at the moment.

The Hon. JOHN HATZISTERGOS: I am just articulating what has happened.

Ms SYLVIA HALE: But I have limited time, you may not.

The Hon. JOHN HATZISTERGOS: You asked a question and I think you should allow me to finish the answer. I am saying there were five schemes: the Isolated Patients Travel and Accommodation Assistance Scheme, the SWISH Travel Scheme which is for families that have babies with severe hearing loss; the Health-related Transport Program which assisted community transport organisations; the Inter-facility Transport Scheme; and the former Transport for Health program which provided co-ordination and administrative support. This Government has brought those programs together. It has achieved some administrative savings and the Government has put in extra money to be able to provide better services.

Ms SYLVIA HALE: What is the average cost of travel and accommodation incurred by people applying to the IPTAAS? What percentage of it is actually refunded by the IPTAAS?

The Hon. JOHN HATZISTERGOS: The average what?

Ms SYLVIA HALE: The amount that people get back. What is the average cost that is incurred and how much of that is refunded to people once they have made their claim? I am looking at the discrepancy between the costs that people actually incur and the amount they receive from the IPTAAS?

The Hon. JOHN HATZISTERGOS: I cannot answer the question about how they much incur. I do not know whether the department has average figures. They would vary around the State from place to place, depending upon how far they travel.

Ms SYLVIA HALE: Would you take those questions on notice and if you do have any figures, will you provide them?

The Hon. JOHN HATZISTERGOS: I will look into whether that information exists. If it does I will provide it to you.

Ms KRUK: I do not think we do collect that information but I will endeavour to get it. I also say that most area health services offer some form of subsidised accommodation as well. I think everyone is very conscious of the costs incurred in travel. As the Minister indicated, the Cancer Institute has put aside dedicated funding in the IPTAAS for that very purpose. It is critical for us, we understand that.

Ms SYLVIA HALE: What prompted my question is that you said the motor vehicle allowance had been increased from 12.7¢ to 15¢ a kilometre. How is that 15¢ a kilometre justified when, for example, members of Parliament are reimbursed at something like 77¢ a kilometre? Members of Parliament are reimbursed at 70¢ or even more a kilometre when they use a private vehicle for their parliamentary duties, but isolated patients suffering from cancer or other diseases and who need to see specialists are reimbursed at 15¢ a kilometres. Could you explain how that differential is justified?

The Hon. JOHN HATZISTERGOS: Firstly, I make the point that the motor vehicle subsidy of 15¢ a kilometre is now one of the highest in Australia, if not the highest. That 15¢ a kilometre provides a reimbursement of $15 per 100 kilometres travelled. The current cost of petrol to travel 100 kilometres in a four-cylinder car is $8.64, in a six-cylinder car it is $11.52, and in a large four-wheel-drive it is $14.40. So the 15¢ per 100 kilometres equates with the cost that I have just identified.

The reimbursement of 15¢ a kilometre is currently more than the cost of petrol for most vehicles: as I said, if it is a four cylinder car, it is $8.64, if it is a six cylinder car, it is $11.52, and if it is a four-wheel-drive car, it is $14.40. For the average person with a four-cylinder car, it is more than double the cost associated with it. But, of course, we are always threatened by petrol prices. The Federal Government continues to allow these fuel prices to go through the roof, and they are impacting on people. So we have had to be careful about this. I would be very concerned if the very generous increase from 12.7¢ to 15¢ a kilometre were to be subsumed by these horrendous petrol price increases that the Federal Government has inflicted on families. As for your other question, I have never had to apply for this 77¢ or whatever it is.

Ms SYLVIA HALE: You have a ministerial car provided.

The Hon. JOHN HATZISTERGOS: But, even before then, I never bothered to apply. I am surprised you did. You are a very wealthy person, with bookshops and everything, and I just thought you would perhaps—

Ms SYLVIA HALE: Minister, what is the average period of time patients must wait for their travel costs to be reimbursed by IPTAAS? What is the average waiting time? And how many people are refused reimbursement under IPTAAS, and why?

The Hon. JOHN HATZISTERGOS: I do not particularly have those figures.

Ms SYLVIA HALE: You might take the question on notice.

The Hon. JOHN HATZISTERGOS: If those exist, and they are important to you, we will provide that information. What was the second question?

Ms SYLVIA HALE: How many people are refused reimbursement under IPTAAS, and why are they refused?

The Hon. JOHN HATZISTERGOS: If they meet the terms of the policy—

Ms SYLVIA HALE: Perhaps you could take the question on notice and provide greater detail in your answer to the question.

The Hon. JOHN HATZISTERGOS: For example, if you were going to go from your house at—where do you live?

Ms SYLVIA HALE: Petersham, so I would not be eligible.

The Hon. JOHN HATZISTERGOS: If you were going from your house at Petersham to Royal Prince Alfred Hospital, and you applied under IPTAAS, you would not get it because you are under the kilometres rating. That is a reason why a person might be refused.

Ms KRUK: Ms Hale, obviously the application of the policy is important, but the chief executive in each area health service has discretion based on compassionate grounds. I am certain you would be aware of instances where that discretion has been exercised. We will take on board providing that material.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Minister, with regard to surgical services in Shellharbour, are there surgeons on call there? If not, why not? I would remind you that this is one of the busiest surgical casualties in the country.

The Hon. JOHN HATZISTERGOS: Perhaps, if we could pass to the next question, we will get the information on that and come back to the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is happening with plans to close Rozelle hospital?

The Hon. JOHN HATZISTERGOS: That is already in the public domain. We have already indicated we are moving to Concord.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So will there be no facilities at Rozelle at all?

The Hon. JOHN HATZISTERGOS: There will be. The issue of Callan Park is one that is presently before the Government. We have made it quite clear that the veterans who are currently at Rozelle hospital will remain. I will give you this note, and this might cover some of your questions. Sydney South West Area Health Service: clinical services at Rozelle hospital will transfer to the new purpose-built facility at Concord in June 2008. Construction has already begun on the new range of mental health facilities, and it is expected to be completed by March 2008, followed by a commissioning period over April and May.

Planning is also under way to transfer patients and services, which will take approximately one week. That is the plan. This will give mental health patients fuller access to the modern facilities available at Concord. Rozelle was built many years ago. Standards of health facilities and services have changed considerably. The current buildings are not suited to modern health care and cannot feasibly be renovated to the required standard. The new campus at Concord will provide a safer and more appropriate environment for the benefit of patients and staff. The new campus will be built at a cost of $58 million and provide 176 beds for acute and recovery services across age groups. This is a significant development for New South Wales Health. It represents the relocation of one of the State's major mental institutions. It reflects the Government's commitment to mainstreaming of mental health services with general health services to benefit people with mental health illnesses, their families and carers.

CHAIR: Minister, would you speak up, please.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Minister, could you tell us the actual percentage of change in the budget for mental health? There have been a lot of announcements of certain amounts over five years and so on. It is not clear what are re-announcements and what are actual announcements. What is the actual change in the mental health budget, both capital and recurrent?

The Hon. JOHN HATZISTERGOS: The actual change?

Ms KRUK: Dr Chesterfield-Evans, you are interested in what is new money and what previously has been announced?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms KRUK: That distinction, and the impact in relation to the percentage?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms KRUK: Okay.

The Hon. JOHN HATZISTERGOS: The 2006-07 budget confirmed the Government's commitment to take the deliver of mental health services in a new direction. This year alone, the mental health budget is a record $946 million, representing an increase of $93 million, or 10.9 per cent, on 2005-06. Since 1994-95 recurrent funding for mental health services has almost trebled, increasing by nearly $600 million. This rapid growth in funding has resulted in a significant improvement in the delivery of mental health care in New South Wales.

This increased funding commitment for 2006-07 is part of the five-year new direction in mental health, which the Government announced on 1 June 2006. There is actually a brochure. If you have not got it, I will give it to you. Under this five-year program, an additional $939 million will be invested to improving mental health services and recruiting hundreds of new mental health staff throughout New South Wales.

The emphasis of the initiative is on community-based care, early intervention and work force developments. The package of additional funding for 2006-07 has three main components. The first is—as part of the Government's four-year $241 million mental health enhancement program, which commenced in 2004—an extra $20.4 million for the continued expansion of mental health beds and community-based services. These funds will be applied to the extension of service initiatives such as the new psychiatric emergency care services attached to emergency departments in major public hospitals and expanding the housing accommodation support initiative. The Rural Critical Care Program will also be expanded. It includes access to the mental health access line and having access to mental health nurses and triage in hospital emergency departments in rural and regional New South Wales.

The second component of the 2006-07 funding enhancement is $33 million in special grants. These comprise a capital grant of $23 million for St Vincent's to redevelop its mental health services; a research grant of $4 million to the University of New South Wales; an infrastructure grant of $6 million to the Brain and Mind Research Institute.

The third component is $38 million, as part of a $300 million program of initiatives over five years, to strengthen community-based and early intervention services. This program builds on the $10 million in community initiatives, which was announced last year, and addresses the priority areas of the forthcoming COAG Mental Health National Action Plan. The $38 million enhancement for new mental health initiatives in 2006-07 covers twelve projects across four broad program areas: work force development, models of care, rehabilitation, family and carers.

Some of the major enhancement projects are: $5 million to expand HASI, which will provide at least 234 extra support packages for people with a mental illness; $6.8 million for out of hours emergency and acute community responses, to assist police, ambulance workers and the community to respond appropriately to psychiatric emergencies;

Further major enhancements include $4 million for specialist community-based mental health services for older people; $2.2 million to improve assessment and intervention through the redesign of the existing confused and disturbed elderly units; $5.6 million for a co-morbidity package to treat people with both mental health illness and substance abuse disorders; $3.8 million for clinical mental health rehabilitation programs; $2.7 million to establish a 24-hour mental health call service to New South Wales staffed by mental health clinicians, which will form part of the National Health Call Centre agreed by the COAG; and $1.3 million to enable community mental health teams to provide specialist treatment and support for adults and adolescents in contact with the criminal justice system. This record $946 million for mental health services builds on the foundations laid by previous budgets, and demonstrates our commitment to providing the necessary resources to deliver accessible, safe, high-quality services to an increasing number of people who live with a mental illness. Dr Matthews wants to supplement the answer.

Dr MATTHEWS: If possible, I would like to clear up some of the confusion about announcements. If you go back to the budget estimates for the financial year just finished, 2005-06, which were published in about May 2005, you will find that the projected mental health budget for 2005-06 was $854 million. Subject to the audited accounts, which are not due until November, the likely spend in 2005-06 is about $940 million, that is almost $90 million more than was originally projected. There are a variety of reasons for this—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The increase last year was pretty modest.

Mr BARKER: No, it was a 7.9 per cent increase. It went from $783 million $854 million.

Ms KRUK: That is not what Treasury said to us.

Mr BARKER: That was a $71 million increase in the mental health budget last year.

Dr MATTHEWS: The critical thing is that that was the projected increase, but the actual increase was round about $90 million more than was originally projected. There are a variety of reasons for that. Likewise, the budget figure that the Minister read out for the current financial year of

about $946 million will doubtless, when we finally get the audited accounts in November 2007, be something in the order of $1 billion.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure, but it was coming from a very low base, and that was the point made in the mental health report.

Dr MATTHEWS: I think—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As far as Aboriginal health is concerned, the budget papers show an increase in spending of 2.6 per cent. Given that Aboriginal life expectancy is still about 17 years less than the Australian average, why is the increase in Aboriginal health spending only 2.6 per cent, which is less than the inflation rate?

The Hon. JOHN HATZISTERGOS: In 2006-07 the Government will invest $58.4 million in Aboriginal health service programs, which is $1.6 million more than previous years and an increase of $47 million since 1994-95—this is dedicated Aboriginal health. The Aboriginal Health Service objective is to raise the health status of Aboriginal communities and provide a healthy lifestyle. Under the program Health provides supplementary health services to Aboriginal communities, particularly in areas of health promotion, health education and disease prevention. These services are being provided through a range of service providers, including community centres, local hospitals, non-government organisations, Aboriginal—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I draw your attention to the amount of the increase, which is only—

The Hon. JOHN HATZISTERGOS: I have not finished my answer, and my answer will answer your queries. Services are also being provided through the Aboriginal Medical Service and Aboriginal community-controlled health services to New South Wales. But New South Wales also has a range of specific health measures targeting the Aboriginal community, including otitis media screening, a Vascular Health Program, a Family Health Strategy, an Environmental Health Program, Housing for Health, Aboriginal environmental health officers traineeships and the Aboriginal Maternal and Infant Health Strategy. I can give you details of each of those strategies, if you want. Funding for otitis media screening of $2.49 million over four years is allocated for this initiative, allowing for an increased number of Aboriginal children aged from 0 to six years to access free screening for the detection of otitis media over the term of the initiative. Approximately 23,800 Aboriginal children in New South Wales are in this age group. This includes the expansion of the otitis media screening and community education services for 0 to 6-year-old Aboriginal children throughout New South Wales through a whole-of-government approach under Aboriginal Affairs, Two Ways Together.

Otitis media, or middle ear infection as it is commonly known, has a significantly higher incidence rate in Aboriginal children than in non-Aboriginal children. But our most recent achievements under this initiative include more than 11,000 Aboriginal children screened for otitis media in 2005-06, and 32 Aboriginal health workers successfully completed audiometry training in 2004-05 and an additional 60 were trained in 2006. The Aboriginal Chronic Care Program is a key initiative of New South Wales Health, which aims to improve the quality of the chronic care of Aboriginal people. This program received a recurrent annual budget of $2.3 million. The Aboriginal Vascular Health Program is a major initiative. There are 31 recurrent Aboriginal Vascular Health projects across New South Wales, including eight in Justice Health and four in Aboriginal community-controlled health organisations. The broad Vascular Health Program approach includes diabetes, heart disease, stroke, hypertension, and kidney disease. It has been adopted because of the shared risk condition and the common approach needed for prevention in Aboriginal communities. In March 2005 Aboriginal Chronic Conditions Area Health Service standards were launched to outline the standards of care and demonstrations of compliance for area health services across areas of cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer.

In December last year I launched Know Your Heart, a cardiovascular training manual for Aboriginal health workers. Aboriginal Family Health strategies include an allocation of $1.2 million in 2005-06. Area health services, non-government organisations, and education centre for violence have worked collaboratively to deliver programs to local communities. The Aboriginal Family Health

Strategy and funded programs aim to reduce the occurrence of family violence and sexual assault in Aboriginal communities, and provide a framework to deal with these concerns in a culturally appropriate manner. The Aboriginal Environmental Health recurrent funding of $1.1 million delivered a number of programs that are improving environmental health conditions in New South Wales Aboriginal communities. Housing for Health is very interesting. It surveys and fixes urgent problems within houses that will affect residents' safety and health, for example electrical, sewerage, water supply, washing facilities, cooking appliances and other items, which can result in health or safety risks. Repairs focus on safety and health, not aesthetic or other issues such as painting. In 1997 more than 1,800 houses across the—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We are a long way from the drop in the budget.

The Hon. JOHN HATZISTERGOS: There is no drop in the budget. There was an increase in the budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am saying it has gone up 2.6 per cent. The question was the budget's rise of 2.6 per cent was less than inflation.

The Hon. JOHN HATZISTERGOS: You do not want to know about Housing for Health?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I do not want a four-page answer to something I did not ask.

CHAIR: Minister, do you want to provide it on notice?

The Hon. JOHN HATZISTERGOS: These are very important projects.

CHAIR: Why do not put on the record all the wonderful things you are doing, and then answer my question?

The Hon. JOHN HATZISTERGOS: I think I have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, you have said nothing—

The Hon. JOHN HATZISTERGOS: And I was in the process of doing that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: —about the fact that the rise in the budget of 2.6 per cent is less than inflation, despite the fact that Aboriginal life expectancy is 17 years less than the national average.

The Hon. JOHN HATZISTERGOS: But I pointed out to you, if you listened, that the dedicated Aboriginal budget has increased since last year, and, indeed, has increased since 1994-95 by $47 million.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that is inflation.

The Hon. JOHN HATZISTERGOS: But beyond that, Aboriginal people also have other health needs, which are mainstreamed and people access those services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am talking about targeting services.

CHAIR: The time for crossbench questions has expired.

The Hon. CHRISTINE ROBERTSON: What will be the impact of 29,000 public sector job cuts on your portfolio?

The Hon. JOHN HATZISTERGOS: This is a very good question.

Ms SYLVIA HALE: It is one that has been asked ad infinitum.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hypothetical.

The Hon. JOHN HATZISTERGOS: The Opposition likes to pretend that its promise of 29,000 job cuts will have no impact on the delivery of health services—

The Hon. ROBYN PARKER: Is this in the budget, your budget?

The Hon. JOHN HATZISTERGOS: —but there is no simple way that this can be true. I am sure that the Leader of the Opposition and the honourable member for North Shore—I am not sure, actually—understand the way the health system works. They talk about backroom bureaucrats that could seem to be eliminated—

The Hon. ROBYN PARKER: This is not in the budget.

Ms SYLVIA HALE: Point of order: The Minister was at pains to reprimand the Committee because it was not asking questions about budget estimates. Now he is proceeding to provide an answer that is totally unconnected to budget estimates. I wish he would be either consistent or be quiet.

The Hon. JOHN HATZISTERGOS: It does relate to the budget.

The Hon. CHRISTINE ROBERTSON: To the point of order: The issue in relation to budget estimates and issues on which points of order can be taken relate to relevance, and it is relevance to the Minister's portfolio not relevant to specific issues other persons may want to hear. I would argue that this is relevant to the portfolio

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To the point of order.

CHAIR: I will rule on it shortly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The fact that another party may or may not promise to make some changes to the public service generally, without any specific reference to Health, is presumably wild speculation and could not possibly be taken to indicate what effect it might have on Health, if there were any numbers cut from Health. As such, it is beyond the scope of this Committee.

CHAIR: Thank you. I will rule on the point of order. The rules for questions are the same here as the rules in the House. Basically, a point of order should have been taken on the question that was asked, not on the answer, because the Minister is answering the question that was asked. The fact is that the question may have been irrelevant to the budget process, but no-one took a point of order so I will allow the Minister to finish his answer.

The Hon. JOHN HATZISTERGOS: Thank you, Madam Chair. The Opposition can go around and talk about backroom bureaucrats, suggesting that they can be eliminated without any impact, but when we are talking about budgets and budget risks, this is highly relevant. It is important that the Opposition comes clean and tells which jobs will go. Robyn Parker last year told the estimates committee that this is not a matter for her to answer at the moment and that she would tell us after the election. We need to know immediately because we need to know how many of the projects that I have outlined in my answer and how many savings that have been achieved through amalgamations will be put at risk by this reckless 29,000 job cuts policy that the Opposition has articulated.

If you look around at the Opposition's policy, what they have promised to do is quarantine the so-called front-line workers. But we want to know exactly who are these front-line workers who will be quarantined. When you look at the average hospital, who are the ones who will be targeted? Will it be the ward staff? Will it be the cleaners? Will it be security? Will it be the kitchen and the linen staff? Will it be maintenance? Will it be the clerical staff who answer the phones, staff the front desk and process the central patient information? We need to know whether these are the people who are on the Opposition's hit list because if you take these people away, the people who the Opposition characterises as front-line staff—the doctors, the allied health staff and the Ambulance Service

officers—they will be left cleaning the toilets, changing light bulbs and they will be buried by mountains of paperwork. The hospitals will grind to a halt.

Perhaps the Opposition is talking about the area health service level. I have already spoken about reforms we have achieved in terms of reducing administrative overlap and duplication through area amalgamations. The Opposition plans to undo this work and restore layers of bureaucracy. Putting the inconsistency of the Opposition's policy to one side and trying to anticipate the cuts that they may have in mind at an area level, maybe it is the clinical governance units that oversee quality and safety. Perhaps it is the health promotion units that run local initiatives, such as school-based healthy eating and exercise programs, or the anti-smoking campaign, or the programs supporting and promoting breast-feeding. Maybe it is something as basic as sacking the human relations people who look after the pay and conditions of thousands of front-line staff. We just do not know who these people are who have been targeted in this 29,000 figure.

I guess the simplest bureaucratic target would be the Department of Health—the so-called head office. But just which of the so-called bureaucrats in the so-called head office would the Opposition target—the staff in the Nursing and Midwifery Office who manage the statewide recruitment of nurses and retention of nurses, the staff in the Centre for Mental Health or the Centre for Aboriginal Health, the staff who provide the support and funding co-ordination for our non-government organisations partners, the staff in Population Health who monitor and work to prevent communicable diseases, or perhaps those working on planning our response to a major terrorist attack or a pandemic such as avian flu, or perhaps it might be the staff who oversee the Patient Safety and Clinical Quality Program? I could go on, but the Opposition really needs to tell us just which of these functions they think New South Wales can do without, which are the ones that are on its so-called hit list.

The concept that Health can meet its share of 29,000 job cuts without undermining front-line services is just a nonsense. Not only is the distinction between front line and non front line services a furphy, but the numbers just do not add up. If the Opposition reads the '04-'05 annual reports with the oodles of advisers that they have in Opposition rooms, they would know that we have 66 per cent of full-time equivalent staff being nurses, medical, allied health and uniform ambulance staff; 18 per cent are hospital employees, such as wards people, technical assistance and ancillary staff; 8 per cent are in hospital services, such as cleaning and catering; 6 per cent are in corporate administration; 1 per cent are in maintenance and trades; and 1 per cent are categorised as other. The overwhelming majority of our staff are involved directly in front-line service delivery.

The member for Vaucluse's 29,000 figure appears to have been calculated on a figure that is roughly 10 per cent of the public sector work force, so we assume that he is looking for a 10 per cent reduction of the New South Wales Health work force which was reported at 87,867 in June '05. That means that his target for Health would be expected to be 8,800 people. The fact is that he could sack every single employee and corporate administrator across the entire system and that would yield him only 5,000 scalps, so where are the rest coming from? The 29,000 job cuts that he talks about is one of the core elements of the entire budget strategy and is supposedly the source of funds for every promise he makes. That cannot be delivered. It poses not only a direct threat to front-line services but a major risk to record Health budgets. If he cannot deliver on job cuts, how can he plug the black hole that he has in his own budget? It is just a question of how he can deliver on what he is promising without making the 29,000 job cuts and without affecting front-line services. We need to be clear about this.

Those of you who are interested in administration and want to wield an axe in administration, go for it. There are 4,000 of them down in Canberra in the Department of Health and Ageing. They do not deliver a single service and they do not treat a single patient, so go after them. Get rid of them. They are useless. They do not do anything. They just get in our way.

The Hon. CHRISTINE ROBERTSON: Minister, in the Health portfolio, what will be the impact of the Federal WorkChoices legislation?

The Hon. ROBYN PARKER: Madam Chair, point of order: In relation to your previous ruling about questions being out of order because they do not relate to the budget, this is clearly unrelated to the Health budget and budget estimates. The Minister is obviously being asked these dorothy dixers to waste time and avoid answering questions related to the budget.

The Hon. CHRISTINE ROBERTSON: To the point of order, Madam Chair: I point out that the only rule in relation to budget estimates is the rule of relevance and its relevance to the portfolio. Most certainly this question is relevant to the portfolio and is not out of order.

CHAIR: Minister, provided you answer the question in relation to the impact on your portfolio and not something that might be a hypothetical, you may proceed.

The Hon. JOHN HATZISTERGOS: I do not think that WorkChoices is hypothetical, Madam Chair. It is very relevant.

CHAIR: You may proceed.

The Hon. JOHN HATZISTERGOS: I do not think you need to be concerned about that aspect of the question. Can I just say that, as a consequence of our legislation that was passed, Health workers in public health in New South Wales are protected from the Howard Government's draconian industrial relations legislation. This is important for nurses, ambulance officers and other public health workers who are at risk of being captured by the WorkChoices legislation due to the structure of their agencies. Indeed, it was very clear that the Federal Government intended to capture them because the booklet that it released on WorkChoices explicitly noted that certain public health organisations would be considered statutory corporations and therefore are covered by the legislation.

It is worth remembering that before we introduced our legislation the member for Vaucluse promised that, when he becomes Premier, he would hand all the workers, public or private, over to the Federal system. The promise for nurses, ambulance officers, and community health officers at that time was to throw them into this dog-eat-dog world. Fortunately there has been a backflip by the member for Vaucluse. He ended up supporting our legislation to protect public health workers. But that is pretty cold comfort when you have promised to sack 29,000 of them. Until the backflip, the Opposition had not said a word in defence of health workers and they did not care about putting the pay and conditions of those workers at risk. They did not care about making it more difficult to balance their work and family commitments or the potential risks to safety for workers and the community with the loss of conditions such as reasonable workloads. This is an important backflip but it was a false backflip. I am sure that the member for Vaucluse's heart really was not in it. For the evidence, you need to look at the fact that the member for Vaucluse has not lifted a finger in defence of workers in the private sector. This has very real repercussions for the public health sector.

Health workers in the private sector, such as nurses and allied health workers in private hospitals and aged care facilities, have been pulled into the WorkChoices nightmare. Their pay and conditions are at risk and they have been left to bargain one on one with their employer without the protection of a comprehensive award system or an independent umpire. I have already started to hear these horror stories. For example, a group of nurses in regional New South Wales were told that their jobs had been restructured overnight, despite the fact that nothing about the job had changed. They were given an ultimatum: either accept the so-called new jobs and sign up to the individual contracts with significantly reduced pay and conditions or accept that they would be made redundant. That is not the only case I have heard of, and I am sure it will not be the last. While the Government will do everything it can to defeat the WorkChoices legislation and protect all workers in New South Wales, the Leader of the Opposition has publicly stated his support for the WorkChoices legislation to apply in the private sector. It makes one wonder what will happen to our legislation of protecting the public sector health workers if a Debnam coalition government were to be elected.

It is about time the Opposition stood up for all health workers, not just when they are shamed into it by the Government. It is about time the Opposition stood up for nurses, allied health workers, support staff in the private sector, workers who deliver our babies, care for us and our families when we are ill, and look after our parents and grandparents. They deserve fair wages and working conditions regardless of the setting that they work in—public or private.

The Hon. CHRISTINE ROBERTSON: Minister, what are the impacts of rising fuel prices on the Health budget and the Health portfolio?

The Hon. JOHN HATZISTERGOS: We are all aware of the terrible impact that rising fuel costs are having on families. As many members would be aware, rising fuel prices also impact on the cost of running vehicles in the Health system. The obvious areas are the community health nurses who are out on the road making visits to patients in their homes, and area health services are required to cover long distances between health facilities in rural and regional New South Wales. One area that the Committee may not be aware of is the impact on the NSW Ambulance Service. In 2004-05 the total fuel and oil expenditure for the Ambulance Service was $4,390,069. In 2005-06 it was 45,081,851—an increase of $691,782 or 16 per cent on the previous year. In 2006-07 the projected fuel budget is $5,665,436 , an increase of $583,585 or 11 per cent on the previous year.

I am advised that given current prices the Ambulance Service expects to spend about 20 per cent more on fuel in 2006-07, at least $360,000 over the projected fuel budget. That growth in fuel costs comes in spite of our significant investment in a new, more fuel-efficient fleet. In 1996 the Ambulance Service operated 880 V8-powered ambulance vehicles that consumed 35 litres of petrol per 100 kilometres travelled. The Government has progressively replaced and upgraded the ambulance feet over the past five years. Currently no ambulance is more than three years old, and the average age of ambulances in 2005-06 was just 18 months.

The introduction of newer ambulances has greatly improved fuel consumption, efficiency and reliability. All V8-powered vehicles have been replaced in modern ambulances are powered by a very fuel-efficient turbo-charged diesel engine that consumes 12 litres of diesel per 100 kilometres travelled. Yet, we are still experiencing massive increases as fuel costs rise. Fuel increases are impacting also on our aeromedical services with our helicopter contracts at the mercy of the CPI, and our fixed-wing aircraft contracts based on actual fuel costs or regular variations based on the posted airfield price per litre.

The Commonwealth's failure to address rising fuel costs is not only hurting families but is eating into the budgets of essential health services. It is about time that we have a clear statement from the Leader of the Opposition that he joins with the Government in calling on the Federal Government to do something about fuel prices. Perhaps he just does not have the guts to stand up to Canberra at times when that is needed to be done.

The Hon. TONY CATANZARITI: Minister, how would the Health portfolio benefit from a share of the $3 billion in GST funding that should be coming to New South Wales?

The Hon. JOHN HATZISTERGOS: I can think of many things that we could spend additional funds on—more surgery, more staff and increased capital investment. But the areas that spring most readily to mind are those areas where we are currently plugging the gaps created by the Commonwealth Government's failure: establishing more after-hour's general practitioner [GP] clinics in our emergency departments to treat patients who are turning up to hospitals because they cannot find a bulk-billing GP, especially after hours; setting up additional integrated primary and community health care centres, to improve co-ordination and integration between our community health services and GPs; to give patients a smoother journey by addressing that disconnects caused by a split in the system's funding, which the Commonwealth refuses to address.

We could invest more in public dental services—and dental has been big on the agenda—and the Commonwealth could take that up as one of its constitutional responsibilities, and restore the funding that the Commonwealth pulled out of the system when it slashed the Commonwealth Dental Scheme in one of its first callous acts upon coming to power and which the New South Wales Coalition seems to be the apologist for. We could make an additional investment in early intervention strategies aimed at keeping people well in the community and out of hospitals, particularly older people and people with chronic illness. One particular program comes to mind in this area; in February of this year I announced a $4 million program aimed at minimising the need for older people to be admitted to hospital. It is called the Sub Acute Fast Track Elderly Program [SAFTE], is a pilot program being trialled out of four hospitals: St George, Hornsby, Queanbeyan and John Hunter hospitals.

The group of people being targeted by SAFTE accounts for 6.3 per cent of the New South Wales population, but in 2004-05 they occupied 30 per cent of all acute hospital bed days. SAFTE provides an integrated health and community care for frail older people who show the first sign of a

slight deterioration in their medical condition. It brings together hospitals, community health services, the Ambulance Service, and home and community services in a co-ordinated way so that older patients get the right care at the right time. SAFTE offers an assessment by a health commission and a ComPacks case manager within 48 hours of referral; fast tracking of diagnostic tests and assessment; and up to six weeks of case management and the provision of access to long-term sustainable parent support thereafter.

As part of the SAFTE care program, people at risk are identified by their general practitioner, hospital staff or community service providers. Early identification is a critical component of the SAFTE Program as it early and often subtle changes in older persons' conditions or capacity could indicate that their health will deteriorate. If we intervene early we can avoid hospital admission and early improvement of that patient's condition and maintain their quality of life in the community. That model has been successfully trialled in with 570 frail older people in their homes, prevented avoidable hospital admissions in 80 per cent of cases. Given the involvement in the primary care of the Commonwealth, I decided to write to Minister Abbott and invite him to partner us in this innovative program. It would mean that people would not have to go to hospital but that they could be looked after in their homes, they could have a better quality of life and this situation would not deteriorate to the point that they require acute services with all the complexities that that involved.

I received an answer from Minister Abbott, which was "No", he would not support this program. When you asked me what I could do with $3 billion, this is one area that I think is very important. When it comes to funding of health it is not just a question of a fair share of funding. The GST rip-off is exacerbated by a range of health-specific rip-offs. Next year we will negotiate the Australian Health Care Agreement [AHCA], which we had to sign in 2003, otherwise we would have lost $1.1 billion. The funding provided under the AHCA was nearly $1 billion short of the Federal Government's own 2002-03 budget estimation of what the State and Territories would need to assist them in continuing to provide services in public hospitals. In New South Wales, the funding is $278 million less than a simple rollover of the 1998-2003 arrangements.

That $278 million could have meant additional services across our hospitals—more nurses and more surgery. But the situation has worsened since the 2003-08 agreement was signed. I am advised that the Australian Government has now revised its indexation rates for the agreement downwards, which means that New South Wales funding from the Commonwealth will decline even further, by some $116 million over the five years of the agreement. During 2004-05 public hospital services came within the scope of the agreement, which is interesting.

A couple of weeks ago I went and saw Kevin Stewart, the former New South Wales health Minister and asked him about the first Medibank agreement he signed up when he was Minister. He told me that in his day the New South Wales Government spent 40¢ to get a Commonwealth dollar. New South Wales is now spending $1.63 for every Commonwealth dollar and that will go to $1.81 for every Commonwealth dollar. That just indicates the sort of shift that has occurred over the course of the last 30 or more years.

The Hon. ROBYN PARKER Mr Barker might be able to answer my next question. I return to the Greater Southern Area Health Service and to the discussion we had earlier regarding cars. How many motor vehicles in the Greater Southern Area Health Service are reverse novated leases which allow access to discounted government fleet prices, stamp duty exemption, et cetera?

Ms KRUK: Ms Parker, we would not collect that data. As I indicated earlier, if we have that data we will provide it to you. I think the terms of a novated lease are very beneficial to the Crown. As Mr Barker indicated, the Crown has no responsibility for the maintenance or care of the car. It is an arrangement that has been factored in to suit the Crown. So, if anything, it has been an encouragement. The Greater Southern Area Health Service, like every other area health service, has been asked to look at the efficiencies it can achieve through the management of its fleet, amongst other things. I do not have those figures with me today. I state again that if representations have been made to you that there are problems in this area I ask that you make them available. If not, I need a bit more detail. The source of your question is a bit unclear to me.

The Hon. ROBYN PARKER: My question related to reverse novations.

Mr BARKER: As I said in answer to your first question, there is a standard policy, which I think from memory has 34—it might be a higher number—approved benefits. The first thing we would verify is whether it was an approved benefit. If it were an approved benefit we would then check, based on any factual information you gave us, whether it was implemented in line with our policy. There are 100,000 employees in health services. These matters are managed at the local level in line with our policy.

The Hon. ROBYN PARKER Referring to the Greater Southern Area Health Service, there are 1,461 people on the elective surgery waiting list. Acting chief executive officer Nigel Lyons stated that a further 22 per cent on the waiting list were on the not ready for surgery list, which equates to 321 people. That makes a total of 1,782. How many of those 321 people listed as not ready for surgery have waited more than 12 months, 24 months, 36 months, 48 months and over? In what categories is their surgery?

The Hon. JOHN HATZISTERGOS: I will ask Professor McGrath to respond to your question.

Professor McGRATH: I cannot give you the exact details of how many on the not ready for care list would be in those categories. The surgical waiting list in the Greater Southern Area Health Service had a major achievement in the last 12 months. Over 12 months ago it had over 270 patients on the ready for care list waiting greater than 12 months for surgery. By June 2006 it had achieved zero patients waiting more than 12 months and also zero patients waiting in the urgent category more than 30 days. The issue of people on the not ready for care waiting list who may have been on that list for greater than 12 months is addressed in the new waiting list policy, which was introduced across the system in June this year.

The process is that all patients on the not ready for care list who have been refused surgery, who have been offered surgery on more than two occasions, and who have not made themselves available for it, or who have been not ready for care, must undergo a clinical review and then be placed on the waiting list. If they continue within the not ready for care system, after six months they need to have a further review and they cannot continue on the not ready for care list for more than 12 months. So the policy has changed to ensure that patients right across the State are not staying on the not ready for care list longer than 12 months. Indeed, they are continually being monitored as to their readiness for surgery. I should also state that in the reduction in the long waits achieved right across the state by June 2006, the total for the not ready for care list dropped by 42 compared to the previous year. In achieving that target there was no shift of patients from the ready for care list to the not ready for care list. That applied also down in the greater southern area. We would need to take the question on notice to provide actual numbers. The policy is such that all those patients will be reviewed and offered the terms under the new policy.

Ms KRUK: I add an important general point. When the former Minister and this health Minister gave us additional money for elective surgery the clear proviso was that the surgical service group, which contains members who had a history of being critical of the management of surgery, was given the task of oversighting the number of procedures and looking at the policy in relation to access to surgery. The people in that group oversight those numbers. I still think that they are the major drivers of change in this system. I can understand why they become somewhat tetchy when there is criticism that the numbers are being fiddled, because this is a process that they oversight. They ensure that the money is spent where it should be spent.

I am aware that Professor McGrath and Professor Brian McCaughan, who is on that surgical services group, went to the greater southern area for the first time about 12 months ago and helped it pull together its surgical services plan. They went down again more recently in the last few weeks. I think that area is performing quite well in relation to surgery, but a whole range of initiatives have been identified that need to be pulled together. Katherine, I think I am correct in adding that additional comment?

Professor McGRATH: Yes. I think we visited Albury Base Hospital about two weeks ago where we met with surgeons and congratulated them on the performance they had achieved across the system.

The Hon. ROBYN PARKER Will you still provide on notice the details that were mentioned earlier?

Professor McGRATH: Yes.

CHAIR: I return to a question that was asked earlier about staff positions under the heading of corporate administration. On that occasion you suggested we should read it in the annual report, where the figure is 5,059. Relying on these so-called vast resources of the Opposition—

The Hon. JOHN HATZISTERGOS: So you managed to get it?

CHAIR: No. I am interested in knowing whether you can explain the difference between that figure and the figure of 9,007, which is described as the figure for corporate services for NSW Health in the figures provided by Treasury under freedom of information in a document analysis of front-line staff by agency. What is the difference between those figures?

The Hon. JOHN HATZISTERGOS: I will ask Mr McGregor to answer that question.

Mr McGREGOR: Two different data sets are used, one by commerce and one by the Public Employment Office. That is a wider definition than the definition we use, which focuses on corporate services staff employed solely in area health services. The definition used by the Public Employment Office is wider and takes into account other corporate positions. As the Minister said earlier, some of those staff members are in hospitals answering the telephones and some are on the front desk, so they get captured in that data set. There are two quite separate data sets.

CHAIR: Are you able to provide us with a clear understanding of the categories that comprise the 5,000 and the categories that comprise the 9,000?

Mr McGREGOR: Yes, there are clear definitions.

CHAIR: So there are two definitions?

Mr McGREGOR: There are two clear definitions.

The Hon. JOHN HATZISTERGOS: I have given you a break up.

Ms KRUK: I add that what is significant is that Health is compared and benchmarked at the rest of the sector. The savings targets of 1,000 that we referred to were clearly administrative positions in the area health service. So there is no discrepancy. I am quite a happy to show how the figures are different. On benchmarking, I do not have the number to hand—

The Hon. JOHN HATZISTERGOS: I have given it to Parliament. Read my answer to Jenny Gardiner's question from a couple of months ago. I have given you the benchmark figures for Health compared with other agencies. We are below peer agencies.

CHAIR: What is your benchmark in relation to the percentage of—

The Hon. JOHN HATZISTERGOS: It is there; it is in the answer to the question that I gave Jenny Gardiner.

CHAIR: Perhaps you could assist us now.

The Hon. JOHN HATZISTERGOS: I cannot recall it off the top of my head but the figure is in that answer. As I said, you have got all these resources. You were able to find the 5,000 figure a moment ago. If you look at my answer to Jenny Gardiner's question—which was about Hunter-New England, incidentally—you will find that there is a benchmark figure. We can give it to you anyway. I am being so generous here.

Ms SYLVIA HALE: The Minister has copious resources.

The Hon. JOHN HATZISTERGOS: Not as many as you have, Sylva. People flutter in and out of your office; there is a conga line of people in and out. I do not know what I would do if I were in your position. I think I would find something. Between June 2004 and June 2005 corporate administration staff were reduced by 426 FTE, or 7.8 per cent, and there was an increase of 2,906 FTE for front-line staff. The increase was 107 FTE, or 1.7 per cent, for medical staff; 2,035 FTE for nursing, or 6.1 per cent; 686 FTE for allied health, or 5.2 per cent; and 78 FTE for uniformed ambulance, or 2.7 per cent. I can also give you a comparison of corporate services ratios and costs for NSW Health with other "super" agencies and agencies in general. Health was 22.4 FTE to one corporate support. The super agencies median is 17.3 to one corporate support. In other words, we have more front-line staff per corporate support compared with other agencies—22.4 FTE to one corporate support. Other super agencies have 17.3 to one corporate support. That gives you some comparison.

If you want to look at the cost of corporate services as a proportion of our budget, ours is 2.81 per cent at 2004-05. That is a decrease on 2002-03, when it was 3.72 per cent. Compared with other agencies of a similar size, for corporate services the average is 3.48 per cent. So we are 2.81 per cent, which as a proportion of our budget is less than what we had in 2002-03 and well down on super agencies. It is 3.48 per cent for super agencies and 2.81 per cent for our corporate services. Of course, if you look at those figures for the Commonwealth, it is 100 per cent because all they do is corporate—sign cheques and tell everybody how to do their job. There are 4,000 of those. It is $1.1 billion. That is something that those of you who are involved in health ought to direct your attention to. I have certainly been doing that.

CHAIR: Out of interest, how many advisers and support staff do you have with you today?

The Hon. JOHN HATZISTERGOS: I do not know; I have not counted them.

CHAIR: Please take that question on notice because I would like to know the answer. I would also like to know the total salary package for everyone who is here today.

The Hon. JOHN HATZISTERGOS: I did not ask for this estimates hearing; you did.

Ms KRUK: If I may add, we endeavour to answer as many questions as we can for the Committee at the time rather than taking them on notice. I think that is in the interests of good governance. Secondly, we are an $11.8-billion business.

The Hon. JOHN HATZISTERGOS: Twenty-eight per cent of the State's budget.

Ms KRUK: And I think it is reasonable that there are technical experts on board to answer your questions. We hope that we do not need to draw on them but I think it is in the interests of the Committee being serviced.

CHAIR: Thank you for that explanation but I would like you to take that question on notice.

The Hon. JOHN HATZISTERGOS: Are you going to tell me how much this estimates hearing is costing? I would like to know that.

The Hon. ROBYN PARKER: Minister, how many patients who underwent treatment in New South Wales public hospitals in 2005-06 were unexpectedly returned to hospital within 28 days of their initial treatment? How does that figure compare with other States?

Ms KRUK: As an introduction and in order to give Professor McGrath a chance to look at the data, I think members will be aware of the fact that we introduced a series of dashboard indicators by which we measure the efficacy, efficiency, quality and safety of the health system. One of those is obviously to look at the readmission rate, but that is obviously quite a targeted initiative in some instances. For instance, in my case readmission may be appropriate. In relation to the comparison of those measures, I think the annual report—

The Hon. JOHN HATZISTERGOS: The annual report provides some comparison. We have higher admission rates per head of population than any other State.

Ms KRUK: You are after readmission rates. Is that correct, Mr Parker?

The Hon. ROBYN PARKER: Yes.

The Hon. JOHN HATZISTERGOS: Yes. But I am saying that you have to bear in mind—I do not have the readmission rates in front of me—that we have higher admission rates per 1,000 people than just about every other State. We have more people per 1,000 being admitted to hospital than most other States.

The Hon. ROBYN PARKER: But readmission rates are on a percentage basis.

Ms KRUK: The Minister is providing background information.

The Hon. JOHN HATZISTERGOS: The readmission rates and those performance indicators are also in the annual report. So you can have a look at those as well.

The Hon. ROBYN PARKER: How does that compare with other States?

The Hon. JOHN HATZISTERGOS: I would have to get other States' annual reports to see whether they provide the same figures. I am sure you can do that.

Ms KRUK: Professor McGrath may have an answer.

Professor McGRATH: This figure is in the annual report on page 46. You can see from that that the figure for 2004-05 is 3 per cent. My recollection of the data compared with other health services around the country is that that information would need to come out of the ACHS report, which they put out annually. It is my recollection—which I will need to verify—that we are approximately average according to the rest of the jurisdictions. So we are in the benchmark ballpark with the rest of the States' performances in this arena.

The Hon. ROBYN PARKER: To clarify, there is a table in that annual report but does it give the percentage rate?

The Hon. JOHN HATZISTERGOS: Yes, it does. You can see it on page 46.

Professor McGRATH: On page 46 there is a graph.

The Hon. JOHN HATZISTERGOS: It has been stable for the past three years.

Professor McGRATH: Readmissions are one of the major dashboard performance indicators for the New South Wales health system. The graph is at the bottom of the page.

The Hon. ROBYN PARKER: Does it state how many patients? That was my question.

The Hon. JOHN HATZISTERGOS: No. The number of patients is the figure that I mentioned earlier. Are you talking about admissions?

The Hon. ROBYN PARKER: No. This is about readmissions that occur unexpectedly within 28 days, which is obviously an indicator of patient treatment. My question was: How many patients were readmitted unexpectedly within 28 days in 2005-06?

The Hon. JOHN HATZISTERGOS: You will be able to get those figures out of the next annual report when they are prepared. At the moment the figures we have provided and are talking about are the figures for 2004-05.

The Hon. ROBYN PARKER: Sorry?

The Hon. JOHN HATZISTERGOS: The figures that Professor McGrath was talking about a moment ago are figures from the last annual report—the 2005 annual report.

Ms KRUK: We are in the process of finalising the most recent annual report.

The Hon. JOHN HATZISTERGOS: We are finalising the 2005-06 figures, and they will be in the annual report that will be tabled in November.

Professor McGRATH: They will be 3 per cent of the total admissions.

The Hon. JOHN HATZISTERGOS: You can easily get the figures. If you go to the front of the annual report—you can get your advisors to do this—you will see a figure there for the number of admissions. You then go into the body of the report, page 46, and take the 3 per cent figure, put it into a calculator and get a figure. If you want to compare it with other States, you look at the Australian Council on Healthcare Standards report and that will give you a snapshot of how the other States are performing.

The Hon. ROBYN PARKER: That is right. It says that New South Wales is 3.3 per cent whereas in States such as South Australia it is only 2.8 per cent. So New South Wales is not doing so well. We are also not doing well in the area of dental, where we are funded the lowest of any State in Australia. Why is there such a large difference in per capita funding for public dental services in New South Wales? It is $17 per capita here compared with Tasmania—

The Hon. JOHN HATZISTERGOS: I do not think you can make those sorts of comparisons.

The Hon. ROBYN PARKER: It is per capita so it is an easy comparison to make. It is worse than any other State in Australia.

The Hon. JOHN HATZISTERGOS: Yes, I know you keep going on about that but you cannot make those sorts of comparisons for a number of reasons. Firstly, not everyone is eligible for free dental care, as you know, and eligibility varies from jurisdiction to jurisdiction. Secondly, just about every, but not all, jurisdiction has co-payments for dental services which infuses the so-called budget for oral services. I take this opportunity to provide the Committee with details of the Government's oral health plans. As you know, the Government made an announcement about it in its budget, and I will comment on it as well as on some alternative proposals which are out there in the community that I think also need to be addressed in this context.

CHAIR: I think you actually need to answer the question that was asked.

The Hon. ROBYN PARKER: The question is: Why is New South Wales funded per capita worse than any other State in Australia?

The Hon. JOHN HATZISTERGOS: I answered that question. Firstly, I do not accept your analysis.

The Hon. ROBYN PARKER: Why is there such a large difference?

The Hon. JOHN HATZISTERGOS: I have rejected your analysis. I made the point first of all that not every person is eligible; that eligibility varies. Secondly, as I have repeated on a number of occasions, most other States make co-payments in relation to those. They are co-payments that are made to the health system for public dental services, which inflates their figures in any event. Thirdly, I said that as you would be aware there has been a significant increase in this year's budget, $40 million over four years to address those issues.

CHAIR: As time has now expired for the Opposition. I will ask the cross bench, one of whom will get 10 minutes prior to the break at 11.00 a.m.

Ms SYLVIA HALE: Minister, please define precisely what activities constitute an individual occasion of service in relation to public dental services?

Dr ROBINSON: In terms of occasions of service it could be represented by people actually attending for an assessment or it could be for someone actually attending for care and treatment, so it encompasses both. It is not always possible when the assessment is being undertaken for care to be provided at that time so the assessment process is also counted as an occasion of service. It does not reflect in any sense people who are admitted to hospital; it is simply those who are provided with care in the community.

Ms SYLVIA HALE: For the purpose of the data that you collect there must be a definition of an occasion of service? Could you provide that definition?

Dr ROBINSON: There is a definition in terms of the categories that patients are placed in rather than a definition of the occasion of service. I am not aware of a definition other than the one that we commonly use which reflects both normal health care and oral health care which is the presentation of a patient and a provision of a service by one of our staff in relation to that patient.

Ms SYLVIA HALE: Could that provision of a service by staff be provision of a service by clerical staff, for example, making or cancelling an appointment or answering inquiries as to when an appointment is taking place?

Dr ROBINSON: I believe there is a category within the oral health information system that enables the clerical work to actually currently be recorded as well.

Ms SYLVIA HALE: Is it possible to provide figures that will indicate how many clerical occasions of service there are as opposed to how many treatments delivered or assessments made by dental practitioners or dental specialists?

Dr ROBINSON: It probably would be possible to do that at each individual site where the services were provided, but it is not any information that I would actually have.

Ms SYLVIA HALE: Would you agree that if provision of clerical services are included in occasions for service, it is possible to suggest that far greater level of service is being provided than is actually the case?

Dr ROBINSON: I am not able to confirm that that actually is the case. My reply was that I believe that information was probably currently recorded at the individual sites so there is an understanding of the work that clerical people are doing.

The Hon. JOHN HATZISTERGOS: We could have given you details of this if you had given us specific questions rather than take up this time.

Ms SYLVIA HALE: In February 2006 the chief health officer and the deputy director general, population health, wrote to the Australian Dental Association, New South Wales Branch and stated:

> *Service level Agreement has been established with Area Health Services which will, in due course, provide the Department with performance on:*
>
> ***Volume of service by occasions of service:***
> - *Children*
> - *Adults*
> - *Dentures*
> - *Specialist Dental Services*
>
> ***Priority Oral Health Program (POHP) Assessment and treatment targets:***
> - *Priority code 1 (24 hours)*
> - *Priority code 3a (5 days)*
> - *Priority code 3b (10 days)*

What progress has been made in relation to the provision of that performance data?

Dr ROBINSON: The service level agreements were developed with each of the area health services and were designed to initially cover the last financial year. We are currently in receipt of one of response from one of the area health services. I do not have the information to hand in specifics.

We have written to each of the area health services and indicated that as part of a performance review process we would want to have that information returned to the department, so it will be returned within the next month.

Ms SYLVIA HALE: Will that information be made public?

Dr ROBINSON: I have not had discussions with the areas over the way in which that information is going to be used. I will undertake that as part of our process.

Ms KRUK: I add, this is something the chief health officer has done that mirrors initiatives in other areas where we want to be certain that the additional and existing funding is actually targeted at oral health. What the chief health officer has done Is actually put in place a service level agreement. So one, we are confident that we are collecting the same data across each and every area health service. Second, in relation to what is the output in relation to that spend. Third, each of the area health services have some quite different oral health needs to ensure they have got strategies that deal with those needs.

Ms SYLVIA HALE: Would you agree that for the public to have equal confidence to that of the department it would be desirable for that data to be made public so that comparisons can be made?

Ms KRUK: I thank parliamentary members who were involved in that process. NSW Health won the gold award in relation to its annual reporting which acknowledged that we were actually both reporting a great deal of data in the annual report and on the web site and one of the few health agencies that actually also made comparison data. We will have a look at the material that is being sought. Area health services report a lot of data at local level for operational reasons that I do not report on centrally. I will give an undertaking to have a look at it.

Ms SYLVIA HALE: Will you provide the Committee with detail as to how many dentists and dental therapists, or their full-time equivalents, are employed by the Greater Southern Area Health Service? How many vacancies currently exist for both?

Ms KRUK: I will have to take that on notice.

The Hon. JOHN HATZISTERGOS: Someone else has asked me that question before.

Ms SYLVIA HALE: Will you detail the success or otherwise of plans by the Greater Southern Area Health Service to hire overseas trained dentists from countries including Ireland, England and New Zealand?

The Hon. JOHN HATZISTERGOS: It is not just Greater Southern Area Health Service.

Ms SYLVIA HALE: Will you tell me in relation to that?

The Hon. JOHN HATZISTERGOS: No, the Government will make a public announcement about that in due course.

Ms SYLVIA HALE: I want you to provide the Committee specifically with detail about the Greater Southern Area Health Service—

The Hon. JOHN HATZISTERGOS: We will not provide that announcement—

Ms SYLVIA HALE: You actually did not give me a chance to finish the question.

The Hon. JOHN HATZISTERGOS: I know what the question is.

Ms SYLVIA HALE: Would you provide the detail—

The Hon. JOHN HATZISTERGOS: of the overseas recruitment campaign—

Ms SYLVIA HALE: of the success of plans to bring the number of public sector dentists to an acceptable level in the Greater Southern Area Health Service and in other services?

The Hon. JOHN HATZISTERGOS: The Government will announce in due course details of its overseas recruitment campaign, which is currently being undertaken, and that will be done publicly and you will be provided with the details of that along with every other member of the community.

Ms KRUK: I add that it is an incredible frustration for us being part of an exercise across the health jurisdictions. Our conservative estimate is we are over 100 dentists short even for today's needs. I know the Minister, myself and the chief health officer have been major advocates to try to get additional positions through the system. It is regrettable that we have to go overseas for additional dentists but we are unashamedly doing that at the moment.

The Hon. JOHN HATZISTERGOS: If you look at the annual report you will see that the overall size of the dental work force has not increased. You will see that the University of Sydney, which makes a big bone about dental care, is at the moment providing 45 Commonwealth supported places per year for dental care. That is less than the number of dentists who are retiring. There is a big private dental practice in Tamworth. Having a look at the local newspaper up there, and you will know that for six months the people have been trying to sell that practice and cannot get anyone interested—and this is a thriving practice!

Ms SYLVIA HALE: Could I turn now to mental health issues, and specifically the Skaltis case, which I believe was settled out of court last week. Obviously, the terms of that settlement will not be made public, but it is my understanding the settlement will be very substantial. Will you please tell the Committee how much of the department's or taxpayers' money has been spent on that case, both in terms of the legal expenses plus the expenses of people working within the department who have been dealing with that case?

The Hon. JOHN HATZISTERGOS: I am not familiar with that case. But I can say that we do account for legal expenditure in our annual report. The Treasury Managed Fund deals with those, and the annual report also deals with major litigation as well.

Ms SYLVIA HALE: This case deals with a young man who was admitted to—

The Hon. JOHN HATZISTERGOS: I said I have no knowledge of this case. I am not aware of the background.

Ms SYLVIA HALE: Well, it was a man who committed suicide within 24 hours of being released from hospital, having been admitted because he had immediately before that attempted to commit suicide.

The Hon. JOHN HATZISTERGOS: I am not aware of the details of that case. From what you are telling me, there has been a confidential resolution of that case. So, to go into the details of it, based on what one of the parties may have said, I am not sure is appropriate. But, in any event, the details in relation to legal expenditure are outlined in public documents which are available to you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you aware of the recommendations made by the Deputy State Coroner, Dorelle Pinch, in the inquest into the death in custody of Mr Scott Simpson?

The Hon. JOHN HATZISTERGOS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will the department develop standardised procedures for admitting mentally ill inmates to correctional centres and hospitals as per those recommendations?

The Hon. JOHN HATZISTERGOS: The Coroner has completed an inquest and has made several recommendations to me as the Minister for Health, to the Minister for Justice and also to the Attorney General. There are four recommendations that are directed specifically to me as Minister for

Health. An interagency task force has been convened to progress all of the following recommendations. Justice Health has written to the Attorney General, the Mental Health Review Tribunal and the Department of Corrective Services asking them to participate in the task force. In terms of the recommendations, I am advised that existing standardised procedures will be reviewed by the task force to incorporate the Coroner's recommendations. Once completed, the procedures will be circulated to all consultant psychiatrists and relevant Justice Health staff. Similarly, with regard to the recommendations concerning discharge summaries, I am advised that preparing discharge summaries is an existing clinical practice that will be incorporated into the overall revised procedure.

Justice Health will review compliance with the electronic patient administration system, and make system improvements as required. I am further advised that New South Wales Health has commenced a review of the Mental Health Act 1990 with a view to adopting processes used in other States to ensure the practical placement and movement of inmates on clinical grounds. In reviewing the Coroner's recommendations, the task force will also consider the current Justice Health and Department of Corrective Services policies in relation to segregation orders, and make necessary amendments to comply with the Coroner's recommendations in this area. As you would be aware, Health has commenced a review of the Mental Health Act. There have been some announcements about that recently. As part of the review I have also requested the President of the Mental Health Review Tribunal, the honourable Greg James, to review the forensic provisions of the Mental Health (Criminal Procedure) Act.

The Coroner's recommendations will be considered in the context of that review. Access to acute mental health services for patients in the correctional system has already been greatly improved through the opening of the screening units at Silverwater in March 2006. A female mental health screening unit at Silverwater will open later this year. I can advise that construction commenced in June this year on the purpose-built maximum-security stand-alone forensic hospital to be managed by Justice Health on behalf of New South Wales Health. When opened in June 2007 the facility will provide best practice care for those not guilty by reason of mental illness, unfit to plead, and the seriously mentally ill in the criminal justice system. When completed the forensic mental health beds for those held in custody will increase from 98 to 135.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that no recommendations of the Mental Health Review Tribunal regarding conditional or unconditional release of forensic patients have been accepted since the commencement of 2006. Is that correct?

The Hon. JOHN HATZISTERGOS: The details of the recommendations that are made to the Minister by the Mental Health Review Tribunal and the decisions of the Minister in relation to those recommendations are published annually in a report that is prepared by the Mental Health Review Tribunal, and that is a published that you are welcome to peruse. I have not, for most of the time that I have been the Minister, been making determinations in relation to those forensics. That matter has been delegated to the Minister assisting in mental health matters, Cherie Burton, although I made a number of decisions in relation to that that would be encompassed by some of the statistics in the Mental Health Review Tribunal report, specifically in the period before the Minister assisting was appointed and also from time to time when the Minister is not available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I need you to answer yes or no. Have any people been released as per the recommendations of the Mental Health Tribunal when it is your discretion or under the discretion of the Minister for Health, if it is delegated, since 2006?

The Hon. JOHN HATZISTERGOS: I cannot answer that question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you released them or have you not released them? You have either released these people when it has been recommended that they be released or you have not released them.

The Hon. JOHN HATZISTERGOS: I am not going to respond to questions in the way that you would like me to. I am going to respond to those questions accurately, and I have. The annual report of the Mental Health Review Tribunal details recommendations and the decisions made. However, let me make it quite clear to you, as I did last year, and as I do to the Committee: I do not regard recommendations of the Mental Health Review Tribunal as something that I should just

rubberstamp. I am entitled, and the Minister assisting me is entitled, to review all the information that is provided and to go beyond the recommendations of the tribunal, if that is appropriate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, you are entitled to do that.

The Hon. JOHN HATZISTERGOS: And that means—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are entitled to do whatever you like, Minister. That is your discretion.

The Hon. JOHN HATZISTERGOS: That is right, and that means to inform myself, and for the Minister assisting me to inform herself, appropriately and, if necessary, to go to other issues. I can recall when I was the Minister and I was doing this, I regularly read those files, front cover to back. I asked for additional information and, yes, I would regularly refuse to adopt recommendations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Invariably refuse, Minister?

The Hon. JOHN HATZISTERGOS: Look, I cannot say whether I did regularly or not. I accepted a lot of recommendations. I also rejected a lot of recommendations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But have you released any since 2006? The answer is either yes or no. They have either walked out the door, or they have not, Minister.

The Hon. JOHN HATZISTERGOS: It is in the annual report. It was in the annual report last year and it will be in the annual report this year. There have been a number of recommendations that have been accepted; there have been a number of recommendations that have been rejected, and the details of all of those are in the reports and you can go have a look at them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is, very clearly, Minister, that when it comes to the report, there have been no recommendations regarding conditional or unconditional release that you have accepted. Is that the case, or not?

The Hon. JOHN HATZISTERGOS: Well, I have not done any for about—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have not released any?

The Hon. JOHN HATZISTERGOS: No, I have not done any for a good—when was Cherie Burton appointed?

Ms KRUK: She has had the delegated authority for over 12 months.

The Hon. JOHN HATZISTERGOS: For most of the last 12 months I have not been making those decisions. They have been left to the Minister assisting. In the period before then, I did. All of those details will be in the annual report of the Mental Health Review Tribunal, which is, as I said, publicly available. I stand by those decisions. They are entirely appropriate decisions. In some instances I deferred making decisions. I asked for a risk assessments to be done. I mean, I am not a rubber stamp. You must think I just sit here and I am just going to cough up whatever the Mental Health Review Tribunal wants. While ever I have the authority to make decisions on these matters, I will inform myself as I see fit.

Occasionally when I was doing these matters I had Dr Basson come in to speak to me. I would talk about the files and I would interrogate him about particular issues and I would inform myself broadly. That is what people expect me to do. They do not expect me to be a rubber stamp. If that means that some files were refused or some recommendations were refused, well that is part of the process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said you had delegated to Cherie Burton.

The Hon. JOHN HATZISTERGOS: I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely if you had, and there are not that many cases. You can be responsible and give an answer.

The Hon. TONY CATANZARITI: Madam Chair, I think he has answered the question.

The Hon. JOHN HATZISTERGOS: There is a large number of those files. It is not correct to say that there was a small number. There is a large volume of files that come into the Minister for approval. Remember it is not just decisions in relation to conditional or unconditional release but also—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are the only ones that I have asked about.

The Hon. JOHN HATZISTERGOS: Yes, but there is a large volume of files. I remember doing them during the transitional period. There is a very large number of files dealing with a whole range of different issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that it is appropriate that there should be ministerial discretion over decisions of the Mental Health Review Tribunal where people have particular expertise in making those decisions?

The Hon. JOHN HATZISTERGOS: I do not accept the argument, based on the present formation or the current statutory structure in relation to Mental Health Review Tribunal and the current process which operates, that when a matter comes to the Minister and the Act says that the Minister has to make a recommendation to Her Excellency the Governor that that my role is perfunctory or is basically a conduit to pass whatever recommendation has been provided. If that is your understanding of what you think a Minister's role should be, I reject it entirely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I do not think that is what a Minister's role should be.

The Hon. JOHN HATZISTERGOS: I think the job of the Minister—myself, or Cherie Burton for that matter—is to read the files, front cover to back. If you are not satisfied about something that has been put forward to you, you make appropriate inquiries and you make a decision, and that is what we do. That is what we do. If from time to time people are dissatisfied with that process, then so be it. I from time to time have made quite explicit my views about recommendations of the Mental Health Review Tribunal that I believe are totally inappropriate, that did not take into account, for example, in a way that I believed appropriate the views of victims or other parties. I am entirely within my rights, and so is Cherie Burton entirely within her rights, to exercise that judgment and make decisions accordingly, and I do not demur or take one step backwards from doing it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that it is a politician's job to second-guess the judicial process?

The Hon. JOHN HATZISTERGOS: We are currently having a review in relation to that matter, but let me make it quite clear that last year there was a discussion paper that went out. There was support among a number of people to remove Executive authority from those decisions, but there is no definite model as to how that was going to be achieved. What we have done is when we released the consultation draft in relation to mental health we charged the President of the Mental Health Review Tribunal, Greg James, who has taken over the presidency during this interim transitional period of around two years, to actually go out to the public with the consultation draft in relation to a variety of different options.

There is no standard system across Australia in relation to processes. I know that a number of the other States do not have Executive discretion, but there is a whole series of different ways in which you can handle that issue. What we have done, or what we want to do, is go out with a consultation draft and put forward a number of those options as to how that can be dealt with, with a

number of different models, and ask groups to make a decision or put forward their views in relation to which is the preferred model.

CHAIR: Thank you, Minister. Before asking the Government members whether they wish to ask any questions, can I clarify a matter? Because we sought advice as to whether questions in relation to mental health would be answered by you or we would have the opportunity to ask the Minister assisting, I understand it has come to you. If there is a question, such as the one from the Hon. Dr Arthur Chesterfield-Evans that may go to decisions taken by the Minister assisting, do we still put them through to you on notice?

The Hon. JOHN HATZISTERGOS: Cherie Burton is on maternity leave for the next couple of months, so you will not be able to ask her about those matters. It is more appropriate that you ask me those questions.

CHAIR: But we will put the questions through to you because you are dealing with them.

The Hon. JOHN HATZISTERGOS: Yes, yes. You can ask me those questions.

The Hon. TONY CATANZARITI: Minister, what are your concerns about the impact of Opposition comments on the Health portfolio?

The Hon. JOHN HATZISTERGOS: Madam Chair, I have a lot of reservations. I indicated earlier about risks to the budget and risks to our process, but my concerns are not just in policy terms but also budgetary terms. The Committee is aware that there has been a lot of angst about the so-called Peter-meter which is causing anxiety among a lot of people.

The Hon. ROBYN PARKER: Point of order: I just wanted to take a point of order again on the question asked by the Government. It is not in relation to the budget, the budget estimates. For the record, I would like you to rule on whether that question is appropriate or not.

CHAIR: I have to say that you are straying very close to abuse in the budget system or the estimates process, Minister. I am very reluctant to ask that Government members provide a different set of questions that are strictly in relation to the budget, but, Minister, I am going to allow it to proceed on the basis of free speech.

The Hon. JOHN HATZISTERGOS: Thank you.

CHAIR: But I really do urge that you stay in relation to the budget.

The Hon. JOHN HATZISTERGOS: These are risks to the budget and it is important to bear in mind that we have an election next year and alternative views have been canvassed around as to how the budget should be allocated. These threats to the budget had to be exposed and addressed. As I said, we have the so-called Peter meter, which has been raising a lot of anxiety around the place. We have the Skinner spinner, which is running out of control and making promises left, right and centre with no consideration of the financial impact. I will deal with the so-called "Wheel of Disfortune" for patients and their families, because the honourable member for North Shore in her reckless vote grab has now reached $835 million. Every day since she has been rehabilitated back into the Health portfolio and became the shadow Minister for Health, an extra $2.3 million is promised.

The honourable member for North Shore is quite clearly out of her depth. Frankly, it is about time that the Leader of the Opposition cut up her credit card, because we cannot afford those reckless promises. As I said, we still have seven months to go before the election; imagine what it will look like at the end of its time. I have already outlined to the Committee that the $29,000 job cut dream of the Opposition cannot be achieved without massive cuts to front-line services. We have another popular source of funding from the Opposition policy documents, and that is the elimination of so-called waste and mismanagement. I previously advised the Committee that the Opposition will not tell us exactly where that is going to come from: which are the front-line services and which additional layers of bureaucracy will it add?

It is not just a question of whether the Opposition can afford its promises, it is also a question of what health services might be cut to plug the budget black hole created by the Leader of the Opposition and the honourable member for North Shore in their flawed budget strategy. I will now deal with some so-called policy articulated by the Opposition that are threats to the budget. It has been a month since I suggested that the Opposition's dental policy was premised on axing the successful private dentist voucher scheme, which the Government instituted in 2001. The honourable member for North Shore still has not ruled it out.

Last year the Oral Health Fee for Service Scheme provided 42,000 patients in rural and regional areas with an opportunity to see a private dentist for emergency treatment or dentures for free. Only very recently Dr Nick Stanley, a dentist from the Hastings region, termed the scheme a "very important service for those who are disadvantaged" and referred to the relief it gives to patients. The lobby group that wrote the Opposition's dental policy had previously presented it to me; it advocated the abolition of that scheme to save $57 million and to put that into salaries. I will come to that in a moment. It seems that not even the Coalition's candidates are buying this so-called new policy. The Liberal candidate for Gosford, Chris Holstien, has said that fluoridation is poison; he then confessed that he had not even read the Opposition's policy on fluoridisation—a policy on which he is standing at the next election, which advocates increased fluoridation.

That is despite the fact that the electorate he wants to represent has one of the highest levels of childhood tooth decay: in part because the council of which he was a member has voted consistently against fluoridating the Gosford water supply. It is bad enough that the Leader of the Opposition has to rely on that lobby group to draft a policy, but one would think one of his candidates would take the time to read it. Perhaps the biggest disappointment in the Opposition's dental policy is its complete failure to grasp the major challenge facing public oral health; and that is work force shortages. There are simply not enough dentists in our work force as a result of chronic underfunding of university places for dentists.

Where are the extra dentists who are needed to deliver the services that have been promised to come from? The Opposition's answer is to provide an overnight pay rise to public sector dentists. This is certainly the first time I have heard the Opposition champion a public sector pay rise, and it is a commitment that sits rather oddly with its promise to slash and burn the public sector. Putting that hypocrisy to one side, a pay increase will do nothing to increase the work force if not enough dentists are being trained. Earlier I mentioned the situation in Tamworth with a thriving dental practice that cannot get a buyer. In a tight labour market the public sector's capacity to pay will never meet that of the private section, which has grown fat on the returns from the Federal Government's private health insurance rebate.

The Commonwealth's belated commitment to 40 more dental HECS places—achieved after intense lobbying from the New South Wales Government and without so much as a peep from the Opposition—will not bear fruit for another four years. By the way, we still do not know whether the University of Sydney is going to use some of those extra places to take away from the full-fee paying students: in other words, there is a suggestion that they will convert some full-fee paying student places to Commonwealth-supported places. No extra dentists; just a different method of funding.

That is why the New South Wales Government has been forced to recruit dentists from overseas. The Opposition's so-called dental policy is a grab bag of empty promises. The Opposition has cut and run from its disastrous hospital boards policy with the release of The National's back to the future plan for district health boards. Interestingly, no-one bothered to update their recently released nursing policy to reflect this new position: it still refers to Deputy Leader of the Opposition, Barry O'Farrell, and John Brogden's 2003 bungled election promise for local hospital boards. That is what the Opposition referred to in its nursing policy release, which is only four or five months old, the so-called district health boards.

The contradictions get worse when the leaders of the Liberals and The Nationals did not compare notes before their ring around on morning radio. On the day the policy was announced, the Leader of the Opposition talked about cutting vital public service jobs and the Leader of The Nationals talked about having specialist administrative units to provide the bureaucratic support for the Coalition's revised boards plan. The Leader of The Nationals wanted to create more bureaucrats while the Leader of the Opposition was talking about slashing 29,000 jobs. That is another sign of

disunity and chaos in the Coalition; the Leader of the Opposition seems unwilling or unable to manage it.

As I have outlined this morning, based on the structure that existed in 1993, the Coalition's policy will create in excess of 41 local and district health boards. It will cost the taxpayers millions to pay for that additional bureaucracy. Ironically, the Coalition plans to abolish area health services, and I have indicated how the reduction of those numbers will provide additional front-line services, and then we get more mixed messages from the Opposition. In the Dubbo *Daily Liberal* of 3 August 2006, The Nationals candidate for Dubbo, Mr Greg Matthews, conceded that some jobs in Dubbo would be targeted in order to fund the Coalition's policies. Mr Matthews also let slip that the Opposition will force nurses to spend more time on paperwork rather than looking after patients.

Meanwhile, during a visit by the honourable member for North Shore to Narrabri, a local councillor reassured the community that it would still be possible to upgrade the complex even though there might be job losses in Narrabri. It is not clear whether the Opposition wants more or fewer bureaucrats. But one thing is clear: the impacts of the district hospital board experiment will not just be budgetary, it will not just create additional bureaucracy, it will not just reverse savings that have been successfully redirected to front-line care. The impacts will also have serious implications for the quality of heath care, especially in rural and regional New South Wales.

The reforms undertaken as part of the Government's amalgamation of area health services have gone beyond savings. The amalgamations linked health services with medical work force shortages to health services where it was easier to recruit medical staff, enabling improved distribution of medical specialist positions across New South Wales. For example, the former South Eastern Sydney Area Health Service was able to recruit medical staff relatively easily while the former Illawarra Area Health Service had recruitment difficulties. Following their amalgamation into the South Eastern Sydney Illawarra Area Health Service, the new chief executive established 29 new medical positions in Wollongong, Shellharbour and Shoalhaven, in areas such as oncology, gastroenterology, neurosurgery, anaesthetics, geriatrics and paediatrics.

The Sydney West Area Health Service has advised that the restructure has allowed for improved rostering of mental health nurses across the service, which has eliminated the need for agency staff. Improved rostering has also enabled Nepean Hospital to reduce its reliance on agency nurses by 75 per cent. The restructure has enabled more clinical cross appointments in the health service, increasing the number of locations served by specialist clinicians. The Hunter New England Area Health Service has had increased expressions of interest for long-term vacant rural allied health positions, particularly from staff in the Hunter who are interested in relocating to rural districts. The restructure has improved rural access to mental health services in communities around Moree and Tamworth.

The amalgamations have enabled health services to build on and extend their clinical networks. For example, in South Eastern Sydney Illawarra Area Health Service, cardiologists from the Prince of Wales Hospital are supporting the coronary artery stenting in Wollongong, so residents of Illawarra do not have to travel to Sydney for that service. Neurosurgery services at Wollongong have been networked with the Prince of Wales Hospital to formalise support for Wollongong where no neurosurgeon is available locally. In the Northern Sydney Central Coast Area Health Service the establishment of an area-wide mental health network has seen the development of a single acute bed management system and subsequently shared learning in relation to patient care and safety. In the North Coast Area Health Service the restructure has broken down the barriers between Coffs Harbour Base Hospital and Grafton and Maclean hospitals, allowing those health facilities to network more closely, with improved management of bed management across the network.

While the amalgamations have resulted in a statewide reduction of area health service senior managers, 42 per cent of senior managers are now based in rural and regional health services. The establishment of larger health services with an increased share of senior management resources will provide better career paths in regional health services, stemming the flow of staff to Sydney and ensuring that health services in country New South Wales have stronger and more stable management. The Coalition's policy will undo all that good work, risking all these improvements in service delivery that have resulted from our reforms.

I deal now with nursing policy. Opposition members recently launched their nursing policy. They have not been talking about it much lately. Perhaps it is because they are embarrassed, as it has been shown to be a seriously undercosted imitation of the Government's current programs. The Opposition's policy fails to grasp the real challenges facing the health system. It does not create a single university place or treat a single extra patient, and it is significantly undercosted. The Opposition's $207 million price tag is approximately $150 million short, with a more realistic costing being closer to $360 million. It is also inadequate compared to what the Government is already doing.

The Opposition's $4 million retraining program pales in comparison to the Government's $35 million nurse recruitment and retention plan. Most importantly, the centrepiece of its announcement—5,000 extra nurses over five years—is not only short by $30 million; it is also 543 nurses short on the number of nurses the Government has recruited since August last year. In relation to the Coalition's plan, Brett Holmes from the New South Wales Nurses Association stated:

> They haven't quite managed to up come to the amount of money that is needed and they are going down the track with some of the clinical issues that would not be acceptable to the broader nursing profession.

Those are the policies of the Opposition. I am equally concerned about its complete lack of policy in key areas such as waiting lists, emergency department performance and critical work force shortages. These are all areas where the Government has comprehensive strategies in place but the Opposition has no ideas. Indeed, it might need to plunder our investment in these areas to funds some of its so-called promises. I refer not just to the Opposition 's policies; it has been racking up promises on capital works to shore up votes everywhere. The honourable member for North Shore has been fast-tracking capital projects all over New South Wales—in Byron Bay, Lismore and Narrabri. They are all on the fast track of this Skinner budget blow out.

However, The Nationals candidate for Tamworth, Mr Wayne Anderson, has been forced to toe the party line. He was wheeled out on Prime television to support the fast tracking of Narrabri hospital, which is not even in his electorate, and he told the people of Tamworth that they do not really need a new hospital. That is the electorate for which he is standing. It is good to have a fighter like Peter Draper in Tamworth because we all know what would happen to the Tamworth hospital redevelopment in the event that Mr Anderson was successful and the Coalition was in government.

If Opposition members want to talk about records relating to capital works, they should remember their shameful history, for which none of them has apologised, in their so-called seven years of government. Thirty hospitals were closed or downgraded. When I visit these hospitals people say to me, "We would like this fixed, or that fixed." In the Coalition's days there was a simple solution: it was just closed down. The former Coalition Government did not worry about fixing it; it just closed down the hospital and forgot about it. The Skinner spinner is being propped up by more closures and privatisation.

When Port Macquarie Base Hospital was being privatised Mrs Skinner is in *Hansard* as saying that there was "no better way". The Auditor-General found this hospital to be the equivalent of having been paid for twice and then being giving away. Mrs Skinner said there was "no better way". She said it was a terrific investment. This most disastrous project cost New South Wales taxpayers $80 million to buy back. Opposition members are totally out of control and the strain is beginning to show.

Only last week Andrew Stoner and The Nationals candidate for Tweed, Mr Provest, called Tweed doctors and nurses "Third World." Fifty-eight per cent of the mothers who give birth at that hospital come from Queensland. Those very discerning citizens prefer to go to Tweed hospital to give birth rather than to go over the border where they live. Opposition members are rapidly approaching $1 billion in unfunded promises and their erraticism is growing day by day. Their promises do not stack up, the money is not there and there are no new ideas. Their inexperience and lack of discipline would put our health system at risk if ever they were to win government.

The Hon. TONY CATANZARITI: What are the main work force challenges facing the NSW Health system?

The Hon. JOHN HATZISTERGOS: Opposition members are always disappointing when it comes to standing up to the Federal Government for the people of New South Wales.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Point of order: The question was about the Opposition's policy. This is a budget estimates committee hearing.

The Hon. CHRISTINE ROBERTSON: It was not; it is about the work force.

CHAIR: The question elicits information.

The Hon. TONY CATANZARITI: I could read out my question again but I do not think it is necessary.

CHAIR: I heard the question. The Minister has three minutes. He can use it in any way he wishes.

The Hon. JOHN HATZISTERGOS: Opposition members are always disappointing when it comes to standing up to the Federal Government for the people of New South Wales. They refuse to demand that our $3 billion in GST be returned. They stood by and simply allowed the Federal Government to take away over $706 million in funding for health since 2003. They never joined with the Government to press the Federal Government on the dire need for more home-grown doctors, nurses and allied health professionals.

Recruitment and retention of health professionals is a national issue. The public health system is the largest health care employer in Australia, with in excess of 92,000 full-time equivalent [FTE] staff. The doctors, dentists, nurses, ambulance officers and allied health professionals involved in direct clinical care comprise two-thirds of our work force. Hospitals all over the world are struggling to meet the growing demands of an ageing population, the high cost of new medical technology, and a shortage in the work force. The Government has been a staunch advocate for the need for more doctors in our hospital system.

We have taken up this fight with the Commonwealth and we have had some success, although it has not been sufficient to meet our immediate needs. We have sometimes had robust discussions with the Royal Australasian College of Surgeons arguing for a fairer number of surgical training places in our public health system. Following the agreement in 2004 with the Royal Australasian College of Surgeons to increase the number of basic surgical trainees in New South Wales from 65 to 79, we have continued to work with the college to increase our surgical numbers. However, for 2007 the college has selected only 64 first-year basic surgical trainees for New South Wales against our need for 110 and, in conjunction with other jurisdictions, New South Wales has referred this matter to the Australian Competition and Consumer Commission.

We have consistently represented the interests of the community in pursuing more doctors for our health system, but all we have heard on this issue is silence from the Leader of the Opposition and the honourable member for North Shore. Recently there has been a flurry of so-called policies and a lot of promises for more nurses more dentists, but Opposition members have not told us where they will get these additional members of staff. It is as though they grow on trees. Staff members need to be trained in universities, which is the responsibility of the Commonwealth Government.

In contrast, and in the face of the Commonwealth Government's failures, we have a comprehensive strategy. We are making significant investments in health work force issues through the implementation of a number of immediate short-term and long-term initiatives, and we are achieving success. In 2006 the salaried medical work force was 6,815 full-time equivalents, a 361 FTE, or 6 per cent increase over the figures for 2005. Earlier I outlined a number of other increases. The Government has committed $3.5 million in recurrent funding for the General Practitioner Procedural Training Program; $2 million in recurrent funding for the Institute of Rural Clinical Services and Teaching; $2.6 million in recurrent funding for basic physician training networks; $2.6 million in recurrent funding for the new psychiatry training networks, which were created in 2006; and $1.6 million in recurrent funding for basic surgical training networks, which will fund up to 182 basic surgical trainee positions.

As health Minister the Premier established the Institute of Medical Education and Training [IMET] bringing together the strengths of the Postgraduate Medical Council and the Medical Training

and Education Council to focus on post-graduate medical education and training. Already eight new basic physician-training networks have been established and came into operation in 2005. These networks will ensure that our regional and rural trainee vacancies are filled first. The creation of the eight basic physician-training networks has led to the appointment of 292 trainee physicians in 2006, which is 23 more than in 2004, and eight more than in 2005.

Networks for basic surgical and psychiatry training commenced in January this year. Those networks build on the strengths of the principles of networks that were established for physician trainees. In all networks priority is placed on filling rural positions, with significant investment in local and State network directors of training. To encourage rural rotations, $2,000 scholarships will be awarded to trainees who complete the double minimum requirement of a rural rotation each year. In 2006 IMET has already allocated 531 doctors to positions and is in the process of allocating a further 74, subject to acceptance by applicants.

Action by the Government has resulted in a change at a national level in terms of university places for health professionals. Was there any role for the Opposition in asking for any of these additional places? Not at all. The Government was doing everything in our power to grow and develop our work force but, unfortunately, this is not enough on its own and we must look to overseas recruitment. I am advised that, as of 6 July 2006, 567 area-of-need positions have been approved. Some 256 positions have been filled, with 72 in hospital non-specialist, 90 specialists and 94 general practitioners. In December 2005 NSW Health was represented at the *British Medical Journal* careers fair in London. We conducted targeted interviews. Approximately 150 doctors expressed interest in working and a number have been recruited into area health services so far this year.

The Government has been supporting permanent resident overseas-trained doctors in their skill development training and preparation working in the New South Wales health system through IMET. In 2006 a total of 55 overseas-trained doctors commenced their supervised year in New South Wales public hospitals after completing the AMC examination and a further 55 applied for positions in June 2006.

CHAIR: Thank you, Minister. In 2004 I recall the Government announced with some fanfare a $241-million mental health package over four years. But the budget papers suggest that only 18.3 per cent of that—or $44.3 million—has been spent to date. Can you explain why there has been only that amount of spending in that time? Do you think that is acceptable to deal with the mental health crisis?

Ms KRUK: Madam Chair, can you restate the numbers in terms of what you believe to be the underspend?

CHAIR: In 2004 the Government announced a $241-million mental health package over four years. The budget papers suggest that only $44.3 million, or 18.3 per cent, has been spent in the first two years.

Mr BARKER: Madam Chair, I think this question was asked last year, from memory. The $241 million was a four-year number, starting at a low number and working up. You cannot spend physically $241 million in year two compared with the zero year. Last year was the second year and this is the third year of the four-year program. So we are now ramped up to, from memory, $65 million per annum this year, and next year it will increase to a higher number—I think, from memory, it is around $90-odd million.

Dr MATTHEWS: The first year was only about $20 million.

Mr BARKER: It is mathematically impossible to have spent $240 million by the end of last year.

The Hon. JOHN HATZISTERGOS: I can give you some information on this, Madam Chair, that might assist you. The honourable member for Willoughby keeps spouting around the place about this issue and I think it is important that we put to bed the nonsense that has been peddled. In 2004-05 the mental health projected budget was $783 million. Every cent of it was spent. In 2005-06 the mental health projected budget was $853 million, and we spend every cent. The honourable

member for Willoughby continues to make reference to the 2004-05 allocation in Budget Paper No. 3, Volume 1, pages 9 and 8. Let my clarify: The Government has clearly stated in these same budget papers that in 2004-05 an additional $24.6 million will be available for mental health services as the first step in the $241-million overall enhancement of mental health services over the next four years. That is clearly stated. That comes from the 2004-05 allocation in Budget Paper No. 3, Volume 1, pages 9 and 8.

The allocated funding was entirely spent, as was the first step of the allocated funding of $48 million in 2005-06. I am advised that we are on target to fully spend our 2006-07 allocation. The 2006-07 mental health budget now stands at a record $945 million. This is two and a half times the mental health budget of 1994-95, and it confirms our commitment to take the delivery of mental health services in a new direction. The honourable member for Willoughby also made a number of other claims about child and adolescent mental health that I can go into if you want, all of which are inaccurate. Of course, they overlook the fact that when the Coalition was in government there was only one child and adolescent unit in New South Wales compared to the numbers we have now. The Coalition also closed 711 mental health beds when you were in government. That is where the savings will come from, by the way. As you are so interested in these issues, I will put on record some quotations that will be of interest. I served on the committee that the upper House established to examine mental health issues in a previous parliamentary session. It was chaired by Brian Pezzutti. This is what Brian Pezzutti has had to say about this issue. Last year on ABC radio, he said:

> Morris Iemma and the State Government have followed the recommendations of my report … I'm very comfortable with the way in which the State Government has put the shoulder to the wheel on this one.

He said:

> I think Morris Iemma, when he was Minister, and now John Hatzistergos, and Cherie Burton, are moving well down the track of making sure that people with mental illness … have support for their normal living.

He then went on to say:

> Working in mental health is so unpalatable, very few people wanted to work in that area … We're moving past that now … we are attracting people to come and work in the State Mental Health Service … you've got to go back to those building blocks of the workforce and the training of the workforce, and that's what we're doing in NSW, I've been very comfortable with those changes … I think people are now seeing that there is improvement in NSW health.

Brian Pezzutti continued:

> Major improvements in the provision of mental health services to people who are in prisons, moving strongly towards diverting people who commit crimes, probably caused by a mental illness, away from the prison system into a health care system.

He said all that on ABC radio. He concluded:

> I think we can see light at the end of the tunnel for those seriously ill people in the community, and in our health service in NSW.

That is what Brian Pezzutti said. He made it quite clear on ABC radio. He is not the only conservative politician who has said that. You also have the likes of Jeff Kennett, who has come up here to praise the work of the Iemma Government.

CHAIR: Minister, you are going absolutely beyond consideration of the budget if you are moving to comments by Jeff Kennett.

The Hon. JOHN HATZISTERGOS: He knows a bit more about mental health than the honourable member for Willoughby.

CHAIR: Turning to this year's budget papers, you promised in the budget an additional $300 million over five years but you have actually allocated only $38 million this year.

The Hon. JOHN HATZISTERGOS: It is the same principle.

CHAIR: When during that five-year period do you propose to spend the majority of that $300 million?

The Hon. JOHN HATZISTERGOS: That is already outlined in the budget papers.

Dr MATTHEWS: Like the $241-million package, it builds up over four years. The first year is $38 million. It reaches its maximum in the fourth year and is recurrent thereafter. The difficulty we face in enhancing mental health services is finding the work force to employ. My problem now, being responsible for these services, is that I have got increasing dollars, increasing facilities but insufficient work force. That is the most important challenge we face now.

The Hon. JOHN HATZISTERGOS: That is why work force development is an important part of the strategy—the new direction statement.

CHAIR: Minister, you have revised down the mental health capital works budget from $51 million to $21 million. Can you explain the reason for that?

Mr BARKER: The reason is that these budget papers are prepared around March of each year. When we did them in March 2005 our best estimate of capital works expenditure at that point in time was $51 million. When we come then to do the 2006-07 budget papers we again do two things: First, we revise where we think we are against that previous number; and, second, we have to estimate what we believe will be the number for the forthcoming year. When that was done at that particular point we thought we were spending at a rate of around $21 million in the capital program. Our final figures, which are now subject to audit, we think will be about $28 million or $29 million. Therefore, we have $45 million provided in 2006-07, which means over the two years around $74 million is what we now believe we will spend on the capital works program in the mental health area.

CHAIR: In answer to an earlier question about the budget you suggested that insufficient staffing is a problem. Yet community-based organisations providing services in mental health receive just 2 per cent of the budget. Would a solution to the staffing problem be to direct greater resources to community-based services?

The Hon. JOHN HATZISTERGOS: That is what we have done.

Dr MATTHEWS: That is what we have done and in this $300 million package something like 17 to 18 per cent will go in the final wash up to non-government organisations through programs such as the housing and support initiative [HASI]—

CHAIR: When will that be? This is a five-year package so you are talking about something a few years out?

Dr MATTHEWS: No.

Ms KRUK: Can I intervene? In essence we draw on a similar section of the work force, and I know they are equally concerned, I think, realistically at the rate of spend in this area. You have to have positions to actually staff. What we have done, and done it also co-operatively with the non-government sector through compacts such as with the Federation of Non-government Agencies [FONGA] is actually look at where we need some change in relation to the university profile, types of positions and curricula. There is only a limited work force whether it is in the Government sector or the non-government sector. What is good about this package from the viewpoint of a practitioner is its focus on community sector. The work force pressures are not lessened.

The Hon. JOHN HATZISTERGOS: I will follow up on that and make one point. There is, as you would be aware, in the annual report of the department a statement under section 301 of the Mental Health Act that provides a comprehensive outline of a number of statistics and figures that would be of interest to you. But one of the important figures you will find is the growth of the mental health work force, which has gone up in the past four years by about 1,000—I think it was 4,000 and it has increased to 5,000. It is a very substantial rate of growth in the work force in mental health. The demands the Government is putting on this area in terms of increasing its work force are far higher than any other section of the health work force. That identifies to you the nature of the challenge that

we have and why the Government is putting so much of its resources in its new direction statement towards work force development.

Dr MATTHEWS: In relation to the non-government sector, as of 30 June we had $19 million recurrent going into the HASI project alone, and that was built up over three years. By the end of the next financial year 2007-08 that will have risen to $29 million and that is putting a similar sort of strain on the non-government work force. The Minister will shortly announce a specific training package for non-government workers funded by NSW Health to boost and enhance that particular work force because it is starting to feel the strain of our additional enhancements in terms of its work force.

Ms KRUK: Mrs Parker sought clarification on a number of questions—one about corporate service numbers and the other about re-admissions—earlier about which we now have additional information. Would you like to do it at this point or at the end of your time period?

CHAIR: I do not propose to take time out of the 20 minutes at this stage.

The Hon. JOHN HATZISTERGOS: We can provide them at the end. Page 131 of the annual report is where you will find those work force numbers. Since 2000-01 the work force has gone from 4,839 to 5,787 which is a fairly steep level of increase.

The Hon. ROBYN PARKER: I refer back to your Government's failure in terms of dental health. Would you tell the Committee how many people in New South Wales are currently waiting for public dental treatment?

The Hon. JOHN HATZISTERGOS: I do not have that information. We do not collect that information centrally.

The Hon. ROBYN PARKER: Why not?

The Hon. JOHN HATZISTERGOS: A matter about which you would be aware, we start at an area level and we are adjusting our systems to be able to provide that information, but we do not at this point, in response to the report of the Auditor General.

The Hon. ROBYN PARKER: When will you provide that information?

The Hon. JOHN HATZISTERGOS: I cannot answer that question.

Ms KRUK: If I can take that question on notice. I think that relates to your earlier question of the chief health officer about the service level agreements and oral health.

The Hon. ROBYN PARKER: I would have thought people waiting for public dental care would want to know how far up the list—

The Hon. JOHN HATZISTERGOS: Have you tried to get into a private dentist? The last time I asked it takes four months to get an appointment. That is part of the problem. There are not enough dentists around, Robyn.

The Hon. ROBYN PARKER: Tell that to the parents of the 4,000 children waiting.

The Hon. JOHN HATZISTERGOS: No, you tell it to the Commonwealth that funds the places for these people.

The Hon. ROBYN PARKER: Will you describe the condition of public dental patients who are assessed as 3a, 3b, 3c and 4?

Dr ROBINSON: The categories that are in place in oral health service relate to the condition that the patient has and the urgency with which their definition requires them to be actually seen. The highest priority obviously is for patients who have significant pain and they are seen ideally within 24 hours, sometimes it takes a little longer than that. The next category is if there is a suspicion that there

is a substantial oral health issue, that is, caries developing et cetera the ambition is to see people within one week. Beyond that where the services are less critical you have the categories that you have just referred to—3a, 3b and 3c. Those patients are seen, usually, some weeks after they have been entered onto the system.

However, I want to say that the amalgamation of the area health services has now been followed by an amalgamation of the information systems for oral health. As part of that process we are conducting an audit of the waiting lists at the present time. These are being done in each of the area health services. It would appear that there is some duplication in people being on a couple of waiting lists at one time. The amalgamation of this information system will now enable us to detect that and to then refine the waiting lists. As the Minister indicated, we will be in a position in the future, given that oral health waiting times are going to be looked at as part of the performance indicators in the future, be able to be in a position to respond to these questions.

The Hon. ROBYN PARKER: Minister, what does "in the future" mean? Does that mean after the March 2007 election?

The Hon. JOHN HATZISTERGOS: I cannot respond to that. We have just got the Auditor General's report and we are working our way through it and I will respond accordingly.

The Hon. ROBYN PARKER: How many people are currently waiting for treatment in those categories you have mentioned?

Dr ROBINSON: I am sorry, I did not bring those figures with me. I cannot answer that.

The Hon. ROBYN PARKER: Would you take that on notice?

Dr ROBINSON: I will take it on notice.

The Hon. JOHN HATZISTERGOS: I am not sure if we can provide that information anyway.

The Hon. ROBYN PARKER: Why not?

The Hon. JOHN HATZISTERGOS: Do you have a question? I am not here to have a debate with you about these issues.

The Hon. ROBYN PARKER: You have been able to talk at length about WorkChoices but you cannot tell me how many people on the waiting list.

The Hon. JOHN HATZISTERGOS: You have had an upper House inquiry in relation to these issues.

CHAIR: You are being asked a question. It is a legitimate question for estimates.

The Hon. JOHN HATZISTERGOS: I am just responding. I am saying that I am not here to have a debate. The fact of the matter is you have had an upper House inquiry in relation to these issues. The Government is required to respond to that.

The Hon. ROBYN PARKER: And you did not supply the answers then.

The Hon. JOHN HATZISTERGOS: Because we are required to respond by the end of September which is the timetable that the Committee set down, and we will.

The Hon. ROBYN PARKER: Why is New South Wales the only State that did not provide dental data for the recent Australian Institute of Health and Welfare report?

Dr ROBINSON: My understanding was that the Australian Institute of Health and Welfare was of the view that the level of detail that we currently had to hand was not sufficient for it to

actually include in the report. Its view was that the collated data from the other States and Territories would provide effectively an overview of what the situation was in the whole of Australia.

The Hon. ROBYN PARKER: Further to the first question I asked, that is because New South Wales is the worst provider of public dental healthcare in Australia?

The Hon. JOHN HATZISTERGOS: That is not a question, that is a rhetorical statement.

The Hon. ROBYN PARKER: Is it not?

The Hon. JOHN HATZISTERGOS: I thought you were here to ask questions and I am here to answer questions.

The Hon. ROBYN PARKER: Is that correct?

The Hon. JOHN HATZISTERGOS: We will respond to that in due course. You have not said anything about the $350 million that was taken out of the Commonwealth dental program and put into subsidising health insurance for the wealthy. You seem to think that is fine and you have not got a problem with it.

The Hon. ROBYN PARKER: You talked about reporting back to the dental health inquiry?

The Hon. JOHN HATZISTERGOS: Yes.

The Hon. ROBYN PARKER: That was the Social Issues Committee of the Legislative Council that undertook an inquiry into the Inebriates Act following the Alcohol Summit. That report has been tabled for quite some time, years in fact, and despite successive letters to you and the previous Minister the Government has not responded. Are those people not important? Is that inquiry not important? Why have you not responded?

The Hon. JOHN HATZISTERGOS: I will ask Dr Mathews to respond to that. The reality is that the matter has been before the Cabinet. It has also been before the—

Dr MATTHEWS: The Expert Advisory Committee on Drugs chaired by Professor Webster.

The Hon. JOHN HATZISTERGOS: I understand it is an issue on the agenda at the next meeting. It does raise some complex issues in relation to recommendations for us to be able to respond, particularly in a positive way to it. There will be discussion before the Cabinet after the advice has been received from the expert panel.

The Hon. ROBYN PARKER: Why has it taken so long, given that the Government was supposed to reply within six months?

The Hon. JOHN HATZISTERGOS: It is a very complex issue. The matter requires discussion amongst a range of agencies in order for us to be able to completely respond. I know these Committees come up with recommendations, and there are many of them. The Committees sit and take evidence and think it is all very simple to write out the paper and that things get done. But this is a complex issue and it affects a number of agencies other than us—resources of Police and various other law enforcement agencies—and if we are going to respond positively and take the Committee's recommendations of an upper House inquiry seriously, we need to be in a position to be able to ensure that the responses are practicable and workable.

The Hon. ROBYN PARKER: Minister, I remind you that report was tabled in 2004 and it is now 2006.

The Hon. JOHN HATZISTERGOS: I have indicated what has happened.

The Hon. ROBYN PARKER: Minister, you mentioned Tweed Heads Hospital. In 2005-06, how many patients were transferred from Tweed Heads Hospital to Mullumbimby Hospital?

The Hon. JOHN HATZISTERGOS: I cannot answer that question off the top of my head.

Ms KRUK: Professor McGrath might answer that.

Professor McGRATH: Tweed Heads Hospital is subject to substantial increased growth and activity, both from its local population, and particularly from transfers over the border, particularly in relation to emergency demand, where Queensland hospitals have gone onto bypass, and Tweed has been continuing to take the overflow across the border. One of the approaches that is being driven very effectively across New South Wales Health at the moment, particularly with the amalgamation of area health services, but in terms of making sure that major centres, which Tweed now is, are able to cope with the really acute and sick patients, is that they are networking very closely with the regional and district hospitals; and patients, when they are towards the end of their treatment and requiring less intense acute care, are being appropriately transferred to less acute hospitals to complete their recuperation. Between Tweed and Mullumbimby, that is a very active initiative at the moment that is assisting Tweed meet both its emergency and elective surgery demand.

The Hon. ROBYN PARKER: With one of those hospitals you are talking about being the Murwillumbah Hospital?

Professor McGRATH: It would be Murwillumbah as well. Mullumbimby and Murwillumbah I think are the hospitals that Tweed is particularly networking with. And, as part of the restructure following amalgamation, that is a health sector within the North Coast Area Health Service.

The Hon. ROBYN PARKER: Could you provide us with the numbers that have been transferred because there are no available beds at Tweed Heads Hospital?

Professor McGRATH: It is not a matter of there being no available beds. That is not the issue. The issue is about using the beds across the network more effectively. It is being used not just in Tweed; it is being used in every area health service. It is one of the strategies helping us improve access through emergency departments at the moment, and also helping to achieve great improvement in surgical waiting lists across the State. It is making sure we utilise all the beds within the State highly effectively and move patients to the locations where they get the right treatment, at the right time, in the right place. So it is not a matter of there being no beds available, but the effect of that on all the beds across the system and using them appropriately.

CHAIR: We will move to questions from crossbench members.

Ms KRUK: Madam Chair, can we answer the two questions?

The Hon. JOHN HATZISTERGOS: We need to clarify matters, without taking up Sylvia's time.

Ms KRUK: There were two issues. There was the issue of re-admission, and I think Ms Parker sought additional information. And there were the corporate supports numbers. If I could ask Professor McGrath to add to her responses to questions.

CHAIR: I propose that at the end of the period of time, just on 1 o'clock, we might take all of those answers.

The Hon. JOHN HATZISTERGOS: No. We can sit on longer. We need to get these out of the way, otherwise we will forget about them. I have got a number as well. If we could deal with these now—

CHAIR: I propose to take them just prior to 1 o'clock. Crossbench members may ask questions now.

Ms SYLVIA HALE: This may be a question to Dr Matthew. I understand that the Friends of Callan Park had a meeting with Health and Planning in March of this year and were told that Health would supply a full and detailed list of New South Wales current mental health beds, including type

and location. That information has still not been forwarded to the Friends of Callan Park. Could you tell me when it will be provided?

Dr MATTHEWS: Mental health beds are dealt with in the annual report, but I am happy to—

The Hon. JOHN HATZISTERGOS: Section 301 statements, page 130 of the report.

Ms SYLVIA HALE: The type and location?

Dr MATTHEWS: I am happy to meet with the Friends of Callan Park and go through those.

Ms SYLVIA HALE: Apparently the department already has undertaken to provide that information to them. My question is: When will that information be provided?

Dr MATTHEWS: As soon as I can arrange a meeting after this session.

The Hon. JOHN HATZISTERGOS: It is 135 to 136. You will find all the beds there.

Ms SYLVIA HALE: Thank you.

The Hon. JOHN HATZISTERGOS: It is in the annual reports. You can have a look at those. It is on the Internet too.

Ms SYLVIA HALE: Minister, earlier you referred to World War II veterans in H ward at Rozelle Hospital, Callan Park, being guaranteed that they will be able to continue there. If you go ahead with the closure of the other wards and facilities at Callan Park, what will be the costs of continuing to provide skilled medical, pharmaceutical, nursing, administration and maintenance backup and catering services for the one remaining ward?

The Hon. JOHN HATZISTERGOS: They will be funded by the Commonwealth.

Ms SYLVIA HALE: Solely by the Commonwealth?

The Hon. JOHN HATZISTERGOS: They are virtually all funded by the Commonwealth.

Ms SYLVIA HALE: Is it anticipated that inpatient and outpatient services also will be provided at Callan Park for veterans of the Vietnam conflict?

Dr MATTHEWS: No. There are currently, I think, about seven or eight of those Second World War veterans left in what is effectively a hostel/nursing home on the peninsula. The facility at Concord will not be finished for another two years. Those veterans who remain in that facility after the opening of Concord will be provided with health services—as the Minister, funded by the Commonwealth—in the same way that they would be in any other stand-alone nursing home or hostel. The services will be provided and will be funded.

Ms SYLVIA HALE: So there are no plans to allow Vietnam war veterans access to those services at Callan Park, or to the people who will be returning from Afghanistan and Iraq suffering post traumatic stress disorders?

The Hon. JOHN HATZISTERGOS: Don't forget that the Concord Hospital itself is a repatriation general hospital, which has a very strong association with the veteran community. They will be able to access extremely high-quality services at that repatriation general hospital, in which they regard themselves as quite significant stakeholders.

Ms SYLVIA HALE: But, Minister, if you recognise—

The Hon. JOHN HATZISTERGOS: And it will be a much better service than is provided at—

Ms SYLVIA HALE: —the significant benefits of the Callan Park environment for the veterans who are living there, why do you not extend the same opportunity to enjoy that environment to non-veterans who currently use, and will continue to use—

The Hon. JOHN HATZISTERGOS: I think there are different issues here. The environment at Concord—and I do not know whether you have been to it, but you are welcome to have a tour of it if you want to—I think is outstanding. It is on a prime piece of real estate, backing Sydney Harbour. I think its value as a site for mental health has been acknowledged by a vast range of experts. The Brain and Mind Research Institute at the University of Sydney, Professor Ian Hickey, mental health consumer groups, and a wide variety of people have welcomed the Government's commitment to that particular site. I do not accept the argument, which is implicit in our question, that there is only one sort of site, latitude and longitude, which can particularly meet the needs of the veteran community and that happens to be at Callan Park.

Ms SYLVIA HALE: Minister, I understand that at Concord we are spending $60 million to provide a 174-bed facility, but that at Callan Park for an expenditure of approximately $40 it would be possible to renovate sufficient of its buildings to modern standards—that is, to 50 square metres per bed—to provide a 400-bed centre of excellence for treatment and rehabilitation, staff training and education and—

The Hon. JOHN HATZISTERGOS: Mrs Hale, this issue has been previously canvassed. I will ask Dr Matthews to respond.

Dr MATTHEWS: The facility at Concord is a total $58 million spend, of which about $44 million is for the construction, the balance being site clearing, furniture and fittings, consultancy costs, et cetera. The problem with the Callan Park site is a very practical one, and a very simple one. It has about $35 million worth of heritage requirements around the site, the sea wall; the drains are all blocked. That is the amount of money that would need to be spent before you can start renovating or rebuilding. That is the first problem. If the Minister gave me $35 million, I would not be spending it on renovating heritage orders; I would be building a new facility on a greenfields site.

The second problem is that the majority of those buildings were built a very long time ago, when the model of care for providing mental health services for people was completely different to the model that is available now, and they are entirely unsuitable for modern health care provision. I know that there is an enormous sentimental attachment on the part of a lot of people about that site, but renovating it and fixing it up is not a sensible, practical, financially viable option that I, in any conscience, could recommend to the Minister.

Ms SYLVIA HALE: But given that under the terms of the Callan Park Act the facility is to remain in public hands, unless the Government is going to pursue a policy of demolition by neglect, which appears to be its policy at the moment, that $35 million must be spent any way in preserving and restoring those facilities.

The Hon. JOHN HATZISTERGOS: The question you have identified is a broader question for government rather than one for the Health Department. The reality is that we will not move into Concord and out of Callan Park until the Concord development is completed and we have facilitated that move, which is at least a couple of years away. The Callan Park Act and the site is a matter that is presently before the Government.

Ms SYLVIA HALE: On a different issue, on 5 July this year the *Sydney Morning Herald* reported a wrongful dismissal case, which involved a false claim by the Chief Executive Officer of Sydney South West Area Health Service that the dismissal had been supported by three senior psychiatrist, including the New South Wales Governor, Professor Bashir. Has that false claim been referred to the Ombudsman or the ICAC, or how is the Government or the department—?

The Hon. JOHN HATZISTERGOS: I will not comment on the details of a case that is currently before the courts. There have been communications with the ICAC, but I will not elaborate on the details of any of the matters that you have referred to beyond what I have already said. There are matters that are still before the courts and appropriate tribunals, and I do not think it is appropriate for me to go into those.

Ms SYLVIA HALE: But once the legal issues have been resolved presumably the department will pursue those matters?

The Hon. JOHN HATZISTERGOS: I have answered your question. I have indicated that there have been communications with the ICAC and I have indicated that it is not appropriate for me to make any further comment at this point in time. But it is a question that you might like to raise with me at a later point in time once those proceedings have been concluded.

Ms SYLVIA HALE: Given the very large numbers of people who are in gaol largely as a result of their inability to access mental health services in a timely and appropriate manner, how many instances of litigation have there been in the past three or four years attempting to seek forms of redress from the department because of their inability to access those services, or how many cases have revolved around the keeping of mentally ill inmates in solitary confinement?

The Hon. JOHN HATZISTERGOS: First, this issue has been raised before. Solitary confinement is not a practice that is used in New South Wales. Let us make that quite clear. The answer to that aspect of your question is—

Ms SYLVIA HALE: You keep them in isolation.

The Hon. JOHN HATZISTERGOS: We do not have that. Corrective Services has a segregation policy, and has a process of dealing with it in accordance with segregation arrangements, which, as I understand it, are oversighted by the Serious Offenders Review Council beyond a certain point and I also think the Ombudsman has some involvement in those matters. I think we need to be clear about that. I know that many people who should be better informed about these matters use words like "solitary confinement", which are quite inflammatory. It is an incorrect use of terminology based on the way Corrective Services operates. In relation to your question about litigation, I am not quite sure about the claims you are referring to. Frankly, I am not aware of any. Does Dr Matthews have any?

Dr MATTHEWS: No, I am not aware of any specifically on that issue. In relation to the mentally ill in prison, there are two mechanisms to deal with that. One is in relation to minor offences or charges with sections 32 and 33 of the Mental Health Act. We have funded the Court Liaison Service to just under $3 million in 18 courts, and in the last financial year we were successful in diverting around about 1,000 people from custody who would otherwise have spent some time in custody. For more serious offences the Mental Health (Criminal Procedure) Act allows before the court a defence of not guilty by reason of mental illness, and that is being used increasingly, which is why the number of forensic patients in the system has increased from 72 to about 280 in the past 10 years. There remain, of course, a significant number of people in prison who have been charged or found guilty of offences of which mental illness was not a factor in the commission of the offence. They are tried in the usual way and it is the responsibility of Justice Health Services to provide adequate mental health services for those people who go to gaol, or who have become mentally ill after being incarcerated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will the Government implement the four recommendations you spoke of in the Coroner's report into the death of Scott Simpson?

The Hon. JOHN HATZISTERGOS: We have a task force that is examining those, involving not only us but also two other agencies. We will respond to the Coroner about each of those recommendations, but I have already indicated to you the approach we are taking.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Greg James is conducting a review of forensic prisoners under the Mental Health Act?

The Hon. JOHN HATZISTERGOS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will he look beyond the provisions of that Act to the way mental illness is dealt with in the justice system?

The Hon. JOHN HATZISTERGOS: It is also looking at the Mental Health (Criminal Procedure) Act to the extent that it overlaps, a may overlap, with forensic issues and he is also doing another review in relation to the administration of the Mental Health Review Tribunal. The terms of reference for that inquiry, I think, are publicly available. If you cannot access it, if you contact my office we will provide you with a copy of it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will there be any public submissions to his review?

The Hon. JOHN HATZISTERGOS: Yes, there will be a consultation process. His office is preparing a consultation draft in relation to the forensic alternatives, that is the various models. If you are going to remove Executive authority or if you are going to dilute Executive authority there is a number of different models that we want to put in the public arena, and there will be an opportunity for those people who are interested to put their views.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Anybody? It will be publicly advertised?

The Hon. JOHN HATZISTERGOS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is the timeframe for that review?

The Hon. JOHN HATZISTERGOS: Twelve months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When will that be completed?

The Hon. JOHN HATZISTERGOS: The actual date is in the terms of reference.

Dr MATTHEWS: Twelve months from the decision of Cabinet, which was approximately three or four weeks ago.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Performance contracts for CEOs in the health system are a large part of their remuneration, is that correct?

The Hon. JOHN HATZISTERGOS: Sorry, I do not understand that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On the web site the remuneration of CEOs in the health system have performance criteria, and that is a fairly large percentage of the remuneration, is that correct?

The Hon. JOHN HATZISTERGOS: Performance criteria are a large percentage of their remuneration?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Performance bonuses that are—

The Hon. JOHN HATZISTERGOS: No, there are no bonuses.

Ms KRUK: Can I clarify that? We have no performance bonus system in the New South Wales health system. What we have done in our performance contracts is made it quite clear what their priorities are, and that is why it leads to dashboard indicators that I referred to with Ms Parker. What the Minister has asked is that we make it clear after the determination that I take into account performance in relation to those major areas of service delivery, making a decision about their determination. We do not have performance pay.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this a semantic issue?

Ms KRUK: No, it is not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They need certain performances to maintain their job and their income.

The Hon. JOHN HATZISTERGOS: No, to maintain their job.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Their salaries are constant, but their longevity relates to the performance criteria?

The Hon. JOHN HATZISTERGOS: Yes, they are required to maintain and to meet those performance standards as a condition of their employment and as a condition of getting those increases. If they do not meet them—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, if they have to meet budget as a key performance indicator then they would not be able to advocate very well because if they did not meet budget they would not have a job. They are between a rock and a hard place in terms of having to advocate for services that they need or being sacked if they do not meet their budgets?

Ms KRUK: No. The management of their budget is one part of their performance agreement. They have equally strong obligations in relation to the quality and safety component. I think you are aware of some of their priorities in relation to mental health; similarly in other areas of service delivery. Their major criteria are clearly identified. They have the responsibility of balancing that portfolio of responsibilities, as I have responsibility as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you take the case of Owen James, who was more or less told to close the Mater, from memory, and would be rewarded if he did—

Ms KRUK: Who is Owen James, I am sorry?

Dr MATTHEWS: He was a former chief executive of the Hunter Area Health Service, who was removed in the early 1990s.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Again if we look at the performance and the situation in the Campbelltown hospitals, it would seem that budgets came before patients. At least, that was according to the inquiry or suggested by the Campbelltown inquiry.

Ms KRUK: I think the Campbelltown inquiry demonstrated a range of other pressures, one of the most significant actually being access to a work force. The Australian Medical Association amongst other parties suggested it was a budgetary issue. I do not think that was ever seen to be the major causal factor. Can I say that the Minister reiterates this publicly in a number of arenas: that we have a responsibility to manage within a budget. We are fortunate that we have had significant increases in that budget for the last half a dozen consecutive years. That does not in any way reduce the pressure in terms of making decisions about where you are making the biggest impact in relation to health outcomes. I would also say I would caution against a focus just in relation to input being the only measure of success in an area. It is a matter. That is why our work in relation to the State Health Plan is significant at the moment and the work that the Premier has done in relation to a State Plan, per se. We are looking to get an improvement in health outcomes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly we would like to have all the answers to our questions in terms of outputs rather than inputs, Minister.

Ms KRUK: We are moving down that path, Dr Chesterfield-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am delighted to hear it. As far as the Clinical Excellence Commission is concerned, does it also look at contracted-out services as to whether they are being delivered, or is it only services under the Department of Health that are looked at directly by the commission?

The Hon. JOHN HATZISTERGOS: No. Contracted services is—

Ms KRUK: Dr Chesterfield-Evans, are you talking about the operation of the private hospitals, the day surgeries—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, private hospitals that you contract out to.

Ms KRUK: They have actually their own legislation that covers their domain and there is a licensing system which the Chief Health Officer is aware of.

The Hon. JOHN HATZISTERGOS: I can say to you—and this is why some of the statistics that already exist through the patient quality and safety report that we produce annually does include information from private hospitals as to those adverse events. What happens is that they are required to provide a report to the department in relation to those matters, and those matters can be translated into a figure that is incorporated in our patient quality and safety report. As I have already announced publicly, we will be requiring a much more robust disclosure by the private operators. They are keen, I must say, to be involved in outpatient safety and quality and to provide us with that information and to link up with us.

Ms KRUK: Yes.

The Hon. JOHN HATZISTERGOS: So our statistics, although they already include some private hospital activity, will, once that legislation goes through, include a greater number of them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How does the Board of Surgical Studies relate to that?

The Hon. JOHN HATZISTERGOS: I am not quite sure what you are driving at.

Ms KRUK: I am not sure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that the Board of Surgical Studies or a surgical studies review?

Professor McGRATH: I wonder, Mr Chesterfield-Evans, if you are referring to the surgery which was contracted out to the private sector?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, I am.

Professor McGRATH: Okay. That is a program that was recommended to the former Minister by the Surgical Services Task Force and undertaken where they played a monitoring role. When the private providers responded to the tender that when out around the surgical services, they were asked to demonstrate how they met quality standards, in particular accreditation through the ACHS. That was a requirement before they could be a participant in that program. The program in the end achieved satisfactory surgical outcomes for 1,200 patients, which is not, at the moment, an ongoing process because we are currently managing within the public sector provision of services. There has been a formal evaluation of that program that showed that patients were particularly pleased with the service that they receive through that process, that there were no major problems identified in the service, and that financially it was very comparative with the provision of public sector services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that publicly available, the results of that study? Where was it?

Professor McGRATH: The report has gone to the Surgical Services Task Force at this time. I do not think we have made a formal decision about whether that would be released publicly. I could take it on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Where was that pilot—that was a pilot, I gather?

The Hon. JOHN HATZISTERGOS: It was an evaluation.

Professor McGRATH: It was a pilot program. It was done right around the State because one of the key elements of it was that the patients did not have to travel too far. It was done in areas where the local public health services did not have the capacity to meet the requirements of the patients receiving their surgery within or according to the appropriate time frame. It was done in quite a number of centres around the State but it was a once-off pilot. We have reserved the right to go back, should we feel the need in the future, but it was done to those 1,200 patients. In the last half, it was between September 2005 and the final patient was completed in February this year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Minister, there has been a review of the Royal Flying Doctor Service [RFDS] which showed that, because of the State base, a lot of people flown by the flying doctor go to the closest big State hospital rather than to the closest hospital, which may be across the border. Can you tell us anything about that?

The Hon. JOHN HATZISTERGOS: Can you say that again?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The flying doctor is organised on a State basis.

The Hon. JOHN HATZISTERGOS: Yes. The flying doctor is actually—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The flying doctor does not fly to the closest hospital. He goes to the one in that State, even if it is a further distance.

The Hon. JOHN HATZISTERGOS: Firstly, the Royal Flying Doctor Service is largely federally funded.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But State administered.

The Hon. JOHN HATZISTERGOS: No. No, it is not. We do not administer it. We provide some funding to it and I might add that they have had funding—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not saying that you are funding it, I am saying that it is State administered. Each State administers it.

The Hon. JOHN HATZISTERGOS: No. It is a national body.

Mr BARKER: No. Dr Chesterfield-Evans, there has been a Commonwealth review. The department, I think last week or the week before—I think the Commonwealth got its report in around February or March. We got it about two of three weeks ago. We are now looking at that to provide advice to go back. The RFDS has this governance arrangement, as I understand it, where they have a national council. But in addition to that, they have four sectors, and the sectors are not aligned to a particular State jurisdiction. I think there is the eastern sector, which is the one based in Broken Hill. There are two in Western Australia and one in Queensland. I think from memory that is how they have developed themselves. It might be in Alice Springs—I am a bit uncertain about the other States. The one in New South Wales I think comes out as far west I think as about Dubbo and it will repatriate patients generally to Adelaide where clinical need indicates that they have to go to Adelaide. Secondly, the RFDS has a contract with the Department of Commerce for the provision of ambulance fixed wing aircraft out of the Kingsford Smith airport, but I think they have gone out to Bankstown.

The Hon. JOHN HATZISTERGOS: I think the issue you might be referring to is one which actually I have raised at the ministerial council, and that is the issue in relation to mental health. Is that what you are referring to?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, that the flying doctor tends to be very State based.

The Hon. JOHN HATZISTERGOS: Well, it is not State based.

Mr BARKER: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It may not be in theory, but in practice it does run on State lines.

Mr BARKER: No, that is wrong.

The Hon. JOHN HATZISTERGOS: That is not correct, but there is an area where they are State based, and that is mental health. The reason is because the Mental Health Act provisions in each jurisdiction differ. They cannot take a patient across the border because of the fact that the mental health laws of New South Wales cannot be administered in Victoria and vice versa. This is an issue that has concerned me. It was raised with me by the Royal Flying Doctor Service and I have put it before the ministerial council to see if we can get some cross recognition of mental health laws so that patients do not have to be transferred lengthier distances within a jurisdiction, if it is possible for them to have access to services across the border that are closer.

CHAIR: Time has expired. Government members?

The Hon. JAN BURNSWOODS: Minister, can you give us some information on what the Government is doing to improve the delivery of care in hospital emergency departments?

The Hon. JOHN HATZISTERGOS: I thank the honourable member for this opportunity to provide the Committee with details of the Government's commitment to new and better ways to provide care to emergency departments. The Government has a proud history—New South Wales Health has a proud history of providing emergency care to the community in New South Wales. Doctors, nurses and support staff working in our emergency departments, hospitals and the New South Wales Ambulance Service play a key role in the front line of health care service delivery. However, demand for health services is constantly increasing and the ageing of the population is presenting new challenges for those delivering health care services.

In the last 12 months we have seen a dramatic increase in the number of patients attending emergency departments in New South Wales. Despite the expertise and dedication of staff as well as a record budget that is being used to employ more nurses and more doctors and additional lifesaving technology, the system has had to deal with a 10 per cent increase in the number of patients, and has felt that pressure.

Whilst individual patient care in New South Wales hospitals is of a very high standard, the systems and processes for co-ordinating that patient care are often outdated and frustrating for both patients and health care professionals. That is why we are developing better ways of providing care in emergency departments, minimising delays for patients in our public hospitals. These new models of emergency care will lead to patients experiencing a more integrated and faster journey through emergency departments.

The new models of care are being progressively introduced to public hospital emergency departments throughout New South Wales include fast-track zones, triage and treat processes, short-stay units and redesigned processes for streamlining the admission of patients from an emergency department into a ward bed. To date 10 fast-track zones have been established in metropolitan and non-metropolitan areas. They include at John Hunter, Nepean, Royal North Shaw, Bankstown, Concord, Tamworth, Port Macquarie, Wollongong, Coffs Harbour and Wyong hospitals.

Those zones have generally improved patient triage performance. Subsequently, $1 million of seed funding has been allocated to support the implementation of new models of care, which includes fast-track zones. I am advised that a further 15 hospitals are planning to implement fast-track zones over the next few months. These include the Children's Hospital Westmead, Prince of Wales Hospital, Westmead, Sutherland, Campbelltown, Maitland, Canterbury, Belmont, Royal Prince Alfred, Gosford, St George and Ryde hospitals. In relation to short-stay units, Westmead hospital has been at the forefront of the implementation of short-stay unit beds. Westmead has reallocated a number of beds in each in-patient unit as short-stay beds, including surgical and aged care beds. The use of those beds involves well-established business rules and policies that drive patient flow and promote timely treatment and discharge.

Access block rates and off-stretcher times have been maintained at Westmead, despite a 14 per cent increase in emergency department attendances. A number of other hospitals have established short-stay units in order to decongest their emergency departments. The Government funded 33 short-stay beds in March 2006 at Liverpool, John Hunter, Wollongong, the Children's Hospital Westmead, Royal North Shore and Nepean hospitals. Since that time a further 60 short-stay beds have opened. I am advised that additional short-stay beds are scheduled to open at Dubbo, with four chest pain unit beds, and that Royal Prince Alfred, with six emergency medicine unit beds.

In the coming months under the State-wide Cardiology Clinical Service redesign project, 38 chest pain evaluation unit beds will be established at 10 hospitals that have cardiac catheter laboratories. Those units will each provide for beds for the short-term evaluation of patients presenting to emergency departments with chest pain. The implementation timelines for those is August to November this year. As a result of the hard work by our doctors and nurses, coupled with the previously mentioned initiatives, there has also been a significant improvement in off-stretcher time and access block across the State. The most recent results show that NSW Health has significantly reduced delays for ambulances and for patients awaiting admission to a hospital bed from the emergency departments.

The redesign of our emergency department systems has resulted in an ongoing improvement in performance. Last week the Opposition proposed to condemn me for car access block, because 75 per cent of patients were transferred to a ward bed from an emergency department within the established time frame. In fact, it is condemning me for improving the system by 5 per cent since June 2005. That was an interesting addition to the Skinner proposal, and it condemned me. However, I do wish to be distracted.

We have real gains in patient care that has been most marked in the Shoalhaven Hospital where access block dropped by 44 per cent between June 2005 and June 2006, Wollongong Hospital dropped by 26 per cent, Blacktown Hospital dropped by 23 per cent, Nepean Hospital dropped 17 per cent, Sutherland Hospital dropped 16 per cent, Port Macquarie Hospital dropped 16 per cent. In the larger hospitals Westmead was down 19 per cent, Royal Prince Alfred was down 8 per cent, and John Hunter was down 6 per cent. These improvements are the result of careful planning and increased investment by the Government. Ambulance off-stretcher time stood at 78 per cent in June 2006, compared to 67 per cent in June 2005.

In May and June 2006 New South Wales emergency departments exceeded the national waiting time benchmarks for triage categories 1, 2, 4 and 5. This is the first time since triage benchmarks were adopted in 1994 that four out of five benchmarks have been achieved in the same month. I remind members that when the Coalition was in office the rate for category 1, those who had to be dealt with within two minutes, was 78 per cent—it has been 100 per cent since Labor came to government. That is a fantastic performance, given the ever-increasing demand on our services. The new models of emergency care have been formulated by the New South Wales Emergency Care Taskforce. That task force has extensively reviewed the systems of care in public hospital emergency departments.

I am very grateful to the emergency department doctors and nurses on that task force who undertook that exceptional work. The Emergency Care Taskforce has revolutionised the journey of all patients through our emergency departments. The community wants to be assured that the sickest patients are treated safely and quickly, they also want to know that other patients who need emergency care will be treated in a safe and timely manner. The new models of emergency care include separating less complex patients from sicker patients, allowing faster treatment to less-complex patients; providing for early assessment, fast tracking and early initiation of clinical care; emphasising a clinical team commencing care, rather than patients waiting to see a doctor, and promoting a direct-to-ward admission for certain conditions.

A key plank in the Government's new directions initiatives for health care is developing integrated primary health and community care services and after-hours GP services. In June this year the Premier and I announced up to $4 million funding would be provided this financial year for the integrated primary care and community care services initiative, which will integrate GPs, community health workers, allied health and other care professions in one-stop shops; encourage patient-centred, co-ordinated and continuous care; and help ensure accessibility to services. The new one-stop shops

provide an opportunity to create what has been missing to date: an integrated delivery infrastructure, effective public-private partnerships and the capacity to bring together a number of major health professionals, functions and funding streams under co-ordinated management.

Our development of those one-stop shops is consistent with the health agenda agreed to by the Council of Australian Governments in February this year. The Government's initiative is a key example of increasing the health system focus on prevention and health promotion and improving the integration of the health care system. The Government is also committed to improving access to primary health-care services. In June this year the Premier and I announced that up to $2 million per year would be allocated for the establishment of 10 after-hours general practice services, co-located with hospitals. The clinics are designed to address the shortage of affordable after-hours access to GPs in the community. I understand that area health services are working with the Divisions of General Practice and local GPs to identify and progress potential sites—and significant progress has been made.

At clinics, patients who do not require an emergency medical treatment will have a choice of attending either the emergency department or a co-located after-hours GP clinic. This initiative is aimed at easing pressure on emergency departments and giving people the right type of care at the right time and the right place. I am indeed encouraged by the improvements made over the past 12 months and I look forward to working with dedicated medical, community and support staff in our emergency departments continuing to drive change and ensuring patients receive the best possible emergency department care in a timely and integrated way.

The Hon. JAN BURNSWOODS: Minister, would you advise the Committee of progress on capital works investment in the health system?

The Hon. JOHN HATZISTERGOS: Earlier I indicated that when the Coalition was last in Government it downgraded and closed more than 30 hospitals. Suddenly the economic rationalists of the past have become the big spenders of the future. The Leader of the Opposition has given the honourable member for North Shore a blank cheque, which may as well be a magic wand, given the commitments she has made over the winter break. Without regard for clinical services planning or due process, the honourable member for North Shore has committed the Coalition to $300 million in promises over the last eight weeks.

CHAIR: Minister, I remind you that the answer must be relevant to the question asked.

The Hon. JOHN HATZISTERGOS: Well, it is. Her promises included a public-private partnership redevelopment of Lismore, an iron-clad commitment for Narrabri, fast tracking Byron, radiotherapy services for Orange, or was it Dubbo, or both? I am not quite sure!

The Hon. ROBYN PARKER: Point of order: Madam Chair, we have sat here patiently listening to the Minister time and time again talk about anything but the budget of his department. The question was nothing to do with what he is saying. It is not relevant to discuss Coalition policy today, as valuable as that policy might be. We have limited time and we could come back at another time. I ask you to bring the Minister back to the question.

The Hon. JAN BURNSWOODS: To the point of order: The question was about capital works investment in the health system. In that context the areas and issues to which the Minister is referring are relevant.

CHAIR: Order! I look forward to hearing about capital works investment in the health budget, but so far we have not got there. Minister, I ask you to be relevant to the question that was asked.

The Hon. JOHN HATZISTERGOS: These matters are relevant. If all these projects have been fast-tracked around the State to such an extent we then have to ask: What will happen to those already on the program? Will it be Tamworth?

CHAIR: The Minister is now dealing with hypothetical issues. He should tell us about the health budget.

The Hon. JOHN HATZISTERGOS: It is hypothetical, but I think the people of New South Wales would expect me to know. Will it be Tamworth? We have already been told that the local candidate there does not have a commitment—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Point of order: The health debate seems to be about what the Government is doing and what the Opposition might do. The debate should be about the health department's budget and the state of excellence that might be achieved. The Minister should not refer to second-hand regurgitated promises. We really ought to hear about the health budget and how health standards can be improved.

The Hon. JOHN HATZISTERGOS: I have said what I am going to say.

CHAIR: Minister, I ask you to be relevant to the question that was asked.

The Hon. JOHN HATZISTERGOS: Contrary to the picture I was just painting, the reality is that, under Labor, every major hospital has been rebuilt, redeveloped, or had its emergency department upgraded. A massive $4.25 billion has been committed to capital works over the life of this Government. Thirty-seven major hospital projects, that is, projects valued at over $10 million, have been completed since 1995. Let me run through the list: The Children's Hospital at Westmead cost $311 million and Albury hospital cost $47.5 million. Young and Mercy hospitals cost $17.2 million and Broken Hill Health Service cost $32.7 million. Dubbo hospital cost $23 million and Bourke Health Service cost $15.7 million.

Maitland Hospital cost $28 million and John Hunter Hospital cost $46.1 million. John Hunter pathology cost $17.3 million and Manning hospital cost $32.3 million. Coffs Harbour Base Hospital, including the ambulance, cost $81 million and Tweed Heads hospital cost $42.5 million. Royal North Shore Hospital and other works, that is, the paediatric, obstetrics and emergency building, cost $63 million and the Central Coast access plan at Wyong Hospital cost $85.4 million. Illawarra Regional Hospital cost $57.4 million and Wollongong Hospital cost $79.7 million. Prince of Wales Hospital cost $267.9 million and St George Hospital cost $186.9 million.

St Vincent's Hospital cost $131.4 million and the Sydney Eye Hospital cost $32.1 million. Sutherland Hospital cost $85.3 million and Shoalhaven hospital cost $35 million. Calvary Hospital cost $19 million and the Bankstown and Lidcombe hospital cost $77 million. Liverpool Hospital cost $205.2 million and Canterbury Hospital cost $80 million. Camden Hospital cost $25 million and Royal Prince Alfred Hospital cost $33.3 million. Liverpool mental health facility cost $32.5 million and Concord Hospital multi-block cost $64.1 million. Garrawarra Nursing Home cost $11.8 million and Lithgow Hospital cost $23 million.

Nepean Hospital cost $185.2 million and Blacktown Hospital cost $103.8 million. Jeffrey House refurbishment cost $23.8 million and Westmead Hospital cost $33.6 million. The Blue Mountains Hospital redevelopment cost $17.8 million. The current four-year capital works program totals around $2 billion. This financial year $979 million in capital works will be contractually committed, including Queanbeyan, Bathurst, Lismore, Royal North Shore Hospital Research and Education Centre, Liverpool Hospital stage two, Wyong Hospital stage two, Auburn hospital redevelopment, and multipurpose facilities at Bombala, Batlow, Berrigan, Bingara, Walcha, Warialda, Merriwa and Nyngan.

This is in addition to 16 major projects estimated at $535 million that will be completed and commissioned this financial year. This includes: Griffith emergency department; Tottenham Hospital; Guyra Health Service, which has just been completed; Walcha multi-purpose service; Port Macquarie radiotherapy; an obstetrics, paediatrics and emergency department and mental health works at Hornsby Hospital; Sutherland Community Health Centre; and Westmead bone marrow ward refurbishment. That does not cover all the projects; I said earlier that it covers the 16 major projects.

Capital spending this financial year represents a $173 million, or a 38 per cent increase, since 1994-95. That has been spent on rebuilding and upgrading health facilities; promoting infrastructure for specialty service programs, major equipment purchases, and information management and technology projects. The strategies include: networking of support services across health services;

building capacity to effectively respond to growing and changing demand; and a commitment to a stronger public health sector. The Government looks forward to continuing this progress.

I would like to take a moment to address some of the capital works projects that Opposition members have been outspoken about. We recently announced what we were going to do in relation to redevelopment at Royal North Shore Hospital—one of the issues raised last week by the honourable member for North Shore. On the one hand she was complaining that the project was not taking off at the pace that she would like but, on other hand, she was saying that it should not take place at all. I referred to news clippings of a month or so ago and to a motion she moved last week about Rotary Lodge, which provides accommodation to families of seriously ill patients.

Everyone knows that, when a hospital is redeveloped on its current site, some of those areas have to be utilised in order to allow for the redevelopment to take place. Alternative arrangements have been made at Royal North Shore Hospital to replace Rotary Lodge with a mixture of on-site and off-site accommodation at no extra cost to carers. The honourable member for North Shore objected to the demolition of Rotary Lodge. God knows how she wanted the hospital to start being redeveloped! Notwithstanding the fact that the area health service looked at all alternatives, it could not find an option that would not impact on direct patient care or on the progress of the redevelopment. In other words, we would not have been able to proceed with the biggest hospital redevelopment in the State's history for the sake of one day's news by Mrs Skinner.

The redevelopment of Royal North Shore Hospital will be magnificent. One of the State's oldest and leading teaching hospitals will become one of the newest and best. New facilities will include operating theatres, procedure rooms, emergency departments, day stay and ward areas, and on-site accommodation for staff, students and family of patients from country areas. This is additional to the $55 million clinical services facility opened in 2004. The construction of the research and education building will begin this year and we expect work to be completed by 2008. We expect work on the new main building to be completed by 2012.

Opposition members recently promised to rebuild Narrabri Hospital, which was overshadowed by other plans to slash the jobs of important health care workers across country New South Wales. I have already referred to that issue so I will not trouble members with it. Recently, when I visited Narrabri Hospital, I announced a commitment of $100,000 for planning to commence the redevelopment of that hospital. Another issue that Opposition members were going to contend is the fact that I allocated $100,000 to commence planning for the redevelopment of Narrabri. I also indicated that this is a project that is listed on our 10-year forward capital works program.

NSW Health is undertaking strategic and project definition of planning for the redevelopment of Narrabri Hospital, a routine component of capital works development processes. In the meantime the Government is continuing to maintain current facilities at Narrabri. In recent years the airconditioning in operating theatres has been upgraded, a new staff accommodation building has been constructed, and the area health service has undertaken a number of other works with the total value exceeding $300,000. An amount of $350,000 was allocated for the relocation and improvement of the hospital's emergency department, and $340,000 was allocated for other rectification works, totalling of $690,000 to improve access for the public and increased security for staff. On my recent visit to Narrabri I was pleased to be able to open that facility.

CHAIR: As only a few minutes remain you can continue with your statement, but your advisers have indicated that they have some answers to earlier questions. So it really is a matter of whether you wish to go beyond 1.00 p.m.

The Hon. JOHN HATZISTERGOS: Coincidentally, I have just about finished. The area health service will continue to consult with Narrabri Council and the community with respect to this matter. This project is identified in the Government's 10-year infrastructure plan, which maps out the Government's priority projects for the future.

Mr McGREGOR: I want to reiterate the issue around the data collections we have in respect of corporate administration. We have for many years gathered information and reported in our annual report on what we call "corporate administration"—it is quite separate from hospital services. Corporate administration includes the Department of Health of North Sydney and also the staff

employed in administration in the area health services offices, not in hospitals. As I said, that is reflected in the annual report. You can see that in recent times that figure has been declining. More recently, the Public Employment Office began benchmarking all administrative positions across the public sector. They do that regardless of the function. So people who are employed in hospitals on clinical support, on clinical administration and in emergency departments are captured by that data base for the sake of that benchmarking across the whole of the public sector.

Notwithstanding all that, as the Minister and I think the Director General said earlier, in terms of our corporate administrative savings, we are in the process of ensuring that we achieve in excess of 1,000 jobs. We will have that audited independently as soon as that project is completed. It will show in the current year's annual report, when it is published, a further decline in the number.

CHAIR: Thank you for that explanation, Mr McGregor, but could you still provide a clear definition?

Mr McGREGOR: Yes, we will provide that.

Ms KRUK: We are happy to include the definition.

CHAIR: Thank you.

The Hon. JOHN HATZISTERGOS: In broad context, what we are talking about includes the people at the front desk and those sorts of people. The Treasury definition encompasses them whereas the Health definition does not.

Ms KRUK: They do not have ward clerks and education. It is a rough attempt to try to get some parity in relation to data collection.

CHAIR: Thank you.

Professor McGRATH: I would like to clarify my earlier remarks about readmissions. I said earlier that New South Wales has a rate of 3 per cent. There was a question about how that relates to other States' performances. The ACHS report does not provide State-by-State comparisons. The ACHS report has individual hospital reporting. It is voluntary and it is only those who choose to report. So you cannot get a State-by-State comparison out of the ACHS report.

The Hon. JOHN HATZISTERGOS: Someone asked me about Shellharbour Hospital.

Professor McGRATH: There was a question about whether there were surgeons on call at Shellharbour Hospital. The answer is, no, there are not. Patients requiring urgent surgery after hours go to either Shoalhaven or Wollongong. That has been the case for quite some time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The other question was whether they are covered by physicians.

The Hon. JOHN HATZISTERGOS: There have been some discussions with the chief executive and, I understand, a doctor as written to Ms Kruk about this issue.

Ms KRUK: From memory, a Dr Dunn may have written to a member of the committee.

The Hon. JOHN HATZISTERGOS: A meeting was held last week, and also perhaps the week before, to resolve his concerns. I do not have a follow-up but I can give you one as to what has happened. But we are aware of the issue and I understand it is being addressed with the chief executive and Dr Dunn.

CHAIR: Thank you.

The Hon. JOHN HATZISTERGOS: I would like to clarify what I said before to the Hon. Dr Arthur Chesterfield-Evans. Local management responded immediately to concerns raised by Dr Dunn regarding the medical on-call roster at Shellharbour Hospital. Further meetings were convened

by local and area health management with representatives, including Dr Dunn. This was a network with Wollongong Hospital to provide additional support. That meeting has resolved to explore further rostering options, and follow-up meetings have been arranged to progress this issue. Again, it confirms the value of networking with other, bigger hospitals.

CHAIR: Thank you. Minister, Director General and advisors, I thank you all for your attendance today. I remind you that replies to questions on notice must be provided 21 calendar days from their receipt in your office. I remind all Committee members that they have until 5 p.m. on Wednesday to submit any further questions on notice in relation to Health estimates. The Committee will make a decision at a later date about whether we need to have any subsequent hearings.

(The witnesses withdrew)

The Committee proceeded to deliberate.