GENERAL PURPOSE STANDING COMMITTEE NO. 2

Tuesday 14 March 2006

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 2.00 p.m.

MEMBERS

The Hon. P. Forsythe (Chair)

The Hon. T. Catanzariti
The Hon. Dr A. Chesterfield-Evans
Ms S. Hale
The Hon. M. Pavey
The Hon. C. Robertson
The Hon. Henry Tsang

PRESENT

Murrumbidgee Division of General Practice
Mr K. Fletcher, *Chief Executive Officer*
Dr M. Reeves, *Chair*

NSW Department of Health
Ms R. Kruk, *Director-General*
Mr R. McGregor, *Deputy Director-General, Health System Support*
Dr R. Matthews, *Deputy Director-General, Strategic Development*
Mr K. Barker, *Chief Financial Officer*
Professor K. McGrath, *Deputy Director-General Health System Performance*

South Eastern Sydney and Illawarra Area Health Service
Professor D. Picone, *Chief Executive*
Mr J. Roach, *Director Corporate Services*

Northern Sydney and Central Coast Area Health Service
Dr S. Christley, *Chief Executive*
Mr G. Harding, *Area Director Financial Services*

Greater Southern Area Health Service
Associate Professor S. Schneider, *Chief Executive*
Mr P. Gould, *Director Corporate Services*

CHAIR: I declare this meeting open to the public. I welcome Mr Keith Fletcher and Dr Marion Reeves from the Murrumbidgee Division of General Practice, together with officials from the Department of Health, to this general hearing of General Purpose Standing Committee No. 2. At this meeting the Committee will examine further the proposed expenditure for the portfolio area of Health. Before questions commence, some procedural matters need to be dealt with.

In accordance with the Legislative Council's guidelines for the broadcast of proceedings, which are available from the Attendants and Clerks, only members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, you must take responsibility for what you publish or what interpretation you place on anything that is said before the Committee. Members and their staff are advised that any messages should be delivered through the Attendants on duty or the Committee Clerks.

I now declare the proposed expenditure for the Health portfolio open for examination.

Mr Fletcher and Dr Reeves, if at any stage you consider during your evidence that certain evidence or documents you may wish to present should be seen or heard in private by the Committee, the Committee will consider your request. However, the Committee or the Legislative Council itself may subsequently publish the evidence if they decide it is in the public interest to do so.

Mr Fletcher and Dr Reeves, do either of you wish to make an opening statement?

Mr FLETCHER: We have prepared an issues paper that we can distribute. We were going to use this to work from, but it is probably more worthwhile and more efficient if we distribute copies for everyone.

Document tabled.

Mr FLETCHER: The document makes three specific references to general practitioners that work in the area, who do not have a problem with the respective issues being raised.

CHAIR: Would you like to speak to your paper?

Mr FLETCHER: Broadly, we want to say that there is a really core problem with the area health services at the moment, that being the way they are funded. It is our belief that the way that our area health service in our area is funded makes it structurally insolvent, in that it is given its funding based on a one-month operational budget. Commonsense dictates that the service is not able to plan adequately for the implementation of services. The prolonged use of this funding method has basically led to a breakdown in the cultures and essentially the core issues that we need to talk about, which we want to raise today: the structural insolvency itself, the distrust and disrespect that has come out as a result of it, the breakdown in transparency, and core accountability. We believe that that structural insolvency needs to be addressed, and that will then come down to addressing the accountability specifically as well.

CHAIR: Is this something that is particular to the change in the structure of Health, that we have gone to this Greater Southern Area Health system? Is this something that you have noticed more particularly under the new structure?

Mr FLETCHER: It has certainly gotten worse under the new structure. In my position, I am looking after the Murrumbidgee Division of General Practice, which is the Western Riverina, the areas that fall within Hillston, Tocumwal in the south, Hay in the West, and Narrandera. It is about 50,000 square kilometres, with a population of about 65,000. I can only speak for that particularly. We were a part of the Greater Murray Area Health Service and are now part of the Greater Southern Area Health Service, which is a combination of, as we understand it, the two worst financially performing area health services in New South Wales.

The Hon. MELINDA PAVEY: In fact, you wrote to the Greater Southern Area Health Service last October to advise of a vote of no confidence from the Murray Division of General Practice. Have you received a response to that letter?

Mr FLETCHER: No, we have not had any response at all.

The Hon. MELINDA PAVEY: A vote of no confidence in your area health service is a big step. Would you have expected a response?

Mr FLETCHER: Yes, we would have. Out of respect, yes. I really want to make the point that there are nine hospitals within our area. Every single one of those hospitals, bar one, relies entirely on general practitioners as visiting medical officers. Griffith Base Hospital, which is the other hospital, also relies very heavily on them as well. But not only that. That letter was put forward by not just the Murrumbidgee Division of General Practice but also the Medical Staff Council of Griffith Base Hospital, so essentially all senior clinicians.

The Hon. MELINDA PAVEY: I refer to issues of mental health, particularly in the Griffith area. I understand that the division employs a psychologist. How many patients a year would that person see?

Mr FLETCHER: The Division of General Practice employs four full-time psychologists. Under the system that we have developed, they are each able to see 1,000 face-to-face services a year, which is quite extraordinary.

The Hon. MELINDA PAVEY: That is 4,000 people from the Murrumbidgee community?

Mr FLETCHER: Yes, from that catchment. We fund the psychologist to go into general practice to deliver those services. We can send them to the more remote communities as well, so that they are receiving the much-needed services. It is based on demand. That is based on the system that ensures the greatest amount of access to patients, because mental health is a major problem for us, as it is certainly Australia wide.

The 1,000 people that they are able to see is an interesting contrast to the five full-time equivalents employed in the Griffith Mental Health Service that cannot see 1,000 people. That is not to target those individuals. I really want to make sure I make that point. For every new patient they see, they have to fill out what is called a 42-page MOAT form, which is ludicrous.

The Hon. MELINDA PAVEY: Why is that required being an employee of the area health service as opposed to the different requirement through the division?

Mr FLETCHER: I honestly could not tell you the answer to that. I understand it is a directive from NSW Health.

CHAIR: When we look at the issues, are they mostly budget related or are they structural as well? For example, is the creation of this very large area part of the problem? If it is, how does it play out with some of the smaller communities, for example, in your area?

Mr FLETCHER: The bottom line is that services are being reduced, and they are being reduced now. Our communities, and we individually, were told that the formation of the new area health service boundaries would create $100 million worth of savings and that those savings would be seen in front-line services. The last we heard, the area health service was $35 million in debt. Services are being reduced. I can tell you from firsthand experience that areas like Coleambally, Griffith, Darlington Point and Hillston, all community nursing services have been reduced in every one of those towns. In turn, it puts enormous pressure on the local clinicians that are remaining. Areas like Coleambally and Darlington Point have solo general practitioners. Any other services that are not there, the general practitioner is looked upon as the sole clinicians to provide those services. We are very concerned about what the ramifications of this will be.

CHAIR: When you say community nursing, does that mean there is simply no-one being employed in that area, or are they just covering a broader area or seeing people on fewer days?

Mr FLETCHER: There is no-one employed in those areas. Griffith has certainly had a reduction in services.

The Hon. MELINDA PAVEY: I wanted to ask about some of the things you have witnessed in terms of the $35 million debt that they cannot pay off, which you have referred to. What sort of shortcuts are they taking on the ground in terms of service to patients?

Mr FLETCHER: I particularly want to refer to the handout I gave you. In our view, some of the decisions being made relating to that debt lack clarity, research and commonsense. For example, they have removed the evening tea and coffee trolley for patients across the Greater Southern Area Health Service.

The Hon. MELINDA PAVEY: When did they stop morning and afternoon tea?

Dr REEVES: It was the evening supper trolley. Recently, part of that has been reinstituted because there was a public outcry. It got the front page of the newspaper, as it did in other areas and Wagga Wagga also. That has been modified according to patient need.

The Hon. MELINDA PAVEY: What are some of the other cost-cutting measures?

Mr FLETCHER: There were other issues there as well, for example, the removal of fruit from the menu across the Greater Southern Area Health Service.

The Hon. MELINDA PAVEY: Is that still the case?

Dr REEVES: Yes, it is.

The Hon. MELINDA PAVEY: So no fresh fruit is being supplied to patients?

Dr REEVES: There are stories that occasionally nursing staff in intensive care have to bring in fruit from home to give to the patients who are on low-fat diets because the fruit is not supplied.

Mr FLETCHER: Most recently, the Meals On Wheels, at a cost of $3.50, used to provide a bowl of soup, a main meal, a dessert and orange juice. The price has now been increased to $6.50, without the soup and without the orange juice. Some pretty silly decisions are being made there in particular.

I really want to make the point as well that from my perspective we have had to take on an enormous amount of recruitment through our area. Six years ago we had 40 general practitioners covering the area that I referred to. We have lost 32 general practitioners over that period, and we are now up to 45. It has been a great success story and there are a whole host of different reasons for that. Even though we are essentially providing the VMO services to those hospitals, we have never received assistance from the area health service.

The Hon. MELINDA PAVEY: In relation to palliative care, have the amalgamations resulted in better palliative care services?

Mr FLETCHER: Palliative care has been very frustrating. We worked very hard to develop a palliative care system within the area, called the Griffith Area Palliative Care Service. It has been regarded so well that it is now being rolled out across Australia through many divisions of general practice. That was done in partnership with the area health service as well, but there were specific times when we were actually carrying up to $70,000 in debt. We are a $2 million organisation. It was extremely tough, and they were very difficult business partners. Most recently we were successful at a meeting we had with then Minister Iemma to receive $80,000 to increase the palliative care system across the rest of our region. We know that that was distributed from NSW Health to our area health services in April. However, we did not see it until January the following year. Through the difficulties that are caused from wanting to deal with outside organisations, we are still having trouble in engaging the local area health services community nursing service to deal with palliative care issues that are being funded by their own department.

CHAIR: It is now cross-bench members' turn and they have five minutes each.

Ms SYLVIA HALE: Obviously the amalgamations were justified on the grounds of the financial savings that would result. You said that in fact they are still in a grave financial crisis. Would you say that the lack of funds is the fundamental problem from which flows the other difficulties with transparency, distrust and lack of respect?

Mr FLETCHER: Not lack of funds, but the actual funding system. They are currently funded on a month-by-month basis; the operational budget is provided on a month-by-month basis. So they cannot plan to use those dollars. If they were to receive the dollars even on a quarterly basis in a total operating budget, when insurances fell due they could be paid and they could step out their decisions a lot better from the management perspective. Unfortunately, this funding system has been sustained for so long that the focus has become the bottom line and it has travelled all the way down. The general manager of Griffith Base Hospital, for whom I have a lot of respect and who has several degrees in health service management, is not allowed to sign off on anything more than $700. That is disrespectful to him and ludicrous.

Ms SYLVIA HALE: If that payment system were improved to perhaps a quarterly system, would the amalgamations be worth proceeding with and would they produce positive results, or do we have such a large area health service now that that is counterproductive?

Mr FLETCHER: If we could fix that funding issue, that would be a step in the right direction. Then we need to tackle the cultural issue, which is very entrenched. We must address the cultural issue and completely change the reporting system back to NSW Health. It should not be bottom-line related but focused on outcomes. If it is, we will think very long and hard about ensuring that the PKIs, or the indicators that they have to report back on, relate to patient care. If that were the case, when community nursing hours are reduced in areas such as Coleambally it stands out just as much as not meeting budget. Individuals must be held accountable because of it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you talk about structural insolvency, if a bunch of money comes in once a month—like an individual being paid—if you budget and your expenses are reasonably constant, that should not be a huge problem. Why do you think that is the source of the problem?

Mr FLETCHER: It would be great if that was how it operated in the real world. However, expenditure does not happen that way. You might have to pay electricity bills at certain times of the year, and you can budget to a degree. However, we need to have some faith in the managers of the organisations to manage. A month-by-month budget creates an environment in which they have to focus such much on the finance they cannot focus on anything else because they are constantly—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is too much attention on minute-to-minute cash flow?

Mr FLETCHER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is no big picture thinking anymore.

Mr FLETCHER: Precisely, and that has gone all the way down through the levels of management.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why I do you think that is?

Mr FLETCHER: The debt levels have continued to rise. It has become a really difficult Catch-22—the debts levels have risen, so the screws have been placed on management, funding levels have been reduced—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is so close to the wind and it is so difficult keeping the bicycle balanced that it makes little headway.

Mr FLETCHER: Yes. I think the managers' role in the area health service is extremely hard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Basically there is an absolute shortage of money.

Mr FLETCHER: No, I am not saying that at all. I am saying that the funding system itself—providing a month-by-month operating budget—is the wrong way to do it. That creates the problem. We still have the issue of debt, but we need to create a completely new system that allows managers to focus on service delivery and to be accountable for that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But would a year-by-year arrangement not cause the same problem starting at about the middle of April and there being no money until the end of the financial year and then there would be huge spending by some managers and none by others—

Dr REEVES: Or do not pay the bills until the beginning of the next financial year, which has certainly happened in the past. It would be okay balancing a month-to-month budget if there was no huge overhang from the last month. If you are struggling to pay off bills that have come due after 90 or 120 days with this month's budget, next month's budget does not look any healthier. Unless there is a forward advance—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This sounds like a chronic starving of money problem.

Dr REEVES: We are all aware that the bucket of money for health is not endless and that health costs are rising. However, there are significant structural issues with so many levels of management that no-one is actually held accountable for anything. If you go to one person, the buck gets passed above them, if you go above them, the buck is passed back down. No-one is responsible, decisions cannot be made appropriately and money cannot be used efficiently because everyone is so worried about structural efficiency that no-one can concentrate on clinical efficiency and patient care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have any figures suggesting that there are more bureaucrats per frontline worker than there were before, or that the bureaucrats are taking more money out of the system than happened 20 years ago, or is this just an impression?

Mr FLETCHER: It is certainly an impression; we do not have any figures on that.

Dr REEVES: We certainly know that frontline clinicians—nurses, allied health professionals and doctors, particularly in the area we look at—are vastly reduced from what they used to be. Our hospital survives on about 11 or 12 clinicians who are all so totally enmeshed that if one falls over or gets tired, because we all do at least a one-in-two or a one-in-three roster, which in many in many parts of the country is unacceptable—

CHAIR: Can you explain "one-in-two" and "one-in-three"?

Dr REEVES: Every second night and every second weekend.

The Hon. CHRISTINE ROBERTSON: Is this only medical clinicians?

Dr REEVES: When I talk about the rosters I am referring to doctors—specialists and GP VMOs. At Griffith Base Hospital at the moment the rosters are either one-in-two for obstetrics, surgery and anaesthetics, and one-in-three for medicine and paediatrics.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note that you said the number of community nurses was cut. Obviously they are much cheaper than doctors in terms of maintaining services. My experience is that the further you are from a capital city the more nurses do and the smaller the gap becomes between what nurses do and what doctors do.

Mr FLETCHER: True.

Dr REEVES: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that the case in these towns? Has the community nursing service been cut to death or were they not replaced, or not replaced on holiday, or are they officially closed and the staff given redundancy?

Mr FLETCHER: They have never been officially closed; it is usually attrition—they are not replaced.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they gradually die out.

Mr FLETCHER: Yes. It feels like it is reduction by stealth.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And now those towns are totally bereft of services.

Mr FLETCHER: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably the GPs left have to pick that up.

Mr FLETCHER: That is correct.

Dr REEVES: It is very hard to find the advertisements for those jobs. You have to look a long way—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are not advertised.

Dr REEVES: I do not know whether they are not being advertised, but you have to look really hard to find them.

Mr FLETCHER: We have not been able to find them yet; we are not saying they are not there, but we have not been able to find them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have a list of the establishment and information about how positions are filled so that you can identify that the Coleambally nurse is not there and ask when he or she is going to be replaced? In other words, do you have an establishment list you can look through and keep track of?

Mr FLETCHER: No, we do not, and—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is what you mean by "transparency".

Mr FLETCHER: Absolutely. This is one of the accountability components that sounds so simple that it should be implemented. We need to look at the population growth areas and ask why more services are not being delivered in those areas. That is part of the core PKI that should be introduced.

CHAIR: Last question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In terms of management, you would like a list of the establishment, noting all the people and what they are doing, that can be compared to some demographic indices.

Mr FLETCHER: Absolutely, and then look at each respective area, whether it is podiatry or dietetics, and determine what there should be per head of population and whether it is there. We need a standard to aim for.

The Hon. TONY CATANZARITI: Can you tell us what ratio of GPs provide bulk-billing in the area?

Mr FLETCHER: It varies from town to town. For example, we run the general practice at Hay, and the bulk-billing component is about 25 per cent, which incidentally directly correlates with the profit margin. Obviously, socioeconomically Griffith is a bit stronger; it goes up to about 50 per cent. The other areas are somewhere between those two figures. Areas like Narrandera and Leeton are 40 per cent to 50 per cent bulk-billing.

The Hon. TONY CATANZARITI: In Griffith it is about 50 per cent.

Mr FLETCHER: Yes.

The Hon. TONY CATANZARITI: I understood that an orthopaedic surgeon was going to be placed in Griffith, but for some reason the team of orthopaedic surgeons at Wagga Wagga decided that that was not in their charter and they would not release the orthopaedic surgeon. Do you know whether that is the case?

Dr REEVES: I do not think it was the decision of the Wagga orthopaedic surgeons not to release an orthopaedic surgeon. I think the application was made by the area health service to New South Wales Health for an area-of-needs status. The decision went to the Australian College of Surgeons, Orthopaedic Branch, which decided in its wisdom not to grant us that status for a population of about 35,000 people. That decision, in turn, unfortunately was not agitated by the area health service and not pushed very hard. Since then we have heard that a number of Wagga orthopaedic surgeons are very supportive and would have been happy to provide supervision. It was for an overseas trained doctor that we required the area-of-need status. Our chances of getting an Australian-trained orthopaedic surgeon are minimal, because the area health service has put a strict restriction on the operations an orthopaedic surgeon can perform in Griffith; that is, nothing that is particularly expensive. There are to be no joint replacements because that would require changing operating theatres and so on. Therefore, our chances of getting an Australian-trained graduate are zero. If we cannot do the procedural operations, we will not get the surgeon.

The Hon. MELINDA PAVEY: And we do not get services in remote areas.

The Hon. TONY CATANZARITI: What sort of after-hours availability does this division and other divisions provide for the communities serviced by the Greater Southern Area Health Service?

Mr FLETCHER: No after-hour services are provided by the Division of General Practice. The nine hospitals that provide 24-hour, after-hours service are all manned by general practitioners. We have had two discussions with the area health service about the implementation of an after-hours service in Griffith, which would seem the most feasible given that it is the larger area. Unfortunately, it came to pass on each occasion that the discussions were not about setting up an after-hours service but about setting up an opportunity for the after-hours clinic to be run by GPs so they could save the cost of CMOs, who are career medical officers who are now running the after-hours service.

The Hon. CHRISTINE ROBERTSON: I just have a couple of questions; one relates to the paper that you have brought to us and the information under the heading of "Structural Insolvency", about removal of anaesthetic equipment, obstetric equipment and the failure of the health service to provide facilities support to a solo general practitioner. Did any of those decisions have anything to do with the role delineation of those individual centres?

Mr FLETCHER: I would say it had a lot to do with the assessment of their role delineation, but those particular GPs were not consulted prior to the removal of any of those services or pieces of equipment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They were actually doing that? They were doing those roles?

Mr FLETCHER: They were delivering those roles at the time.

The Hon. CHRISTINE ROBERTSON: They were using anaesthetic equipment but not necessarily within the role delineation of the centre?

Mr FLETCHER: At the time that they were being used that fell well within the role delineation of those hospitals, but it was a matter of course with removal of those systems and the role delineation of those hospitals was then changed.

The Hon. CHRISTINE ROBERTSON: Delineation of a hospital actually requires a huge mass of different issues to come together, so it would not have actually been about the one piece of equipment, it would have been about all of the issues.

Dr REEVES: We admit it is a couple of years ago, if your emergency obstetric equipment is removed it is no longer feasible for you to practise obstetrics; it is no longer medico legally safe and you can no longer have that clinical service.

The Hon. CHRISTINE ROBERTSON: Within the hospital?

Dr REEVES: Within that particular hospital, which means within the community. And in those communities you are looking at 100 kilometres at least, particularly for obstetrics.

The Hon. CHRISTINE ROBERTSON: For delivery?

Dr REEVES: Yes.

The Hon. CHRISTINE ROBERTSON: Does the division of general practice in the Greater Southern Area Health Service participate in the planning process at all?

Dr REEVES: We actually have five divisions of general practice in the Greater Southern Area Health Service and the chairs and CEOs of those divisions met with the senior executive of the area health service last year and put forward a very well-worked proposal for a liaison position between the area health service and the divisions of general practice. We were basically told that we should expect no money from the area health service to try and help fund that position and that that liaison person had already been established in the area health service and we were going to get the personal assistant of a third level manager to liaise with the divisions of general practice, which represent—I do not know the exact figures—at least 90 per cent of the VMOs in that area.

The Hon. CHRISTINE ROBERTSON: When the health service and the local hospital are working on their future clinical plans, which they do all the time—I understand they are undergoing the process at the moment—the individual doctors and you people are not integrally involved?

Dr REEVES: The division of general practice is not integrally involved. The clinicians are occasionally consulted, often at last-minute, which is very difficult when you have busy clinical practices, as we do. There is a varying level of how much notice is taken of the clinicians, I would have to say.

Mr FLETCHER: Obviously it is important that we try and be a part of some of those decisions, but we certainly have sent representation to many of the meetings and some of our senior GPs have reported back, on seeing the minutes, that it was no point because what they said was not even minuted or adopted during the course of the meeting. There is a lot of frustration there.

The Hon. CHRISTINE ROBERTSON: You talked about outcomes for community health and as an example you gave us outputs and the amount of time that the community health person is available. What sorts of ideas do you have for outcomes to measure the effectiveness of community health?

Mr FLETCHER: It could be the numbers of patients that are being seen or the number of hours that they are doing as well.

The Hon. CHRISTINE ROBERTSON: Outputs?

Mr FLETCHER: Give me an example.

Dr REEVES: Decreased hospital lengths of stay; decreased readmissions to hospital. One of the things that we work integrally with in our palliative care program, we have proven by use of community nursing staff, which have been gradually eroded, that we can improve hospital days of stay for people who are terminally ill and undergoing palliative care treatment, not just for cancer but for chronic end-stage heart disease or lung disease. We can improve emergency department admissions; we have improved readmissions—and this has all been documented by our evaluation. They are the sorts of outcomes I think you are talking about.

The Hon. CHRISTINE ROBERTSON: Yes. This project was in partnership?

Dr REEVES: It was, yes.

The Hon. CHRISTINE ROBERTSON: What does that mean for you?

Dr REEVES: It was in partnership with the area health service, and we were proud to be in partnership with the area health service. The difficulty was in getting the money. But we will get there.

The Hon. CHRISTINE ROBERTSON: So it was an outcome partnership?

Dr REEVES: Yes. It was a working partnership.

The Hon. CHRISTINE ROBERTSON: You are saying you had trouble getting out of the area health service the money to pay for their half of the positions?

Mr FLETCHER: That is correct.

The Hon. CHRISTINE ROBERTSON: One of these examples here, Dr Bob Byrne, is he the chairman of the area health service?

Mr FLETCHER: He is the chairman of the advisory council.

CHAIR: Mr Fletcher and Dr Reeves, thank you very much for the time you have given us. I thank you for your submission, which has been tabled. If there are any additional matters that arise that you think the Committee should be made aware of, you are quite at liberty to forward any material to us. There were no questions taken on notice so I do not have to give you a time limit on that. We appreciate the fact that you have travelled a distance to be with us today to help our understanding of the system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would they accept any further questions in writing from the Committee?

Mr FLETCHER: Absolutely.

Dr REEVES: Certainly.

CHAIR: Ms Kruk, do you wish to make an opening statement?

Ms KRUK: I would like to take the opportunity as much just to set a factual basis for a range of issues that are not necessarily always portrayed factually in the media. I just want to look at the financial situation. Just to summarise the finances: you are dealing with a recurrent budget of $11 billion and a capital budget of $600 million. The budget has grown more than 100 per cent in the last 11 years. We have got over 100,000 staff employed across 200 facilities. We constitute 1.2 per cent of Australia's GDP. I think that makes us the biggest trading company in the southern hemisphere.

We spend approximately $2.8 billion a year on goods and services. Just to give the Committee an indication: on a daily basis that works out to about $7.7 million a day we spend on creditors for those goods and services. In short, the health sector is growing faster than the economy

as a whole, and I will touch on the fact that our proportional spend as a part of the Government's budget is also growing—certainly the State budget.

A brief summation of activity in the system I think is also important. In 2004-05 we performed nearly 2.5 million medical and surgical procedures; that compares with 1.5 million in 1996-97. 1.4 million people were admitted to public hospitals; this is 20,000 more than the previous year and 130,000 more than 10 years ago. We do 25 million out patient services a year. 2 million people are treated in emergency departments a year. With ambulance response, on average there is an ambulance response every 33 seconds. On a typical day in a New South Wales public hospital 3,877 people are admitted, 17,019 spend the day in hospitals and 5,490 people are seen in emergency departments.

A short summation of the budget: an additional $35 million in 2004-05 and per annum to increase elective surgery was given to health. A further $10 million in 2004-05 and $15 million in both 2006-07 was specifically targeted to reduce long waits. $227 million was provided to us in 2005-06 for an additional 823 new beds, bringing the total number of permanent new beds to 1,300 since 2004-05. $19.7 million was dedicated in 2005-06 to an innovative program where we worked with clinicians to improve patient flow through the hospital system. $71 million extra in 2005-06 was provided for mental health services; this is an increase of 9 per cent over last year. We spent $288 million in 2005-06 on disease control, immunisation, health promotion, cancer screening and other prevention strategies.

I want to touch on creditors because I anticipate that will be one issue raised by the Committee. All area health services are required to pay within contract terms. The benchmark we have set, and I stress it is a benchmark, is that they should not exceed 45 days. We are the most transparent of all health administrations in the fact that we publish all of those figures. The Auditor General has made the point that in relation to its annual reporting standards across all of its indicators health is the most transparent of agencies in New South Wales, and certainly if you make that comparison, nationally as well. For instance, the Victorian and Federal health departments do not provide the transparency in reporting that we do.

In 2004-05 seven of the 11 health services achieved the 45-day requirement as at 30 June 2005. What is important to recognise—and I think this figure will be of interest to the Committee—is that Dun and Bradstreet, which does an analysis of these matters in the private sector, indicated that the average trade payment is 55 days—this is a figure released in December 2005. What is interesting is that industry—such as the mining industry—takes on average 60 days to pay its creditors. The majority of health services in New South Wales perform better than the Australian industry average. The Minister has made it quite clear and it is certainly quite clear in our protocols that creditor delays are unacceptable, but it is important to make that comparison in relation to the practice of the private sector.

The department recently introduced protocols requiring health services to do the following: Have a dedicated telephone line for creditor inquiries; provide timely feedback to creditors in relation to inquiries; purchase orders to contain appropriate telephone contact numbers; and a log of telephone inquires to be maintained. Members would be aware of the fact that government undertook a major reform of health administration in the last couple of years. I would just like to report on progress, because that is not something that would be contained in your papers to date. Savings targets of 1,000 administrative staff have been identified to date. As at 31 January, 584 staff, which is 52 per cent of the target, has been reached. Savings for front-line services of $24 million in 2055-06 and $70 million in 2006-07 will be achieved.

Our Planning for Better Health Services will lead to over $100 million in savings being directed to front-line services. Can I also say that quite clearly the Chief Executive Officers [CEOs] you have around the table here in many instances run budgets of over $1 billion, approaching $2 billion. The reality is you need a solid administrative and systems structure to manage budgets of those types, going back to the size of the organisation. That is an issue I am happy to expand on later on. In 2005 we introduced a key performance indicator, Direct Care Staff, as a percentage of total staff and I think we were the first health service to do that. Between June 2004 and 30 June 2005, corporate administrative staff was reduced by 426 FTE, or by 7.8 per cent. Increases in the same

period of 2,906 staff were directed to front-line services. That meant an additional 107 medical staff, 2,035 nursing staff, 686 allied health staff and 78 additional uniformed ambulance officers.

We have made the comparison about corporate service ratios with that of other super-agencies—in other words, agencies that have staff numbers in excess of 10,000, and we compare very favourably in that regard. In relation to the health cost of corporate services, it is 2.8 per cent of our budget. If you compare that with other agencies the range is between 3 per cent and 7 per cent of their budget. Knowing also the figures in relation to the private sector, we actually perform better than the private sector. I will leave some additional matters for further questions. I do want to touch on some of our achievements because I do not think the newspaper is often that keen to actually refect some of those.

Throughout winder 2004 access block was on average 7 percentage points lower than in the previous year for metropolitan hospitals involved in a clinical redesign program, that I mentioned earlier. In each month of the calendar year 2005 the access result was better than in the same month in 2004. At Prince of Wales Hospital, for instance, access block was 22 percentage points better during July 2005–which is clearly our heaviest winter period—than it was in 2004. In February 2006 off stretchered time over benchmark at Westmead Hospital dropped to 20 per cent, half the level of last year. In January 2006 access block at John Hunter Hospital was down to 15 per cent. Manly Hospital access block dropped by 30 percentage points between July 2004 and July 2005. Concord Hospital dropped by 27 percentage points, and Mt Druitt Hospital dropped by 23 percentage points, Sutherland and Blacktown hospitals, 21 and 19 percentage points respectively.

In the heaviest winter month of August, the access block figure for 2005 of 32 per cent was 6 per cent better than in August 2004. In the six months from July to December 2005 access block dropped to 27 per cent, compared with 32 per cent for the same period in 2004. Reduced off stretchered time dropped to 28 per cent, compared with 33 per cent for the corresponding six-month period of July to December 2005 and July to December 2004. I want to stress that those improvements in performance were achieved in a climate where emergency department [ED] attendances were up 10.2 per cent in the year to date for the period July to December 2005, when compared with the same period in 2004. Admissions through EDs were up 8.7 per cent for the same period. Reduced long waits, 10,214 in December 2004, these were reduced to 3,889 in December 2005.

I just want to finish by summarising our end-of-year financial performance. NSW Health achieved its net cost of services budget in 2004-05. The 2004-05 year is similar to results in previous years. I would be naïve to say that that has not been done with considerable effort of all parties involved, and also in the face of considerable demand pressures. In addition, health services achieved a net cost of service budget in all but one year in the last four. Health services generally pay suppliers in less than 45 days, whereas upon industry surveys, as I have indicated, the industry business average time is 55 days. If NSW Health performed to the Australian industry performance based standards identified by Dun and Bradstreet, it is estimated that we would have $280 million worth of creditors over the 45-day benchmark, not the $15 million as at the end of February 2006, or $13 million as at the end of June 2005.

What is also significant, as I indicated, is that private sector companies do not publish their performance against budget in their financial statements, nor do Victoria or Queensland health, the next biggest health authorities. The organisations we refer to, like most organisations, only publish actuals. May I, in summary, say it is quite clear there are pressures within the health system. It is quite clear that the changes in governance across the area health service put in place the platform to make major changes in relation to work force, the freeing up of resources to go back to clinical services, the putting in place across the State of a set of consistent systems—financial, quality and safety. Most significantly they give us an ability to obviously compare like with like, and also, I think, have provided far greater transparency in reporting for the health system. I am happy to take any questions.

The Hon. MELINDA PAVEY: Ms Kruk, I am hoping to clarify an announcement by your Minister that appeared in the *Sun-Herald* newspaper on 26 February. The announcement was to the effect that Mr Hatzistergos was rewarding the public health system with an extra $64 million to pay off creditors. Is that a loan or is it a cash payment to the area health services to pay off bad debts?

Ms KRUK: I will start and then ask Mr Barker to go on. It is not a loan; it is a cash payment. A certain component of that is actually recognising the good performance of the area health services in relation to their workers compensation. It is a TMF hindsight adjustment.

The Hon. MELINDA PAVEY: Is that Treasury managed fund.

Ms KRUK: Treasury Managed Fund. I might get Ken to elaborate. Clearly, it is not a loan. We certainly requested the area health services to direct those payments to the payment of creditors. That is consistent with the Minister's direction. Ken, would you like to add.

Mr BARKER: The 64—certainly the $40 million, which was the gross value of TFM hindsight.

The Hon. MELINDA PAVEY: What does that mean?

Mr BARKER: The way workers compensation works within New South Wales government is that at the time the budget is handed down actuaries assess what is your budget based upon a combination of actuarial assessments that come up with an industry budget. Compared to that we have what they call a deposit premium. The deposit premium is based upon your own experience, which goes into the equation. NSW Health in recent years has always done reasonably well when the deposit premium has been calculated and we have had a surplus. That surplus is retained by each health service in accordance with the actuarial calculations, and their assessed value of deposit premium.

Once they pay their premium, it then goes into a process that is held for them by the TMF, which is controlled by Treasury. Against that premium then are the costs of claims and administrative costs connected with the management of those claims. After three years the actuaries come back and they have a look at how that health service is performing and in aggregate NSW Health. They then come up with what they call a three-year interim hindsight, which compares how you are going after three years, and make an actuarial assessment of the value of unfinalised claims—or open claims, as they call them—and then they will give you an adjustment. You may have to pay in money or you may get money back.

After five years, which is a further two years, they then come up and have what they call a final hindsight. So they see what is then happened in that next two years in terms of their assessments for the open claims. That information is then fed into Treasury and Treasury will then do a declaration of what the whole claims were. As the Director General said, the hindsight as at 30 June 2004, which relates to a three-year interim hindsight and a five-year final, health services got $40 million in benefit, which is an outstanding performance by the health services involved.

Ms KRUK: Can I add that the area health services in many instances have actually invested money up front to improve things like staff going back to work if there is an injury or if there are any other events occurring at work. So it is reflective of good work at the CEO level and a number of area health services were major beneficiaries of that. We are recognised by Treasury to be one of the best performers in that regard.

The Hon. MELINDA PAVEY: So that I am on the right wave length here, you basically had about $40 million sitting there because you had done a good job over five years, and that money came back in from the Treasury managed fund to pay the overdue accounts?

Mr BARKER: No. It came back to NSW Health and it was then distributed to the health services based on an actuarial assessment.

Ms KRUK: It was money they owed us.

The Hon. MELINDA PAVEY: It was money that they owed you. Can you determine what, of that $40 million, was the payment to each of the area health services?

Mr BARKER: Yes, and it has gone to each of them—

Ms KRUK: We can give you a run through on that. I do not have that material with me. The clear thing is that health has performed well for a number of years. What Ken is saying I will try to say in non-accountant language. There is always a lag in the payment of that. It is in recognition of work done and it is obviously an adjustment. It is not a loan; it is a clear benefit to the area health services and they were asked to apply it to creditors.

Mr BARKER: One of the things you need to remember is that a number of health services do spend money to get a good result. There is clear evidence that some other agencies really have a deficit because they do not take seriously the fact of looking after your workers, having good occupational health and safety and, good risk management policies, early return to work, rehabilitation, and good manual handling factors. What happens in health, and it may be because we have a health focus, is that the majority of health services are very focused on their workers and manage these claims very effectively. As a result of their good work, and in a lot of cases they actually spend real money. They then get this money back on hindsight.

CHAIR: If it is not a loan, does it mean that those area health services that were in the worse financial shape were rewarded?

Mr BARKER: No. It is done on a specific basis, so the $40 million is the gross. The two health services that are in deficit clearly have to improve their performance—

Ms KRUK: To the contrary. In area health services, because the money went back—and I might get Deb to speak to it, or one of the other CEOs, they were given the money, which they had in effect earned by good performance in relation to things like workers compensation.

Mr McGREGOR: In fact, the Minister's press statement made that clear.

The Hon. MELINDA PAVEY: What were the two that were in deficit.

Mr BARKER: Greater western and greater southern

Ms KRUK: It is not in deficit. It means that they did not get the benefit.

Professor PICONE: If you have lower claims it means you are a better performer because you have got better occupational health and safety systems in place. It is not really a reward, it is like how your house insurance works if you do not kept making claims.

Ms KRUK: A no-claim premium almost.

Professor PICONE: But it costs you money because you have to have good systems in place.

CHAIR: What will happen, say, in the next year if the area health services again run up overdue accounts? Is there another $40 million available–sitting there, able to be drawn upon?

Ms KRUK: If you look at it for a start most area health services can actually predict the amount of money they will get in this particular regard. A good chief executive will factor that into his or her budget as being one of the revenue streams that will come up during the course of the year. This is not just a one-off payment. If I look, last year—and I will ask Bob and Ken to help me—there was also a hindsight adjustment by the TMF. It is part of their planning in relation to revenue streams. If I could just finish: For those area health services that did not get the benefit of that, it is a real call to arms about the fact that they really do need to look at what systems and processes they have in place to keep their costs down. The incentive structure is right: You do the right thing, the money goes back. What we have done, at the Minister's request, is make sure that that actually goes to the payment of creditors in the first instance, and I think that is good business.

CHAIR: Dr Christley, was it in your budget?

Dr CHRISTLEY: We had our estimates of our expected hindsight.

CHAIR: What was that?

Dr CHRISTLEY: Ours was $3.7 million.

CHAIR: What did you get?

Dr CHRISTLEY: That is what we got.

CHAIR: And what was in your budget?

Dr CHRISTLEY: This was our anticipated allocation. We were planning always to put that to creditors and the other agreement we had with the department was that we had, last year, got a loan. We used that to pay off a portion of that loan according to the loan repayment plan. I might just point out that one of the benefits of the area mergers is that it often put a poor performing area around workers compensation together with a good performing area, and this was certainly the case in the merger of northern Sydney and Central Coast area health services. So we believe that some of the good systems would flow across the whole of the new area health service and increase our return at the time.

Ms KRUK: Chair, if you do not mind, I can see where you are going. If I look at one of the area health services that has a problem and, right, it is Greater Southern, what we have done in the last few months is that the team from Hunter, which is the area health service which has had probably one of the best and longest-term records of getting positive payment, working with the Greater Southern teams, by looking at how they can actually improve it. That is a positive initiative in terms of trying to build that culture in. You only get a return if you actually invest in it. A lot of it is actually investing in systems, looking at how you manage your sick leave, et cetera, et cetera.

The Hon. MELINDA PAVEY: Professor Schneider from the Greater Southern Area Health Service, how are you placed in terms of accounts overdue to this date, considering you were the poorest performing area health service?

Associate Professor SCHNEIDER: The accounts, you are referring to?

The Hon. MELINDA PAVEY: Yes.

Associate Professor SCHNEIDER: For over 45 days?

The Hon. MELINDA PAVEY: Yes.

Associate Professor SCHNEIDER: As of today, ready for payment, we have zero creditors over 45 days ready for payment.

The Hon. MELINDA PAVEY: So you owe nothing over 45 days?

Associate Professor SCHNEIDER: That are ready for payment, no, we do not.

The Hon. MELINDA PAVEY: What do you mean by "ready for payment"?

Associate Professor SCHNEIDER: There are some accounts where the claim or the invoices will be submitted and there will not be sufficient information as to what volume of account the particular bill is representing. There will be disputes about the price from the original contract. There will be incomplete delivery of all the goods and in some cases the quality of goods. Since taxpayers' dollars are involved, we are quite diligent that we ensure that we are paying for what we contracted to receive.

The Hon. MELINDA PAVEY: What would be the value of those accounts in dispute, approximately?

Associate Professor SCHNEIDER: Over 45 days, approximately $1.1 million.

CHAIR: Professor Schneider, you would have heard the evidence that we previously received from the witnesses before about the hospitals in your area and there was a suggestion—

Associate Professor SCHNEIDER: No, I have not.

Ms KRUK: Chair, he has not. So if we could have the benefit of getting a summation?

CHAIR: Okay. It was put to us that some hospitals receive basically a budget on a monthly basis, or receive money on a monthly basis. I think one might have been identified. Do you remember which hospital was identified by name?

The Hon. MELINDA PAVEY: Griffith.

CHAIR: Griffith, I think it might have been. We know, and indeed the director-general has reminded us today, that the benchmark for paying creditors is basically 45 days. How do you reconcile on the one hand getting a monthly advance, if you like, when you are dealing with all contracts on a 45-day basis. How do you reconcile that if you are a hospital administrators?

Associate Professor SCHNEIDER: As part of any annual process, our budget is broken down by monthly program and cash flows according to localised budgets and demand.

CHAIR: Are you aware of any hospitals that are having difficulties at the moment paying creditors within your area?

Associate Professor SCHNEIDER: The reference that you have asked me is for the entire area health service.

CHAIR: Yes.

Associate Professor SCHNEIDER: There are zero ready for payment over 45 days. So all of the health services within the Greater Southern Area Health Service have zero invoices over 45 days ready for payment.

The Hon. MELINDA PAVEY: How were you able to make those payments? Was that through the advance from the TMF?

Associate Professor SCHNEIDER: No. We were not the beneficiary of an advance.

The Hon. MELINDA PAVEY: How did you clear away those debts that were obviously a part of the Greater Southern Area Health Service?

Associate Professor SCHNEIDER: At any one time in our cycle, on a daily basis, we are spending money, so we have creditors due. It fluctuates, and at this instance and at this time, with our budget and cash flow management priorities, we have zero.

The Hon. MELINDA PAVEY: I have a letter here from an obstetrician-gynaecologist from Moruya which talks about the difficulties they have experienced.

Ms KRUK: May we have the benefit of having a look at the letter if it is cited in evidence?

The Hon. CHRISTINE ROBERTSON: May I pass my copy of the letter along?

CHAIR: Yes.

The Hon. MELINDA PAVEY: And this letter cites the failure of the Greater Southern Area Health Service to pay for four to six weeks and up to two months at a time. Is this just a one off, or has this been a part of the general problems with the Greater Southern Area Health Service that you, as a new-ish recruit to that area, have been able to fix?

Associate Professor SCHNEIDER: I will defer to the chief financial officer of the area health service to respond.

Mr GOULD: In terms of payment in relation to BMIs, they do receive priority payment as far as creditors are concerned.

CHAIR: How do you explain the circumstances of the letter?

Mr GOULD: In relation to payment, it could be a situation where an invoice has gone "not received". It could have been lost in transit somewhere through the organisation. So, as with any organisation, you have to appreciate the volume of invoices received by the organisation at any point in time. Therefore the situations do arise from time to time and as soon as they are brought to our attention, we will follow them up and address them.

Ms KRUK: Chair, can I ask that the area actually gets time to have a look at it?

CHAIR: Yes.

Ms KRUK: As I said before I gave you an indication in relation the magnitude.

CHAIR: Yes. We will take that on notice and we will not deal with it any longer. We will take it on notice.

Ms KRUK: Can I also say, and it may be an opportunity for the other CEs to comment on it as well, that I do not think any of these guys have had a particularly easy time, in most instances, pulling together two different information systems under one statewide structure, Oracle. I am not an IT person but in effect we will now move to one bill right across the State. In some instances they would have found varying quality and level of controls. I think Stuart would say quite honestly in some of the hospitals he has actually had to go down and look at paper invoices because of the absence of information systems. That is a difficult situation to get a grasp of what his or her budget is. Bob and Stephen are free to comment in their own regard, but I know all of them have made, as one of their driving forces, the need to actually look at the controls.

I have told you the figures in relation to the demands on the system. I have no doubt that any one hospital in the State could successfully consume three-quarters of the health budget if there were not appropriate controls put in place. That is just the nature of the business we are in. We do not control the front door. All we can try to do is ensure that where we spend the money, it is done as fairly and as equitably as possible. A lot of this is about controls. Stuart was blessed with a number of hospitals in that area that had quite weak controls in relation to their spending, and that is one of the challenges that he, but not he uniquely, has had to face.

The Hon. MELINDA PAVEY: Just following up with Professor Schneider, in relation to the Southern Area Health Service and moneys owing, you did say in your answer that you owe nothing over 45 days, except those that may be in question. I have it on advice from the Murrumbidgee division of general practice that they are actually owed $27,000 and it has been that way now for more than 90 days. Do you have any comment to make on that?

Associate Professor SCHNEIDER: I would have to take that on notice because—whether there is an error in the system or whether there is advice I have not received—

Ms KRUK: My understanding, and Stuart will know more facts than I do, is that there has been a dispute with that division. If I can remember that from my briefing notes, there is obviously a matter of some contesting between the area health service and the division. We will take it on notice.

Professor PICONE: Chair, I am just wondering, following on from the director-general's earlier comments—just to give the Committee another view of the state of those organisations—on a daily basis, we process 1,000 invoices per day, 365,860 a year, and there is no question at all that, with the amalgamation of the two area health services, we did find different platforms between one area health service—

CHAIR: Thank you, Professor Picone. Can I ask you, Dr Christley, how many invoices are currently outstanding for the Royal North Shore Hospital? Are you aware of that situation?

Dr CHRISTLEY: The number of invoices, I cannot recall.

CHAIR: Well, the amount?

Dr CHRISTLEY: The outstanding—the greater than 45 days for the whole of the area, which reflects all the hospitals, is $2.9 million.

CHAIR: But you are not able to give a breakdown specifically to North Shore itself?

Dr CHRISTLEY: We do not break it down by such a return. That is an aggregate figure.

The Hon. MELINDA PAVEY: I was interested in your rundown on the restructure of the health service and how it was going. I did take notes but you were speaking very quickly and very strongly, as you do.

Ms KRUK: I am sorry—sorry.

The Hon. MELINDA PAVEY: But referring to the figure of $100 million in projected savings, was it not originally $150 million for projected savings? I have that recollection.

Associate Professor SCHNEIDER: No.

The Hon. MELINDA PAVEY: It was always $100 million?

Ms KRUK: I do not go wrong on $50 million, I can assure you.

The Hon. MELINDA PAVEY: No.

Ms KRUK: There might have been savings identified in other areas. What I focused on was specifically the administrative savings and the targeting of those administrative savings because that is jobs.

The Hon. MELINDA PAVEY: So it was basically undoing a health restructure that had taken place about six years previously—

Ms KRUK: No.

The Hon. MELINDA PAVEY: Now you are taking it back to what it was.

Ms KRUK: Can I just build on that? The area health structure has been in place for over 20 years in effect, the way that it was divided up by 17 area health services across the State. As you know yourself, in any given area you represent, it probably did not make a great deal of logic any more in relation to where people moved, transportation patterns were different, et cetera, et cetera. The driving force for us—and I think Stephen has picked on it as well—is that it was not an issue in relation being driven by money. We saw in relation to, say for instance, central and south-western Sydney that I think members are familiar with—I have appeared before you many times on that—where you had central, which was well resourced in relation human capital, in other words medical staff, nursing staff and clinical staff, and generally you had south-western Sydney that was not able to attract staff for a whole range of reasons. What sat underneath the merger was the combination of those areas: normally well resourced in relation human resources and growth areas.

In most instances as well, there were stronger systems in some areas. I will put on the record—because I do not think it is unknown—that Stuart inherited far greater problems in relation the quality of systems within the old Southern Area Health Service and Greater Southern. I do not think that is unusual. Having talked to Roger Corbett after he did the restructuring in relation the various Woolworth chains, he would say the same in relation to bringing it together as part of a more federated model as opposed to individual satellites. He faced some of those similar challenges.

The issue for us, and we are now about 18 months into the restructure, is we are meeting those targets. We have those targets, understand, independently audited to keep everyone honest, and the area CEOs have the obligation to show how they go back to service delivery at the front line.

The Hon. MELINDA PAVEY: This was the basis of my question. So 18 months down the track, you have reached the 580 staff.

Ms KRUK: We are half way in, yes.

The Hon. MELINDA PAVEY: When do you expect to meet the other half?

Ms KRUK: The figure, and I will get Bob to add to it, by I think June 2006 we intended to reach 1,000—Bob, was it not, straight off?

Mr McGREGOR: Of that order.

Ms KRUK: The issue is, and I put it on the record, I am from the country as well. We are the major employer in many towns. You do not want a situation where in effect you literally put staff out overnight. In areas like Broken Hill for instance, the CE, Dr Clare Blizzard, has worked incredibly hard to make sure that when there were staff who were displaced, other opportunities were identified for them, where effective, or there was retraining. So it has been a process which has to be stepped. If I look at it, say, for instance in Deb Picone's case, similarly, particularly in certain parts of the State. If health actually pulls out one or two staff, it is a major issue. So it has been a matter of doing it in a structured manner where Deb has had workshops, have you not, most recently, and some of your warehouses where you have combined those, that has been structured. We will meet that target. Can I say that is a big target and it is a difficult exercise to do without having disruption, particularly in country areas.

CHAIR: Thank you. The time for the Opposition's questions has expired. It is time to hear from the crossbench.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You say these bills are paid within 45 days. Is that 45 days from when they are received or from when they are assessed?

Mr BARKER: The 45 days is the date of the invoice plus two days to allow time from the supplier to the health service. When we talk about 45, it is effectively 47 days from the date of invoice to allow for those two days.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To get through the mail?

Mr BARKER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say that the average in the private sector is 55 days, does that take into account retailers that have, say, a contract, in which you will not be paid for three months? In other words, they use money like a bank on the short-term money market?

Ms KRUK: I will get Ken to table the document, if you want to see it; the document from which we have taken the comparisons. Is that useful?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, that is fair I suppose. I note that there has been an extraordinary amount of evidence from a number of committees about unpaid bills. The Auditor General seems to—

CHAIR: Mr Barker, will you table the document?

Mr BARKER: I will table, if you like, a document from Dun and Bradstreet, which covers 10 industry sectors. The 55 days the Director-General spoke about is the average. As the Director-

General said, they go from 53 in agriculture, forestry and fishing, to 59 days in mining. How they get the information, you would have to ask Dun and Bradstreet.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In summary, it is the Health Department's position that they are very good payers and pay generally within their 45 days?

Ms KRUK: No, I am always very straight with the Committee. You can also say that there are challenges in doing so. Each of the chief executives would have their own view in that regard. This is one of the most difficult exercises. Also understand that we are, in many instances, waiting for payment. We are part of a long food chain in relation to payments from funds and other parties. In many instances I unashamedly take responsibility for the fact that the Health Department can be a better payer of its creditors. It is my job to look at the systems in place to ensure that we do that as well as we can. We are not up to benchmark in four areas at the moment, and it is a difficult thing to keep on pushing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean for area health service areas?

Ms KRUK: Yes. I ask Debora Picone to add to that, concerning something she mentioned to me earlier in the foyer.

Professor PICONE: As at the end of February our areas reported creditors over 45 days is $4.6 million. So it is an improvement on the previous—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is that a percentage of?

Professor PICONE: Our total budget, not including expenses, which is $1.4 million.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Per year or per month?

Professor PICONE: Per year. I would love it to be $1.4 million a month!

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is $4.4 million; say one-twelfth of a billion, is it?

Professor PICONE: I will ask John to calculate the percentage. I will continue with the issue that was raised by the director-general, which I think is quite important. It is interesting to note that at the end of February 2006 the area health service was owed more than $25 million from our general debtors.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they over $45,000?

Professor PICONE: And private health funds. I will go through it. This is something that is never acknowledged. We are owed $25 million from general debtors and private health funds. The high levels of outstanding patient revenues are common for an area health service such as ours that has a number of world-class teaching hospitals that employ highly skilled specialists who, obviously, perform very complex procedures. For example, at the end of February 2006 the area health service was owed $5.8 million by private health insurers, but $3.1 million of that amount was over 30 days outstanding with some more than 90 days**.** A number of private health funds are delaying payment and querying the patient's length of stay. That process is challenging a number of our senior doctors. It is time consuming and is placing further pressure on them and certainly on us in relation to our cash management. I could go on about ineligibility—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, that is quite enough, thank you.

Professor PICONE: It was $2.9 million—

Ms KRUK: Dr Chesterfield-Evans, do you notice that today is different from other estimates committees; that there are a number of calculators around the room?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is largely what happens when I seek figures from them.

Professor PICONE: That is $25 million—

Mr BARKER: Madam Chair, it needs to be recognised from the Public Accounts Committee inquiry in the 1980s that all area health services retained all the revenue. The budget paper, page 8-15, states that 12.4 per cent of our expenditure budget is covered by revenue. That is an important thing for health services to collect. As at the end of January health services were owed collectively $223 million of which some $40 million was over the normal trading terms, that is around 40 or 45 days. Of that, there was $11.4 million owed by health funds for private patients.

The Hon. CHRISTINE ROBERTSON: Did you mean the subsidised ones?

Mr BARKER: There were $7.3 million owed by ineligibles, which are overseas people and not Australian taxpayers, and therefore—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it wishes to put out information about how wonderful it is doing, could it do so as a press release and not go beyond what is—

Ms KRUK: It was in response to your question, Dr Arthur Chesterfield-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but we do not want to take up all our time with one question, do we? When will the PADP review be completed? We will find out then when that money is coming through.

Ms KRUK: I will call on Dr Richard Mathews to answer that. He has been working on the review. Any announcement on the budget in relation to funding for the PADP would be part of the budget announcement anyway, Dr Chesterfield-Evans.

Dr MATTHEWS: A review of the PADP has been conducted by PricewaterhouseCoopers. We are expecting its draft report anytime now. It has been asked to look at the current commitment, the current waiting lists, the demand, the relationship between NSW Health and DADHC, who is also a supplier of aids and equipment, in order to introduce efficiencies into the system. We expect to get that review result anytime now, in draft form.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will that be immediately released?

Ms KRUK: I would like to see it first.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but how long would it take you to read it and respond to it?

Ms KRUK: Never long, Dr Chesterfield-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am sure that is right, but can you give a—

Ms KRUK: The issue will be that it is informing our input into the budget process. It has been a very open process. I have met with a number of providers too. I think we will get some good lessons from it, to be honest. I think it will have an impact in relation to how we provide those services.

Dr MATTHEWS: And part of the aim is to do it more efficiently, so we get more current levels of funding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was funded to half the level that was estimated from conception, was it not? Therefore, that gap has basically never been filled by the increases that have been above the consumer price index [CPI]. Is that correct?

Dr MATTHEWS: They have been above CPI, certainly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but they started off at half what was estimated.

The Hon. CHRISTINE ROBERTSON: By whom?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By the people who set it out.

Dr MATTHEWS: Demand is elastic.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but if you make an estimate that it is X and fund it to ½X, you would not be surprised if you did not quite meet the mark?

Ms KRUK: We could go on about this for some time. I think the issue that is coming through from the review is that we can be better and smarter in relation to how we provide the services. Also we should sensibly look at whether we are targeting in the right areas. It is a joint program between ourselves and DADHC and there are issues on that front, without pre-empting the outcome of the review.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One point raised by the group from the Murrumbidgee Division of General Practice was that the establishment staff are not known and there is not transparency in the establishment staff, so that if jobs are not filled and tasks are not done they are not necessarily aware of that. For example, the Coleambally nurses. Is the Department of Health willing to make its establishment staff on the publicly available site so that people can look at what staff are available and then look at the demographics of what job needs to be done?

Ms KRUK: I will answer generically first and Stuart will answer on Coleambally, I hope. That was why there was a commitment, as part of the restructure, Mrs Pavey, in relation to getting the exercise audited. It has been a challenging exercise to get an exact number of staff. So many staff, as Dr Chesterfield-Evans knows, are on contract arrangements. In a number of areas we also use agency staff quite extensively. The Committee would be aware of the number of locum staff that we use as well. That has been a solid platform to build that upon. Stuart may wish to talk about the particular challenges in his area.

Associate Professor SCHNEIDER: You are correct that the two areas merged. There are a number of databases containing staff establishment facilities. The controls of identifying the agreed database is a challenge for us. There are nursing rosters that staff have had for many years and hold dear to their hearts that that is our staffing establishment. There are budget processes that define salaries and wages budgets per year and allow flexibility in how that will be built up by the local particular health service. Then there are other historical total budgets that are actuals for a particular health service. Our due diligence since the merger has identified FTE control as a major challenge for us. This year's process of the current year, the year we are in and going into next year, and the budget process of having only one FTE agreed position by location will be achieved by us. That will require industrial and medical consultation with all of our 47 hospitals, 60 community health centres and 33 community centres across the site.

Ms SYLVIA HALE: Ms Kruk, I change the topic entirely and refer to the M5 East tunnel, which has been the subject of—

CHAIR: You will have to explain carefully how that meets our terms of reference.

Ms SYLVIA HALE: I shall, indeed. As far back as July 2003 the department wrote to the Roads and Traffic Authority [RTA] concerned about its in-tunnel studies of the particulates and other pollution that motorists were experiencing in the tunnel. In May 2004 Dr Greg Stewart sought information from the legal and legislative services branch as to whether the provisions of the Public Health Act could be used to compel the RTA to comply with the requirement that warning notices be displayed to motorists. The advice received on 1 July from Geoffrey Bloom, the principal legal officer, referred to sections 5, 9 and 10 of the Public Health Act and concluded that section 5 was inappropriate because it regarded imminent risks. However, sections 9 and 10 stated that use of the

power to direct a public authority in this situation would be appropriate only if all normal channels seeking to persuade the RTA had been exhausted. What has been done to compel the RTA to act to require the display of warning signs to motorists using the M5 East tunnel? Have all normal channels being exhausted?

Ms KRUK: At the outset I should apologise for the lack of attendance of my chief health officer, Dr Denise Robinson.

CHAIR: The Committee received a letter in that regard.

Ms KRUK: Ms Hale, you are testing my memory in this regard, I am focused on numbers today rather than on broader health issues. I do recall very clearly seeking of advice in relation to our powers under the Public Health Act. I remember that advice coming back. I remember also numerous meetings with the RTA in relation to the issuing of warnings. I must admit I was pleased to receive, when I got my licence renewal not that long will go, health warnings that were included with that documentation. I will need to take the question on notice about those personal meetings that I attended.

CHAIR: The Committee accepted that there was one—

Ms KRUK: My apologies, I could not knock that back.

CHAIR: Was it the Council of Australian Governments [COAG]?

Ms KRUK: No, it was a counter-terrorism exercise on COAG, so I could not fall back.

Ms SYLVIA HALE: I would like you to take on notice the question of whether the department has exhausted all normal processes in seeking to persuade the—

Ms KRUK: I am happy to do that and I am also happy to detail what we have done.

Ms SYLVIA HALE: Right. The Committee is aware that since May 2004 the number of vehicles using the M5 East tunnel has increased by approximately 25,000 vehicles a day, that is 23,000 above the anticipated maximum, and that pollution audits have shown that safety standards are regularly breached and that the RTA is now proposing to allow pollution and emissions to be exhausted through the portals. What is the Department of Health doing to stop that rapidly deteriorating situation which endangers health?

Ms KRUK: Can I take that on notice? I stress—and we have covered this previously in committees—that we are not a regulator of the RTA. I am happy to take all of your questions on the tunnel on notice. I cannot do them justice today. If that fair enough, Chair?

CHAIR: Yes.

Ms SYLVIA HALE: Can you take on notice also the question about the audit report into air quality that has just been released on the M5 East that showed many of the key conditions were unclear and difficult to enforce, that the RTA's pollution monitoring equipment was not properly maintained and pollution readings inside and outside the tunnel were not reliable. Can you take on notice what NSW Health is proposing to do as a result of this?

Ms KRUK: I am happy to do so. I am sorry about that, Chair.

CHAIR: We accepted last week the explanation.

Ms SYLVIA HALE: Will Mount Druitt Hospital be receiving beds for the mentally ill?

Ms KRUK: I might ask Dr Matthews, who has been most closely involved in the allocation of the mental health beds in that area health service, to answer that question.

Dr MATTHEWS: We are increasing community health services in Mount Druitt. Justice Health, in partnership with Western Sydney Area Health Service, is increasing child and adolescent mental health services and a new adolescent forensic health service to assist the Department of Juvenile Justice in assessing those young people with mental illness who are before the criminal justice system. We are currently preparing our plan for child and adolescent beds.

We have increased beds in a number of sites around the State and more are due to be opened. We are looking at the Western Sydney situation where there are beds at the new Children's Hospital and at Redbank House, on the grounds of Westmead and the next site for child and adolescent mental health beds will almost certainly be Mount Druitt but we have not finalised our planning nor our timing at this stage but we are increasing the community services there in preparation for that future expansion.

Ms SYLVIA HALE: That future expansion relates only to child and adolescent beds. What about mental health beds for the general population?

Dr MATTHEWS: No. The adult acute and sub-acute beds for that area are found at the Cumberland campus and Nepean. There are 15 new acute beds opening at Katoomba Hospital before the end of this financial year and we have increased the number of beds in the last 18 months at both the Cumberland campus and at Pialla at Nepean. At this stage there are in no plans for an adult acute unit at Mount Druitt; only child and adolescent.

Ms SYLVIA HALE: With those child and adolescent units would there be provision for long-term stays?

Dr MATTHEWS: No. The current model of care does not really call for very long stays except in some exceptional circumstances.

Ms SYLVIA HALE: When you say that you are increasing community-based mental health services in the area, what specifically are you doing in that particular area?

Dr MATTHEWS: Both Western Sydney and Justice Health received additional resources of $400,000 each this year for child and adolescent services, which are being concentrated in the Mount Druitt area. In addition, Justice Health was funded $800,000 this year rising to $1 million next year to establish the new adolescent forensics service, which is specifically going to target young people initially in Western Sydney but then further afield, who have come into contact with the criminal justice system, and provide an assessment to the courts. The first adolescent court liaison services started in Cobham Court as part of that and the magistrate is very enthusiastic about that and the adult system has been very successful. We intend over time to slowly expand and develop that service on to other sites and, in addition, to provide services to the Department of Community Services for their problem folk.

Ms SYLVIA HALE: Ms Kruk, how many community-based mental health services have been closed in the State in 2004-05?

Ms KRUK: I will ask Dr Matthews to answer that?

Dr MATTHEWS: I will have to take that question on notice.

Ms KRUK: Are you aware of one in particular that you want to ask a question about, Ms Hale?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Cremorne or Chatswood?

Dr MATTHEWS: Neither of those is closed. Cremorne is still in place. Part of Chatswood has moved to the Royal North Shore and in partnership with Dr Christley we are looking at options to develop part of that Chatswood site and relocate them back there.

Dr CHRISTLEY: I might say that since the service was relocated at North Shore its attendances have gone up by 10 per cent so a lot of the argument about what is the appropriate model

of care is still open. We are sitting down and talking with a range of people about what is the right model of care around Chatswood, Cremorne and North Shore. The integrated primary care model and NSW Health's approach to that, I think, will provide the way forward. There are still services operated at Chatswood; there are still services operating at Cremorne and there are some of the services from Chatswood that it was, for physical facility reasons, necessary to temporarily locate them at North Shore.

Ms SYLVIA HALE: But my question related to community services across the State, so if you could take that on notice, as well of providing any further details about those.

The Hon. MELINDA PAVEY: And some may not be operating because of lack of staff, not necessarily because you have closed them.

Ms SYLVIA HALE: Ms Kruk, can you tell me what percentage of public dental health positions are currently unfilled in New South Wales, both the percentage and the raw figure?

Ms KRUK: Off the top of my head, no. I know that that has been the subject of the discussions in another place. You have had an inquiry into that. I am quite happy to go back to that documentation. [*Time expired.*]

CHAIR: It is now time for Government questions.

The Hon. TONY CATANZARITI: What sort of drain does the cross-border play on the budget of the Greater Southern Area Health Service?

Ms KRUK: I am sure that Professor Schneider would know the details better than I do. I think the Minister has also made a comment on this in the upper House, that it is my job to ensure that health funding—and obviously in an area health service there is a budget—is the most equitably spread and most efficiently used. Put quite simply, the deal with the Australian Capital Territory is a dud. It is something that comes out of a health care agreement that does not necessarily service particularly well. It puts us in a situation where I would argue that residents in the further reaches of Stuart's area health service are disadvantaged because of the access to services provided in Queanbeyan, and I think Ms Pavey would be familiar with it. It is an agreement where we have very little control in relation to cost structures where we, in effect, contribute to the building of Canberra Hospital, where over $50 million goes across the border into the Australian Capital Territory for support to some of the financial issues of that Government and we also basically pay an average cost rather than a marginal cost.

That is not a good deal. The difficulty is the way the AHCA agreement is actually structured. When we hit a point of difference it goes to arbitration and at the end of the day the Federal health Minister takes the call. The instrument from my viewpoint is the health administrator has all the health incentives. It is inefficient; it is inequitable in relation to access to service for patients across area health services. Stuart knows more than I do. I have a very strong belief that that is an issue that does need to be addressed. The Minister in the upper House last week or the week before made it quite clear that he believes that now we should proceed to arbitration and should attempt to point out some of those inefficiencies. Stewart, you may wish to add, as I am a bit short on details.

Associate Professor SCHNEIDER: Greater Southern Area Health Service has cross-border flows to two other government jurisdictions; Victoria along the Murray and the Australian Capital Territory that we surround. Our estimates for 2004-05 year are that while the financial figures have not been finalised, the director general is quite correct, it is in excess of $50 million; indeed it is almost approaching $60 million. To Victoria it is $26 million, so we have flows in the order of $86 million for the 2004-05 year, unconfirmed figures, and total cross-border flows for the State of New South Wales of just over $100 million.

For us, that is a significant impost when you compare the two contracts with Victoria and New South Wales; one is approximately 20 per cent dearer than the other—that is, the Australian Capital Territory is a considerable cost of 20 per cent over the Victorian contract and for the Australian Capital Territory contract. If we were able to have a more equitable basis as for the Victorian one, it would be a savings to us of approximately $10 million per year. Turning around

services to do those closer to home and in hospitals where like work could be done as in the Australian Capital Territory, the savings would be in the order, for us, of approximately $2.1 million on average cost or savings of $3.7 million on marginal costs.

We are endeavouring to pursue a two-pronged attack in the financial effects of cross-border flows just in the Australian Capital Territory. That is the new agreement to proceed to get significantly reduced costs and the $10 million that I am referring to could be achieved, and reversing flows out of the Australian Capital Territory would bring savings closer to home of $3.7 million for us. That is approaching $14 million in benefits to us just from the Australian Capital Territory alone and then with Victoria it would be nowhere near the amount of savings but will mean services closer to home with the injection into a rural area and one of the benefits of merging health services to give increased clinical capacity.

Ms KRUK: Put quite simply, it means that the bulk of your focus can go into the Australian Capital Territory, and that is a disadvantage for the residents of that area health service as a whole. We have attempted to mediate it and the Minister has now directed that we now go to arbitration on it but it is the limitations of the current agreement. I am not optimistic that that will be a good outcome and I think that is disappointing.

The Hon. TONY CATANZARITI: The Government has given a commitment to making savings from area health services through the amalgamations and to put these services into front-line services. Can you elaborate on what further progress has been made?

Professor PICONE: The amalgamation of the former Illawarra and South Eastern Sydney Area Health Services will see a savings of $4.5 million in the 2006-07 financial year as a result of a reduction of 209.6 full-time administrative staff. All these savings are being redirected into front-line online services. Having said that, I have to say that that in no way diminishes the contribution of those administrative staff such as information technology staff, human resources staff and staff to provide food catering services, laundry and the rest because they have made major contributions to both organisations so that as we have reduced each position—and to date we have reduced 113 full-time equivalent staff—we have brought on line clinical services, particularly to the southern part of the area health service which, of course, includes Wollongong Hospital and its associated facilities, and also the Shoalhaven.

We have already put $1 million to expand interventional cardiology services at Wollongong Hospital. That has been done in conjunction with the Prince of Wales Hospital, which has created a network from the east heart down to Wollongong with a fantastic result. Already 102 pacemakers and 470 diagnostic and angiography procedures have occurred, building up, we hope, to stenting and those sorts of procedures in the near future. We have given $600,000 to fund the creation of four new surgical positions, including two surgical registrars, one anaesthetic registrar and one neurosurgical registrar. One of our happiest results has been the expansion of renal dialysis at Wollongong Hospital, including putting two new chairs in the previous dialysis unit and opening a new unit in the in-patient unit. That is extremely important because just at the point we did that, we had a number of patients who would have had to travel to the Prince of Wales Hospital for their dialysis and, as you know, travelling three times a week to be on a machine is extremely difficult, and we are very pleased about that.

We have also created an acute geriatrics service and have attracted a very senior staff specialist in geriatrics and now a very good team is built around her. She is quite outstanding. It has allowed us to change the role, and network the Bulli service closer in with Wollongong Hospital. We are also pleased to report that we have appointed 1.5 additional oncology medical staff, radiation oncology and medical generally, and that has allowed us to expand the network of services between the Illawarra, the cancer care centre, the Shoalhaven and Milton-Ulladulla, which has been a great result.

$200,000 has been allocated to provide additional medical and nursing support to the Shellharbour hospital emergency department, including the creation of an additional medical officer position. $400,000 has been allocated for additional medical services, including the creation of an additional endoscopy staff specialist and one advanced trainee, which is a great result in

gastroenterology at Wollongong hospital. $800,000 has been provided for after-hours MRI services both at Wollongong and Prince of Wales.

Just recently we have been able to attract another 12 registrar positions for what we are starting to call the Royal Wollongong Hospital, in medicine, surgery and cancer, and the appointment of a thoracic surgeon at Wollongong Hospital. $1 million has been provided for maternity and obstetrics care, particularly in Aboriginal health.

The Hon. TONY CATANZARITI: My understanding some time ago was that there was supposed to be an orthopaedic surgeon starting at Griffith hospital. The orthopaedic surgeons at Wagga Wagga apparently had some difficulty allowing one of their orthopaedic surgeons to go to Griffith. Could you set the record straight as to what is happening there?

Associate Professor SCHNEIDER: You are quite correct with your emphasis on the word "happening". We are committed to orthopaedic services at Griffith, both consulting and operating. The recruitment to secure an orthopaedic surgeon to that role is the challenge. We have advertised that that as an area of need position. The Australian College of Surgeons and the orthopaedic section thereof have concerns, quite rightly, about the safety of a sole orthopaedic surgeon in the area, and we are now negotiating with the Wagga Wagga orthopaedic surgeons to have that as part of one comprehensive service but not to deny Griffith the capacity to have orthopaedics occurring in the operating theatres.

It has taken longer than no doubt your community or the community of Griffith would prefer. It has taken longer than we would prefer to finalise that, but the end result still remains the objective. I am confident that in the coming months the surgical services clinical reform program that we are undertaking with regard to the Southern Area Health Service, part of that being based at Wagga Wagga, will see the medical staff at Wagga Wagga, together with the area, arrive at a solution that is satisfactory to Griffith, that will see orthopaedics in Griffith operating theatre.

The Hon. CHRISTINE ROBERTSON: Professor Schneider, we have heard evidence from representatives of the Murrumbidgee Division of General Practice. What sort of relationship does the area health service have with the division? Does the division participate in the clinical planning process?

Associate Professor SCHNEIDER: We have five divisions of general practice, and their geographic areas coincide with the Greater Southern Area Health Service. Our objective is to include all the divisions in the planning to which you refer. We have met on more than one occasion to have the divisions achieve a method of having one voice for all divisions, so that we can work in unison with all the divisions and not have one favouring the other. Recent discussions within the last two weeks have indicated that they are now receptive to one voice. The mechanism to get that, I believe, will be secured in the coming months.

As a result, we have nominated one very senior person in our area to be that contact point, and we look to the divisions having one contact point. We have many planning meetings across the area, engaging medical staff. We have to make the best use of their time and we look to the divisions to give us their guidance as to whether they wish to have officers of the divisions represent them or medical staff on a particular occasion, and how to work out submissions that we can secure funding for. Or, conversely, the divisions have the capacity to attract health funds from a number of sources in Australia, and we are providing that one contact person who will be extremely responsive to signing off any proposals or working in a partnership to work up proposals with them. There is a desire to have all divisions involved in planning in a transparent way with the affairs of the Greater Southern Area Health Service.

The Hon. CHRISTINE ROBERTSON: Do the medical practitioners themselves participate in local area planning, or do they want to be paid for it? Is there an issue there?

Associate Professor SCHNEIDER: The director-general required that, with the announcement of the mergers and then when the mergers were effected under the legislation on 1 January 2005, we would establish clinical service plans and work force plans. With regard to the clinical service plans, we involved clinicians to work with us on that. We do not have an issue with

payment. But, recognising that in businesses doctors leave when they do have to participate, there are payments that are prescribed for that and generally we work within those prescribed limits.

The Hon. CHRISTINE ROBERTSON: The Murrumbidgee Division of General Practice representatives also raised with us the fact that the area health service owed them money. What would you be paying them for?

Associate Professor SCHNEIDER: Would you repeat the question?

The Hon. CHRISTINE ROBERTSON: They said that the area health service owed them money.

Associate Professor SCHNEIDER: The only one that comes to mind is that there was a psychologist position that we jointly recruited to. Again with taxpayers dollars, we have requirements for reporting on the activity of that position, and we sought to have the division give us details on reporting. We were very determined that we were able to account for the contact visits and details of the activity. We resolved that we only wanted to discuss that with de-identified patient information, and I understand we have reached agreement. I do not understand the claim that there is a sum of money outstanding. It may be in the not-ready-for-payment amount of $1.1 million. I just do not have that information before me.

The Hon. MELINDA PAVEY: Could it be a palliative program?

The Hon. CHRISTINE ROBERTSON: He said it was a psychologist.

Ms KRUK: It is about a psychologist, from memory.

Associate Professor SCHNEIDER: It is a psychologist position, and we support it. There are issues around the reporting and information, and in my mind we have resolved that. The outstanding issue is on the payment of it, and I undertake to get back to you as to what that is.

Ms KRUK: I think all the area health services are in a similar position. The development of area health service plans is a major exercise. In my experience across the State, that has been done very co-operatively with most of the GP divisions because it is very consistent with our drive to put in place integrated primary care centres. In many areas, that has been driven by the GP divisions. So if there is tension between one area and a GP division, that is something that Stuart is on more than able to sort out. But they are an important part of that planning exercise.

I also stress that in relation to the make-up of the area health advisory councils, you have a mix of clinicians involved in that structure as well. It is a comprehensive planning process, and arguably one that has never been followed at that scale. I know that in relation to Debora's area, having gone to some of the sessions, she has had about 500 clinical staff involved in her planning exercise. I think Stephen has probably had a similar magnitude. But given the business and we are in, it is unavoidable not to do something at that scale.

May I say, the issue of payment is not something that has really read its head that my level. I know we have paid the Area Advisory Council members, in effect, an appearance fee, because most of them give up time and travelling. But it does not in any way reimburse the time that they truly put into it.

The Hon. CHRISTINE ROBERTSON: The Murrumbidgee Division of General Practice representatives also referred to the removal of equipment from some hospitals. In particular they referred to the removal of anaesthetic equipment from Tocumwal and obstetrics equipment from Finley, and a medical support place at Coleambally. Could you tell us whether this had anything to do with role delineation issues in those places? The representatives claimed that there was little or no consultation about the removal of the equipment. Was it in your time?

Associate Professor SCHNEIDER: I am not aware that it has been in my time. I will have to take the question on notice. But the Committee should appreciate that anaesthetic and obstetrics

equipment is an integral part of providing high-quality services, and role changes generally is the point at which that equipment has to be considered.

The Hon. CHRISTINE ROBERTSON: Could one of you explain how the Australian Health Care Agreement works for New South Wales?

Dr MATTHEWS: The Australian Health Care Agreement is the instrument by which the Federal Government provides part of the funding that NSW Health uses for its services. It is negotiated every five years. The current agreement runs from 2003 to 2008. It is always a difficult time negotiating that agreement. You would all remember that at the signing of the last agreement, the position put by the Commonwealth Government was unacceptable to all States and Territories, but eventually they were forced to sign because effectively they were being fined a very large amount of money every day that they did not sign. So there are features of that particular agreement that we are not happy with, and have never been happy with. One of those features is the so-called WC1, which is the indexation rate. It runs at about 2.1 per cent, which is far below the increase in costs of the drugs, goods and services, and technology.

Ms KRUK: May I had one thing here. The major issue is in relation to the funding. As Treasury reminds me on a daily basis, the percentage of spending on the health budget in the State has gone up significantly, last year approximately 8 to 9 per cent. I am speaking without notes. The Commonwealth contribution has effectively gone down. Each of us—and the CEs have their own experience in this regard—have had to adjust to less money going down to the area health service, despite the fact that the people knocking on the front door have gone up. That is one of the pressures we face.

The words that are put around that, suggesting that that pressure is met in the private sector, is not the case. 95 per cent of emergency admissions go to our emergency departments. 48 per cent of admissions into the hospital are from the emergency department. The private sector takes 5 per cent. Our growth figures—I am happy to put them on record—are publicly known. I do not think anyone disputes that we are under increase in demand pressure. Under the current health care agreement, our funding federally is going down. State funding has trebled in that period. I do not have the numbers.

Professor PICONE: The other issue to do with the Australian Health Care Agreement is the dysfunctionality at a clinical level, because neither party was able to achieve the reforms we needed. The classic example of that is cancer care. We can provide clinical example after example, but it is not just about the Australian Health Care Agreement, it is about the need to fundamentally reform both the funding and the delivery of health services in this country. The clock is ticking.

CHAIR: The clock is ticking here as well.

The Hon. CHRISTINE ROBERTSON: So you can pick up my question during my next turn, which will never come.

CHAIR: So that committee members understand, we were a little late starting. I will now divide the time into blocks of 12 minutes and see how we go with time. That will take us past 4.30 p.m. I would like to confirm something that was said earlier. Is it true that four area health services are not meeting the benchmarks, and can you identify them?

The Hon. CHRISTINE ROBERTSON: Which benchmarks?

CHAIR: The 45-day benchmarks.

Ms KRUK: At which time point in time? Was that from my opening commentary?

CHAIR: Yes.

Ms KRUK: That was in June. I can be corrected if I am wrong, but I think they are Greater Southern, South Eastern, Northern Sydney—

The Hon. CHRISTINE ROBERTSON: She thought she had something there. She got all excited.

Ms KRUK: No, it was my confusion.

Mr BARKER: As at the end of February, five are currently over benchmark for the $15 million that the director-general spoke about.

CHAIR: Can you give me the five?

Mr BARKER: Sydney South West, South Eastern Sydney-Illawarra, Northern Sydney-Central Coast, at the end of February, Greater Southern was over by a little more than $1 million, and the Children's Hospital at Westmead.

CHAIR: Can you give an average in terms of how much over the benchmark for each?

Mr BARKER: I will give you a dollar value; that would be easier than the number of days. This is calculated on the number of invoices they have and the value of those invoices over the benchmark. Sydney South West was at $3.8 million; South Eastern Sydney-Illawarra, $4.6 million; Northern Sydney-Central Coast, just under $3 million; Greater Southern, just over $1 million; and the Children's Hospital at Westmead, about $2.7 million.

CHAIR: In relation to Northern Sydney, the State Opposition got some figures recently under FOI about accounts overdue and there were no figures for Northern Sydney. Can you tell us why that was so?

Dr CHRISTLEY: The figures that were sought and supplied related to November 2005. That is some time ago. The question asked for creditors at 1 to 30 days, 31 to 60 days, 61 to 90 days, and 90 days and up.

CHAIR: Why was Northern Sydney—

Dr CHRISTLEY: That is not consistent with the normal way we assess creditors. We have said repeatedly here today that we work on the basis of a benchmark of 45 days.

The Hon. MELINDA PAVEY: Why was Northern Sydney—

CHAIR: Why was Northern Sydney not included?

Dr CHRISTLEY: Mr Barker just gave you some figures for February. These figures were for November last year.

CHAIR: That is not the question.

Ms KRUK: Dr Christley is saying that they were provided—

Dr CHRISTLEY: As an area health service we provided information, so I do not—

The Hon. MELINDA PAVEY: So, Mr McGregor—

Dr CHRISTLEY: The information for Northern Sydney-Central Coast has been released.

CHAIR: That was not provided to the Opposition. We also have a total amount across all of them as at November 2005 of $51,663,000. I want to know whether that includes Northern Sydney or whether it is a separate figure.

Mr McGREGOR: There is obviously some confusion. But in terms of the response to the FOI, my understanding is that the Northern Sydney-Central Coast Area Health Service received payment for release of that information, and I also understand that it was released on Monday.

CHAIR: Could you take it on notice?

Ms KRUK: I am happy to clarify—

The Hon. MELINDA PAVEY: It is in the mail, is it? You released it Monday.

Ms KRUK: The requests were directed to the area health services individually, so they have released them sequentially.

CHAIR: We certainly do not have figures. We have figures for all the services but Northern Sydney.

Ms KRUK: Dr Christley has indicated they have been provided, so we will take it on notice.

Dr CHRISTLEY: I note that our January performance is remarkably better than November's.

CHAIR: We are pleased to hear that.

Ms KRUK: I stress the point that these are difficult gigs to run. That was a call to arms for most of the chief executives. I also understand in relation to the timing that that goes in after the winter period. I do not think honourable members would be surprised about some of pressures that go with that. We have made it clear that we all accept responsibility for the need to pull the creditors into line.

CHAIR: Director-General, you said that one of the things you do not control is who comes in the front door. In fact, by designating certain periods as low activity or no elective surgery times, you are able to have some control at the front door. Can you advise in relation to the Easter period? Is there a general policy about what will be done over that period? Will hospitals have a period when there will be no elective surgery? Is it a general instruction to hospitals or is it determined by the individual hospital? What period will it cover?

Ms KRUK: I will pick up the first component. Honourable members should understand the contribution that that makes to our business. I think our surgical load is about $1.78 billion, but I stand corrected. I might call on Professor McGrath to add to this. What has been significant is that we have increased our surgical activity—the numbers I mentioned in my introduction. That means that a number of area health services have pulled staff back to work earlier. St Vincent's staff started back earlier because they wanted to. We are caught in a balance here because we want people to have a break. The staffing of hospitals pulls together a considerable team.

Professor McGRATH: Our focus this year on elective surgery has been to increase the throughput, and we are working closely with area health services to ensure that that has occurred. Year to date, admissions from the waiting list have gone from 21,000 to 23,000 compared to the pervious 12 months, and that previous 12 months also increased on the year before. We do not specify the times that area health services must have surgery available; we focus on getting the throughput. We allow the area health services to plan how they do that to ensure maximum and efficient utilisation of the theatre time available. They must ensure that staff have adequate leave. One of our concerns is that requiring staff to work 24/7, 12 months a year leads to burnout and loss staff working and recruitment within area health services.

The Hon. MELINDA PAVEY: We might be best to ask each of the area health service chiefs.

Ms KRUK: Remember there is elective surgical activity and there is emergency surgical activity. So those two components need to be separate.

CHAIR: I was clear about what I was asking.

Ms KRUK: Fine.

Professor PICONE: In relation to Easter, all of the emergency activities—

CHAIR: No, the elective surgery.

Professor PICONE: At this stage, we have not planned out to that extent. What affects—

The Hon. MELINDA PAVEY: It is a couple of weeks away.

Professor PICONE: Not weeks; it is a month away. What affects non-emergency surgical activity or planned surgical activity over that period is the availability of staff. Many staff, particularly those with younger families, will take leave. That is the surgeons, anaesthetists and nursing staff. I am not avoiding giving a straight answer; I just do not have the figures in front of me. The leave load always goes up over the Easter break because of school holidays.

Ms KRUK: People also do not want to be in hospital for elective surgery over Easter, so there is an issue of demand at play.

Professor PICONE: The heaviest leave load in the year is during the anaesthetists' and surgeons' conference. They are our lowest activity days.

CHAIR: Dr Christley, what is happening in Northern Sydney?

Dr CHRISTLEY: At the beginning of the year we set elective surgical throughput targets and general activity targets on the basis of waiting lists, population growth and our anticipated growth in emergency separations. So the growth in activity projections this year for different hospitals ranges from—

CHAIR: What do you think you will be doing over Easter?

Dr CHRISTLEY: I can tell you that. We then tell the hospitals to manage to that volume of elective surgery or surgery generally in the most effective way they can. North Shore is going ahead as usual, the four district hospitals in the old Northern Sydney—

The Hon. MELINDA PAVEY: What is "as usual"? Will it not be doing elective surgery for the two weeks over Easter?

Dr CHRISTLEY: My most recent information is that the only hospitals anticipating a slowdown over Easter are the four smaller hospitals.

CHAIR: Can you name those four?

Dr CHRISTLEY: Manly, Mona Vale, Ryde and Hornsby. As I said, they are meeting their surgical activity targets. Our waiting lists 15 months ago were more than 1,000, our long waiting lists are now down 412 this month. Activity targets are being exceeded. That is perfectly appropriate management.

Associate Professor SCHNEIDER: In advance, similar to Dr Christley, there has been a plan for a slowdown over the Easter period. We exceeded our patient targets last year by 6.2 per cent. That is built into our yearly program of leave, conference leave and other staff vacancies.

Professor McGRATH: In relation to Greater Southern, its long waits have reduced by 60 per cent from January 2005 to January 2006 from 431 to 178. There has been a marked improvement.

Professor PICONE: They are all point scoring so I thought that I should tell you—

The Hon. MELINDA PAVEY: I would love to listen, but we have only one more minute to go. I will take that on notice. Thank you, Professor Picone. Associate Professor Schneider, I want to follow up on that very relevant issue about the $10 million overpayment to Victoria for patient care in the ACT health system. You may need to take this question on notice. Can you provide information to

the committee about the number of patients referred to the ACT for elective surgery from New South Wales, and where they come from—whether it is Bega, Goulburn or Queanbeyan? Can you also provide a list of the types of procedures being undertaken within the ACT health system as opposed to within the New South Wales system? You quite rightly pointed out that we are paying a hell of a lot more to have that surgery done in the ACT. Any taxpayer would ask why we are not doing it at the Queanbeyan, Cooma, Bega or Goulburn hospitals?

Ms KRUK: I have found it incredibly difficult to get that information from the ACT Government. Many of the cross-border negotiations obviously come back to me sooner or later. That has been a frustration. There will be inevitable movement of patients across into the ACT hospitals. The tertiary facilities are there. That is probably one of the reasons that the Minister has said—and I shuddered when he suggested it—that we should take over the ACT and have a properly co-ordinated health service in the southern part of the State. We can provide a rough breakdown of what services are tertiary. I do not know whether we have details about where they come from. I have been not been able to get those answers from the ACT. It is on their waiting lists, not necessarily on ours.

CHAIR: Our time has almost expired. Associate Professor Schneider, would you like to add something?

Associate Professor SCHNEIDER: In relation to the data and the question of supplying it, we should point out that we have only just received from the ACT data that is almost 12 months old, and it is in the process of being cleaned up.

Ms KRUK: You must understand that it is the doctors who refer to Canberra hospitals; it is not information that Associate Professor Schneider or the area would necessarily have. That has been one of the frustrations in relation to working out the throughput, the likely demand and some of those equations. It is complex and that is a frustration from a health administrator's side, looking at how you balance that.

The Hon. MELINDA PAVEY: You could better resource Cooma and Queanbeyan and get those operations happening there. Is that what you are saying?

Ms KRUK: Associate Professor Schneider picked up in his reply earlier that some of those services could be provided more effectively closer to home. Some of the services are tertiary and should be done across borders. The issue then is to do it in a sensible and cost-effective manner. Associate Professor Schneider and Dr Matthews are looking at whether there are some private providers we can go to. We want to push the contestability of this market.

The Hon. MELINDA PAVEY: But once you have analysed that data you will be able to provide some details?

Dr MATTHEWS: We can. States and Territories have to provide services to folk who come across borders, and a lot of those patients are referred by doctors. The area does not have the details and we are locked into an agreement with the ACT Government, which was imposed upon us at arbitration.

CHAIR: Our time has expired. Dr Christley, you identified four hospitals in your area that will not be offering elective surgery over the Easter period. Could you provide in writing to me, because we have run out of time, the time that they will be effectively not offering those services?

Dr CHRISTLEY: I did not say they were not providing that surgery, I said there was some slowdown. I can provide that information.

CHAIR: Could you indicate in writing the nature of that slowdown, if we are talking in terms of days, and the nature of it? Crossbench members are going to get 7½ minutes each because we have taken 15 minutes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Christley, evidence was given to one of our committees that the lady who did cardiac testing could not buy paper to send her results out

until the end of the financial year. How much do you solve these budget problems by simply telling staff not to order things?

Dr CHRISTLEY: We solve our budget problems by improving the way we do things. We have a plan around change in the area health service, and this is one of the real opportunities that has emerged, to take a fresh look at how you do things. It covers a range of non-clinical savings over and above the merger savings. It is not just about savings, it covers a whole range of safety initiatives and quality initiatives; it covers a range of process improvement initiatives, and that is how we make our savings.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you do not order things that are absolutely necessary how can you deliver a good service? In this case it was letters to GPs telling them the results of cardiac testing.

Dr CHRISTLEY: I am not aware of what you are talking about. Quite often these anecdotal statements are not based in fact at all. I would like to perhaps take that one as being another. I find that the newspapers quite often quote things—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This was face-to-face with a person who could not order paper.

Ms KRUK: Dr Chesterfield-Evans, why do you not give Dr Christley the information? Dr Christley spent the weekend responding to media claims in relation to sterilised—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is the Mona Vale inquiry transcript.

Ms KRUK: If we could have the facts.

Dr CHRISTLEY: I would be delighted, in that case, to be made aware of some of things that were put forward at that inquiry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could I come to the access block figures, Ms Kruk? I noticed it was a warm winter and there is an article in the paper today about how the funeral industry is suffering terribly from the lack of deaths. Has that improved the access block figures as well?

Ms KRUK: I will rely on Professor McGrath's detail here. Seasonality is actually considerably diminished. If I look at the throughput figures in relation to the emergency departments, what has been significant is that there are more and more people knocking on our door, irrespective of whether it is summer or winter. I think there was some press over the Christmas period looking at the demands on the emergency department, but I will get Katherine to deal with that.

Professor McGRATH: There is no seasonality in terms of presentations nor admissions through the emergency department. In the winter months in the middle of the year we do seem to see a slowdown of patients moving through the system so we get longer lengths of stay where this seems to relate to the proportion of elderly people coming through at that particular period of time and the nature of their illnesses. But year to date, in terms of both attendances at the emergency departments and admissions through the emergency departments, we have seen a 10 per cent growth in presentations across emergency departments uniformly, across particularly the metropolitan area, and indeed in terms of admissions through the emergency departments we have seen something like about a 9 per cent growth. So it has been an extremely busy year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How meaningful then are these access block figures? They were quoted extensively by Ms Kruk in her ambit statement.

Ms KRUK: Ms Kruk did not put an ambit claim in, Ms Kruk actually identified the fact that the access block improvements were achieved despite a significant increase in relation to throughput. That was my point.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand the point you are trying to make, but can I come to the nature of the access block figures rather than the total numbers that you are quoting? We had evidence in the Campbelltown inquiry that the administrators often seemed to be rostered on so that they can decide when access block exists or what level of block, and this decision is not made by the clinicians anymore. The suggestion was that the clinicians are bullied into accepting cases when their emergency department is full in order to improve the access block figures. What would you say about that?

Professor McGRATH: That is not the case, and does not underlie what is a major improvement across the system due to the extremely hard work and active involvement by clinicians in quite a number of hospitals across this State.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying there are fewer people on trolleys in corridors and so on? Waiting times have actually dropped?

Professor McGRATH: Yes, absolutely. What underpins this is a recognition that the old models of care that were in place for managing a patient's journey through the emergency department ward and back into the community had lots of points of constraint and lots of delays built into the traditional ways of doing practice. In line with both the UK, and you may have heard of the modernisation agency, in line with the Institute of Health Care Improvement in the US, we have recognised that if we are going to cope with the growing demand that is coming through emergency departments we have to change the way we do business.

In order to change that, we have engaged over the last two years with staff, clinicians, doctors, nurses, allied health and managers together in a highly facilitated process of looking at the data of where those blocks and constraints occur and coming up with solutions, and we have worked very strongly with the management teams to make sure those solutions have been implemented. If you take, for example, the two, I think, most outstanding examples, Westmead Hospital and John Hunter Hospital—two of the busiest emergency departments in this country—if you take both of their results, John Hunter about three years ago, Westmead over 12 months ago, their access block, the number of times that patients waited on trolleys in emergency department for admission to hospital, was about 60 per cent of patients needing admission waited in emergency departments and that led to people being on trolleys in corridors, ambulances being delayed.

Both of those hospitals now—John Hunter has been running below 20 per cent access block through major changes in the way they do business for the last almost two years now and Westmead has made a major change and indeed has got down as low as 14 and 15 per cent, and some of the hospitals surrounding, like Blacktown and the other hospitals out that direction, are running even lower than that.

Professor PICONE: Chair, if I could just throw in, because I did not get a free kick last time—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think we have had enough on this question. I do not want to ask one question and have a very long answer; I would like to ask four or five questions with short answers.

CHAIR: Professor Picone, if you could take that on notice and provide it in writing to us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you redefined people being in emergency medical units within emergency departments rather than having them within emergency departments? Has there been a redefinition phase here as well?

Professor McGRATH: There has not been a redefinition; what we have recognised as one of the major causes of delays in emergency departments is that the population of patients who are really growing in demand and growing in presenting to the front door of emergency departments are people over the age of 65, particularly 75 and 85.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this because of inadequate community support?

Professor McGRATH: No, I think it is because we are hitting the rise in the ageing of the population. People over the age of, particularly 75, have high health care needs. I think that the current models of care as exist around the world—

CHAIR: Dr Chesterfield-Evans, time is up.

Professor McGRATH: If I could summarise just briefly: the community services' needs are redesigned to better address those results.

Ms KRUK: I presume we will get questions on notice anyway.

CHAIR: Any questions we need to put on notice under the budget process go through the normal questions on notice, which has a different time frame. You have 14 days to reply back to us through questions taken on notice. If we put the question on notice it is 35 days.

Ms SYLVIA HALE: Ms Kruk, could you advise me as to what role the department plays in the testing and the issuing of health warnings about poisonous substances?

Ms KRUK: I will take that on notice for the chief health officer.

Ms SYLVIA HALE: Was the department involved in the testing of green life from Sydney Harbour?

Ms KRUK: That is why I will take that on notice because both Dr Robinson and Dr Kerry Chant were involved. Is this in relation to the dioxin matter?

Ms SYLVIA HALE: Yes, it was.

Ms KRUK: We will take that on notice. They are part of an interagency exercise and work with both the EPA and primary industry in relation to some of those testing matters.

Ms SYLVIA HALE: So who has ultimate responsibility in terms of the testing of the sediment and the marina animals from the harbour?

Ms KRUK: The EPA has a role in that regard. Our role actually deals more with the health impacts. So it is an interagency exercise.

Ms SYLVIA HALE: I understand there were some questions as to whose standards were to be applied, whether it was the World Health Organisation or—

Ms KRUK: This is beyond my comfort zone. What I can tell you is that I understand there was a significant change in the standards, which was to do with world health standards. My partner is actually a fisherman so I heard both views on that issue. But I will take those questions on notice.

Ms SYLVIA HALE: Have there been any protocols put in place to ensure that the monitoring, inspection and reporting of toxicity levels are carried out in a more efficient manner?

Ms KRUK: I will take that on notice. Dr Chant, I think you would have seen, did the initial health warnings with the other agency, so she is more than able to answer those questions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Mental Health Outcome Assessment Tool [MOAT] figures have been much criticised as being full of red tape. What figures do you get from the MOAT and what you do with them?

Dr MATTHEWS: The MOAT is a tool which does literally what it says: it measures the outcomes of treatment. It is administered in acute admission units on reception after a period and on discharge, and it actually gives extremely good demographic information about the people who are being admitted and it actually gives you a very clear and good measure as to whether or not the treatment you have provided has improved their clinical situation. As well, it is not simply limited to

clinical symptoms, it also goes to social functioning and level of disability, which is extremely important, obviously, in mental illness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: All we hear about is that mental health is in a disastrous situation and people are sick of filling in the forms. What indices do we have of progress relating to these MOAT figures?

Dr MATTHEWS: That is not all I am hearing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is all we seem to hear.

The Hon. CHRISTINE ROBERTSON: From whom?

The Hon. MELINDA PAVEY: The newspapers.

Dr MATTHEWS: As you know, I run a health service—Justice Health—and what the MOAT tells me as the chief executive is where my most sick patients are and where my patients who are doing well are and allows me to actually align the staff to the clinical need. It also gives you a really good measure as to whether or not the interventions you are putting in place are actually working, and surely that is important.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we get collected State data for that? Obviously, you have a fairly captive population, if you will excuse the pun.

Dr MATTHEWS: People in acute units, being as they are these days, 70 to 80 per cent in involuntary treatment, are also a captive audience, and yes, we are collecting data. Are we demonstrating that people are getting better in our care? Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We would love to see collected figures of that because mental health, as you know, is getting fairly negative publicity lately.

CHAIR: Is that something you are seeking to have?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, I am seeking figures on those. Could I ask about the flying doctor service and the air ambulance? How much co-ordination is there between those two entities?

Mr McGREGOR: They are fundamentally two separate organisations. The ambulance service does have a medical retrieval unit that co-ordinates all of the fixed wing and helicopter responses across the State, but not for the Royal Flying Doctor Service, although there is a co-ordination between them when necessary.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What co-ordination is there and what are the mechanisms of it?

Mr McGREGOR: I would have to ask the people in the operation of the air ambulance service to respond to that. If we could take that on notice?

Ms KRUK: The Commonwealth is doing a review of the Royal Flying Doctor Service as well. I know for a fact that Greg Rochford, CEO of the ambulance service, has also been involved in some of those discussions. We will provide you with more detail.

Mr BARKER: The Royal Flying Doctor Service [RFDS] also has the contract to provide the aeromedical service out of Mascot.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hang on. There is an air ambulance separate from the RFDS. The RFDS is State-based, is it not?

Mr BARKER: The RFDS is contracted to provide the aeromedical service, fixed wing, out of Mascot. Then it provides the one Bob was referring to. They have a service at Dubbo and another

service at Broken Hill, which they have funded generally through the Greater West Area Health Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that the air ambulance is the RFDS?

Mr BARKER: No. It is contracted through the State Contracts Control Board for the service it provides out of Mascot.

The Hon. CHRISTINE ROBERTSON: Can you tell us what imposts are place on New South Wales under the Australian Health Care Agreement [AHCA]?

Dr MATTHEWS: I am not sure what you mean by "imposts"?

Ms KRUK: Limitations.

Dr MATTHEWS: The first thing to point out is that each year for every dollar contributed by the Federal Government, the number of dollars contributed by New South Wales goes up. I can provide some exact figures. It was $1.37 I think three years ago, then $150 and now $1.60-something. That is the first impost. The percentage of the total divided by the State is increasing. In 2002-03 for every Commonwealth dollar there was $1.39 from New South Wales; in 2003-04 for every Commonwealth dollar there was $1.56 by New South Wales; in 2004-05 for every Commonwealth dollar there was $1.63 by New South Wales. So that the State contribution as a percentage is going up; the Federal contribution as a percentage is going down. The 2005-06 figures are not yet finalised, but the State contribution will be higher again.

The reporting requirements are onerous. Indeed, within the AHCA there is a $1 billion what is called "compliance payment" and if the State does not meet its reporting requirements of data from 31 January, it can be fined in any given year 20 per cent of that compliance payment, or $200 million a year, by the Federal Government with that decision being solely at the discretion of the Federal Minister for Health and Ageing with no appeal mechanism whatsoever. We have each year very considerable and very onerous, and each year increasing, reporting requirements to the Federal Government.

Ms KRUK: I would just add here that it is one of the difficulties of the current arrangement, and Hon. Dr Arthur Chesterfield-Evans picked on it, we recently tried to put in place a program whereby you sought to provide greater support for elderly people within a community setting rather than them staying in an acute setting. That is both, can I say, good patient care and also a sensible use of resources. We tried to enlist the support of the Commonwealth Government in this regard and were told quite squarely, "Why would we do that? There are no benefits for our system because the savings are likely to be within the State health care system." That is one of the structural flaws of that agreement, whereas, in effect, all of us should be pushed in such a way that we have the incentives to cause savings ultimately from a taxpayer perspective as opposed to the beneficiaries being one or other level of government.

Dr MATTHEWS: Of considerable contention, that I was speaking about before, is of course the way that the payments are indexed on an annual basis, according to this formula—known, unfortunately, as the WC1—which has been running at about 2.1 per cent. We should note that MBS has been going up an average of 10 per cent or 11 per cent per year, PBS about 8 per cent. This year private health insurance premiums went up 5.00-something per cent. Last year 8.00-something per cent. So all the other indices of health costs have been going up at an annual percentage increase which is far greater than the indexation of the health agreement, which partly explains the increase in contribution of the State.

As I said before, we signed up to this agreement looking at lost funding of $1.1 billion if we did not sign. That is a considerable incentive to sign. The funding provided by the Australian Government was nearly $1 billion short of the Australian Government's own 2002-03 budget estimation of what the States and Territories would need from the Australian Government to assist them in continuing to provide services. This has placed the public hospital system under increasing pressure and for New South Wales the funding is $278 million less than a simple rollover of the 1998-

2003 arrangements. New South Wales and all the other States and Territories have expressed ongoing concerns about the adequacy of the funding to allow public hospitals to continue to deliver core services. To date that concern has been ignored.

The Australians Government has revised the index rate for the agreement downwards. This means that New South Wales funding will decline even further by some $114 million over the five years of the agreement. When we signed, we were required to match on a percentage basis the Australian Government's increase in funding to public hospitals. During 2004-05 the public hospital services within the scope of the AHCA, the New South Wales Government contributed that $1.63 for every dollar contributed by the Australian Government. This is the Australian Government's own definition of public hospital services and has been independently varied. New South Wales has funded services under the scope of the AHCA by 28.9 per cent increase over the two years 2003-04 and 2004-05, while the Australian Government contribution only increased by 9.8 per cent over the same period. The fact remains that the Federal Government funding is increasing by just over 2 per cent a year while public hospital costs are increasing at a rate of about 8 per cent.

The Hon. CHRISTINE ROBERTSON: How does New South Wales compare with other States in the bed ratio per 100,000 of population?

Ms KRUK: May we take that question on notice? I do not have that information with me.

The Hon. CHRISTINE ROBERTSON: Yes please.

Associate Professor SCHNEIDER: If that question is exhausted, I can clarify the previous question I was asked about Tocumwal obstetric equipment and Finley equipment. I believe that occurred as a result of a role conversion of those health services. The question was quite insightful. I do not believe I was in the area when it occurred in the 1990s unless there have been some other changes of equipment.

Ms KRUK: I am advised that we are the second highest at 2.7, the highest being 2.9. I have taken that on advice.

Professor PICONE: I wonder if I too could clarify a question I was asked earlier? Our total expenses are $1.8 billion and our creditors over 45 days are $4.6 million, which represents 0.2 per cent. Of course, if those general debtors, who owe us the $25 million, paid us the money that we are entitled to, particularly the private health insurers who owe use $5.8 million, we would have no problems at all.

Ms KRUK: May I clarify something as well, while we are clarifying? The Hon. Melinda Pavey made the point earlier that the restructure was about six years ago and that there had been some change in direction.

The Hon. MELINDA PAVEY: There was a restructure when Dr. Refshauge came in as Minister for Health.

Mr McGREGOR: In 1996 and we are certainly not reversing that. There have been, I think, four major changes in organisational structure since the first introduction of area health services in 1986. There were changes by the conservation Government that occurred in 1991-92, going from public hospitals in rural areas to districts. The 1996 changes were from districts to areas in rural areas and this is now the merger of those and the abolition of the boards. So, it has been progressive and incremental to some extent.

The Hon. CHRISTINE ROBERTSON: When the figures come back from the Australian Capital Territory, for example, for analysis, even though they are twelve months old, is it possible to break them down—not by elective referrals, which makes no sense at all, but in relation to tertiary or non-tertiary referrals?

Dr MATTHEWS: Yes. The Director General as written a letter to Dr. Sherbourne, quite a detailed letter, being very explicit about exactly what data she expects to get and the timeliness with which she expects to get that data.

The Hon. CHRISTINE ROBERTSON: How long before this information will be in a form able to be analysed?

Ms KRUK: What I have asked is that that material be there when we go into arbitration. I do not think you can have a sensible arbitration without having some of the facts on the table. I am frankly horrified that that information is not sitting underneath the current agreement. I understand all health administrations have issues with data, but this is quite pivotal in relation to being able to work out a sensible agreement. So it was a somewhat terse letter.

The Hon. CHRISTINE ROBERTSON: Recognising in some cross-border flows, such as the Queensland border and even the Victorian border, where you do not necessarily have district hospital functions except maybe over the other side of the border—so that you do have flows on purpose in some of those places because, you know, district level—is it possible for this information to be reported so that we not have so much political nonsense every year about it?

Dr MATTHEWS: Yes. It is possible to be reported. Geography in a way means that New South Wales has the greatest number of any State. We have a significant population in the top right-hand corner, who are very close to Brisbane; a big population along the northern side of the Murray, who are closer to Melbourne than Sydney; and a big population around Canberra. We also have Broken Hill, which naturally flows to Adelaide. As a State geography confers upon us an enormous difference between the natural outflows and the natural inflows. There are very few people in Queensland or Victoria who are closer to Sydney than they are to their capital city—in fact, none. That gives us a considerable problem. We have to negotiate separate agreements with each State and, as I said before, the agreement we have with the Australian Capital Territory was imposed upon us at arbitration and it is not a good agreement.

The Hon. CHRISTINE ROBERTSON: How did the Southern Area Health Service pay its creditors? Was it a loan or budgetary money?

Mr GOULD: It was made available by the Department and it is by way of a loan to be repaid.

The Hon. MELINDA PAVEY: On what terms?

CHAIR: No, I am sorry, I have to be fair about that one. Time has now expired.

Ms SYLVIA HALE: May I just ask you a question? I have a number of questions about Rozelle and Concord hospitals. Can I put those on notice by the committee here?

CHAIR: There were certain people who were unable to attend today because of other commitments. Are these questions that would have been put to them? Otherwise, they are normal questions that go on the notice paper, as any other question would at any other time.

Ms SYLVIA HALE: Could I put them on notice and, if they cannot be answered because the person was here, they can be ignored.

CHAIR: Questions can be put on the notice paper at any time, and that is the issue. Basically the standing orders say they can take them on notice and we have given a 14-day notice period.

I thank all members of the area health services, particularly those who have travelled some distance, the director-general, and the other senior officers of NSW Health, for the time that you have given us again, and I thank you for your co-operation. We look forward to receiving those answers that you have taken on notice.

Ms KRUK: Chair, thank you very much. I would also like to acknowledge the work done by staff right across the area health services and within the department. Obviously we take the exercise seriously. The preparation that goes into it is quite considerable. Thank you both for your courtesy today and for the way in which the session was conducted.

CHAIR: Thank you. We will see you in a few months time again.

Ms KRUK: I am sure.

(The Committee continued to deliberate)
