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GENERAL PURPOSE STANDING COMMITTEE No. 2

Monday 14 September 2009

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 9.15 a.m.

MEMBERS

The Hon. R. M. Parker (Chair)

The Hon. A. Catanzariti	Ms S. Hale
The Hon. G. J. Donnelly	Reverend the Hon. G. K. M. Moyes
The Hon. M. A. Ficarra	The Hon. C. M. Robertson

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PRESENT

The Hon. John Hatzistergos, *Attorney General, Minister for Industrial Relations, Minister for Health, Minister for the Central Coast, Vice President of the Executive Council*

Department of Health
Professor D. Picone, *Director General*
Dr R. Matthews, *Deputy Director General, Strategic Development*
Ms K. Crawshaw, *Deputy Director General, Health System Support*
Dr K. Chant, *Director General, Population Health and Chief Health Officer*
Dr N. Lyons, *Acting Deputy Director-General, Health Systems Quality, Performance and Innovation*
Mr J. Roach, *Chief Financial Officer*

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CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

Corrections should be marked on a photocopy of the proof and forwarded to:

Budget Estimates secretariat
Room 812
Parliament House
Macquarie Street
SYDNEY NSW 2000

DEBORA PICONE, Director-General, Department of Health,

KAREN CRAWSHAW, Deputy Director-General, Health System Support, Department of Health,

NIGEL LYONS, Acting Deputy Director-General, Health Systems Quality, Performance and Innovation, Department of Health,

KERRY CHANT, Deputy Director-General, Population Health and Chief Health Officer, Department of Health, and

JOHN ROACH, Chief Financial Officer, Department of Health, sworn and examined:

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

CHAIR: I declare this hearing of the inquiry into budget estimates 2009-10 open to the public and welcome Minister Hatzistergos and accompanying officials. Today we will examine the proposed expenditure for the portfolio of Health only. This was to have been an examination of both the Health and Central Coast portfolios.

The Committee has guidelines about the broadcast of proceedings. Only Committee members and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings the media must take responsibility for what they publish and what interpretation they place on anything said before the Committee. The broadcasting guidelines are available on the table at the door. Any messages from the public gallery need to be passed through Chamber and support staff or the Committee clerks. Minister, you are allowed to receive notes from your advisers directly. Please turn mobile phones to silent mode. Anyone receiving electronic messages should keep their mobile phones away from the microphones because they interfere with the reception.

The House has resolved that answers to questions on notice must be provided within 21 days. The transcript of this hearing will be available on the web from tomorrow morning. Minister, as you are already sworn as a member, you are not required to be sworn this morning. It has been resolved that the Minister will not make an opening statement, so we will go straight to questions. Minister, after Jana Horska's miscarriage in September 2007 at the Royal North Shore Hospital the then Minister for Health announced that pregnant women presenting at emergency departments with a threatened miscarriage would be transferred to the maternity unit. Has that policy been abandoned?

Dr MATTHEWS: There is a very strong body of opinion among clinicians and, indeed, among women who are miscarrying that maternity units are inappropriate places to be sent. The reasons for that are obvious. It is an extremely distressing time and inappropriate to be surrounded by women who have had babies and who are obviously enjoying that experience. We established two things as a result of the Hughes-Walters inquiry. The first was the early pregnancy advisory service, which is co-located with emergency departments. If a woman presents with a threatened miscarriage, she can be sent to the service to get the appropriate advice and guidance.

The other was early pregnancy units, which, again, are co-located with the emergency department. That is to take up a recommendation of the inquiry that women in this rather difficult emotional time, where there may not be a serious clinical issue or danger but nevertheless there is a significant degree of emotion, can be taken somewhere quiet where they can be given the appropriate counselling and they are away from the hurly-burly.

About $5 million was invested in that. There were clinical initiative nurses and 16.5 full-time equivalents funded and recruited and there are early pregnancy units being set up or already set up in John Hunter, St George, the Royal Hospital for Women, Wollongong hospital, Shellharbour, Shoalhaven, Royal Prince Alfred, Westmead, Nepean, Blacktown and Auburn. There is in the Campbelltown hospital both an early pregnancy unit and an early pregnancy assessment service. It is a slightly long-winded answer but all the advice of both clinicians and the consumers we consulted was that going to a maternity unit where women are having babies at this time was inappropriate.

CHAIR: You have just said that Campbelltown hospital has an early pregnancy assessment service.

Dr MATTHEWS: That is correct.

CHAIR: If that is correct, what has gone wrong then?

Dr MATTHEWS: Well, if you are asking me to comment on the details of a particular case that has been the subject of recent media reports, I think it would be inappropriate of me to do that. But I can say there is an early pregnancy assessment service functioning at the Campbelltown hospital and there is an early pregnancy unit.

CHAIR: So you will be continuing with that policy and that process?

Dr MATTHEWS: Absolutely.

CHAIR: Will it be rolled out further?

Dr MATTHEWS: The sites for both these services were chosen on the basis of the data which showed the number of presentations for this particular problem. There would be a number of hospitals where this, for obvious reasons, is a relatively uncommon presentation. In those places we have a process of training the emergency department staff or the general practitioners who staff many of our emergency departments in the appropriate responses. But it would be inefficient to set up a unit for a relatively rare presentation. But they are being set up in those places that are extremely busy, and I read out the list.

CHAIR: Part of that process is that women presenting are supposed to be admitted. Is that not correct?

Professor PICONE: No, they are given a choice.

Dr MATTHEWS: No, we have to remember that something like 25 per cent of all pregnancies miscarry. Many of them are unknown. As you get further in it is about 10 per cent miscarry. Given there are 95,000 births in New South Wales every year, that is about 9,500. So the clinical presentation is the key to whether or not admission is required. The earlier in the pregnancy, clearly the less likely that admission is clinically required. Many of these miscarriages, once they become what is known as inevitable, happen with a complete loss of the products of conception. With others the products are incompletely lost and in those cases a dilatation and curettage is required in order to remove retained products. That is a clinical decision, and you really would not want—nor would many women wish—to be admitted for an early miscarriage of pregnancy which was proceeding normally, if I can use that expression. It is a clinical decision.

CHAIR: A clinical decision if someone has presented and they are told to go home twice? Surely there is something going wrong here?

Dr MATTHEWS: I would not necessarily say there is something going wrong. It is not always an easy decision but you have to remember the first presentation can be a little bit of bright bleeding. That is common in many pregnancies that proceed to full term. The key to this is compassion, advice and, in many cases, patient choice.

CHAIR: If a patient asked to be admitted and they are refused twice and then sent home to miscarry do you think that is an appropriate, compassionate way to treat someone?

Dr MATTHEWS: It is a slightly emotive question. Asked for admission—I assume you are referring to a particular case and, as I said, I cannot really comment on any individual case. Each one of these decisions has to be made on clinical grounds, taking into account all the factors, including the emotional state of the patient also.

CHAIR: The assessment processes that have been adopted, that you have talked about, are they finalised processes? Are they key processes that everybody understands and knows how to follow?

Dr MATTHEWS: Yes. The new guidelines that attempt to cover all of the complex political issues have been approved by the maternal and perinatal task force and are out for final consultation with a broad range of stakeholders, including chief executives and consumers. They will be signed off, and they will be the

guidelines—I stress and underline guidelines—for clinical care. Each case is different and clinicians have to make decisions based on the individual clinical presentation.

CHAIR: So in spite of $500,000 being made available for these announced changes that this will be rolled out in November 2007, those guidelines and protocols are still in draft form, is that correct?

Dr MATTHEWS: Well, it is $5 million not $500,000 and the services that that $5 million is paying for have been rolled out: staff have been employed and the services are there. The guidelines are the underpinning document. In an area as complex as this and an area where, I have to say, opinion is not uniform, there are differences of opinion between clinicians and amongst consumers about what is appropriate, the process of consultation to get a consensus view takes a while, but the actual services have been rolled out.

The Hon. MARIE FICARRA: An investigation will occur into this particular incident at Campbelltown Hospital, will it?

The Hon. JOHN HATZISTERGOS: Dr Andrew Child, who is one of the most experienced obstetricians, has already reviewed this case that you are referring to and has indicated that he believes that the care was appropriate. Nevertheless, if the patient disputes whether she received the treatment that she believes she was entitled to the Health Care Complaints Commission will be asked to examine the issue.

The Hon. MARIE FICARRA: With the guidelines that exist, with patients who present at this emotional time and with pain in miscarriage situations, are you satisfied that the level of information given to patients as to what to expect and what to do once they do go home if they are not admitted is appropriate, and will this be looked at in this particular instance?

Professor PICONE: I think this is an excellent question because my understanding, without going into the details of this issue because of patient privacy reasons, is that the staff are quite convinced there was a discussion around the options of going into hospital or going home. As you have just said, rightly so, when people are so distressed communication becomes paramount, so certainly the family are not happy. We have had Professor Andrew Child saying that appropriate care was provided. I think that when this matter does go to the Health Care Complaints Commission we will ask them to look at the communication aspects. As you know, we can always improve communication and put in better systems of communication. I think that is an excellent point.

CHAIR: I turn to issues that have been in the media for a great deal of time. Minister, do you think it is acceptable that a small family company providing medical supplies is currently owed over $100,000 with all but $13,000 of that amount overdue?

The Hon. JOHN HATZISTERGOS: Is owed how much?

CHAIR: Over $100,000 in unpaid bills. They supply the health department bandages, aids and things like that and they are a small family business and all but $13,000 of that is overdue.

The Hon. JOHN HATZISTERGOS: I answered a question relating to these issues in the House last week and I refer you to my answer but, in addition, I will emphasise what I said on that occasion that it is important that those persons who transact business with the health system—and there is no issue in relation to supplies that have been made or the contractual obligations having been fulfilled—be paid within appropriate benchmark times. In any instance where that has not occurred I am happy to examine the circumstances.

Health pays $3.6 billion to suppliers every year, which is about $9.7 million every day. The percentage of overdue creditors is very low—that is, those persons over the benchmark time—but our aim should always be to get it down to zero. Businesses that provide goods and services that assist our health system to function should, in the absence of a reason such as those I have indicated, be paid within benchmark times and the Government expects that that should occur.

I indicated last week in my answer to the House a number of steps that have been taken across the State for health services internal control practices to be strengthened, including the dedicated telephone number for the creditors inquiries, the timely feedback to creditors in relation to their inquiries, health service purchase orders containing appropriate telephone numbers, contact numbers for supply inquiries, maintenance of a log of telephone inquiries and payment to suppliers occurring within the stipulated terms.

A number of health services have been targeted for direct intervention to ensure that these strategies are being implemented along with appropriate financial management practices. We are also working with those persons and organisations that have outstanding accounts with the health system. Just as issue can be taken in relation to non-payment within benchmark times by the health system, there are a large number of persons who owe money to the health system that do not meet the benchmarks in relation to payment. In fact, I can give you those details later on.

CHAIR: In relation to these unpaid bills, for example, what sort of responsibility do you think you have to these companies? For example, the one I am thinking about has to employ a full-time person just to chase up unpaid bills owed to the company by a government department?

The Hon. JOHN HATZISTERGOS: You have given me some details, which, unfortunately, I am unable to comment on. I do not know the circumstances of the account. I do not know the length of time that is involved. I do not know whether there is a dispute, genuine or otherwise, in relation to the account or whether all information has been paid. Last week there was a story in the newspaper relating to a claim that there was $60 million owing by an area health service. In fact, the figure was $14 million and, indeed, there is more money owing to that health service than it owes. If you are able to give me some further details I am happy to take the issue on notice and examine the particular circumstances.

CHAIR: What is your understanding of the benchmark time?

The Hon. JOHN HATZISTERGOS: The recent "Report on Business Payments" by Dunn and Bradstreet indicates that the average payment time for industry sectors was 54.8 days. We are under that benchmark but we endeavour to pay as soon as we can and often are earlier than that: 45 days is the figure that people keep using and it is the figure I have been using for the purpose of indicating the $14 million that is owing in Sydney west, but I make the point that 54.8 days is the industry average.

CHAIR: Perhaps that is the case, but the Department of Commerce contracts with these suppliers states 30 days. How do you reconcile 45 days, 54 days or whatever figure with the contract, which says 30 days?

The Hon. JOHN HATZISTERGOS: For the people we deal with it is often more than that. The benchmark figures that we state is 45 days, which, as I said, is more than—

CHAIR: The question was how do you reconcile that with the 30 days contract?

The Hon. GREG DONNELLY: Point of order: The Minister is endeavouring to answer your question and you are speaking over him, which makes it very difficult for me and other members of this Committee to hear precisely what the Minister is enunciating and explaining.

CHAIR: The Minister might like to take that question on notice.

The Hon. JOHN HATZISTERGOS: Yes.

Professor PICONE: I wonder if the chief financial officer might want to comment on the issues of benchmarks and where we fit into the industry generally and improvements in our cash management procedures, particularly creditors and debtors. It would just be short. We have made a lot of improvements in the last 12 months.

CHAIR: It might be appropriate to take that information on notice. The documentation could be provided given the limited time we have for questions. Could you also give us information on how much is currently outstanding in overdue accounts?

The Hon. JOHN HATZISTERGOS: Would you like the information on how much we are owed?

CHAIR: No, just how much is outstanding in overdue accounts. Perhaps you could take that on notice.

The Hon. JOHN HATZISTERGOS: I am happy to give you that, but I also highlighted—and I said I could come back to it if you wished me to—the amount of money that is owed to New South Wales Health by a range of people, including workers compensation insurance companies, medical benefits funds, and so on.

CHAIR: Perhaps you could supply that at some other point. At the moment we just want to know how much is overdue. Could you take that on notice, if you are unable to provide it, in respect of each of the area health services and the Children's Hospital at Westmead? Could you advise how many overdue accounts there are?

The Hon. JOHN HATZISTERGOS: Yes.

CHAIR: Could you also tell us whether area health services are obliged to make penalty payments if bills are unpaid?

Professor PICONE: The chief financial officer can answer these technical questions. But the debtor issue is important. Currently New South Wales Health is owed around $67 million. So clearly there is materiality in a cash management sense, then to the creditor situation. But the chief financial officer might want to comment on that.

Mr ROACH: The credit of over 45 days and due at 30 June, the $69 million, related to South Eastern Sydney and Illawarra, $12 million; Sydney West $14.3 million; North Sydney Central Coast, $15.2 million; North Coast, $7.4 million; Greater Southern, $10.5 million; and Greater Western, $9.8 million. With regard to the comments you made before about the Department of Commerce contract, the contract stands for 30 days plus 30 days. For any contract, an invoice paid on the first of the month is not due until the thirtieth of the following month, so that is up to 60 days old, in accordance with the commerce contract.

Our benchmark determines it is 45, which we try to pay within that period. So, whilst the contract for commerce is 30 days, it does go back to the previous month. Any invoice presented in month A must be paid before the end of month B. So some of those invoices could be over 60 days and still be eligible to be within the contract term. Whilst we use the 45-day benchmark, that is from the date of the invoice. In some cases, though, in accordance with the contract terms, they may be not overdue. We also have vendors where we have negotiated specific contracts where the contract terms are 60 days or greater. That is the importance of both the supplier's desire to meet conditions and our ability to then pay them on those due terms.

The Hon. MARIE FICARRA: My question is to the Minister. Please do not take offence, but there is public accountability—

The Hon. CHRISTINE ROBERTSON: I am sorry, that was not our 20 minutes; that was the Opposition's 20 minutes.

CHAIR: We will take it off the next allocation. I am sorry about that.

The Hon. MARIE FICARRA: It is a very short question and it goes to the heart of public accountability given recent media reports, particularly this morning. My question is—and this would be asked of every Government Minister—in your time as Minister have you ever met with or had a phone discussion with Graham Richardson?

The Hon. GREG DONNELLY: Point of order: The nature of the questioning associated with budget estimates goes to the matters covered by the parameters of the budget estimates hearing. For the life of me, I cannot see where this question relates to the terms of reference for this budget estimates committee hearing.

The Hon. MARIE FICARRA: Madam Chair, a conversation could have been regarding the portfolio of the Minister.

The Hon. GREG DONNELLY: You can go on fishing expeditions all you like. It is an outrageous question.

The Hon. JOHN HATZISTERGOS: I can answer that, Madam Chair. To the best of my knowledge and belief, I do not think I have ever had a conversation with Graham Richardson about my portfolio responsibilities. I am not sure that they are portfolio responsibilities that he takes an interest in. But, to the best of my knowledge and recollection, I cannot recall it.

The Hon. MARIE FICARRA: Can I ask whether it is outside your portfolio interests recently?

The Hon. JOHN HATZISTERGOS: No. He is not on my Christmas card list. I do not have a reason for that; it is just that there are only so many people you can send Christmas cards to.

Ms SYLVIA HALE: Minister, in speaking about the moneys that were owed to the Department of Health you suggested they were from workers compensation insurance companies and so on. When you provide the breakdown of the figures as to what is owed to the Department of Health, could you break that down into categories?

The Hon. JOHN HATZISTERGOS: We can do that. We could name for you the relevant insurance companies that owe us the money. There are also debts that are owed by some overseas patients who were treated here, who do not get free treatment. Some of them have insurance companies that we await the receipt of money from as well. So we could give you that detail. I do have some details here, but I do not have all the details of the breakdown. I have the domestic ones, but I do not have the overseas ones.

Ms SYLVIA HALE: That will be a breakdown in terms of, say, private health insurance companies as well as insurance companies that deal in, say, workers compensation?

Professor PICONE: That is correct. In relation to the patients that we fondly describe as ineligibles, as you know, Australia has a number of reciprocal healthcare agreements with countries where a citizen can receive treatment in this country, and there are other countries that we do not. It is extremely difficult for us at times, when a patient presents who is sick and who needs urgent treatment, not to offer that treatment. Sometimes they can go into long-term treatment. The classic example of this is patients on dialysis. They are not eligible to receive universal health care in Australia, and of course that is a major issue. As I often say, our healthcare system ought to show compassion in these circumstances, particularly if a person is going to die if we stop treatment. It is a major issue for us.

The Hon. JOHN HATZISTERGOS: I can give you some figures on patient fees from Australian health funds.

Ms SYLVIA HALE: I would like fairly comprehensive figures, rather than just one or two. Could you provide those on notice?

The Hon. JOHN HATZISTERGOS: I just want to be clear about your question. I can give you breakdowns in the categories; I can also give you individual companies, like MBF and Medibank Private. Is the latter what you are seeking?

Ms SYLVIA HALE: Yes, if you would. Minister, on 1 September the National Preventative Health Report was released with a number of recommendations. Can you explain what processes you have in place to respond to those recommendations? I believe the report outlines a very clear role for the New South Wales Government in this new preventative health agenda.

The Hon. JOHN HATZISTERGOS: Yes. The National Preventative Health Strategy was released by the Australian Minister for Health and Ageing on 1 September. It addresses the burden of chronic disease caused by tobacco, obesity and excessive consumption of alcohol, and provides strategies to deal with this burden. The strategy sets out a number of actions for achieving the targets to be implemented over three multi-year phases until 2020. Specifically, the strategy proposes activity in the area of self-regulation to address food advertising on television to children, higher taxes on cigarettes, and the elimination of exposure to second-hand tobacco smoke in public places.

The Government has made its position clear on a number of the issues raised by the Preventative Health Taskforce. In relation to the advertising of junk food, there is ample evidence that television advertising influences children's food preferences, and the Government has consistently advocated for national action for tighter restrictions on television advertising. In 2002 at the health Ministers conference the Government recommended action to restrict the advertising of junk food and beverages to children. In fact, I was the Minister at the time. Was I?

Professor PICONE: Yes, you were the Minister.

CHAIR: It is hard to remember.

The Hon. JOHN HATZISTERGOS: I do remember this one, because I advocated it very strongly—against the wishes of the then health Minister, Tony Abbott. I will never forget it, because we spent a whole day negotiating a proposal that we thought everyone could agree upon, and at about five minutes to midnight a note came in that the Prime Minister was opposed to it and the whole resolution was scuttled. In any event, I digress.

In its submission to the Preventative Health Taskforce discussion paper, the New South Wales Government advocated for a ban on advertisements for junk food and drinks during peak viewing times for children. Similarly in its submission to the 2008 Australian Media and Communications Review of Children's Television Standards, the Food and Drink Advertising and Marketing Practices State and Territory Jurisdictional Working Group, chaired by New South Wales, recommended that advertisements for junk food and drinks be banned during peak viewing times for children.

As we know, tobacco is one of the leading causes of preventable death and disease in Australia, with a greater burden amongst the disadvantaged. So increasing taxation is a strategy that has been shown to be effective in tobacco control, including amongst those groups with a higher prevalence of smoking. In the discussion paper entitled "Australia the healthiest country by 2020", which was prepared by be the National Preventative Health Task Force, they cite five measures that significantly reduce the rates of smoking. One of these measures was ensuring that cigarettes become significantly more expensive.

In the submission by the Government to the Preventative Health Taskforce, New South Wales supported the recommendation that cigarettes become more expensive. New South Wales Health prepared a joint submission on behalf of the Northern Territory, Western Australia, South Australia, Tasmania, New South Wales and the Australian Capital Territory health Ministers for the Australian Government's Henry review and consultation on Australia's future tax system. That submission highlighted the important role that taxation plays in tobacco control and recommended the Australian Government increase the price through taxation; and, further, abolish the duty-free sale of tobacco products. I commend the Commonwealth for the Preventative Health Taskforce and the commitment it has made to tackle chronic disease. New South Wales will continue to work with our colleagues in order to ensure that we address this problem.

Ms SYLVIA HALE: Minister, will you be producing a public response to the report, and will it outline the particular strategies that you are going to put in place to implement the recommendations of that report?

Dr MATTHEWS: Yes, we will be. It is a little complex at the moment because there is much happening in the Federal sphere. As well as this report, there is a draft report into primary health care in Australia, which is critically important in relation to this endeavour; there is the Health and Hospitals Reform Commission report; and there is currently being conducted, and yet to be released, an inquiry into the MBS item numbers. This endeavour, if you like, has to be seen as part of a larger picture. We will be responding to them all but a key or important question is: What will be the Government and funding structures that sit behind this? That will come out of the response by the Prime Minister to the Health and Hospitals Reform Commission. In responding to each of these we have to hold back a little until we see the whole picture.

Ms SYLVIA HALE: Do you have any notion of when you will be in a position to make a formal response?

Professor PICONE: We might ask the Chief Health Officer to respond because we really have provided national leadership on advertising, tobacco and—my favourite topic—alcohol.

Dr CHANT: New South Wales Health has been strongly committed to a community approach to health. We have implemented a lot of the suggestions listed within the preventative task force. Recently we have increased tobacco constraints. We have implemented additional bans on the display of tobacco products. We have implemented additional fines for smoking in cars with people with young children. As to obesity, we have rolled out a number of obesity prevention programs targeted at both child and adult. Most notably for adults, is our Get Healthy Coaching line. There is additional planning involved in rolling out additional child services and we are also integrating with early intervention programs run out through the primary health care and community partnerships area. We are also doing a lot of work in indigenous health in relation to early intervention and prevention. We are doing a suite of sports strategies, which in some ways are dovetailed and informed by the prevention task force. But we are aware of the evidence, in terms of the prevention task force scoping it, and

have been responding in an evidence-based way and, as we develop the evidence, we have been implementing programs.

Ms SYLVIA HALE: You mentioned obesity as being one concern. As you may be aware, the New South Wales Environmental and Planning Assessment Act does not have as one of its objectives the promotion of public health. Notwithstanding that, does the department negotiate with the Department of Planning in order to promote urban design that, for example, encourages walking? Do you have any direct input into those sorts of aspects of planning in this State?

Dr CHANT: We have been doing quite a lot of work. We have funded a project, which I am happy to give you some details about, in collaboration where we are actually looking at our evidence base about the walkability of urban environments and urban design and its impact on health. It is an area we are actively engaged in.

Professor PICONE: There is a whole-of-government strategy in relation to that, and I can forward that information to you. We could also forward to you our various submissions to the preventative task force as well give you the line that New South Wales Health has been taking.

Ms SYLVIA HALE: Given your concern about the abuse of alcohol, do you have any input with the Department of Planning when it comes to recommendations or otherwise for increasing the number of liquor licences?

Professor PICONE: The Commissioner of Police and I have been very active in relation to the liquor licence issue. I will ask Dr Matthews to comment on the particulars of that case. I also have a view that we may need to take some of these policy matters even further. There have been successes in the Northern Territory and Queensland around river communities and those sorts of issues. We are looking at working up some policy direction in that area at the moment.

Ms SYLVIA HALE: Can you indicate the sorts of ideas you have at the moment?

Professor PICONE: There is some evidence coming through that actually restricting alcohol into those communities is working.

Ms SYLVIA HALE: That may work in those communities but how will it work in an urban environment?

Professor PICONE: If I had my way I would restrict it in urban communities but I do not think I have any chance of that.

Reverend the Hon. Dr GORDON MOYES: Following the Garling inquiry there was a whole range of recommendations to the department and not all of them have been implemented. Can you mention the ones that were not implemented, and explain why not?

The Hon. JOHN HATZISTERGOS: I thought we had detailed the comprehensive response to the Garling report and that is available publicly.

Professor PICONE: The Government accepted all the commissioner's recommendations other than two for implementation. One was in relation to infection control. If a patient had acquired an infection in hospital—

Reverend the Hon. Dr GORDON MOYES: That is precisely the reason why I am asking that question.

The Hon. JOHN HATZISTERGOS: We can discuss that, but there was a comprehensive response provided and that is available publicly.

Reverend the Hon. Dr GORDON MOYES: I have read that. One of the recommendations that was not fully accepted had to do with infection control. The department provided additional staff for wiping around window ledges and so on. But I think everybody knows that previously infection control was not because of

window ledges; it was due to the lack of barrier prevention nursing. What additional work has been done to help staff with infection control, because nothing is said in the report about that matter?

Professor PICONE: Minister, with your permission. I will ask the Chief Health Officer to explain why the recommendation in relation to hospital-acquired infection was not adopted by the Government, and then I will go on as to what we are doing around infection control in hospitals generally.

Dr CHANT: Some of the considerations relate to the administrative difficulty or the difficulty in assessing whether the infection was actually acquired in hospital or was a consequence of it. People carry in their noses staph; they can actually infect themselves or other people can infect it. They can often carry that bug with them. Whereas in the past we could assume that if you had a staphylococcus aureus—that is, a resistant organism—it was acquired in a hospital setting; but increasingly we are finding that that is occurring in the community.

There is also a range of other infections that people can acquire in the community. So the practical implementation of defining whether someone actually had a hospital-acquired infection as opposed to an infection that they acquired in the community was administratively challenging and fraught with issues of reasonableness in relation to you versus another patient in the hospital.

Reverend the Hon. Dr GORDON MOYES: Doctor, nevertheless, with the swine flu hospitals stuck up paper notices on the doors saying that if someone has these kinds of symptoms do not enter. You faced the administrative difficulty there. What about other forms of infection?

Dr CHANT: I think it is actually a different administrative issue about determining someone's eligibility whether they fit the category of a hospital-acquired infection. The view was strongly held that we needed to take on the challenge of reducing hospital-acquired infections.

Reverend the Hon. Dr GORDON MOYES: Indeed.

Dr CHANT: We can do that through many strategies, including basic issues such as increasing hand washing. Also there are a number of other elements, as we did with human swine flu by making it clear that people should not be visiting hospitals if they are unwell.

Professor PICONE: If I could come back to what I think Reverend Dr Gordon Moyes is asking—barrier nursing and reverse barrier nursing, they are excellent questions. Our view is there are two significant infection controls in a hospital setting. One is hand washing. As you know, we have had major campaigns on hand washing now for a couple of years.

The Hon. JOHN HATZISTERGOS: Longer.

Professor PICONE: For longer—

Reverend the Hon. Dr GORDON MOYES: Professor, the point is that there is no account of that in the reports.

Professor PICONE: There is.

The Hon. JOHN HATZISTERGOS: I can give you some information as to what we are doing this year.

Professor PICONE: The other infection control is antibiotic prescribing. We can come back to that as well.

The Hon. JOHN HATZISTERGOS: This year we are investing about $1.8 million to provide for laboratory screening to improve detection of multi-antibiotic resistant organisms; clinical improvement initiatives to control and prevent multi-antibiotic resistant organisms, including the implementation of contact precautions and hand hygiene strategies; the development and implementation of clinical improvement programs to reduce central line associated blood stream infections in intensive care units and staphylococcus aureus bloodstream infections; and improved reporting of health care associated infections. We have five key strategies being rolled out to better educate medical professionals: hand hygiene; correct antibiotic use;

adherence to contact precautions; effective use of environmental cleaning programs; adherence to intensive care unit guidelines. These are aimed at strengthening our capacity to prevent patients acquiring health care associated infections during all stages of their care and treatment.

Reverend the Hon. Dr GORDON MOYES: Thank you, Minister. That is exactly the information I wanted.

Professor PICONE: We have the lowest central line infection rates in the country and probably internationally, according to a study that was just published. What the swine flu did for us was allowed us to accelerate in people's minds that you really do have to wash your hands.

The Hon. JOHN HATZISTERGOS: Could I go on? We are committing an additional $25 million over four years to extra cleaning services for major metropolitan and regional hospitals. Furthermore, the new nurse-in-charge position will be an identifiable leader empowered to act decisively in the interests of patients.

Reverend the Hon. Dr GORDON MOYES: Minister, may I interrupt?

The Hon. JOHN HATZISTERGOS: If I could just finish, I will not be long. They will provide leadership on infection control and monitoring of hygiene practices, including hand washing.

Reverend the Hon. Dr GORDON MOYES: My point is that in the report and in the budget there is money set aside for basically domestic cleaning. The argument I am trying to make is: What are you doing to help staff with such elementary tasks as you have just referred to?

The Hon. JOHN HATZISTERGOS: I have just outlined them.

Reverend the Hon. Dr GORDON MOYES: Yes, that is right, but it is not in the report.

The Hon. JOHN HATZISTERGOS: I have given it to you now. I am sorry if I have offended one of God's representatives.

Ms SYLVIA HALE: Minister, can you provide the budget figures for the amount of funding allocated for hospital cleaning services in the last three years? You mentioned you were about to increase it. I would like those figures for the last three years. Further, can you tell me whether there has been a decline in the allocation over that period?

The Hon. JOHN HATZISTERGOS: For hospital cleaning?

Ms SYLVIA HALE: Yes. Presumably you have contracts for people to come in and clean.

The Hon. JOHN HATZISTERGOS: Yes, but I am not sure that is necessarily an indicator.

Ms SYLVIA HALE: It may not be.

The Hon. JOHN HATZISTERGOS: To the extent we are able to, I imagine there would be significant variations, which can be accounted for. In any event, we will take that question on notice.

Reverend the Hon. Dr GORDON MOYES: Professor Picone, I appreciate your comments about alcohol, drugs, obesity and so on. Recently issues were raised in the House with the previous Minister about trans fats. What is the department doing?

The Hon. JOHN HATZISTERGOS: This is food, is it?

Dr CHANT: I can help you with that. The health department's role in relation to trans fat is that we work in collaboration with the New South Wales Food Authority and we provide health advice. This matter has been raised by food Ministers, and FSANZ, which is the food regulatory expert group in Australia and New Zealand, has done some assessment of the issue. Fortunately in Australia the issue of trans fats is not as significant as it is in other parts of the world. So at this stage a monitoring process is underway whereby we are contributing to monitoring food for the levels of trans fats to ensure that we are seeing a decline. At the moment a regulatory action is not considered warranted.

Reverend the Hon. Dr GORDON MOYES: Doctor, in essence, in response to my questions to previous Ministers in the House about what is happening, your reply is: "We are waiting and seeing."

Dr CHANT: No. My understanding is we could provide that from the Food Authority. The New South Wales Food Authority has participated in national monitoring of trans fats and those reports have been taken to the food ministerial council, of which the health Minister of New South Wales is part, at times.

The Hon. JOHN HATZISTERGOS: The primary industries Minister is the lead.

Dr CHANT: The primary industries Minister is the lead Minister in that. Basically that has been assessed and, working with industry, a number of strategies have been put in place to ensure that trans fats are minimised. The Ministers have made it clear that if there is any lack of a positive trend downwards in this case, in relation to trans fats further regulatory action would be considered.

The Hon. JOHN HATZISTERGOS: I have some information I can give you. Do you want it?

Reverend the Hon. Dr GORDON MOYES: Could you place it on the record?

Ms SYLVIA HALE: Yes.

The Hon. JOHN HATZISTERGOS: I am aware that there have been some calls for bans on the use of artificial trans fats in restaurant food. Trans fatty acids, also called trans fats, are unsaturated fats but unlike good unsaturated fats found in fish and vegetable oil, trans fatty acids act similarly to saturated fats in the human body. Naturally occurring trans fatty acids can be found in red meat, milk and milk products. Manufactured trans fatty acids are generally found in less healthy products such as processed edible foods.

CHAIR: Minister, perhaps you could take that question on notice.

The Hon. JOHN HATZISTERGOS: They did ask. Two members wanted the answer.

Ms SYLVIA HALE: I think he is informing himself.

Reverend the Hon. Dr GORDON MOYES: Thank you.

CHAIR: The Government members are itching to ask you questions. It is time for Government members.

The Hon. GREG DONNELLY: My question is to the Minister and other officers who may be involved. How have our hospitals performed, given the record demand for services and the onset of the swine flu pandemic?

The Hon. JOHN HATZISTERGOS: According to the Commonwealth Government and the Australian Medical Association, New South Wales has the best-performing hospitals in Australia. We have a record health budget in excess of $15 billion and there is more hospital construction in New South Wales than in any other State in Australia. Every day hundreds of procedures are performed without incident, every day hundreds of babies are born without incident, and every day thousands of people are presenting to our emergency departments in what is, I believe, the best hospital system in the world. In the face of demand for a health system with growth in the order of 8 per cent each year, the system does have its challenges. Faced with an 8 per cent growth in demand, plus a pandemic of swine flu, it will have its challenges. But they are challenges that we have risen to.

The State's hospitals have experienced unprecedented numbers of presentation to emergency departments and admission to intensive care units as a result of the swine flu. Despite this, more patients are receiving treatment in emergency departments within benchmark time than ever before in New South Wales. The pandemic H1N1 2009 influenza also had an impact on operations and those patients requiring intensive care management post surgery. These patients are now being prioritised to undergo their surgery. It is a credit to the public hospital system and its dedicated personnel. The June 2009 performance data shows 174,000 emergency department attendances recorded during the month, a massive 8.2 per cent increase on the same time last year. For the year we had in excess of 2 million presentations. Emergency department admissions also continued to

increase, with a 3.7 per cent of patients admitted to hospital in the same period compared with last year. This means over 36,000 patients were admitted to hospital after initial emergency department triage during June. For the year there were in excess of 400,000 emergency department admissions.

The increased demand for health services is also reflected in the State's ambulance workload, with a 2.7 per cent increase in ambulance transports statewide compared with the same time last year. Despite this rise in demand, New South Wales remains the nation's best performer in terms of emergency department triage benchmarks. Patients are more likely to be seen at the clinically appropriate time in an emergency department in New South Wales than anywhere else in the country. It is a tremendous performance by the hospital system and its staff. These improvements are the results of careful planning, the setting of clear targets, the allocation of funding, and support for these services.

In addition to this, our elective surgery performance continues to be sustained, and New South Wales is effectively meeting the national benchmarks that are set for elective surgery. The recent Australian Institute of Health and Welfare highlighted that New South Wales has the lowest percentage of residents waiting for surgery in excess of 365 days. In New South Wales only 1.8 per cent of residents waited in excess of the 12-month benchmark, a slight improvement on last year and compares with the national figure of 3 per cent. Most importantly, support is being given to clinicians and nurses through the emergency care and surgical services task force and the clinical services redesigned program. The Government has invested in excess of 2,000 new permanent beds and bed equivalents in the public hospital system since 2005 to ensure ready access to health services for the people of New South Wales.

This financial year we will deliver 69 medical assessment unit beds; 30 acute hospital beds; three intensive care unit beds at John Hunter, St George and Gosford; three neonatal intensive care unit beds at the Royal Hospital for Women, where two beds will be allocated and one bed at the Children's Hospital at Westmead; and an expanded community acute and post-acute service for over 8,000 places at a cost of $12.6 million. The Government will continue to invest in health service delivery, we will continue to actively support our doctors and nurses and we will continue to improve access to health services for the people of New South Wales.

The Hon. TONY CATANZARITI: Minister, what is the latest information about how the Government is managing the health system?

The Hon. JOHN HATZISTERGOS: NSW Health is one of the biggest health departments in the world, comprising more than 200 hospitals and 100,000 staff. To manage such a huge system the department is broken down into eight area health services. The system works well because it is focused on the delivery of front-line services and patient care and safety. Area health services were introduced by the Wran Government in 1986, and I note the policy was continued by the Greiner Government. The services superseded the old-fashioned hospital and district boards, which had remained in rural areas until 2005.

The most recent reforms have redirected over $100 million a year from administration and boards to front-line healthcare. Today the health system is more efficient and integrated and delivers improved health services to our community, compared with the old board system, where there was frequent confusion as to the respective roles of the boards and area health services. That often created conflict and blurred responsibility for decision-making. Some of the boards mismanaged their budgets and hospitals so badly that their local communities travelled to Sydney to protest outside this very Parliament and call for their sacking. You probably remember it.

Accountability in health administration in New South Wales is now much clearer, and accountability is a key element in managing a very substantial budget. Area health services are now governed by chief executives who are directly accountable to the Director-General of Health. The director-general is, in turn, directly accountable to the Minister for Health. As noted in the Garling report, New South Wales has one of the best health care systems in the world, but we need to meet the challenges of the future, including the rising cost of health care and an ageing population. In relation to area health services, Commissioner Garling's recommendations 134 and 135 are crystal clear, He said:

> I recommend that … there be no … alterations to the current area health service governance structure.
>
> I do not recommend … boards of directors whose task it is to govern the various area health services.

Despite this expert advice I note that the Opposition wants to wind back the clock when it comes to area health services and bring back the old boards system. I understand the Opposition's proposal is for some 20 boards. Independent experts calculate that it would cost in the vicinity of $300 million a year. That is the equivalent of 3,500 registered nurses. If they are not going to add $300 million to the health budget to pay the bureaucrats to staff their 20 boards, the money would have to come straight out of front-line services. Instead of getting more nurses and more hospitals we would get a whole lot of backroom bureaucrats. That would mean that obviously there would be an impact, and that could mean more hospitals closing, particularly in rural and regional New South Wales, which would be squeezed out and denied services as funding would be directed to the larger metropolitan hospitals.

We have had the most comprehensive review of public hospitals in the history of New South Wales, but instead the Opposition has opted for a flawed, uncosted policy, developed without consultation and against the evidence. The Government is about patients and investment in front-line health services, where, regrettably, the Opposition is about more bureaucracy, more red tape and old-fashioned boards, which would not help a single patient.

The Hon. CHRISTINE ROBERTSON: Minister, can you tell us what is happening with the health hotline service that is available to New South Wales residents?

The Hon. JOHN HATZISTERGOS: Healthdirect Australia is a 24-hour telephone health advice line staffed by registered nurses to provide expert health advice. The hotline provides quality health information to all callers anywhere 24-hours a day seven days a week. By simply dialling 1800 022 222 you can ask questions such as whether your symptoms are serious or nothing to worry about; why your baby will not stop crying and what could be wrong; where you might find a doctor because you are away from home; or if you need to know more about managing chronic disease such as diabetes, asthma or another health condition.

The nurses on the line follow a set of procedures developed by a team of health professionals who can connect you to an emergency service if necessary. To make sure people receive the best advice, medical professionals monitor our service to maintain the highest quality at all times. During its first operation in this State this advice hotline has been well received by New South Wales residents, with 170,000 calls—about 465 a day—being made. That is why the Rees Government is pleased it has made an investment of more than $25 million over four years to the hotline service.

The money is not only going to help callers but will have long-term health benefits. For example, healthdirect is improving links between the public and health care services; it is getting advice to people on attending the most appropriate health services, for example, going to a general practitioner rather than to the hospital emergency department; it provides easy access to health information and advice without increasing pressures on other health services; it is improving community health in the long term because it promotes better access to health promotion, prevention and early intervention; it takes pressure off general practitioners—especially after hours—as callers will be able to get good health advice, particularly on minor ailments, at any time; and it gets health information and advice to disadvantaged groups such as Aboriginal people, people in rural and remote Australia, people with disabilities and elderly people.

During the past year the majority of calls to Healthdirect included 14,700 for flu-like symptoms, 9,800 for fevers in children, 8,300 for coughs, and 4,600 for abdominal pain. Research shows that after talking with the Healthdirect nurses, about 30 per cent of the callers are able to confidently manage their condition at home, and those who need urgent follow-up treatment are given advice on where to get the right help. Moreover, the registered nurses working on the hotline are supported by advanced health software, a website and a directory of local health facilities to ensure the quality of their information and advice. The nurses are regularly updated on current issues so they can deliver the latest health information to callers. However, it is important to note that the hotline is not an emergency service and people with health emergencies should still ring triple-0. Calls to Healthdirect Australia on landlines are free, but charges may apply to calls from mobile phones. For more information, people can visit *www.healthdirect.org*.

The Hon. GREG DONNELLY: What is the latest information regarding hearing tests for children in New South Wales?

The Hon. JOHN HATZISTERGOS: New South Wales was the first State in Australia to introduce universal hearing screening for newborns as young as six hours old. The screenings detect congenital hearing impairment as well as any hearing loss in the cochlear and hearing nerve. In the period 2002-03 to 2008-09,

more than $29 million has been allocated to the statewide infant hearing screening program, commonly known as SWISH. These figures include almost $4.5 million budgeted for 2008-09 and almost $4 million budgeted for this financial year. I am delighted to say that almost 560,000 newborns have been screened in New South Wales since SWISH began in December 2002. This is a significant milestone when one considers that the figure represents almost 40 per cent of all screening carried out across the country. In fact, New South Wales has achieved the highest percentage of newborn hearing impairment screening in the country with more than 98 per cent of newborns screened.

Since the screening began, more than 1,700 infants have been referred to specialists for treatment. Sadly, in excess of 650 have been diagnosed with significant hearing impairment. The good news is that early diagnosis is essential to optimise speech and language development for children with hearing loss and it can prevent early learning difficulties. If the hearing loss goes undetected, school-aged children can suffer behavioural problems that can affect their ability to learn. Research suggests that intervention before six months of age may result in optimal speech and language development. It is because of our infant hearing screening that early detection takes place.

The SWISH program relies on a dedicated group of hearing screeners who use a test called the automated auditory brainstem response, which is a non-invasive test that takes just minutes to perform. Screening is conducted at numerous locations, including maternity and birthing hospitals, community health centres and in homes across the State. Earlier this year, a group of children who had been diagnosed with hearing impairment through the SWISH program started in mainstream schools. That is a clear indication of the success of the program. The fact that these children are detected early means that they have been fitted with hearing aids or cochlear implants and have learnt to speak.

Before the infant screening hearing program was implemented, children with hearing loss were typically not diagnosed until they were 18 months of age. This meant that they were not receiving intervention until nearly two years of age, by which time critical speech and language milestones had been missed. The Government has continued to invest in SWISH to ensure that screening is delivered in the most effective way and that children get access to the services that they need as early as possible. SWISH brochures are available informing parents about the screening processes and they have translated into 21 different languages.

The Hon. TONY CATANZARITI: What is the Government doing about the problem of vision impairment?

The Hon. JOHN HATZISTERGOS: A common misconception is that vision impairment affects only older people. The truth is that problems associated with eyesight are also a serious issue for children. Children often develop eye problems very early in life. They can suffer from turned eyes and refractive errors that can lead to lazy eye syndrome and also serious conditions such as cataracts. Left untreated, some problems can cause permanent vision loss, which affects a child's ability to concentrate and to learn.

There is a defined visual development period from birth to approximately eight years of age. I understand that during that early development period the visual system in the child is particularly plastic or amenable to intervention. That plasticity decreases after school entry and the older the child becomes the more difficult it is to treat vision problems. Once a child turns eight, the opportunity to achieve an optimal vision outcome is often lost. To minimise the impact of eyesight problems amongst children, the Government has invested $14.2 million over four years in the Eyesight Preschoolers Screening Program, commonly known as STEPS. In designing STEPS, the peak eye professional groups were consulted and were actively involved in providing professional advice on its implementation.

The earliest visual acuity can be accurately and reliably tested in children at four years of age. Not all four-year old children can name the letters of the alphabet. Therefore, STEPS tests children's vision by using the Sheridan Gardiner linear chart. Children identify mirror image letters such as X, O, T, H, A and V on a chart and match them to letters on a board placed on their lap. Tens of thousands of four-year-old children have undergone free eye tests across the State and more than 3,000 children have been diagnosed with eye or vision problems and received follow-up treatment. The treatments have been as simple as ongoing medical checks, wearing glasses or an eye patch, taking medication or in more complex cases undergoing surgery. However, where problems have been serious the children have been given a priority referral to undergo specialist treatment and even undergone surgery to save their sight.

As I said, problems with eyesight are not confined to adults. However, the difficulty with child eyesight problems is identifying them in the first place. Of the 3,222 children identified so far by STEPS as having an eye or vision impairment, a staggering 85 per of their parents had no prior concerns about their child's vision. That is often the case because children rarely complain of problems with their vision because they are unaware that it is abnormal. It can be hard to detect without proper screening. Children born prematurely are at greater risk of developing eye and vision problems, as are children born into the families that have a history of eye-related complaints. That is why it is important that parents have their children tested under the STEPS program.

In the meantime, parents should be on the lookout for some of the signs and symptoms of eye and vision problems, which can include moving closer, squinting or rubbing their eyes when trying to focus at a distance, abnormal head posture or turning the head when trying to focus and turning in one or both eyes. Children do not grow out of eye turns and they can cause lazy eye and permanent loss of vision. Eyesight screening is conducted at numerous locations, including preschools and local child and family health centres. I encourage all parents to make an appointment.

The Hon. GREG DONNELLY: I note that there has been 24 minutes of questioning so far for both the Opposition and cross-bench members.

CHAIR: That is noted. I plan to allow no more than five minutes for morning tea.

(Short adjournment)

The Hon. MARIE FICARRA: My question is to the Minister. You were saying that the number of people on waiting lists more than 12 months has reduced but, according to the Department of Health's own website, page 8, on waiting times and elective patient management policy, "Planned admission dates of greater than 12 months will not be accepted." According to your own guidelines doctors cannot place patients waiting longer than 12 months on the waiting list so how can you say you have reduced waiting lists?

The Hon. JOHN HATZISTERGOS: I might ask Dr Lyons to talk to you about that policy because I think you misunderstand it.

Dr LYONS: The policy is clearly articulated to make sure that we meet the benchmarks for waiting times for surgery. The aim, of course, is always to make sure that the category 3 patients, those patients who require admission within 365 days, receive that care. The purpose of that statement in the policy directive is to ensure that surgeons and hospital management work very closely to ensure that patients who are booking onto the waiting list receive their care within that timeframe. It is a flag to ensure that surgeons do not continue to book above what is able to be delivered in terms of care. It is to ensure there is a trigger for a discussion around how the increasing number of patients can be cared for within the appropriate benchmark waiting times.

So, the aim is quite clearly that when they are at a point when they are booking patients who cannot receive their care within that timeframe a review is triggered to ensure that either the surgeon is provided some more operating time to make sure those patients are receiving their care in the appropriate timeframe or other avenues are explored to make sure that those patients can receive their surgery. That may include being referred to another surgeon in the same specialty who has shorter waiting times or, alternatively, the area health service and the hospital might consider other arrangements—like having those patients cared for at another hospital within the area health service on an arrangement where the surgeon might visit there to provide the care and, in some circumstances, it is even to the point where there has been a contracting of care to other surgeons in the private sector to ensure that those patients are cared for within the appropriate waiting time. The policy directive is quite clearly there to make sure that we continue to deliver appropriate care within the appropriate waiting times for all patients.

The Hon. MARIE FICARRA: So is there communication? Do you have a handle on how many patients need surgery outside the 12 months, and what guidelines do the surgeons and clinicians have in who they place on those lists, seeing they have been very critical of the scrutiny given to them about waiting lists?

The Hon. JOHN HATZISTERGOS: Sorry, just go back to your question again—patients needing care after 12 months, did you say?

The Hon. MARIE FICARRA: Patients needing surgery outside 12 months. We know you are not including them outside the 12-month time frame.

The Hon. JOHN HATZISTERGOS: That can occur due to a number of factors. A patient may have a scheduled date for surgery and not turn up or may have a complicating condition that precludes them from attending their surgery and therefore it has to be delayed. A whole range of variables can occur that can influence it.

The Hon. MARIE FICARRA: That would be in the minority.

The Hon. JOHN HATZISTERGOS: No, you would be surprised at how many patients.

The Hon. MARIE FICARRA: My question is how does the Department of Health know how many people are waiting outside that 12-month period?

The Hon. JOHN HATZISTERGOS: We publish the figures.

Dr LYONS: Could I respond to that? In that policy directive which I think you quoted earlier there is also a requirement for every visiting medical officer or appointed medical officer in our public hospitals to ensure that any patient that they have who requires admission lodges a request admission form with the hospital's admission office. So, it is a requirement that every person who requires admission to our hospitals and comes through the booked surgical program will be known about by the hospital. Then we can count what is the waiting time for those patients and ensure that we continue to provide adequate amounts of surgery to ensure that those waiting times are met. That review occurs in each of the different categories, so if I can just talk about the different categories. You have talked about category 3. There is also category 1, which relates to those patients who require admission within 30 days for urgent care. There is also category 2, where patients require admission within 90 days.

The Hon. MARIE FICARRA: My question was category 3.

Dr LYONS: Each of those categories has some criteria around it to assist the surgeon and the other clinicians in making the right decision about what patients should be admitted or booked in in each of the categories.

The Hon. MARIE FICARRA: If those records are kept, are they available or published?

Dr LYONS: Each of the hospitals has very detailed records about the patients that are on the booking list. They are reviewed and audited on a regular basis and audits conducted are both clerical audits to ensure that the details of the patients are correct and also clinical audits—and I think you might have been alluding to some of the clinical audits when you talked about the discussions that occur with the clinicians around whether or not that is an appropriate categorisation for that patient. This is to ensure that we get the right alignment of our activity to make sure that we meet the care needs of those patients in each category. So the review process is very thorough and the hospitals are very well aware of their responsibilities in this regard,

The Hon. MARIE FICARRA: Are surgeons and clinicians given guidelines in how they are supposed to categorise their patients?

Dr LYONS: Indeed they are, and very detailed work has been undertaken through the Surgical Services Taskforce to assist us in that regard and they have worked with us—groups of specialist surgeons—providing advice about what types of patients in each of the specialties should be categorised into each of the category one, two and three patients. If I could add, the work that that Surgical Services Taskforce has done has really assisted us in seeing significant improvements in patient care, reducing waiting times in each of the categories and, as was alluded to by the Minister previously, providing a level of performance in relation to an elective surgery which, I think, is the envy of many other States.

The Hon. MARIE FICARRA: Are those guidelines publicly available?

Dr LYONS: The guidelines are available and they are used by the clinicians.

The Hon. JOHN HATZISTERGOS: I might add that when I was first Minister for Health the over 12 months category was about 10,500. It is now down to—

Dr LYONS: It was 668 at the end of June.

Professor PICONE: It is 688.

The Hon. JOHN HATZISTERGOS: It has been lower than that. It has gone up a bit in more recent times. There has been a significant amount of work and I do take credit, not personally, but I do want to pay tribute to the Surgical Services Taskforce. I went to a number of the meetings—and I know the previous Minister did—of the taskforce. They did an extraordinary amount of work.

The Hon. MARIE FICARRA: I now move to front-line jobs, in particular nursing. Do you stand by your Government's claim that there have been no and will be no front-line jobs lost in health?

The Hon. JOHN HATZISTERGOS: Yes.

The Hon. MARIE FICARRA: You do, okay. How do you then address the multiple media reports based on many area health services, the North Coast Area Health Service, Greater Western Area Health Service, South Eastern Sydney Illawarra Area Health Service, Sydney West Area Health Service, Greater Southern Area Health Service all documenting information passed on to the media, to the Opposition and to the crossbenchers from clinicians, nurses, paramedics of front-line jobs lost. Who is telling the truth? The Government?

The Hon. JOHN HATZISTERGOS: I am not going to account for the media commentary. That is a matter for those persons who inform them and, indeed, for those persons who produced the articles but I can tell you what our position is. That might, in a way, respond to your question. Our substantive workforce continues to increase. In 2008-09 the health system workforce increased by 923 full-time equivalents and of those there were 272 doctors extra, 113 nursing staff and 461 allied health professionals. We are continuing to make enhancements to our workforce.

The Government's response to the special commission of inquiry "Caring Together" and the health action plan for New South Wales includes an investment of $22 million over four years to expand out-of-hours and weekend coverage for our allied health staff, who also play a vital role in supporting the needs of patients. The Government has a program to enhance our clinical pharmacists workforce. We have an investment there of $37 million over four years and—you will remember this from our response to the Garling report—500 clinical support officers are currently being recruited to support our doctors, nurses and allied staff so that they can focus on patients, not paperwork.

The Hon. MARIE FICARRA: My specific question was on the hours of nursing, in particular, when one looks at registered nurses and enrolled nurses. How many hours of nursing have been lost in New South Wales Health in those two categories? I am not talking about assistants in nursing; I am talking about registered and enrolled nurses.

The Hon. JOHN HATZISTERGOS: What do you want?

The Hon. MARIE FICARRA: I want to know numbers and hours?

The Hon. JOHN HATZISTERGOS: I do not understand the question.

The Hon. MARIE FICARRA: I want to know the full-time equivalents, to be specific.

Professor PICONE: The overall nursing workforce increased by 100 full-time equivalents. I will have to take on notice the actual breakdown of assistants in nursing. To explain the assistants in nursing, I think 800 of a workforce of around 50,000 are assistants in nursing, remembering that we have had assistants in nursing, as I like to say to everyone, since World War 2. They provide, and have always provided, a very important role and function. We have been looking at increasing the number of assistants in nursing, particularly in long-term aged care. As you know, we run a large number of long-term aged care facilities, so the ratio we are thinking of is a registered nurse on the shift and an enrolled or assistant in nursing; we do not need all registered nurse staff. I think that is a wise use of money.

I will undertake to look at it. There has there been an absolute increase in the number of assistants in nursing in the last couple of months. I will do my best to look at that for you, but I do need to be very clear about the nursing workforce and medical—well, the whole health workforce. As you know, being a 24-hour

service, operating seven days a week, we were becoming increasingly dependent on overtime shifts, casual shifts and a whole range of what I call quite expensive labour sourcing. For example, an overtime shift can cost you 50 per cent or 200 per cent more than a full-time staff member. We have been moving to increase our permanent staff and reduce our dependency on agency nurses, overtime shifts, additional casual staff.

In the last 12 months I have had a lot of work done around improving rostering practices. These rosters are not easy to do—the medical and nursing rosters are never easy to do—but you can, by improving the way you do your rostering, reduce your overall expenditure on salaries and wages. For example, you can still have, say, five, four and three on a shift, and do that over a roster for, say, a medical or surgical unit and reduce your salaries and wages expenditure by simply improving your rostering practices. We have been doing that. I have had expert teams going into some of our larger facilities over the last 12 months to assist the staff there to improve those practices, and I am going to continue to do that because I think that is wise use of public funds. And it can be quite significant. That side of things can sometimes be around 4 or 5 per cent of your total salaries and wages expenditure.

The Hon. MARIE FICARRA: My question in relation to registered, enrolled nurses, as against assistants in nursing, connects back to comments by the General Secretary of the New South Wales Nurses Association in July this year, "We need to alert the public and politicians about safety posed by the Government's approach to cost cutting and introducing unlicensed workers." I take you also to the University of Technology Sydney study, which says, "A skills mix with a higher proportion of registered nurses who are university trained produced statistically significant decreased rates of negative patient outcomes." My question is: Why are registered, enrolled nursing components being reduced and the assistants in nursing component being increased—other than because of a cynical cost-cutting measure by the Department of Health?

Professor PICONE: Assistants in nursing have been a part of the nursing team since the Second World War. In fact, at the end of the Second World War, as those groups of staff were demobbed, particularly from the 100th and the 13th Army General Hospital, they were offered positions as assistants in nursing or enrolled nurses. I understand the concerns of the General Secretary of the Nurses Association because I have discussed this directly with him. But remembering this: The Nurses Association, as a part of its pay increase, agreed to participate with us in looking at the general skills mix of the nursing workforce across the State.

I could ask my colleague Karen Crawshaw whether there has been a flood of assistants in nursing into registered nurse positions. I know the answer to that: The answer is no. She is the one who keeps the workforce figures. But I do expect that the Nurses Association will work with us on these skills mix issues. I do not believe that every ward needs an all-registered nurses workforce. In fact, that has never happened in this State; we have always had a mixture of assistants in nursing, enrolled nurses and registered nurses.

There are certain units in departments that do it. For example, I was told two years ago by the Operating Theatre Nurses Association—a group not to mince with—at their annual conference that enrolled nurses are now working quite happily in operating theatres and in anaesthetics. So I do expect that the Nurses Association will cooperate with us in an undertaking that they made around improvements in productivity for their pay increase. Karen might want to explain the matter further.

Ms CRAWSHAW: I think we now have about 900 assistants in nursing in the system. That has certainly not been an increase. In fact, I think that in 2008-09 there was a slightly bigger increase in the registered nurse workforce as a proportion of the overall nursing workforce. As the director general mentioned, we are certainly looking at opportunities to, where we can, increase the use of the assistant in nursing workforce. We have a process underway—a very careful process—where we are working with the Nurses Association in other areas where we might be able to use the assistant workforce as well in the allied health area. We are also looking at it in a way where we can actually improve the quality and expertise of the assistant in nursing workforce by tying the use of this category of nursing staff to training in certificate III training. We are actually looking to boost—

The Hon. MARIE FICARRA: You are trying to upskill the assistant in nursing workforce?

The Hon. JOHN HATZISTERGOS: That is a national qualification: certificate III in health services.

Ms CRAWSHAW: Yes, we are. I envisage that the use of the assistant workforce will not be so much a substitution issue as opportunities to expand that category workforce.

The Hon. MARIE FICARRA: Can you provide those statistics in terms of full-time equivalents for those three categories?

Ms CRAWSHAW: Yes, I am happy to do so.

The Hon. JOHN HATZISTERGOS: We will take that on notice. I might add that these issues were canvassed quite heavily in the Garling report and what we are doing is in accordance with the recommendations that Garling put forward.

Professor PICONE: Could I correct myself? The figure is not 800; it is 900. There are around 900 assistants in nursing currently in the workforce.

The Hon. MARIE FICARRA: We had 1,300 enrolled nurses trained last year, and then there was a move to cut this program after protests. The Government then replaced them with only 200 scholarships and 400 places for full fee paying students. Do you believe that this is a good way to promote your nursing mix, by making training of enrolled nurses unaffordable? What have you done with the enrolled nursing training program?

Professor PICONE: I might ask Karen Crawshaw to explain that.

Ms CRAWSHAW: I am happy to do so. We have moved to a pre-service model of training for the enrolled nurse. Essentially, when enrolled nurses now come into our workplace they are fully qualified with their certificate IV, or in some cases they are moving to a diploma qualification. That means that they are getting their training before entering the workforce.

The Hon. MARIE FICARRA: The numbers have been reduced?

Ms CRAWSHAW: Yes, the trainee enrolled nurses are being phased out because we are moving to this pre-service model of training. That means that when an enrolled nurse now comes into the workforce they are fully qualified. That said, we are continuing to work with TAFE to make sure that we make available clinical placements for those who are wishing to train and get their certificate IV and become enrolled nurses in our workforce. I might add, we are still training enrolled nurses through the system; they do not fully phase out until next year. We are now moving to build and support the pre-service model with scholarships and fee support, and that will build up over time.

Reverend the Hon. Dr GORDON MOYES: Professor Picone, I am interested in the primary and community-based services. With regard to detoxification treatment, I was interested to note that the number of people treated in 2006 was 12,853, in 2007 it was 12,853, in 2008 it was 12,853, in 2009 it was 12,853, and, with remarkable consistency, the forecast for 2010 is 12,853. As this is a category of the numbers of people treated, would you like to comment on that consistency?

Professor PICONE: Could I ask Dr Matthews to comment on that?

Dr MATTHEWS: I think what you see there is a system that is operating efficiently at capacity. Detoxification is often seen as a cure for drug dependence. It is not. It is the treatment of the symptoms of withdrawal from drug dependence. The real issue is not stopping. If that were the issue, a locked room would provide the solution. The real issue is putting in place strategies that prevent people from commencing drug-taking again, and that is quite difficult. The average number of relapses that an individual has, whether we are talking about nicotine dependence, alcohol dependence or dependence on illicit drugs, between an intention to give up and abstinence is five. That detoxification system is operating at capacity. Those numbers do not include, of course, the residential rehabilitations conducted by NGOs—those are the outpatient detoxifications—within our hospital system.

Reverend the Hon. Dr GORDON MOYES: Do you have any idea of what we might call turn-away figures: the people whom you do not treat or cannot treat?

Dr MATTHEWS: I do not have that information in my head.

Reverend the Hon. Dr GORDON MOYES: NGOs do?

Dr MATTHEWS: As a result, I believe, of a very significant event in the Drug Summit in 1999, there have been considerable impacts made in relation particularly to illicit drug use. The tobacco story is well known and the alcohol one has been canvassed here already. The recent use of any illicit drug was down from 19.8 per cent to 12.1 per cent, recent cannabis use was down from 16.7 per cent to 8 per cent, and recent heroin use was down from 0.6 per cent to 0.2 per cent. There has been—and many people argue for the credit—in this State a very considerable decrease in illicit drug use. The only category of illicit drug that has shown some concerning increase has been the so-called party drugs or stimulants; various forms of manufactured amphetamine. But the actual prevalence of illicit drugs overall has significantly declined in the 10 years since the Drug Summit.

Reverend the Hon. Dr GORDON MOYES: Accepting that, and looking at the consistency in the methadone treatment places also which has not increased over the last five years, but noticing that the number of employees has increased quite considerably, does this show a lack of productivity among employees?

Dr MATTHEWS: No. Whilst the number of methadone places has remained relatively consistent we have over that period introduced a very significant opioid treatment program with buprenophine. I used to work in a clinic—sadly I no longer work there in many ways—at St Vincent's called Rankin Court and the staff there, including me, as well as doing methadone maintenance did buprenophine maintenance and provided counselling services. I think what you see in looking at the methadone numbers is a decline in new users but a very significant number of people who are old, existing users, with the introduction of the new treatment modality in buprenophine, which in many ways is safer but not quite as efficacious for some, and the capacity to be involved in other forms of treatment such as counselling.

Ms SYLVIA HALE: I turn to the provision of public dental services. I am sure we all recognise how important they are to the maintenance of good oral health. I believe that benchmarks on access to care have been set but no data is publicly released relating to whether or not these benchmarks are met. I gather there are tables that show the waiting lists by area health services but these do not disaggregate the data to show how long each person has been waiting and the treatment they are waiting on. Therefore it makes it very difficult to determine how effective the funding of these health services is and whether the services are improving or not. Minister, will you provide the data—particularly the breakdown?

The Hon. JOHN HATZISTERGOS: We will take your question on notice. I am not sure that I am able at this point to decode every aspect of what you are seeking, but I will endeavour to do it on the notice paper. I can give you some information on oral health waiting lists if you wish me to.

Ms SYLVIA HALE: If it is brief.

The Hon. JOHN HATZISTERGOS: It is a couple of pages—I will read it out. The oral health service budget has increased substantially over recent years, and you would be aware of this, from $122.5 million in 2005-06 to $163 million in 2009-10—that started when I was Minister for Health. In 2009-10 we saw the Government invest a further $4 million in recurrent funding to strengthen our oral health services. We targeted recruitment and retention of public oral health practitioners statewide, we upgraded our clinical facilities and we introduced the international dental graduate program. Since June 2008 there has been an overall reduction in ambulatory dental care waiting lists of approximately 11 per cent. As well as increasing the funding and reducing the waiting lists, we have also set targets for reducing waiting times across the State in each of our health services, as you have indicated. Oral health productivity targets will again be negotiated with the area health services to assist with the continuing waiting list reduction.

The cessation of the Commonwealth dental health program by the previous Coalition Government in 1996 had a major impact on the waiting time of States for care; it increased dramatically. In this year's budget the Commonwealth has renewed its $290 million to the establishment of the Commonwealth dental health program but it has reallocated this funding over the next four years. Under this program, which commenced in July 2008, New South Wales was originally set to receive $91.3 million over three years to provide an additional 327,000 dental visits. The Commonwealth dental health program holds great potential to assist New South Wales Health in reducing public health dental waiting times in continued provision of dental health care to those most in need, especially preschoolers, Aboriginal and Torres Strait Islanders, and people with chronic conditions.

Area health services also continue to make available additional theatre capacity for treatment of general anaesthetic cases and these cases are now all within benchmark times. Commonwealth funding is also being

used to upgrade equipment in theatres. In an effort to improve the oral health of high-risk children already on the general anaesthetic waiting list, the Sydney West Area Health Service is participating in a project aimed at reducing the need for further treatment through education and prevention of further caries. This project aims at providing extensive oral hygiene and diet advice to families of high-risk children, as well as caries-control treatment, fluoride treatment and family assessment and priority treatment for eligible siblings, where indicated.

Ms SYLVIA HALE: A comparison of dental funding of States and Territories shows—and it has shown it consistently over a period of years—the continuing low level of funding that New South Wales provides to dental health. However, New South Wales Health argues that direct comparisons are not useful because of different methods of calculating reporting on budgets across jurisdictions—

The Hon. JOHN HATZISTERGOS: It is more than that.

Ms SYLVIA HALE: —but no evidence of this is provided. Will you provide a breakdown of the jurisdictional budgets that show the different factors that go into making up the performance of New South Wales so it is possible to do a comparison between the States and Territories?

The Hon. JOHN HATZISTERGOS: You have asked me that question previously in the House, and I have responded to you. There is a range of differences between other jurisdictions in eligibility. We have the most generous eligibility. The other States restrict eligibility to a very select group of people. New South Wales does not have co-payments; other States do—they charge people who access public dental health programs. The other thing is, in terms of New South Wales, a significant part of our work is done in priorities also in the area of population health. I mention particularly fluoridisation. I know your party is opposed to it but the reality is that fluoridisation—

Ms SYLVIA HALE: I do not think we have a position on it.

The Hon. JOHN HATZISTERGOS: That is not the way I understand it. I understand there were people particularly on the North Coast campaigning against fluoridisation. We are very proud of the fact that in New South Wales we have the highest level of fluoridisation of the water supply. We have assisted councils with the capital costs in promoting fluoridisation. We have gone out and provided information. Sometimes we have had battles with the anti-fluoridisation lobbies that have campaigned vigorously against us, spreading misinformation and distress to a number of communities. We have the highest level, and we make no apologies for that. We support the councils that work with us to ensure that the costs are able to be manageable for them. A number of other jurisdictions do not have the same emphasis that we do.

Professor PICONE: There is no co-payment.

The Hon. JOHN HATZISTERGOS: I mentioned that. A range of significant differences has to be taken into account. I recognised when I was previously health Minister that there was a need for us, notwithstanding the fact that the previous Coalition Government had abandoned the Commonwealth dental program, to ensure that we could do what we could. We had a program that was directed at increasing our capacity. The Government also introduced the voucher scheme, which enabled large numbers of people to be able to access care through dentists in the private sector. We had a situation at one stage where dentists were retiring at a greater rate than they were graduating. We had a significant workforce problem.

Reverend the Hon. Dr GORDON MOYES: They were all going to Queensland.

Ms SYLVIA HALE: Accompanied by a downgrading of funding for university faculties.

The Hon. JOHN HATZISTERGOS: At one stage we had 80 graduates. We had only one university producing dental graduates, and that was Sydney. I spoke to the universities myself when I was previously health Minister. We encouraged the previous Government and, fortunately, we did get an increase in funding for dental places. Charles Sturt has now started a dental program, as you would be aware, which is very important, particularly in providing for areas in rural New South Wales. I can remember a case—

Ms SYLVIA HALE: With due respect, you are not really answering my question.

The Hon. JOHN HATZISTERGOS: I am.

Ms SYLVIA HALE: No, you are not.

The Hon. JOHN HATZISTERGOS: I can remember a major practice in Tamworth that could not get a dentist.

Reverend the Hon. Dr GORDON MOYES: There was a transfer to Queensland because they were getting paid more.

Ms SYLVIA HALE: My question was, in the interests of accountability and transparency and to enable appropriate comparisons to be made amongst the States and Territories, would you provide budgetary breakdowns to enable the comparisons to be made? Otherwise, New South Wales consistently appears at the bottom of the table.

The Hon. JOHN HATZISTERGOS: I am happy to provide information that is not available on the public record. What I am not prepared to do is act as a research service.

Ms SYLVIA HALE: Minister, you trot out the answer every time if you do not want to provide information that you are not a research service.

The Hon. JOHN HATZISTERGOS: I am happy to provide information. I understand the information that you are referring to is available. I have given you answers. Obviously you do not accept those answers, and that is your prerogative. I am happy to decode your question further after I have read it in *Hansard* to see what further information can and should be provided, and to provide that on notice.

Ms SYLVIA HALE: Thank you. Minister, I now turn to the impacts of lead on children who live in the vicinity of mines. Are you aware that there is a series of lawsuits in Queensland in relation to the blood lead levels of people living in the vicinity of Mount Isa mines? Are you aware that Minewatch and the New South Wales Environmental Defenders Office are calling for an independent health study into the impacts of coalmining and power station emissions in the Hunter? Given that your Government is making millions of dollars from the Upper Hunter coal industry, will you agree to fund an independent health study to provide data on mining-related illnesses, such as asthma, and heart, lung and kidney diseases?

The Hon. CHRISTINE ROBERTSON: That is not lead.

Ms SYLVIA HALE: I used "lead" in relation to the Mt Isa mines. I refer to the impacts of coalmining on children and the community as a whole.

The Hon. JOHN HATZISTERGOS: You are going from one area to another.

Ms SYLVIA HALE: I am talking about airborne diseases caused by fine particulate matter that results from mining.

The Hon. CHRISTINE ROBERTSON: Not black lung, surely?

The Hon. JOHN HATZISTERGOS: I will have to take that on notice. It will be a matter for the new Minister. The Chief Health Officer may be able to help you.

Dr CHANT: I could perhaps make some general comments, but again I would be happy to support the Minister in providing a more detailed response. Usually with major developments, environmental impact assessments are undertaken and they include analysis of health risks as a component. The health department and our local public health units are involved in looking at those health environmental impact assessments to make sure they encompass the major health risks that we are worried about. We would be reviewing those. I could provide you with some examples of health risk assessments or environmental impact statements that we have looked at, if it would assist.

Ms SYLVIA HALE: Clearly, I would assume, in Queensland health risk assessments were done in relation to mining there.

The Hon. JOHN HATZISTERGOS: I thought you said lawsuits.

Ms SYLVIA HALE: I want to know whether in New South Wales health risk assessments associated with coalmining, for example, are so inadequate that they leave the State open to legal action as a result of children developing diseases such as asthma, and heart, lung and kidney diseases from their exposure to coalmining activities.

The Hon. JOHN HATZISTERGOS: I will take the question on notice.

Reverend the Hon. Dr GORDON MOYES: I commend the department for the approximately 50 per cent increase in funds that are being provided for indigenous health services. I note that the objective in broad terms is to raise the health status of Aboriginal people. If you are going to increase the budget by an additional 50 per cent, what benchmarks do you have so that by this time next year I can see whether you are getting close to those benchmarks?

Professor PICONE: I will let the Chief Health Officer answer you in detail. Clearly there is a range of health outcome measures that we use routinely—infant mortality, maternal mortality. There is a whole series of work that we did around vision, middle ear infections and growth dates. They are still all there but we have had much more targeted effort into program areas where we have had very beneficial outcomes. The most significant of those has been the maternal and perinatal program, the early intervention program. The Chief Health Officer might want to comment generally around the health of Aboriginal people and how we will measure that investment. I would ask Richard to comment on the early intervention program because it has been highly successful as well.

Reverend the Hon. Dr GORDON MOYES: There is a good comment in the budget papers about that.

Dr CHANT: In the Chief Health Officer's report there is a particular section on health inequalities, which details the health status of Aboriginal people and indicates where there are significant differences between the indigenous population and the non-indigenous population.

Reverend the Hon. Dr GORDON MOYES: It gives the benchmarks.

Dr CHANT: In terms of moving forward, many of the Closing the Gap targets will not be achievable in a year or even two years. They will require a decade of change. But in a number of them we can measure them on a yearly basis and hope for a decline. Cigarette smoking, I suppose, is one example where indigenous people—

Reverend the Hon. Dr GORDON MOYES: Alcoholism, obesity.

Dr CHANT: —are very much disproportionate. In all our programs that we are rolling out we will have indicators which have to do with the reach and the uptake of the program, as well as outcome indicators, which would be such things as smoking rates, breastfeeding rates, immunisation rates and a number of other elements.

Reverend the Hon. Dr GORDON MOYES: Thank you, Dr Chant. Would you please take it on notice and I will follow this up next year?

Dr CHANT: I look forward to that.

The Hon. JOHN HATZISTERGOS: By the way, an implementation plan is publicly available.

Dr MATTHEWS: I will just add to that, Dr Moyes, because it is a really important question. We can put in place KPIs to measure how we are responding to illness and disease in Aboriginal people. If we are serious about improving the health of Aboriginal people, which is a different thing, we need to take more of a generational approach. It is not simply about our work—although our work is important—it is about jobs, education and social determinants. One strategy we do have which we are very proud of is the Aboriginal Maternal Infant Health Strategy because it does take a generational approach. The best indicator of your birth weight is your maternal birth weight. The best indicator of your educational outcomes is your maternal educational outcomes. So this strategy in providing culturally appropriate services for Aboriginal women who are pregnant measures the time at which they come into antenatal care, with a view to making it earlier, reduction in smoking during pregnancy, breastfeeding rates and the length of time that women breastfeed. It is

already showing a significant improvement in those indices, as well as a significant reduction in perinatal mortality.

CHAIR: Dr Matthews, I hate to be rude and interrupt you. It is a fascinating discussion and perhaps one we could continue offline. It is the Government's time for questions.

Reverend the Hon. Dr GORDON MOYES: I congratulate the department on the extension of the budget on that, and thank you for enabling me to blame my mother for a number of problems.

The Hon. CHRISTINE ROBERTSON: My question is broad ranging and about outlining the achievements of New South Wales Health this year. Perhaps some of the directors can give us some information, for example, in relation to Dr Matthew's outline of the excellent program.

The Hon. JOHN HATZISTERGOS: I will give you a snapshot of the system. Every day 6,000 people are admitted to our emergency departments; 4,900 people are admitted to a public hospital; 3,000 ambulance calls are made for people who need help; 200 babies are born; about 1,000 people are having surgery in hospitals including, on a typical day, 20 patients having a hip replacement, 18 patients having a knee replacement, 73 having their cataracts removed, 14 children having their tonsils removed, 19 patients having their appendix removed and 33 patients having their gall bladder removed. More than 2.4 million people every year go through our emergency departments—almost one million more than any other State—and a quarter of a million patients have surgery over a year.

Per capita, we perform more elective surgery than any other State. Every day we spend $41 million on health services, $15.1 billion this year alone—more than twice what we spent a decade ago. Every year, on average, more than $4,200 is spent on the health care of every person in New South Wales. In our budget, which was delivered by the Treasurer on 16 June, we announced major components of the $117 million allocated this financial year for Caring Together. That included $44 million for the 500 clinical support officers that I referred to earlier, $13.3 million for the emergency physicians, $8.6 million for 65 clinical pharmacists, $7.4 million to improve staff morale and implement programs aimed at reducing bullying, $6.3 million for improved cleaning services, $6.8 million for 45 additional junior medical doctor positions in rural areas, $3.9 million for on-the-job training, $3.7 million for 13 new clinical initiatives nurses and $3 million to ensure single-sex rooms and areas wherever possible.

In addition, as part of the Government's Keeping Them Safe: A Shared Approach to Child Wellbeing action plan, the Government will commit $3.6 million to establish a child wellbeing unit within New South Wales Health as part of a $14.4 million project over four years to improve the health and safety of children. New South Wales Health will also provide $3.6 million to non-government agencies to establish a regional intake and referral service, part of the $23.5 million four-year commitment to improve access to community support services for vulnerable children and families. We have introduced our predictable surgery program, which has brought the median wait time for a category 1 patient down to 10 days—well under the agreed national guideline time of 30 days. For less urgent category 3 patients, the median wait time in New South Wales is just on four months.

To put it simply, patients are getting their surgery sooner. We have the lowest diabetes mortality rate of any State. We have provided more than 800 mental health beds in the last decade. We have the lowest suicide rate in Australia. We have the third highest life expectancy in the world. We have dramatically reduced deaths from cardiovascular disease and cancer. We have 13 public oncology services providing radiotherapy; 36 linear accelerators by the end of 2009; and six PET scanners, all of which contribute to the identification and treatment of cancer. We have specialist stroke services across the State, including seven now in rural communities, that help make sure that patients are able to receive their care closer to home. And we have the equivalent of 94,000 staff.

We have upgraded or rebuilt almost every major hospital and emergency department in the State, but there is more to come. In 2009-10, the health budget will deliver $603 million in capital works, part of a $2.4 billion four-year program to upgrade and rebuild a number of health facilities across the State. This investment in important health infrastructure will deliver health services and support health workers with the latest medical equipment and modern work environments to improve patient care. We have over 2,000 more beds and bed equivalents than in 2005 and 9,500 more nurses and midwives than we had in 2002. Our doctors and nurses are delivering some of the world's most advanced health treatments, including robotic surgery; split liver transplants for children; the PilCAM, which helps diagnose gut and liver disease; deep brain stimulation

for severe epilepsy in children and adults; pancreatic transplantation, of which we now do around 25 a year; interventional neuroradiology to help stroke, aneurysms and brain tumours without the need for more invasive surgery; twin-to-twin transfusion using laser therapy to help treat potentially fatal blood flow between unborn twins; heart-lung transplants—we now perform around 20 to 30 lung transplants each year, with survival rates that exceed many international centres.

Is the system perfect? Of course not. We know that there are always ways to improve both the way health care is delivered and the economic and management systems that sit behind that care. We know that there are individuals and families whose care could and should have been better. We also know that every day there are thousands of people whose health and wellbeing is addressed and cared for appropriately, leading to good health outcomes without incident or complaint. Our health system never stops changing; it never stops helping people. The only thing that never changes is the carping and criticism, often less than constructive. And let us not forget that when the New South Wales community last trusted the Coalition with governing health care we saw some 7,000 beds closed and the downgrading or the closing of 30 hospitals.

The Government has accepted 134 of the Garling report's 139 recommendations and has been working hard to put together and implement its Caring Together action plan. It is important to reflect on that response and compare it with the eight-page brochure that has been put out by the Opposition spelling out a six-point plan—which is really only a two-point plan because one point is outlined in five parts. That plan is called Making It Work. It should be called Making It Up, because it is clear that they have not consulted doctors or nurses or the community and have not carried out any costings.

A closer inspection of the two-point plan reveals that the Opposition has accepted four of the Garling recommendations—only four. One of their plans is the complete opposite to what Commissioner Garling recommended: the proposed return to hospital boards and more than double the number of area health services from eight to 20. This will deliver not one new hospital, not one extra nurse, not one doctor, not one new dialysis chair, not one new cancer centre. All it will deliver is $300 million for new health bureaucrats. They are the achievements and that is the comparison with the alternative.

The Hon. GREG DONNELLY: Minister, what is the latest information on the fight against cancer in New South Wales?

The Hon. JOHN HATZISTERGOS: I am very grateful for this opportunity to be able to provide some information on the major achievements of the Government in this area. Instrumental in the campaign is, of course, the Government's establishment of the Cancer Institute in 2003. It was the first statewide government-supported cancer control agency. It was a government agency that was charged with some extremely important tasks, increasing cancer survival rates for cancer patients, reducing the incidence of cancer in the community and improving the quality of life for cancer patients and their carers. Professional input from the Cancer Institute has enabled the Government to lead the way nationally and internationally with tough new legislation to protect children and young people from tobacco-related harm.

In 2008, the Government introduced world-class legislation to ban the display of cigarettes in shops and other retail outlets, with the aim of denormalising tobacco products for children and young people. The legislation also provided for on-the-spot fines for people smoking in a car with a child inside and therefore enforcing a decrease in children's exposure to environmental tobacco smoke. These new laws also include a negative licensing scheme for tobacco retailers, banning tobacco from store shopper loyalty programs and increasing the penalties by up to tenfold for offences such as selling cigarettes to children. These new laws commenced on 1 July with some phase-in periods applying to enable businesses to plan for compliance. Australia is at the forefront of tobacco control and it is the Government's intention to demonstrate leadership in New South Wales in protecting children from the harmful effects of tobacco. Each year in this State smoking causes more than 6,500 deaths and the Government is determined to reduce these preventable deaths.

In line with its overall aims, the Government has implemented many initiatives to improve the provision of cancer services in rural areas. Rural health services invest in cancer treatment services as part of planning in response to local needs. In addition, the New South Wales Rural Health Plan provides an additional $2 million annually to complement existing services. These specific enhancements include chemotherapy clinics at Lithgow, Parkes and in the New England area; expanded services on the North Coast, including the employment of a breast cancer clinical nurse consultant; additional cancer clinics at Moruya, Bega, Goulburn and Young; an arrangement for public patients to receive chemotherapy and radiotherapy at the Riverina Cancer Care Centre; expanded cancer services in Dubbo, including a lymphedema service; expanded palliative and

outreach services at Mudgee; expanded cancer services in Broken Hill; an expanded allied health service at Coffs Harbour-Port Macquarie and oncology services to augment the cancer services provided by medical and nursing staff; expanded outreach oncology services at Muswellbrook; expanded oncology services at Shoalhaven; and the establishment of the Milton oncology clinic.

The North Coast Cancer Institute at Coffs Harbour and Port Macquarie was established in 2007 and radiation oncology treatments commenced in Coffs Harbour in May 2007 and in Port Macquarie in August of that year. More 900 patients have been treated from the commencement in 2007 to the end of 2008. The second linear accelerator at Coffs Harbour has been installed and should commence operation later this year. Two linear accelerators commenced operation at Calvary Hospital in June 2007 and will provide increased capacity for patients in the New England area, bringing our service capacity to five machines at that centre. The Lismore Integrated Cancer Centre, the third site of the North Coast Cancer Institute, is on track for the commencement of radiation oncology services in 2010. In addition, $16.8 million has been allocated this financial year to complete the integrated cancer centre development at Lismore. The total cost of this service is $27 million. The Orange radiotherapy service will provide services close to home for residents of the Central West whether they are in Orange, Dubbo. Parkes, Forbes or Mudgee.

Under the Public Health Outcomes Funding Agreement, the New South Wales Government and the Federal Government jointly fund breast screening services in this State. Breast screening is crucial to the detection of breast cancer and the reduction of mortality from this disease. This year, $42 million is being invested in BreastScreen New South Wales. Breast cancer is the leading cause of cancer in women, and one in 11 women have developed the disease by the age of 75 and one in nine by the age of 85. About 12,000 women are diagnosed with breast cancer every year in Australia. The chances of survival from breast cancer are improving, with a 97 per cent chance of survival if it is detected early. Deaths from breast cancer have declined by 14 per cent in the past 10 years.

BreastScreen New South Wales, as part of BreastScreen Australia, is a population-based screening program aimed at enabling the early detection of breast cancer through the provision of free mammographic screening. It is open to all women over the age of 40, but the 50 to 69 age group is the target group. More than 70 per cent of breast cancers occur in women aged 50 and older, and that is the age group for whom mammograms are most effective. This financial year, BreastScreen New South Wales will complete the digital mammography equipment rollout that was commenced last financial year. This will provide faster results and better detection and it will ultimately save more lives. In particular, this new technology will enable higher quality breast screen images to be transmitted electronically from screening centres to well-resourced central X-ray reading rooms for analysis by experienced radiologists. However, I stress the importance of educating women about screening, particularly the fact that a full recovery is almost always certain if it is detected early.

The Hon. GREG DONNELLY: Thank you for that detailed answer, Minister.

The Hon. TONY CATANZARITI: What is the Government doing to deliver ambulance services to the people of New South Wales?

The Hon. JOHN HATZISTERGOS: In 2009-10 the Government is investing $405 million in ambulance services. That is $65.3 million more than the budget last year and an increase of more than 19 per cent. Key features of the 2009-10 budget are an additional $4.8 million to fund the purchase of new helicopters and $3.4 million to expand the extended care paramedic program. Our ambulance service is one of the best performing in the country. However, the pressures on our service and paramedics are intense. In 2008-09 there were 1.1 million ambulance responses to emergencies and non-emergency incidents. Average daily demand for ambulance services has grown by almost 7 per cent over the past two decades, and from 2002 daily demand has increased by 22 per cent.

The requirement to respond immediately to life-threatening incidents places considerable pressure on ambulance operations. In prioritising emergency triple-0 calls, New South Wales is in line with modern ambulance services in ensuring the best response possible. This Government has made significant investments in the ambulance service. That investment has ensured that, despite increasing demand, response times have remained stable overall. In 2008-09, the budget provided the funding necessary to complete the final year of the implementation of the Sydney Metropolitan Strategy. The final 95 new staff were recruited by December 2008.

The Ambulance Service continues to implement reforms to ensure minimal impacts on response times and to improve services. Regular adjustments are made to ambulance crew deployments to better match

available resources to known demand patterns in Sydney. Ambulance liaison officers in Sydney, Newcastle and Wollongong continue to improve communication between hospitals and the Ambulance Service and ambulance and area health services staff continue to work closely to improve the way ambulance patients are allocated across the hospital network to manage clinical conditions and emergency department capacity.

As we all know, ambulances are a vital part of patient treatment rather than just a transport service. Many members would be aware of the coronial inquest into the tragic death of David Iredale and the Coroner's recommendations. I again extend my sympathy to David's parents, his family and his friends. The Ambulance Service receives more than one million calls a year. However, the handling of David's calls was unsatisfactory and it has been the subject of some criticism. The Coroner handed down three key recommendations: the establishment of an agency working party; software improvements; and a root-cause analysis.

Senior officials from the Ambulance Service, the State Emergency Service, New South Wales Fire Brigades, the National Parks and Wildlife Service and Telstra have established a group to review the structure, operations and management and training of staff at triple-0 emergency call centres. The members of the group are assistant commissioners and the Department of Premier and Cabinet has a coordinating role. The group has met twice and is making progress in developing a detailed response to the Coroner's recommendations. The Ambulance Service has already made moves to implement the Coroner's recommendations.

One of the criticisms levelled by the Coroner related to how call centre operators deal with calls where there is no actual street address. About 4 per cent of calls come from national parks, beaches or other remote locations. When a call comes through with no street address, a senior supervisor now immediately takes control. The supervisor will work with the caller to identify local landmarks and with agencies such as the State Emergency Service and the Police Force, who have local knowledge that can make everything happen more quickly.

The second recommendation proposes that the Ambulance Service immediately address the limitations of its existing software package and database so as to more effectively deal with taking, logging, recovery and transfer of emergency calls. One of the issues was the ability to send the audio of the call to another emergency service. We do have that capacity and procedures are now in place where they can be emailed. We are also working with the Commonwealth to give emergency service operators information about where anyone on a mobile phone is calling from. The technology exists to pinpoint a person's exact location. However, we need further cooperation from the Commonwealth and phone providers to achieve that.

The coroner also recommended that the Ambulance Service carries through an internal review and root cause analysis of its involvement in the Iredale incident, examining conduct and system issues. Importantly, we are determined to take this one step further and engage two experts from outside New South Wales, including one from Victoria. The root cause analysis made six recommendations that the Ambulance Service has either implemented or is in the process of undertaking. The Ambulance Service has commissioned the development of a program for technological changes at the ambulance operations centre to assist call takers to identify repeat callers, to develop new procedures for call takers and for incidents in remote locations, and to develop a joint protocol with police on sharing information.

The Ambulance Service is also reviewing current resources and policies in relation to the development of a protocol whereby call takers could relay survival instructions to callers. It is important for people to have confidence in our ambulance service and know that in the event of a medical emergency they should call triple-0 and ask for an ambulance.

CHAIR: There is some time left. I propose to divide the remaining time equally between Coalition members, the crossbench and Government members. Minister, we have discussed a broad range of issues today about a number of matters, but in relation to obesity I want to ask you a few questions about the treatment of obese patients. Principally, how many hospitals have been upgraded in line with your Government's commitment to allocate funds to treat these patients? Those commitments included enlarged wards and operating theatres with lifting and other specialised equipment needed to treat obese patients.

The Hon. JOHN HATZISTERGOS: I would have to take that on notice. However, it is not just hospitals, it is also the ambulances.

CHAIR: Yes, but this is specifically about hospitals. There was a commitment from the previous health Minister and a strategy rolled out. I just want to know how many hospitals. If you want to take that on notice, that is fine.

The Hon. JOHN HATZISTERGOS: Are we just talking about acute care?

CHAIR: We are talking about the commitment your Government gave to treat obese patients. That included bariatric surgery in particular.

The Hon. JOHN HATZISTERGOS: Bariatric surgery we are now providing.

CHAIR: In how many hospitals?

The Hon. JOHN HATZISTERGOS: It is a specialised procedure and the surgical services task force, I think, has worked on it.

Professor PICONE: If I can answer broadly and then get the particulars?

CHAIR: In the interest of time, if you can just give us an indication of how many, because it was to be rolled out across a number of health services.

The Hon. JOHN HATZISTERGOS: We will take it on notice.

CHAIR: We want to know how many have been undertaken, how many are providing those services. Also, in relation to that, one particular hospital was Sutherland hospital. Can you tell us how much staff time is involved and what the cost of staff time in terms of planning has been?

The Hon. JOHN HATZISTERGOS: Planning?

CHAIR: Planning for the bariatric surgery alterations that I mentioned before.

The Hon. JOHN HATZISTERGOS: I will take that on notice.

CHAIR: And also when the proposal is for that unit to be established at Sutherland hospital—in other words, a timeline?

Professor PICONE: Can I answer some of these things generally and then get the particulars? We have always undertaken bariatric surgery for very extreme patients. You are quite correct, about 18 months or two years ago the Government announced a strategy which was a combination of medical clinics so the patient would come in and have an endocrine and other assessments and, if necessary, would move into bariatric surgery. The program was going to go out across the system over two to three years and sites were identified for that. I know about the Royal Prince Alfred unit. I cannot bring any of the others forward, but we can take that on notice and provide it to you.

CHAIR: Thank you. It is really a progress report across those six area health services and, particularly, the question about Sutherland. Perhaps you could also take on notice what your plans are for those patients who have been categorised as being at risk while they wait for the rollout of those services?

Professor PICONE: The clinical side of this, the protocols, were developed by the surgical services task force. Remember there was never any intention, nor would it be clinically appropriate, to be undertaking bariatric surgery as much as we see it in the private sector. Diabetes was added as a criterion that is not necessarily the case in the private sector. I can take that on notice and send that information through to you. It is quite different. We are not planning to set up the processes you are currently seeing being provided in the private sector. It would be deemed to be clinically inappropriate.

The Hon. MARIE FICARRA: You might take my question also on notice, because it is quite lengthy. In regard to each of these hospitals, promised new hospitals, Northern Beaches hospital, Bega Regional Health Facility, Tamworth hospital, Wagga Wagga hospital, Dubbo hospital, Parkes hospital, Forbes hospital, can you provide what is the time frame for the development of each of these facilities, when will construction start on each, what is the expected completion date of each and how much is the estimated cost of each project,? Did

you apply to the Commonwealth for funds from the Commonwealth health and hospitals fund for any or all of these projects? If not, why not? If so, were they not approved? Why were they not approved, given the substantial funding provided to other States? I do not expect you to go through it now, but if you could take that on notice?

The Hon. JOHN HATZISTERGOS: We will provide you with as much information as we can. As you know, a number of those hospitals are in planning, and the planning will inform the time frame. That also includes community consultation because, as you know, in a number of these centres you can get community disputes developing, as has occurred with Parkes-Forbes and has also occurred with Bega-Pambula, which need to be taken into account.

The Hon. MARIE FICARRA: Sure. I am sure you will include that in your answer.

The Hon. JOHN HATZISTERGOS: We will.

The Hon. MARIE FICARRA: Shifting to radiotherapy questions: In June this year the Audit Office recommended that New South Wales Health establish centralised booking systems for radiotherapy by December this year. Can you advise whether this recommendation is on track for implementation, whether there is any cost in implementing the centralised booking system and has provision being made for this in the budget?

Dr MATTHEWS: Yes, the recommendation is on track. The second part of your question, about how much the systems will cost, I will have to take on notice. I do not have that in my head.

Professor PICONE: Can I just add that our system of waiting times for radiotherapy is so well regarded that other jurisdictions around Australia will be following our system and are taking it up.

The Hon. MARIE FICARRA: Can you confirm the completion date for the development of the cancer centre at the Orange Base Hospital, including the estimated date from which the radiotherapy service can be provided? If you do not have that on hand, that is fine. A similar question about the cancer centre at Lismore Base Hospital, again, can you tell us the estimated date that radiotherapy services will be provided? As part of the development of the cancer care centre at Lismore hospital, what provision has been made for patient accommodation? I do not expect you to have that in front of you.

Professor PICONE: I was only up there two weeks ago. The building is going up. I cannot give you the exact dates. We have been negotiating to provide accommodation locally as well and I think that is nearly completed. We would be best to take that on notice.

The Hon. MARIE FICARRA: In May of this year the Cancer Council of New South Wales reported in its "Improving Radiotherapy" paper that in some parts of New South Wales the only radiotherapy treatment centre is private. They used examples of the Riverina and the Central Coast. In these areas local residents have to choose between paying the cost charged by the private provider or travelling further afield.

The Hon. JOHN HATZISTERGOS: We provide some services through those centres.

The Hon. MARIE FICARRA: The Cancer Council of New South Wales recommended that NSW Health should establish a funding mechanism to purchase treatment from the private providers in those areas—

Professor PICONE: We already do.

The Hon. JOHN HATZISTERGOS: We do that.

The Hon. MARIE FICARRA: —so that patients are not required to pay the gap fee. Does NSW Health have data on the number of patients who travel out of the area because they cannot afford to use the private centres closer to home, and has NSW Health developed a model for purchasing services from the private providers so that these cancer patients can access radiotherapy treatment locally? They seem reasonable requests.

Dr MATTHEWS: There are a couple of issues in there. One is, of course, there is a medical benefits schedule [MBS] rebate for these services and that is set by the Federal Government through the Health Insurance Commission. The amount of co-payment that the private sector can charge is, of course, entirely a

matter for them and it cannot be restricted either by the State or the Federal governments. There is also a cash flow issue in that the MBS payment is not paid until the treatment is finished, so the patients cannot access their moiety but in many cases are required to pay as they go for treatment that goes over three months.

So there are a number of quite tricky issues there. The Health Insurance Commission, the Federal Government, could resolve that one with the stroke of a pen by making the MBS payment available in a staged way so that the cash flow problems of the providers and the patients could be resolved and that would have no cost implications for the Federal Government—merely a cash flow implication.

The Hon. MARIE FICARRA: That is a very good suggestion. Has that been passed on to the Federal Government?

Dr MATTHEWS: Absolutely.

Professor PICONE: We regularly pass suggestions on to them. Sometimes they do not take our suggestions up, though.

Dr MATTHEWS: The second part of your question, we can attempt to provide the numbers. I should point out that sometimes the place in which people receive their treatment is the result of doctor's referral patterns. The fact that a patient goes from Wagga Wagga to, say, Royal Prince Alfred is not necessarily related to cost but whether or not the general practitioner has referred them to Sir Lancelot Spratt.

Professor PICONE: Can I add that we do have arrangements where we do purchase services on behalf of our patients from private sector providers, particularly chemotherapy, and the Riverina, of course, is one of those arrangements where there are not out-of-pockets for patients. We can give you details on those areas.

The Hon. MARIE FICARRA: The Audit Office report listed geographic areas in New South Wales of need for radiotherapy. It listed the Central Coast, the Hunter-New England and the Illawarra-Shoalhaven. What provision is being made to address the need for radiotherapy in these areas?

The Hon. JOHN HATZISTERGOS: We can give you that information. There will be another estimates hearing, as I understand it, where the Minister Assisting the Minister for Health (Cancer) will appear. Some people from the Cancer Institute will no doubt be present and they will be able to respond to some of those issues. I am not saying that to preclude you from asking the questions. We will certainly take those matters on notice and provide you with additional information.

The Hon. MARIE FICARRA: Thank you. On 31 August the New South Wales Government announced the appointment of a project management firm to plan the expansion of radiotherapy services on the Central Coast. When does NSW Health expect that expanded radiotherapy services will be available to these residents on the Central Coast? I believe it is a very heated issue that has received a lot of media attention, with patients claiming a lot of inconvenience?

The Hon. JOHN HATZISTERGOS: The Government does understand the need for cancer treatments close to home, particularly services like radiotherapy. I know there is a strong push for a radiotherapy facility to be provided on the Central Coast and that is a key issue for many patients and families. Radiotherapy services, as everyone would be aware, are highly specialised. They require a specialised workforce and very large investments for the establishment and maintenance of those services.

Often there is not a quick solution to the provision of such services in all the locations where it is demanded. In relation to this specific area, the Northern Sydney Central Coast Area Health Service has implemented transport strategies to improve services for public inpatients in the short term. The Government will be submitting a proposal to the Commonwealth for consideration as part of the regional cancer centre's initiative, which forms part of the health and hospitals infrastructure fund. We are delighted to have a Commonwealth Government at last that is interested in funding hospital infrastructure.

We are currently awaiting the publication of the principles for the initiative and confirmation of submission time frames. In the meantime, consultants have been appointed to undertake more detailed planning for consideration of all the potential options for the expansion of these services. The Government has increased access to radiotherapy over the last decade by some 30 per cent, but I do understand that there is a need and demand for us to be able to expand radiotherapy services across different parts of the State. We will continue to

work with the community across New South Wales to ensure that the best access is able to be provided and also the best treatment.

The Hon. MARIE FICARRA: I have one last question, and it arises from a matter reported in today's media, from the *Dubbo Daily Liberal*, which quotes the Dubbo Base Hospital Chief Executive Officer, Brian Semmler, saying that NSW Health case mix funding proposal will turn an already troubled hospital system into a system that is set to crash. He criticises the case mix funding for the Greater Western Area Health Service, which, as you know, applies to many hospitals. Can you elucidate on this criticism?

The Hon. JOHN HATZISTERGOS: He is not the general manager.

The Hon. MARIE FICARRA: This is the former Dubbo Base Hospital chief executive officer, Brian Semmler, criticising NSW Health case mix funding, saying it is a complete disaster for the area.

Professor PICONE: Case mix funding and activity-based funding always brings these wide diverging views around policy application. I do not agree with that at all, but I will ask Dr Matthews to talk about how this funding arrangement will work, remembering as part of the Australian health care agreement, each jurisdiction in Australia will be going to a case mix-based funding arrangement as a decision of the Council of Australian Governments [COAG], so we are preparing our jurisdiction for that, clearly.

Dr MATTHEWS: As the director general said, the Council of Australian Governments has made a decision that as part of COAG's interest in healthcare delivery, there will be a nationally consistent approach to episode funding right across the country. The Commonwealth and all the States and Territories have signed up to that. There are a number of important things that need to be said in response to Mr Semmler. Firstly, the introduction of episode funding has not influenced any area health service budget this year. They were set in the usual way.

Episode funding is just a technical tool to assist with technical efficiency. It provides data, which enables peer hospitals—in other words, hospitals at the same level—to have their performance in relation to costs and the efficient delivery of services compared. That is all it does. There is a great deal of misinformation, as the director general said. The hospitals are provided with episode funded budgets based on the peer price and they are expected to perform efficiently as their more efficient peers do.

Professor PICONE: From a transparency point of view, and I think it is also quite helpful from the good citizens point of view, because they can also see how many procedures and what types of procedures are undertaken at an individual hospital. It also provides quite helpful information. It was originally designed, as you know, by a group out of Yale University to describe the work that doctors undertake. Instead of saying we have 60,000 separations, you can say 5,000 are maternity, 5,000 are upper-gastro, and so on. It was originally designed to describe the work we undertake.

The Hon. MARIE FICARRA: No-one is really enamoured by the American health system though?

Professor PICONE: I totally concur with you on that. But not Yale University—they are a very fine group of thinkers. They are quite different to the American Government, I hope.

Reverend the Hon. Dr GORDON MOYES: My question is directed to either the director general or the chief health officer. It seems that the levels of reduced illness and death, in both children and adults, by vaccine preventable diseases have been stable now for quite a number of years. In light of a renewed and very well-organised campaign against immunisation that backbenchers are receiving via emails at the moment—

The Hon. JOHN HATZISTERGOS: From the national vaccination network.

Reverend the Hon. Dr GORDON MOYES: Among others, I think, but certainly that is true. It fills my email box each day. What is the department doing to counter that, and to improve the rates of vaccine preventable illness?

Professor PICONE: I think that is probably the most important public health question that has been asked here today. It is a significant issue which we have been working on, and also providing some national leadership on. I might ask the chief health officer to comment on some of the specifics of some of the programs.

Dr CHANT: Australia has a good track record with immunisation, and New South Wales in turn has an excellent track record. We should remember that we are achieving good childhood immunisation rates. So, while there are a small percentage of the population who are represented with views against immunisation, we should remember that the majority of people are very supportive of immunisation. Some of the important ways we are responding to that is by making it easy for people who wish to get vaccinated, to have their children vaccinated. An excellent example is the rollout of the school-based vaccination programs. We know that is a very easy way of getting school-aged children—who are at a time in their lives when they are not attending general practitioners—vaccinated. Whereas, general practitioners in New South Wales achieve excellent coverage in the early childhood group. In addition, our general practitioners achieve greater coverage for people with chronic diseases with the influenza vaccination.

We are recognising that we need to make sure that people have informed information on which to base their decisions to vaccinate. In all cases, the vaccine side-effects are much less than catching the disease. However, all vaccines have some risks and benefits associated with them, and it is those risks and benefits that sometimes are put out of context by groups that perhaps do not support immunisation. It is important, however, to recognise that that group is a small group and that we have to work on ensuring that people have information. The majority of people when presented with clear, concise information that is factually correct, will decide to vaccinate their children or themselves. In addition, we have to work at systems: making it accessible, making it easy to get people vaccinated, addressing issues of access to general practitioners, and having community health services vaccinate where there may be shortages, particularly in working with indigenous people through Aboriginal medical services to ensure they have access to vaccines.

However, at the last health Minister's conference New South Wales auspiced a paper which encouraged the national Government to increase its activity around a national immunisation strategy. Their work on that had been planned and previously endorsed, but we are very keen to see a national immunisation strategy because that will then provide an excellent platform for ensuring information and campaigns which provide parents and other members of the community with information on vaccination.

Reverend the Hon. Dr GORDON MOYES: As I reply to people who email me, can you make sure I get some factual material?

Dr CHANT: We would be happy. There are a couple of books, which are called *The Myths of Vaccination*, but I think it is appropriate that we relook at the way we provide information. We must also remember that we have to move with generational change in relation to the way younger people are accessing information, and make sure our messages are tailored—

Professor PICONE: But we can provide the material to your office. Your question is very pertinent, given that we are about to embark upon, at a national level, the single largest immunisation program since polio. Being mindful of that, we have been working hard around these issues concerning immunisation. Swine flu immunisation will be the biggest immunisation program since polio.

Reverend the Hon. Dr GORDON MOYES: Make sure those people that will support you have some material.

The Hon. JOHN HATZISTERGOS: We have also pushed, through the health Ministers, for a national immunisation strategy, which can include social marketing campaigns.

Ms SYLVIA HALE: Minister, I want to clarify my earlier question. You said you would take it on notice. The question was: Will the department fund an independent health study to provide data on mining-related illnesses? If you could take that on notice. If you decide not to fund it, perhaps you could explain why.

The Hon. JOHN HATZISTERGOS: I will obtain some more information.

Ms SYLVIA HALE: I now turn to the issue of abortions and abortion law reform. Minister, are you aware of any hospitals, doctors or other health workers in the abortion field who are nervous about, or reconsidering, the provision of abortion services as a result of the upcoming trial of a Cairns couple charged with procuring an abortion under laws that are almost identical to those that prevail in New South Wales?

The Hon. JOHN HATZISTERGOS: The question is argumentative. I am not going to—

Ms SYLVIA HALE: I am just asking you whether you are aware of any hospitals, doctors or other health workers who are reconsidering their position.

The Hon. JOHN HATZISTERGOS: No.

Ms SYLVIA HALE: There are reports—for example, there was one in the *Australian* on 27 August 2009—that New South Wales hospitals have said they will review the case for carrying out abortions on Queensland women travelling to New South Wales because of the situation in Queensland. Have any talks been held with the major hospitals in New South Wales regarding this situation?

The Hon. JOHN HATZISTERGOS: I am not aware of any. I would have to find out.

Professor PICONE: There have been no discussions, that I am aware of as director general, between one hospital and another—

Ms SYLVIA HALE: What about between the department and the hospitals?

Professor PICONE: No. There have been referrals. Richard might know of a little more detail. But I know there has been one referral between one doctor and another.

Dr MATTHEWS: The Queensland issue, in one way, is a bit of a furphy. Under the Australian Health Care Agreement, any patient is free to move across the border and can be referred across the border, and the jurisdiction into which they travel or go is obliged to provide them with treatment and cannot refuse. So, regardless of whether a person comes from across the border, a decision to treat on any illness or any condition becomes a clinical one, according to the usual guidelines. The fact that someone comes from Queensland is, in essence, irrelevant.

Ms SYLVIA HALE: If a person is in Victoria, that State's laws have been amended to completely decriminalise abortion. But, if they go to Queensland, for example, where they may be seeking the identical treatment, they may be subject to legal prosecution?

Professor PICONE: The law in New South Wales holds that termination is a matter that should be determined between the woman and the doctor. I am not running around your question, I want to assure you of that. If a doctor refers a woman to one of our health services, that is a referral that we cannot and would not wish to interfere in. If I want to hop on a plane and go to the Royal Perth Hospital to have my sore toe treated, under the Australian Health Care Agreement I am entitled to do that. You asked whether our doctors or nurses are concerned. I have had no feedback that they are.

Ms SYLVIA HALE: Do you know how many Queensland women have been accepted by hospitals in New South Wales for an abortion as a result of the uncertainty of the suspension of services in that State?

Dr MATTHEWS: No. We do not collect data in that way.

Professor PICONE: We do know who our interstate patients are, but not for the purposes of this.

Ms SYLVIA HALE: Minister, will you ask the Premier to ask the New South Wales Law Reform Commission to conduct a review of abortion laws with a view to decriminalising them in New South Wales, as they are in Victoria?

The Hon. GREG DONNELLY: Point of order.

Ms SYLVIA HALE: Surely it is a legitimate question to ask the Minister whether he will ask the Premier to conduct an inquiry?

The Hon. GREG DONNELLY: I am not sure that question is in order, in terms of asking a Minister to request of the Premier that he carry forth and proceed with a particular action. I thought the nature of the questioning of estimates was to question a Minister with respect to his portfolio responsibilities. That is the nature of the fundamental questions at budget estimates, not making actual requests. There are obviously other opportunities for the member to make requests or invitations in another way—using the forms and the procedures of the House—but not through questioning of a Minister during budget estimates hearings.

Ms SYLVIA HALE: To the point of order: Clearly the state or otherwise of the law in New South Wales has a direct bearing upon the capacity of the hospitals in New South Wales, for example, to carry out abortion procedures. Therefore, if there is an ambiguity or a lack of clarity it is surely relevant to the portfolio that the Minister should seek from the Premier as to whether he will conduct a review.

CHAIR: Does anyone else wish to make a comment?

The Hon. GREG DONNELLY: Yes. The member has simply gone forth and made certain assertions about the position of ambiguity in respect of terminations in the State of New South Wales. I do not believe that is the official position. Indeed, I think in answering one of the earlier questions from the member the Minister made it clear that is not the case. Coming here and making assertions does not make it the case; it just makes it an assertion.

CHAIR: Rather than get into the substantive matter of the question asked, it would be more appropriate if Ms Sylvia Hale were to reword her question in terms of the responsibilities of the Minister for Health about any discussions he might have or undertakings he might make.

Ms SYLVIA HALE: Minister, in terms of meeting your obligations and responsibilities as the Minister for Health, will you ask the Premier whether he will request the New South Wales Law Reform Commission to conduct a review of abortion laws in this State with a view to their decriminalisation?

The Hon. JOHN HATZISTERGOS: I am going to answer your question, but it probably has more to do with my other responsibilities than it does as Minister for Health. I make the point that, first of all, this is a difficult and sensitive issue, and a lot of people in the community have different views in relation to it. No-one has come forward to me and identified any issue with the current law that requires it to be the subject of a review in the way you have suggested. Moreover, there are some logistical issues as well with the Law Reform Commission: it is heavily committed at the moment to assignments I have otherwise given it. As you know, we will be establishing an Information Commissioner early next year. It has a reference in relation to privacy and the interaction between privacy and freedom of information, which I am pushing the commission to finalise its report this year so we are in a position to be able to meet our commitment for early next year—that is a very important priority that it has. Apart from a number of other assignments that it is currently doing, a review on the law of complicity—

Ms SYLVIA HALE: Thank you, Minister, I think you have made your point.

The Hon. JOHN HATZISTERGOS: —the Mental Health (Criminal Procedure) Act and a number of other assignments. There are some logistical issues as well, but I again make the point that the concerns that people have raised in relation to this matter have not been articulated to me in terms of any shortcoming in the law as it stands at the moment.

Ms SYLVIA HALE: But if they are raised you will undertake to look into them?

The Hon. JOHN HATZISTERGOS: If someone comes to me indicating any deficiency in the current law then I will examine it, but at the moment people are saying the law might change or something might happen. As I said, there are balances to be struck in this area. I accept that there are deeply felt views in the community in relation to this. I have indicated previously that the law in relation to this matter is one that essentially makes it a health issue. A procedure can be performed with the consent of a woman by a legally qualified medical practitioner on the grounds that the medical practitioner has an honest belief based on reasonable grounds that it is necessary to preserve the woman from serious danger to her life or her physical or mental health. Of course, those grounds may be medical, economic or social, and in the circumstances the operation is not out of proportion to the danger being avoided.

Ms SYLVIA HALE: Thank you. I turn to the provision of food in hospitals. Given that the Garling report showed that the move to centralise food provision had the potential to raise food prices, reduce freshness and make communication between staff and food providers more difficult, and given that the Garling report showed that one in four older patients becomes malnourished during their stay in hospital, how can you guarantee that this will not occur in New South Wales if the Government's plan to centralise and privatise the provision of hospital food is implemented?

The Hon. JOHN HATZISTERGOS: The centralisation of food, of course, has a number of components to it. The Government spends approximately $300 million on producing patient meals in public hospitals every year. Some 2,800 food services staff are involved in the supply of some 22 million meals to hospital patients. The department is migrating food services currently under individual area health services to its shared services entity, which is HealthSupport. The objective is to improve the quality and safety of food while achieving economies of scale by consolidating and standardising the food supply. To date about half of the food services have transition, with the remainder to be completed by July 2010. Once it is fully transitioned, Health food services will be one of the largest, by volume, food service providers in Australia. This is not new; it has been operating to a limited extent in some of our hospitals. I have sampled the food myself on other occasions and I disagree with your description of it.

Reflective of the changes in the broader community, prepared and pre-packaged food has been an increasing part of the meals supplied to our patients over many years. Of the 22 million meals provided annually, approximately 40 per cent already contain some pre-packaged components. The extent to which pre-packaging prepared food is used in patient meals varies across the health system from individually sourced items, such as cereal, fruit juice and dessert, to fully prepared portion-controlled meals in some places. As outlined in the November 2008 mini-budget, future plans for NSW Health food services include continuing this trend by expanding the strategic sourcing and buying in of pre-packaged and prepared foods. The implementation of these plans takes account of the recommendations contained in the Garling report relating to food.

Specifically, Commissioner Garling recommended that NSW Health improve the packaging and containers used for hospital food so they comply with food safety standards and patients can easily open them. The rationalisation of food services within a shared services model and the expansion of strategic sourcing and buying of pre-packaged food necessarily require less food production units. Currently we have nine, but under the food services strategy this number will be rationalised over time. NSW Health will retain some food production unit capacity to cater for patients with special dietary requirements, children and the elderly. Food production in kitchens in some small facilities and regional remote areas will also need to continue. Advice on food nutrition and appeal will be provided to inform the strategy by an expert group chaired by the Chief Health Officer. This will ensure consistent and nutritional food safety standards are applied whilst providing opportunity to increase the consumer appeal of food and providing greater choice of food to patients.

Receiving kitchens that assemble and deliver meal trays to patients will continue to operate with an appropriate level of staff. While the food services plan involves achieving increased efficiency and an overall reduction in the number of staff involved in food services over time, there will be retraining opportunities for our staff, such as, assistant in clinical support roles. We are committed to consulting with the workforce, unions and staff on how to best progress the food services strategy to improve patient experiences and optimise the cost-effectiveness of these services. We look forward to their cooperation in this endeavour, consistent with the commitments given in the current memorandums of understanding providing for wage increases, which is to work cooperatively and positively with New South Wales Health to facilitate the implementation of clinical, corporate and business reform.

Reverend the Hon. Dr GORDON MOYES: Minister, I have had hospital food. I do not have a problem with its quality; I have a problem with opening the plastic.

Professor PICONE: That is what we are changing. The packaging is being changed. Thank you for complimenting our food. You have asked a very important question about older, longer-term residents. We have about 1,200 longer-term aged care residents within the health system. I was at Coonamble hospital a couple of weeks ago. I thought I was in for a pleasant discussion with eight elderly residents. They said, "So you're the woman responsible for taking our food away."

Reverend the Hon. Dr GORDON MOYES: "How can we eat cheese?"

Professor PICONE: Exactly. I was able to reassure them that we have no intention of taking away their freshly prepared food in their little kitchen at Coonamble. We are obviously using commonsense about people who are with us long term and people who are with us short term in terms of food preparation. That is an excellent question about expecting people who may be with us three or four years to constantly eat the food that Dr Moyes has been eating. It may be a bit much.

CHAIR: Government members now will ask questions.

The Hon. CHRISTINE ROBERTSON: Minister, can you let us know what is happening with the emergency helicopter services?

The Hon. JOHN HATZISTERGOS: In May 2007, following public tender, the Ambulance Service of New South Wales upgraded its emergency medical service helicopters for the greater Sydney area. The helicopters are operated and maintained by CHC Australia, which was the successful tenderer. The Ambulance Service now has five larger and more capable emergency medical helicopters operating from bases in Wollongong, Orange and Sydney under a strict commercial contract. The dedicated backup aircraft came on line in June 2009, providing even greater service continuity. Since commencing operations CHC Australia's contract performance has been exceptional, providing the Ambulance Service with 95.18 per cent availability, representing an average of only 28.3 hours downtime per aircraft per month. Under previous arrangements operators were required to provide 77 per cent availability in Sydney only, with no performance measures for Wollongong and Orange.

The performance by the previous providers was 50 hours downtime per aircraft per month. These figures indicate that under the new contract with CHC Australia the availability of two helicopters in Sydney and the helicopters in Orange and Wollongong has improved by 21.7 hours per month for each helicopter. I mention that because when we went into this there was a lot of controversy. In fact, Peter Debnam, the previous Opposition leader, said that he would rip up the contract if he came to Government. That is the difference in performance since the new contract was entered into. That means safer, more reliable aircraft equating with the aircraft being available to the Ambulance Service for an extra 86.8 hours, or 3.6 days per month. With the increasing availability of helicopters, the Ambulance Service flies an extra 240 missions per year, which is an increase of 14 per cent.

The Ambulance Service provides the doctors and paramedics that work on the helicopters and directs the helicopter tasking and clinical priorities through the Ambulance Aeromedical Operations Centre. The new emergency medical services helicopters are a significant upgrade of the previous helicopters with standard equipment and fit-out to allow interchange between crew and aircraft, better range, and improved capacity to carry patients heavier than 120 kilograms. That was one of the issues with the previous aircraft. It could not take heavy people and they needed to be placed on fixed wing aircraft because the helicopter could not take them and the equipment. The new helicopters also have the capacity to carry additional life-saving medical equipment, improved poor weather performance, better access to backup helicopters to cover scheduled and unscheduled service requirements, and much improved aircraft availability. The three new Agusta AW 139 choppers are operational and the remaining two Bell 412 helicopters will be progressively replaced by two new Eurocopter EC 145 helicopters by the end of this year or early 2010.

In addition to the features I have mentioned, these new helicopters will have an even greater range. They will fly 30 per cent faster and provide improved service continuity through additional backup arrangements. The Government recognises the important contribution made by NRMA CareFlight and the Southern Region Helicopter Rescue Service, which operated the Westpac Rescue Helicopter Service in Sydney. These organisations have provided many years of dedicated service and their assistance ensured a seamless, uninterrupted transition to the upgraded services. Westpac rescue helicopters continue to operate in Newcastle, Tamworth and Lismore. I am advised that the Ambulance Service has negotiated new five-year contracts with the operators of these helicopters. Since the implementation of the new contract the Ambulance Service has negotiated a commercial contract with CareFlight to continue to supply some of the medical staff for the air ambulance helicopter service. CareFlight also continues to operate the head injury retrieval trial. The trial catchment area was expanded to include the Central Coast in December 2007.

The Hon. GREG DONNELLY: One of my earlier questions related to how New South Wales hospitals were performing in relation to the extra demand and pressure placed on them by the swine flu pandemic. Would you comment more generally on their performance and how the health system in general has kept pace with the swine flu pandemic?

The Hon. JOHN HATZISTERGOS: While there continues to be large numbers of presentations of influenza-like illnesses to New South Wales emergency departments, the number of presentations is declining from its peak in mid-July of this year. It is now similar to the largest seasonal influenza peak of recent years. I want to take this opportunity to thank and congratulate the health workforce, which has coped with an enormous increase in presentations. The pandemic has created a unique set of circumstances, which, of course, has had an impact on how hospitals conduct their day-to-day business. But the system flexed up and met the community's

needs. New South Wales is working with the Australian Government and other jurisdictions on the pandemic virus vaccination campaign, initially targeting those at greater risk of severe illness from influenza and people who care for this group.

New South Wales continues to liaise with State and Commonwealth agencies to ensure that appropriate information about preventing the spread of influenza and the importance of early treatment is available to those most at risk of severe illness from influenza. While the current strain of human swine influenza is mild in most people, we remain particularly concerned about people who are at greater risk of developing complications, including pregnant women and people with conditions such as diabetes and heart or lung disease. The New South Wales community and our health experts continue to pay considerable caution to protect our most vulnerable members of the community. To date, estimates produced by New South Wales Health have indicated that the swine flu crisis has cost the State about $75 million. Two-thirds of that figure goes straight to covering core hospitals services, beds and direct patient costs for victims of this global pandemic. That is money that we have not hesitated to spend on services that have saved lives.

A national emergency such as a pandemic is just that—a national emergency. Although States and Territories cannot be expected to bear the financial burden of responding to national emergencies, the Commonwealth has put up a model for funding national medical emergencies that requires a crisis to be 20 times worse than that which we have just gone through before Commonwealth funding kicks in.

That means that the cost of a major health event would have to reach $1.44 billion before the Commonwealth would step in. We want to work cooperatively with the Commonwealth and other jurisdictions around these issues but, quite clearly, this threshold needs to be significantly decreased. There is a nationwide consultation process underway to look at the issues of health reform, led by the Prime Minister. This is an issue that can and should be considered in that context. The Treasurer has already replied to the Federal Treasurer recommending that many arrangements be debated at the Treasurer's ministerial council in Canberra in late October.

CHAIR: Have Government members concluded their questions?

The Hon. CHRISTINE ROBERTSON: Not quite, but the Minister has to go.

The Hon. JOHN HATZISTERGOS: If there are further questions they can be placed on notice.

CHAIR: We will conclude the hearing, noting that the Minister has to leave and that this was the agreed time for completing the hearing. I remind everybody that a number of issues and questions have been taken on notice in the time provided. I note that there will be other questions. I thank everyone for their attendance today and the way in which they have participated in the hearing.

(The witnesses withdrew)

The Committee proceeded to deliberate.