CORRECTED

GENERAL PURPOSE STANDING COMMITTEE No. 2

Friday 26 October 2007

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 5.00 p.m.

MEMBERS

The Hon. R. M. Parker (Chair)

The Hon. D. Clarke
The Hon. A. R. Fazio
Reverend The Hon. G. K. M. Moyes
Ms L. Rhiannon
The Hon. C. M. Robertson
The Hon. M. Veitch

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PRESENT

The Hon. R. P. Meagher, *Minister for Health*

New South Wales Health
Professor D. Picone, *Director General*
Dr D. Robinson, *Chief Health Officer and Deputy Director General—Population Health*
Dr R. Matthews, *Deputy Director General, Strategic Development*
Ms K. Crawshaw, *Deputy Director General—Health Systems Support*
Mr K. Barker, *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

CHAIR: I welcome the Minister and the departmental staff, members of the gallery and members of the Committee. I declare open the inquiry into budget estimates for 2007-08 for the portfolio of Health. I welcome Minister Meagher and accompanying officials to this hearing. At this hearing, the Committee will examine proposed expenditure for the portfolio of Health. Before we begin, I would like to make some comments about procedural matters so that everybody is clear about how I propose to conduct the hearing. First, as many people would be aware the Joint Select Committee on the Royal North Shore Hospital has recently been established to enquire into the quality of care of patients at the Royal North Shore Hospital. Questions regarding the Royal North Shore Hospital should not attempt to debate the unreported proceedings of the joint select committee, but this does not prevent members from asking questions that deal with the subject matter of this inquiry. I will rule questions out of order only if they concern the private deliberations of the select committee.

In relation to sub judice, it is possible that some of the matters raised during the hearings may be the subject of legal proceedings elsewhere. While the Committee may discuss a matter that is being considered by another inquiry, the sub judice convention requires that the Committee members assess the risk that a particular inquiry or line of questioning will prejudice proceedings before a court. In making any ruling on this issue, I will consider these issues as well as the implications of an individual's right to privacy. In relation to broadcasting of proceedings, in accordance with the Legislative Council's *Guidelines for the Broadcast of Proceedings*, I remind members of the media that 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. Most members of the media have been here before. They must take responsibility for what they publish or what interpretation they place on anything that is said before the Committee. There are guidelines by the door for anyone who would like to know what the guidelines are.

Anyone in the public gallery wishing to pass messages must do so through the Chamber and support staff or the Committee clerks. Minister, you and your staff of course are able to pass notes directly to each other. I ask everyone to please ensure that their mobile phones are turned off. The Committee has agreed to a format of the hearing that takes time allocation in order from the Opposition, crossbench and Government members. We will be having a break for 10 minutes after two hours, but if anyone needs a break before then, we will consider it. The Committee has decided on 21 days for a return date for answers to questions that you might take on notice during the hearing. We will proceed to swear in witnesses. Minister, you have already taken an oath.

DEBRA MARGARET PICONE, Director General, New South Wales Health, and

DENISE MARGARET ROBINSON, Chief Health Officer and Deputy Director General—Population Health, New South Wales Health, and

KAREN JANE CRAWSHAW, Deputy Director General—Health Systems Support, New South Wales Health, and

KENNETH REGINALD BARKER, Chief Financial Officer, New South Wales Health, sworn and examined:

RICHARD MATTHEWS, Deputy Director General, Strategic Development, New South Wales Health, affirmed and examined:

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

Ms REBA MEAGHER: The Iemma Government considers the health of the people of New South Wales to be one of its highest priorities. That is why approximately 28 per cent of the 2007-08 budget is now allocated to protect and improve the health of the New South Wales community. The 2007-08 annual recurrent budget for NSW Health has been increased to a record $12.5 billion. That is an increase of $831 million, or 7.1 per cent, compared with last year. The 2007-08 budget also provides for the largest ever health funding to rural and regional New South Wales, with spending of $3.69 billion on health services. This level of spending is an increase of $225 million on last year, or 6.5 per cent.

The 2007-08 budget marks a significant shift towards early intervention through health promotion, disease prevention and health care at home. The aim is to keep people out of hospital and try to ensure that they remain healthy in the community. This sits alongside our longstanding commitment to cut elective surgery waiting times, improve services in our emergency departments, increase access to health services in regional and rural areas and enhance funding for mental health. The Iemma Government has also developed the State Plan. The State Plan sets two surgery targets: that 100 per cent of urgent surgery be undertaken within 30 days, and that 100 per cent of non-urgent surgery be undertaken within 12 months. To this end, New South Wales has worked extremely hard to reduce the number of patients waiting more than 12 months for their non-urgent surgery. In August 2007 there were only 118 patients waiting longer than 12 months compared with January 2005 when this figure stood at 10,514 patients.

The New South Wales Government has funded 1,800 beds and their equivalents in the past three years, 456 beds and bed equivalents in 2007-08, an additional eight intensive-care beds and cots and an additional $18.5 million for more elective surgery. Another State Plan target has been set to achieve the national triage benchmarks for access to emergency departments. New South Wales has made solid progress on this front despite a 10 per cent increase in presentation at emergency departments in the past year. We meet 100 per cent of life-threatening cases. We exceeded the national benchmarks for triage categories 2, 4 and 5, and we significantly improved our performance in category 3, from 62 per cent to 71 per cent.

We have made sustained improvements in recent years and will continue to do so through the following initiatives: $18 million over four years to keep elderly people healthy at home, $8 million over four years to establish 12 new after-hours general practitioner clinics, $5.4 million over four years to recruit and support the emergency workforce, $60 million over four years to support medical education and training, and new initiatives through the Clinical Services Redesign Program, such as additional surgery beds, fast-track zones and additional short-stay units. In terms of readmissions, the State Plan has a target to reduce the readmission of mental health patients to inpatient facilities. Already readmissions have reduced to 10.8 per cent, which is close to the lowest level in 10 years. This has been the result of a considerable investment in extra beds, more community-based resources and a range of workforce initiatives.

We also have a significant capital works program, with the New South Wales Government committing about $2.4 billion towards Health major capital works over the next four years. The 2007-08 asset acquisition program as described in the budget papers is $714 million, and $506 million will be spent to continue work on major strategies that are already under way. The New South Wales public health system is the largest healthcare employer in Australia, with more than 90,000 full-time equivalent staff. The doctors, dentists, nurses, ambulance officers and allied health professionals involved in direct clinical care make up more than 65 per cent of the health workforce. The remaining staff provide valuable support functions to our clinical staff.

Health workforces across the country and the world are experiencing a shortage of qualified health professionals. The seriousness of this issue was reinforced by the Productivity Commission's report on Australia's health workforce in 2005. Despite the international shortage, the Iemma Government has worked hard to attract and retain a sustainable health workforce. Since June 2002 we have increased the number of doctors by 1,500, the number of nurses by 7,216 and the number of allied health professionals by more than 1,000. These increases are a direct result of the Iemma Government's recruitment policies. We have invested an extra $28.7 million over the past two years in post-graduate medical training. This funding has meant that more than 700 training specialist positions in psychiatry, surgery and medicine have improved access to training and built networks in rural and regional hospitals.

Since 2003 more than 150 general practitioners have received skills training in emergency, obstetrics, anaesthetics, surgery and mental health to take up positions in public hospitals. The Iemma Government is working hard to build a strong and stable health workforce. In the face of rising demand for health services in this country we need an increase in the supply of graduates from our universities. Unfortunately, this is a fact that the Howard Government has ignored through a decade of neglect. This year New South Wales asked for an extra 1,769 nursing university places from the Federal Government for 2008. Only 200 were funded. We also asked for 122 additional medical places but none were allocated, 37 additional dentistry places but none were allocated, and 66 additional allied health staff and only 50 were allocated. The lack of graduates domestically has forced NSW Health to look overseas for health professionals. NSW Health is at the moment conducting a major recruitment drive in the United Kingdom. To remove barriers to overseas recruitment the Iemma Government supports the introduction of a national assessment process for international medical graduates.

Since 2000 the Commonwealth has reduced its share of funding to public hospitals from 50 per cent to below 45 per cent. This was confirmed by the Australian Institute of Health and Welfare last month, which showed underfunding of public hospitals by $2.2 billion a year across Australia. Despite rapidly increasing demand, in 2003 the then New South Wales shadow health Minister, Barry O'Farrell, stood in Parliament urging the New South Wales Government to sign the Australian healthcare agreement. We know that the agreement we were forced to sign, with the threat of sanctions and penalties, has ripped off New South Wales to the tune of $750 million every year—and we have had to pick up the difference.

Since 2002 New South Wales has increased spending by 42 per cent compared with 14 per cent from the Howard Government. This Government now spends $1.72 for every Commonwealth dollar on New South Wales public hospitals. Amid all this, John Howard's only solution has been to go back to the future by adding a third layer of bureaucracy with the reintroduction of hospital boards. This Government is already actively ensuring that money is being spent in the most beneficial way by shifting resources away from administration and into front-line health services. The amalgamation of 17 area health services to eight in 2005 has resulted in a reduction in back-of-house services by over 1,000 full-time equivalent staff. This has redirected funding of $70 million per annum to front-line services. Procurement reform has delivered further savings of $68 million per annum through initiatives such as statewide telecommunications contract, targeted procurement savings and corporate contracting. That is a total of $138 million per annum to match growing demand for health services.

I am advised that while back-of-house staff has been reduced since 2004, there has been an increase in full-time equivalent staff, including 856 medical staff, 2,578 nursing staff, 539 allied health professionals and 288 uniform ambulance staff, that is an increase of 4,261 full-time equivalent front-line staff in the areas over the past three years to match growing demand for health services. There are fewer administrators, more doctors, more nurses, more ambulance staff and more allied

health professionals delivering better care to people living in New South Wales. And every single one of them makes a valuable contribution.

The New South Wales health system is one of the most complex businesses in Australia. It admits over 1.5 million patients a year, it treats 23.3 million outpatients and over 2.3 million people present to emergency departments in a year, and we spend over $12.5 billion a year, which is about $24,000 a minute. Nearly 90,000 staff work to deliver the best care they can to the people of New South Wales. In my six months in the job I have made more than 50 visits to hospitals, community health centres and ambulance stations across all eight area health services in New South Wales and I have to say I have been overwhelmed by the commitment of our doctors, nurses and ambulance staff, and other allied health professionals.

Running Health is a learning experience, part of a system designed to learn from itself. We learn from the good things, but with something as important as health we do not sweep things under the carpet. We remain accountable where necessary to improve patient safety and clinical quality across the entire State public hospital network. That is why we have the Clinical Excellence Commission. The Clinical Excellence Commission is a key component of the New South Wales Patient Safety and Clinical Quality Program launched by the Government to improve front-line clinical care.

The program is ambitious and sets the agenda for one of Australia's most comprehensive clinical quality programs. Ensuring patient safety and excellence in health care is the top priority for the New South Wales system. That is why we have rolled out the incident information management system across all area health services. The incident management system has been in place since May 2005 and provides a comprehensive systematic mechanism to enable incidents to be electronically notified and managed. Because the Iemma Government is committed to openness and transparency, New South Wales Health has for the past three years published an annual report on incident management. We are the first Government in Australia to do so.

Another important initiative of the New South Wales Patient Safety and Clinical Quality Program has been the statewide implementation of the open disclosure policy. The open disclosure policy ensures that patients and their carers are informed that an incident has occurred, that an investigation will be undertaken and that patients and their carers will be advised of the results of the incident investigation process. These are the everyday features of our health system, which ensure ongoing improvements in quality of care and patient safety. In addition, we are committed to investigating events when things go wrong so that we can learn how we can make the system better and move forward by strengthening the system. In other words, when things go wrong, we take action.

The tragic circumstances experienced by Jana Horska and Mark Dreyer demonstrate this point. The very morning that this case came to my attention in late September I announced an inquiry into procedures governing the treatment of women presenting with signs of miscarriage. Professor William Walters, head of the Royal Hospital for Women at Randwick, and Professor Cliff Hughes, head of the Clinical Excellence Commission, today reported back to me with their provisional findings. These findings will be used to develop a new model of care for women who present at hospital with signs of miscarriage or complications with appropriate clinical care and emotional support.

Soon after coming to the Health portfolio it became clear to me that there were hospital management performance issues at Royal North Shore Hospital. Parliament is the appropriate forum for an examination of the running of this hospital and I have spoken to Reverend the Hon. Fred Nile and indicated that my department and the staff at Royal North Shore Hospital will cooperate fully with the joint standing committee inquiry. However, we have been active in pushing for change at Royal North Shore Hospital. In her very first week, the new director general of Health replaced the chief executive of the area health service and put in place a new management team. Even through the recent weeks, the team has been getting on with the job of implementing improvements and responding when new issues arise.

There are in fact many positive initiatives being implemented at Royal North Shore Hospital. The issue of bullying has been a concern at Royal North Shore Hospital, having been raised with the former management some time ago. The new management team is now leading the charge for change

and improvement. It has established a professional practice unit, which will directly report to the chief executive on staff complaints. It will also refer patient complaints where appropriate to the Health Care Complaints Commission. When concerns over bullying were raised they were immediately investigated by the new management team.

Vern Dalton and Judith Meppham were commissioned to undertake a complete review, including all previous investigations into allegations of bullying. They completed their report in late September. The report has been released to staff and staff forums have been convened by the new chief executive to ensure that all staff are aware of the zero tolerance policy to bullying and to get their input and support for the implementation of change. An external facilitator, Professor Trevor Waring, the chancellor of the University of Newcastle, was engaged to facilitate these mandatory information and education sessions for all staff.

The new chief executive has established a nursing task force consisting of nurses from across the hospital. The nursing task force now meets weekly and reports to the chief executive on a fortnightly basis. I met with the task force earlier this month to hear firsthand the issues that they were concerned about and to ensure that a plan of action for improvement was developed with the full input of the nursing staff. The task force has developed a plan and a timetable for action to address specific concerns relating to management systems failure on staffing, the workplace environment and management nursing communication issues within the hospital. Improvements in all of these areas will result in improved patient care.

A number of actions have already been implemented including a review of nursing rosters; a review of employment-related processes to streamline the recruitment of nurses; the commencement of a recruitment campaign for the vacant nursing positions and the appointment of a nurse manager to coordinate "nurse link" programs, such as the Nurse Reconnect Program and targeted overseas recruitment. A new clinical reference group has also been established bringing together senior doctors from across the hospital to work with the chief executive to develop and implement a new plan for Royal North Shore. I met with these senior doctors at their first meeting on 2 October and I was impressed by their commitment and their willingness to make improvements at the hospital. They too have committed to giving the new executive team an opportunity to make improvements and to work with them to achieve this goal.

I have visited Royal North Shore Hospital on a number of occasions in recent weeks and I have consulted with the staff. I know that the staff at Royal North Shore Hospital are committed to working with the new management to get the hospital back on the front foot. The Opposition has taken every opportunity to kick down the reputation of the hospital. We have acknowledged that when things go wrong we need to work with our doctors and nurses to improve our system performance. However, when mistakes are made, the Health Care Complaints Commission is the forum to which complaints should be taken. All of these mechanisms are to try to ensure that we make the system as strong as it possibly can be.

As I answer detailed questions as part of this hearing I hope to detail many of the successes which manifest themselves every single day in New South Wales Health due to the amazing work of our doctors, nurses and ambulance staff, and allied health professionals. I welcome the opportunity to share with members of this Committee the many highlights I see on my travels throughout the health system each and every day.

CHAIR: You raised a number of issues in relation to Royal North Shore Hospital, including some of the initiatives you have taken on board in recent weeks since the crises came to light. In relation to the Northern Sydney Central Coast health budget, which shows that the Royal North Shore and Ryde health services budget was overspent by $18 million last year and $18 million the year before, why on earth did you cut the budget by $13 million from $359 million to $346 million this year? Can you explain why you have disputed these figures twice, figures that come directly from the region, claiming that the hospital's budget has gone up by $9.5 million?

Ms REBA MEAGHER: I think you are relying on some incorrect information in relation to the last part of your question. In relation to the first part of your question, I can say quite clearly that there has been no cut to the budget for Royal North Shore Hospital. The operating budget for the hospital has increased by $9.5 million this year and $34 million over the past two years. So the

assertion that you make is incorrect, and I will ask Mr Barker, the chief financial officer, to work through that in detail for you.

CHAIR: The question was not specifically about Royal North Shore Hospital. It was about the whole area health service.

Mr BARKER: In terms of the hospital's budget—and I am aware of the document you are referring to—there are two things that need to be understood. Firstly, the hospital is allocated a budget by the health service. The department and the Minister allocate money to each health service and the health service then has a responsibility in terms of its deliberations, in terms of its community obligations, to allocate money to all the facilities and services under its control. So Ministers per se do not approve a budget for a particular facility. That is the first thing that needs to be corrected. That is done by the health service.

CHAIR: The questions are about the health service in general, not about a specific hospital.

Mr BARKER: You indicated that the Minister approved the budget. What I am saying is that hospital budgets are approved—

CHAIR: The Minister has been out disputing the figures. That is why the question was directed to her. She has been disputing the figures.

Mr BARKER: Then let me just go through this. The next thing to say is that the initial budgets as we call them are allocated at the start of each financial year. They will often vary during the course of the year for a number of matters. When we compare our budgets, we compare initial with initial because that is a level playing field to compare how movements have occurred. We do not compare the final budget of one year to the start of the next year because effectively you are comparing a budget at midnight on 30 June with another number one minute later on 1 July, and some of the things that are supplemented during the course of the year are one-offs in nature and naturally will not be there the next year.

CHAIR: Surely a $18 million overspend two years in a row gives you an indication of what you need to do, that you need to increase the budget rather than cut it.

Ms REBA MEAGHER: Indeed, that is exactly what happens. As you know, this year's budget was a record budget for New South Wales Health, and that is represented also by the increases in all the area health services. For Sydney's South West, there was an increase of 4.6 per cent on last year; for the South Eastern Sydney and Illawarra, the budget increased by 5.3 per cent; Sydney West increased by 6.2 per cent—

CHAIR: No, I am asking questions specifically—

Ms REBA MEAGHER: —and Northern Sydney and Central Coast increased by 5.1 per cent. You said they were general questions about area health services.

CHAIR: No, not about a specific hospital. I am asking questions about the North Sydney and Central Coast budget.

Ms REBA MEAGHER: The real increase was $58.8 million, which represents a 5.1 per cent increase on the budget from the year before.

CHAIR: Can you table documentation that demonstrates that to be the case?

Ms REBA MEAGHER: It is in the budget papers.

CHAIR: So they are different figures from what the North Shore Central Coast health budgetary figures show.

Ms REBA MEAGHER: I do not know what papers you are referring to.

CHAIR: I am happy to table them and then we can read along together.

Ms REBA MEAGHER: That would be very helpful.

CHAIR: For the benefit of *Hansard*, these are the North Shore Central Coast health net cost of services summary, salary summary, overtime summary—

Ms REBA MEAGHER: From when?

CHAIR: That is this year's budget.

The Hon. CHRISTINE ROBERTSON: Are these published documents?

CHAIR: I am sure the Minister and staff would have seen them before. Mr Barker, I am sure you have seen those before.

Mr BARKER: I have spoken to the area about these documents, and these are what is deemed going through all their facilities. The area's view as it has advised the department is different from the view that they have on these documents. They have given us an improved result compared to here. For example, to let you know some of the concerns about reading this, the year-to-date budgets, if you look at the Royal North Shore Ryde figure, it is exactly 25 per cent of the full year budget. One would expect that if you are running a hospital and you have winter, you will vary your cash flow on a year-to-date basis to allow for a higher level of expenditure in the first three months of the year than just simply take 25 per cent.

In fact, what the hospital appears to have done here is just taken a pure 25 per cent and said, "Therefore on the year-to-date basis compared to that, we are overbudget". You would expect if you do that you will be overbudget because you have not factored in seasonality and workloads during that part of the year. Therefore when it is assessed the prediction then appears to be an extrapolation along that path. The area has looked at that information and advised us that they do not believe they will have a $29 million problem but a figure far less than that.

CHAIR: But these figures say that it is $10.4 million overbudget within the first three years. That is 12 per cent. If you keep that going that overrun will be $41.6 million.

Mr BARKER: If you multiply the $87 million by four you will come up with a figure of $346 million. So they have simply cash flowed their budget at one-quarter of the annual budget. Therefore, if you think about it, in hospitals you would have most of your work in winter. Winter normally goes through until late August, mid-September. They have not factored into their budget on a year-to-date basis the seasonality and the workload requirements of the hospital. Therefore, when you look at the year to date you are looking at a false position because they have not cash flowed their budget properly. Therefore when they then come to do the extrapolation of the hospital level they then worked that through on that basis. So their starting point is wrong.

The area has gone through this information, and when they did their analysis they formed the view that the projection of the hospital was substantially overstated so they have now revised that figure down in terms of the arrangements with the area. I have been talking to the area—I was up there last week and I have been up there this week. We talked with area about their financial position. It is a much better position than on this particular table, which was not signed off by the chief executive but somehow it has been released by junior staff, I imagine, within the area without going through a validation process. It is a working document. There are errors in the document, and I can indicate some more errors on the document if you like.

CHAIR: Clearly this area has overrun by $18 million two years in a row so there is something not going well, yet there has been less in the budget. The other point you are talking about in terms of what is expected, my reading of these documents is that there will have to be some claw back. If the budgeting is the way that you say can you tell me that there will not be any cutbacks in order to claw that money back, in order to claw back the 9 per cent overbudget, that there will not be staff cutbacks, that there will not be delays to surgery, that there will not be a position where we will stop surgery in order for that area to reach its budget position?

Professor PICONE: I think we have established that those documents that we are now looking at are not correct, that they have come through some mechanism at the hospital. The area health service is now looking at those. To answer your questions about the budget situation at the hospital, the cash flow has not followed the way we would normally cash flow. These winter months are extremely heavy on goods and services and staff. Normally we would not do a straight quarter extrapolation, and I can absolutely assure you of that. In relation to the Royal North Shore Hospital position, we believe that one area for improvement already identified at Royal North Shore Hospital is the procedure for example for raising revenue and billings. So there is a whole range of activities that every hospital in this State engages in that we will be working on with Royal North Shore Hospital.

Mr BARKER: The other thing I would say is this. The area's unaudited figures, if you are talking about the area health service, its result in terms of two years ago was $9.4 million favourable and its result—it is an unaudited result—last year is about $2 million favourable, which is now subject to audit for its financial statements. An area health service's budget has a range of various components. This component is one component of their overall budget. So it is not as simple as looking at a draft working paper and automatically leaping to a final conclusion. You need to understand, as the Minister said in her opening address, about the complexity of financial management in Health; it is not as simple as running a small business.

CHAIR: I am sure it is not, but I can read from the summary that $18 million was overspent two years in a row.

Mr BARKER: That is not correct.

CHAIR: Do you have an alternative document? Do you have documentation that demonstrates your position?

The Hon. DAVID CLARKE: Minister, do you have any comment to make on these documents?

Ms REBA MEAGHER: I am very keen to give an outline of the activities that are occurring in the North Sydney and Central Coast Area Health Service.

The Hon. DAVID CLARKE: Have you seen this document before?

Ms REBA MEAGHER: They are not documents that would normally make their way to my office, no. As Ken Barker has outlined they are not used in planning the services.

CHAIR: Minister, are you able to table budget documentation that agrees with your position that those figures are not directly from the region and that the budget has not gone up by $9.5 million?

The Hon. CHRISTINE ROBERTSON: Point of order: That was a very confusing question. The papers were from the region. Someone has given you working papers, according to the answer. Therefore, the question was confusing and difficult to answer.

CHAIR: Ton the point of order: I will rephrase my question, so it is easy to answer. If there is a dispute about the budget summary, could you table documentation that demonstrates otherwise because this documentation demonstrates that there is an $18 million overspend two years in a row. It demonstrates that the budget has been cut from $13 million, from $359 million to $346 million this year.

Ms REBA MEAGHER: There is documentary evidence, it is called the New South Wales budget, and it shows that there has been an increase in funding of 5.1 per cent to the area health service, which represents a $58.8 million increase on last year.

CHAIR: Can you categorically tell us that in order to meet the current position that Mr Barker says is at the beginning of the cycle, that there will be an increase? Can you tell us that there will not be cuts to surgery, cuts to staff, in order for that area health service to reach its budget? Currently on the projected figures they will be overspent massively.

Ms REBA MEAGHER: I think Mr Barker has tried to explain politely that it is not uncommon for hospitals to show that they are operating over the budget at the end of a particularly busy winter. There would be nothing particularly unusual about that, but it is the requirement of management to bring those budgets into line.

CHAIR: Where exactly in the budget is the report on the area health service expenses? Is there such a thing?

Mr BARKER: We do not put in the budget papers details for each health service. On budget day the Minister issues a media release that indicates the growth and initiatives of each particular health service.

CHAIR: With all due respect, how are we supposed to find out that information? That is what we would like you to table, if you would.

Mr BARKER: As I said, there is a media release that was issued, including the Central Coast budget.

CHAIR: No, no. This is a simple question. Someone within the 15 staff members here, or at some other point, might be able to give us the actual budget figures for the North Shore Central Coast Area Health Service to demonstrate your position.

Dr MATTHEWS: In relation to the assertion that they have been well over budget two years in a row, the 2005-06 year is available in the annual report. As Mr Barker said, they were about $9 million favourable. In relation to the last financial year I think he said that they were $2 million favourable, sorry, unfavourable, but that is yet to be determined by the final audited report. In relation to this financial year, I think he said that the area incorrectly cash flowed its budget without appropriately taking into account the winter activity, and he is now working with them to appropriately and correctly cash flow their budget to show that their final position at the end of this financial year will be fairly close to budget.

CHAIR: Is the summary sheet that I have provided to you in correct?

Mr BARKER: The summary sheet you have provided dated September, from talking to the director of finance in the Northern Sydney Central Coast is an internal working document released by a junior staff member, has not been verified that all by the director of finance or other senior staff, including the chief executive in the area. Therefore, in my view it has no standing whatsoever until the chief executive and the director of finance, in their normal responsibilities, go through a process and verify it. Prior to this coming to our attention to date ago they had already reported to us of their assessment of every facility within the health service, as required. The figure for Royal North Shore-Ryde is substantially less than in the internal working document you have given to us.

CHAIR: So would you provide that to the Committee?

Mr BARKER: Will I provide what?

CHAIR: The budget information.

Mr BARKER: The budget information I have here. I have some information on expenses if you want that.

Ms REBA MEAGHER: But also to assist the Chair, these accounts are audited and published annually and we are more than happy to also provide the Northern Sydney Central Coast if that would assist you.

CHAIR: Thank you.

Reverend the Hon. Dr GORDON MOYES: Madam Chair, on that point you need to follow up the line to get some financial people to realise how frequently winter occurs, so the budget can be adjusted annually to take winter into account.

CHAIR: Absolutely.

Reverend the Hon. Dr GORDON MOYES: And flu epidemics as well.

Professor PICONE: You cannot predict flu epidemics. Reverend the Hon. Dr Gordon Moyes is quite correct about the cash flow.

The Hon. DAVID CLARKE: Good afternoon, Minister.

Ms REBA MEAGHER: Hello.

The Hon. DAVID CLARKE: It is fair to say that you have had a rocky road since you became the Minister for Health, have you not? That is with the media and doctors and legions of unsatisfied patients.

Ms REBA MEAGHER: I have made the point that I always knew Health was going to be a challenge. My experience of recent weeks has confirmed that.

The Hon. DAVID CLARKE: It has certainly been a challenge for you. At any time since you became Minister have you asked the Premier to be relieved of your portfolio, or to be shifted to a less onerous portfolio?

Ms REBA MEAGHER: Absolutely not.

The Hon. DAVID CLARKE: Okay. Has the Premier at any time warned you that if your performance does not improve he will have to relieve you of your position?

Ms REBA MEAGHER: I have the full support of the Premier—no ifs, no buts.

The Hon. DAVID CLARKE: He supports you fully?

Ms REBA MEAGHER: Yes.

The Hon. DAVID CLARKE: He has not expressed any concerns to you whatsoever about your running of the department?

Ms REBA MEAGHER: I work very closely with the Premier on the administration of Health in New South Wales and he has expressed to me, on numerous occasions, that he has confidence in my ability to do this job.

The Hon. DAVID CLARKE: So, in view of all the adverse publicity that you have had over the past few months, virtually since the day that you took over the portfolio, the Premier has never once expressed to you any concern about any matter relating to the running of your department?

Ms REBA MEAGHER: Do you have a question about the budget?

The Hon. DAVID CLARKE: Yes, I have that question. It is an opening question to match your opening statement. It is a very simple question. Has the Premier at any time expressed to you his concern?

Ms REBA MEAGHER: I have answered your question.

The Hon. DAVID CLARKE: With great respect, I am asking you a very simple question. Has the Premier at any time expressed concerns to you?

Ms REBA MEAGHER: I have answered your question.

The Hon. DAVID CLARKE: With great respect, Minister, you have not. Is there a point in time when, if things do not improve, you would be prepared to offer your resignation to the Premier?

Ms REBA MEAGHER: I am determined to work with our doctors and nurses to overcome the challenges across the New South Wales health system so that we can deliver a first-class system for the families of New South Wales. I am 100 per cent committed to that task.

Professor PICONE: Could I comment about the assertion. The Minister has received—and I have worked in the health system for 33 years, so I am in a place to make a comment—a great deal of support from clinicians, doctors, nurses, allied health and ambulance officers. In fact, on Wednesday night a group of our most senior clinician leaders from across New South Wales met with the Minister to talk with her, one on one, around issues such as too much red tape in Health. I do not support the assertion that you made earlier in your statement. I feel that I should at least put that on the record.

The Hon. DAVID CLARKE: Thank you, Professor. I will refer to the support that the Minister receives from clinicians in due course.

Reverend the Hon. Dr GORDON MOYES: I wish to ask the Minister a question that I am sure she can answer quite easily. The Australian Medical Association [AMA] produced that report card on hospitals in New South Wales as well as public hospitals throughout Australia in general. Speaking about them you said that there were two problems and that the first was inadequate funding. I know that you have addressed that issue and the approach has been to blame the Federal Government for inadequate funding. The second was the poor management of public hospitals. You cannot blame the Federal Government for the poor management of public hospitals. In your opinion, what are the reasons causing this poor management, according to the AMA?

Ms REBA MEAGHER: The AMA report demonstrated that there had been a remarkable improvement in the performance of hospitals in New South Wales. It cited a 30 per cent reduction in access block since 2004.

Reverend the Hon. Dr GORDON MOYES: Minister, you know as well as I do that if you start from a very bad base you can obviously have a good improvement. However, that was not my question. I asked: What is the reason for the AMA declaring that there was poor management in public hospitals?

Ms REBA MEAGHER: I come back to the point that the report card put out by the AMA demonstrated that there have been very good management improvements in the patient journey. One of those was a 30 per cent reduction in access block since 2004, which is a terrific improvement. Great credit needs to go to our doctors and nurses for being able to achieve that result.

Reverend the Hon. Dr GORDON MOYES: I think you are ducking the issue. Did Dr Rosanna Capolingua state, "The entire system is in crisis"?

Ms REBA MEAGHER: Again I come back to some of the points that I made in my opening statement about the hard work that has been undertaken by our doctors and nurses to improve the performance of health in New South Wales. One of the areas in which it has been particularly notable has been through our Predictable Surgery Program. We have been able to reduce long waits for open surgery—

Reverend the Hon. Dr GORDON MOYES: Minister, I ask you not to skate off onto other subjects. I asked you a very simple question.

Ms REBA MEAGHER: These are fundamental indicators of performance.

Reverend the Hon. Dr GORDON MOYES: She said that the entire system is in crisis, and she indicated that there were two reasons for this poor management. Did she or did she not say that?

Ms REBA MEAGHER: I stand by my statement about the demonstrable improvement in performance in the health system in New South Wales. I have always said that there are opportunities to continue that improvement. The best opportunity we will have to achieve that is with a cooperative and committed Federal partner. That is why I am keen to see Kevin Rudd elected in the upcoming Federal election. He has already indicated—

Reverend the Hon. Dr GORDON MOYES: You are skating off the issue again. Could you please leave out those political comments and give me an answer relating to the problem within your jurisdiction?

Ms REBA MEAGHER: He has already indicated a willingness—

Reverend the Hon. Dr GORDON MOYES: You are responsible for the management of our public hospitals. You have not answered the question I asked you which was: In the face of criticism that our system is suffering from poor management, what are the reasons for that?

Ms REBA MEAGHER: I have already indicated in my opening statement—and I will reiterate it—that there has been a demonstrable improvement in the performance of health in New South Wales in the triage categories, in surgery and in improving patient flow through our hospital system.

Reverend the Hon. Dr GORDON MOYES: That was not my question.

Ms REBA MEAGHER: We also—

Reverend the Hon. Dr GORDON MOYES: I did not ask you what percentage improvement there has been; I simply asked you what were the reasons for this poor performance?

Ms REBA MEAGHER: I cannot agree with the premise of your question. There has been demonstrable improvement in performance areas and there is room to improve. We are committed to working with our doctors and nurses and, more importantly, with a Federal government that is committed to public health care.

Professor PICONE: I do not understand what the word "crisis" means, except I know that people use the word.

Reverend the Hon. Dr GORDON MOYES: Could that be part of the problem, Professor, that you do not understand what is a crisis?

Professor PICONE: I understand what is a crisis. I can assure you—

Reverend the Hon. Dr GORDON MOYES: Which of those two statements is right—that you do not understand it, or that you do understand it?

Professor PICONE: The incorrect use of the word "crisis". I will just give you an example. I am going to contest your thesis—

Reverend the Hon. Dr GORDON MOYES: It is not my thesis; it is the thesis of the AMA.

Professor PICONE: Well, the thesis that it seems to me you imprudently put on behalf of the AMA. The report of the Australian College of Emergency Medicine took a nationwide snapshot of emergency department functions in June 2007—this year—when the alleged AMA crisis was occurring. It revealed that New South Wales emergency departments performed the best of the five States. It is not a government report or a Federal Government report; it is a report from a college of emergency medicine.

Reverend the Hon. Dr GORDON MOYES: Can I follow this up with a question—

Professor PICONE: I do not think that is sign of a system in crisis, by whatever definition.

Ms REBA MEAGHER: I also think it—

Reverend the Hon. Dr GORDON MOYES: A good way to answer a question is by pointing out that you have other information that you want to give.

The Hon. AMANDA FAZO: Point of order: Reverend the Hon. Dr Gordon Moyes should be asked to stop talking when a witness is giving an answer because, quite frankly, I cannot follow what is going on.

Reverend the Hon. Dr GORDON MOYES: I would be very happy not to talk over a witness. I will talk slowly so that the Hon. Amanda Fazio can understand it.

The Hon. AMANDA FAZIO: That is patronising behaviour from Reverend the Hon. Dr Gordon Moyes.

Reverend the Hon. Dr GORDON MOYES: Professor, I remember—

Ms REBA MEAGHER: I think Dr Matthews indicated that he would also like to make a comment.

CHAIR: Order! Reverend the Hon. Dr Gordon Moyes is frustrated, as he is not getting quick answers to his questions. He has agreed not to talk over witnesses. If we received direct answers to our questions these proceedings would flow more smoothly and we would all be able to pay attention.

Dr MATTHEWS: I wish to respond to Reverend the Hon. Dr Gordon Moyes. Assertions about poor management and crisis are easy to make, and anybody can make them. If they are to have credibility they have to be backed up by data. As the Minister and Professor Picone said, the performance of the system in New South Wales has improved dramatically and, in many areas, is the best in the country—not in every area, but in many areas. So those who make assertions of poor management need to back up those assertions with some kind of data that demonstrates their assertion.

Reverend the Hon. Dr GORDON MOYES: Dr Matthews are you are saying that the AMA is not credible on those issues?

Dr MATTHEWS: Having examined the report that it put out this morning, I state that it was a very superficial analysis of the situation in the health system.

Reverend the Hon. Dr GORDON MOYES: That is a clear answer, thank you.

Dr MATTHEWS: I would be prepared to debate the matter with the AMA at some length. It has already made a decision about contacting the good doctor to have that discussion, because I do not agree with the assertions that she has made.

Reverend the Hon. Dr GORDON MOYES: Professor Picone, following up on performance, which is something you were talking about earlier, in a meeting such as this I remember the laudatory manner in which Dr Stephen Christley was appointed as chief executive of the North Sydney and Central Coast Area Health Service. Is it correct that he was terminated not long after your appointment?

Professor PICONE: Yes, it is.

Reverend the Hon. Dr GORDON MOYES: Were you responsible for that decision?

Professor PICONE: After discussion with him, yes, I was.

Reverend the Hon. Dr GORDON MOYES: Did that have anything do with poor performance?

Professor PICONE: It had been brought to my attention at the time of my appointment that there had been issues to do with performance, both at Royal North Shore Hospital and generally

within the area health service. I am just getting some notes so that I can give you the correct advice. The major area of concern was around issues such as surgical access for emergency patients and other areas. I am advised that after discussion with the deputy directors general this had been raised with Dr Christley for some time.

On my appointment the Minister for Health also raised her concerns in relation to this matter. I met with Dr Christley at the time and went through these issues with him and asked him whether he had a plan to improve those areas of concern. I felt after discussion with him that he did not. I then discussed with him whether he felt it was time for new leadership within that area health service. As you know, these jobs are incredibly difficult and he certainly had been in it for some time. He agreed with me that he felt that he did not have a plan or solution, and on the basis of that I then discussed with him the termination of his contract.

Reverend the Hon. Dr GORDON MOYES: Thank you, Professor Picone, that is quite clear. In those discussions was a major point a blow-out in budgets in the area health service?

Professor PICONE: That was a part of the discussion, but my major concern was around the access issues for patients.

Reverend the Hon. Dr GORDON MOYES: The final question I wanted to ask you, I have no criticism of you making that decision. My only criticism is that the decision should have been made much earlier. Does this mean that your predecessor did not do the job properly?

Professor PICONE: I have the highest regard, sir, for my predecessor. My understanding is that I had come at a point in time where, regardless of who sat in my position, they would have been called to make that decision. A period of time had passed and I happened to be the person there. Also, the Minister did raise it with me at the time of my appointment.

Ms LEE RHIANNON: Minister, are you aware that a senior executive of Sydney West Area Health Service has substantial shares in a software company Specialist Information Services and that Specialist Information Services has sold breast cancer management and monitoring software in April this year to his own hospital? We have the order number, and for your interest it is dated 10 April this year, the number is 690566?[1]

Ms REBA MEAGHER: I have not heard of these matters. I will take it on notice.

Ms LEE RHIANNON: Maybe to help your memory, and hopefully we can get some information now, but I understand that one of the major shareholders, who is also a chief executive of Sydney West Area Health Service, is Professor John Boyages. His brother Steven is another large shareholder.

Dr MATTHEWS: If I could just make one correction. Dr John Boyages is not Chief Executive of Western Sydney Area Health Service.

Ms LEE RHIANNON: But he is—

Dr MATTHEWS: Steven Boyages is the chief executive.

Reverend the Hon. Dr GORDON MOYES: It is his brother who is the chief executive.

Ms LEE RHIANNON: So Steven is the CEO?

Dr MATTHEWS: That is right.

Ms LEE RHIANNON: Okay, I apologise. Thanks for correcting that. So, Minister, can you enlighten us further on that?

[1] Please see correspondence from Professor Debora Picone, Director General, NSW Health. This correspondence can be found on the hearing transcript page, 26 October 2007, on the inquiry website.

Ms REBA MEAGHER: I have taken it on notice.

Ms LEE RHIANNON: Is it possible for New South Wales Health to apply on behalf of all New South Wales hospitals for doctors working at New South Wales Health to be able to prescribe RU486?

Ms REBA MEAGHER: I need advice on that.

Dr MATTHEWS: That is a matter for the Commonwealth. The Commonwealth grants an application to individual doctors the authority to prescribe that drug.

Ms LEE RHIANNON: I am actually trying to understand the process because we have conflicting advice here. I realise it is a Commonwealth matter, but I did not want it to get into a ping-pong match because clearly there is a point of some State involvement. So I am trying to understand the level of State involvement. Are you really saying only a doctor at a time can apply?

Dr MATTHEWS: Before any drug can be marketed in Australia it must be assessed and approved for use by the Commonwealth Therapeutic Goods Administration, generally known as the TGA. Applications for market approval must be lodged by the product manufacturer and must include data that addresses the issues of quality, safety and efficacy.

Ms LEE RHIANNON: I am going to interrupt because I know I am not going to have much time tonight; I have a heap of questions. I am really interested in the process within New South Wales. I appreciate there is a process for approving RU486, and that was not my question. The question is about the New South Wales Government's involvement in the process? That is the bit I am after, for approval?

Dr MATTHEWS: No, no. The approval to prescribe that particular drug is granted to an individual doctor through a process of the Commonwealth Government.

Ms LEE RHIANNON: So you are saying the New South Wales Government has no involvement at all?

Dr MATTHEWS: In that authority to prescribe the drug, no.

Ms LEE RHIANNON: Because I understand the Victorian Government has been assisting some of its hospitals. You are saying that is incorrect information I have?

Dr MATTHEWS: I cannot speak with certainty about what happens in Victoria, but like many drugs that are restricted to particular groups of doctors or individual doctors, the authority to prescribe this drug is a matter for the Commonwealth.

Ms LEE RHIANNON: Minister, have you yourself done any advocacy around ensuring that, like, women in rural areas have access to this drug?

Ms REBA MEAGHER: I think Dr Matthews has given you an indication about how the medical profession accesses the use of that drug. So I have done no individual advocacy, no.

Ms LEE RHIANNON: Minister, does the Department of Health keep records of internal complaints by public health staff about incidents of bullying and intimidation?

Ms REBA MEAGHER: Well, at first instance a report would be made within the facility, or if it is not managed there, it would then be dealt with through the clinical governance unit of the area health service. Then if it fails there, it would escalate up the line. But perhaps Professor Picone could outline to you what records are held by the department.

Ms LEE RHIANNON: It sounds like there is qualitative data kept and that is what I am interested in.

Professor PICONE: So you want to know do we have, say, the number of claims of bullying and harassment kept in a table in the head office?

Ms LEE RHIANNON: Yes, and that was the conclusion from the Minister's answer.

Professor PICONE: We do not, but—

Ms LEE RHIANNON: Can I just stop you there because how the Minister described it was that the complaint comes in, if it is not solved at that point it moves up a scale. So you would assume at each level records are being kept?

Professor PICONE: Yes, that is correct, but we do not collate other data from the individual area health services, but I—

Ms LEE RHIANNON: But you collate it? You must collate it at the top level?

Professor PICONE: At the area health service. But if I could also assist you, from time to time people are unhappy still with the processes at the local level and, of course, they either can use the Ombudsman's Office or, alternatively, they do write to the director general. And then I have a unit within the department, which has a range of other duties and responsibilities, which will look into and investigate those claims. So, I cannot give you the exact number of those that I would get through a year.

Ms LEE RHIANNON: So are you saying you cannot do it or that you just do not have it?

Professor PICONE: No, we do. We investigate them. At times people are still unhappy. We have a whole policy, as you know, around bullying and harassment and we have had a major education program on it. The best place to deal with it is actually at the local level, and then we have a series of escalations after that. So, from time to time people may be even unhappy with the call that a chief executive officer has made and will appeal directly to the director general. That does happen.

Ms LEE RHIANNON: So can you get us data? Sorry Minister?

Ms REBA MEAGHER: There is also provision for staff to make complaints to the HCCC if they are still dissatisfied.

Professor PICONE: Under the Protected Disclosures Act.

Ms LEE RHIANNON: Okay, so that is the process. So, can you just take that on notice, how many in the past 12 months, say 2006?

Professor PICONE: Yes.

Ms LEE RHIANNON: Staying with the bullying problem, one of the aspects that has come out recently is that staff at public hospitals often feel pressured not to speak to the media. Is there a directive that they should not speak to the media or are there rules of who can speak to the media and who cannot? Could you explain how that works?

Ms REBA MEAGHER: Yes. There are codes of conduct for area health services and for hospitals. If people are making a comment on behalf of their facility, then that has to be signed off at a senior level. No-one is precluded from making comment in a private capacity, but they cannot use their title in advocating their position. It is deemed to be a private position. That is spelled out in the code of conduct and that is also available in the annual report.

Ms LEE RHIANNON: So does that mean that if a doctor or nurse speaks on 2GB talking about something that has happened in a hospital, they are not allowed to say, "I am a doctor" at such and such a hospital? They just use their name, is that how the directive works?

Ms REBA MEAGHER: I would have to refer to the annual report to look at the specifics.

Professor PICONE: We have a code of conduct. This is detailed, the expectation of the staff member, in that code of conduct. So, I could have that tabled for you. I do not know if we can get it now.

Ms CRAWSHAW: If an individual wants to make a public statement, there is no difficulty, obviously, identifying the fact that they may work at a particular facility. What we would expect is that they make it clear that they are not making that comment in an official capacity, but that they are making it in a private capacity.

Ms LEE RHIANNON: They can say, "I am Dr So-and-so but I am speaking in a private capacity." Thank you for clarifying that. Could you now inform us of some of the complaints you are dealing with, whoever deals with them, concerning health professionals who have felt bullied because they spoke to the media in a private capacity?

Professor PICONE: I have not received any complaints of that nature.

Ms LEE RHIANNON: That is not an issue that you are aware of, particularly in the past few weeks?

Professor PICONE: I have not received a complaint from a member of staff that they have been victimised or bullied as a result of speaking in the media. We also, as you know, have professional practice units that would handle that. That would then become, I imagine, the subject of a grievance. If a staff member felt that that had occurred, they have every right to lodge a formal grievance. I believe we have quite strong grievance processes as well within our institutions.

Ms LEE RHIANNON: So you are satisfied you are doing enough to counter the bullying that we are hearing about and many of us are receiving complaints about?

Professor PICONE: We have very strong bullying and harassment policies. Bullying and harassment is not tolerated in the workplace. I heard the Minister recently make very strong statements about that, particularly in relation to the issues that we have been experiencing and that had been reported at the Royal North Shore Hospital. Every New South Wales Health employee, and that includes our permanent, temporary, casual, volunteer, research or contract staff, must agree to abide by our code of conduct, and that is included in it. The code clearly states that employees will never harass, discriminate or bully other staff, patients or members of the public, or encourage or support other staff members in harassing, discriminating or bullying staff, patients or members of the public, or victimising—

CHAIR: Professor Picone, do you want to table that?

Professor PICONE: I just thought it was—

CHAIR: I guess it is a lengthy document.

Professor PICONE: Because this bullying issue is quite important, with your permission I will just finished this because it is a key thing. We expect our staff to abide by a code of conduct. That is mandatory. We have zero tolerance to bullying and harassment and we have set up a good mechanism, from protected disclosure right through to professional practice units, and we undertake very broad sweeping education of staff about what actually does constitute bullying or victimisation. I have not at this stage received any reports of either victimisation or bullying of any of our staff as a result of any discussions in the media in the last weeks.

Ms CRAWSHAW: Can I just add that as recently as July this year the department put out a set of guidelines to assess area health services in implementing our zero tolerance bullying and harassment policy. That was a document that provides practical advice to area health services and helps them to manage their occupational health and safety obligations in relation to bullying and harassment. It was a document carefully worked through with the area health services themselves but also with the employee associations and the various unions.

Professor PICONE: We also strongly encouraged our staff to report any incidences of bullying. As Reverend the Hon. Dr Gordon Moyes would know, because I think he was quite instrumental in this through the Campbelltown-Camden matters, section 16 of the Health Care Complaints Act also now protects those people who wish to lodge complaints. We have created, I believe, a lot of venues, should that be occurring. The best place though is at the local level, but we also have other protections for workers on these issues.

CHAIR: Can I just clarify that you agree to take it on notice and table the code of conduct, including guidelines on speaking to the media.

Professor PICONE: Yes, Madam Chair.

CHAIR: Ms Crawshaw, would you like to table that advice too, or take it on notice?

Ms CRAWSHAW: Certainly.

The Hon. CHRISTINE ROBERTSON: Will the Minister inform the Committee of the outcome of the review undertaken by Professor Hughes and Professor Walters, to which she referred in her opening statement, into a new model of care for women who present to emergency departments with a threatened miscarriage, following the experience of Jana Horska?

Ms REBA MEAGHER: Women facing a threatened miscarriage should be afforded the dignity of being provided with suitable care by appropriately trained staff in an environment which meets their specific needs. This was highlighted by the recent case of Jana Horska and Mark Dreyer, the details of which have been widely and publicly canvassed. This couple's experience has given rise to discussion about appropriate models of care for women in similar circumstances. I commissioned Professor Cliff Hughes and Professor William Walters to review this particular couple's experience and to provide advice about how the health system might provide more appropriate care for women threatening to miscarry.

Professor Hughes is the chief executive of the Clinical Excellence Commission, an independent body that ensures patient safety and excellence in clinical care is a top priority across every health facility in the New South Wales Health system. He is an experienced cardiothoracic surgeon who is a leader in the field of health quality at a State, national and international level. He has published more than 45 independent academic peer-reviewed papers in medical journals in both Australia and overseas. He has led five medical teams to China and has also operated in Hong Kong, Singapore, Malaysia, India and Bangladesh.

Professor William Walters is a leading obstetrician and the chief executive clinical director of the Royal Hospital for Women. He has been instrumental in establishing primary health care maternity services across New South Wales. Professor Walters is an emeritus professor at the University of New South Wales. He is chair of the New South Wales Maternal and Perinatal Health Priority Task Force, chair of the New South Wales Maternal and Perinatal Committee, and a member of the Health Advisory Committee. Professor Walters has published more than 180 research papers on obstetrics and maternity services, cementing him as a leader in his field.

Professor Hughes and Professor Walters today have provided me with their report. The report found that Ms Horska had to wait too long in the waiting room and that she was denied the dignity to which she was entitled when miscarriage occurred; that staff working in the emergency department on the night of 25 September acted appropriately within existing protocols and none would be referred to the Health Care Complaints Commissioner by the inquiry team; there was an absence of specific protocols for women presenting with a threatened miscarriage, who should be assessed as a matter of priority; new models of care should be developed as matter of urgency for all public hospitals concerning the management, care and treatment of patients presenting with miscarriages or threatened miscarriages.

It is important that appropriate emotional support be provided to women who present with miscarriage or threatened miscarriage in an emergency departments setting. There should be a public education program targeting people who present to emergency departments with relatively minor conditions that could be better managed by a general practitioner [GP] clinic or other primary care

facility. The report also made a number of recommendations specific to Royal North Shore Hospital, including that it review its policies relating to security and the physical environment of its emergency department. A number of other recommendations have been made in relation to statewide guidelines to ensure uniformity of emergency department signage, and the development of fact sheets and other communication for patients who present to emergency departments with a threatened miscarriage or for staff who deal with those patients.

A key recommendation was that the Government explore opportunities to provide information on early pregnancy including miscarriage with pregnancy testing kits sold at pharmacies. This would require the assistance of the therapeutic drugs administration authorities. The experience of Jana Horska and Mark Dreyer made it clear that we needed to find a better way of providing care for women threatening miscarriage. While it was important that Professor Hughes and Professor Walters conducted their comprehensive review—and indeed there are important lessons to be learned from their work—I announced on 28 September that we would develop and implement new models of care for women presenting to public hospitals with symptoms of miscarriage.

I have asked Professor Walters to look at the existing models of care across the system and provide me with advice about how we can learn from those models that are working well and how we can roll out those models across all of our hospitals. Not all of our hospitals are the same. This would present challenges for our small rural hospitals, but there are already some good examples upon which we can draw. I am advised that already at Nepean, Westmead, Royal Prince Alfred, Auburn and Blacktown-Mount Druitt hospitals, women who present to the emergency department with early pregnancy bleeding may be referred to the Early Pregnancy Assessment Clinics. It is important to note that in all cases where the life of the mother is thought to be at risk the patient is treated in the emergency department.

In many hospitals pregnant women who present with complications and who are further than 20 weeks pregnant are referred to the delivery suite. For example, at Nepean Hospital the early pregnancy assessment clinic is known as the acute gynaecology assessment unit. It is a specially designed area away from the delivery suites where care can be provided for women who are at risk of miscarriage. Clinics such as these consider both the physical and psychological needs of the women and are designed to have special rooms in the women's health area designated for women who are at risk of early miscarriage.

Women who present to the Prince of Wales Hospital emergency department are also managed under a specially designed protocol whereby they are triaged and seen by an obstetrics registrar. If they require urgent attention the women are transferred directly to the Royal Hospital for Women, which is collocated on the hospital campus. Patients who are assessed by the obstetrics registrar as not requiring urgent medical care are referred to the early pregnancy assessment clinic. General practitioners may also refer directly to the clinic. The clinic has specialist doctors and midwives and is fully equipped to assess women as required. An ultrasound is available at the clinic. The clinic has been operational for approximately 12 months.

Many health professionals have written in support of the development of new models of care for women in these circumstances, including Professor Pat Brodie and Professor Caroline Homer from the Centre for Midwifery, Child and Family Health at the University of New South Wales. Professors Brodie and Homer wrote that they are keen to develop models of care that increase the utilisation of midwives in the community. While the recommendations of the Hughes-Walters review are being fully examined and Professor Walters is looking at new models of care to be rolled out across the New South Wales health system, NSW Health has already acted to ensure that all hospitals are reviewing their current protocols to consider how best to implement the new models once they are completed. However, no new models will be commenced until staff are trained and relevant positions are filled to ensure that safety is not compromised.

This is about providing women seeking treatment through the public health system with the confidence that they will have access to the appropriate level of clinical care and that they will be afforded the emotional support and dignity they deserve. I have asked the Director General of Health to develop an implementation plan with a view to rolling out the recommendations of the Hughes-Walters review as soon as possible. I will report back to the Parliament on the implementation within the month.

The Hon. CHRISTINE ROBERTSON: Thank you, Minister.

The Hon. AMANDA FAZIO: Minister, can you tell the Committee about the $1.2 million research project on nurses workload, which I think has been undertaken by the University of Technology, Sydney?

Ms REBA MEAGHER: Nurses are the backbone of our health system and are one of our most important assets. They are at the front line of public healthcare delivery, working hard every day to provide patients with the best possible care. But no-one pretends it is an easy job. Nurses have to deal with difficult and emotionally and physically draining work on a daily basis. As I move around the health system visiting hospitals and community health centres, I am continually impressed with the professionalism, dedication and compassion shown by our nurses. The Iemma Government is working hard to provide nurses with the support they need to get the job done. That is why we take the issue of their workload very seriously.

In 2003 Premier Iemma, as Minister for Health, commissioned a $1.2 million study into nursing workload, skill mix and models of care. The then health Minister announced that a study would be undertaken to inform future policy development on nursing workforce issues. Following a tender process the University of Technology, Sydney was selected to prepare one of most comprehensive studies of its kind in the world. Few other jurisdictions have undertaken research of this detail and importance on nursing workload. New South Wales has led the way once again. I am pleased to announce that the study has now been completed and the paper has been published. Due to the complexity of the research the paper has taken more than three years to complete. For the first time the study has examined nursing workload at the hospital ward level.

Eminent international nurse researchers Professor Linda O'Brien-Pallas of Toronto university in Canada and Professor Donna Diers of the Yale-New Haven Health System in the United States have been part of the research team led by Professor Christine Duffield from the University of Technology, Sydney. Yesterday I met with Professor Diers to discuss the report's findings and the issues facing nurses world wide. The study was designed to include patient and workforce data extracted from hospital administrative data systems between 2000 and 2006, and original data collected from a sample of 80 hospital wards located in 19 hospitals across New South Wales.

The information contained in the report is complex and will require analysis by the department. One of the key findings of the report is the fact that the severity of illness of patients has increased over time in our principal referral hospitals. This change in patient acuity reflects the fact that our population is both ageing and suffering from more chronic, complex diseases. Nurses and physicians now have to spend more time on diagnosis and treatment. This presents challenges as we attempt to meet the community's growing demands for health services over the years ahead.

The report also found that there have been significant increases in the number of nurses in the New South Wales public health system, with strong growth in all categories of nursing, particularly in enrolled and trainee enrolled nurse numbers. This reflects the massive investment that the New South Wales Government has made in increasing the number of nurses in the public health system. In fact, we have increased the total nursing workforce by 8,051 nurses in the past five years. We now have more than 42,000 nurses and midwives working in the public health system—and we need more. The New South Wales Government acknowledges this fact. The report also makes this clear. It highlights research that indicates that the demand for nurses nationally will increase by 2.56 per cent annually until the end of the decade. There is expected to be a national shortfall of 40,000 registered nurses by 2010.

We just do not have enough nurses to go around. This is a direct consequence of the Federal Government's failure to invest in our universities. The low point nationwide was in 2002 when the Federal Government cut the university intake nationally to 7,500—down from 8,800 in 1994. It returned the intake to 8,500 in 2004 but it still lagged far behind the increased demand for beds and hospital services. Just this year New South Wales identified the need for an additional 1,769 university nursing places. The Federal Government's response was to allocate an extra 200 places only. In the face of the Federal Government's neglect, New South Wales has acted to boost enrolled nurse numbers. Some 1,100 will graduate this year from TAFE courses and we are also recruiting

nurses from overseas. The New South Wales Department of Health is currently actively recruiting more than 1,200 permanent nursing positions across the State.

The report also found that there are substantial movements to and from nursing wards, which can have an impact on nurse workloads as nurses need to be involved in such movements. This movement is partly a result of the increase in emergency department admissions. Patient movement is also the result of treatment needs—from ward to imaging, back to ward, to theatre, back to ward and so forth. The report also highlighted that the average length of stay across all hospitals in the study declined from 78.3 hours to 77.6 hours between 2001 and 2005. This is part of a worldwide trend that reflects improvements in patient care and medical technology. Nevertheless, the report found that this trend has impacted on the workload of nurses.

Another significant conclusion from the report is that the skill mix of a ward is important and contributes more to patient outcomes than hours of care provided. More than one-third of nurses surveyed reported experiencing recent emotional abuse and about one in five nurses reported threats of physical harm from patients and their families. This is a concerning result and further indicates the difficult conditions that our nurses work in. The report clearly provides much food for thought for government. It provides us with further understanding of what constitutes and impacts on nursing workload and provides guidance on areas of further consideration. What the research tells us is that the resolution of nursing workload issues is not to be achieved by focusing on only one factor, such as hours or skill mix. Rather, there are many factors at play that need to be considered.

The report emphasises that nurse leadership is of vital importance in the ward. This is where the nursing unit manager plays a key role. The pivotal role of the nursing unit manager—or NUM, as they are known—has already been recognised with the commencement of the NUM project, which this Government has made a commitment to support. This project will assist NUMs in achieving the appropriate skills and support to undertake this key role in our health system. It was pleasing to note in the research that more than 80 per cent of nurses rated the care they were able to provide to patients on their last shift as excellent or good, more than 70 per cent were satisfied with their profession and most were satisfied with their current positions.

However, it is important to now act on the research. I will therefore be asking the New South Wales reasonable workloads committee to consider the specific findings on workload. While the report does not make specific recommendations, it does provide information about nursing hours of care, the impact of the movement of patients, the mix of patients on wards and the length of stay on workload. All of these will need to be considered in reviewing the general workload calculation tool, which provides guidance on staffing in public hospitals. I have also directed the Department of Health to establish an advisory committee on the nursing workforce and patient safety to consider the rest of the findings of the report.

This committee will include representatives from the nurses' association, the Clinical Excellence Commission and nursing managers from metropolitan and rural hospitals. The committee members will work together to consider the findings of this report and how it can be applied to the New South Wales public health system, but I would like to make it clear that the Iemma Government has not been sitting on its hands while waiting for this report. We have been acting decisively over many years to support our nurses. We prepared the general workload calculation tool and rolled it out across the health system. As I have indicated, this provides guidance for public hospitals on staffing.

This initiative has seen an increase in the hours of care provided to patients and is reflected in the increased number of nurses in our public health system. In addition, the Government has recognised the importance of clinical nurse educators by committing $14 million over the next four years for an additional 80 clinical nurse educator positions. This will bring the total number to more than 420. As I mentioned, we have boosted the numbers of nurses in New South Wales by more than 24 per cent in the last five years. Our nurses and midwives are the highest paid in the country. They have enjoyed a 47 per cent increase in salary since 1999. We have improved their conditions through increased maternity leave, more flexible rostering and more professional development opportunities.

The Iemma Government has also acted to protect our nurses from John Howard's WorkChoices laws. This year's record $12.5 billion health budget includes $35.8 million over four years for nurse recruitment, retention and training initiatives. This year $46.5 million has been

allocated to the Investing in Nurses Program. This includes 30 new nurse practitioners and 1,600 scholarships for registered and enrolled nurses. We have also launched initiatives such as the Nurse Reconnect program, which by August 2007 has brought more than 1,600 nurses back to our public hospitals.

Our initiatives and funding have generated good results during a period of national and international nurse shortages. Our success to date is encouraging and our commitment is ongoing. The Iemma Government is proud of our nurses and is working hard to provide them with the support they need to get the job done. I would like to put on record my appreciation of the nurses who participated in this important research and to the researchers for their excellent work.

The Hon. MICHAEL VEITCH: Can you update the Committee on the relationship between the State and Commonwealth Governments in delivering health care to the people of New South Wales?

Ms REBA MEAGHER: The health of the Australian community depends on equitable and affordable access to health services. The Medicare system, which combines free public hospital services, the medical benefits scheme and the Pharmaceutical Benefits Scheme, is designed to provide that affordable access. The Medicare system cannot survive without adequate public funding and a committed partnership between the States and Territories, and importantly the Australian Government, to provide best quality health services.

There are several challenges facing both levels of government when they seek to improve the delivery of health services to the Australian community. For New South Wales the key challenge is the Commonwealth Government's rejection of its funding responsibilities to the public health system, particularly the public hospital system. In June this year the States and Territories published a joint report, "Caring for our Health? A report card on the Australian Government's performance on health care". This report highlighted a number of serious concerns with the current system.

The pressure on public hospitals is continually increasing with the number of emergency admissions between 2001 and 2005 growing by more than 11 per cent, or an additional 67,000 admissions. The number of people being educated and trained to work in the health system is not keeping up with demand for health services caused by population growth, the ageing of the population and the increased prevalence of chronic disease. There is a shortage and maladministration of general practitioners across the country and specialists are overwhelmingly concentrated in major cities. Unlike the reporting requirements of States and Territories under the Australian Health Care Agreement, there are few meaningful performance measures for Commonwealth Government expenditure relating to private health insurance, the medical benefits scheme and the Pharmaceutical Benefits Scheme [*Time expired.*].

CHAIR: Minister, thank you for that information. If there is more information that you would like to table—

Ms REBA MEAGHER: Perhaps I could come back to this.

CHAIR: In the Government's time, I am sure that will be fine. I wonder also if you would agree to give the Committee a copy of the report you referred to at length about the nurse workforce studies?

Ms REBA MEAGHER: It is on the website.

Reverend the Hon. Dr GORDON MOYES: If it is on the website, I am wondering why we had to have it read here?

The Hon. CHRISTINE ROBERTSON: I do not think that the Minister was reading the report, she was commenting on the report.

The Hon. AMANDA FAZIO: You are a very rude man, you know.

CHAIR: The Minister was answering Government questions and that is how she chose to answer the questions. Minister, you have spoken at length about nurses. The Federal Government has increased the number of nursing places offered in New South Wales universities from 2,000 positions in the year 2000 to 3,602 in 2007 and your own New South Wales Health annual report shows that there are 99,638 registered enrolled nurses in New South Wales. I note that there are only 36,920 actually working in the public health system, so really I think it is time that you were honest about this and admitted that the nursing shortage in New South Wales is a result of nurses not willing to work in the public system because of your Government's chronic poor management, lack of funding and poor workforce conditions. I know that you are happy to pass the buck on to the Federal Government, but why do you not acknowledge the reality of those facts?

Ms REBA MEAGHER: I think it is important to note that we have actually recruited over 8,000 nurses in the past five years. What has been interesting about that too is that we have reduced the turnover of nurses, so the retention rate of nurses has improved by I think around 3 per cent, but I will get the exact figure for you, over the past couple of years. That is an indication I think that we have been able to work very closely with our nursing workforce to make conditions more desirable. As I have outlined, we made rostering more flexible, we increased maternity leave, and we do work very closely with the workloads committee to ensure that we can provide the best possible environment for our nurses when they do a tough job.

I think it is also important to highlight that there are other options for nurses. I think something like one in three work outside of the public healthcare system, but it is important to highlight that there was in fact a body of work done recently that showed that we would be requiring 19,000 nurses this year. In fact I think the training positions available were woefully inadequate, which meant that there were going to be quite significant shortages—not only in New South Wales but right across the country—and we have identified the need for 1,700 nursing positions for 2008. As I have already outlined to this Committee, the Federal Government responded by only allocating an additional 200 places, so we are already going to have a shortage of 1,500. The point is that these are our registered nurses. That is what is so important about the research that I have outlined to the Committee: it is about skill mix on the wards. So the right number of registered nurses in the system is very important and there is a recognised workforce shortage.

CHAIR: Nurses are complaining about 17-hour shifts and the conditions provided. There are a number of nurses not employed currently. Included in the 8,000 you have noted is agency nurses. Would you please provide a breakdown of the nurses who are agency nurses and paid through the public payroll system?

Ms REBA MEAGHER: The most senior nurse of them all will answer your question.

Professor PICONE: If I could assist, in January 2002 there were 34,004 permanently employed nurses. They were both full-time and part-time. By August 2007 there were 42,081 nurses employed in permanent positions. These are permanent positions. That is a net increase of 8,077 or 23 per cent from 2002. They are the correct numbers and they are reported in the Department of Health reports. You asked how much we are using agency nurses.

CHAIR: How many agency nurses are currently being paid through the public payroll?

Professor PICONE: Agency nurses have always been used in New South Wales.

CHAIR: Do you have a breakdown?

Professor PICONE: By way of background, agency nurses have always been used and they help fill vacancies when recruitment proceeds and ensure appropriately qualified nurses can step into positions, sometimes at short notice, such as sick leave. The total nursing agencies payment for 2003-04 was approximately $60 million. In 2004-05 nursing agency payments reduced to $58 million. We are reporting that the trend of decreasing nursing agencies continued. I am trying to get you a full-time equivalent number. Can I take that on notice? I could do a rough calculation in my head and divide 70,000 through $58 million but the grey cells are not as good as they used to be.

CHAIR: You can take that on notice. The full-time equivalents I have here in the 2006 annual report shows 36,920 nurses—

Professor PICONE: That would be the permanent staff.

CHAIR: What we want—

Ms REBA MEAGHER: I think Dr Matthews can add to your information.

CHAIR: In a moment. I will just clarify that we want a breakdown of agency nurses who are paid through the public payroll. Can you provide that information?

Ms REBA MEAGHER: I will take it on notice with some concluding commentary from Dr Matthews.

Professor PICONE: I will be interested to hear Dr Matthews' response.

Dr MATTHEWS: I only deal in facts. I simply wanted to comment on the workforce numbers. I should point out that the intake into nursing across the country declined steadily throughout the 1990s and the absolute nadir of nursing intake entry was in 2001—the 2001 intake, the 2004 graduates to 2007 third-year people starting to become experienced in the system. It is also about the time in nursing when you get the greatest attrition rate as people travel overseas, have babies and do all sorts of things that people do. So because of that low intake point in 2001, we are this year in the absolute bottom, the nadir, of new available nursing numbers. The advertisements that you see in the press every Saturday seeking nurses, and the fact that in many streams we have facilities and resources and no staff, are a reflection of that series of facts, which I am sure Professor Picone will agree with.

Professor PICONE: Thank you, that was quite fascinating. At some stage I would like to talk to you about the 85 shortages. Earlier you asked about the agency nurses. I think there will be a little difficulty because the way we pay those nursing staff is on an eight-hour shift basis. You could perhaps just work an eight-hour shift. I will ask Mr Barker to assist me in answering the Committee's question correctly. I am just thinking that there may be some difficulty around it. You can imagine that thousands of nurses undertake agency work although over the years we have tried to increase our own casual pools at the hospital so that our own nursing staff at a local hospital will get that shift.

CHAIR: You can take on notice and give us as much information as you are able to make. I am sure Mr Barker has an accurate accounting breakdown of absolutely everything.

Reverend the Hon. Dr GORDON MOYES: I must declare an interest. Having set up a nurse agency service, I appreciate the Government's use of Wesley Mission's Noakes nursing service, which is used widely on the North Shore. It is a very profitable business.

CHAIR: I am sure you would agree that clinicians are best placed to make decisions about medical management and what should and should not happen with patient care.

Ms REBA MEAGHER: Most certainly in relation to their own patients.

CHAIR: What I cannot understand—and you have discussed the report you have had from Dr Walters and others—is why you jumped in straightaway as a member of Parliament and not a clinician and released your miscarriage model of care before you had the review into the Jana Horska case and before your review team had come back. In spite of recommendations, you just immediately announced that you had the answer. Why would you do that, particularly in light of the fact that one of the review team, Dr Walters, said that he had been aware of the problem for a long time, and your Labor parliamentary colleague Andrew McDonald said that he had tried to introduce the practice for 10 years and had been ignored by the Labor Government? Why did you think you knew what to do?

Ms REBA MEAGHER: I reject the premise of your question. I did not indicate a new clinical response. What I indicated was a determination that we would move to new models of care that would more appropriately deal with the needs—emotional needs, privacy needs and dignity

needs—of women who were presenting to hospitals threatening miscarriage. I made that announcement with Professor Walters, who has done an enormous amount of work in this area.

I signalled very early the intention and determination to improve our system so that we could prevent the distressing circumstances at Royal North Shore Hospital from occurring again. I think it is very much the responsibility of the Minister to be able to signal that intention on behalf of government and also to make it clear to my department that I considered this a priority. So that is exactly what I did, and I think it was most appropriate because what I learned during that episode as well was that the system does not behave uniformly in delivering this care. There are pockets of excellence in the system that have not been driven or rolled out to provide an appropriate systemwide protocol.

CHAIR: So is it going to be your practice to make announcements such as this before you have a review?

Ms REBA MEAGHER: It is the responsibility of government to learn lessons when things go wrong and to demonstrate determination to make the system improvements so that we can provide a better standard of care, and that is exactly what I did, and I am very proud of it.

CHAIR: I and puzzled as to why you are proud of it because what you said at the time was that those women presenting at emergency departments would immediately be sent to an obstetric ward. I do not think that is the recommendation today, from what you are telling us from the inquiry that you established. It is different from what was decided.

Ms REBA MEAGHER: There were different models of care that existed in different parts of the system. That was one example that we gave to demonstrate that in fact a higher standard of care and more responsive standard of care could be afforded to women presenting in emergency departments threatening miscarriage. I signalled very clearly at the time that I would ask Professor Walters, who was with me when we made the announcement, to provide advice to government on how best to deliver new models of care, taking into account—

CHAIR: It would have been better to wait for that advice before you made the recommendations, would it not?

Ms REBA MEAGHER: Let me finish. Taking into account that different health services have different services available to them and different hospitals will also require different kinds of models to be introduced, and recognising that the system is not uniform, but articulating very clearly, the principle that we can and should be affording a higher standard of care, a care that provides women with privacy and dignity when they need it most.

CHAIR: Today you announced a report into the issue of Jana Horska's miscarriage. Were Jana Horska and Mark Dreyer interviewed before that report was compiled?

Ms REBA MEAGHER: Professor Walters indicated today that he had made appointments with Mr Dreyer, appoints that were not kept by Mr Dreyer or Ms Horska. I understand that they were decisions that were taken by them under legal advice. I wrote to the couple, urging them to make known their side of the story. I urged them to do that. I understand that contact has been offered in relation to discussing the findings of the report as well. To date, those overtures have been rejected by the couple, under legal advice.

CHAIR: It is a pretty sensitive issue. Have you spoken with them? Had you given them a copy of your report before your press conference today?

Ms REBA MEAGHER: I did speak with them when the event occurred. I made it very clear to them that I was keen to see something good come of this, so that we could improve the way we are delivering care. I was determined that we delivered that. Regarding the report, as I understand it, contact was made last night with the couple offering to go through the report with them. Mr Dreyer indicated that he did not want to be disturbed until after 2 o'clock today. I understand that he is a shift worker. When the Department of Health attempted to make additional contact, those offers were rejected again, under legal advice. Both Professor Hughes and Professor Walters had indicated that

they would be more than willing to step through the report with the couple and explain the findings to them.

CHAIR: So the answer is that you went ahead with the press conference even though you had not given them a copy of the report?

The Hon. CHRISTINE ROBERTSON: That is a distortion.

Professor PICONE: A copy was faxed to them. We are having to work, at the request of the family, with their solicitors. The information has been passed on to the family. To confirm what the Minister has said, an attempt was made last evening. When I say "attempt", we now have to contact the solicitors, at the request of the family obviously.

Ms REBA MEAGHER: Also it is important to highlight that the report back date was part of the terms of reference, I made it very clear at that time that this would be a public report and the findings will be available publicly. As soon as the report was made available to me, I made it available publicly.

The Hon. DAVID CLARKE: I draw your attention to a statement that you made, published in the *Sydney Morning Herald* in an article headed "Grim Reba Admits It's Broken". You are quoted as saying, "relationships between the department and our emergency doctors seem to have broken down". Did you make that statement?

Ms REBA MEAGHER: Yes.

The Hon. DAVID CLARKE: When you are talking about "department" that means you as the Minister, does it not?

Ms REBA MEAGHER: No.

The Hon. DAVID CLARKE: You are saying that the relationship has broken down between the people sitting on both sides of you and everyone behind you, but has not broken down between you and clinicians?

Ms REBA MEAGHER: The point I made is that there had been a difficulty in the relationship between the Department of Health and the emergency physicians as a result of an industrial dispute in 2006. At that time the emergency physicians made a decision to withdraw from the health priority task force, where they are normally part of discussions with the department. We have that dialogue with the senior clinicians and they feed their issues in and work with the Department of Health.

They withdrew from those dialogues and that committee in January this year. They were very clear that they had a strained relationship with the Department of Health as a result of the standing issues of that industrial action. I am pleased to say that we have been able to work through that by re-establishing the task force.

The Hon. DAVID CLARKE: So the bottom line is that relations have broken down but certainly not because of you?

Ms REBA MEAGHER: As I said, the industrial dispute took place in 2006.

The Hon. DAVID CLARKE: I will come back to that issue if we have further time.

Reverend the Hon. Dr GORDON MOYES: Minister, I have two very simple and very polite questions. In light of the previous vexatious issues between the Mona Vale and Manly hospitals, what is the future of both hospitals? What are the budget ramifications?

Ms REBA MEAGHER: The New South Wales Government has committed to building a tertiary hospital at Frenchs Forest, which will have a bigger bed base than both Manly and Mona Vale hospitals. That was announced last year. It is a $370 million investment that will deliver state-of-the-

art facilities to the northern beaches community. Planning is underway. The Northern Beaches Health Service strategy has been finalised and will be considered by Cabinet soon. Funding of $500,000 has been allocated already to allow the engagement of consultants to undertake the preparation of the project definition plan, which is expected to be completed by mid-2008.

I am advised that part of the location for the new northern beaches hospital at Frenchs Forest comprises 11 private dwellings, four of which have already been acquired. Further, the remaining seven private owners did not accept the department's offers to purchase the properties, which included a significant payment towards relocation costs.

Reverend the Hon. Dr GORDON MOYES: If I may interrupt, I am aware of the future hospital at Frenchs Forest. My concern is what is the ongoing role of the existing hospitals at Mona Vale and Manly?

Ms REBA MEAGHER: Cabinet is considering the services planned for the northern beaches. I am advised that the future configuration of the complementary health services at Mona Vale Hospital would be considered as part of that planning process.

Reverend the Hon. Dr GORDON MOYES: My second question concerns the claims that the current Government closure of 2,300 beds is fuelling the current public hospital crisis. Why is that claim wrong?

Dr MATTHEWS: Are you referring to the claim by the Australian Medical Association?

Professor PICONE: No, I know exactly what he is saying.

Ms REBA MEAGHER: There was an international trend to reduce the number of hospital acute bed spaces. In that regard New South Wales did not respond any differently from any other State and began closing beds in the late 1980s. That practice was reversed in 2002, when Morris Iemma was the Minister for Health. It was reversed because it became apparent that the population was changing, so the complexity of patients presenting and the length of their stay was changing considerably as our nation aged. As a result, we started putting beds back into the hospital system.

We have been able to fund 1,800 beds over the last three years. This year's budget makes provision for 456 beds—acute, sub-acute and community. As well, there will be transitional beds. In that regard, Australia performed as did other health jurisdictions and those decisions were undertaken because of the change of technology and the move towards day-only surgery and outpatient procedures. As a result of that, we have been able to certainly increase the number of people we treat. Dr Matthews might like to add to that.

Reverend the Hon. Dr GORDON MOYES: I do not need the number of people treated. I appreciate that the number of day-bed fulfilments are declining as treatments improve. I want to know why it was wrong to claim that 2,300 beds have been closed?

Ms REBA MEAGHER: Because we are embarking on putting beds back into the system. Over the last three years 1,800 have already been funded and allocated for the system and an additional 456 will be allocated as part of this year's budget.

Professor PICONE: I wish to add a general comment to that. You would well know that the use of the currency of a bed has changed a lot, but we still keep running the old currency of a bed. We then start talking about things like bed equipment and about chairs as being part of a bed. I think we might need to modernise ourselves.

Reverend the Hon. Dr GORDON MOYES: People are being set up for dialysis and so on?

Professor PICONE: That is right. So we might need to modernise our thinking of what equates to care being given to a patient. Things are not as they were 20 years ago when a bed was a bed. The world has well and truly moved on since then.

Ms LEE RHIANNON: Minister, what action has been taken by your department to follow up on the recommendations in the New South Wales interagency plan to tackle child sexual assault in Aboriginal communities? I was also interested in the budgetary expenditure.

Ms REBA MEAGHER: We have implemented initiatives to address child abuse in any community and we work co-operatively with the Federal Government on that issue. The New South Wales Government was the first government to support the proposal to send police officers to the task force in the Northern Territory. Tackling Aboriginal disadvantage and child sexual assault requires a holistic and coordinated response from the Government. That is why we established the Aboriginal Child Sexual Assault Task Force. It is a core responsibility of government to ensure the safety of children in our communities. We have already acted on the recommendations of the task force. The 88 measures will be delivered to communities at a cost of more than $30 million over the next four years.

We have established a ministerial advisory panel chaired by Sandra Bailey, chief executive officer of the Aboriginal Health Medical and Research Council of New South Wales to monitor and report on the implementation of the interagency plan to tackle child sexual assault in Aboriginal communities. Membership of the advisory panel has been drawn from the Aboriginal Child Sexual Assault Task Force, Aboriginal communities and public servants with relevant expertise. They are all people with high levels of expertise, commitment and community confidence. A preliminary meeting of the advisory panel was held on 10 September 2007. The panel's term of reference have now been finalised and the next meeting of the advisory panel is planned for 27 November.

The New South Wales Government will continue to work in close partnership with Aboriginal communities. The New South Wales Government is committed to tackling Aboriginal disadvantage. That is why we have made this issue a priority in the State Plan. The New South Wales Government has allocated $1.8 million in 2007-08 and $8 million over four years through NSW Health to address actions identified in the New South Wales interagency plan to tackle child sexual assault in Aboriginal communities from 2006 to 2011. The Aboriginal Family Health Strategy, which aims to reduce family violence and sexual assault in Aboriginal communities through a partnership between area health services and non-government organisations, has been in place since 1995.

To date, achievements of the strategy include: the establishment of 20 Aboriginal family health care worker positions to implement the projects in their local communities; the development of the Aboriginal Family Health Network, which brings workers together for ongoing support and professional development; and investment in work force development such as the nationally recognised certificate for family domestic violence and sexual assault and Aboriginal family health by the Education Centre Against Violence, which equips workers in this challenging area of work. Child sexual assault is not an issue that can be resolved overnight, but I can assure you that it is a clear priority for this Government and for NSW Health. NSW Health will continue to invest in strategies to respond more effectively, building on the strong foundations established by our dedicated staff and working in partnership with Aboriginal communities.

Ms LEE RHIANNON: What preparations has your department undertaken in response to the impact of climate change, and what do you understand those impacts to be on New South Wales?

Ms REBA MEAGHER: I will ask the chief health officer to give you some information.

Dr ROBINSON: Climate change effects are something to which we have been paying attention, as you quite rightly said. Our environmental health branch looks at issues relating to quality of the environment and we have received specific funding from government to look at the impact of climate change across the health system in particular.

Ms LEE RHIANNON: How much did you receive?

Dr ROBINSON: I am sorry, I will have to take that question on notice as I do not have a brief on this issue. One of the things that we are examining is the effect on elderly people in particular. As you are aware, when we have periods of elevated temperature—in particular, when we have elevations of temperature at night—elderly people find it extremely difficult to cope and, as a consequence, we tend to see an increased level of admissions through the emergency department for care. Through our surveillance system we are endeavouring to monitor the periods when we are seeing

that increase in attendances and to couple that with the surveillance that we also have with the environmental health branch to look at what is happening over those periods and to map it to the temperatures. If you would like, I could provide, on notice, a broader explanation with respect to that matter.

Ms LEE RHIANNON: Yes, I would. I will ask another question on this issue.

Professor PICONE: I wish to stay for a moment on the climate change issue because it is extremely important. I will ask Dr Matthews to comment on mental health issues, which are quite significant in rural areas as a result of the drought. I also have Mr David Gates who could talk about the work we are doing around our building codes to create a greener footprint. I will just make a general statement, if I may, that staff in the hospitals have taken the water savings and water safety issues quite seriously, to the point where a couple of months back an extremely senior surgeon raised with me the way in which taps ran constantly when they were scrubbing up to do surgery.

They have now set in motion a system to turn off the taps after surgeons have finished scrubbing up and washing off. Members of staff are looking at practical ways of saving water. When I worked in the South Eastern Illawarra Area Health Service senior medical staff at Shoalhaven were quite concerned that we had not put in big enough tanks for the runoff, and they indicated that we could have recirculated that water. I want you to know that we are thinking more and more about this issue. Mr Gates could talk about the building code issues and Dr Matthews is across the mental health issues.

Ms LEE RHIANNON: I would be grateful if one of them could pick up this issue or take it on notice. I was also interested to hear you speaking about heat stress. Are people looking at the possible increase in tropical diseases in northern New South Wales?

Dr ROBINSON: Work is certainly being done but it is not being done specifically by NSW Health; it is been being done at the national level with the participation of all jurisdictions. They are looking at how those patterns are changing. As you rightly identified, the changes in temperature have made a difference to the distribution, in particular, of mosquitos, and mosquitos carrying different diseases. So that is being mapped at the national level and work is also being done in conjunction with veterinary people.

Ms LEE RHIANNON: Is that information publicly available—the mapping of where those diseases could be?

Dr ROBINSON: Parts of it would be.

Ms LEE RHIANNON: Could you take that question on notice?

Dr ROBINSON: Yes, I will see what I can provide for you.

Professor PICONE: Dr Matthews might want to talk about the significant mental health areas in rural New South Wales because of the drought and other issues.

Dr MATTHEWS: I am happy to do that. That was covered fairly extensively by Minister Lynch last Friday night.

Ms LEE RHIANNON: I can look that up then because if you had things to add to that, I am conscious of time.

Professor PICONE: I can assure you that David Gates is much better than me at building, but I shall do my best. The New South Wales health system is working with the conservation department to assemble greenhouse gas targets to 2020 and to design a strategy to address how we achieve these. We also have a firm developing new engineering guidelines for all our new facilities. We have a working party in the area health services to work diligently on reducing that; they meet monthly. It is a shame David is not here, but we can also take that on notice.

Ms LEE RHIANNON: If you could take that on notice, that would be good. Minister, I follow on from a previous question I asked. When you answered my question about the interagency plan to tackle child sexual assault in Aboriginal communities you gave some outlines. Could you explain what new money has come from Health to put in place the recommendations of the task force and the "Breaking the Silence" report?

Ms REBA MEAGHER: An additional $2 million was provided in 2007-08 and $3.5 million will be provided in 2008-09 to increase screening programs for chronic diseases, and provide new skills and support tools to Aboriginal health workers to assist them in identifying health-risk factors.

CHAIR: I think the question was about "Breaking the Silence"?

Ms REBA MEAGHER: I will take it on notice and come back to you.

[*Short adjournment*]

The Hon. DAVID CLARKE: Minister, prior to the adjournment I was discussing your statement in the *Sydney Morning Herald* that the relationships between the department and our emergency doctors seemed to have broken down. You went on to state that while they may have, in your view, broken down between the department and its doctors, they certainly had not broken down between you. So it is the people around you that they have broken down with, but not with you. So, I would like to explore that relationship between you and the doctors, physicians and others who work in our hospitals. I refer to another article which is dated 16 September this year in the *Sunday Telegraph.* It is headed, "Ms Invisible, the sick State of Minister Meagher's health portfolio". Incidentally, when were you sworn in as Minister?

Ms REBA MEAGHER: In April.

The Hon. DAVID CLARKE: When in April?

Ms REBA MEAGHER: I think the exact date is 2 April.

The Hon. DAVID CLARKE: The beginning of April?

Ms REBA MEAGHER: I think so.

The Hon. DAVID CLARKE: In that article, the Acting President of the Australian Medical Association, Dr Morton, said that he waited almost four months before you had a meeting with him whereas previous health Ministers met with the Australian Medical Association more regularly. Is he stating the true situation?

Ms REBA MEAGHER: I first met Dr Andrew Keegan, the President of the New South Wales branch of the Australian Medical Association, at a business breakfast in Sydney much earlier than that. We had met each other. We had a formal meeting not long after that. I also make the point that I felt it was very important as health Minister in the early days to be visiting the doctors, nurses and other allied health professionals and our ambulance officers who work in the public health-care system.

The Hon. DAVID CLARKE: And that would include those bodies who represent the doctors who work in that system?

Ms REBA MEAGHER: That is right.

The Hon. DAVID CLARKE: And one of those is the Australian Medical Association. I am not talking about a breakfast where you may have come across the former president. I am talking about—

Ms REBA MEAGHER: He is still very much the president, is he not? Actually, he is still very much the president.

Dr MATTHEWS: He is the president.

The Hon. DAVID CLARKE: Thank you. We will move on from there. I refer to rural doctors. They are an important part of the health system in New South Wales. The President of the Rural Doctors Association, Dr Wollard, said he was disappointed. To summarise, I think he indicated that he felt you acted in a very tardy way when you met with him. He claims you turned up late.

Ms REBA MEAGHER: That is not true.

The Hon. DAVID CLARKE: He thought it was a waste of time, and that was also some four or five months after you had become the Minister. Is that more or less the situation?

Ms REBA MEAGHER: I think it is important to highlight that when I became the Minister I started a regional tour of country hospitals almost straightaway. In fact I was out there I think it was on Anzac Day that we commenced a trip, so I visited 20 country hospitals and community health facilities, I think it was, before meeting with—

The Hon. DAVID CLARKE: Even more reason for you to meet with the President of the Rural Doctors Association before you undertook that tour, surely?

Ms REBA MEAGHER: I think it is important as Minister for Health you move around the system and talk to those doctors and nurses at their workplace. I found that very valuable in getting a sense of particularly the workforce shortage issues that are confronting rural and regional New South Wales. So that was very informative. Yes, we did meet with the Rural Doctors Association.

The Hon. DAVID CLARKE: Fine, four months later. I think there was a similar situation with the Chairman of the Royal Australian College of General Practitioners. In fact, as at 16 September, you had not even met with her. Is that right?

The Hon. CHRISTINE ROBERTSON: I heard this on radio. This is a nonsense.

The Hon. DAVID CLARKE: With great respect to my colleague, I will ask the questions.

The Hon. CHRISTINE ROBERTSON: I know it your questions time. I beg your pardon.

The Hon. DAVID CLARKE: Have you finally got around to meeting with the Chairman of the Royal Australian College of General Practitioners?

Ms REBA MEAGHER: She is a member of the Health Care Advisory Council that I met with very shortly after becoming the Minister and that is actually a very valuable body because it is an opportunity. It is the real very senior people from right across the health system representing different areas that are important.

The Hon. DAVID CLARKE: With great respect, you are meeting with her in a different capacity.

Ms REBA MEAGHER: Oh, come on!

The Hon. DAVID CLARKE: I am talking about you—

Ms REBA MEAGHER: Oh, come on! I think it is very important that we have the opportunity through the Health Care Advisory Council to be able to canvass issues with the doctors.

The Hon. DAVID CLARKE: Have you had a meeting between yourself and the Chairman of the Royal Australian College of General Practitioners since you became the Minister? It requires a simple yes or no answer.

Ms REBA MEAGHER: Three hour meetings on two occasions with the Health Care Advisory Council—

The Hon. DAVID CLARKE: What dates?

Ms REBA MEAGHER: —on which those people are represented.

The Hon. DAVID CLARKE: We will move on. I think the answer is very clear.

Ms REBA MEAGHER: I would like to come back to—

The Hon. DAVID CLARKE: As at 16 September, you had not had any meeting with the Cancer Council of New South Wales or the Australian College of Surgeons. Is that correct?

Ms REBA MEAGHER: There is actually a Minister for cancer in New South Wales so think it is important you understand the way that responsibilities have been divided up.

The Hon. DAVID CLARKE: I do understand. So you do not believe it is necessary for you to meet with the Cancer Council?

Ms REBA MEAGHER: Absolutely. My door is open. I try to meet with as many people as I possibly can.

The Hon. DAVID CLARKE: But is your door open to the Cancer Council since becoming the Minister?

Ms REBA MEAGHER: I think it is also important to highlight the fact that it is a huge system with many stakeholders. It is not possible for me to sit here and say to you that I would have met them all in the first six months, nor do I think that it would be possible to meet them all in the first 12 months.

The Hon. DAVID CLARKE: You have not met virtually any of them that I have mentioned so far.

Ms REBA MEAGHER: I think that is a very unfair reflection on the work that I have undertaken since I became the Minister to Health.

The Hon. DAVID CLARKE: Those medical bodies do not agree that it is a very unfair. Anyway, let us be clear—

Ms REBA MEAGHER: With these workforce issues—

The Hon. DAVID CLARKE: —the Federal Government—

Ms REBA MEAGHER: I would like to come back to the point that you made—

The Hon. DAVID CLARKE: —did not stop you meeting with these bodies, did it?

Ms REBA MEAGHER: —about the emergency physicians—

The Hon. DAVID CLARKE: It had nothing to do with funding.

Ms REBA MEAGHER: —because I think it is important to understand that I asked the emergency physicians to reconvene the task force so that we could have the opportunity to work together cooperatively through the pressure points that they had identified in the system. In fact I have now met with them a second time. The comments that have come from that have been very positive. I think it has been a good opportunity and I think the physicians like it as well because it means they have direct input into the way we are going to manage these issues. This is one example of, I think, a demonstrably collaborative and cooperative approach to solving problems.

The Hon. DAVID CLARKE: I guess their response is: better late than never. Moving on to your good relationship with the clinicians, how can you justify your claim, as stated in the *Sydney Morning Herald* on 28 September that nine doctors were enough to staff the Royal North Shore

Hospital emergency section when Dr Joseph, who is the head of the department and also the Chairman of the College of Emergency Medicine in New South Wales—so I assume he is somebody who knows what is talking about—pointed out that the Australian Medical Workforce Advisory Committee has recommended between 11 and 16 doctors to fill those positions. What do you say about that?

Ms REBA MEAGHER: I do not question that Tony Joseph has a very good understanding of what is occurring in New South Wales Health. I question the fact whether you do because he is not actually the head of the emergency department. The name of the doctor in charge of the emergency department is—

Dr MATTHEWS: Dr Rob Day.

Ms REBA MEAGHER: Dr Rob Day.

The Hon. DAVID CLARKE: Be that as it may, he holds a position of prominence and importance in the hospital system, does he not? You say that Dr Joseph is wrong?

Ms REBA MEAGHER: I said you were wrong.

The Hon. DAVID CLARKE: I am talking about the number of doctors. I am not quibbling about the exact position. The thrust of my question is about the number of doctors, not about his full title.

Ms REBA MEAGHER: You see, the value of the Emergency Care Task Force, which I have now met twice since we established it, is that we have agreed to review the staffing levels in emergency departments across New South Wales, starting with big hospitals that have demonstrated double-digit increases in demand. That was in fact an action that was agreed to last Friday when we last met.

The Hon. DAVID CLARKE: Dr Joseph went on to state: "The Australian Medical Workforce Advisory Committee's recommendations were for between 11 and 16 senior specialists at a teaching hospital such as Royal North Shore", and, "the miscarriage incident was the result of a dangerous overstretched system." The miscarriage incident is something I will come to in a minute. You believe that Dr Joseph is wrong and you are right.

Ms REBA MEAGHER: I would like to show you the press release that I was able to issue last Friday after meeting with the Emergency Care Task Force where we have actually agreed to a review of the staffing levels but, importantly, we have also agreed to undertake a review of the work that has been done by the various bodies and at various times into recommendations in relation to staffing in emergency departments.

The Hon. DAVID CLARKE: If you would like to make that press release available to us, thank you.

The Hon. CHRISTINE ROBERTSON: He will not listen to your answers, so do not worry.

The Hon. DAVID CLARKE: What I am asking is that you disagree with Dr Joseph and you believe that nine doctors in that situation is sufficient for the Royal North Shore Hospital, do you?

Ms REBA MEAGHER: To the contrary, I made the point that the Emergency Care Task Force agreed last Friday to undertake a review of staffing levels in the emergency department of the major hospitals. On that point Tony Joseph and I agree wholeheartedly.

The Hon. DAVID CLARKE: I am sure they do want a review of staffing levels. But that is not what I am talking about. I am talking about the fact that the committee is recommending between 11 and 16 and you are recommending nine.

Ms REBA MEAGHER: No.

The Hon. DAVID CLARKE: Let us move on. We seem to be at an impasse on that. On what basis have you questioned the clinical judgment of some of the most senior doctors working in New South Wales hospitals? I refer you to the *Daily Telegraph* of 11 October, for example. Would you advise the Committee what medical qualifications you had to give credence to your questioning the clinical judgement of Dr Tony Joseph? Are you aware of that particular article?

Ms REBA MEAGHER: I also said—

The Hon. DAVID CLARKE: That is the article in which he said—I am sorry to interrupt—that in his expert opinion it was inappropriate to keep a patient for 24 hours in a treatment room cum storage space. I guess he is talking there about the outrageous saga involving the poor 91-year-old lady. I am sure you are familiar with that case. What do you have to say about it?

Ms REBA MEAGHER: I make the same point as I made at the time: I do not know whether Tony Joseph spoke to the nurses involved, but I went to the hospital that night when I became aware of the allegation. I spoke to the nurses who had been on duty the night before and made the decision. They told me that they made the decision based on best patient care. I defended them in their right to make that decision. These were very experienced nurses; they were senior nurses. That is what we train our nurses to do. So I think it is important that, as Minister, I defend them when there has been no error and no cause for concern.

The Hon. DAVID CLARKE: What about Mrs King?

Ms REBA MEAGHER: At the end of the day what we expect of our nurses is that they will take an interest in patient care, that they will show initiative and that they will act on that initiative. That is exactly what occurred in this case.

The Hon. DAVID CLARKE: The nurses can only act using the facilities that you provide to them.

Ms REBA MEAGHER: That is what happened in this case.

The Hon. DAVID CLARKE: So you believe Mrs King was quite appropriately treated, do you?

Dr MATTHEWS: I am happy to respond. At a press conference that was held subsequently there were questions from the press in relation to the comments that you are quoting. I undertook as a result of that to contact Dr Joseph, whom I have known since he was a lad, and speak to him and discuss his concerns. During the course of that conversation he clarified that he was raising systems issues but he had no concerns about the care provided to that particular patient. We discussed the room in which that patient was placed for better observation during the night. I pointed out to him that the room had been designed for that purpose because it had a call button, suction and oxygen and provided better observation of that patient.

The Hon. DAVID CLARKE: With respect, Doctor, I do not believe Dr Joseph has withdrawn the remarks he made to the media. But if we are talking about systems—

Dr MATTHEWS: He has and he said he was happy for me to be on the public record as saying that he had no concerns about the care provided to that individual patient.

The Hon. DAVID CLARKE: I would like that to be confirmed with Dr Joseph. Let us talk about the general systems operating, which is the issue you raised. Dr Joseph said about rooms used for clinical reasons, "They are unsafe and it is part of the overcrowding policy. When emergency departments are bursting they will put patients in these side rooms." He is not talking about a specific instance there; he is talking about a whole culture of this going on. How do you respond to that, Minister?

Ms REBA MEAGHER: The point I made at the time—and I will make it again now for your benefit—is that these patient treatment rooms have been used for these purposes I was advised in

2001, but I know that there are opinions around that suggest that it has been happening longer than that. These patient treatment rooms will continue to be used until we redevelop the hospital.

The Hon. DAVID CLARKE: So we could have more situations arising involving patients like Mrs King. Is that correct?

Professor PICONE: Madam Chair, could I comment about the decision that the nursing staff made that evening because I also went to meet with them? If they were here this evening this is what they would say to you—because it is exactly what they said to me. At around 10 o'clock they made a clinical decision to bring a patient under their care closer to them at the nurses bay for observation so that they could both hear and see this patient, who at the time had an acute delirium. They believed it was the right decision. They were extremely senior nurses.

One of them was actually my vintage but has stayed on in clinical nursing and another was a nurse who has come back to the profession through Nursing Reconnect. It is a treatment room and treatment rooms have been for decades in hospitals of all types used for treating patients. In the room there is a call bell and oxygen and suction and all those things. I totally support the decision that those nurses made that evening in the best interests of the patient. Where the nurses station is you can hear what is going on. They believed that was in the best interests of the patient, and I totally support their decision.

The Hon. DAVID CLARKE: You supported their decision on the basis that they had no other appropriate rooms to put the suffering patient into.

Ms REBA MEAGHER: That is in fact not true because she was already in a ward.

Professor PICONE: She already had her own room.

Ms REBA MEAGHER: She was on a ward. This was not a patient transferred out of emergency; this patient was on a ward and was moved from her ward bed to afford better observation during the course of the evening.

Dr MATTHEWS: I should also point out that Tony is quoted today in the *Daily Telegraph*—I assume he is quoted correctly—as saying that Royal North Shore Hospital has 300 beds. In fact, there are 599 acute beds. I would like to correct the record. I can only assume that Tony was misquoted there.

The Hon. DAVID CLARKE: The truth of the matter is it not, Minister, that there were no alternatives other than this pokey little side room?

Ms REBA MEAGHER: No, you are wrong.

The Hon. DAVID CLARKE: Okay. Let us move on. How do you respond to Dr Valerie Malka, who submitted a list of concerns about substandard levels of care in a letter to the chair of the Medical Staff Council at Westmead Hospital, where she is head of the emergency department, that included claims that lack of funds and resources prevented the delivery of the level of expertise and care we know is acceptable and appropriate? Are you aware of that list of concerns?

Ms REBA MEAGHER: Could you repeat the question?

The Hon. DAVID CLARKE: I am referring to a list of concerns from Dr Valerie Malka about substandard levels of care that she put in a letter to the chair of the Medical Staff Council at Westmead Hospital. Are you aware of that list of concerns that she has raised?

Ms REBA MEAGHER: I do not have the letter. I know that the chief executive did sit down recently with the doctor to discuss some of her concerns. I was asked a question in the House yesterday in relation to some of her claims. Some of her claims were that in fact we are employing more bureaucrats than medical staff. I made the answer clear in the House yesterday that that is simply not true. When we amalgamated the area health services from 17 to eight we were able to get rid of more than 1,000 positions by coordinating a lot of back-of-house functions. During that time too we

were able to employ I think close to 4,200 additional medical staff. So the actual ratio that we now have of medical staff within the Department of Health who have face-to-face contact with patients is 4 out of 6—which is very good.

The Hon. DAVID CLARKE: Thank you, Minister. Is there anyone among your staff or officers of the department who is aware of this list of concerns raised by Dr Malka—after all, she is the head of the emergency department?

Ms REBA MEAGHER: No, she is not.

The Hon. DAVID CLARKE: She is not. What is her position?

Dr MATTHEWS: I believe she is director of trauma at Westmead Hospital.

The Hon. DAVID CLARKE: Is that an important position in the hospital?

Dr MATTHEWS: Of course it is.

The Hon. DAVID CLARKE: Thank you. Is anybody here aware of her list of concerns?

Ms REBA MEAGHER: We do not have the list here.

The Hon. DAVID CLARKE: Are you aware that she raised these matters?

Ms REBA MEAGHER: As I said, I answered some questions in relation to this matter in the House yesterday so my comments are in *Hansard*, if you would like me to refer you to them.

The Hon. DAVID CLARKE: Where did you become aware of her concerns?

Ms REBA MEAGHER: Generally two weeks ago through media reports.

The Hon. DAVID CLARKE: Through media reports?

Ms REBA MEAGHER: Yes, and I spoke directly with the chief executive of Sydney West to ask him what were the issues and he told me that he had sat down with her to work through those issues, and then I was asked again about it in the House yesterday, as I have explained.

The Hon. DAVID CLARKE: Can I ask the director general: did you become aware of these concerns through media reports?

Professor PICONE: I did hear Dr Malka was concerned, again through media reports—and I don't know why you are giving that look because sometimes that is the first time that you hear— and I do understand that the chief executive has met with Dr Malka and gone through those concerns. Whether there is a resolution around those matters at this stage I am not aware.

Dr MATTHEWS: When a clinician chooses to raise their concerns through the media, it is not really surprising that that is the first place we hear about them. As a result of that, Professor Boyages, who is the chief executive and responsible for local management, met with her to discuss her concerns.

The Hon. DAVID CLARKE: She raised it in an official capacity?

The Hon. CHRISTINE ROBERTSON: Point of order.

The Hon. AMANDA FAZIO: It is not your turn.

CHAIR: There is no need for a point of order, we will move on to crossbench questions.

Ms LEE RHIANNON: Minister, what is the financial impact on the Health budget when people are unable to be discharged from hospital owing to a lack of other services being available to them? I am referring to the Program of Appliances for Disabled People [PADP].

Ms REBA MEAGHER: The issue that you have identified is perhaps greatest in relation to aged care. I will address your specific concerns about the Program of Appliances for Disabled People, but there is enormous pressure on the New South Wales health system. It is estimated that on any one day there are 230 patients medically suitable for discharge, but they remain in acute hospital beds because there is no suitable aged care bed or facility that can take them, and that is going to become an increasing problem.

Ms LEE RHIANNON: That is 230 patients?

Ms REBA MEAGHER: On any one day, who should be discharged but cannot be because there is nowhere for them to go, and this will increase because something like a third of all acute beds are currently being used by somebody who is over the age of 75 years and they stay much longer.

Ms LEE RHIANNON: Does that figure of 230 include people who may be waiting in relation to PADP?

Ms REBA MEAGHER: I do not have the specific number of people that that would apply to.

Dr MATTHEWS: The number that the Minister quoted is of people who have been assessed by the aged care assessment teams as needing nursing home care, but there is no bed or facility available, so they remain in the acute hospital.

Ms LEE RHIANNON: I am also interested in the number of people who have been waiting for various appliances so that they can leave hospital and lead their lives.

Ms REBA MEAGHER: I do not have that figure; I will take it on notice.

Ms LEE RHIANNON: I assume you would agree that it is a serious problem? I have not got the recent figures, but the 2003-04 Australian Institute of Health and Welfare [AIHW] figure for a bed per day is $864 and a motorised wheelchair comes in I think at about $15,000, so people would not have to be kept in hospital for too long before that equipment is paid for. I am wondering how proactive it is to be moving people out of hospitals and having equipment ready for them?

Ms REBA MEAGHER: I take on board the premise of your question. I am advised that the Government has allocated $24.1 million this budget for the Program of Appliances for Disabled People, which represents a 134 per cent increase on the 1994-95 budget. In addition, for 2007-08 the New South Wales Government has allocated $2 million specifically for equipment for children. This funding will allow the program to provide assistance to more than 16,000 people this financial year. I am advised that since 1999/2000 more than 60,000 people have already been assisted by the program with items like wheelchairs, hoists, toilet and shower aids, continence aids and pressure care mattresses.

Support for the ongoing development of the program is provided through the New South Wales Program for Appliances for Disabled People Advisory Committee, which includes a range of stakeholders like the Spastic Centre, Physical Disability Council, Multiple Sclerosis Society and Spinal Cord Injuries Australia. The equipment prescribed through the program not only assists the clients themselves; it also greatly assists family members and friends in their role as carers.

Area health services allocate program equipment through local advisory committees that include consumer representation. These local advisory committees assist in planning and oversight of the program at a local level and provide clinical expertise to assist decision-making. Once eligibility has been confirmed, all applications for equipment are assessed on the basis of clinical need. Area health service coordinators are located at 24 sites known as Program for Appliances for Disabled People lodgement centres. These lodgement centres are based in hospitals and community health centres across the State. These coordinators have day-to-day operational responsibility for service

delivery within their health service, including responding to inquiries, processing applications, purchasing aids and appliances, and supplying them to people with disabilities in the area.

A number of reforms have been undertaken to improve the program. A new unit called Enable New South Wales was established to progress key statewide initiatives to improve the quality, effectiveness and efficiency of the program. Enable New South Wales is part of Health Support, a New South Wales health organisation responsible for delivering shared services on a statewide basis across the public health system. Health Support offers considerable expertise in procurement and the development of efficient business models while staff within Enable are experts in disability equipment assessment and prescription. There are four pilot sites to test new procurement arrangements aimed at enabling the program to assist more people within the available budget: Calvary Healthcare Lodgement Centre in South Eastern Sydney and Illawarra Area Health Service; the Balmain Lodgement Centre in Sydney South West Area Health Service; and Tamworth and Wallsend lodgement centres in the Hunter and New England Area Health Service.

A committee, including clinicians who prescribe program equipment and procurement specialists, is leading this work. Evaluations of these pilots are currently underway, after which extension of the pilots to other categories of equipment and other sites will be considered. These pilots are already delivering benefits with examples of savings including $233 for each manual wheelchair purchased and $40 for each shower commode purchased. Another reform includes a new information system being developed to support the more efficient operation of the program. The new system is expected to be implemented by 1 July 2008.

To assist with the process of equipment assessment and prescription, groups of expert clinicians are preparing guidelines to ensure a consistent approach to equipment prescription across New South Wales government services. Public consultations are about to commence on new processes, including a common equipment request form, an equipment evaluation form, prescriber qualifications and experience, and a list of commonly prescribed equipment for procurement purposes. This work is being led by New South Wales Health and the Lifetime Care and Support Authority.

Expert statewide equipment advisers have been employed to provide advice and support for clinicians preparing prescriptions for high-cost or complex equipment. In addition, to assist with the process of determining eligibility, work on a clinical priority assessment tool has been undertaken in consultation with key consumer groups and clinicians. It is hoped that the tool will enhance statewide consistency in the decision-making process and ensure that those most in need have priority access to equipment.

Ms LEE RHIANNON: Unfortunately, we do not have the figures, but I understand that there is certainly a large number of people in hospital who cannot leave hospital because of the lack of equipment. Earlier, in relation to the North Sydney hospital, you said that the New South Wales Government is committed to taking action when things go wrong. Would you acknowledge that things have gone wrong with regard to people with disabilities who are ready to leave their hospital bed but, like many elderly people, are unable to leave because the system has not delivered for them?

Ms REBA MEAGHER: That is why I think it is important that we do have these review processes in place so that we can ensure that we are targeting our resources to those who are most in need. Dr Matthews, would you like to add to that?

Dr MATTHEWS: We had to take your question about the actual number of people on notice. Some of the equipment is complex in nature, some has to be custom-made, and that can take a period of time. We will take your question on notice and see what we have on that.

Ms LEE RHIANNON: That was a question about people who are caught in hospital and cannot get out. I am also interested in people who end up being stuck in their homes because equipment has not been fixed. There is a case of a woman in Orange who has not been able to leave her home for weeks because her wheelchair has not been fixed. Do you have quantitative data on people who are in a similar situation?

Professor PICONE: We would know, or should know, about that situation through the local Program of Appliances for Disabled People service.

Ms LEE RHIANNON: I would be interested in that.

Professor PICONE: We will take that on notice.

Ms LEE RHIANNON: Those are the sorts of complaints we are getting.

Dr MATTHEWS: We have taken steps to make this much more efficient through what is now called Enable. We have taken a number of these initiatives, not just the Program of Appliances for Disabled People but home oxygen and the care of ventilator-dependent quadriplegics. Enable is now part of shared corporate services, and there will be statewide coordination and procurement in order to streamline and make the process more efficient, first, to allow more of the money for the equipment itself, and, secondly, to try to speed up the approval processes and supplying these things.

Reverend the Hon. Dr GORDON MOYES: I would like the department to reply to a question on notice. I want to know about continuing education for registered nurses. How many nurses are undertaking upgrading training? What percentage of the whole nursing force is that? What programs does the department have for the continuing education of registered nurses? How many places in continuing education are being funded by the department? Can you take that on notice?

Ms REBA MEAGHER: In relation to the general nursing workforce we can, but Dr Matthews has indicated that he would like to give you the information specifically for mental health nurses now.

Reverend the Hon. Dr GORDON MOYES: No disrespect but I would be happier to know about the whole service because that is what I am concerned about.

Professor PICONE: Also, we can detail the nursing strategy reserve fund. You would be quite aware of the role of the College of Nursing in relation to that.

Reverend the Hon. Dr GORDON MOYES: I would be very happy to have that information.

Ms LEE RHIANNON: I understand that Blacktown-Mount Druitt has one of the highest levels of mental health in New South Wales, the local hospital has no psychiatric section and the units at nearby hospitals are extremely full when people attend them. This is another area where we get a lot of complaints in terms of lack of services.

Dr MATTHEWS: There are no acute or sub-acute inpatient beds at Mount Druitt. There are, however, a considerable number of beds at Cumberland Hospital and at Blacktown and Penrith. Recently we have renovated an area at Mount Druitt for a specific adolescent forensic service to meet some of the needs of that community. Two new PECS are planned to open by the end of this year. One will be at Blacktown Hospital nearby and one will be a six-bed unit at Campbelltown Hospital.

Ms LEE RHIANNON: Is it true that these services are usually full, that it is difficult for people to get in and that there is a long waiting list?

Dr MATTHEWS: It is true that there is a great demand for services. That is correct. There has been a considerable increase in the number of beds and in community services.

Ms LEE RHIANNON: At what rate are you turning people away?

Dr MATTHEWS: It depends on what you mean by that question. People who need services get access to services so there is not a rate of turning people away.

Ms LEE RHIANNON: Are you saying that if people present they will be given a level of service?

Dr MATTHEWS: That is correct. Every area health service has an intake for mental health. Soon we will introduce a 24/7 number across the State but at the moment if you ring that number you

will be triaged over the telephone and the level of need will be determined. In some cases assistance will be sent; indeed, in some cases the police need to be sent. You will be given an appointment with the mental health services, depending on your clinical need.

Ms LEE RHIANNON: Are you aware that former health Minister Mr Andrew Refshauge gave a commitment to carry out a health study of the effects of the coal industry in the Hunter region? Do you know if this study was undertaken and has it been completed?

Dr ROBINSON: I am sorry but I do not know the answer to that question. There were some studies undertaken in the Hunter in relation to lead and smeltering but I am not aware of anything in relation to the coal industry. I will have to find out for you.

Ms LEE RHIANNON: I do not think it was when he was health Minister. I think it was recently when he sat on one of the so-called independent inquiries into some of the coalmining projects. I think it could have been a recent promise. I do not think it was from years ago.

Dr MATTHEWS: He ceased to be health Minister in 1999.

Ms LEE RHIANNON: Yes. I did not want to confuse you that it was from such a long time ago. Are you aware of a study by the Hunter urban division of general practice that found that the number of family doctors in the Hunter has effectively decreased by 8 per cent over six years, which is the equivalent of 35 full-time general practitioners? The population is increasing; it has gone up by about 10 per cent in the same time. What is the Government doing to increase general practitioners in the Hunter?

Ms REBA MEAGHER: As you would be aware, the provision of primary health care services—that is general practitioners—is the responsibility of the Commonwealth but a report entitled "Caring for Health" was released earlier in the year by the States and Territories which showed that it is much harder to access a general practitioner now than it was 10 years ago. It is also much more expensive in relation to the out-of-pocket expenses than it was 10 years ago. This is a trend not only in New South Wales but across the country because of workforce shortages. The New South Wales Government has invested significantly in trying to overcome that by working cooperatively with the Commonwealth to establish the after-hours general practitioner clinics. Trying to re-establish that front line for primary care is twofold. The options are certainly better for families after hours and on the weekends but also it is a strategy that we have designed to try to alleviate the pressure in our emergency departments.

I had the opportunity to speak with some doctors from the Newcastle area when I first became health Minister and I was looking at the after-hours general practitioner clinics. In the four years since they were established they have seen 290,000 patients. That is an indication of the demand for the service but also what would happen to those patients if they were not there. They would end up in our emergency departments seeking assistance. So it is an important strategy and we are committed to rolling out—we have funded another—

Ms LEE RHIANNON: Do you have an idea of over what period you can deliver more doctors? Do you have targets?

Ms REBA MEAGHER: We are very much dependent on what comes out of our universities but we employ all sorts of recruitment strategies to try to provide a medical workforce for the community. Particularly in rural and regional areas, that is difficult. That is why area of need programs exist so that we can encourage general practitioners to establish there. We work cooperatively.

Ms LEE RHIANNON: So you do not look at an area like the Hunter or the Illawarra and identify that that area needs so many doctors and we will go out and put these programs in place to ensure that they come.

Ms REBA MEAGHER: There is certainly workforce planning.

Dr MATTHEWS: There is. I should point out that primary care general practice numbers are the responsibility of the Federal Government, and there is no way of affecting the mal-distribution of the existing numbers.

Ms LEE RHIANNON: I understand the Commonwealth involvement. What I am hearing from that last statement is that you are not in a position to work in an area like the Hunter, identify how many doctors it needs and do everything—

Dr MATTHEWS: There are not enough doctors to carry out the strategy. The private sector is shrinking. A moment ago you mentioned mental health. I can tell you that in 2001-02 there were 690,000 occasions on which the Medicare benefits schedule was accessed by psychiatrists in private practice. In 2006-07 that number had shrunk to 603,000—a one-seventh reduction. As that reduction occurs in the private sector the work is inevitably picked up by the services which are always open, and they are our services.

Ms REBA MEAGHER: We certainly do workforce planning around population needs and projected needs but we cannot compel doctors to work in certain areas. One of the issues discussed, not at that ministerial council but at the previous one when John Hatzistergos was the Minister for Health was the idea that the States and Territories want the Commonwealth to review the allocation of provider numbers so that instead of all provider numbers belonging to doctors, and doctors deciding where they are going to hang their shingle, we may develop a system of allocating provider numbers to certain areas or to certain communities and encourage the take-up of practice in those areas by that mechanism. Certainly work needs to be done and the issues are most profound in rural and regional areas of how we are going to encourage the medical workforce to take up practice in those areas.

Ms LEE RHIANNON: I turn now to dental health issues. Last month you stated that increased funding will cut the number of children on dental waiting lists by 20 per cent. How long will it take to achieve that 20 per cent reduction?

Ms REBA MEAGHER: The Chief Health Officer will answer that.

Dr ROBINSON: There was some specific funding allocated by the Minister with the focus on the provision of services for children. That represents $4 million this year and we have indicated to our services that we would expect that the waiting lists for children will be addressed within an 18 month to two year framework. That is what we are looking at.

Ms LEE RHIANNON: So, that is 20 per cent down over 18 months to two years?

Dr ROBINSON: No, we would like to address the extent of the waiting list, the undue waiting lists over a period of 18 months to two years. There will always be a waiting list of some description, but the issue is whether the children are waiting inappropriately. Strategies are designed to eliminate that unnecessary wait over a period of 18 months to two years.

Ms LEE RHIANNON: I am interested in the 20 per cent reduction. You have talked about an unnecessary waiting list. Is the unnecessary waiting list separate from the 20 per cent?

Dr ROBINSON: No, that 20 per cent is included in that undue wait. The only figures I have to hand at present in respect of Sydney West, which as you know has one of our larger oral health hospitals. There has been a significant reduction in the children who are waiting for general anaesthetics at that hospital. It has been reduced from 600 down to 400, from recollection. That is actually exceeding the 20 per cent target that we have established.

Ms LEE RHIANNON: How many children are on the waiting list altogether?

Dr ROBINSON: I do not have the figures with me for that particular area health service, I am sorry.

Ms LEE RHIANNON: Can you take that question on notice?

Dr ROBINSON: Yes.

The Hon. MICHAEL VEITCH: Minister, last time around you were part way through answering a question from me in relation to the State and Commonwealth governments providing health care to the people of New South Wales. Would you like to continue with that?

Ms REBA MEAGHER: I would be happy to. One of the central planks of Commonwealth-State funding arrangements is the Australian Health Care Agreements. These are bilateral funding agreements under which the Commonwealth Government provides funding to the States and Territories to equally share the cost of provision of public hospital services. The current agreement covers the period between 2003 and 2008. Historically these agreements have been based on a 50:50 split between State and Territory governments. However, based on the Commonwealth Government's own fund-matching formula, New South Wales has increased its funding by 42 per cent between 2003-04 and 2005-06, the Commonwealth Government has increased its funding by only 14 per cent over the same period.

According to the latest data from the Australian Institute of Health and Welfare for 2005-06, based on the Commonwealth's contribution, the States and Territories funded 55 per cent of public hospital expenses, and the Commonwealth funded just 45 per cent. This data shows that the Commonwealth's funding to Australian public hospitals was $2.2 billion less than the funding provided by States and Territories in 2005-06. Based on a simple population share, that equates to a New South Wales share of around $750 million. The Commonwealth Government is reducing its funding to public hospitals at a time when the health sector is experiencing the highest inflation rate in a decade.

In the period from 2003-04 until 2004-05 the annual health sector inflation has been 4.2 per cent, according to the Australian Institute of Health and Welfare, which is well in excess of general economic growth. New South Wales and the other States and Territories have expressed ongoing concern about the adequacy of the funding provided by the Commonwealth Government to allow public hospitals to continue to deliver full services to the community. To date, New South Wales and the other States and Territories have been ignored. A key challenge is to examine the funding formula in the agreements and change it to one which recognises that public hospitals across the country are under more, not less, pressure.

Public hospitals need adequate funding from the Commonwealth Government to guarantee their sustainability. As demonstrated in the "Caring for Our Health" report, hospital services are only one part of the overall picture in addressing Australian's health needs. The report highlights how the Commonwealth has failed to adopt a whole-of-system approach to health care funding and delivery by limiting the scope of the Australian health care agreement to hospital services only. For example, the "Caring for Our Health" report shows that the Commonwealth Government has not addressed general practitioner and specialist workforce shortages.

The report shows also that the cost of health care is increasingly being transferred to State and Territory governments because of inadequate indexation arrangements and to consumers as rising out-of-pocket expenses for medical services and prescription drugs. As Chair of the Australian Health Ministers Conference in July, I called on Tony Abbott to immediately begin negotiations for the next Australian health care agreement so that we can find a way to bring about vital reforms in the health system. Mr Abbott refused to talk to the States and Territories, saying that he had to focus on winning the election. It is a position that sums up the current Commonwealth Government: Politics before people.

The Hon. CHRISTINE ROBERTSON: Can you inform the Committee about the detail of some of the capital works, both major and minor, which are funded for rural areas in this year's budget?

Ms REBA MEAGHER: The New South Wales Government is committed to providing people living within rural and regional New South Wales with greater access to quality health care. There are very real challenges faced by people in our State who live in the bush, in the heart and soul of the State. I have taken the time to travel to many of those areas and have heard the concerns raised by our rural communities. That is why investment in our rural communities is a key feature of the Iemma Government's record $12.5 billion health budget this year. The budget invests a record $3.69

billion in rural and regional New South Wales; that is over 38 per cent of the budget allocated to rural and regional New South Wales.

Over the next four years the Iemma Government will commence construction on $550 million worth of new hospital redevelopments in rural and regional New South Wales. That includes complete redevelopment of Tamworth, Narrabri, Wagga Wagga, Bega, Parkes and Forbes hospitals. Our rural capital works program in 2007-08 includes $1.6 million for planning the redevelopment of Narrabri Hospital; $800,000, or $10 million over three years, to redevelop and expand the emergency department at Maitland Hospital; $400,000, or $3.5 million over four years, for the ambulance computer-aided dispatch system and new ambulance stations and Nelson Bay and Deniliquin; a $4.8 million upgrade and enhancement of a range of medical imaging and patient monitoring equipment in hospitals across New South Wales, including the Children's Hospital at John Hunter; and $2 million to support the further introduction of water fluoridation in rural New South Wales, including Port Macquarie and Gosford as well as the building of dental clinics.

We are also continuing to roll out a number of projects, including the $56.7 million to redevelop or upgrade 13 rural hospitals and services, including Batlow, Berringen, Bombala, Junee, Merriwa, Tingha, Walcha and Warialda; $24.1 million to progress a range of other rural projects, including the Manning Base Hospital emergency department, Ballina rehabilitation unit and Bega District Hospital operating theatres; $32.6 million to continue redevelopment of Bathurst Base Hospital; $12.3 million to continue the redevelopment of Gosford and Wyong hospitals, under the Central Coast Area Health Access Plan; $19.8 to improve hospital and clinical services at John Hunter, Belmont, Newcastle Mater, Calvary, and the new Newcastle community health centre, under the Newcastle strategy; and continuing the Orange Hospital redevelopment with $12.2 million for construction of the new acute hospital and associated services on the Bloomfield site.

We are redeveloping Queanbeyan Hospital, with $17.6 million allocated this year for the redevelopment of a hospital on the current site, including increased capacity. An amount of $39.5 million will be spent to improve mental health facilities in regional New South Wales, and $14.5 million for the Ambulance Service to develop stations at Dubbo and Port Macquarie as well as fleet and equipment upgrades. The New South Wales Government is committed to establishing multipurpose services in rural and remote communities. Multipurpose services offer an innovative and integrated service delivery model that allows for greater flexibility in service delivery and consequently better matches the needs of the local community.

Multipurpose services bring together a range of health and age care services under a single management structure, generally in a single location. These services include home-based or residential age care, community health, and primary health care services. More than $270 million has already been provided to establish the 38 multipurpose services that are currently operational in New South Wales. These services are located in some of the State's most remote areas, including Lightning Ridge, Emmaville, Bourke, Gilgandra, Dunedoo and Warren. An additional nine sites included in this year's funding allocation are in the final stages of capital planning, with construction due for completion by September 2008. Just some of these locations include Junee, Bombala, Batlow, Tingha, and Merriwa. An additional service at Boorowa Hospital is also being planned and we are planning for more.

An extra $59 million in capital funding has been allocated for additional multipurpose sites in rural New South Wales over the next eight years. On top of this I am pleased to advise the Committee that we are also investing $2.3 million over the next 12 months for other enhancements to rural hospitals under the Rural Minor Works Program. These enhancements focus on improvements to staff accommodation in remote areas and are part of the strategy to improve recruitment and retention of clinical staff in rural communities. The recruitment and retention of health professionals in rural and remote areas is an issue of national importance and is a challenge also faced in the international community. That is why we are working hard to attract adequate numbers of qualified health professionals to work in rural communities.

By improving our country health facilities we are making our hospitals more attractive to doctors, nurses and other allied health professionals. This means we are better placed to attract and retain experienced staff. Some of the important projects funded under the Rural Minor Works Program include: $300,000 to convert a currently vacant building at Tenterfield Hospital into staff

accommodation—this will provide up to 14 staff rooms—$100 to refurbish staff accommodation at Moree hospital; $200,000 to expand refurbish staff accommodation in Wilcannia; $200,000 to upgrade maternity services at Dubbo Base Hospital; and $322,000 to refurbish and extend existing facilities at the new Bombala Multipurpose Service to provide accommodation for staff. Currently, no staff accommodation is available on the site.

There will also be $400,000 to improve patient access to Moruya Hospital, particularly for the elderly and disabled; $120,000 to complete repairs to the Lithgow Hospital operating theatre roof; $80,000 to install air-conditioning at the Lithgow Community Health Centre; and $200,000 to purchase specialised equipment for Shoalhaven District Memorial Hospital for better care for bariatric patients. These significant investments in rural and regional New South Wales are helping to maintain and improve the working environment in our rural hospitals, making these hospitals more attractive to the health work force. This is because the Iemma Government is committed to improving access to quality health care for people living in rural communities and attracting more doctors and nurses to work in rural New South Wales—all part of this Government's commitment to improving services for the people of rural and regional New South Wales.

The Hon. AMANDA FAZIO: Minister, can you advise the Committee about any improvements in hospital performance?

Ms REBA MEAGHER: Yes.

The Hon. AMANDA FAZIO: Madam Chair, could you ask people in the gallery to be quiet?

CHAIR: Order! People in the visitors' gallery will cease laughing.

Ms REBA MEAGHER: The surge in emergency department activity in public hospitals experienced in 2005-06 has been sustained in 2006-07 and continued unabated during the first three months of the current financial year. Similarly, our elective surgery performance continues to be sustained with over 200,000 elective surgical procedures performed during the last financial year. On elective surgery our performance is effectively meeting the national benchmarks that are established for elective surgery. In September 2007 there were just 184 surgical patients who had been waiting longer than 12 months for their non-urgent surgery. In January 2005 over 10,551 patients were waiting for periods greater than 12 months. The number of patients who are waiting for urgent surgery in excess of 30 days, such as urgent cancer patients, also continues to decline. In September 2007 only 133 urgent surgical overdue patients were awaiting their surgery.

In January 2005 over 5,300 urgent patients were waiting for periods greater than 30 days. Our day of surgery admission performance for September 2007 is currently 91 per cent, which is above the benchmark, and our day-only surgery performance is currently 56 per cent, only four points below the benchmark. No other public health system in Australia has this sustained improvement in performance in its surgery program. This result has been achieved in tandem with the New South Wales public hospital system coping with significant growth in the number of patients coming to emergency departments. I am advised that emergency department attendances grew by 7.8 per cent in the three-month period from July to September compared to the same period last year. In September 2007, 154,710 attendances were recorded by the emergency department information system.

This continued growth in demand for emergency department services also reflects the very busy winter our health services have just been through. There was a cold winter coupled with a particularly virulent strain of the flu. Emergency department admissions to hospitals during 2006-07 grew by 27,000 admissions, or 6.9 per cent, compared to figures for the previous year. Hospitals recorded over 14,000 admissions via the emergency department in the last financial year. In the month of September 2007 there were almost 34,000 admissions to hospitals via the emergency department. For the year to date, emergency department admissions stand at 14,616, which is currently 2.8 per cent greater than the same time last year. Despite this increased demand for service our health system continues to perform extremely well.

Despite the significant increase in attendances and admissions by our very busy emergency departments, the time taken for the transfer of patients arriving by ambulance to emergency

departments is steadily improving. This indicator is referred to as the off-stretch time, and the benchmark time frame is 30 minutes. I am advised that in September 2007 this rate was 76 per cent. In August 2005 the performance was just 66 per cent. This is a tremendous improvement and shows the cooperation of both our ambulance and hospital personnel working together to ensure that patients receive faster and better care in a reasonable and appropriate time frame. At the same time we continue to see a marked increase in demand for ambulance services by the community, with incidents having increased 7.1 per cent on the figures for the previous year, responses having increased 7.6 per cent on the figures for the previous year, and ambulance transports having increased 9.1 per cent on the figures for the previous year.

This performance is as good as last year's performance, despite the high growth in demand for ambulance services. Emergency departments always give priority to the most life-threatening cases. New South Wales hospitals continue to treat 100 per cent of the most seriously ill within the national benchmark of treatment—within a designated two-minute time frame. I am advised that figure was a mere 77 per cent when the Opposition was last in government. I am pleased to advise that there has been a continued and steady improvement at all levels of triage during September 2007. These standout performances were in triage two, three and four. For those patients classified as triage two or imminently life-threatening, the national benchmark is: 80 per cent of patients to receive treatment within approximately 10 minutes.

I am pleased to advise that performance in September 2007 was 83 per cent of patients treated within 10 minutes, which is 3 per cent above the national benchmark. For those patients classified as triage category three, the national target is 75 per cent of patients to be treated within 30 minutes. The result for September was 70 per cent, close to the national target, and a significant improvement on the previous year's performance of 66 per cent. Significantly, improvements have also been achieved for those patients who are classified as triage category four. I am advised that September 2007 data indicates that over 74 per cent of triage four patients had treatment commence within 60 minutes, and this was 4 per cent above the national benchmark for the previous year. The previous year's performance was 71 per cent. The triage category five national benchmark once again was exceeded during September with 88 per cent of patients receiving treatment within 120 minutes. This is 18 per cent above the national benchmark.

The benchmark for admitting patients to an inpatient bed from the emergency department is 80 per cent. In September emergency admission performance improved for all patients with 76 per cent of ward admissions transferred from the emergency department within eight hours. In August 2004 the figure was 62 per cent for New South Wales. It is a terrific improvement in ensuring greater access to in-patient care in a timely manner. The 76 per cent emergency admission performance represented over 25,672 admissions within eight hours; a strong performance given the increased demand for emergency services during the last three months. These improvements are the results of careful planning, setting clear targets in the State Plan and the allocation of funding and support for the services, most importantly through support being given to clinicians and nurses through the Clinical Services Reform Program and the Surgical Services Task Force.

We have invested in 563 new permanent beds in places that opened in 2004. An additional 800 beds and bed equivalents were funded in 2005 followed by another 426 beds and bed equivalents in 2006-07. In total, the Government has opened nearly 1,800 new permanent beds and bed equivalents in the public health system since 2004. As outlined in the recent budget, a record $12.5 billion was allocated to the health budget and there will be more to come. The 2007-08 budget included $34 million for improved access to hospital and community-based treatment through 456 community-based bed equivalents and hospital beds, $18.5 million for more elective surgery and $18 million over four years to keep elderly people healthy at home and thereby avoiding admission to hospital.

The record State health budget recognises that chronic diseases are increasing rapidly in our community. Our population is growing and the population certainly is ageing at a faster rate. The demand for emergency department services is growing at around 8 per cent a year. Accordingly, solutions to these problems will not be solved merely by more beds in hospitals or bigger emergency departments. New South Wales Health is leading the way in preventing and managing patients with chronic disease so they are maintained well at home or experience a short hospitalisation. Managing

the vast majority of patients with chronic diseases such as heart failure, diabetes, chronic lung disease and mental illness can be supported out of hospital with a clinical team approach.

I was very impressed recently to hear first hand of the work being undertaken by the New South Wales Physicians Task Force, which is chaired by Professor Peter Castaldi. Professor Castaldi's task force is overseeing the implementation of the medical assessment and planning units that are designed to expedite rapid assessment and comprehensive management of medical patients who attend our hospitals. The map used will introduce better models of care for chronically ill and aged patients. We have been investing in health service delivery. We actively support our doctors and nurses, and we have recruited an additional 8,100 nurses since January 2002.

The Hon. CHRISTINE ROBERTSON: Could the Minister just be allowed to finish the question.

Ms REBA MEAGHER: The New South Wales Government will continue to work with our doctors, nurses and other allied professionals to reform our public health services.

The Hon. CHRISTINE ROBERTSON: We have agreed not to ask any more questions.

The Hon. DAVID CLARKE: But you do not have any more time.

CHAIR: I think we all agree there is more to be done with health. Minister, if we could just go back a few questions. Ms Lee Rhiannon asked some questions about dental health care and you agreed to take on notice and provide to the Committee the numbers of children on the public dental health waiting list. I wonder if you could provide also the total numbers and a breakdown of area health services?

Ms REBA MEAGHER: Yes, I can take that on notice.

CHAIR: I was interested in some of your comments about triage times, emergency department waiting times and elective surgery waiting times. Dr Rod Bishop is a member of your Emergency Department Task Force.

Ms REBA MEAGHER: He is the co-Chair.

CHAIR: He is the co-Chair. I think he is also head of trauma at Nepean Hospital, is that correct?

Professor PICONE: No, he is the head of the emergency department.

CHAIR: I believe in an article in the *Sunday Telegraph* on 17 October he said that there is no excuse for the public to wait long periods for emergency treatment. What do you intend doing about the fact that there are 8,661 patients, which is 25 per cent of the total, who waited for more than eight hours to be admitted to hospitals through our emergency departments in June?

The Hon. CHRISTINE ROBERTSON: That does not mean they are not getting emergency care.

Ms REBA MEAGHER: The first comment I would like to make is that there has been tremendous improvement in our ability to meet the triage categories. The triage categories and time frames were actually developed by the College of Emergency Physicians, which we then incorporated into our State Plan target. So, we take very seriously improving performance in that way. Part of the reason we have re-established the Emergency Care Task Force is to look at access issues and work with the physicians to overcome some of those pressure points that we have in our public hospitals.

One of the points I made in my last answer is that increasingly as our population ages the number of people presenting to emergency departments who are frail and aged will increase over time, and they take longer to work up in a diagnostic way. So, one of the things we are very interested in doing is looking at alternative models of access to the hospital instead of re-presenting at the

emergency department. That is the principle underpinning the establishment of the medical assessment units. Essentially it is creating a third door to the hospital so that we can alleviate that.

CHAIR: So you would agree with him that it is unacceptable that people have to wait for so long?

Ms REBA MEAGHER: Well, we all agree that we want to improve the performance of the hospital system and, in fact, to that end there has been some tremendous work done by the doctors and nurses with Katherine McGrath in improving that. I would like the Committee to be able to hear some of that work on the clinical services redesign program.

CHAIR: Perhaps if we have some time later we can swear in Dr McGrath, but at the moment I am just happy to ask you some questions. What I would like to know is your response to the fact that 45 per cent of patients waited for more than eight hours at Royal North Shore Hospital? Surely that is unacceptable? They are your figures off your website.

Ms REBA MEAGHER: I am not sure what you are referring to.

Professor PICONE: You are referring to the access block?

CHAIR: Yes, through the emergency department.

Ms REBA MEAGHER: There has actually been significant improvement in access block at Royal North Shore Hospital. In fact, I met with my chief executive this morning because, as you know, I am now having weekly meetings with him while he is working with the doctors and nurses to get Royal North Shore back on the right footing.

CHAIR: But you agree that was the position in June?

Ms REBA MEAGHER: There is no question that the management of the hospital needed to improve, but I was very impressed today that he has been able to show me improvements in general performance around emergency triage categories, but also significant improvements in access block. So, I think in a short period of time he has been able to work with the doctors and nurses to overcome some of these problems. Really, that is the right approach.

CHAIR: There has been a great deal of discussion in the media about patients waiting for elective surgery and particularly in recent cases. What about the fact that there are 56,640 patients waiting for elective surgery and out of those 1,248 were at Royal North Shore? I remember when Labor came into office and promised to halve the waiting list. There are thousands more people waiting now since you have been in office. What are you going to say to those people waiting on the elective surgery list?

Ms REBA MEAGHER: The indicator of good quality care is whether clinical time frames have been exceeded while people wait for surgery. So, the actual volume is not the indicator. The indicator is exceeding the recommended clinical time frames. That is where there has been tremendous work done by our surgeons through the Predictable Surgery Program. I have outlined those figures for you, but two years ago we had a situation where there were more than 10,000 people exceeding the clinically recommended time for surgery. That has come down to about 118 today. That is tremendous work. The point is—

CHAIR: There are many people on the waiting list who would like to know why, if it was good enough when you came into office to halve that waiting list, it is not good enough at least to make that effort now.

Ms REBA MEAGHER: Professor Picone, would you like to explain the waiting list to the Chair?

Professor PICONE: Perhaps Professor McGrath can be sworn in. If you are agreeable, while that is happening I will respond. We have had a very senior group of the State's surgeons advising on how to improve surgical access and surgery generally. It has truly been an amazing time

to be able to guarantee members of the public that the zero long wait policy works and that if you have a priority set for surgery that that priority will be met, particularly the urgent cases. We have as a health system made this happen. It has occurred by working with the surgeons—the people best placed to tell clinically what needs to happen—and then making it happen in the hospitals. Professor McGrath has led this process with people like Professor—

CHAIR: I am well aware of Professor McGrath's experience. However, we have 20 minutes left in the hearing in which to ask a number of questions to which I know patients want answers.

Ms LEE RHIANNON: With regard to time, I understand there was 30 minutes in the new round of questions. Can we split that 15 minutes for the Coalition and 15 minutes for the cross-bench?

The Hon. AMANDA FAZIO: That is fair.

CHAIR: I am sure the Government members think that is fair. We have absolutely no chance of hearing from Professor McGrath.

Ms REBA MEAGHER: I have met on a number of occasions with the Surgical Services Taskforce to discuss how it achieved those performance improvements and how we might be able to work with other groups of physicians for that kind of system improvement. The members of task force have been very helpful and informative. I understand a number of them are providing assistance to Royal North Shore Hospital as well.

CHAIR: About 18 months ago doctors in the Hunter were told that they were not allowed to put patients on a waiting level unless they could be treated within a clinically appropriate time. Is that correct?

Ms REBA MEAGHER: I will seek advice on that. Professor McGrath would be able to answer that.

CHAIR: I think there was a memo. You are determined to get Professor McGrath sworn in and we have demands on time. Surely she can pass you a note.

Ms REBA MEAGHER: I am unaware of a memo issued 18 months ago.

CHAIR: Perhaps you can take that question on notice. If that is the case, it has big implications for what we are talking about.

Ms LEE RHIANNON: Can we be clear about the time? We thought that 15 minutes and 15 minutes was fair. We still have the option of extending at some other time.

CHAIR: We have more questions to ask and there will not be enough time to ask them. Perhaps we can hold another estimates hearing. We can certainly put questions on notice. We will have a few more minutes of Opposition questions and then we will go to the cross-bench.

Professor PICONE: I would like to raise a serious issue. Earlier in the committee proceedings a question was raised by one of the members about an allegation concerning Professor Stephen Boyages. We have tried to follow that up, and thank you for being helpful. At this stage I have not had an opportunity to talk to Professor Boyages. However, I am obligated under section 11 of the Independent Commission Against Corruption Act to refer this matter to the Independent Commission Against Corruption, and I will do so. I remind the Committee that this is an allegation and it requires investigation.

CHAIR: Thank you for that clarification.

The Hon. DAVID CLARKE: Minister, you recall the comments made by Dr Linda Dayan. I refer to her claims about funding being determined according to an area's wealth and level of private health insurance. Do you recall that incident? You said that that was not the case. In fact, you said on television that it was absolute nonsense and you refuted the claim without reservation. You then went

into print and said, "We utterly reject that claim." Subsequently you were forced to admit that that was the situation and—

Ms REBA MEAGHER: Let us be very clear. I refuted the claim that there had been a budget cut to Royal North Shore Hospital, and I stand by that.

The Hon. DAVID CLARKE: No, you went further than that; that was not the only refuting you did. You went to the substance of Dr Dayan's claim and rejected it. You were then forced to back down. In that situation—

Ms REBA MEAGHER: First of all, I am not sure that I know the clinician you are referring to. If I recall correctly, there was a media story that may have involved that doctor and a cut to Royal North Shore Hospital's budget based on private insurance figures. I refuted that claim.

The Hon. DAVID CLARKE: Do you not recall that you were on Channel 10 with Dr Dayan.

Professor PICONE: Dr Day, as in D-A-Y?

The Hon. DAVID CLARKE: Yes. Do you not recall this incident?

Ms REBA MEAGHER: Of course I recall the issue; it related to the resource distribution formula. I also clearly recall an allegation that had been put to me, which I refuted, and I stand by that. The allegation was that in fact—

The Hon. DAVID CLARKE: Except you did not stand by it when you said—

Ms REBA MEAGHER: —the Royal North Shore Hospital budget had been cut because of private insurance figures. I ruled that out.

The Hon. DAVID CLARKE: I am talking about when you confirmed in the *Sydney Morning Herald* that private health insurance was taken into account at a marginal level. I think the *Sydney Morning Herald* article went on to say that your department had been repeatedly asked to reveal the weighting. That is what I am talking about and that is what Dr Dayan raised.

Ms REBA MEAGHER: Let us be clear. There are two separate claims. One was that a budget had been cut—

The Hon. DAVID CLARKE: I am not talking about that.

Ms REBA MEAGHER: —based on the resource distribution formula, and I rejected that. Private hospital bed utilisation is one of the determinants of the resource distribution formula. There are about 30 determinants. The formula is used as a guide to allocate funding to area health services, and then area health services fund hospitals according to their activity. Let us be clear, the resource distribution formula was brought into existence under Nick Greiner. It has been around for a long time. It has been subject to parliamentary scrutiny and academic review. It is seen as perhaps the most appropriate way to allocate funding throughout the State.

The Hon. DAVID CLARKE: I am not going into the question of the history of the matter. I am saying that Dr Dayan raised it and said that there was this weighting depending on area and wealth. You specifically rejected that.

Ms REBA MEAGHER: I think you agreed earlier that she had used that to claim that a budget had been cut. That is what I refuted.

The Hon. DAVID CLARKE: I did not say that at all.

The Hon. AMANDA FAZIO: You did.

The Hon. DAVID CLARKE: No, I did not.

The Hon. AMANDA FAZIO: You did so; I heard you.

The Hon. DAVID CLARKE: You are denying what you said on Channel 10 and what you were quoted as saying in the *Sydney Morning Herald* on 28 September.

Ms REBA MEAGHER: Let us be very clear. The resource distribution formula is not used to allocate funding to hospitals. If there is any suggestion or a claim that is being made that a hospital budget was cut because of the resource distribution formula, that is simply not true. That is not the way the system works. I stand by what I said before.

The Hon. DAVID CLARKE: With respect, Minister, the State Health Minister has admitted private health insurance does play a role in how funds are distributed to each area for hospitals.

Ms REBA MEAGHER: "each area". It guides how the funding is distributed to area health services, and then area health services make a determination to hospitals according to their activity. Also let me make this point: The North Sydney and Central Coast Area Health Service is above its resource distribution formula. It was above its resource distribution formula by 1.9 per cent last year and I think in this budget is 2.1 per cent above, so it is actually getting more. The North Sydney and Central Coast Area Health Service is getting more than is recommended by the resource distribution formula.

The Hon. DAVID CLARKE: So you are saying that there is a big difference between funds to hospitals and funds to areas for hospitals. Is that what you are saying?

Ms LEE RHIANNON: Madam Chair, my time is disappearing fast. Minister, you indicated earlier that plans for PADP were being run to increase efficiency within the present budget. I understand they were your words. I notice that the New South Wales Government, as part of its submission to the Productivity Commission research study into the economic implications of an ageing Australia in November 2004 stated about PADP: "PADP still struggles and to meet current demand and will require a further increased level and rate of investment if New South Wales Health is to prevent avoidable admissions to expensive acute care services." Will you increase the budget? It has been clearly identified that is the only way we are going to get over this problem. Is that the recommendation in the PriceWaterhouseCooper review of 2006?

Ms REBA MEAGHER: I am advised that the budget has increased since we came to office by 134 per cent and that there was an additional $2 million made available in this budget specifically for children. The rest of your question I will have to take on notice.

Ms LEE RHIANNON: When you say since you came to office, you are referring to 11 years ago?

Ms REBA MEAGHER: Over the life of this Government, it has increased the budget by 134 per cent.

Ms LEE RHIANNON: Have you got the increase recently?

Dr MATTHEWS: We can take that one on notice and give it to you by year.

Ms LEE RHIANNON: The increase over last year, yes, because I think there was a big jump in the mid-90s and then it slowed down.

Dr MATTHEWS: Mr Barker has the figures now.

Mr BARKER: The PADP budget that we have here is that in 2004-05 it was $18.8 million. In 2005-06, it went up to $21 million. In 2006-07, it went up to $22 million. This year we then supplemented 2005-06 with another $1 million to get it to $22 million. In 2006-07, a further million was embedded in one of the earlier bases to make it $23 million. In 2007-08, it is up to $24.1 million, and that is where it is running at present. It has gone up from $18.8 million in 2004-05, which included a once-off $1 million enhancement, to currently $24.1 million per year.

Ms LEE RHIANNON: Minister, I repeat the other part of that question. I am sorry, but I am conscious of the time. Is your recommendation about a budget increase one of the recommendations of the PriceWaterhouseCooper review of 2006 for a budget increase?

Ms REBA MEAGHER: I cannot comment because it is actually subject to Cabinet consideration.

Ms LEE RHIANNON: I will go back to some dental questions. I want to go back to this 20 per cent reduction. I understand there are six categories of waiting lists for children. We are talking about a 20 per cent reduction for each of the categories? I am just trying to understand how the 20 per cent works. The cost is such a clear figure that you gave.

Dr ROBINSON: In my earlier response I was actually referring to a reduction in the waiting list for children for general anaesthetics who have needed to wait to have their extractions undertaken by admission to hospital.

Ms LEE RHIANNON: Is that one of the six categories?

Dr ROBINSON: No, this is a separate group. Oral health services are provided in two ways, as you probably are very well aware of. One is by people attending an outpatient clinic or having a community-based service, and that is the categorisation to which you are referring; then there is a group, such as children or disabled people, who are not suitable to operate on or to have their teeth extracted or cared for while they are actually conscious, and they need to have some form of sedation. So that is a group that has to go into our hospital service for the provision of that, and I am sorry, but that was the group that I was referring to earlier.

Ms LEE RHIANNON: Sorry to rush, but I am conscious of the time. Is the 20 per cent referring to all six categories? I am just trying to work out what this 20 per cent refers to because it only really has meaning if we have some benchmark or it has a context.

Dr ROBINSON: We are in the process now of refining the information system surrounding dental services. Again, as you are probably aware, community-based information services have not been very well developed in the past. On the recommendations that we received months ago, we are going through and refining the oral health information systems and we are doing a cross check between the different areas and refining the information with respect to the waiting list. You asked earlier if you could have the information about the waiting list by area health service. As we have previously advised, that is something that the department has not traditionally collected.

We are getting to the stage now of actually refining the information systems with a view to having consistent definitions across the area health services and being able to collect the information and make it publicly available. That is the categorisation that I believe you are referring to: category 1, where the patients actually get care within 24 hours because they have an urgent situation, and category 2 where we hope to have that service provided within a week, and then progressively down the list as the complexity diminishes.

Ms LEE RHIANNON: I must admit I am still worried about the 20 per cent. Anyway I will just ask you about the $4 million. In the budget you announced about $4 million that is aimed at reducing waiting lists for children.

Dr ROBINSON: Yes, that is correct.

Ms LEE RHIANNON: How will the money be spent? Over what period of time will it be spent?

Ms REBA MEAGHER: The boost in funding announced in the 2007-08 budget will support a suite of initiatives, including targeting early intervention and prevention of oral health problems and treating more people on the waiting list, particularly children and those living in rural and regional areas. New South Wales eligibility criteria for children's dental services are some of the most generous nationally. All children and young people between the ages of zero to 18 who are

undertaking full-time education are eligible for public oral health services in New South Wales. A statewide project is currently underway to further address paediatric surgical waiting lists by centralising waiting lists in New South Wales to minimise duplication and maximise operating theatre sessions.

Area health services had been asked to identify and make available additional theatre capacity for the treatment of paediatric dental cases. Over the past few months median waiting times for the Children's Hospital at Westmead have been reduced. Statewide planning is in place to ensure that all paediatric surgical and dental waiting lists are within the benchmark times so that no child is waiting more than 12 months for care. I am advised that 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 the project aimed at reducing the need for further treatment through education and prevention of further caries. The project aims at providing extensive oral hygiene and diet advice to families with high-risk children as well as cavity controlled treatment, fluoride treatment and family assessment and priority treatment for eligible siblings, where indicated.

Mr BARKER: The other thing I think we should clarify is that the Minister's approval is annual, so it is only $4 million, but it is $4 million every year thereafter.

Ms LEE RHIANNON: So it is each year.

Mr BARKER: Yes.

Ms LEE RHIANNON: I was also interested in the rural oral centres and where they are going to be located.

Ms REBA MEAGHER: Yes.

Ms LEE RHIANNON: Are these new centres?

Dr ROBINSON: There has been funding that has been allocated for new and upgraded facilities at Bathurst, Orange, Port Macquarie and Nepean.

Ms LEE RHIANNON: Can you say which are new and which are upgraded?

Dr ROBINSON: I do not think that I can actually make that distinction.

Professor PICONE: We will take that on notice.

Ms REBA MEAGHER: Yes.

Dr ROBINSON: We will provide that to you, and there is a new expanded service that is being planned currently for Nowra.

CHAIR: Can I clarify something before we conclude the hearing? There are a number of issues taken on notice and we will trawl through *Hansard* and find those references and make sure that we have it correct in terms of what needs to be done. There are a number of people who will no doubt be very busy over the next 21 days. At one point at the beginning of the hearing, Mr Barker under took to provide on notice a summary for budgetary projections and mentioned that it was available in the audited statement. I managed to get the Auditor-General's financial audits since the beginning of the hearing. It is not broken down and itemised, as Mr Barker said. But what we do want you to take on notice and bring back to the Committee is the summary, which is the same figure that we were talking about, but with a breakdown into health services, such as the Central Coast, Hornsby, Ku-ring-gai, North Shore, Ryde and the northern beaches area health service—the same breakdown that is in the summary because it has not been provided in the auditor's report.

Mr BARKER: I do not know that I actually said what you have inferred. I said I think the statement was that the audited statements actually reflect the financial position for the area health service per se—the functional units within the area health service. But what you are talking about is

internal management documentation. The Auditor-General per se does not audit each facility within the health service. They audit the overall health service.

CHAIR: Given that the total is the same, could you please provide on notice a breakdown of those categories, at least?

Mr BARKER: Yes.

CHAIR: There being no further time for questions, I thank very much everyone who participated, particularly for participating at this time of night. The Committee will be having a very brief deliberative meeting after this when we will make a determination of what we will need to do in the future. I thank everyone for your patience and for your good manners. I am sorry that so many people who came did not have an opportunity to speak. Even with four hours, we did not have enough time, so I apologise for that.

(The witnesses withdrew)

The Committee continued to deliberate.