GENERAL PURPOSE STANDING COMMITTEE No. 2

Tuesday 20 September 2005

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 8.00 p.m.

MEMBERS

The Hon. P. Forsythe (Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. K. F. Griffin
Reverend the Hon. Dr G. K. M. Moyes
The Hon. R. M. Parker
The Hon. C. M. Robertson
The Hon. H. S. Tsang

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PRESENT

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

NSW Health
Ms Robyn Kruk, *Director-General*
Mr Robert McGregor, *Deputy Director-General*
Mr Kenneth Barker, *Chief Financial Officer*
Dr Richard Matthews, *Acting Deputy Director, Strategic Development*
Dr Denise Robinson, *Chief Health Officer*

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CHAIR: I welcome the Minister, the Hon. John Hatzistergos, and departmental officers who are attending today. At this meeting the Committee will examine the proposed expenditure for the portfolio area of Health. Before questions commence some procedural matters need to be dealt with.

In relation to broadcasting of proceedings I point out that in accordance with the Legislative Council's guidelines for the broadcast of proceedings, available from the court officers and clerks, only members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photos. In reporting the proceedings of this Committee, you must take responsibility for what you publish or what interpretation is placed on anything that is said before the Committee.

In relation to the delivery of messages can I remind everybody that there is no provision for members to refer directly to their own staff while at the table. Members and their staff are advised that the any messages should be delivered through the court officers on duty or the Committee clerks.

In relation to the allocation of time, the Committee has agreed to the following: We will ask questions in blocks of 20 minutes across the portfolio. It was to be the Opposition, the cross bench and then the Government members in that order, but I have agreed to vary that because Rev. The Hon. Dr Gordon Moyes does have a need to leave as soon as possible and we will take questions from him first and we will balance the time afterwards.

I now declare the proposed expenditure open for examination and I ask the Minister, do you wish to make a brief opening statement?

The Hon. JOHN HATZISTERGOS: No.

CHAIR: Dr Moyes, would you like to commence please?

Rev. The Hon. Dr GORDON MOYES: Thank you, chair. I just might explain I do have questions I wanted to ask but I have been notified of the death of a close friend and I need to go and make a visit there.

Minister, relating to funding of front line medical staff, which has been spoken about on a number of occasions, what is the overall percentage of staff employed by New South Wales Health in front line capacities, that is the consulting or operating doctors and nurses who are actually treating patients?

The Hon. JOHN HATZISTERGOS: About the staff, I am not sure of the actual proportion in the front line services, but we will take that on notice and get back to you with details on that.

Mr McGREGOR: The material on the distribution of staff does appear in the annual report and we will make that available to you.

Mr BARKER: Dr Moyes, on page 161 of our 2003-2004 annual report we do detail the number of staff as at 30 June each year and our last published figure is June 2004 and as at June 2004 we indicated we had a total in our controlled entity and the department of 84,780 staff, of which 6,363 were in medical, 33,491 were in nursing, in allied health there was 12,308 and the ambulance uniformed officers were 2,870. There were other staff dealing with administrative areas: hospital employees, hotel services and maintenance staff. Not included in that number are our visiting medical officers, who are independent contractors who also provide a range of medical services to our public hospitals and associated facilities. We have indicated in this year's budget papers that we think our total staff will be around 93,000. You would imagine that when we decide what we are doing with our amalgamations, those numbers will most probably continue and might increase I would expect.

The Hon. JOHN HATZISTERGOS: Ms Robyn Kruk wants to say something.

Ms KRUK: Reverend Moyes, that figure will change. As Mr Barker indicated, we are undertaking quite a significant reduction in staff.

Rev. The Hon. Dr GORDON MOYES: My understanding is there are about a thousand

staff to go with the amalgamation of areas.

Ms KRUK: Over a thousand staff. Can I also stress it is a somewhat rudimentary figure just to look at the ratio of medical, nursing and allied health staff, because in many instances, if you look at for instance in a hospital environment, a ward clerk, who would be considered to be in an administrative position, is in an incredibly valuable position and actually probably one which is better utilised in that respect than using nursing staff to undertake clerical duties. So that distinction needs to be made.

Rev. The Hon. Dr GORDON MOYES: I understand. Minister, in relation to funding - this is on page 6 - for intensive care units why is it that an ICU for children has not been established in Wollongong Hospital given that around a quarter of a million people reside in the Wollongong area and as recently as April this year a child by the name of Matthew Starkie died because there was no available ICU bed in the Wollongong region?

The Hon. JOHN HATZISTERGOS: I am not familiar with the situation but I will get some information on it.

Rev. The Hon. Dr GORDON MOYES: In relation to the department's funding of mental health improvements, you are obviously spending record levels on mental health--

The Hon. JOHN HATZISTERGOS: Thank you for acknowledging it.

Rev. The Hon. Dr GORDON MOYES: --but what issues are actually working in prevention of the onset of mental illness as opposed to clinical treatment?

The Hon. JOHN HATZISTERGOS: Are you talking about diagnosis--

Rev. The Hon. Dr GORDON MOYES: Yes, preventative measures.

The Hon. JOHN HATZISTERGOS: --are you talking about drug induced psychoses, that sort of information, is that what you are talking about?

Rev. The Hon. Dr GORDON MOYES: No, drug induced psychosis would come under clinical treatment. I am referring to what preventative measures are being undertaken.

Ms KRUK: Minister, if I may - Rev. Moyes, I may also ask Dr Matthews to assist in this regard. You are probably familiar with a number of the more youth related initiatives. I think you would be familiar with programs such as the School Link Program. I think one of the greatest desires of all health systems is to get an early intervention into troubled families. We have had some incredibly positive results in interventions of that type. I think that has also been manifested in the reduction in suicide rates over the last couple of years. The Minister might want to add some more detail in this regard.

The Hon. JOHN HATZISTERGOS: Prevention and early intervention initiatives have been developed across New South Wales to provide a range of mental health needs across a broad range spectrum from infant peri-natal health care through to older people and a promotion, prevention and early intervention strategy is being developed during 2005. The Integrated Peri-natal Care initiative is based on a population model for universal assessment of all women during the antenatal and post-natal periods. IPC focuses on early identification and management of risk factors for mental health problems in pregnancy, throughout infancy and early childhood. The initiative also aims at identification of existing parental mental illness to reduce relapse rates and lower the impact of the illness on the development trajectory of young children.

The New South Wales Strategic Framework for Mental Health document developed by the Centre for Mental Health is currently being distributed across area health services and key stakeholders for final consultation. The framework outlines a number of key strategies and principles to assist implementation in area health services. This initiative will identify women, infants and their families who have psycho-social difficulties that increase the risk for poor physical and mental health outcomes and offer appropriate care and support response.

The New South Wales Parenting Program for Mental Health is primarily an initiative of the Centre for Mental Health. It provides a co-ordinated, comprehensive approach to implementing parenting programs. This program links to the New South Wales Government's Families First initiative. New South Wales Health and non-Government services across New South Wales are participating in this initiative. Programs for children of parents with mental illness have been established across the State. Family liaison positions have been appointed to enhance adult mental health services provision of family focussed care to clients who have children. A New South Wales strategic plan is currently in development and will be a core component of the New South Wales prevention strategic plan, which will be released for comment later this year.

Another initiative, which I think Ms Kruk was referring to, is School Link, which supports links between child and adolescent mental health services, schools and TAFE in order to promote mental health and prevent mental problems. This includes the facilitation of evidence based identification, management and support of students with mental health problems and the development of local pathways to care, providing access to services for young people and their families and carers. School Link has been successfully developed as a collaborative initiative between New South Wales Health and the Department of Education and Training and is a key initiative of New South Wales Health's policies and strategies. It has received wide acceptance and recognition in New South Wales, across Australia and internationally. A state-wide review of schools initiative is under way to deal with assisting in developing a planning, monitoring and reporting framework for the next stage of the initiative, which will be finalised by late 2005.

The New South Wales Early Psychosis Program aims to improve outcomes for young people who are experiencing psychoses. During 2005-2007, 30 workshops are being conducted to provide training and evidence based interventions for clinicians across New South Wales who are working in the area of early psychoses. The early psychosis intervention elligibility indicator has been developed as a mental health outcomes assessment tool to increase early identification of young people with psychosis.

The child and adolescent mental health state-wide network was established in March 2003 to complement existing child and adolescent services and provide co-ordinated assessment and care for children and adolescents across the State. Funding for this program in 2003-2004 was $74.38 million, approximately ten per cent of the overall Mental Health Program budget. In 1997-1998 public expenditure on child and adolescent mental health in New South Wales was six per cent of source. The teams I was referring to, CAMHST, which are all over New South Wales, are to be enhanced with a further $14.6 million worth of funding from 2004-2005 to 2007-2008 to provide linkages with other child and adolescent government and non-government services, links to specialised inpatient services and support nurses who will consult to paediatric and general hospital inpatient services. Whilst most children and adolescents with mental health problems do not need to be admitted to hospital for treatment, some do, so new inpatient units for children and adolescents have been established at the Children's Hospital, Westmead, the Sydney Children's Hospital, the Nexus Unit at John Hunter Hospital and Gna Ka Lun Unit at Campbelltown Hospital and Redbank House Acute Adolescent Unit at Westmead are also acute specialist tertiary units. The Children's Hospital received $800,000 of funding in 2003-2004.

CHAIR: Minister, I am going to interrupt you and say, Dr Moyes, your ten minutes is up, unless you want to take your other ten minutes at this time.

Rev. The Hon. Dr GORDON MOYES: No. I will just wait for the Minister to finish his answer, Madam Chair.

The Hon. JOHN HATZISTERGOS: The Children's Hospital received $332,000 in funding for 2002-2003, $2.2 million in 2003-2004 and $2.25 million in 2004-2005 and will receive recurrent funding of $2.25 million. The Nexus Unit at John Hunter and Gna Ka Lun Unit at Campbelltown Hospital and Redbank House Acute Adolescent Unit at Westmead are also acute specialist tertiary units.

Rev. The Hon. Dr GORDON MOYES: I will go through the Hansard on that, Minister.

The Hon. JOHN HATZISTERGOS: There is additional information I could provide you about telemedicine services that are also operating. If you want to, I can give you that information.

CHAIR: Minister, did the department open temporary winter beds this year and, if so, how many and, if so, between what dates were they opened?

The Hon. JOHN HATZISTERGOS: The answer is I do not know the details.

Ms KRUK: If you can wait a few moments, we can get some details in relation to the additional number of beds opened.

The Hon. JOHN HATZISTERGOS: This is just temporary beds you are asking?

CHAIR: Temporary beds, yes, for winter. The 2003-2004 New South Wales Health annual report on page 117 includes 717 general hospital unit bed equivalents, including ambulatory admissions and community care packages in the total bed count. The figures provided for 1998-1999 in an earlier annual report indicate that these general hospital unit bed equivalents were not counted in previous years. Why have they now been added to the count?

The Hon. JOHN HATZISTERGOS: I have not got those reports with me. I will take that on notice and come back to you on it. Can I just go back to the question you asked me before, however, about winter beds. In 2004 to meet the growing emergency demands of our hospitals, the then Minister announced that 200 winter beds would be kept open. I am pleased to advise that these 200 beds, which normally would have been closed at the end of winter, have now been carried forward this year as permanent overnight beds. These beds include ICU beds, one in Sydney West, two in Sydney South West and two in Eastern Sydney Illawarra.

Additional beds have also been opened in 2005. In 2005-2006 the Government will invest $227 million for 882 new public hospital beds as part of a major plan to meet the capacity in the public hospitals system over the coming year. This $227 million in recurrent funding will provide for 345 additional permanent, acute and sub-acute beds over the next 12 months, subject to the availability, of course, of work force. The 200 winter beds opened in 2004 are now permanently funded, 221 additional permanent beds effective from May 2005 and 57 adult neonatal, paediatric intensive care beds and cots from 1 July 2005. In June this year there were a total of 21,281 beds and bed equivalents. With the advent of the 882 beds proposed for 2005-2006, in addition to the 563 beds opened in 2004-2005, this means the Government will have opened more than 1,300 new permanent beds in the hospital system since the 2004-2005 budget.

CHAIR: Can you confirm the dates that those temporary winter beds were opened?

The Hon. JOHN HATZISTERGOS: These were the winter beds that we opened last year in 2004. I have not got the precise dates but they are permanently funded now.

CHAIR: Would you take that on notice?

Ms KRUK: You are after the exact dates, are you?

CHAIR: Yes.

The Hon. JOHN HATZISTERGOS: It may be a range of dates.

CHAIR: How many bed equivalents were there at the census dates of 1994-1995, 1995-1996 and 1996-1997?

Ms KRUK: If we could take those questions on note?

CHAIR: Yes.

Ms KRUK: What is clear in our annual report is we differentiate the various categories of beds. I am quite happy to take any of those questions on note to give you a detailed answer.

The Hon. JOHN HATZISTERGOS: Those details are actually in the annual reports and I am sure you can look up the annual reports.

CHAIR: Thank you. I think the Director-General has taken that on notice.

Ms KRUK: I will refer you to the annual report if they are in the annual report.

CHAIR: If that is not easily attainable, you will provide that information, thank you.

The Hon. JOHN HATZISTERGOS: You can find it in the annual report. If you have difficulty finding it--

The Hon. ROBYN PARKER: Minister, could you tell us--

The Hon. JOHN HATZISTERGOS: Page 117 I am told of the annual report.

The Hon. ROBYN PARKER: Is data kept on how many physical beds exist in New South Wales public hospitals?

The Hon. JOHN HATZISTERGOS: I just answered that question. It is in the annual report.

The Hon. ROBYN PARKER: How many of those beds are being used and not used? Can you provide a breakdown of that?

The Hon. JOHN HATZISTERGOS: I just want to know what you are talking about. Are you talking about physical beds--

The Hon. ROBYN PARKER: Yes.

The Hon. JOHN HATZISTERGOS: --or are you talking about beds in terms of active beds that are staffed?

The Hon. ROBYN PARKER: Yes, physical beds.

The Hon. JOHN HATZISTERGOS: How many physical beds?

The Hon. ROBYN PARKER: Yes, and how many of those are active and not active if you want to use the right terms.

Ms KRUK: Ms Parker, that obviously changes on a day-to-day basis in terms of bed occupancy. Our bed numbers are reported and are reported very regularly. They are also audited. The occupancy of those beds would change on a daily, if not an hourly, basis. The other issue is that I cannot understate the significance of concepts such as the compacts, where in effect we are offering supported care in assistance packages in relation to getting people back into their home as soon as possible. So rather than, in effect, putting on additional beds, which arguably is an insurmountable task, we look to ensuring people receive the care appropriate in a hospital environment and also receive supported care in a home environment. So bed equivalents and compacts are an incredibly important suite for New South Wales Health.

The Hon. JOHN HATZISTERGOS: I will just remind you that beds and bed occupancy levels are all in the annual report, a document which you have no doubt consulted prior to preparing your questions.

The Hon. ROBYN PARKER: Does the department collect data on how many patients are treated in the emergency departments for an extended period without ever being admitted to the hospital at all, as was the case recently with David Napier at Camden Hospital in July?

The Hon. JOHN HATZISTERGOS: We do keep figures in terms of access blocks if that

is what you are talking about and those figures the department keeps.

The Hon. ROBYN PARKER: How many of those people spend more than a day in the emergency department without being admitted?

The Hon. JOHN HATZISTERGOS: Into where?

The Hon. ROBYN PARKER: Admitted into a hospital from an emergency department.

Ms KRUK: I am unsure as to your question, because obviously a number of people go to the emergency department and receive, in effect, ambulatory care. The number of patients who actually go to the emergency department requiring admission would be a lot smaller number, which is reported quite regularly on our web site. I am not sure exactly what you are asking there.

CHAIR: How many stay in emergency for more than a day?

The Hon. ROBYN PARKER: We gave you an example of David Napier, who stayed on a bed for more than one day.

The Hon. JOHN HATZISTERGOS: In an emergency department?

The Hon. ROBYN PARKER: In an emergency department.

Ms KRUK: We report obviously, as the Minister indicated, in relation to our access data, patients who are in excess of eight hours. Can I stress again that in many instances the level of care that is offered in the emergency department means that it is the appropriate place in terms of the sort of treatment and supervision of patient's needs, but we do report on a monthly basis on our web site patients and the time they are taken to be seen in emergency departments.

The Hon. ROBYN PARKER: Could you also provide then to us how many spend more than one day, more than two days, more than three, four and five days?

Ms KRUK: Your question was whether we monitor that. I will give to you the information that we actually monitor. I am not familiar with the particular member of the public you refer to. Was it a Mr Napier?

The Hon. ROBYN PARKER: Yes.

Ms KRUK: We will take that on note.

The Hon. ROBYN PARKER: These questions are in relation to access blocks, and it is about access blocks that we are asking. In access block, for example with the patient we are talking about, it was not appropriate that they stay long in bed. You talked about appropriate treatment. It was in cases that were inappropriate. That is the information we want in relation to access blocks.

The Hon. JOHN HATZISTERGOS: The figures we have are people who stay in the emergency department for longer than eight hours, and that is irrespective of whether there is a reason for them being in emergency more than eight hours or not. Sometimes there is a reason why a person may need to be in an emergency department longer than eight hours. It obviously depends upon the hospital and where that person is best able to be located. They are the figures we collect and they are public and you are able to have access to those, but in terms of reasons why people may be in emergency for longer than eight hours, whether you regard them as legitimate or not, we do not collect the reasons.

CHAIR: But given the access block is such a key indicator, if you never include the people who are not admitted in the access block figures but who spend a long period of time in the emergency, does that not deflate the figures?

The Hon. JOHN HATZISTERGOS: No, access block is the percentage of people who are waiting in emergency departments for longer than eight hours. That is what access block is.

Ms KRUK: Also, if I could assist, I think members would be aware we have in the last couple of years created the emergency management units, which in effect is an area of care dedicated to patients who do not necessarily require admission but who would benefit from some supervision for a prescribed period of time. That can be up to 24 hours, in some instances slightly over that. Again, they are not admitted patients, but in the interests of the quality of care they receive, supervision is actually the desirable course of action.

I will take on notice - I am not familiar with the Napier case. I am reluctant to actually proffer a view on the Napier case without knowing the circumstances. We collect extensive data in relation to access and I think a whole range of initiatives, which I think members would be familiar with, in relation to clinical redesign and we are actually looking at improving a whole range of those admission processes.

The Hon. ROBYN PARKER: Could you also provide how many of those patients remained in emergency because there are no beds available? That is the crux of what we are talking about.

Ms KRUK: No.

The Hon. JOHN HATZISTERGOS: We do not keep those figures. Sometimes a person may need to be in emergency for a longer period than eight hours for clinical reasons. It depends upon the extent of supervision.

CHAIR: If I go back to the Napier case, as I recall it only had publicity last week, there was no bed for him to be admitted to hospital and he stayed in emergency for five days as I recall, the point being that if access block is a measure, and it is an important measure, but is only based on those people who eventually are admitted to a ward, what do you do to keep statistics about those people who are never admitted to a ward but are a case like Mr Napier, who are kept in emergency for a period of a number of days, because that statistic would never show up in your access blocks because it is only on people admitted to--

The Hon. JOHN HATZISTERGOS: No, it would show up in our access block.

CHAIR: How would it do that?

The Hon. JOHN HATZISTERGOS: If he was not admitted into emergency within eight hours, so he features in our access block figures. So he does feature in our access block. So the suggestion that he does not is wrong. He does. Irrespective of the circumstances, if he is not admitted within eight hours, he registers as a statistic on our access block.

The Hon. ROBYN PARKER: I am surprised that you are unfamiliar, Ms Kruk, with this case. In particular, the Premier was asked a question about this in Parliament last Thursday.

Ms KRUK: Ms Parker, I think you are aware of the fact that I am reluctant to talk about individual patient circumstances without knowing the background. I am sure you respect that.

The Hon. ROBYN PARKER: In regards the Nurses Reconnect Program listed on pages 8 to 10 in the budget estimates, how much has been spent on the program to this point?

The Hon. JOHN HATZISTERGOS: Can you speak a bit louder? I am having trouble hearing you.

CHAIR: That works both ways.

The Hon. ROBYN PARKER: I am talking about the Nurses Reconnect Program. How much has been spent on the program to this point?

The Hon. JOHN HATZISTERGOS: I will get you that information. It has been a very successful program.

The Hon. ROBYN PARKER: If it has been successful, could you tell us then what is the net number of nurses recruited at this point?

The Hon. JOHN HATZISTERGOS: I will go to the information. Are we talking about nurse recruitment or Nurses Reconnect?

The Hon. ROBYN PARKER: Nurses Reconnect.

The Hon. JOHN HATZISTERGOS: The Government's Nurses Reconnect was designed to attract nurses and midwifes back to our hospitals who had been out of the nursing work force for a number of years. As at July 2005, 1,254 nurses have returned to working in public hospitals since the program began in January 2002. Rural area health services have employed 369 nurses through the Nurses Reconnect Program. Overall, the retention rate has been 75 per cent for Nurses Reconnect nurses. Not only, therefore, are we recruiting nurses through this scheme, but we are retaining them. I have not got the actual cost.

Ms KRUK: Mr Barker, would you have any specific figures on the expenditure?

Mr BARKER: No, I would have to come back on that.

Ms KRUK: We can give you that figure, Ms Parker. Can I stress again, and I had a meeting with the Chief Nursing Officer today, it has been one of the most successful initiatives we have undertaken in relation to nursing recruitment. I was fortunate enough when I was at Dubbo Hospital two weeks ago to run into a number of nurses that were re-enlisted through that program. It is quite superb. The retention data is significant. In most instances these women have been in family responsibilities in the interim, in many instances running rural properties as well, and 75 per cent is superb. The numbers from memory are very low. I think most members would have seen the campaign that we used about 12 months ago. We certainly intend to run another campaign given its success.

The Hon. ROBYN PARKER: Minister, I have heard the word "success" used quite often in relation to this Nurses Reconnect, but given the vacancies were 1700 when the program was launched and currently there are now 1830 vacancies, you have spent I would assume millions of dollars, how come, if it is so successful, you have still ended up with more vacancies?

The Hon. JOHN HATZISTERGOS: First of all, Ms Parker, the thing that you have to focus on is that we are expanding the number of bed places and we also need to expand our work force and Nurses Reconnect is only one of the strategies that we have employed in terms of getting more nurses. It is not the only strategy.

Regrettably, this year I have had to go overseas to engage in major recruitment campaigns because I cannot get the nurses that we require to open the additional hospital beds that the Government is committed to. Two campaigns have already been done, stretching three continents, which have been successful and we have already seen 250 nurses come here and another 257 have been approved to come here. They are just waiting for their visas and registration before they arrive. Later on this year I will be embarking on two additional recruitment drives again overseas, focusing on a number of continents, in Europe, in America and also New Zealand maybe a little bit later, to try and get additional nurses to come to our work force.

I would prefer if I did not have to do it. I am on record as saying that. It is regrettable that I have to go overseas to get nurses to be able to open additional beds, when last year there were some 3,000 young Australians who wanted to undertake nursing at two universities alone, UTS and Charles Sturt University, and were denied places in those universities. I have told the Parliament repeatedly, and I repeat it again, that until the Federal Government commits to the things that were set out in the Preston report on nursing, which indicated that across Australia there would be work force shortages and there needed to be additional places funded in universities for nursing, I will have to go overseas in order to be able to meet our work force requirements because I cannot get those nurses places here. The situation is that this year we asked the Federal Government to give us another 1,800 places and we were given 430 odd. So if you have got any pull with your Federal colleagues, please get on the

phone to them and tell them to start committing to providing the places in Australian universities, particularly in New South Wales rural and regional areas where you live, to provide those places so that we can have the work force in the future that we will require to meet the demands particularly of an ageing population.

The Hon. HENRY TSANG: What about doctors?

CHAIR: Your turn will come.

The Hon. ROBYN PARKER: Could you tell us how long the average nurse stays in the public health system?

The Hon. JOHN HATZISTERGOS: I can get that. The average nurse, I do not know--

The Hon. ROBYN PARKER: Not an average nurse. You would know what I mean.

The Hon. JOHN HATZISTERGOS: I can you tell you this much, that in June 2005 there were 39,125 nurses and midwives employed in permanent positions. That is an overall increase of 5,121 since 2002. In other words, in the three years that we have been running these various programs we have had 5,121 additional nurses employed.

The Hon. ROBYN PARKER: The point though, Minister, is in terms of retention--

The Hon. JOHN HATZISTERGOS: And in terms of retention--

The Hon. ROBYN PARKER: Recruitment it is one thing, but retention is another.

The Hon. JOHN HATZISTERGOS: It is wonderful to recruit them. We also have the highest wages for nurses in the country and we are constantly looking at ways of--

The Hon. ROBYN PARKER: So you will provide the average retention rates?

The Hon. JOHN HATZISTERGOS: Yes, I can provide the retention rates, but I can tell you one thing, the thing that will not work is the strategy that you are going to go to the next election with under your party, which is to have--

The Hon. ROBYN PARKER: Minister, if you will take that on notice, that would be great, thank you.

The Hon. JOHN HATZISTERGOS: --for free you are going to have these people working for you. You are not going to pay them a cent in aged care, in mental health, in intensive care, in surgery. They are the areas where we have critical shortages and you are going to put students on there for free to do the work of nurses.

CHAIR: The time for Opposition questions has expired. I will ask Dr Chesterfeild-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would like to come back to the questions that I have asked in previous years.

The Hon. JOHN HATZISTERGOS: I am glad I was not here in previous years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many full-time equivalent clinicians are there in New South Wales and what is the ratio to the New South Wales population?

Ms KRUK: I will have to get a detailed answer to you again and if you are unhappy with it from previous years I will have a look at it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not sure that you can take it on notice. I am talking about clinical psychologists--

Ms KRUK: I am taking it on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the Minister aware of the new medical evidence implicating serotonin re-uptake inhibitors in suicides and does this make the Minister more willing to use psychologists and non-drug treatments for depression rather than using psychiatrists?

The Hon. JOHN HATZISTERGOS: I will have to get some advice on that. That is a clinical issue. Ms Kruk might want to answer that.

Ms KRUK: Dr Chesterfield-Evans, I am actually familiar with some of the serotonin based research from my own clinical background, but can I answer more generally. We have, as part of the initiatives to increase the uptake of our workers working in the mental health area, actually been working very closely with the College of Psychiatrists with a view to expanding the role of clinical psychologists. Some of those discussions I think have been quite encouraging. We are also optimistic that we will get a far more positive response from the Federal Government in relation to getting MBS coverage for psychologists in a number of these areas as well. Obviously the New South Wales Health public sector is a major employer of psychologists, but the provision of psychologists in a whole range of the mental health related areas would be of benefit to the community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have been talking about this for several years. We had an inquiry some years ago. There is a terrible shortage of psychiatrists and psychiatric nurses and we have psychologists as a virtually untapped resource and you are still unable to tell me off the top of your head how many psychologists we have.

Ms KRUK: No, Dr Chesterfield-Evans, I am asking that I give you a correct number and I do not have the exact data on me and I will give you that number.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are not psychiatric or psychological treatments evaluated in New South Wales Health in terms of their effectiveness?

Ms KRUK: Sorry?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are psychiatric and psychological treatments evaluated in New South Wales Health in terms of their effectiveness?

Ms KRUK: I would have to take that question on notice to give you the detail that you are after. The various treatments would have evaluation models behind them. If you could give me some more detail about what particular treatment you have an interest in, we might be able to focus our answer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There has been some discussion as to the comparison of psychiatrists with drug modalities and psychologists with psychotherapy as to which is the more effective. I understand there is quite a lot of data on that. I understand psychologists have given it to you in order to strengthen the case for them having a larger part in New South Wales Health. Perhaps you could tell me the status of that situation.

Ms KRUK: I think this actually answers your question, but I am not sure. It is no secret that we are currently working with the College of Psychiatrists and IMED, the Institute of Medical Education, to look at expanding the use of psychologists amongst other things. Psychologists represent a significant work force group offering mental health specialist interventions for a range of mental health problems and disorders. Psychologists contribute specialist knowledge and skills that complement the work of doctors, nurses and other care professionals working in our mental health program.

Better utilisation of psychology and clinical psychology services in New South Wales would result in some of the following things: increased utilisation of cost effective treatments in both mental health and general health programs; better utilisation of already present and expert resources currently being submerged in other structures and frameworks; and substantial expansion of current specialist psychiatrists and specialist medical resources; thereby meeting much of the current unmet community

demand, particularly in mental health, without extra training or overseas recruitment.

New South Wales Health has worked collaboratively with the Australian Psychological Society to produce the document *Towards a More Efficient and Effective Mental Health Service in New South Wales* for the development of an effective clinical psychology work force. I think you are familiar with that document. This initiative seems to address utilisation of one of the specialist mental health service providers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You need not read all of that. Can I ask is that document the submission from the APS or is that actually what is going to be your policy?

Ms KRUK: We have worked with the APS on that document.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So what you are reading me now is your future policy? What is the status of the document you are reading?

Ms KRUK: I have indicated we are working with the college to actually expand the role of clinical psychologists. We have been very proactive in this respect. We can certainly go a lot further. You are familiar with the document. We are currently working on actually implementing the recommendations from this paper in order to further advance the current status and future directions for psychology services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Please, please, please. All I get is generalisations. I need timeframes and numbers. We have been talking about this for years and you have been assuring me that discussions have been progressing and I get platitudes. Can you tell me how many psychologists you are going to get in and when?

Ms KRUK: I am prepared to give you more detailed answers in relation to the timing for some of these recommendations. With respect, I have not given you platitudes. I have indicated that we are working to increase the number of psychologists and also to increase the areas that they provide coverage. I think you are more than familiar with some of the constraints we have in this regard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly short of specifics but I look forward to your answer if you would take it on notice.

Ms KRUK: Thank you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Minister, has there been an effort to tell people with knowledge of the problems of mental health to go through the proper channels and not give individual evidence to the dental health inquiry without having their submissions checked by the department?

The Hon. JOHN HATZISTERGOS: Sorry, you spoke about mental health and then you spoke about dental health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dental health, I have changed the subject to dental health.

The Hon. JOHN HATZISTERGOS: Could you just ask the question again?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have there been any efforts that you know of to tell people with knowledge of the problems in dental health to go through the proper channels, i.e. have their submissions checked by the department before they give evidence to dental health inquiries?

The Hon. JOHN HATZISTERGOS: No, I am not aware of any.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will you then guarantee that any clinician may give evidence to the inquiry of any opinions they have or facts that they have without

any fear of retribution?

The Hon. JOHN HATZISTERGOS: I think you know the answer to that question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I want to hear it from you, Minister.

The Hon. JOHN HATZISTERGOS: Ms Kruk will answer that question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would like to hear it from you.

The Hon. JOHN HATZISTERGOS: It is just a matter of law, is it not? Is there not such a thing as contempt of Parliament? You people keep rabbiting on about people being intimidated not to give evidence. No-one has come to me and said they want to give - I do not know anyone who has come to give evidence to the inquiry yet. There are a lot of things that I have known in the last six weeks that I have been Minister, but I can tell you no-one has come to me who wants to give evidence to the inquiry and has been stopped.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People have come to me, Minister, and said that they have had a phone call telling them not to give evidence without running any submission they might make through the department. The suggestion is that there was an effort to keep people quiet. That was the clear suggestion given to me.

The Hon. JOHN HATZISTERGOS: Well, I have no knowledge of that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have no knowledge. That is fine, Minister. I do not have a problem with that but can you guarantee that if they do come forward they can give their facts and opinions without fear of retribution?

The Hon. JOHN HATZISTERGOS: Fear of retribution from whom?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably the people who are telling them to run their submissions through the department.

The Hon. JOHN HATZISTERGOS: What retribution are we talking about? I do not understand this. I do not know. What is the retribution, the sanctions that the department is--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Minister, I am not the public servant being frightened. I am not an expert on this subject. People have said that they have been--

The Hon. JOHN HATZISTERGOS: I do not know of any individual who is frightened, but you say can they give evidence free of retribution. What retribution can I offer? I think the question is really bizarre, with the greatest of respect.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think the question is far too simple, Minister. If it is an absolute routine that anybody may say anything they like to a government inquiry, surely you can give me the assurance that they may.

The Hon. JOHN HATZISTERGOS: Well, no, they cannot, because they have to say the truth first of all you see. They take an oath to say the truth, so they cannot say anything they like--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, they can say anything they believe, Minister.

The Hon. JOHN HATZISTERGOS: --and they cannot run around defaming. There is a whole series of restrictions on what they can say and they have to be pertinent to the questions and the issues that are germane to the inquiry, but you can run that through the inquiry. Do you really have to waste the time of estimates committees now to talk about that. I do not know of any individual. If you have some individual that you are particularly concerned about, perhaps you can come and talk to me about it, and unless Ms Kruk wants to say anything--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have there been any retributions against people who gave evidence in the Campbelltown Hospital inquiry?

The Hon. JOHN HATZISTERGOS: What retributions? What are the retributions we are talking about?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People believe that their careers have been damaged by the fact that they gave evidence to the Campbelltown inquiry and people presumably are also in fear when they want to give evidence to the dental inquiry. Will you guarantee that nobody will be punished for giving evidence to a parliamentary inquiry, Minister, yes or no? It is terribly simple.

The Hon. JOHN HATZISTERGOS: Be punished for giving evidence to a parliamentary inquiry?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

The Hon. JOHN HATZISTERGOS: Why would I want to punish people for giving evidence to a parliamentary inquiry? Before you were talking about running their evidence through the department. Now you are talking about--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you guarantee that if it appears such retribution was occurring that it would be investigated and restitution made to the people?

The Hon. JOHN HATZISTERGOS: I would hope that the Parliament would investigate it, if there was an issue of breach of privilege in relation to any evidence that is given before a committee. I have been on committees before--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If someone is disadvantaged in their career, from day-to-day and over a period of years--

The Hon. JOHN HATZISTERGOS: --all powerful privileges come in here and deal with it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a very difficult thing to prove, Minister, when it is a matter of his word and her word and promotions within bureaucracies.

The Hon. JOHN HATZISTERGOS: I have no idea what you are talking about. Perhaps if you could give me specifics.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Very convenient, Minister.

The Hon. JOHN HATZISTERGOS: No, it is not convenient. It is the truth. I have no knowledge of what you are talking about. Give me some information and I will certainly examine it.

CHAIR: Dr Chesterfield-Evans, your time has now expired. You will have further time later.

The Hon. JOHN HATZISTERGOS: Before you go on, can I just answer the question that was referred to me before by Ms Robyn Parker now that I have the information in front of me?

CHAIR: It does take time from the Government.

The Hon. JOHN HATZISTERGOS: It will be very quick. The recruitment and retention for nurses in 2005-2006 was $35.5 million and that included everything, including our scholarships, our study leave and increased enrolled nurse places.

CHAIR: Government members, do you have further questions? Your time is now ticking.

The Hon. CHRISTINE ROBERTSON: My question relates to the health ramifications of an ageing population and what the New South Wales Government is doing to actually prevent those ramifications and better treat the aged and better treat the ramifications within the system.

The Hon. JOHN HATZISTERGOS: Thank you. Madam Chair, this is an important issue that I want to address before you this evening.

The ageing of the population is at the planning forefront for future provision and delivery of health services in this State. Persons aged 65 and over account for 13.4 per cent of the New South Wales population and persons aged 65 and over account for 41 per cent of acute admissions from emergency departments.

By 2044-2045 the Productivity Commission predicts that one in four Australians will be aged over 65. Health care costs are predicted to rise by 4.5 percentage points of GDP by 2044-2045, with half that increase generated by the ageing population. This will provide major challenges for our health services and the Government in using available resources most effectively. We will see an increased need for information to help better prevent and manage ill health and to help individuals take best care of their own health. Hospitals are seeing an 8 per cent annual increase in emergency department attendances by patients over 80 years of age. In order to improve health care and prevent the deterioration of older people's health, research is imperative.

I therefore wish to advise that a study is to be conducted to be known as the 45 and Up Study, which is a long term research project which will capture detailed information about people aged 45 and over, their health needs and use of health services; all in order to provide an integrated picture of health in mid to later life. This information will strengthen our knowledge and contribute to better information and targeted decision-making in terms of health needs and services into the future. Around 250,000 people, or one in 10 New South Wales residents in this age group, will eventually be involved in the study. This is the largest study of its kind in the southern hemisphere.

Participating in the study, which is completely voluntary, will involve completing periodic postal questionnaires, over a time-span of 20 years. By tracking the health of 250,000 New South Wales residents over 20 years or more, the 45 and Up Study will have immense power to explore factors that promote good health, prevent diseases such as diabetes and arthritis, keep older people out of hospital and keep them living in their own homes for as long as possible. The study is a result of collaboration by over 120 medical experts, scientists and researchers. It has been granted the requisite ethics and research approval. The study is auspiced by the Sax Institute, which will receive funding of $5.4 million from New South Wales Health over the next three years. The Cancer Council New South Wales and the National Heart Foundation (New South Wales Division) will together provide a further $2.5 million over five years towards the 45 and Up Study.

The New South Wales Government is supporting the 45 and Up Study because we need good research evidence to help us to tackle the challenges of healthy ageing. The population of New South Wales will change dramatically over the next 20 years. Populations across the State will age, with people aged 65 and over making up more than one quarter of the population in many areas, especially up and down the coast. This will be accompanied by big increases in the number of people living with chronic conditions such as diabetes, arthritis, vision impairment and dementia.

Already, patients aged over 65 years account for around a third of overnight admissions to hospitals in New South Wales. The New South Wales Government will need good research evidence to help us plan health services to effectively meet the growing needs of an ageing population across the State. Even more importantly, we will need to understand the factors that help people to stay active, stay healthy and stay independent.

The study will look at all aspects of health in mid to later life, including common causes of ill health such as cancer, heart disease, diabetes and mental health. It will look at health problems that reduce our capacity to enjoy life and to remain active and independent, such as arthritis, depression and obesity. It will examine the ways that lifestyle, health services and social factors impact on the development of these health issues.

The study will investigate the following priority research areas: the determinants of healthy ageing, including the effects of retirement, social support and socio-economic status; the health effects of obesity, overweight and physical activity, with a particular focus on the risk of cancer, cardiovascular disease and diabetes; risk factors for and detection and management of cancer, including prostate cancer, breast cancer and colorectal cancer; risk factors for the management of cardiovascular disease, including heart attack and stroke; risk factors for mental health problems in later life, including depression, and the use of mental health services; the use of health services in relation to ageing, including the determinants of use of residential aged care and nursing homes.

I will be launching the recruitment phase of the 45 and Up Study tomorrow (21 September 2005). I would like to encourage everyone who receives an invitation to join this study to think seriously about taking part. By participating, you will contribute to maintaining and improving health and health services for yourself, your family and other members of the community well into the future.

The Hon. CHRISTINE ROBERTSON: Thank you, Minister, and much of the outcome of this study will look from the questions towards increases in public health facilities and health promotion, so we would be expecting, as the study results come forward, to be hearing more about that?

The Hon. JOHN HATZISTERGOS: The study will help us plan future health provisions in New South Wales. A major aim of what we are trying to achieve is not only to include the quality of life of people who are older, but also to be able to more appropriately manage their health issues so that they can remain healthy. If we can keep them out of hospital, we not only reduce the demands on the hospitals, but we also manage to improve their quality of life. So a major aspect of the research is to help us obtain information which will work towards that directly.

The Hon. KAYEE GRIFFIN: Minister, could you inform the Committee about the State of the meningococcal vaccination program?

The Hon. JOHN HATZISTERGOS: The 2004-2005 budget for the implementation of the National Meningococcal C Vaccination Program and the New South Wales Adolescent Vaccination Program was approximately $1.5 million. This program aimed to vaccinate all those aged one to 19 years in 2003 over a four-year period with the six to 19 year age group to be vaccinated via school clinics. This budget does not include vaccine costs which were provided by the Australian Government. I am pleased to advise that New South Wales Health completed the Meningococcal C Vaccination Program in December 2004, well ahead of the 2006 completion date set by the Australian Government.

In 2005/06 the budget allocation for the continuation of routine school based vaccination services in New South Wales is estimated to be $1.1 million. This represents a substantial commitment by the New South Wales Government to protect adolescents from vaccine preventable diseases such as hepatitis B and chicken pox. In addition, the Government will allocate $1.7 million in recurrent funding for immunisation co-ordinator positions in area health services to implement the strategic goals and objectives of the New South Wales Immunisation Strategy 2003-2006.

In 2004, New South Wales Health successfully implemented a national recommendation to establish adolescent school vaccination service provision in all New South Wales high schools. This was achieved through the implementation of the Meningococcal C; Diphtheria-Tetanus-Whooping Cough; and Hepatitis C Vaccination Programs. New South Wales Health took the opportunity to introduce school-based vaccination service provision with the introduction of the school-based component of the National Meningococcal C Vaccination Program, which offered meningococcal C vaccine to all high and primary school children between August 2003 and December 2004. Through the program, a total of 823,197 students were vaccinated, representing an excellent coverage rate of 74 per cent. Since completion of the program, there has been a notable reduction in the incidence of meningococcal C disease in the target age groups. Vaccination against meningococcal C disease continues through the routine vaccination of infants at 12 months of age.

The Hon. HENRY TSANG: Minister, you have given us a comprehensive answer to the recruitment of nurses. What about doctors and specialists? Are we getting more doctors trained, and

if not, are we able to recruit doctors from overseas?

The Hon. JOHN HATZISTERGOS: I have some information on this. This is a complex situation. At this point in time there is a shortage of doctors, particularly in rural New South Wales, and there is certainly a shortage of specialists in a number of areas. Again, we are faced with the ongoing problems of our work force being constrained by the number of places that are being offered in universities to medical practitioners by the Commonwealth Government.

In relation to the issues relating to specialists, again we are constrained, as I indicated to the Parliament earlier this week, by the colleges and the ACCC, which determine the number of trainee positions which are being offered in New South Wales. In the number of areas where we are short, we are actively recruiting overseas in order to be able to meet our work force demands. It is regrettable, again, that we have to do that. The Commonwealth seems to take the view that they would rather us recruit overseas, I believe for two reasons: (1) because they do not have to provide for the education of these doctors. If they have us go overseas to recruit doctors, they do not have to provide for the education of those people, and at the same time they do not have to provide the provider numbers for them. Because the Commonwealth itself has a registration process through the Medicare system for the issue of provider numbers, doctors who may come and work in the hospital system in New South Wales do not automatically get one, as opposed to people who are trained locally. So there is always a constraint in the Medicare system and also no doubt to be able to save on education costs and also to require the States to be able to go into recruitment action, they are happy for us to go overseas. I find that a regrettable and shortsighted position.

For those of you who are interested in rural health, I indicated that we have a shortage, particularly in a number of rural areas, which is regrettable. One of the things the Commonwealth could do, if it was anxious to try and recruit more doctors to rural locations, is to make provider numbers location specific, to say to a doctor that if you go to this particular location you will have a provider number given to you that rests at that location. I would have thought that that is something the Federal Government should embrace in order to encourage particularly practitioners who might otherwise not be inclined to go to rural areas to want to go there and practice. I have been to a number of locations in country areas where people have taken up practice there and they have actually found it a fairly satisfying experience. Regrettably there is not much incentive for them to want to go there if the situation is that they can work in the city and have access to the same provider number that they would have in the country. If you want to provide positive incentives, here is one that the Opposition might want to take up with the Commonwealth.

CHAIR: Minister, can I ask in relation to the Breast Screen Program in New South Wales, in a leaflet that accompanied reminder letters to women it states that the Breast Screen Program targets women aged 50 to 69 years because evidence shows that this age group benefits most from breast screening. Does this statement imply that women aged under 50 and over 69 are not at risk of breast cancer?

The Hon. JOHN HATZISTERGOS: I think it indicates that they are not in the target group. I have got some information on this. I did speak to Jim Bishop, who is the head of the Cancer Institute, and he explained it all to me. I will read what I have got here. It will probably address the issue.

Amongst females breast cancer is the most frequently diagnosed cancer and is the most common cause of cancer related deaths. In New South Wales from 1991 to 2001 the incidence of breast cancer increased at an annual rate of 1.4 per cent. During the same period breast cancer mortality rates climbed by an average of 2.2 per cent.

Breast Screen New South Wales is part of a national Breast Screen Australia Program which provides free breast screening tests for women over 40 years of age. The program specifically targets women 50 to 69 as there is sound evidence that this group benefits most from screening. Breast Screen performs more than 240,000 mammograms a year. Women in the target group are encouraged to have a mammogram every two years. Regular two yearly mammogram screening detects breast cancer at an early stage and gives women the best chance of a good outcome in addition to requiring less surgery. Women aged 50 to 69 who have regular breast screens every two years can reduce their chance of dying from breast cancer by about 30 per cent. All evidence from clinical studies will

continue to be closely considered in conjunction with data on current screening and mortality rates and the maintenance of the aged related policy.

In 2004-2005 the New South Wales Government granted a capital works allocation to Breast Screen New South Wales of $11.1 million over four years. This funding has allowed the development of an additional six fixed screening and assessments sites, two mobile screening units and a relocatable demography machine, major expansion of one screening and assessment site, additional computer hardware, six digital biopsy mammotone units and five digital demographic units. The development of the fixed sites will in turn allow the current mobile service to be diverted to other areas. This means there will be increased quality of access for women to breast screening in New South Wales.

CHAIR: Minister, do you expect the statistic, one that you will often hear me quoting in the Parliament, that women under the age of 50 account for 18 per cent of breast cancer cases and women over the age of 69 account for 27 per cent. Why are they not included in the Breast Screen Program?

The Hon. JOHN HATZISTERGOS: The best person to ask about this is Professor Bishop, but the advice he has given me, and this incidentally is accepted by your Commonwealth colleagues because this is a joint Commonwealth/State program, is that protection in women outside those age groups through the breast screening operations we have done is not as effective in detecting incidences of breast cancer, and that is the reason why that target group is checked, because it is the age group where the screening is most likely to produce results.

CHAIR: What is the average wait for women to get a breast screen in New South Wales?

The Hon. JOHN HATZISTERGOS: I cannot give you that information. We would have to get back to you on that.

CHAIR: How many women are unable to get appointments because the books are full for Breast Screen New South Wales?

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

CHAIR: According to media reports yesterday, there was discussion about new digital equipment which was purchased by Breast Screen New South Wales which would particularly benefit women under the age 50, to quote Channel 9.

The Hon. JOHN HATZISTERGOS: That is the digital.

CHAIR: How will women under the age of 50 be able to access that?

The Hon. JOHN HATZISTERGOS: From the information I have about that, that has actually been a pilot that has been done overseas and I think we have done some research into it as well. I am not sure how generally available it is at the moment. I would have to take that on notice.

Ms KRUK: Ms Forsythe, that is clearly one of the advantages of having Jim Bishop and the Cancer Institute because technology will change in this area. I stress, and I think the Minister picked up the point, this is a jointly funded Commonwealth/State program. It is targeted, very clearly, but the Cancer Institute and its future plans really do look at the higher risk groups and a whole range of interventions. Their other brief is very clearly to look at the access issues. We will get answers to the specific questions you have asked.

The Hon. ROBYN PARKER: I wonder if you could tell us what the maximum time is to have a breast tissue biopsy done under the Breast Screen Program?

The Hon. JOHN HATZISTERGOS: I would have to take that on notice. I do not know.

The Hon. ROBYN PARKER: Could you also provide, if you are taking that on notice then--

The Hon. JOHN HATZISTERGOS: Sorry, are we talking about women in the target group?

The Hon. ROBYN PARKER: You are only dealing with women in the target group now, are you not?

The Hon. JOHN HATZISTERGOS: No, I am not sure that that is - no, that is not because if a woman--

The Hon. ROBYN PARKER: Let us say it would be women who are referred because they have had issues.

The Hon. JOHN HATZISTERGOS: That is right, if a woman needs a breast screening procedure done at any age for diagnosis reasons, then it will be done. If we are just talking about a random, not random, but a regular screening program--

The Hon. ROBYN PARKER: No. These are women who have a specific need to have a biopsy done because of obvious--

The Hon. JOHN HATZISTERGOS: I am sorry, I am not as closely aware. Frank Sartor is acutely aware of these issues, but I will follow it up for you.

The Hon. ROBYN PARKER: Could you also provide the average time taken to provide a biopsy?

Ms KRUK: If we can give Professor Bishop those questions - has this Committee seen Minister Sartor or is that another committee?

The Hon. KAYEE GRIFFIN: No, it is another committee.

The Hon. JOHN HATZISTERGOS: We will follow it up.

Ms KRUK: We will follow it through, not a problem.

The Hon. ROBYN PARKER: Could you tell me what savings have been made by Hunter New England Health since Hunter Breast Screen stopped offering free mammograms and some 20 per cent of Hunter women started using private breast screening?

Ms KRUK: If you have other questions on breast screening, if you would just read them onto Hansard we will follow it through.

The Hon. ROBYN PARKER: If you are going to provide Hunter New England, could you also then perhaps provide the savings made since you changed the target group for other area health services?

Ms KRUK: I do not think it is an issue of savings. I will certainly look at the issue in relation to Hunter New England as to any changes they have made in the service.

The Hon. ROBYN PARKER: And all other area health services, thank you. Minister, turning to issues in relation to mental health, last year your Government announced a $41 million mental health package over four years and the forecasts were that $48.5 million would be spent this financial year at that time, but now only $23.9 million is forecast to be spent. Why are you under-spending on mental health this year?

The Hon. JOHN HATZISTERGOS: I might just make some general remarks about this and then ask Dr Richard Matthews to address the specifics of your question.

The State's mental health budget expenditure has received an instant boost with an extra $71 million in 2005-2006, bringing the level of program expenditure for mental services to $854 million, representing now 7.9 per cent of the total New South Wales Health budget. Since 1994-1995 funding

of mental health services in New South Wales has increased by 141 per cent or some $500 million. This rapid growth in recurrent funding has resulted in significant improvement in mental health care throughout New South Wales.

CHAIR: Minister, could I interrupt to suggest if you are going to give a particularly long answer--

The Hon. JOHN HATZISTERGOS: No, it is not long at all.

CHAIR: --I could indicate that the Committee will need to come back on another occasion.

The Hon. JOHN HATZISTERGOS: That is okay, I am coming back. Just let me finish. The 2005-2006 budget increases include $22 million for New South Wales enhancement funding for the expansion of the psychiatric emergency care services and new community based initiatives of $10 million. I will just ask Richard Matthews--

The Hon. ROBYN PARKER: The key point to the question is why are you under-spending.

The Hon. JOHN HATZISTERGOS: There is an implication in the question, so I will ask Richard Matthews to address the issue.

Mr BARKER: I will just explain the mathematics to you. The $48 million included $25 million in 2004-2005. So that was in last year's budget. The incremental effect into the 2005-2006 budget is the next $23 million. So your $48 million, you have got 25 in last year plus 23 this year, which will give you a total of 48 in this year compared with what was in the 2003-2004 budget. On top of that, as the Minister said, there was another $22 million for other new initiatives and the residual of the $71 million is for increasing awards and cost escalation and other types of movements within the mental health program. So in terms of the $241 million, yes, the $48 million is in there this year, plus the other $22 million, but remember you are comparing 48 with 2003-2004, not with 2004-2005.

The Hon. ROBYN PARKER: You are going to have quite a spending spree then in the last couple of years to spend the $41 million.

Dr MATTHEWS: No, it steps up. It is the annualised effect, so that the first year, $24 million runs over the fours years, so you get an annualised effect of 96. The second year steps up, another $24 odd million, annualised effect over three years, the next year another step up and the fourth year another step up. The additional $22 million is also annualised, as Mr Barker said, $12 million for the emergency initiative in the emergency departments and an additional $10 million on community mental health. If you annualise those over four years, which is a slightly different four years because it commenced this year, you get an additional $88 million.

The Hon. ROBYN PARKER: Minister, in terms of adolescent patients under the age of 18, could you tell me how many were placed in adult psychiatric units in 2004-2005 and how many beds did they actually account for?

Dr MATTHEWS: I will take the actual number on notice, but I would say that it is not always inappropriate to place an adolescent in an adult bed. We actually supply across the State what are known as swing beds and they are when an adolescent is placed in an adult unit and through the CAMHSNET process they have a special nurse who looks after them. That may be appropriate to keep that young person close to their family. If their level of acuity is such that they need to go to a specialised unit, they may have to travel some distance. We also have swing beds in paediatric units, so that sometimes children who have got psychological psychiatric disturbance will be placed into a paediatric ward, but again they will be special. That is an appropriate clinical intervention to allow care to be delivered close to where that person lives.

CHAIR: How many adolescent psychiatric beds are there throughout New South Wales and where are they located?

Dr MATTHEWS: 18 at Redbank; 12 at the Children's Hospital at Westmead; six currently opened out of 10 at Campbelltown; the next unit I believe is 12.

The Hon. JOHN HATZISTERGOS: I believe I outlined them before.

Dr MATTHEWS: There are four at Nexus, eight at Randwick. We are, in addition, building new beds at Lismore and at Orange.

The Hon. JOHN HATZISTERGOS: I also indicate the swing beds are located at Port Macquarie, Taree, Coffs Harbour, Maitland, John Hunter, Tamworth, Gosford Royal, Broken Hill, Lightning Ridge, Wagga, Dubbo, Orange and Albury, and also Goulburn.

The Hon. ROBYN PARKER: I just wanted to ask you some questions about area health services and the merging of area health services. You were talking before about staff. How many positions have already been abolished so far? Could you provide a breakdown of how many and in which regions?

The Hon. JOHN HATZISTERGOS: Mr McGregor can give you that information. I do know the approximate numbers but I will let Mr McGregor answer it.

Mr McGREGOR: In terms of the total impact that emerges, as the Minister just said and the Premier said previously, the total number is in excess of 1,000 at the present time, that is to the end of August the number is approximately 250 positions which have been deleted as part of the process. In August and early September a number of letters were issued to staff who were either directly affected by the mergers or potentially affected by the mergers. So we anticipate the number of--

The Hon. JOHN HATZISTERGOS: Approximately 284.

Mr McGREGOR: 284 is the exact number.

The Hon. ROBYN PARKER: Which areas did they come from?

The Hon. JOHN HATZISTERGOS: They came from Hunter New England--

The Hon. ROBYN PARKER: How many from Hunter New England?

The Hon. JOHN HATZISTERGOS: 42. South East Sydney Illawarra.

The Hon. ROBYN PARKER: How many from there?

The Hon. JOHN HATZISTERGOS: 54.83. North Sydney Central Coast 46. I have not got all of them actually.

The Hon. ROBYN PARKER: Could you take that on notice and provide that information for us?

The Hon. JOHN HATZISTERGOS: Yes.

The Hon. ROBYN PARKER: Could you tell us how many redundancy packages have you offered and what has been the cost of those redundancy packages?

The Hon. JOHN HATZISTERGOS: I do not know but there are a lot less than the 29,000 that you are proposing.

The Hon. ROBYN PARKER: Could you provide that information then on notice?

The Hon. JOHN HATZISTERGOS: Yes. Could you provide the 29,000 where you are taking those--

The Hon. ROBYN PARKER: Minister, this is about your Government.

The Hon. JOHN HATZISTERGOS: Yes, I want to know about the 29,000 you are going to get rid of.

The Hon. ROBYN PARKER: This is your estimates, your budget.

The Hon. JOHN HATZISTERGOS: Can I just ask when are you going to tell us about the 29,000 you are abolishing?

The Hon. ROBYN PARKER: You will be able to talk to our budget when we get into government in 2007.

The Hon. JOHN HATZISTERGOS: Is that when you are going to tell us?

The Hon. ROBYN PARKER: Minister, I was wondering if you could tell us in terms of--

The Hon. JOHN HATZISTERGOS: By the way, have you got an objection to the abolition of these administrative positions?

The Hon. ROBYN PARKER: I am just asking for the information.

The Hon. JOHN HATZISTERGOS: I just want to know what your position is, seeing as you are asking the questions.

The Hon. ROBYN PARKER: We are interested in your answers. That is our position. Could you tell us what the grade and salary scale is of each CEO in each--

The Hon. JOHN HATZISTERGOS: That information is provided in the annual report.

CHAIR: That does not prevent us from asking you questions.

The Hon. JOHN HATZISTERGOS: No, but I am not going to provide information that is in the annual report. I am not a research service for the Opposition. I have made it quite clear. The information is in the annual report.

CHAIR: Maybe you do not understand the process of estimates, Minister. You are not entitled to question the nature of the questions being asked.

The Hon. JOHN HATZISTERGOS: I am not questioning anything. I am simply referring you to the annual report.

CHAIR: You are just trying to--

The Hon. JOHN HATZISTERGOS: No, I am not. I am saying look at the annual report. Let us be clear about this. At great expense this Parliament has indicated that there should be an annual report published by this department which provides, amongst other things, the information you are requesting, and that report is a statutory obligation. We are publishing that information and you have the opportunity to read that information at your leisure and to make whatever appropriate analysis you want, but do not us ask us to do your research.

The Hon. ROBYN PARKER: Minister, we are talking about an annual report that has not yet been released. We are asking questions about these CEOs and their salaries and what they might be. We are not able to have that information at this point as the annual report has not been released.

The Hon. JOHN HATZISTERGOS: But it will be released.

The Hon. ROBYN PARKER: We want to know the information now.

The Hon. JOHN HATZISTERGOS: And it will be released in accordance with the

statutory timetable that you and your colleagues have voted for.

CHAIR: If the information is not available to us, Minister, we are entitled to ask questions.

The Hon. ROBYN PARKER: Clearly you do not want us to know that information.

The Hon. JOHN HATZISTERGOS: No, no, on the contrary, it will be published in the annual report.

CHAIR: Can I ask what total savings you expect to make from the abolition of the positions?

The Hon. JOHN HATZISTERGOS: Yes, we can give you that. It probably would be in the annual report, but we will give it to you anyway as a matter of courtesy. The savings that will result are $24 million in 2005-2006 and $70 million in 2006-2007. These savings the areas will be required to put into their frontline services and there will be an independent audit to ensure that that is realised.

The Hon. ROBYN PARKER: Minister, are bonuses or incentive payments offered to area health service CEOs for achieving budgets or other benchmarks?

The Hon. JOHN HATZISTERGOS: No.

Ms KRUK: Ms Parker, I think I had this question asked of me last year as well. It is clearly Government policy not to have bonuses or performance payments.

The Hon. JOHN HATZISTERGOS: That was also announced. It is also a matter of record. By the way, you might want to know that when you left office there was only one unit in New South Wales that provided the full range of acute inpatient services to children and adolescents. That was at Redbank House. So you can see that the services have expanded considerably since you left office.

[*Time expired.*]

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Minister, some clinicians have been investigated by the HCCC as a result of inquiries associated with Campbelltown Hospital. Will you guarantee that managers who made resource decisions that led to staffing decisions are also subjected to an inquiry process?

The Hon. JOHN HATZISTERGOS: But there have already been inquiries. There has been a parliamentary inquiry and there has been an HCCC inquiry and there have been decisions made on personnel that you would be aware of in relation to Campbelltown/Camden. So I am not exactly sure--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the HCCC not confine its investigations to doctors?

The Hon. JOHN HATZISTERGOS: It was not the HCCC. There were decisions made on the basis of the HCCC, the special commission of inquiry and then there was the parliamentary inquiry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Walker inquiry was mainly concerned with legal recommendations to change the Mental Health Act. The parliamentary inquiry did not go into individuals and their behaviour with regard to each other in sufficient detail to have any meaningful investigation of those individuals, and it is my understanding that the HCCC is statutorily limited to doctors. Are those three points not correct?

The Hon. JOHN HATZISTERGOS: No, it is not statutorily limited to doctors. What was the other point? You said the parliamentary inquiry did not look into details. I thought it did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It did not look into details of individuals, Minister.

The Hon. JOHN HATZISTERGOS: And the legal issues, I am sorry, I must have misread the Walker report. You are suggesting it was about mental health. I cannot recall the--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Walker inquiry was not about mental health.

The Hon. JOHN HATZISTERGOS: That is what you just said a moment ago. You said it was about mental health. So I am not in a position to be able to respond--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Walker inquiry was about changes to the Health Act, not mental health, the Health Act.

The Hon. JOHN HATZISTERGOS: It was about the whole issue of what was going on in Campbelltown/Camden, and of course there are also the coroner's investigations that are taking place, two of which have continued to be outstanding, and there is a further ICAC report, which is coming out shortly I understand. So I am not in a position to respond to your question, and also your question, with respect, is not focused enough. I am not quite sure what you are trying to--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are the managers subject to the same scrutiny as the doctors? That is the nexus of my question.

The Hon. JOHN HATZISTERGOS: The managers, who are you talking about?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The managers in the Campbelltown Hospital.

The Hon. JOHN HATZISTERGOS: But which managers are we talking about? What are their names? Who are the people that you are--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not here to name individuals. There are a number of doctors being investigated by the HCCC for some of the poor outcomes that were identified.

The Hon. JOHN HATZISTERGOS: The area health service individual was removed. I do not want to go into that because--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the subject of litigation.

The Hon. JOHN HATZISTERGOS: That is right, and the board was abolished.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are many people in the administrative structure who are involved in staffing and resource decisions who obviously would have some considerable bearing on the output or outcomes of the health system. It is not just the doctors.

The Hon. JOHN HATZISTERGOS: Ms Kruk in her position would be able to deal with it.

Ms KRUK: Dr Chesterfield-Evans, having appeared before the parliamentary inquiry on a number of occasions, certainly the resources of the area health service came up in a number of questions at that point in time. Bret Walker QC also commented on resourcing issues relating to specific instances of patient care, and as the Minister has indicated, there have been significant management changes at that area health service level to date.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The doctors are being held personally accountable through the HCCC in those investigations, are they not?

The Hon. JOHN HATZISTERGOS: No, they will be held accountable through the

appropriate tribunals and professional bodies.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are personally accountable for those - they are investigated personally.

The Hon. JOHN HATZISTERGOS: There will be issues that they will have to confront before those bodies, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do managers have the same sort of procedure as the doctors?

The Hon. JOHN HATZISTERGOS: The issues that the HCCC were looking at were different to the issues that you are identifying. There is no professional body for managers, if that is what you are talking about.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the individual doctors are subject to professional scrutiny, why are managers who make decisions not subject to the same sort of scrutiny?

The Hon. JOHN HATZISTERGOS: But they were. I mean the CEO was removed and the board itself was dismissed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is at the very top level, but the doctors getting shot are at the very bottom level, are they not, of the hierarchy?

The Hon. JOHN HATZISTERGOS: Who are the other individuals? Again, you are talking about - I do not want to be disrespectful, but this has got some sort of synergy with some of the earlier questions you were asking. I have only been in the portfolio six weeks. I am not suggesting in the slightest that I am conversant with every aspect of what went on in the inquiry, but who are the individuals that you say should be brought to account and something happen to them?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I did not come here to state names, but there were a number of managers named in the whistleblowers' submission and criticised in that their decisions had made a great deal of difference and had impaired patient care. If the individual doctors and nurses are held personally accountable, then surely it is reasonable to look at the managers in the same fashion. What I am asking is what procedures are there? Is it because there is no such thing as a management body that the managers are unaccountable as the professionals are?

Ms KRUK: Dr Chesterfield-Evans, remembering quite clearly your committee actually looked at individual circumstances, the ICAC actually looked at the circumstances relating to managers at the area and there was also disciplinary action taken against a number of managers that were mentioned in various allegations, it is probably not appropriate to go into the ins and outs of this. Some of those matters are still under way at the moment and are now before the industrial commission. So I would argue that there is a stream to consider professional conduct and those matters are currently before the HCCC. Fortunately, a good number of those have been resolved, but in relation to management action, it was taken two years ago.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that some of the managers who were adversely named in those allegations have since been promoted, which obviously is some cause for concern.

Ms KRUK: I am not familiar with the people you are talking about. I am certainly aware of a number of investigations that were taken around Camden/Campbelltown at that point in time. As I said, there was the ICAC, the HCCC at the moment, your parliamentary inquiry and Bret Walker. It was an area that was intensively scrutinised and there was disciplinary action taken and a number of contracts terminated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would be interested in details of which contracts were terminated and what disciplinary actions were taken. If that is going to be made public in the HCCC context, then can it be made in the same managerial context?

The Hon. JOHN HATZISTERGOS: I am happy, when all the issues surrounding the matter of Campbelltown/Camden have been concluded, to make an appropriate account for what has happened in terms of the recommendations that were made in the various investigations and what actions the Government has taken. It may not satisfy you, but at the moment there are I think at least two inquests that are ongoing. There are only two inquests I think. All the others have been terminated. There are a number of professional proceedings which have to take their course. The Government, as I indicated to the house today, has established a quality and safety system around the incident management system and the clinical governance units and the clinical excellence commission. All those structures are now in place. I am happy to do a full report at an appropriate time by ministerial statement or some other means.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the Beaume committee still active in these matters?

Dr MATTHEWS: The Beaume committee is still active. It has produced its first report, as you know, *Tracking Tragedy*, which dealt with deaths by suicide and homicide in care. Its second report dealt with those within 28 days of discharge and it is currently dealing with matters within a year of discharge. So it is still active and has almost the same membership as before.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it will continue to report annually, will it, as was its original intention?

Dr MATTHEWS: Its original intention, I think, was that it would report on those three areas to the Minister.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As well?

Dr MATTHEWS: I do not believe that was specifically stated but its task was to report to the Minister in those three areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And does it report regularly?

Dr MATTHEWS: It has produced its first two reports. It is working on its third.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we have a list of the deaths within the mental health system with the numbers of them that were suicides?

Dr MATTHEWS: Those in those first two reports are a matter of public record, as is the Government's response to those two reports. The third report, when released by Professor Beaume, will also be a matter of public record.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you tell me, Minister, how many forensic patients the Mental Health Review Tribunal has recommended for release and are still waiting for your recommendation?

The Hon. JOHN HATZISTERGOS: No. All the ones that I have received since I have been Minister, as I said, there was a number of them that obviously banked up during the transition, but all of the ones that I have received, to my knowledge, I have actually dealt with. There may be two or three that are still in the system that are coming through.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is there were six.

The Hon. JOHN HATZISTERGOS: Six what?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Six people in November 2004, at least six, waiting, who have been found not guilty by reason of mental illness and they were in correctional detention. Now, the Mental Health Review Tribunal recommended them for release, or some for release, they were waiting to be released and they were waiting on the okay from the Health Minister to release them.

The Hon. JOHN HATZISTERGOS: As far as I am aware, I have dealt with all of those.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there none waiting for release or have you dealt with them but they are still in gaol?

The Hon. JOHN HATZISTERGOS: No, I have dealt with them. I cannot off the top of my head indicate what my decisions have been.

Dr MATTHEWS: When you say they are in custodial care, you need to be aware that the maximum secure forensic facility at Long Bay is both a prison and a forensic hospital. There are a number of recommendations made by the tribunal for transfer to medium secure facilities, minimum secure facilities, conditional release and unconditional release. There are a raft of different types of recommendations which can be made to the Minister, and I am not really clear from your question which category your six would fit into.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There were people who had not been released because they were waiting on ministerial approval, if you like, of the implementation of their recommendation.

The Hon. JOHN HATZISTERGOS: First of all, I do not regard myself as a rubber stamp for the Mental Health Review Tribunal, so if you are suggesting that somehow it is a fait accompli when it comes to me from the tribunal, I would correct you, because I take my duties quite seriously and I review all the information that they provide, together with any additional information that is in the file, together with any other information that I may seek in order to inform myself appropriately and to make a judgment, so do not assume that simply because the Mental Health Review Tribunal makes a recommendation to me, that I am going to rubber stamp it. I have never taken that attitude to my responsibilities.

The second thing is that as far as I am aware all of those files that were held up in transition I have actioned. There may be a very few that have come in the last couple of days that have not been actioned, but certainly the large backlog has been dealt with. In terms of whether it was favourably or adversely to the recommendations that were made by the tribunal, I do not have that accounting, but the Mental Health Review Tribunal I think every year publishes an annual report and in that annual report they indicate the extent to which I accept or reject their recommendations, and that is a matter of public record.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am delighted to know that you have actioned these ones, which were I understand quite a significant backlog and were demoralising people in that the tribunal was making recommendations which were not implemented.

The Hon. JOHN HATZISTERGOS: I dealt with them as soon as I could. I did appreciate the importance of them. I have been in the position for six weeks. I have not travelled extensively into rural New South Wales, certainly not as extensively as I would like. I have a number of invitations and I would like to do it, but I did make that as one of the priorities, together with the briefings. I still have not met all the interest groups which have sought to come to see me and I will see them in due course as well, but I did regard it as a priority that I should clear those ones that had been waiting. Some may have had final decisions made on them in terms of what my position is, some of them I may have required further risk assessments or sought additional information, additional to what the tribunal itself recommended, but I have actioned them all as far as I am aware.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Over the last year there was some difficulty accounting for the spending of mental health money. There was plenty of money allocated and there was some doubt about whether the money was spent by the area health services on mental health in the way that it was allocated from head office. Has that accounting problem been fixed?

Dr MATTHEWS: I am not certain in whose minds there was uncertainty. We are certain of what has been spent and what has not been spent. We have no uncertainty.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is new. When we did the

mental health inquiry there was some doubt about how moneys were spent and the suggestion was clear that moneys allocated to mental health had been spent in other areas and had been transferred because the area health services had control of the final spending of their moneys.

Dr MATTHEWS: We now have in place with the area health services mental health services agreements which are between the Director General and chief executive. They define the budget, they define the FTEs, they define the activities, and as new advancements come on line, they define what will be expected from those through new announcements.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we confidently say that every dollar allocated to mental health in this year's budget, and indeed in last year's budget, was spent on mental health in the way it was intended?

Dr MATTHEWS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we guarantee the same thing for dental health?

Dr MATTHEWS: Dental health - I'm on the M not the D, I am afraid.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The question is: Are there now agreements to make sure that money spent on mental health is spent on mental health, but not that all moneys spent are on all areas that they will be spent in, then we may have a recurrence of the problem in dental health as we try to update our dental health services maybe?

The Hon. JOHN HATZISTERGOS: Dr Chesterfield-Evans, no doubt you will keep us to account on those issues in forthcoming estimates committees and in the event that somehow the department is not meeting its obligations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I will do my best Minister.

The Hon. JOHN HATZISTERGOS: I have got confidence in your capacity to be able to draw attention to it anyway.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there an intensive care unit admission policy, and if not, why not?

Ms KRUK: Can I just add, and I think Dr Matthews may wish to pick it up as well, the Minister is meeting with Professor Malcolm Fisher tomorrow, and I think it probably relates to Ms Parker's question earlier in relation to intensive care beds. It is that specialist group made up of ICU clinicians that makes recommendations to the Government about both the number and the placement of ICU beds across the hospital system. I think Professor Fisher was actually on the record last year as saying that the Government gave him more beds than he had actually asked for. So there are procedures and policies in place in relation to both allocation, the number and the type, in other words the level of complexity of ICU beds. Dr Matthews?

Dr MATTHEWS: In relation to admission--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Admission policy.

Dr MATTHEWS: --it is clearly a clinical decision made between the clinicians in the emergency departments and the intensive care units based on the patient's condition.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that there is a problem with the lack of an admission policy and that people who are terminal are admitted because they require large nursing loads, rather than because intensive care would like to do them any good, and this results in a sad waste of resources and energy and an exclusion of others who might use the bed more efficiently. Is that the case?

Dr MATTHEWS: I would take issue with that understanding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would not?

Dr MATTHEWS: I would.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would?

Dr MATTHEWS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is an admission policy?

Dr MATTHEWS: No, no, I would take issue with your understanding. I do not think what you are saying is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is an admission policy and people are excluded who are not appropriate to go there?

Dr MATTHEWS: No, I am saying the admission policy is based on a clinical decision made between clinicians in the emergency department and clinicians in the intensive care unit, depending upon the condition of the patient.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The average clinician--

The Hon. JOHN HATZISTERGOS: I was actually at Royal North Shore when a patient arrived and was dying of lung cancer at a very young age and was at end stage and the family was insisting that everything be done to keep him alive.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And was he admitted to intensive care?

The Hon. JOHN HATZISTERGOS: Yes, he was, and they asked for him to be intubated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And was he?

The Hon. JOHN HATZISTERGOS: Yes, he was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would that have been against an admission policy which optimally used intensive care beds?

The Hon. JOHN HATZISTERGOS: Again, it was a clinical decision that was made. It is very difficult. You have to respect what the family wants and the whole circumstances of clinical practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As an ex-clinician might I comment that if you are in casualty with--

CHAIR: I suggest you actually ask the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am making a point. If you have a very sick patient, you send them to the intensive care unit because you do not know what else to do with them, particularly if you do not have an admission policy that says you cannot admit terminally ill people.

Dr MATTHEWS: I think Professor Fisher would probably take issue with the assertion that you send people to intensive care because you do not know what to do with them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My point is coming after discussion with Dr Fisher and I am concerned because I do not believe you do have an admission policy. You cannot tell me what it is and you cannot give me a copy of it.

Dr MATTHEWS: It is extremely difficult to sit down and write a policy about who gets admitted to ICU and who does not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not think that is the case at all, with respect.

The Hon. JOHN HATZISTERGOS: I am meeting him tomorrow and I will ask him the questions that you have directed. Perhaps I could speak to you about it afterwards.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hopefully you and he will work out such a policy. Are there any studies of the cost-effectiveness of intensive care units being carried out in terms of the quality of adjusted life years achieved?

The Hon. JOHN HATZISTERGOS: Not that I am aware of but I will look into it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there are no studies of the cost-effectiveness of intensive care units in New South Wales, is that the situation?

The Hon. JOHN HATZISTERGOS: These are not easy decisions. These are decisions that have to be made by experienced clinicians and they are not really matters that I want to say "You are in and you are out" on the basis of some rationalisation of where this ICU bed is best utilised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In that it is a short resource and a large amount of money can be wasted as a pre-funeral expense, Minister, my questions are really quite reasonable and I am disappointed that you are not responding to them.

The Hon. JOHN HATZISTERGOS: That is why we have specialist advice on this issue and that is why Professor Fisher is there.

Dr MATTHEWS: The answer to your question is almost certainly yes and we can do a literature review for you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In New South Wales Health, in your hospitals?

Dr MATTHEWS: I will take that on notice, but we will do a review for you and give you the international literature.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I suspect you cannot in New South Wales hospitals but I would be interested if you could.

[*Time expired*.]

The Hon. CHRISTINE ROBERTSON: I wish to ask what is the latest information on bulk billing and Medicare?

The Hon. JOHN HATZISTERGOS: 2004-2005 data shows an increase in the general practice bulk billing rate compared to the previous financial year. However, the financial year outcome of a 73.2 per cent bulk billing rate is still significantly lower than the 1996-1997 level of 80.6 per cent. The average patient co-payment of $15.18 for the 2004-2005 financial year for a visiting general practitioner is at a record high level. Since the 2003-2004 financial year the co-payment has risen by nearly 5 per cent and has nearly doubled since 1995-1996 when the average patient contribution was only $8.32. This high level of co-payment means that access to affordable general practice services is falling. Between 2003-2004 and 2004-2005 the average number of visits to a general practitioner for the Australian population remained stagnant at 4.8 visits.

The New South Wales Government has consistently voiced concern about the decrease in access to affordable GP services and the impact this has had most importantly on the health of NSW citizens and also the hospital system. The GP Medicare remuneration levels are inadequate and bulk billing rates, despite marginal improvements, are at one of the lowest levels ever. As a result of a

blow-out in the Medical Benefits Schedule (MBS), the Australian Government has recently reneged on its Safety Net election promises implemented as part of the Strengthening Medicare package. The Safety Net arrangements create a negative funding outcome, as there is an incentive in this package to charge higher fees and potentially over-service as patients are protected by the Safety Net. These arrangements are also inflationary.

Total MBS outlays for all services increased by 15 per cent between 2003-2004 and 2004-2005. This is nearly two and a half times the amount of growth between the 2003-2004 and 2004-2005 financial years and nearly four times the amount of growth between the 2002-2003 and 2003-2004 financial year. However, whilst the growth in the total MBS outlays continues to grow exponentially, the number of services provided has only grown by just over 4 per cent - around a quarter of the growth in expenditure. Expenditure and patient contribution growth significantly exceeds the level of growth in services, which shows that the real drive of growth in outlays is a price effect. This is likely to have an inflationary effect on outlays with no offsetting increase in services.

Total MBS outlays increased by 18 per cent between December 2003 and December 2004. This is four times the amount of growth of 4 per cent between December 2002 and December 2003. In addition, the number of services provided only grew by 6.5 per cent between December 2003 and December 2004. This means that the level of spending grew by nearly three times the level of services provided. This unsustainable growth in expenditure between the December quarters led the Australian Government to roll back its Safety Net arrangements. The Australian Government has increased the current MBS Safety Net thresholds by 67 per cent from $300 to $500 for people receiving Family Tax Assistance and concession card holders and 43 per cent from $700 to $1,000 for all other eligible people. In percentage terms, low income earners will be more heavily penalised than higher income earners. This strategy is seen as a solution by the Australian Government to the blow-out in the cost of the current MBS safety net arrangements from a predicted $440 million over four years to around $1 billion.

This cost containment strategy is unlikely to work while the policy of a safety net along with the payment of 80 per cent of out of pocket, out of hospital expenses remains. The following scenario could emerge: (1) There may be an initial decrease in the rate of outlays due to the higher safety net. This will be offset by an increase in the amount of out-of-pocket-expenses as clinicians already raise fees because of the safety net arrangements. (2) As the Australian Government has no control over doctors' fees it is likely that clinicians may respond by increasing their fees again to allow patients to reach the safety net. (3) Given that the safety net is now higher and the rate of payment remains at 80 per cent of the out of pocket fees expenses, this is likely to expose the MBS to an even higher rate of blow-out.

The number of MBS services per head has been declining steadily from 5.6 in 1995-1996 to the current rate of 4.8. It is not clear that the Strengthening Medicare measures will stall this decline. Already the combination of an increase in the patient co-payments and the massive increase in outlays suggests that Strengthening Medicare is having a transfer effect from the individual to the Australian Government as people reach the safety net.

The inflationary effects of the Strengthening Medicare package is yet another example of the Australian Government's failure to contain the growth in its health outlays, like the Pharmaceutical Benefits Scheme (PBS) and the private health insurance rebate. The PBS is increasing at around 10 per cent per year and the rebate has increased at an average of 13 per cent per year since it was introduced. The Australian Government however fails to assess whether increasing the expenditure on health in such an open-ended and unconditional manner is effective or efficient. What the Australian Government does in an attempt to "balance its books", is provide further funding cuts to public hospitals. The Australian Government has in fact cut funding to NSW public hospitals since the last Australian Health Care Agreement by $700 million.

In other words, what we are getting out of the Commonwealth is a massive amount of expenditure. None of it is being analysed in terms of its effectiveness. The States are being confined, under the health care agreement, to a four per cent increase for their hospital funding. At the same time as the States are being given four per cent, the Commonwealth is not only happy to increase its PBS by 10 and its MBS by 13 per cent, but it is also prepared to give the private hospitals, through the subscription premiums, an increase of between eight and nine per cent annually, and yet it confines

the States, which have to look at all the failings of primary health that is largely controlled by general practitioners, to account for that with the four per cent increase.

The Hon. KAYEE GRIFFIN: Minister, could you outline the development of the provision of renal services in rural areas?

The Hon. JOHN HATZISTERGOS: Yes, I can. $2.5 million was allocated on a recurrent basis under the Rural Health Plan for the continued expansion of renal services. This funding is in addition to that provided by area health services. In addition to the Rural Health Plan, a further $10 million has been made available over four years for rural renal services**.** This funding, which commenced in 2003-2004 will allow for additional dialysis services and ongoing support for staff into the future. Provision of renal services, especially dialysis, to residents of rural New South Wales is a priority for the Government.

Current New South Wales Health initiatives include the establishment of new dialysis services, the provision of additional support services to patients with kidney failure and ensuring a skilled, sustainable workforce to provide renal services in rural New South Wales. Service improvements that have been made possible through this specific purpose funding include: For the Hunter New England Area**:** $250,000 recurrent from 2003-2004 was made available under the Rural Health Plan to employ an Aboriginal health educator, a renal nurse, educator to provide training and support to satellite units and to contribute to an area manager of renal services. The Moree renal dialysis unit, which opened in June 2002, was allocated $90,000 in 2003-2004 and $50,000 recurrent from 2004-2005 for an additional two dialysis machines, with an expanded unit having a total of six dialysis machines. The Armidale renal dialysis unit opened in June 2000 with four patients. Funding of almost $300,000 in 2004-2005 and close to $400,000 recurrent from 2005-2006 was provided to increase limited care dialysis services and appoint a part-time social worker dedicated to meeting the social and psychological needs of persons with kidney disease. A total of eight patients are able to access limited care haemodialysis in Armidale as a result of this funding. In fact, I visited the unit recently when I was in Armidale. Since 2004-2005, $200,000 has been provided annually, to improve access to dialysis for residents of rural sectors of the northern Hunter area. This funding is used to expand services at Maitland Limited Care facility. This service has increased from 3 to 6 days per week, and now accommodates 40 patients, up from 25 patients per week.

Almost $460,000 was provided in 2002-2003 under the Rural Health Plan to contribute to capital costs of establishing a unit in the Tweed Valley. That unit opened in early 2004. Since 2003-2004, $227,000 recurrent funding has been made available under the Rural Health Plan to employ an Aboriginal liaison officer and an additional case manager on the North Coast. This funding was also used for additional consumables to treat an additional four patients at Lismore. Since 2003-2004, close to $130,000 has been allocated, on an annual basis under the NSW Rural Health Plan for additional nursing and dietetic staff to improve case management of clients on the mid north coast.

Funding of almost $380,000 in 2004-2005 and $470,000 recurrent from 2005-2006 has been allocated to fund additional renal services on the mid north coast. Six additional limited care dialysis places have been provided at Coffs Harbour Health Campus, taking the total of people able to be treated to 24. A kidney biopsy service has also been established at Coffs Harbour at an operating cost of $120,000 in 2005-2006. The establishment of the biopsy service means that people no longer have to travel to Sydney for this service. Since 2004-2005 an additional six limited care dialysis places have been created at Kempsey at an operating cost of $164,000 each year. In addition, just over $485,000 in 2004-2005 and $645,000 annually from 2005-2006 has been provided to fund 15 additional dialysis places in the Northern Rivers at locations such as Ballina, Grafton and Tweed Heads.

In the Greater Southern Area Health Service from 2003-2004, almost $315,000 recurrent has been provided to construct and operate a new six chair renal dialysis unit in Moruya, which opened in April 2005. Just over $230,000 in 2004-2005 and $300,000 recurrent in 2005-2006, enabling the establishment of a six chair unit in Goulburn which opened in May 2005. From 2003-2004, almost $435,000 recurrent was allocated to establish and operate a six chair renal dialysis satellite centre at Griffith and to establish an outreach service for people on home based dialysis in Wagga Wagga and Griffith, providing support to 20 patients. The outreach service commenced in 2003-2004 and the Griffith Unit opened in October 2004. Further funding of $100,000 in 2004-2005 and $200,000

recurrent from 2005-2006 has enabled an immediate expansion of the Griffith unit to treat an additional six patients. That unit now has a total of 12 chairs. Since 2004-2005, $103,000 recurrent has been made available to fund an area renal services manager position to co-ordinate access to services and improve overall continuity of care for renal patients.

In the Illawarra $200,000 per annum from 2004-2005 has been provided to improve access to renal services for residents of rural sectors of the southern Illawarra area through the establishment of a medical director position for the Shoalhaven who will provide additional outpatient clinical services.

In Greater Western, since 2003-2004, $273,500 each year was allocated to establish and operate a four chair renal dialysis satellite centre in Bathurst. That unit opened in February 2004. Further enhancement funding in 2004-2005 of $268,000 and $277,000 from 2005-2006 has enabled an additional three patients to be treated at Bathurst and enabled the employment of a renal clinical nurse consultant. Funding of almost $375,000 in 2002-2003 and over $450,000 annually from 2003-2004 has enabled the renal dialysis unit at Dubbo to expand from six to ten chairs. The expanded unit opened in May 2003 and has resulted in vastly improved facilities, higher levels of patient comfort and a better environment for the hard working staff. Further funding of $143,000 in 2004-2005 and $390,000 recurrent from 2005-2006 will enhance home based care for dialysis patients in Dubbo and Wellington. Almost $295,000 annually has been provided from 2004-2005 for the employment of a part time medical director, a specialist nurse and an Aboriginal health worker and additional infrastructure in the upper western sector of the Far West to improve access through better support of home dialysis.

During 2004 there was an assessment of the training needs of rural renal staff in response to requests from rural clinicians. This has resulted in a process for developing a training package and resources for the range of staff working in rural renal services. Projects which will be particularly beneficial for indigenous people have been initiated through the Aboriginal Vascular Health Program. These are funded to the extent of $7 million over four years (from 2003-2004 to 2006-2007), and $2 million each year thereafter. This funding is used to improve prevention and care services and fund programs which target diabetes, cardiovascular disease and diseases of the circulatory system.

All these initiatives will allow the increasing demand for renal services to be met closer to home for residents of rural New South Wales. They demonstrate the Government's commitment to making renal services a priority.

The Hon. ROBYN PARKER: Minister, back onto the State Health budget and in relation to elective surgery. On average how many patients were added to the elective surgery waiting list per day in 2004-2005?

The Hon. JOHN HATZISTERGOS: That is actually on the internet, is it not? You can analyse it from the internet.

The Hon. ROBYN PARKER: If you would like to take that on notice, could you also at the same time provide how many per day were added in 2003-2004, 2002-2003 and 2001-2002?

The Hon. JOHN HATZISTERGOS: It is all on the internet.

The Hon. ROBYN PARKER: It would be easy for you to provide it for us. Can you take it on notice?

The Hon. JOHN HATZISTERGOS: It is easy for you to look it up. I am happy to provide information that is not accessible to you but that is accessible to you, so you can go and look at it.

The Hon. ROBYN PARKER: So you are going to take it on notice then and provide it for us?

The Hon. JOHN HATZISTERGOS: I will provide any information that is not available to you on the internet or in any public document. That information, I believe, is available publicly.

The Hon. ROBYN PARKER: In relation to a list of surgery waiting lists, when was the

person who has been on the elective surgery waiting list the longest added to the waiting list?

The Hon. JOHN HATZISTERGOS: When was the person who - what, in the last year or the last ten years?

The Hon. ROBYN PARKER: Over the last year.

The Hon. JOHN HATZISTERGOS: What is the longest person on the waiting list?

The Hon. ROBYN PARKER: The person on the waiting list, they might have been on the waiting list for a year, two years, three years, however, but there is a person who has been on the waiting list in New South Wales for the longest. When were they added to the waiting list? Was it a year ago, two years ago, three years ago? Who has been waiting the longest and when did they start waiting?

The Hon. JOHN HATZISTERGOS: I will take that on notice. I believe that can be ascertained from the internet anyway but I will take that on notice.

The Hon. ROBYN PARKER: Could you also tell us what sort of procedure they have been waiting for?

The Hon. JOHN HATZISTERGOS: That is all on the internet.

CHAIR: No, I do not think so.

The Hon. ROBYN PARKER: You will take that on notice as well?

[*Interruption*.]

The Hon. CHRISTINE ROBERTSON: The persons who are observers are interrupting.

The Hon. JOHN HATZISTERGOS: This person you are talking about, this mythical person who has been waiting the longest, what procedure he has been waiting the longest for. Is that what you are talking about?

The Hon. ROBYN PARKER: That is right, there is a person on the waiting list who has been waiting the longest in New South Wales. I want to know how long they have been waiting and what they have been waiting for.

The Hon. JOHN HATZISTERGOS: So you want me to find the person who has been waiting the longest on the waiting list of the 60,000 that are currently on the waiting list.

The Hon. ROBYN PARKER: Of the thousand on the waiting list.

The Hon. JOHN HATZISTERGOS: There are 60,000. You want me to find the person who has been waiting the longest. Actually, you could narrow it down because the long waiting is list is now around 5000. We have actually halved it in the last year or so.

The Hon. ROBYN PARKER: It depends on how you calculate that, but anyway we want to know that.

The Hon. JOHN HATZISTERGOS: So you want me to find out those 5000 who have been waiting the longest?

The Hon. ROBYN PARKER: Yes, please, and what they have been waiting for.

The Hon. JOHN HATZISTERGOS: And the procedure they have been waiting for.

The Hon. CHRISTINE ROBERTSON: And get their consent.

The Hon. ROBYN PARKER: Thank you. We do not need to know their names.

CHAIR: Dr Chesterfield-Evans, would you now like to ask a question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. In the Department of Health study of the M5 East, why were there no exposure measurements of the people in the target areas?

[*Interruption.*]

The Hon. HENRY TSANG: Point of order, Chair. Can you ask those staff at the back please to stop their laughter because this is a serious inquiry.

[*Interruption.*]

The Hon. CHRISTINE ROBERTSON: Out of order.

CHAIR: There should be no talk from the public gallery. You may proceed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Minister, why was there no exposure measurement in the Department of Health's study of air quality in the M5 East tunnel?

The Hon. JOHN HATZISTERGOS: What is this exposure?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was no exposure measurement of the people who were complaining about ill health due to emissions from the M5 East tunnel.

The Hon. JOHN HATZISTERGOS: I do not understand what you mean by "exposure measurement".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You see how much they have to breathe in of what, of nitrous oxide or of the particulates or of carbon monoxide. You measure what they are exposed to. You do not just ring them up and ask them, "Have you been sick lately".

The Hon. JOHN HATZISTERGOS: How do you do that?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is quite an art. That is why it has to be done properly.

The Hon. JOHN HATZISTERGOS: I am just wondering how you do it. You are asking why it has not been done. I am struggling with what you expect us to do. What do you expect me to do, go underneath their nostrils and just pick it up or something?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not expect you to do it, Minister.

The Hon. JOHN HATZISTERGOS: How do you expect anyone to do it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I expect you to get some public health researchers to do it, as they have done in many other studies in many other countries, but sadly not in the M5 East study which is why it lacks credibility.

Ms KRUK: We will provide an answer to that. The Chief Health Officer indicates she will provide an answer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask one further question on the same subject?

CHAIR: Yes, you have got a minute fifteen.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was an assessment by three

experts commissioned by the Lane Cove Council which recommended that the M5 East Health study should not be accepted. Why was there no response from the Government in terms of either defending or withdrawing that study?

The Hon. JOHN HATZISTERGOS: Could you repeat that question? I may be able to answer that. I just want to be clear on what you are asking. Could you just ask the question again?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Lane Cove Council commissioned three independent experts from interstate who found that the New South Wales Health findings of the M5 East study should not be accepted. Why did New South Wales Health not publicly withdraw the allegedly erroneous findings or defend them?

The Hon. JOHN HATZISTERGOS: Lane Cove Council commissioned a review of both phases of the study that was conducted by the Department of Health in 2003. The Department of Health has closely analysed the report of Lane Cove Council. The claimed flaws uncovered by the review amount to no more than limitations of the study already made clear by the Department of Health in April 2004.

The department also advises me that that study was not designed to assess long-term health impacts and could not exclude the possibility that certain sensitive individuals do experience symptoms related to stack emissions. The Department of Health study was not designed to look at these two aspects because there is simply no feasible scientific method currently available to establish or disprove either of these possibilities. As such, in light of the findings of the M5 study, the department concluded no further epidemiological investigation would be justified.

Subsequent to the completion of the health investigation, New South Wales Health was advised by the Roads and Traffic Authority in August 2004 that the M5 tunnel was not operating as expected during the investigations. Consequently, New South Wales Health has undertaken some updated exposure information and re-analysed the health status of the community using the updated exposure profiles. It is anticipated that this re-analysis will be completed by the end of this year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it then true that the RTA stated that there was no risk and they were vindicated by this study?

Dr ROBINSON: Could I ask you again please to repeat the last question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not the case that the RTA claims that they were vindicated and there was no danger as a result of the results of the health study?

Dr ROBINSON: Certainly, the health study that was conducted did not confirm that there was any effect on the health of the individuals in association with the emissions from the tunnel. As the Minister mentioned, however, there was some further advice that was subsequently received from the RTA that the portal emissions during the study period had been somewhat different to those that were modelled, and as a possibility the portal emissions could change the exposure to participants during the process, but a further review is actually being undertaken.

The CSIRO is re-modelling community exposure during the study to include the portal emissions that have now been made available by the RTA and that work will be completed at the end of this month and we have engaged Professor David Steele to provide statistical expertise to enable the re-analysis of these reported health outcomes by the updated modelling and this will be completed by the end of the year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And is there exposure measurement in that protocol?

Dr ROBINSON: No, this is simply a re-modelling of the work that has previously been done as the phase 1 and phase 2 of that study.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you aware of the Californian studies which show changes in children's health in response to low levels of pollution?

Dr ROBINSON: I am not personally aware but I am sure that my people in environmental health are.

CHAIR: Thank you, I will have to call an end to the inquiry. Minister, can I thank you, Director-General, Mr McGregor, Mr Barker, Dr Robinson and other members of the department for your attendance tonight. Can I also indicate that prior to the commencement of the public hearing section, the Committee resolved that in relation to anything taken on notice that we would ask for return of the questions within 14 days but that if it is not possible for to you provide an answer in that timeframe, that the Minister advise the Committee if there is any difficulty.

The Hon. JOHN HATZISTERGOS: Is that just the questions we took on notice today or the supplementary ones that you asked afterwards?

CHAIR: Yes, any other questions that we put on the notice paper.

The Hon. JOHN HATZISTERGOS: We have 14 days for all of those?

CHAIR: 35 days.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We would like to put some more on.

The Hon. JOHN HATZISTERGOS: When will we have the additional questions?

CHAIR: There is not an immediate timeframe. It will be just during the sitting of the house as normal. It is just the normal procedure. There is no provision under the Standing Orders for budget estimates questions on notice. So they will be placed on the notice paper in the normal course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They get 35 days then.

CHAIR: They get 35 days, yes. 14 days for those--

The Hon. JOHN HATZISTERGOS: So the only questions we have to worry about are the ones we have taken on notice here?

CHAIR: No, Minister, you should take all questions placed on notice today.

The Hon. JOHN HATZISTERGOS: The ones on the notice paper are separate but the ones that you have given us here today, they are the ones that you want us to answer within 14 days.

CHAIR: Yes.

The Hon. CHRISTINE ROBERTSON: Or contact us if there is a difficulty.

(The Committee proceeded to deliberate)