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GENERAL PURPOSE STANDING COMMITTEE No. 2

Monday 24 June 2002

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 1.00 p.m.

MEMBERS

The Hon. Dr. Arthur Chesterfield-Evans (Deputy-Chair)

The Hon. Ron Dyer
The Hon. John Hatzistergos
The Hon. Ian West
The Hon. John Jobling
The Hon. Don Harwin
The Hon Dr Peter Wong

PRESENT

The Hon. C. Knowles, *Minister for Health*

Health Department
Mr Robert McGregor, *Acting Director-General*
Mr Ken Barker, *Chief Financial Officer*

DEPUTY-CHAIR: I welcome the Minister and the departmental officers to this General Purpose Standing Committee No. 2 budget estimates hearing. Before questioning commences, I remind Committee members that the Committee is authorised to broadcast all public proceedings. Should it be considered that the broadcast of these proceedings be discontinued, a member will be required to move a motion accordingly. We will be examining the proposed expenditure for the portfolio of Health. Part (4) of our terms of reference requires that evidence be heard in public. We have resolved to authorise this in the past. In accordance with the Legislative Council's guidelines for the broadcast of proceedings, 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 the Committee, the media must take responsibility for anything they publish or any interpretation placed on anything said before the Committee.

There is no provision for members to refer directly to their own staff while at the table. Witnesses, members and their staff are advised that any messages should be delivered through the attendant on duty or the Committee clerk. For the benefit of honourable members and Hansard, will departmental officers identify themselves by name, position and department or agency before answering any questions referred to them. The sequence of questioning will be 20 minutes, 20 minutes and 20 minutes, with the Opposition going first.

The Hon. JOHN JOBLING: Minister, what happens to, say, a Central Coast patient who is in the need of an angiogram?

Mr KNOWLES: I will get out some details about the upgrade of Central Coast health services but, if my memory is right—and I think it is—historically people who live on the Central Coast largely had the prospect of travelling, depending on the referral patterns of specialists, to Royal North Shore Hospital to have their treatment, their cardiac angiography, which is the diagnostic component of their service, followed by the commonly referred to stenting type of services or their ongoing treatment. Honourable members will recall that three years ago we recast the budgets, and the budget we are dealing with today by and large completes that forward commitment we made then to more fairly distribute health funding around all areas and services including—

The Hon. JOHN JOBLING: Can I help you with the answer because it leads to something. You can have angiograms done at a local private hospital in Brisbane Waters, and you have answered the second question I was going to put to you: What happens if it is found after the angiogram that they need cardiac surgery? As you correctly said, they are sent to Royal North Shore Hospital for treatment. That raises the question: Is it correct that there have been no cardiac beds available at Royal North Shore Hospital since last Tuesday?

Mr KNOWLES: Bed pressures are always tight in the system, as you are aware, but to try to complete the question you asked, that is why we are now building facilities at Gosford. I was there just a couple of weeks ago. There will be a new cardiac catheterisation service incorporated into the new facility, with a more localised service to obviate against some of those patient transfers that occur and frequently cause the transfer of patients in and out of hospitals out of area. This is about ensuring that money is redirected to places where the need is the greatest, and that is occurring.

The Hon. JOHN JOBLING: It is correct that no cardiac beds were available at Royal North Shore Hospital since last Tuesday, and that leads onto the next question which is of much more interest to me. Did a Wyoming man have a serious heart attack in Gosford Hospital last Saturday while waiting for a bed at Royal North Shore Hospital for heart bypass after having an angiogram on the Central Coast last Tuesday?

Mr KNOWLES: The information I have here is in addition to the funding going to the Central Coast. We have identified the allocation of a further $3.28 million for Royal North Shore Hospital specifically to further upgrade cardiac services, among other services, and to continue to expand services there. The point I would make to you, and the point you are trying to make in your question, is that the issues associated with access to services are not new. The best and only way to deal with them is to ensure that more services are opened up with the additional funding that we are providing, which I just outlined. In addition, we have to ensure that clinical services are properly networked where transfers are required if services are not provided in a local setting, such as the

Central Coast—where they historically have not been. Preferably, we would ensure that services are provided locally—what we are doing. We will check on the cardiac beds, but I will take on notice whether beds were available and provide further accurate information when it comes to hand.

The Hon. JOHN JOBLING: Thank you. I am sure that will be a great comfort to the patient. You referred to the cardiac catheter laboratory. Is it not correct that, according to my recollection, it will only do angiograms and not follow-up cardiac surgery?

Mr KNOWLES: I am sorry?

The Hon. JOHN JOBLING: The cardiac catheter labs that you referred to going into Gosford. What they actually do is extremely limited, is it not? Is it not a fact that they only undertake angiograms, but not follow-up cardiac surgery?

Mr KNOWLES: Given the history of what was available in public facilities on the Central Coast, moving to an angiography suite is exponentially more—

The Hon. JOHN JOBLING: Minister, I just want to clarify—

Mr KNOWLES: If you would let me answer the question without—

The Hon. JOHN JOBLING: But you are not. What I want to know is what they did. I accept that it is of benefit to improve medical services, but I do not wish the impression to be gained that it does other than it does, and that is what I have asked you. Is it correct that they only do certain things?

Mr KNOWLES: As we expand services on the Central Coast it will continue to expand the range of cardio services it is able to provide. It would be nonsense to suggest that from day one it will be able to do heart transplants, for example. Going from a base of zero heart services on the Central Coast to providing the $30 million-odd as part of the $190 million-odd upgrade of Central Coast hospitals is a start at the lower end of service delivery, particularly in cardio—that is, angiography—and we will build up to categorisation, stenting and other surgical interventions as and when we can attract the specialists. One of the issues here is building the critical mass of skills and quality in a particular area. You might have wanted to have Victor Chang, should he be alive, on every street corner. The facts are that those sorts of skills are not necessarily available in every nook and cranny of the health system, and they have to be planned and networked.

The Hon. JOHN JOBLING: We would all agree with that, Minister, and we all desire that. I thank you for the answer, which clarifies my view. I go back a little to the history which I am sure you probably recall. On 8 March 2000 you made an interesting announcement that Health would have a three-year forward budget, which you described as "to provide budget certainty for area health services and to assist forward planning". That is the most desirable object. What are the NSW Health forward budgets for the next three years and, in particular, the allocation for each area health service for those years?

Mr KNOWLES: I cannot tell you today, but they will be published within the next six weeks. As you will be aware, we have only got our global budget from the Treasury in the past few weeks. They are now being worked out with the areas, as they have every year.

The Hon. JOHN JOBLING: The ones for 2001 were published?

Mr KNOWLES: We published three-year forward budgets for March 2000 three years in advance. That was off the back of negotiations with Treasury then, and commitments have been honoured in every aspect.

The Hon. JOHN JOBLING: Could you tell me where I might find a copy? I looked and could not find one, and I would like to know precisely where they are.

Mr KNOWLES: I read them into the record of these estimates committees last year. I suggest that that could be one place.

The Hon. JOHN JOBLING: I would have grave doubt that that would be possible in the time—with the whole area of health services forward budgets to the various areas, the particular allocations. Could you make a copy available to the Committee?

Mr KNOWLES: I will certainly make them available.

The Hon. DON HARWIN: If I could take you to Budget Paper No. 3, page 8-6, which refers to a major metropolitan planning initiative. Could you provide a breakdown of initiatives included under the $60 million in this major planning initiative, the allocations to them and where they are located?

Mr KNOWLES: Yes, we can. Budget Papers Nos 2 and 3 make reference to annual funding of some $60 million arising from the comprehensive review of the metropolitan health services by the Greater Metropolitan Transition Task Force [GMTT]. You would be aware that that is a group of clinicians—approximately 40 of them—chaired by Professor Kerry Galston from, most recently, the Northern Clinical School, Professor Don Dwyer and Professor Graeme Stewart. It is a major metropolitan planning initiative and resulted in the current enhancements, as I said, of $60 million per annum and is in keeping with the recommendations of the Greater Metropolitan Services Implementation Group. The funding will be directed to providing the health service that the health professionals have identified and where they are required to be located.

They include complex transplantations, including organ retrieval, severe burns units, severe enhancements for spinal cord injury, cardiac services enhancements, better management and service enhancements for brain injury rehabilitation, bone marrow transplantation service enhancements for otologists and allergenaic transplants, clinical networking and specialty nurses and training for neurosurgery services, clinical service enhancements in neurology, enhancements in services in renal transplantation, improved radiology services, improved emergency department services in metropolitan hospitals, general announcements and quality of services funding for metropolitan general and specialty hospitals, and hospital transport transfer systems in the metropolitan area. The final proposals for service locations are currently being collated by the GMTT group prior to my formal announcement of them in the next two to three weeks.

The Hon. DON HARWIN: I presume that when you make that announcement we will then be able to have a list of the allocation to each of them and the locations?

Mr KNOWLES: I make the important point that the process arising from the Greater Metropolitan Services Implementation Group was to consult by clinically led consultation and peer consultation with major metropolitan hospitals—that is, the teaching hospitals as well as the district level hospitals. That process has been highly complex and, to the great credit of the clinicians in the health system, highly collaborative and co-operative, despite the claims and expectations of some who would portray that as a potential for hostility and division amongst the medical communities. They have worked very closely together. For example, I attended a workshop run by clinicians for the leading clinicians of district hospital facilities three or four weeks ago at Ryde where they all came together to talk about the role and function of district hospitals.

That allows the Greater Metropolitan Services Implementation Group and the Greater Metropolitan Transition Task Force to build up a picture of the type and location of services that I outlined in the earlier part of my answer to ensure that, to pick an example, a burns unit is properly located or another facility or piece of equipment is properly located. Basically, it is doctors and nurses identifying the sorts of facilities they need on the basis that they are networked with each other. The networking concept is extremely important, given the complexity of some of the procedures that are implied in some of these procedural areas. For example, someone with a severe burn needs the best treatment and, based on all the clinical evidence internationally, that is best located in one or two facilities—I do not think this would surprise anyone—that is, Concord and Royal North Shore. That allows us to build up, based on that clinical advice, the budgeting component—$60 million in this case—and the allocation of those services. Those components of the greater metropolitan plan are being put together and have been put together over recent times and are getting ready to be rolled out with clinical support.

The Hon. DON HARWIN: Can you tell me how many bureaucrats are on the Greater Metropolitan Services Implementation Group?

Mr KNOWLES: I could. I will provide written advice as well. If my memory serves me correctly, it is serviced by a small secretariat from the Department of Health of, I think, three people. While she sort of cross-dresses these days, I think Associate Professor Debra Picone, who is the Deputy Director of the Department of Health and is sitting behind me—I suspect she is probably about to throw something at me—is also a member of the committee, but most people would still regard Associate Professor Picone as a clinician at heart doing an odd job as a bureaucrat.

The Hon. DON HARWIN: We look forward to that answer.

Mr KNOWLES: There would also be the occasional area chief executive officer. As I think you may be aware, depending on the clinical groups, each one of those procedural areas that I have outlined brings to it the experts in the field so when they are sitting talking about severe burns you would expect to see the people who knew about burns. When you are talking about neurology you would expect to see a group of neurosurgeons there and so on. The group would, by necessity, be focusing on each clinical area and that would occasionally bring some of the area-based executive members of the system to the table so they can participate in the planning.

The Hon. DON HARWIN: We look forward to the answer on notice. Do you have a fund for your discretionary use commonly known as L4?

Mr KNOWLES: Yes.

The Hon. DON HARWIN: How much money has been expended in L4 for each year of your term?

Mr KNOWLES: I will ask Mr McGregor to respond.

Mr McGREGOR: There is a contingency fund, a small amount, which is included at the Minister's discretion.

Mr KNOWLES: We will provide the cash amounts.

Mr McGREGOR: That is used to meet emerging needs in relation to service provision that occur during the year.

Mr KNOWLES: For example, in the recent changes to blood management in this country because of things like the emerging evidence around mad cow disease and the need to further enhance the regime associated with the Australian Red Cross blood service, I am advised by Mr Barker that the L4 was used to supplement the State's contribution to the Australian Red Cross blood service because a funding source had not been previously identified.

The Hon. DON HARWIN: In terms of the process associated with expenditure from L4, can you advise whether all those allocations were made with the concurrence and full knowledge of the department?

Mr McGREGOR: Every expenditure from L4 has been approved specifically by the Minister primarily on the recommendation of the department.

The Hon. JOHN JOBLING: In your comments you said that L4 was a contingency fund and had a small amount. What do you describe as a small amount? In other words, what is the sum of money available in that fund?

Mr KNOWLES: Unless someone can advise me now, I will provide the information to you. I do not carry it around in my head.

The Hon. JOHN JOBLING: A discretionary fund? It is unusual, is it not?

Mr KNOWLES: No. I understand that L4 has existed under every health Minister since time began for things—

The Hon. JOHN JOBLING: Can you tell me why it is called L4?

Mr BARKER: That is the accounting ledger we maintain it in. It is like in chartered accounts—every account in the chartered accounts and every cost centre has a number. It just so happens that the Minister's contingency is L4. The other point I think I would add is that Treasurers have asked Ministers to maintain funds for contingencies that arise during the course of the year. This has been a requirement for some time and that is why we are required to maintain this account for the Minister's discretion as the year transpires. Of course, the Treasurer maintains his own one and that is called the Treasurer's Advance account, which he also uses for all of government.

The Hon. JOHN JOBLING: Can you provide the figures for the sums of money allocated to L4, not only for this year's budget but for the two years prior to that?

Mr KNOWLES: I would like to go better than that because the implication is that the Minister has some sort of fund over to the side, which is clearly wrong and has clearly been identified by Mr Barker. We will not only provide the detail of L4 in terms of its quantum but what the money has been expended on and the authorisations by the department. Frankly, if there is an implication in that—no hands in the air or pious—I resent it.

The Hon. JOHN JOBLING: I am anything but pious, you may be assured of that.

The Hon. Dr PETER WONG: In March this year you announced in the lower House that the Government is looking at regulations which may lead to a fine if restaurants do not advise customers that they have added MSG to their cooking. I have since prepared a detailed document on MSG. This document is endorsed by Dr Coralie Katelaris, head of the allergy clinic at Westmead Hospital, who said:

> As I said, I think it's an excellent document, well balanced and clear.

The document is also endorsed by Dr Ramon Bullock, another prominent allergist. I will give a copy to you and to the Committee afterwards. This issue has created a great deal of anxiety among the ethnic communities, in particular the restaurant owners. My question is: Will the Minister consider this issue carefully and consult and meet the ethnic communities, in particular the restaurant owners, before any final decision is made?

Mr KNOWLES: The Government has made its position clear but, of course, in the preparation of any regulation—I am going back to my days on the Regulation Review Committee—there is a requirement to consult anyone. Even if there was not a requirement, I am more than happy to do just that. I have had representations, indeed I think—and I will stand corrected—from some of the individuals you mentioned in your question. I would be more than happy to ensure that the appropriate scientific people and public health people in the department at least meet with them and if there is a necessity for me also to meet I am more than happy to do that. I make the point that I have already indicated that I would work with the New South Wales Restaurant and Caterers Association as part of the Government's desire to implement this requirement. There is ongoing liaison with that association and, as I said, they and other industry groups will be formally consulted during the development of the regulation before it is finalised.

In addition, it might interest you to know—because I have to say from the discussions I have had, and no doubt you have had with them as well—there are differing views about the effects or alleged effects of MSG, and I am conscious of that. However, I do not think that is anything new. I think those views go back as far as the 1960s. In that sense we want to also assist the allergy unit at the Royal Prince Alfred Hospital and the chair in paediatric allergy at Westmead to encourage further research and public education about allergic reactions generally and food intolerances specifically. I think it is something that is worth doing and that of course is all under way.

The Hon. Dr PETER WONG: After the announcement I visited the Royal Prince Alfred Hospital and spoke to the person concerned. His answer to your comment that 5 to 10 per cent of

people may be intolerant to MSG was that there was absolutely no research evidence. His exact word was that it was a "guesstimate" using a Phd thesis from one student as a basis of an allegation and it is totally unscientific. I know that you are a very good man, but sometimes experts may not be experts if they appear to make an allegation not made on a scientific basis.

Mr KNOWLES: I am a lay person; I am not a scientist. Food allergies, intolerances, the impact of chemical additives and genetically modified foods—as is on the front page of one newspaper today—are subject to much argument within the scientific community. It does not surprise me that there are assertions and counter assertions about these sorts of issues. When somebody writes the definitive tome on food allergy or intolerance, the following week yet another book is published with more research arguing the other way. That is never a surprise—that is the nature of the business. Not only is the science around the impact of food on the human condition poorly understood but, from a scientific point of view, there are clear commercial interests in relation to genetically modified foods—depending on which side of the grocery counter you stand, you will have a different argument.

In addition to seeking to advise consumers of the existence of added MSG in food, we are funding some specific research into food intolerances through the allergy centre at Royal Prince Alfred Hospital. Whether it is anecdotal, a preparatory PhD or one of the many pieces of research literature that assert one way or the other, you do not have to talk to too many people about the impact of MSG to understand that many people—whether real or perceived—get crashingly blinding headaches, illnesses and symptoms. From a perspective based on the advice we received, it led us to believe that with the co-operation of the Restaurant and Caterers Association and other industry groups it may be appropriate to consider some advice to consumers. The Government has traditionally regarded that as a fairly basic right—whether it is about gene foods or this sort of thing—and it is not unusual for us to request that.

The Hon. Dr PETER WONG: I am concerned that the person who had it investigated based it on allegations, not on research. I have spoken to him, and I will say it publicly outside, that he showed me not one document.

Mr KNOWLES: I am not arguing with you; I think I am endorsing the point you make. You get lots of different people arguing different things, sometimes based on hotly held views. I can almost pick off every elected member in this room and say who has a particular view about a particular issue. The chairman has a view on tobacco, for example. It does not necessarily mean their views are right or wrong, but they are strongly held. That is why we are funding research.

The Hon. Dr PETER WONG: How many beds are operating in the maternity section of Rooty Hill and Blacktown hospitals? In ideal circumstances, what is the maximum capacity for beds in those hospitals? How many beds are open now in New South Wales public hospitals? How many beds are closed due to funding shortages? How many beds are closed due to staff shortages?

Mr KNOWLES: I will take on notice the question in relation to the Rooty Hill hospital. I can find that out fairly quickly. Blacktown/Mt Druitt is—and has been for many years, indeed probably since it was built—regarded as two hospitals but one health service. The Deputy-Chair is nodding in agreement. The services are linked clinically across the campuses and so they are connected in that way, but I will find out the specifics for you. With regard to the second part of your question, I can advise you that 153,000 more patients were treated in New South Wales public hospitals in the past financial year compared to 1994 and 1995. Back then 1.28 million people were admitted compared to 1.42 million, which is a 12 per cent increase. Of course, as you would be aware, the changes in clinical treatment have meant great differences in the way services are now provided. They once required beds, but they are now done on a day surgery basis. That is fairly commonly understood.

We have introduced changes for patients. For example, people who need procedures such as a colonoscopy, chemotherapy, biopsy, cardiac catheterisation or a blood transfusion used to have to be admitted to hospital, but they now typically have their procedures done in outpatient settings. Changes in those areas are equivalent to more than 20,000 overnight admissions each year. In terms of the issues of staff shortages, we clearly acknowledge as a matter well and truly in the public domain that there are workforce shortages right throughout health system, not only in New South Wales but around Australia. The issues are always about endeavouring to provide more services with those

constraints on the system. In conclusion, I give great credit to the men and women of the health service for their work.

DEPUTY-CHAIR: In a letter Ian McManus sent to the Hon. Alan Corbett dated 4 October 2001 he stated that the Department of Health is exploring the possibility of estimating the prevalence of self-imported chemical sensitivity in the New South Wales population. Is the department proceeding with that survey? Has a budget been allocated to it?

Mr KNOWLES: It has proceeded at least to the point where we have been provided with quite considerable literature from around the world on this subject, building up the foundations of the knowledge bank. But, as you are aware, and as it was reported last year, there is clearly vigorous debate in scientific and medical literature about multiple chemical sensitivity [MCS] and how typical symptoms can be triggered by susceptible individuals. I know that the partner of the Hon. Alan Corbett is one such individual, and I respect that fact. It is fair to say that there is no consensus about the issues of causation and what affects people in those areas, but they do appear to experience adverse health effects which can, in some cases, be quite debilitating.

Because of the potential similarities between MCS and some of the other chronic disabling conditions the International Program on Chemical Safety of the World Health Organisation organised a workshop. It recommended that the term MCS should be discouraged because it makes an unsupported judgment on causation and should be replaced by a more descriptive one: idiopathic environmental intolerance [IEI]. The Hon. Alan Corbett may have to change his terminology from MCS to IEI to comply with the World Health Organisation requirements.

DEPUTY-CHAIR: It seems reasonable that there is a condition. Should the department quantify it?

Mr KNOWLES: As I said, I do not treat this lightly—even though a tiny proportion of the population purport to suffer from MCS. The Chief Health Officer advises me that this work is being undertaken and these studies are occurring. Mr McGregor has just drawn my attention to this component of a position statement on idiopathic environmental intolerances dated January from the Journal of Allergy and Clinical Immunology, which states:

> IEI also called environmental illness and multiple chemical insensitivities has been postulated to be a disease unique to modern industrial society in which certain persons are said to acquire …

DEPUTY-CHAIR: We do not need a discussion of the nature of the disease.

Mr KNOWLES: I thought that was what you asked me.

DEPUTY-CHAIR: No. Have you proceeded with a survey? Have you a budget for the survey? Is someone in the department allocated to reading these documents or is there a budget to do our own survey?

Mr KNOWLES: No. The Chief Health Officer has advised me that he is studying the literature before he recommends to me the allocation of a substantial budget amount to undertake specific research. It would seem, based on his advice to me, that there is global research taking place in this area. Frankly, to be blunt about it, if we can have the research done by someone else, have it validated through World Health Organisation channels, and have it properly and ethically supported then I would prefer to pick up on that literature than necessarily sponsor specific research here.

DEPUTY-CHAIR: We are not about to do that research here?

Mr KNOWLES: No, I am not. Despite the coincidence that a member of the New South Wales Legislative Council has a partner who has MCS it does not necessarily merit the expenditure of public funds on a major research program when there is substantial work being done globally, to which I have referred. The Chief Health Officer has advised me that he is studying that material to determine whether there is any applicability for the global research to be applied to the Australian circumstances. If, based on his advice, there was a need for further Australian-specific research, and if he supported research to be undertaken, I would do so. The advice to me at this stage is that there is

sufficient work being undertaken globally to allow us in this jurisdiction to have the benefit of that research and to apply it where necessary.

DEPUTY-CHAIR: When is he likely to report? Is there a time frame?

Mr KNOWLES: No, I do not have a time frame.

DEPUTY-CHAIR: There has been no fall in tobacco consumption by males or females in the past three years. Again, this year's budget does not have a line item on tobacco control. Will there be an increase in the tobacco control budget? If so, what is that budget? Has it increased?

Mr KNOWLES: The Australian Institute of Health and Welfare reports that, indeed, between 1998 and 2000 the proportion of the Australian population that smoke daily had declined by two percentage points to 19.5 per cent. Most of this decline was in young males and females in the 20 to 29 years age group, with no significant changes for any other group. Occasional smoking that was weekly or less than weekly was similar in 1998 to 2001 at about 3.6 per cent of the population overall and among teenagers, females were more likely than males to smoke daily. At all other ages, males were more likely to smoke than females.

I have to say—having received a Noffs Foundation award for our work in tobacco control, particularly passive smoking and the impact of smoking on young people—that New South Wales can regard itself as having taken some steps which have now been emulated by jurisdictions in the area. I do not pretend there is not more to be done. Indeed, I would foreshadow ongoing work in this area. But I would like to make the point that from 2000-01 funding of $3.3 million has been allocated annually to implement the Tobacco Action Plan, and of this an amount of $1.5 million is an enhancement of funding for tobacco control strategies.

That, of course, does not represent the full extent of the Government's funds used in tobacco control. Beyond the Health portfolio, a number of agencies—such as WorkCover, Police, and Gaming and Racing—all have particular roles in the area of tobacco control. Even within NSW Health a range of areas other than the Health Promotion Branch are involved in tobacco control, including the department's Environmental Health Branch, Epidemiology Branch and Aboriginal Health Branch. In addition, it is estimated that $2.1 million is allocated by area health services to tobacco control activities, for project work and staff salaries. Area health services have a range of personnel actively involved in promoting smoking cessation and assisting smokers in quitting, monitoring and enforcing of tobacco advertising restrictions and restrictions on sales.

DEPUTY-CHAIR: Could I have a summary of those people, Minister, so that we may know how much money is being spent on tobacco control overall?

Mr KNOWLES: I can give you a couple of examples now.

DEPUTY-CHAIR: I do not want examples. I would rather a list of what money is spent, and where.

Mr KNOWLES: I am happy to do that. You have a genuine and longstanding interest in this area. Indeed, I think you are on record—I have *Hansard* somewhere—as saying that, through your long experience with BUGA -UP and your various tobacco activities, our legislation has probably been more valuable in terms of overall cessation of tobacco smoking and promotion of anti-tobacco smoking than anything you have seen before. I am verballing you in your presence, and you have the right of reply, so I am being careful, but I am pretty sure, in relation to our various passive smoking legislation, that in the second reading debate that is the sort of thing you said. I did not believe it when I heard it, but I did begin to believe it when I turned up that we had a Noffs Foundation award for our legislation, which is regarded as a national model.

DEPUTY-CHAIR: My view has always been that it is better 40 years late than never.

Mr KNOWLES: Forty years ago I had not started school.

DEPUTY-CHAIR: I understand that, Minister. I am not blaming you for the 40-year delay. It is very much a compound thing. When can we look forward to the smoking in pubs legislation?

Mr KNOWLES: I have some material on that. But, in general terms, as you know, the reason you were so congratulatory about our legislation is that it took with us large sections of the community that were historically hostile to any curtailment of smoking. I talk particularly of the Australian Hotels Association, which historically has been vigorously opposed, and to a lesser degree but not without consideration Clubs New South Wales—the old Registered Clubs Association. The fact that we were able to link that end of the spectrum to the anti-smoking lobby – the Action on Smoking and Health [ASH] groups, cancer councils and so on—I think was the success of the legislation. The legislation proposed the continued phase-in, with cessation in dining areas of pubs and clubs, which commenced last year. There are some further regulations and consideration in train right now.

DEPUTY-CHAIR: I understood, though, that the 2000 legislation gave pubs and clubs 12 months to work out how they would go smoke free, or it would be imposed on them. I gather there is a smoking working party, which has not done very much, and keeps being boycotted by the AHA.

Mr KNOWLES: That is not fair, and it is not true.

DEPUTY-CHAIR: What is the status of that committee and its working party, and what is the state of progress towards smoke-free pubs?

Mr KNOWLES: I can advise you that I have signed a Cabinet minute—which will go to Cabinet in the very near future—which you will be able to discuss in terms of legislation on specifically those issues. The working party has been active. Nobody pretends this is easy. I think what has happened though, frankly—as I predicted, and I think you predicted back then—is that it would be less the legislative measures and more the workplace safety issues and public demands for smoke-free environments that would see the last components of these areas of concern change. The Wollongong court case sent a shock wave through the clubs industry and saw them develop, in very quick time, if I remember correctly, codes of recommended practice for their members. The hotels industry is also conscious of the impact on occupational health and safety issues, and of course they are part of the componentry of change, including the work of the working party, which has been very hard and solid but quite diligent.

The Hon. RON DYER: Minister, are you able to tell the Committee what initiatives are contained in this year's budget for the Westmead campus?

Mr KNOWLES: Westmead, of course, is slated as part of the overall upgrading of Sydney's teaching hospitals, for upgrade after its original construction 25 years ago, in round figures. That, of course, is appropriate, given the increased recurrent budgets for Western Sydney and that the undertaking to upgrade capital works, including the redevelopment of Westmead, is now firmly on the agenda. The western integration network—known as WIN—strategy has received $178.5 million over six years for phase one. This year we are providing $8.8 million. That will mean a major upgrade in the areas of rehabilitation, allied health, cancer care, cardiac services, maternity, imaging, operating theatres and patient wards. It will provide a contemporary standard of service delivery.

An intensive care unit hot floor will be established, as well as an ambulatory care zone and comprehensive clinical centres, operating theatre wards will be fully refurbished, and advanced medical technology and information infrastructure will be provided. Major planning is currently under way. The first project to begin at Westmead, in conjunction with the Ambulatory Procedures Centre, will involve redeveloping the areas for day surgery, women's health, newborn care, imaging and emergency as well as associated building engineering. The total cost of that work is $7.05 million. Another $1.79 million will be spent on planning subsequent stages of the strategy. The Ambulatory Procedures Centre—a $6 million capital project—will provide an integrated one-stop centre where patients can have their tests and surgery and then recover from the anaesthetic in familiar surroundings. It will also provide an enlarged pre-admissions centre and endoscopy service. There will be no need for overnight hospitalisations, so families will not be dislocated. The centre should be completed by October this year.

Construction of a new $3.8 million Breast Centre will begin mid-year. This new facility will provide a statewide service including research, education and breast screening. It will also analyse data supplied by a network of multidisciplinary breast clinics at Liverpool, Nepean and other hospitals. The Breast Centre will complement and build on the internationally acclaimed research work of the Westmead Institute of Cancer Research, the Centre for Virus Research, the Storr Liver Unit and the Institute of Immunology and Allergy Research, which combined and opened in March 2000 as the $11.4 million Westmead Millennium Institute.

On top of that, it is worth noting that the new facility for the Neonatal Emergency Transport Service—a $6.5 million capital project—will be under way in August. That will provide a purpose-built facility between the adult hospital and the Children's Hospital, and will include a new helipad for the Westmead campus and a base for the Child Flight service. Capital and recurrent funding enhancements to Western Sydney have seen increases in critical care services at Westmead. With the $500,000 provided by government, an additional two intensive care beds were opened, allowing better access to Westmead for highly complex surgical cases. Cancer services, respiratory medicine, haematology, diabetes and stroke services have all been enhanced. I remember late last year opening the beautiful, newly-refurbished oncology outpatient treatment unit at Westmead, with great contribution, largely in kind with some cash, from patients historically of that cancer ward.

That $200,000 project gives more privacy and provides something of a home-style environment for patients while they are getting chemotherapy for several hours at a time. I pay tribute particularly to the Parramatta Leagues Club, Carlton and United Breweries and the Sydney Ports Authority, who made some donations. Of course, all those years later Westmead remains one of the great jewels in the crown of the Australian health system. I was out there just this morning recognising that beyond just now an adult teaching hospital has such a vitality around that campus, where you have the Millennium Institute, the Children's Medical Research Institute, the adult hospital, the Children's Hospital and the psychiatric facilities—just to mention a few. It offers a great opportunity for Western Sydney residents, not only in terms of high-quality clinical services but also the capacity to see that campus flourish as one of the world's leading sites for integrated research, medical research, biomedical research and research linked to clinical trials. It is a great opportunity in terms of the capacity of that campus. We have some of the world's best and brightest. Of course, that means this capital funding is backing a terrific team in that environment.

The Hon. IAN WEST: Minister, can you tell the Committee how New South Wales is responding to the vacuum in dental health services left by the abolition, by the current Federal Howard Government, of the dental health program?

Mr KNOWLES: Once again we have provided funding over and above additional funding announced a couple of years ago for oral health services. I will give a bit of history first. For the three years commencing 1 July 2001, funding for oral health gradually increased by a total of $33 million and recurrent spending on oral health programs will have increased from $72.5 million to approximately $92 million by 2002-03, with a $20 million enhancement of funding being allocated in 2002-03 alone. In addition to an increase in funding, significant reforms in oral health have been introduced to improve efficiency in the delivery of oral health services. We have established six oral health networks from within the 17 area health services within NSW Health. The reforms provide the basis to improve the co-ordination of efficiency and value for money in the delivery of oral health care. That, of course, was made necessary by the cessation of the National Dental Health Program by the Howard Government which, in conservative terms, has ripped in excess of about $100 million out of this State and many more millions of dollars out of the nation.

It is a sad fact that every commentator, whether that is the Australian Institute of Health and Welfare or any of the other health commentary organisations, believes that oral health and dental care should be one of the national health priorities and should be co-ordinated nationally. The fact is that unless and until a national government, irrespective of political persuasion, establishes a national dental health program, there will always be pressures on the States to deal with those people who simply cannot afford to take out their own private health insurance. The great tragedy is that while the Commonwealth program took about $500 million in round figures nationally out of the national dental program for the provision of dentures for older people and poor people, the Commonwealth Government gave that money straight back to people who could afford to take out health insurance

through the health insurance rebate schemes, through which 46 per cent of Australians now have insurance.

The cruel irony is that in closing down a national dental scheme, elderly people particularly, but people generally, who simply are unable to afford insurance are no longer able to obtain access to dental services other than through the State-funded programs which we have further supplemented this year. The obvious point to make is that that money is now going straight into dental programs for people who can afford insurance. In a community that prides itself on looking after the neediest in our society, that is a perverse outcome of a national policy decision and something in which the Commonwealth Government cannot take any pride. That has been constantly pointed out to the Commonwealth Government. I make the point that in addition to the $20 million in recurrent funding previously announced for 2002-03, a further $5 million in recurrent funds will be allocated, bringing the total recurrent funding to $25 million in the forthcoming financial year. That represents a total recurrent oral health budget of $97 million, which is an increase of 35 per cent in funding since 1999-2000, and $2 million of that will be allocated to the provision of an additional 4,000 denture services to older persons across the State on an annual basis.

The amount of $1 million will be allocated to increase the delivery of specialist oral health services and $1 million will be allocated to improving Aboriginal oral health care, in consultation with the New South Wales Aboriginal Health partnership. In addition, $1 million will be allocated to the establishment of three rural and regional oral health centres. Nobody could accuse this Government and, I put it to the Committee, nobody could accuse any State or Territory Government of not trying to pick up the tab after the cessation of that national program, but it is inadequate on any measure that in this country there is no national program. In the end, like all other priority issues, such as diabetes and respiratory illnesses, particularly asthma, oral hygiene and dental care should be listed as one of the national health priorities. I have no doubt that it will inevitably come back to haunt the current Commonwealth Government that, for an interregnum of some years between when the Commonwealth Government stopped the program and whenever it is reintroduced in the future, too many people will have missed out on proper dental care in. That is simply unreasonable.

We have to recognise that the big money that has gone in—and it is big money: a 35 per cent increase in funding since 1999-2000—covers a great deal of extra work. We have incorporated innovative programs with the Australian Dental Association in trying to cover as many people as we possibly can, and the additional funding for more dentures, particularly for older people this year, goes quite a considerable way to address some of the longstanding problems of dental care. But the point that I make again is that governments and oppositions without any political bias need to ensure that we press for the re-establishment of a national dental health program.

The Hon. JOHN HATZISTERGOS: In relation to rural health services, what initiatives have been taken in this year's budget?

Mr KNOWLES: My starting point is to thank, in his absence, the usual Chairman of this Committee, the Hon. Dr Brian Pezzutti, who is recorded in *Hansard* on 5 June as saying that there is no doubt that more money is being spent in providing health services in country New South Wales. He went on to talk about the longstanding need to give the area health services their fair share, and said:

> Under the current funding formula the Northern Rivers and mid North Coast—two of the poorest areas in New South Wales—will receive within 2 per cent of the share of the health budget.

That of course recognises the Government's program, which was established three years ago, to ensure that the resource distribution formula was more equitably spread right around the State so that in every part of New South Wales people got their fair share. For the first time, because we set a three-year program to achieve it, this budget delivers an equitable share of Health dollars to people, wherever they might live. In round figures I think it is something like 28 per cent of the State's recurrent budget that is going to the rural communities health budget, and 28 per cent of the population receive a fair share.

The Hon. Dr Brian Pezzutti went on to state that because of that increase in health funding and because of the certainty in budgeting, that is "an issue on which this Government should be congratulated." I recognise a compliment when it is decently given. Given that the compliment was made by the Chairman of this estimates Committee, who is a doctor in his own right, I take it that he

meant what he said. It is true that our rural communities now get a fairer share than perhaps they once did, and that goes to the heart of the work that we did with the Rt Hon. Ian Sinclair when he chaired the review of health services in small towns on behalf of the Government. That ministerial advisory committee recognised the need to have a better health plan for rural communities. To do that, the Rt Hon. Ian Sinclair led a very diverse group of individuals, but many of them with clinical backgrounds from rural communities, on a visit to 41 small communities right round the State.

They talked to not only health care providers but also aged care providers, local councils, non-government organisations, various other government agencies and other professional bodies. They found very fertile ground for work that is well and truly rolling out round the State following the recommendations. The review committee made a total of 108 recommendations, many of which relate to building and the need to co-locate rural health services through the Multipurpose Services [MPS] Program. I can advise the Committee of something that the Government is particularly pleased with—the ongoing roll-out of multipurpose services. They have now been constructed at Barradine, Braidwood, Culcairn, Delegate, Dorrigo, Grenfell, Lake Cargelligo, Oberon, Trangie, Trundle, Tumbarumba, Urbenville, Urana, Warren and Wilcannia, and there is an ongoing program that sees those MPS plans continue.

Ian Sinclair is actually conducting a review of the processes and the outcomes of the MPS program. That is being used to pave the way for the Rural Hospital and Health Service Program. It is certainly pleasing to note the restoration of the original hospital at Wilcannia, which I recently opened. The hospital was falling to pieces but has now been redesigned and reinstated. It is a beautiful place that not only provides good health services but also has just won a major heritage award. We can almost go town by town through the small towns' major upgradings of facilities, and redevelopment or creation of new facilities right across country New South Wales.

DEPUTY-CHAIR: Minister, perhaps you might table your answer or take it on notice rather than go through it right now.

(Short adjournment)

The Hon. JOHN JOBLING: I referred in an earlier question to Health having three-year forward budgets. The Minister said that he would make available to the Committee the three-year forward budgets for area health services.

Mr KNOWLES: I intend to publish forward budgets for area health services as soon as they are completed, not only for the benefit of this Committee but also for the benefit of the health system.

The Hon. JOHN JOBLING: My first question relates to the Western Sydney health strategy and, in particular, to Westmead and Auburn hospitals. Why has the completion date for the Western Sydney health strategy, which includes the upgrade of Westmead and Auburn hospitals, been extended to 2008? The completion date for the Westmead hospital Ambulatory Procedural Centre has been extended by two years to 2004 and that project was underspent by $3.41 million last year. The completion date for the New South Wales Westmead hospital Breast Centre has been extended to 2003. I am led to believe that that project was also underspent by $722,000 last year.

Mr KNOWLES: I will look at those specific issues. I will go through the Western Sydney strategy to which I referred earlier.

The Hon. JOHN JOBLING: Because of time limits I will accept the Minister's undertaking to provide us with those details. Did Mr David Harley undertake a review of metropolitan hospital emergency departments? What funding was allocated to Mr Harley to undertake that review? When will the report be released? How will that report differ from the emergency department clinical services plan which was completed in June 2001? I believe that Mr Harley's consultancy has been extended to rural emergency departments. Would the Minister care to comment on those issues?

Mr KNOWLES: Mr Harley was contracted by the New South Wales Department of Health. His report is not yet ready for release, but it is being prepared. He worked with the group that looked at the clinical aspects of the emergency department services plan, with specific reference to consumer issues. I believe that he has been considered to undertake a review of the metropolitan component of it

in collaboration with clinical groups that undertake broader planning work on emergency departments. Mr McGregor cannot remember what funding was provided off the top of his head, but we will happily provide those figures to the Committee.

The Hon. JOHN JOBLING: I ask the Minister also to inform the Committee of the anticipated release date of the report. Will it be one month or three months?

The Hon. DON HARWIN: In each of the last five years how many psychiatric patients under the care of NSW Health have committed suicide?

Mr KNOWLES: I would have to take that question on notice. I am happy to find out for the honourable member. As I understand it, that information is available.

The Hon. DON HARWIN: In each of the last five years how many psychiatric patients under the care of NSW Health have, first, injured themselves; second, injured hospital staff; and. third, injured others?

Mr KNOWLES: Is the honourable member referring to psychiatric patients?

The Hon. DON HARWIN: Yes, psychiatric patients. Has the Minister received Dr Barclay's report regarding homicides by mentally ill patients over the last five years, by year? When will the Minister release that report? Can the Committee have a copy of that report?

Mr KNOWLES: I certainly have no such report. Mr McGregor tells me that Dr Barclay is providing evidence to the upper House inquiry into mental health. If he has a report to submit to that group, that might be the report to which the honourable member is referring. I have no report from Dr Barclay.

DEPUTY-CHAIR: That report has not been submitted by Dr Barclay. He said that he could not release that report as it was owned by the Minister and that he required the Minister's permission to release it. Will the Minister give Dr Barclay permission to release that document?

Mr KNOWLES: I will find out whether I own this report, as is suggested by you, Mr Chairman. If I do, I will look at it and talk to Dr Barclay about it. I have not met with Dr Barclay; I have only heard about him as someone who is giving evidence to the upper House mental health inquiry.

The Hon. JOHN JOBLING: When I examined the budget papers I looked for a budget allocation for air ambulance aircraft as a few might need to be replaced. Where can I find a budgetary allocation for new air ambulance aircraft? Is it the Minister's intention to lease them or to purchase them?

Mr KNOWLES: Air ambulance replacement has been part of a tender selection process for the replacement of the Ambulance Service's fixed-wing aircraft. Tenders have to comply with a wide-ranging set of criteria, including compliance with specifications for capacity competence performance, quality control, value for money and safety of passengers and crews. The process will examine the feasibility of using a range of options. The service transports about 12 patients each year. It is my understanding that the tender process is nearing conclusion. I suspect that it is going through its final processes now. Mr McGregor might want to say something about that. Budgeting for aircraft replacement is incorporated in the Ambulance Service budget. Because I am not aware of the outcome of the tender process I have no intention of pre-empting it.

Mr McGREGOR: The report of the Ambulance Service tender evaluation committee, which was submitted to the department in the last few weeks, is at present being reviewed. We hope that a decision will be made in the next few weeks.

The Hon. JOHN JOBLING: Tenders have been closed and a determination will be made. You must then have put some money aside for that in the Ambulance Service budget. It is difficult for us to establish what moneys have been allocated. Will the Minister tell me what money has been

allocated or break down the Ambulance Service budget? The Minister might want to take that question on notice.

Mr KNOWLES: I am happy to assist where I can. However, I will not talk about tendering amounts until the tenders have been determined. But honourable members can be assured that funding for the proposals to replace existing aircraft is budgeted for and provided in the budget.

The Hon. JOHN JOBLING: After what I have been hearing, I hope that there is an adequate amount in the budget. I am somewhat concerned about the funding that is available to enable the Ambulance Service to meet its accounts, in particular in rural areas. Will the Minister inform the Committee whether the New South Wales Ambulance Service currently has bills outstanding over 30 days and 45 days? If so, what amounts are outstanding?

Mr KNOWLES: I cannot give the honourable member specific figures, but I can assure him that, when the accounts for the Ambulance Service are concluded at the end of this month, there will be no creditors over the 45-day benchmark

The Hon. JOHN JOBLING: That is a little more than is available in commercial practices.

Mr KNOWLES: To the contrary. The honourable member knows that that is wrong. Most commercial businesses have creditor accounts of 120 days.

The Hon. JOHN JOBLING: It depends on the business that is being run and on the skills of those running the business. According to the Minister, there are no bills over 45 days. Will the Minister supply us with information relating to any bills that are outstanding up to 45 days?

Mr KNOWLES: Yes, I am able to do that. I have done that every year for the last four years. I am happy to do it again.

The Hon. JOHN JOBLING: It has been suggested that the New South Wales Ambulance Service has to obtain a loan or an overdraft from Treasury to help pay its bills. Is that suggestion factual?

Mr BARKER: No health service is allowed to have an overdraft, and health services had to approach Treasury for any sort of financing facility of that nature.

The Hon. JOHN JOBLING: What you have said is that you do not have a loan in any form, whether it is from Treasury or an overdraft facility, for the Ambulance Service?

Mr BARKER: That is correct.

The Hon. JOHN JOBLING: So there is no loan to be repaid?

Mr BARKER: Not between the Ambulance Service and Treasury.

The Hon. JOHN JOBLING: Between the Ambulance Service and anybody else?

Mr BARKER: They had a loan about four years ago, which they are negotiating with the department to retire.

The Hon. JOHN JOBLING: Could you supply the details of that?

Mr BARKER: From memory, it is about $2.6 million.

The Hon. JOHN JOBLING: How do you propose to retire that loan?

Mr BARKER: That is a matter for negotiation between the department and the service.

The Hon. JOHN JOBLING: Are you able to advise the Committee where the money will come from to retire that loan?

Mr BARKER: That is part of the negotiation process.

The Hon. JOHN JOBLING: So you have made provision for it in this budget?

Mr BARKER: I did not say that.

The Hon. JOHN JOBLING: I just asked you the question. There is no provision in the budget to repay it?

Mr BARKER: It has been there for a couple of years.

The Hon. JOHN JOBLING: So it is simply accruing interest?

Mr BARKER: I think there is no interest on that particular loan.

The Hon. JOHN JOBLING: It is an interest-free loan?

Mr BARKER: Yes.

The Hon. JOHN JOBLING: Where would we be able to find that in a budget document?

Mr BARKER: It would be in the service's annual financial statements.

The Hon. JOHN JOBLING: Could you provide a copy of the document to the Committee, with the Minister's concurrence?

Mr BARKER: I think they are already in the Parliamentary Library.

The Hon. JOHN JOBLING: If you know where it is, I would prefer that you photocopy it and send it to us.

Mr KNOWLES: I will help you. If you cannot find it in the Parliamentary Library, we will happily provide you with an additional copy of a four-year-old loan between one part of the health service and another part. I want to add a brief supplementary answer on this issue of creditors, given the quips that were going backwards and forwards about the length of time. Mr McGregor has just handed me a note to say that Dunn and Bradstreet have recently released its latest Australian trade payment analysis covering the payment schedules of major companies and businesses. On average, companies took 56 days to pay their creditors. We know that many of those larger companies had much later and longer creditor periods than that. I simply put that on record.

The Hon. JOHN JOBLING: I note that the ambulance response time benchmarks have changed from eight minutes to 10 minutes; they have blown out by two minutes. Is there any special reason for that?

Mr KNOWLES: They have not. In fact, response times have improved, and it is to the great credit of the Ambulance Service that that is the case. With the collaboration of a pretty solid union, the Health and Research Employees Association, they are some of the most fundamental changes in management and industrial culture I have seen in any organisation. I am not going to cop any suggestion that the service's performance has done anything other than improve. At the end of May the Ambulance Service had achieved a 53.2 per cent response within 10 minutes, compared to 47 per cent for the corresponding period in the previous year. Overall, response times have improved significantly during the last 12 months period. In emergency response times in the metropolitan area, the improvement is 56 per cent within 10 minutes, compared to 46 per cent for the corresponding period in the previous year. Of course, that recognises a major increase of 13.3 per cent in 000 calls, representing a 5,900 increase in emergency responses. So not only is the service doing more, but it is doing it faster, and that is to its credit.

The issue about the timing has been well publicised—Mr McGregor, who sits on the ambulance board, may want to join in on this — based on international practice in a desire to get some

of those international reforms that we have incorporated following the Auditor-General's report, which had a lot to say about the performance of the Ambulance Service. We now time calls from the minute they are received, rather than from when the ambulance is despatched, so it is a full picture of the episode. That reflects both contemporary national practice and also international practice—all very much part of our investment in the Ambulance Service. To achieve that, we have introduced, with initially considerable industrial resistance but now with greater collaboration, more flexible rosters.

I recall being told by some people that the end of the world was near when we sought to change the rosters in three ambulance stations out of the State's 250 as part of a trial auspiced by the Industrial Relations Commission. We are now rolling out those rosters across the metropolitan area. We have further refined patient transport services, in line with the Auditor-General's suggestion that we could delineate between acute and urgent transport services and those that are better identified as patient transport services or interhospital services. There has also been the introduction of fluid deployment practices, greater and more definitive monitoring of performance issues, and more effective rapid response operations.

They have been very creditable improvements. However, I always put the caveat on the New South Wales Ambulance Service that, given the starting point, there is always a long way to go. I make the point that the operational review, the strategic review and the industrial reforms that are taking place in the New South Wales Ambulance Service will only ever occur with the support and co-operation of the industrial arm of that service, that is, the membership of the Health and Research Employees Association—so much so that without that collaboration, support and co-operation we still will see an ambulance service that has all the hallmarks of a management structure and industrial relations practice best suited to the 1960s, as opposed to contemporary environment. The Auditor-General—

DEPUTY-CHAIR: Minister, could you keep your answers short.

Mr KNOWLES: I am sorry. I refute, in the strongest terms, the assertion that this great organisation is not doing anything other than making substantial inroads into a range of important and serious issues that were raised by the Auditor-General, and it has been moving solidly on all of those fronts ever since.

The Hon. DON HARWIN: I take you to Budget Paper No. 3, subprogram 44.2.1, emergency services. Of the $761.7 million in expenses for 2001-02 and $791.6 million in expenses budgeted for 2002-03, would you deconstruct those figures and tell me how much in each figure relates to hospital emergency departments and how much relates to the New South Wales Ambulance Service?

Mr KNOWLES: As it is a fairly solid question, I would like to be able to go through on almost an area by area basis—

DEPUTY-CHAIR: Perhaps you could take the question on notice, if you intend to do that.

Mr KNOWLES: You asked me to deconstruct $791 million into the services provided. I start to do that, and you tell me not to do it.

DEPUTY-CHAIR: If you do it area health service by area health service, we will—

Mr KNOWLES: Do you want it hospital by hospital, or emergency department by emergency department? How would you like it to be deconstructed?

DEPUTY-CHAIR: I would like it to be done relatively briefly, that is all.

The Hon. DON HARWIN: Would you deconstruct it into two different categories, hospital emergency departments and the New South Wales Ambulance Service?

Mr KNOWLES: To try to comply with the request of the Chairman to deconstruct a $791 million budget but not do that, I will have a go. I am trying to give you some ideas of what people think of it. First of all, we should recognise that it is an 8.8 per cent increase over the budgeted amount

of the previous year's figure of $727 million; it is a very substantial increase. It recognises that in almost every part of the emergency services system is being enhanced. I can report to you, for example, that where we are substantially enhancing the emergency departments in western Sydney, the head of the division of critical care at Liverpool health service wrote to me:

> I am writing to congratulate you on the expertise and commitment you have brought to the health portfolio. I would like to add that the staff as a whole of the South Western Sydney Area Health Service, and in particular Liverpool Hospital, are grateful to you and your commitment to the redevelopment of the Liverpool Hospital emergency department.

I also received correspondence from members of the critical care service at Nepean hospital, that is, the head of emergency and the nurse unit manager. The area director of critical care wrote:

> We are writing to congratulate you on the outstanding result of the New South Wales Health budget. From your visits to our department—

DEPUTY-CHAIR: Minister, this is heart-warming stuff, but—

Mr KNOWLES: You asked me to deconstruct a $791 million budget—

The Hon. DON HARWIN: The program description clearly puts it into two categories: the provision of emergency road and air ambulance services, and the treatment of patients in designated emergency departments. Surely we only talking about two figures. With regard to those two allocations, I want to know the hypothecation to those two elements of the program description. It does not require a folder full of testimonials from people who have written to you about emergency departments.

The Hon. JOHN JOBLING: The reference is page 8-23, subprogram 44.2.1.

Mr KNOWLES: I will happily go through, area by area, where that money is going. I will not play favourites with one area over another, as some members of this Parliament seek to do. We provided an equitable distribution of $791 million. We are rebuilding emergency departments left, right and centre. We are supplementing funds right around the State, and in every part of the emergency services area, with additional staffing, additional services, and additional capital construction, and I am happy to list those if you want me to. Chairman, you clearly do not want me to do that, because it is a long list, as you would expect.

DEPUTY-CHAIR: As it is a long list, and as the times for these committees have been set down by the Government to be a good deal shorter than some of us would like, perhaps we may compromise by asking that the documents be tabled, and then the Committee can re-form if that is not satisfactory to members who ask the questions.

Mr KNOWLES: By all means, but in fairness Chairman, when I started to go through, you told me not to do that. I was not trying to—

DEPUTY-CHAIR: You have made a fair offer to list the services and provide that information upon notice. That is a sensible way of approaching it, given the time constraints.

Mr KNOWLES: I want to be clear about that. We have a very good emergency services and department budget.

DEPUTY-CHAIR: I was not suggesting you do not.

Mr KNOWLES: I would have been very happy to put every last brick on the table.

The Hon. Dr PETER WONG: No doubt you are aware of the overseas doctors briefing course issue. As the Federal Government has indicated, it is withdrawing the funding of this successful program. Has the New South Wales Government promised to increase its assistance to overseas doctors in this regard?

Mr KNOWLES: I think I am the only health Minister in the nation who has been feted by the overseas-trained doctors association for the work we have done to change the rules in this State to

allow overseas-trained doctors to have a fairer entry into the health system in this country. The fact that the Commonwealth is now withdrawing funds—and, indeed, historically has made issues around the provision of visas extremely difficult—is simply a further indictment of the management of that particular jurisdiction's efforts in the provision of health services, particularly rural health services, to areas of need.

We have provided—and I will correct the figure to be precise—in the order of 250 overseas-trained doctors who are now practising either in towns or places where we have unneeded facilities and where in many cases there have not been doctors for years. Contrary to them being regarded as second-rate, as some people assert—particularly some of the medical/industrial organisations—they are very credible performers. A good example is Dr Robin Williams, who works out of Gulgong. He was a person I met in my first week of becoming a Minister. He was due to go home to Wales within a week because the artificial rules said he had to stop practising after two years. That was more than two years ago. We changed the rules and Dr Williams continues to practise in Gulgong. More than that, he is now also the chairman of the division of general practitioners for the mid-west and Macquarie areas of this State. He is not only not a bad doctor, according to the townsfolk of Gulgong, he also has the respect of his peers in the region.

There are stories like that of Robin Williams dotted all around the State. The provision of overseas-trained doctors to communities without medical services has been one of the real success stories of the provision of health services in this country. It is not just in New South Wales now but in other States; Western Australia springs to mind. There have been real efforts there. One would have thought that this is an area where the Commonwealth and States could work very closely together. In fairness, I have to say that historically that has been the case. I am not sure why at this stage the Commonwealth has decided to withdraw funds. I do not necessarily believe it is being pressured by some of those medico-industrial organisations to do that. I am simply unsure why it has done it, but it needs to rectify it quickly.

Having said all that, I put on the record that the provision of overseas-trained doctors, suitably qualified, divides into two camps. There are those who are resident in Australia who may be working in other fields of endeavour because their qualifications were not recognised. We have given those individuals the opportunity to have the first go at the alternative pathways set up under the New South Wales Medical Board changes made in 1999. I always indicated very clearly though that once we have been through that group of individuals, variously estimated between 1,000 and 2,000 doctors, and determined their suitability based on quality, their ability to provide a high-quality and safe service, we would then potentially look overseas if the shortages continue. All of that is against a backdrop of the need to better train and better provide our own home-grown doctors.

An enormous amount of collaborative work is going on among the various industry groups like the professional colleges, universities and the governments—and this is an area where the Commonwealth has not slackened off—States and Territories to ensure that at every opportunity we rethink the way in which medical undergraduates are selected from our schools. That applies to everything from the tertiary entrance rank [TER] through to how they are placed in universities, where they are placed, how they do their training, what degree of experience are they given in rural communities and how they are supported by the Commonwealth and the States, not only financially but with other resources necessary. The ongoing development of the rural medical schools around Australia, although it will not be a short-term solution, offers great prospects in my view for the development of a revitalisation for the provision of rural medical services in future years. In the meantime, we have to make sure that we remove any barrier to a well-qualified, suitably assessed doctor with overseas qualifications.

The Hon. Dr PETER WONG: In the meantime, Minister, do you intend to continue the bridging course without the Federal funding?

Mr KNOWLES: We will continue whatever it takes to provide medical services to rural communities. In the end, it is a bit like dental services. When the Commonwealth pulls out, the needs remains, and the States and some of the medical organisations who also supplement some of these programs have to provide more resources. However, let us not take the pressure off the Commonwealth. There is no explicable reason why it has pulled out. We should all be joining together to ask that the program and its support funding be put back.

The Hon. Dr PETER WONG: With the recent medical indemnity crisis, what steps have been taken to ensure that the State has enough obstetricians and surgeons in the future? Is there any plan to assist women who prefer to give birth to their child at home?

Mr KNOWLES: I do not want to upset the chairman anymore, but I could talk about this for a long time. Parliament supported the Government's Health Care Liability Act, which, as you are aware, was regarded and is still regarded by the medical profession as the model it would like to see implemented nationally. That was affirmed as recently as the weekend by the national president of the Australian Medical Association. In addition to that, the Government, largely following the events of September 11 and the consequent failure of St Paul's to continue to work in the medical indemnity market, as well as HIH and other celebrated failures of the reinsurance markets worldwide, has picked up the costs associated with doctors' public work in public hospitals or public facilities under the Treasury Managed Fund. That effectively left United Medical Protection [UMP] as the insurer of doctors' private work.

Nonetheless, the issues around UMP are now well and truly documented. They saw the appointment of an Australian Prudential and Regulation Authority [APRA] inspector in March. The Prime Minister was, frankly, dragged into the debate, I suspect largely because of more junior Ministers who were not watching the issue or presumed that medical indemnity insurance was the same as general insurance—it is not—and therefore that the prescriptions that might apply to the APRA rules around the general insurance industry may equally apply to the medical indemnity insurance industry. That was one of the mistakes and it has now seen the Prime Minister being driven to underpin the work of doctors initially to 30 June and now through to the end of the year. That is to his credit.

In the meantime, the next phase in the provision of service—be it neurology, obstetrics, home births or minor procedural work undertaken by the Family Planning Association—will have to be resolved by national co-operation and certainly around the issues associated with how one turns age-old mates clubs, which are frankly what medical defence organisations have been—doctors for doctors, subsidising each other and then making discretionary decisions as to whether they would cover a claim—into properly and potentially regulated entities under the Commonwealth jurisdictions of APRA, the Australian Securities and Investments Commission and the Australian Competition and Consumer Commission. The transition from a discretionary mutual to a potentially regulated entity is the real conundrum the Prime Minister has. If he handles it badly—

DEPUTY-CHAIR: Minister, can we ask what you are going to do? The comments about the Prime Minister are of interest, but what is the Government going to do?

Mr KNOWLES: We changed the law. We picked up $200 million-odd of liability off UMP's books.

DEPUTY-CHAIR: Thank you. I would now like to ask—

Mr KNOWLES: Excuse me, Dr Wong has asked a very important question that goes to the provision of medical services.

DEPUTY-CHAIR: If the answer takes a long time, Minister, perhaps you could put it on notice.

Mr KNOWLES: Sometimes not even a spectacular performer like you can get an answer in a seven-second media bite. Some of these things are complex and they need explanation. I choose to remind the Committee and anyone else listening that the issues associated with medical indemnity insurance have not gone away. We are in an interregnum between now and Christmas that will see a return to the problems we have been encountering over recent months unless there is very sensitive management of the issue at national level. That is endorsed by every commentator who understands this, recognising that so much that can be done a State level has been done and now we need to see how you turn not just UMP but the other medical defence organisations in the country into properly and potentially regulated entities rather than them being discretionary mutuals.

I am not accusing you, Mr Deputy-Chairman, of getting testy about this because you are a doctor. I am saying that it is important that the community understands that these doctors clubs that have existed for generations—cross-subsidising each other, not bringing their incidents but not reported [IBNRs] to account and having, therefore, very long liabilities, which in the case of UMP have come home to roost with St Paul's collapsing—will still need to be managed. That is the fundamental cornerstone of the solution to medical indemnity insurance, how to bring these companies into an environment where they are properly and potentially regulated.

DEPUTY-CHAIR: . My speech on the second reading of the Civil Liability Bill was a gem of brevity. I will not go into that now.

Mr KNOWLES: Did you advocate a no-fault scheme?

DEPUTY-CHAIR: You had better read it, I do not want to take up the time of the Committee. One would say that the Government cannot define short committee hearings and then give long answers; we cannot do it both ways. If it is a problem, the best thing to do is give written answers and then come back if necessary. Otherwise, we have to continue to extend the time in which you are dragged back here. My next question is: Have the midwives commenced their services in the maternity unit at Katoomba hospital?

Mr KNOWLES: I do not believe so, because there was never an intent that they would start from anything other than planning it and taking it through the various professional organisations.

DEPUTY-CHAIR: When will it start?

Mr KNOWLES: We are doing two things at once. We are advertising and seeking overseas support for the areas of need—in a generic sense, for anaesthetists and obstetricians—and at the same time working up a program from proposals put to me by John Dwyer and others, if they are ticked off by groups like the college and the midwives. It would only start after those ticks were given. It would be within two or three months at least.

DEPUTY-CHAIR: At least? It might be more than two or three months?

Mr KNOWLES: Yes.

DEPUTY-CHAIR: What are the medical indemnity insurance arrangements for those midwives?

Mr KNOWLES: If they are working in the public system, they are covered.

DEPUTY-CHAIR: You have advocated $250,000 to purchase an emergency vehicle to run from Katoomba to Nepean?

Mr KNOWLES: No, Professor Dwyer and others have advocated that. In the event that this trial is to proceed, many things need to be attached to it, part of which is the availability of emergency transport in the event of a midwife delivery requiring further intervention by, for example, an obstetrician. Those sorts of things are the subject of clinical assessments. Proving up of this is being undertaken by the various colleges, but all have been involved. The one thing I will say is that nothing will start up there by way of clinical or medical trials unless it has the agreement of those organisations.

DEPUTY-CHAIR: You are quoted in the *Katoomba Gazette* of 22 May as saying that there is $250,000 for that vehicle.

Mr KNOWLES: The money is available for the trial to start but the trial cannot start unless it has clinical auspice. You know that.

DEPUTY-CHAIR: I am asking the questions of you, Minister.

Mr KNOWLES: Yes, but I am saying that you know as a—

DEPUTY-CHAIR: I know it has to be run competently, but how you do it is essentially your responsibility.

Mr KNOWLES: No, it is not my responsibility because I am not a clinician. The one thing you well know is that clinical services have to be provided with clinical auspice and oversight. I can wish as I might, as indeed any government or aspiring government may wish as it might, but unless the practices are safe and properly credentialled, the clinicians will not do the work. This project has been proposed by clinicians and is now being worked on by clinicians. I said I will make money available for the work if it is able to proceed. I am assured that it can. Again, until it gets all those ticks, I will not start a pilot project or any sort of trial until they are satisfied and are willing to sign off on it.

DEPUTY-CHAIR: Obstetrics units as such are not really a trial. Things have been going for a long time and things are managed. Of course, the clinical elements have to be put in place.

Mr KNOWLES: We are talking about a midwife trial, not an obstetric unit. That is the difference. That is the nature of the trial. It would be the first of its type in Australia. To establish not an obstetric unit but a midwife-led delivery service requires a great deal of clinical assessment and analysis. While I have said I am happy to make the funds available, I wish to assure anyone that no service will be provided unless it is clinically safe and signed off by the clinical groups which need to support it. In the meantime, while the clinicians are working up the basis for such a trial, we are at the same time seeking overseas recruitments, leaving no stone unturned to advertise and provide anaesthetic coverage and, indeed, obstetric coverage for the Blue Mountains and, indeed, like Canberra.

DEPUTY-CHAIR: Does that mean that it may not go ahead at all?

Mr KNOWLES: It will only go ahead if the clinicians sign off on it, as it should.

DEPUTY-CHAIR: But that does not mean that it may not go ahead if they do not sign off on it.

Mr KNOWLES: Would you be brave enough—you might because you are a doctor; I am not—as a doctor to install a service into a hospital that does not have clinical support?

DEPUTY-CHAIR: That is the key question, is it not?

Mr KNOWLES: Of course it is.

DEPUTY-CHAIR: The thing has always seemed bold to me. That is why I am trying to ascertain where it is up to.

Mr KNOWLES: I would not have expected anything other than this work to be done with full clinical support. It was proposed by clinicians initially, by Professor Dwyer to start with but with others joining an. There is a lot of debate about whether the midwives are competent to deliver babies and whether there has to be an obstetrician and anaesthetist there at every turn. Everyone wants the safety of that. But in the event that that is not possible due to the inability to provide anaesthetic coverage, this is a model being proposed by clinicians. I just say in defence of midwives though that in all our public hospitals every day of the week the 88,000 babies born each year in our system are largely delivered by midwives. I do not want you to be suggesting by implication that midwives are somehow not competent to do that sort of work.

DEPUTY-CHAIR: I am not suggesting that.

Mr KNOWLES: Good.

The Hon. RON DYER: What is the Government doing to support medical research in New South Wales?

Mr KNOWLES: Medical research is in somewhat of a renaissance in this State at the moment, I think largely because of the underpinning work we have done over the past couple of years with the New South Wales biotechnology strategy, which brings with it a whole range of research grants and services. In addition to that, I think it is fair to place on record the leadership by the Premier around the need for a strong research community and a biotechnology community, recognising the opportunities for investment and growth that it provides to the State but also the opportunity and hope it provides for the discovery of cures to some of those illnesses that bedevil us. The 2002-03 Health budget includes $36 million for medical research under our biotechnology strategy.

The Research and Development Infrastructure Grants Program provides funding on a competitive basis to organisations engaged in health and medical research. In that area, when I came into the portfolio most of the research entities and, indeed, the universities had the common complaint that while there was funding around for particular programs, usually under the National Health and Medical Research Council [NHMRC] umbrella, there was very little, if any, money around for infrastructure support. So our infrastructure grants program, competitive and clearly aimed at supporting the research community, has been very well received. It is part of the overall health system research and development strategy aiming to promote research and development and aligning the department's investment with health system priorities.

At present there are funds in the order of $18 million allocated to health and medical research organisations in New South Wales. The grants that are awarded to successful applicants are for three years, and the magnitude of individual grants is determined on the basis of peer-reviewed grant income received by each successful applicant. Prior to 1996-97, infrastructure grants had been provided to a range of health and medical research organisations on an historical basis from the external research budget. Currently, 34 research organisations are in receipt of infrastructure funding, with the objectives of providing infrastructure on a fair and equitable basis, aligning funding with health system priorities, ensuring that research organisations receive funds in compliance with accountability requirements, and promoting the dissemination and application of research results.

As I said, that program was reviewed in March 2002. In addition to assessing the achievements effected to date, the review examined the appropriateness of current eligibility and selection criteria. In summary, the outcome of the review showed that there were some broad trends between round one and round two when examining institutes which were funded in both rounds. It was observed that peer-reviewed grant income increased, that is, as a consequence of that infrastructure grant money they were able to get more money from peer-reviewed grants like NHMRC programs. They were able to increase their research staff, and the number of research staff generally increased. The number of postgraduate students increased in these institutions, the number of research degrees completed increased, and the number of patents held generally increased.

So it has been money well spent and well targeted under the Government's overall biotechnology and research grant strategy. It recognises that by seeding funding in this way they are able to attract more money and more fire power at each of the organisations. In that sense, those infrastructure grants have been one key component. The broader areas of biotechnology work are contained in the New South Wales biotechnology strategy. That ranges from everything from molecular and cellular biology and biochemistry through to immunology and the biological applications of information technology. It has already delivered significant benefits ranging from cochlear implants and a diagnostic test for ovine Johne's disease to DNA matching in criminal investigations.

Practical examples of biotechnology application included, for example, better and safer drugs, new and improved vaccines and diagnostics, new therapies for incurable diseases such as diabetes, cancer and Parkinson's disease, and the testing and treatment for genetic components of disease. The current budget will see a total of $7.4 million being used by New South Wales Health to establish the St Vincent's research and biotechnology precinct, develop the millennium research institute hub at Westmead and enhance existing research capabilities through the establishment of research clusters. As for St Vincent's, that will see from memory a $20 million major upgrade of the Garvan adjacent to the existing Garvan on land which the institute owns and linking that world-leading facility with not only the existing Victor Chang, with some expanded facilities there, but also the Penny facilities—I think its formal title is the Centre for Immunology.

At Westmead, the millennium research institute hub offers great prospects for great collaboration between the cure-research end of biotechnology and clinical and medical research at the clinical services end. We have put $8 million into stage two of that. I might note in passing, particularly given what one Committee member was saying about the Commonwealth pulling out funds, that was made on the understanding that there was a matching amount of money, that is, $8 million, coming from the Commonwealth Government. I understand that the millennium research institute has been advised that the Commonwealth will not provide its share of the money. In Western Sydney, the millennium institute stands above many other facilities as an opportunity not only for the discovery of cures—they do cancer and immunology research. It is also a major magnet for postgraduate students, for people doing their PhDs, all those sorts of things. That is building up the critical mass and the intellectual firepower of that terrific health precinct. It is a great tragedy that the ongoing march in development of the millennium institute seems to be slowed down by the failure of the Commonwealth to hand over its share of what was expected of it. So they are a range of issues.

The other thing that is worth noting, because it was central to our announcement around the reconstruction of Royal North Shore, instead of just rebuilding the hospital, we also recognised the need to underpin the research efforts at Royal North Shore. Of course, it is the home of the Northern Medical School, one of the annexures of the University of Sydney. It has teaching and training laboratories, and it has a terrific research group led by Professor Carol Pollock, who established a group called BioMed health. That is an innovative venture based on the sharing of research expertise at Royal North Shore Hospital and industry resources in the corridor largely between St Leonards through Lane Cove, North Ryde, picking up on all the fire power that is up there, the cochlear group, ResMed and many other research institutes and linking them in a major research precinct. As part of the overall redevelopment of the North Shore campus, we will see a new research facility built there. That is the way it should be: linking good, solid research with good, solid clinical services.

BioMed North will establish a partnership of both medical and applied research, biotechnology, industry, government and investors in order to improve health outcomes, advance technological expertise and strengthen the commercial and economic base of research in the network. That is just one example. The Westmead campus, the central Sydney hub around the University of Sydney, the eastern Sydney campus around Prince of Wales and the University of New South Wales, as well as St Vincents and the Garvan, will ensure that our funding under our infrastructure grants program and funding under the biomedical research and BioFirst programs are well targeted, encouraging groups to cluster together.

DEPUTY-CHAIR: We are out of time. I ask the Minister to give an undertaking to answer the questions he has taken on notice. The Committee has said that should be within 35 days, and you will receive them within 48 hours. If you would like to answer them in a shorter time, we would appreciate that. I am informed that some Committee members wish to move that you appear again before the Committee, and we would like to know your future availability.

Mr KNOWLES: That sounds like last year. I will let you know. I am happy to take the questions on notice. I cannot guarantee that I will be able to reappear, as could not in previous years. I will do my best.

The Committee proceeded to deliberate.