GENERAL PURPOSE STANDING COMMITTEE No. 2

Monday 6 November 2000

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 2.00 p.m.

MEMBERS

The Hon. Dr. B. P. V. Pezzutti (Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. R. D. Dyer
The Hon. A. G. Corbett

PRESENT

Department of Health
Mr M. Reid, *Director-General*
Mr R. McGregor, *Deputy Director-General, Operations*
Mr K. Barker, *General Manager, Finance and Commercial Services*

CHAIR: The Committee has authorised the broadcasting of all its public proceedings. Should it be considered that the broadcasting of these proceedings be discontinued, a member will be required to move a motion accordingly. I welcome everyone to this public hearing of General Purpose Standing Committee No. 2. First, I wish to thank the director-general and departmental officers for attending today. At this meeting the Committee will examine the proposed expenditure for the Consolidated Fund for the portfolio area of health. Before questions commence, some procedural matters need to be dealt with.

As members would be aware, part 4 of the resolution referring the budget estimates to the Committee requires the Committee to hear evidence on the budget estimates in public. Under Standing Order 252 of the Legislative Council this Committee has resolved to authorise the media to broadcast sound and video excerpts of its public proceedings held today. The Committee's resolution conforms with the guidelines governing the broadcast of proceedings adopted by the Legislative Council on 11 October 1994. The attendant on duty has copies of those guidelines.

I emphasise that only members of the Committee and the witnesses before them can be filmed and recorded. People in the public gallery are not considered part of the proceedings and, therefore, should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, as with the reporting of the proceedings of both Houses of Parliament, members of the media must take responsibility for what they publish and what interpretation is placed on anything that is said before the Committee. The Committee will deal first with the questions that were taken on notice at the last hearing by the director-general and others.

Motion by the Hon. R. D. Dyer, seconded by the Hon. A. G. Corbett, agreed to:

That the answers to questions taken on notice be made public.

I take the opportunity to ask for a similar motion in relation to questions taken on notice relating to the community services portfolio.

Motion by the Hon. R. D. Dyer, seconded by the Hon. A. G. Corbett, agreed to:

That the answers to questions taken on notice relating to the community services portfolio be made public.

Why was there such a delay in these answers being presented to the Committee, given the undertaking to get back to us in a relatively short period of time?

Mr REID: I apologise for the delay; it was unavoidable. It has obviously been rectified by the answers being with you, but I do apologise. Out of our last meeting I have not received the *Hansard*. We have the *Hansard* from the third coming but not the second coming.

CHAIR: But you received the draft?

Mr REID: We have not received any draft. As a matter on notice, in a question on that occasion I misled the Committee.

CHAIR: On one occasion only?

Mr REID: On one occasion only.

The Hon. R. D. DYER: Unintentionally I am sure.

Mr REID: Unintentionally, although at the last hearing, you will recall, which was just before the rugby league grand final I said that Eastern Suburbs would win, and they did not.

CHAIR: The Committee received a letter from Minister Knowles, the same as the one it received from Minister Lo Po', that declined to provide those answers. Did you get a copy of that letter?

Mr REID: No, I do not have a copy of that letter.

CHAIR: That letter was not transmitted to the department?

Mr REID: It may have been transmitted to the department. Many things come into the department without coming to me, but I have not seen a copy of that letter.

CHAIR: An important letter such as this from the Minister?

Mr REID: I have not received a copy of the letter. Can I get a copy of it?

CHAIR: Yes. That letter will now need to be made public.

Motion by the Hon. R. D. Dyer, seconded by the Hon. A. G. Corbett, agreed to:

That the Minister's letter be made public.

CHAIR: That letter says:

Given the GSPC No. 2 has already reported to the House Budget Estimates, if honourable members are still interested in obtaining a response to these questions, I respectfully suggest that those members place the questions in the ordinary question and answers. I will be happy to respond accordingly.

Did you receive that communication?

Mr REID: No.

The Hon. R. D. DYER: I make the point that that does not constitute a refusal to answer questions; it is simply an indication that the questions will be answered in another way.

CHAIR: Yes, I understand that. Has the director-general received that letter so that he can advise his department that the answers that were being worked on can perhaps now be worked on in a different format?

Mr REID: I did not receive the letter.

CHAIR: In relation to the Royal Prince Alfred Hospital and the Hospital in the Home [HITH] program, how much money was allocated to Royal Prince Alfred Hospital for the Hospital in the Home program in the last financial year? How much has been allocated to the program this financial year? How many patients were treated through the scheme? How will they be treated under the scheme in this financial year? In other words, has there been a change or is it ongoing? About how many people will be impacted upon?

Mr REID: The HITH program is a service which provides treatment to patients with stable medical conditions in their own homes, and is part of a worldwide trend. We set up a pilot program in 1993. In 1994 HITH was established as a unit andhas undergone many changes.

CHAIR: That was Commonwealth funded from memory.

Mr REID: There was a further evaluation, and a report was completed in October 1998. The program operates not just at Royal Prince Alfred Hospital. It operates at Albury, Broken Hill, Moruya, Prince of Wales Hospital, Royal North Shore Hospital and at other hospitals. It is often referred to as either Hospital in the Home or a post acute care program. The benefits include increased patient choice and access to acute services, increased flexibility and patient management and, coincidentally, reduced inpatient costs. In 1993-94 it was first piloted in central Sydney at Royal Prince Alfred Hospital. The department provided a one-off grant of more than $400,000 for the purpose. Following that initial grant it has been funded entirely from the area. I am not privy to the annual grants from within the area for central Sydney.

CHAIR: Is it just picked up as part of its general budgetary process?

Mr REID: That is right. It is still operational and funded. It has not stopped; it has not run out of funds. However, referrals have been declining in Royal Prince Alfred Hospital although in other areas they are still increasing, so it is variable due to complexity of patient care needed and shorter lengths of stay.

CHAIR: Is there a dollar value you can give for the operation of that?

Mr REID: There is no dollar value other than the one-off grant. You asked questions about the number of admissions. In 1998 there were 221—

CHAIR: I did not actually ask that. I asked how many patients were treated under the program.

Mr REID: Yes, that is what I am saying. In 1998 there were 221; in 1999, 147, and so far this year 125. It looks as though it has picked up a bit in 2000.

CHAIR: Do you have any idea how much money from the general budget of Royal Prince Alfred—

Mr REID: No, because it is just run as another part of Royal Prince Alfred Hospital. I do not have that information.

CHAIR: To that extent we could not find whether it runs out of money or not?

Mr REID: No, but I have been informed by the area that it has not run out of money and that the program is continuing. We have contracted the Centre for Health Economics and Research Effectiveness to produce a discussion paper which is linked in with the Commonwealth department's funding, and that will provide a general overview for Hospital in the Home right throughout the State, taking into account the evidence for effectiveness and the cost effectiveness, and that is one thing I am really looking forward to.

CHAIR: Will that document be made public when it is completed?

Mr REID: That is correct.

CHAIR: When do you expect that it will be completed?

Mr REID: It will be completed and widely distributed during the current financial year.

CHAIR: The results or the white paper?

Mr REID: The paper.

CHAIR: What about the results?

Mr REID: The results will be within the paper.

CHAIR: In relation to question No. 3, given that legislation was passed by Parliament in 1997 which provided that area health service board members be paid for their services, why has it taken the Government almost three years to implement that decision by Parliament?

Mr REID: I know it is a far cry from 1997 to the current date. Board members have now been advised that payment will commence as of 1 July 2000. It was an unusual arrangement. The nature of health service boards is different to other board arrangements, which are normally funded under the various government committees. They are not employees. It was an issue taken up in the health council report about their roles and responsibilities. I would like to table chapter 7 of that report, which talks about some of that—

CHAIR: That is a public document?

Mr REID: Yes, but I would like to draw the Committee's attention to chapter 7, if that is all right. Needless to say, we have been through a range of processes in trying to get the rules and protocols correct. But when that has been done—

CHAIR: When legislation was passed in Parliament, I would have thought the Minister would have thought that out before he put it into the Act.

Mr REID: The legislation in Parliament enabled boards to be paid. It was a different decision to pay boards. There are two distinct features there.

CHAIR: In relation to that question, they had been advised that payment will be commenced. Can you confirm that these payments have been made?

Mr REID: No, I cannot, because they have not.

CHAIR: They have not been made?

Mr REID: No. What I have confirmed is that payments will be made effective from 1 July of this year. At the moment we are getting the protocols right as to how the payments will take place, and board members will be backdated to 1 July when the payments roll out.

CHAIR: What sort of money are we talking about for a board member? How much money are we talking about?

Mr REID: It is about $20,000 for a board chair and about $12,000 for a member of a board. I do not have the exact amount. Obviously, it will exclude the chief executive officer of the area health service, who is a member of the board.

CHAIR: Perhaps he will get a bonus payment?

Mr REID: Bonus payments, as the Chair would know, are no longer a feature of the New South Wales public sector payment system, except for those that are wholly-owned enterprises.

CHAIR: Exactly. The question is: will that be paid out of the existing budget, will the budgets that have been put out as final budgets to the year 2000 and whatever it is be augmented, or will the money have to come out of existing budgets?

Mr REID: The budgets that are in the areas at the moment will not include the payments for board members or chairs, and the budgets of every area health service will be supplemented by an amount that we have held centrally to accommodate those payments.

CHAIR: That will go for the next two budgets that you have already announced?

Mr REID: That will go through the current three-year budget period.

CHAIR: In relation to question 7, in response to the question about dental waiting lists, the Minister stated that the information was not currently aggregated at a departmental level. I do not want the aggregated data. I want the data from the area health service. I did not ask about the aggregated departmental level; I wanted to know how many people were waiting in each area. I wonder if we could have the raw data for each area health service.

Mr REID: I do not have that information in front of me by individual health area service, but I am happy to take that question on notice to see if it can be provided.

CHAIR: You understand that the process is difficult. Is that a difficult task?

Mr REID: I do not know. I would have to check.

CHAIR: If it is not available, does it mean that the Government is no longer keeping the records of how many people are waiting for dental treatment?

Mr REID: Sorry?

CHAIR: If it is not readily available to you, knowing that it was on the list and knowing that it is something I would ask, does that mean the department is not keeping the raw data?

Mr REID: I would have to take that question on notice to try to answer that question.

CHAIR: If that is your claim, how could the Minister recently refer to a figure of 276,000 waiting for treatment when he made the announcement about dental treatment?

Mr REID: As I said—

CHAIR: The Minister made some claims about a number. We would like to know where those numbers exist.

Mr REID: The 270,000 was not an issue of the numbers on the list. It was a calculation made on the basis of the Commonwealth withdrawal of its $33 million.

CHAIR: If you claim that you do not have the numbers, is that because you are not bothering to keep the numbers? You said you would have to check. I then asked how can the Minister suddenly pluck a figure of 270,000—

Mr REID: I was just trying to answer that question. The figure of 270,000 was quoted by the Minister in his 4 April press release about the very large increase of State money to be put into public dental services, that is, the Carr Government's injection of $33 million over the next three years. That figure of 270,000—

CHAIR: Again, that is the $4 million plus $9 million plus $20 million?

Mr REID: That is correct.

CHAIR: It is not suddenly going to increase by 31 at the end of the time?

Mr REID: That is correct.

CHAIR: Not like the other ones that we have established are?

Mr REID: That is correct. If you read the press release, it said that the $33 million increase comprises $4 million in 2000-01, $9 million in 2001-02 and $20 million in 2002-03. The figure of 270,000, which is quoted in there, is not a figure of people on a list. It is a calculation of the damage that was done by the withdrawal of the Commonwealth money; how many people could not be treated because of the withdrawal of Commonwealth money.

CHAIR: Would you give us the raw data behind that calculation, if there is an actual calculation?

Mr REID: I will take that question on notice.

CHAIR: I notice that the answer about how much money is coming forward is part of question No.11. That is given as the number of dollars. It is staggering to me that in 2000-01 the Carr Government has allocated $94,000 for dental and oral health. That is a staggeringly small amount of money.

Mr REID: No, $4 million by 2000-01. It is in the announcement of 4 April.

CHAIR: No, that is the increase for the Central Coast.

Mr REID: You did not mention the words "Central Coast".

CHAIR: If I did not, I meant to. Looking at the answer to question No.11, the figure is a $94,000 increase. Even with that $4 million, how many extra patients do you think that will treat?

Mr REID: I would have to calculate that, but I am more than happy to take that on notice.

CHAIR: If the Minister can calculate the other one, surely he has calculated precisely to the last one how many patients there are?

Mr REID: We believe that the increased funding will enable an additional 30,000 patients to be treated in 2000-01 and by 2002-03 an additional 200,000 patients each year.

CHAIR: In relation to question No. 5, can you now reveal the specific budget for the New South Wales drug program for 2000-01? If not, why not?

Mr REID: Yes, I can give you the budget for the drug program for 2000-01. Or the bureau?

CHAIR: Yes.

Mr REID: When we answered the question, that was not available. But I finalised budgets for the sectors of the Department of Health two weeks ago, or a week ago, or whenever it was. The budget for the bureau—and I will give you the three years' figures—are: in 1989-99 the budget was $1.633 million; in 1999-2000 the budget is $2.059 million; and in 2001 it is $2.150 million. On top of that we also have the budget for

CEIDA—the Centre for Education, Information and Drug Action—of $4.2 million. So that is an increase of a quite substantial amount over that period of time.

CHAIR: You have got actual places where that CEIDA money will go?

Mr REID: Like all the rest of the department, there are specific program items where we will spend that money, yes.

CHAIR: Is that public?

Mr REID: No.

CHAIR: Now that you have announced it in the budget, is it public information?

Mr REID: I think other than within the department, this is the first announcement I have made of the actual budgets for those areas.

CHAIR: So there is no detail available in respect of that $4 million for CEIDA?

Mr REID: Not here, not at the moment, no. I should add that that $2.15 million is solely the budget for the department's area itself and excludes those things where we might have business partners or fund non-government organisations separately, which are additional amounts on top of that.

CHAIR: How much is that? I mean in round figures; I do not expect you to have it absolutely accurately.

Mr REID: I do not have the detail. I will ask Mr Barker to respond.

Mr BARKER: That really feeds in, I think, to question 6, where subsequent to that response we have estimated for this year in total we are spending over $100 million on drug and alcohol services across the State. That includes the component for non-government organisations, business partners and what area health services spend on a range of drug and alcohol-related activities.

CHAIR: Is it possible for the Committee to have a detailed breakdown of where that money is going—for instance, to which area health services, to which business partners you have, and so on? Otherwise it is just a large amount of money. The community asks us where that money is going, and what is it meant to address, and so on.

Mr REID: I am quite happy to take that on notice and provide that information.

CHAIR: It should be in paper form, I would think.

Mr REID: Yes.

CHAIR: In relation to your response to question 8, given that sexual assault services have been in the news of late, have you now got an allocation for sexual assault services, by area health service? The Minister answered in his question that it was, I presume, a matter for the annual budgets of the area health services. I am interested to know what the demand is and what moneys the area health services are expending in this area.

Mr REID: This is one area in which there has been a dramatic increase in budgets over a period of years, so that what we are spending today is a far cry from what we spent five or six years ago. There is no specific budget allocation for funding sexual assault services. As you say, it is globalised within the area health service budgets. Information provided in our annual reports in 1998-99 indicates that over $9.1 million was spent on the provision of those services by New South Wales Health. The estimated $9.154 million does not include the full cost of the provision of medical services which are also provided to children and adults after sexual assault. So it is solely that component that relates to the distinct service. Some areas are unable to isolate that medical cost from their other medical costs. So that $9.1 million is an estimate. The cost may include after-hours calls as well as follow-up assessment. In addition to that, we provide an additional $835,000 to non-government counselling services for victims of sexual assault.

CHAIR: That is across the State?

Mr REID: That is across the State. That brings the total estimated expenditure to $9.985 million. We have a network of 50 sexual assault services based in hospitals and community health centres. Those services include crisis counselling and medical response to all recent victims of sexual assault. Of the services, 39 operate on a 24-hour basis to provide an immediate response to victims. In the metropolitan area, three services provide a response to children only through child protection units.

CHAIR: So really you are working from what the expenditure has been rather than the preparation of an actual budget?

Mr REID: That is correct. It is not a budget allocation, because it is part of the global budget.

CHAIR: That is what was actually spent last year?

Mr REID: That is correct. It is an estimate of what was expended.

CHAIR: And if there is a growing need, that would have to be picked up within each area health service, which would have to come back to you next year saying that this area had increased, and so on?

Mr REID: That is correct. In calculating their budgets internally—and remember, they already have a fixed budget for the next three years—they will make judgments on how to utilise their growth funding within their budget, or how to reallocate within their budget, which is the normal management thing to do.

CHAIR: That is if we agree that there is any growth funding.

Mr REID: There is significant growth funding.

CHAIR: That is if we agree.

Mr REID: In my opinion, there is significant growth funding of $8.1 billion in the years 2000, 2002 and 2003. I think it is an extraordinary achievement that those areas that have been historically underfunded—such as the area from which you come, Mr Chair—receive some of the greatest percentage increases, figures of up to a 30 per cent increase, in their budget allocation over a three-year period.

CHAIR: They still have not got the largest number of people waiting more than 12 months for anything to happen to them. In regard to question 9, which relates to Olympic shutdowns, Minister—

Mr REID: I am the Director-General, Mr Chair.

CHAIR: It is nicer dealing with you.

Mr REID: Thank you. Could we delete that comment from the transcript?

CHAIR: No, we will leave it there. The Minister may well have had to come to the Committee and apologise for misrepresenting my views but the director-general never has. Given that your answer to the question about elective surgery shutdowns during the Olympics states that hospitals continued to conduct both urgent and non-urgent elective surgery, why has the number of people waiting for elective surgery increased by almost 2,000, from 56,000 to 58,300, during that period?

Mr REID: Could I first answer the implication in your question, in which you said that last time the director-general indicated that there would be no elective surgery shutdowns during the Olympic Games.

CHAIR: Was that the director-general or the Minister?

Mr REID: It was the director-general who indicated that.

CHAIR: Did he?

Mr REID: According to the question you asked. If I can turn to *Hansard*—

CHAIR: Was I misquoting the director-general? Was that the Minister's statement?

Mr REID: You were misquoting the director-general.

CHAIR: So it was the Minister who said that?

Mr REID: No. The director-general said on 19 June that "There may be some downturn in elective surgery, but I would be very surprised if there was any full-on closure in elective surgery." That is in fact what occurred. During the Olympic school holiday period hospitals continued to conduct both urgent and non-urgent elective surgery. If I could go through some of those, the New Children's Hospital continued with its urgent and non-urgent elective surgery list; all hospitals in the Western Sydney Area Health Service and the South Western Sydney Area Health Service conducted urgent and non-urgent elective surgery; Concord and Canterbury hospitals did both urgent and non-urgent elective surgery; so did North Shore, Ryde, Manly, Mona Vale and, naturally, all the rural hospitals. Some hospitals that had special Olympic roles—and here I am talking particularly about Royal Prince Alfred Hospital and Nepean Hospital—did only urgent elective surgery.

CHAIR: So those hospitals are responsible for the rise in the waiting lists?

Mr REID: No. I am responding, in the first instance, to your comment that claimed there would be elective surgery closedowns. I am saying that in all the hospitals both urgent and non-urgent elective surgery was conducted. The Olympics did coincide with school holidays. It has been a longstanding practice, in times of less demand, such as school holidays, that there be consolidation of services, and this applies to both doctors, nurses and patients. At one hospital during the Olympic period 65 people cancelled their own elective surgery.

CHAIR: So, are we blaming the patients?

Mr REID: No. I am saying that during school holidays periods it is a normal course of events—there is a downturn—and it did occur this year. Doctors and nurses were engaged in other activities, including the Olympics, and patients made the judgment at some stage about their non-urgent elective surgery.

CHAIR: Will the department now provide additional funds to area health services so that hospitals can remain open for all categories of service over the six-week Christmas period to try to catch up with what has become a substantial blow-out in waiting lists and times?

Mr REID: Your comment is incorrect. If one looks at waiting times in this State, there are two comments to be made: one is that we have some of the best waiting times in the country.

CHAIR: Are these the waiting times you put on each doctor's list?

Mr REID: First I want to comment about waiting times. We have some of the best in this country. In Western Australia, 30 per cent of people on the waiting list have been waiting more than a year. In Queensland, 32 per cent of people on the waiting list have been waiting more than a year. In Victoria, they do not collect or publish figures. In New South Wales, 14 per cent of those on our waiting list have been waiting more than a year.

CHAIR: How do you calculate 14 per cent? More than 8,000 divided into 58,000 is still a very large number.

Mr REID: Well, it is 14 per cent. The second point I wish to make is that you made the comment of a blow-out in waiting times. Waiting times in this State have not only been amongst the best in the country, but on average people receive their elective surgery within six to 10 weeks. That has been the same for approximately the past four years. There is no blow-out of waiting times in this State. The focus of any modern health system should be on waiting times, not waiting lists. That is what we are focusing on. It is still unacceptable that a significant number of people wait more than a year, and I am as concerned as you about those. That is where our focus should be, on trying to alleviate those who are waiting a long time for their non-urgent surgery—inappropriate lengths of time.

But I draw attention to the fact that 60 per cent of those people—as you know and would have read—are on the list of only 50 of our 2,000 doctors in this State. That is one of the reasons we provide further information to general practitioners [GPs] and patients; we put our waiting times on the web site. We encourage patients to talk to their GPs about looking at other options. Obviously, it is not a choice made solely on waiting times. It is a choice made upon access, quality of doctor and a range of other factors. There is significant

variation of waiting times amongst individual medical practitioners. Sixty per cent of those long waits are on the list of 50 doctors. We would encourage patients to ask their GPs to visit the web site and to look at whether other options are available.

CHAIR: I do not want to bore people senselessly, but if I were one of those patients and transferred to another doctor, under the old rules during the wonderful hospital waiting list reduction program I would instantly stop waiting until I was accepted by the new doctor and then my waiting time would start again when I went to the new doctor. Is that still the case?

Mr REID: No.

CHAIR: Is that mechanism of bureaucratic handling of waiting times and waiting lists still going on?

Mr REID: This is not an issue to try to fiddle figures in any way. This is trying to present information to people. I hope Committee members would agree it is one bit of information. There are other bits of information, but at the moment we now have on our web site the information of the waiting times of every doctor in this State. We ask them to constantly update and verify the figures. At the moment, 60 per cent of those who have long waits are on the lists of only 50 doctors in this State. We would encourage patients to talk to their general practitioners to see what other options are open to them. That is the sole point of it.

CHAIR: And when they do, they are not penalised?

Mr REID: That is correct.

CHAIR: What are you going to do about more funds to catch up with what has become a bit of a blow-out in the numbers, and obviously the number of people waiting more than 12 months, as that is crystal clear?

Mr REID: I make two points: first, there has been a significant increase in the budget of $6.9 billion up to $8.1 billion over the next three years. The most significant amounts for underfunded areas will flow in years two and three. As a component of that, an extra $10 million has been designated and announced to specifically go into those long-wait patients. We have asked all area health services to give us a strategy for long waits. They have provided that, and I am just as keen as you to try to reduce some of those inappropriate long waits.

CHAIR: To put it in perspective, $1 million will pay for 100 hip and knee replacements.

Mr REID: No. I think it is quite unfair to consider $1 million as compared with $10 million. If you consider $8.1 billion and what could be bought with $8.1 billion, I think that is a fair question.

CHAIR: The extra money you talked about was $10 million.

Mr REID: No, $10 million on top of growth on top of an existing budget.

CHAIR: So this is $10 million extra?

Mr REID: Yes, which is already invested.

CHAIR: How many of those 50 doctors are orthopaedic surgeons?

Mr REID: You can check the web site. I do not have that detail with me at the moment. I make the point that you are correct: the vast majority of those long waits are in a limited number of specialties, which are orthopaedics, ENT, ophthalmology and general surgery.

CHAIR: Will you now increase the amount of money to allow these hospitals to stay open longer over the Christmas period?

Mr REID: The budgets of the area health services are out there. As I said, we are negotiating, with area health services about how to reduce the long waits and waiting times and will continue to do that. There will be various strategies in different areas.

CHAIR: So, is there no more money?

Mr REID: There will be various strategies in different areas. For example, the Hunter already has a surgical funding model. Other areas are looking at adopting that model where they have agreements with their clinicians and there are other strategies around in that vein.

CHAIR: But no more money?

Mr REID: And there is considerably more money flowing into the health system over the next three years where the budget goes from $6.9 billion to $8.1 billion. That is substantial growth of funds in our health system.

CHAIR: But there is no added response, is what we are asking.

Mr REID: I am sorry?

CHAIR: No added funding.

Mr REID: The funding has already been announced and I have indicated that $10 million, which is already announced, will be very much targeted in that area.

CHAIR: Given that the Minister advised the Committee that a $2 billion cash injection announced in March—

Mr REID: Which question are you asking now?

CHAIR: The same question: question 9 about the downturn. Given that the Minister announced a $2 billion cash injection that will improve the speed at which elective surgery patients are treated in New South Wales, how do you explain that there have been now 800,000 people waiting 12 months, some of which is demonstrably due to the Olympics because it has increased by 1,600 since the Minister took over?

Mr REID: I make the point that the focus is on waiting times, not waiting lists. We have some of the best waiting times in the country. Our average waiting time for elective surgery is between six and 10 weeks, and that figure, or round about that figure, has remained stable for the previous four years.

CHAIR: How do you explain that the average waiting time is now 2.19 months as compared to 1.4 months when the Carr Government came to office?

Mr REID: It has ranged from 1.4 through to about 2.2 back to 2.1, and it has been variable between that amount. But over the past four years it has been roughly around that figure of 2.1 and 1.6.

CHAIR: So the average waiting time has increased effectively by a month in five years?

Mr REID: I do not have those exact figures, but I take the point.

The Hon. Dr A. CHESTERFIELD-EVANS: There is a slight difference between the questions that I asked you on 23 August, as clarified, in a memo and the ones from the Committee. I thought I handed them over to you.

Mr REID: I have a set of questions that relate to questions Nos 5, 16 and 17. They are the only questions I have from you.

The Hon. Dr A. CHESTERFIELD-EVANS: It seems extraordinary that you do not have a copy of the ones I promised to send you, because I would have thought my office would have done that. However, the difference is not huge. Question No. 13 referred to the mental health implementation group.

Mr REID: These questions are directed at the second appearance before the estimates committee, whereas the questions we are dealing with today are those from the third hearing before the estimates committee.

CHAIR: You are asking whether at the second Committee hearing the witness took that matter on notice?

The Hon. Dr A. CHESTERFIELD-EVANS: The answer says that they could not answer it because, as at some time in June, the Committee had not met.

Mr REID: Sorry, okay.

The Hon. R. D. DYER: Which question number?

Mr REID: Question No. 13 of the previous hearing.

The Hon. Dr A. CHESTERFIELD-EVANS: Yes. The mental health implementation group was going to decide how to spend the $36 million on mental health in community services, and the answer was that they had not met as at some time in June.

Mr REID: Yes, I can give you the answer. At the hearing on 7 June it was indicated that such information could not be given until the mental health implementation group had met and deliberated on how the moneys were to be spent. The first meeting of that group was held on 4 August, so this issue has been brewing for some time. At that meeting the group agreed on a work plan that focused on the development of mental health emergency department care, the early intervention strategies for mental health of young people, the development of an eating disorders program, in-patient mental health care for children and adolescents, the New South Wales mental health non-government organisation [NGO] strategy, the review of the non-acute mental health care area, the prevention of strategies for consumers and carers, and the review of the risk and management strategies associated with the enhancement funding of $107.5 million. Notwithstanding all that, they have not yet specifically allocated dollar amounts within each of those areas.

The Hon. Dr A. CHESTERFIELD-EVANS: And youth suicide is within that, is it? It is not a separate program?

Mr REID: There is already an existing youth suicide program, but I am not too sure whether specific new funds are flowing into that area. I can take that question on notice.

The Hon. Dr A. CHESTERFIELD-EVANS: The other questions were not answered satisfactorily at the previous hearing, such as how the $36 million was decided on if you did not know how you were going to spend it. It is interesting that you could allocate $36 million without having costed it and decided where it would be spent.

Mr REID: I think I made it clear at the last hearing, if we check *Hansard*, that it was important to bring New South Wales up to a level of funding that matched all the other States, and a calculation was done on that basis.

The Hon. Dr A. CHESTERFIELD-EVANS: The other question related to the $284 million health costs and the 18 per cent extra health costs for smokers; how many smokers could be expected to quit because of spending on Quit campaigns and what calculations could be done to break even. The answer was that there had not been any costings done, except in Victoria, which showed a return of 16:1. Is that right?

Mr REID: Yes.

The Hon. Dr A. CHESTERFIELD-EVANS: And if they have not been done in New South Wales, why not, when there has been a wonderful return on capital of 16:1 and the New South Wales Quit campaign has been so emasculated since its heyday in the early 1980s, in Lismore many years ago?

CHAIR: Bernie McKay Healthy Lifestyles, which was very successful.

The Hon. Dr A. CHESTERFIELD-EVANS: Yes, but why did it die?

Mr REID: I undertook to check whether a cost benefit analysis had been done within the jurisdiction. In doing that I found this paper, which is the basis for the Victorian cost benefit analysis and makes interesting reading,

CHAIR: Is that a public document?

Mr REID: I am not too sure but I am happy to table it as a document for this Committee.

Motion by the Hon. A. G. Corbett agreed to:

That the paper entitled "Social Costs of Tobacco in Victoria" be tabled.

The Hon. Dr A. CHESTERFIELD-EVANS: Given this wonderful return in capital of 16:1 and the emasculation of the Quit campaign in New South Wales, what changes and improvements might we expect?

Mr REID: Given the return of 16:1, if that applies as one would expect, one would expect there would be a significant increase in the benefits to the community of quitting smoking. Just to digress for a moment, it is interesting to look at the study that has just been done that is in the *British Medical Journal* this week showing for the first time there has been a turnaround in the smoking habits of 12- to 17-year-old girls in the United Kingdom. The best available evidence is that it coincides with the upsurge in the availability of mobile phones. People have something to give them street credibility, so quitting tobacco strategies can come from the most unexpected quarters if that is true, and I suspect it is true. It is very interesting.

The Hon. Dr A. CHESTERFIELD-EVANS: May I have an answer on the lack of costing for New South Wales and the implications? If you are talking about waiting lists, are waiting lists looked at in a demand-management sense? By the time a person gets on the waiting list, with the focus on acute care and waiting lists—which are really treatment—we never go back into the preventative area, yet here we have an area of prevention that pays 16:1, that appears to be grossly neglected.

Mr REID: That is not quite true because the tobacco action plan for 2000-2004 that we are just embarking upon has received a funding increase of $1.5 million and of the $3.3 million now available for tobacco and health programs—

CHAIR: Per year?

Mr REID: Per annum, $1.8 million has been allocated to public education programs and strategies in 2000-01, so I am sure you will be pleased to hear there is an increase in that area of expenditure.

The Hon. Dr A. CHESTERFIELD-EVANS: But it is still nowhere near the Californian levels that are the best in the literature? How does it compare to the Californian levels, which are dollars per head whereas we talk about cents per head?

Mr REID: I do not have detailed information on the California literature with me. However, one other strategy that is quite important and about which the mention of California reminded me, is that this State's banning of smoking in restaurants and other areas as a first step in this connection will be viewed in hindsight as a significant public health measure.

The Hon. Dr A. CHESTERFIELD-EVANS: It will, but we need to extend it to pubs, clubs and discos.

CHAIR: I have written to the Minister—I do not know whether I have written to you directly—about changing the messages on packets from "Cigarettes Kill" to "Cigarettes Cause Blindness". What steps have you taken to implement that?

Mr REID: People have trouble reading that.

CHAIR: If they do they are already blind. The issue is that the macula problems suffered by 40 per cent of people in the State, of which a large number therefore are officially or legally blind, are caused by smoking. That information has only been available for the past two years. I have written to the Minister at least twice. I cannot write to you; I have to write to the Minister, but he may not pass on information like that to you. The issue is that this new information that smoking causes blindness should be conveyed to the smoking public.

Mr REID: We will do that. That is a very important point and we will take it on board, and I agree with you.

The Hon. Dr A. CHESTERFIELD-EVANS: I think I referred to child sexual assault services.

Mr REID: Which question are we on now?

The Hon. Dr A. CHESTERFIELD-EVANS: That came up in a discussion last time. I do not think it is in the questions.

CHAIR: I think you only have the one question on corrections health.

The Hon. Dr A. CHESTERFIELD-EVANS: Yes. It may be that that did not get a guernsey as being asked in writing. Has there been an increase or a decrease in the child sexual assault services offered by New South Wales Health?

Mr REID: I think that is outside the questions that were asked.

CHAIR: I think the other question you asked was about Aboriginal health. We shall move on to the Hon. A. G. Corbett.

The Hon. A. G. CORBETT: Mr Reid, I simply want to ask some general follow-up questions on the answers to questions 22 to 25, which all relate specifically to breast cancer and research. In answer to question 22—How much money is allocated in the budget to researching breast cancer?—the department replied that New South Wales Health does not fund specific research proposals. I am a little confused, because Budget Paper No. 3, Volume 2, program 48.6.1, Teaching and Research, states:

> Program Objective(s): To develop the skills and knowledge of the health workforce to support patient care and population health. To extend knowledge through scientific enquiry and applied research aimed at improving the health and well being of the people of New South Wales.

Can you explain why there seems to be a discrepancy? New South Wales Health says that it does not fund specific research proposals, yet Budget Paper No. 3 refers to extending knowledge through scientific inquiry and applied research.

Mr REID: Those two statements are not mutually incompatible. The role of State health agencies is to provide, in the main, infrastructure grants, which we are doing, rather than grants for specific research, although many of the dollars that flow out of our public hospital system end up being directed at research. In the main, the role of our agency is to assist the major research institutes in this State in an infrastructure way, many of which are doing research into breast cancer. So we are not funding specific breast cancer research but the organisation to enable it to have the infrastructure to undertake that research.

The Hon. A. G. CORBETT: By "infrastructure" do you mean equipment and so on?

Mr REID: Yes, and broad money to support their administration costs and the maintenance of buildings and those sorts of things. For example, in round two of our infrastructure grants program, funding of $22.484 million was provided to the following institutes that conduct breast cancer research: Garvan, which got $9.505 million in infrastructure grants; Centenary Institute of Cancer Medicine and Cell Biology, which got $4.2 million; the Institute of Magnetic Research, which has demonstrated accurate diagnosis of breast cancer using MRI, got $1.854 million; and the Hunter Medical Research Unit, which got $2.850 million. Members of that are the ANZ breast cancer trial groups and the Westmead Millennium Institute, which got $4.073 million.

They are just the research institutes that are engaged in—amongst other things; they are not solely involved in breast cancer research—aspects of breast cancer research. So the funding of the State health agency goes to support those organisations which then might gain through National Health and Medical Research Council [NHMRC] grants or other sources of funding, research institutes, pharmaceutical companies or wherever—

CHAIR: Or even the private sector.

Mr REID: —or even the private sector. Increasingly, the private sector. I think the recent very welcome announcement by the Packer family regarding the Children's Research Institute might be the forerunner of much more involvement of the private sector in research activities in this country.

CHAIR: Even leverages on government.

Mr REID: Correct, on both governments. So those agencies are then involved in breast cancer activity.

The Hon. A. G. CORBETT: In answer 24 you refer to competitive grant funding for infrastructure. New South Wales Health gets a number of submissions and then it determines where the money is to go.

Mr REID: That is correct.

The Hon. A. G. CORBETT: On what basis do you determine where the money goes?

Mr REID: I would be more than happy to provide the member with some details, and I could undertake to do that. But there is a very strict criteria by which this takes place, because obviously you could anticipate that if the process were not transparent and justifiable there would be cries from various bodies that would be deemed to miss out.

CHAIR: It is a shame that the rest of New South Wales Health was not so transparent.

Mr REID: An external committee was established under the chair of Professor Stephen Leader. Research institutes are categorised by the nature of the research and their size factors. Certain amounts of money go to those research institutes on the basis of their submission and a whole range of criteria around sustainability, and particularly their involvement in peer review or access to NHMRC funds and those types of things.

CHAIR: There was a wonderful result of major consultation, I think, in 1993, 1994 and 1995.

Mr REID: I think a bit later, yes.

The Hon. A. G. CORBETT: Question 23 asked whether New South Wales Health has an equivalent to the National Breast Cancer Centre, and the answer was "No, the centre is a national resource". Is that entirely funded by the Commonwealth?

Mr REID: No. If I just go through it, the NHMRC National Breast Cancer Centre was opened in 1995 by the Commonwealth Government, mainly in response to community concerns about the human costs of breast cancer. It was funded to the end of 1999 and is managed by the New South Wales Cancer Council. It has a management committee appointed by the Commonwealth Minister for Health and Aged Care, and it has a range of advisers, advisory committees and working groups that set their work program. It is mainly doing work around analysing research and making it readily available to women, developing clinical guidelines, providing information to well women and women with breast cancer, primary care providers and breast cancer specialists, and developing a national monitoring system. It has a special responsibility to improve access to information and services for women and health professionals in remote areas and non-English speaking women and Aboriginal and Torres Strait Islanders.

The New South Wales Breast Cancer Institute is the peak breast cancer organisation in New South Wales and was awarded to the Western Sydney Area Health Service after a competitive tender at the end of 1994. Its funding consists of a $750,000 recurrent allocation and a capital allocation of $1.5 million. In 1996 the then Minister for Health, Dr Refshauge, also announced enhancement of $300,000 recurrent funding for the establishment of a clinical breast centre, as well as $828,000 capital for a breast cancer centre of excellence. It runs three programs: a research program, an education program and a clinical breast centre.

It has had major achievements. It has published 27 articles and made 13 conference presentations. It has a part-time research director and is particularly committed to exploring research which improves the quality of care for women in the State with breast cancer, with particular emphasis on epidemiology, breast cancer outcomes after breast-conserving therapy, research into treatment techniques of the axilla, research into ductal carcinoma, and research focusing on support of women and their families. It runs an education program and a clinical care program.

It sees 20 new patients with breast cancer every week, and more than 100 patients attend for follow-up. It is an interaction and a clinical interface which I believe is unique in Australia and something we should be very proud of at Westmead. It does differ from the National Breast Cancer Centre, which is an office-based national policy and guidelines unit. This is really a coalface unit which develops a model of best breast practice care in the State.

The Hon. A. G. CORBETT: I refer to the answer to question 25, which refers to who the experts are. As the answer indicates, there is a broad spectrum of activity in various domains. Could you take the Committee briefly through the various domains of breast cancer research so that we may have some idea of the scope of the research?

Mr REID: I think I covered some of the domains in the research program in the previous area. Question 25 relates to experts?

The Hon. A. G. CORBETT: Yes.

Mr REID: There is room for interpretation of the term "experts in breast cancer research", as the term could cover aspects of breast cancer from the basic biomedical research through to the psychosocial aspects of palliative care, for example. I am not too sure of the purpose of the question. It would not be my function, nor I think the department's function, to credential individuals as to their expertise in breast cancer research. That is a judgment which is made by the peers and through the literature, and through their funding agencies, which are not us but bodies such as the National Health and Medical Research Council [NH&MRC], and I think it is better left in that arena.

However, the ANZ trials group is probably the best-known and longest-established group of clinical researchers in breast cancer, so that would be a good arena in Australia and New Zealand. That comprises a collaboration of more than 50 institutions. It has just put out its twenty-second annual report. In this State the areas that participate in that group are at Concord, Dubbo, Newcastle at the Mater, NHMRC clinical trials at the University of Sydney, Orange, Prince of Wales Hospital, the Royal Hospital for Women, Royal North Shore, Royal Prince Alfred, St George, St Vincents and Westmead, and there are a number of a satellite units that hang off each of those. I am sure that when *Hansard* is published tomorrow I will get a call from someone whom I have left off that list.

The Hon. A. G. CORBETT: Where is this research channelled so that people can look at the connections that have been made, so that one person is not working in isolation to another person? Is the National Breast Cancer Centre the appropriate point for all this information to flow to?

Mr REID: From my knowledge, I think the answer to that question would be yes. I think that would be the place where one would go. That is the national group, it has a national role in cancer control, it is not a front-line activity, and it does the practice guidelines and those types of things, so presumably it would have a co-ordination role in that area. People from that centre would also be involved in the major funding aspects through, presumably, being sent applications regarding breast cancer funding grants, which come though the NHMRC as part of the review processes for those areas.

[*Short adjournment***]**

The Hon. A. G. CORBETT: I return to question 25, which refers to the different areas of breast cancer research. Is there any area that is starting to look into the influence of diet, for example? It seems to me that during breast cancer month and on breast cancer day there was a lot of talk about the fact that the only way one can actually prevent breast cancer is by having early diagnosis. I do not think that that is probably good enough for the women of New South Wales and Australia. Is some research going on into preventing breast cancer in the first place?

Mr REID: I do not have that information available, but I will get a gentleman in the department, Mr Nelson, to follow that through and provide some information to you.

CHAIR: In response to question 20 you provided information in response to the initial cash allocation to the ambulance service. Could you now provide the estimated capital expenditure for the current financial year out of the total budget referred to in your answer to question 20?

Mr REID: Yes. Capital is over and above that. As you know, at the moment we are in the process of replacing all our fleet on those issues, and I may have some information on capital.

CHAIR: I notice that your answer relates to capital allocation and not budget. There is a great difference. Your answer to question 11 does not refer to the wonderful $8.7 or $25.4 billion you continually talk about, but you have actually given us the cash allocation for the area health services. The ambulance cash allocation is $158 million, which you then say, in answer to question 20, is $159.2 million?

Mr REID: Yes.

CHAIR: Again, the figure of $161 million that you give is not the same as the answer you give to question 20?

Mr REID: Yes.

CHAIR: It is not the same answer you give in question 20, which refers not to budgets but to cash allocations?

Mr REID: I will ask Mr Barker to clarify this in some detail. I simply point out to you that the answer to the first question was drawn from the Minister's announcement of March 2000 of the three-year budgets, and since then I think some additional moneys have been provided to the Ambulance Service.

Mr BARKER: I refer to the Minister's announcement of 8 March, which was prepared in about February. The answers to question 11 are similar to that announcement. The way the answer to question 20 was interpreted is that it referred to the operating budget, because there have been no three-year budgets for capital. Nowhere in that question was the word "capital", so the response to that was the initial cash allocation which went out some time after that. You will note that those figures are similar to the figures referred to in question 11, because they are operating budget figures in terms of the cash allocation provided to the Ambulance Service and are not capital. If we have misinterpreted the Hon. J. H. Jobling's question—

CHAIR: Question 11 is actually lower than question 20.

Mr BARKER: That is because the timing issue was done in February; whereas, the figure that actually went to ambulance was $159.2 million.

CHAIR: We asked the Minister, and he said that he did not have a budget for ambulance. When we asked you the last time you were here, you said you did not have a budget for ambulance. That is why I asked the question and why you took it on notice. What is the full budget for ambulance, not just the cash allocation? The cash allocation for other area health services is added to by a whole lot of other things.

Mr BARKER: And that happens with ambulance as well.

CHAIR: What is the budget picture?

Mr BARKER: Do you want the expenditure budget, or the net cost of services budget?

CHAIR: The budget as would normally be put out for an area health service, including the capital budget.

Mr REID: I think they are two separate questions. The budget we put out for area health services, on a three-year budget, does not include the capital components. Of that $8.1 billion a year, or $7 billion odd that we are now operating on in a recurrent sense, there is an additional close to half a billion, which is not three-year rolled out. The three-year roll-out solely related to the recurrent budget.

CHAIR: How much of that figure of $468 million, or whatever it is, includes capital? Does that include ambulance?

Mr REID: Yes.

CHAIR: Where is that in the budget papers, in terms of expenditure by ambulance on capital works or purchases?

Mr BARKER: The majority of the ambulance budget is reflected in the emergency services program budget, and it would be a portion of that capital—

CHAIR: Can you give us some idea how much capital has been allocated to ambulance this year?

Mr REID: We will take this question on notice. That is quite easy to give you, and we can calculate that and provide it to you.

CHAIR: How much of it will be spent on the 200 new vehicles which are currently being introduced?

Mr BARKER: The majority of the ambulance vehicles are being leased. Under the Government 's program with the health fleet, as they replace their older fleet with more contemporary vehicles such as Mercedes Sprinters and Holden Commodores, they are all coming under a lease arrangement.

CHAIR: That comes in under the current budget, but it is not part of the capital procurement process?

Mr BARKER: That is correct. Because you pay an operating lease payment to the lease company.

CHAIR: That is therefore included. How much do the 200 new vehicles cost, in terms of coming off the top of the operating budget?

Mr BARKER: We are working with ambulance to work through that process.

CHAIR: So you have no idea?

Mr REID: We do have an idea, and I am more than happy to provide you with two things: first, the actual capital allocation of the Ambulance Service, that is, what it gets out of the $468 million; and second, the lease costs which are being incurred for the lease arrangements for the new vehicles. Remember, they are not three-year figures.

CHAIR: Over what time frame will the 200 new vehicles be introduced into the fleet?

Mr REID: Sorry, to return to our earlier question, and I will confirm the figures, the ambulance strategy capital for 2000-2001 is $7.5 million. That will reduce the age of the front-line ambulance fleet by accelerating the fleet replacement—there are other components, the lease which I will come back to—reducing the backlog of priority ambulance station refurbishments, renewal and enhancement of medical and lifesaving equipment, renewal and enhancement of IT, which relates to the roll-out of the new CAD system, and ambulance stations.

CHAIR: Are any of the capital allocations going to routine maintenance of vehicles? It goes to routine maintenance of vehicle and comes out of the operating budget, is that correct?

Mr BARKER: That is normal running repairs, that is correct.

CHAIR: Because the budget allocation for ambulance is a separate issue, I cannot see the figure for repairs or maintenance and so on. Is it possible to get a breakdown for repairs and maintenance for the Ambulance Service, as there is for an area health service?

Mr REID: I cannot see any problem with that, yes. If you indicate where your question is leading, that might help us to provide the answer.

CHAIR: I just want to understand what is happening. You would appreciate that some of the vehicles that are operated by the New South Wales Ambulance Service have wings. How much of the capital allocation will be spent on purchasing new aircraft, given the Minister's recent announcement that the ambulance Beechcraft Super Kings are to be replaced? What is the estimated cost of replacing those planes? From what you have said there is no money this year for that. When will it start and how much will it cost?

Mr REID: With due respect, Mr Chairman, I think you are drawing a longbow from the original question 20.

CHAIR: But question 20 related entirely to the details of the three-year allocation of the Ambulance Service.

Mr REID: Question 20 related to budget allocation in total. You are now asking different questions. I am not trying to hide any information.

CHAIR: I asked a question about the capital allocation, which is part of the budget.

Mr REID: And I am happy to answer that.

CHAIR: You said what the capital budget was going to, but you did not mention the Beechcraft, which the Minister has announced is part of the capital budget of the Ambulance Service.

Mr REID: I can give details about the capital budget of the Ambulance Service. The Ambulance Service in this State operates 880 ambulance vehicles, and 250 support vehicles. It is the largest ambulance fleet

in Australia and arguably one of the largest in the world. We are undertaking a very ambitions modernisation program. The 340 Ford F-series ambulances currently in use are being phased out over the next three years and replaced with a Mercedes-Benz Sprinter ambulance. It is interesting that historically whenever an ambulance is replaced by another type of ambulance there are dissentions in the ranks as to the pros and cons of the new ambulance compared to the one being phased out. Almost without exception in this instance the Sprinter by Mercedes-Benz has received remarkable acceptance.

CHAIR: But that is 200 over three years. I am asking about the Beechcraft Super Kings.

Mr REID: I will get to that. The Sprinter ambulance has undergone extensive testing and development work over the past 12 months. The latest production units incorporate passive control devices including anti-lock brakes, driver and passenger air bags and traction control. During the Olympics the service used 50 Mercedes-Benz vehicles before they were sent to cities and rural areas. That was the first batch of 200 new Mercedes that have been rolled out across the State. The cost of the new Mercedes ambulances will be $5.5 million a year and they will be replaced with new models after three years or 60,000 kilometres.

CHAIR: I assume that that is all part of the leasing arrangement, is it not?

Mr REID: Part lease, part buying. In addition, over the past 12 months, 45 Toyota Tarago class three ambulances have been replaced by Volkswagen Transporters class twos, with the remaining 40 Toyota Taragos programmed for replacement during 2000-01. The Volkswagen TA is equipped with the latest passive safety devices.

CHAIR: At what cost?

Mr REID: I do not have the detail but I am happy to take your question on board. I am also happy to take on board the question of costs in relation to repairs to the fixed-wing aircraft.

CHAIR: From what you have said, is there anything for the ambulance in this year's capital works budget, which the Committee has not seen, or the capital budget, or any other budget? From what you have said, there does not seem to be any money in this year's budget for the Beechcraft Super Kings.

Mr REID: My understanding is that the Super Kings are not yet due for replacement. Capital is only one year. But when they are due to be replaced there will be a budget item and I will endeavour to find the line item component which relates to their R and R.

CHAIR: How do you work out the total replacement cost? I presume they are leased the same as cars?

Mr REID: No, I think they have all been purchased.

Mr McGREGOR: In the past they were purchased outright, but we are looking at leasing the next round. We are looking at the cost benefit of leasing versus outright purchase.

CHAIR: So, therefore, if you do that, will you receive the buy-back value of the vehicles or will that go to Treasury as part of the deal?

Mr REID: It is kept within the Ambulance Service.

CHAIR: I refer to the additional questions relating to the budget for the Ambulance Service. Is it possible for you to give me some idea of the proportion of Ambulance Service debts that are outstanding for more than 45 days?

The Hon. R. D. DYER: From what question does this issue arise?

CHAIR: It is one of a series of questions I prepared about the ambulance budget. However, when the director-general said that the ambulance budget had not been finalised I could not ask those questions. I now have an answer to my question relating to the cash allocation. This question relates specifically to how much of the Ambulance Service debt is outstanding by more than 45 days. I am sure that the answer the director-general is going to give me is, "None."

Mr REID: With due respect, the provision to you of answers to your questions has only ever been limited by the time available to you. It has not been limited by the response of the director-general.

CHAIR: At that time you said that you would get back to me with the budget, and you did not.

Mr REID: I draw to the attention of the Chair his letter to the Minister, which states:

> I schedule a public meeting on Monday 6 November 2000 at which the Director-General of Health be required to attend before the Committee—

and I emphasise this point—

> to pursue answers to the outstanding questions, if necessary.

Those outstanding questions relate to questions Nos 1 to 25. I believe that the Chair is going beyond the scope of those questions.

CHAIR: So are you begging for mercy?

Mr REID: I am merely trying to adhere to the rules of the Committee.

CHAIR: I had these questions prepared because you could not give me a budget for the Ambulance Service at the last hearing of the Committee. You were still negotiating. I accepted that. I accepted it the second time.

Mr REID: There are other ways in which to put those questions.

The Hon. R. D. DYER: Point of order: The Committee really ought to follow due process. Procedures have been established for the Committee to follow. On this occasion, relevantly, one of those procedures is that we ought only to ask questions arising out of a document containing 25 questions on notice, to which the Department of Health has given 25 responses. It is well understood and common ground, according to my understanding, that we are only to ask questions arising out of the responses to those 25 questions on notice and the answers already given.

CHAIR: I asked, for example, how many pensioners were currently waiting for public dental health treatment. The answer that was provided was that the information was not currently aggregated. Today, when I asked an additional question relating to that matter, the director-general gave me some calculation concerning 270,000 people who would have been treated if the department had received the money that it had received in the past. I asked the director-general how many additional patients could have been treated as a result of the additional allocation of $400 million, but he did not go close to answering my earlier question about how many pensioners in New South Wales were waiting for dental treatment.

It cuts both ways in this regard. Those serious questions have not been answered in the questions and answers paper. I attempted, through my follow-up question, to obtain the average waiting time for dental treatment. I hope that the director-general will get back to me on that issue later today. Today I also asked a series of questions about the Olympic Games. Again the director-general said that there were no general cutbacks. I asked the director-general whether waiting times increased as a result. The answer provided by the department to question No. 11, though not misleading, is difficult to understand. Reference is made to a cash allocation rather than a budget expenditure for each area health service. The director-general kept talking about the expenditure of $8.1 billion or $8.2 billion, which adds up to only $5.6 billion of cash allocation.

The Hon. R. D. DYER: Take that as an example. Question No. 11 states:

> Can you provide a breakdown of the allocated funding to each area health service over the next three years?

It appears to me, even though you might find it difficult to understand, that that is precisely what Mr Reid has done. He has given you the figures.

CHAIR: If Mr Reid had referred earlier to the amount of money that was budgeted to be spent and not to the cash allocation of funding, that would have been understandable. But he continued to talk about a budget increase from $6.2 billion

Mr REID: No, it was $6.9 billion.

CHAIR: The director-general talked about a budget increase from $6.2 billion to $8.1 billion, which appears to be just over a $1 billion increase, whereas the cash allocation that is coming out of his pocket, if you like, is actually an increase of $400 million.

The Hon. R. D. DYER: Mr Chairman, to use your own language, you state:

> Can you provide a breakdown of the allocated funding to each area health service over the next three years?

That is precisely what has been given.

CHAIR: The amount of money that has been allocated increases from $5.2 billion to $5.66 billion—a growth of $400 million. Yet the director-general continues to talk about how much money the system will spend or how much money is budgeted to be spent as though it is all his money. While I asked in that question for a breakdown in the allocation of funds, the issue to which I am now referring relates to the ambulance budget. That question, which might have been phrased somewhat differently to question No. 20 on the notice paper, refers to a three-year budget allocation. That is the question about which the director-general was talking when he referred to $8.1 billion. I want the budget allocation and not the cash allocation. I want the budget for the Ambulance Service and how it is proposed to be spent.

Mr REID: If the Chair wants to know what the budget is for the ambulance service and how it is going to be spent, as I have already indicated, I will endeavour to provide that. But I believe the Chair is moving beyond the scope of the letter that the Chair wrote to my Minister. I am here as a result of that letter.

CHAIR: Okay.

Mr REID: For the fourth time, I am here as a result of that letter. I have endeavoured to provide answers to the many numerous hours of questions arising from appearing before the estimates committees which have preceded today. I will continue to do so. But the rules under which this is brought together are indicated by you, Mr Chairman. I believe you are stepping outside the scope of the 25 questions which you originally asked. Notwithstanding you may have a concern about some misunderstandings of the nature of the answer, that is a separate issue.

CHAIR: That is why we are here—not just because of the nature of the answers received but because we have follow-up questions. Had this information been available, we might have been able to follow up those questions. You understand what I am talking about, though, that when you present the cash allocation and the difference between that and the budget figure—because you have kept using the budget figure, the $8.1 billion—

Mr REID: The addition from $6.9 billion to $8.1 billion is additional money provided by the Government. In that budget item there are also revenues and other matters that make up the total budget figure as distinct from cash allocations. In addition to the items shown here, there are also other amounts that are not shown here. For example, the Department of Health is not shown here.

CHAIR: That is true.

Mr REID: That is not what you asked for.

CHAIR: That is not very much money, is it?

Mr REID: It is a significant amount of money.

CHAIR: Is it?

Mr REID: Yes, Mr Chairman.

CHAIR: I am shocked.

Mr REID: I was sure you would be. We run a number of statewide public health programs.

CHAIR: I know you do.

Mr REID: They include Quit and CEIDA, statewide programs out of the Department of Health. I just make the point that you cannot just line those figures up in a cash or budget sense with the $6.9 billion or the $8.1 billion anyway.

CHAIR: Equally, director-general, you could not for example take Northern Rivers having a cash allocation of $197 million. That is not the entire budget for the operation of the Northern Rivers Area Health Service, is it?

Mr REID: That is correct. I have never indicated that it would be, but when I talk about the additional cash that will go into the Northern Rivers Area Health Service by the appropriation of Parliament, it is additional cash which goes into the area.

CHAIR: Yet the cash allocation which you indicate here goes from $5.24 billion to $5.66 billion. The point I am trying to make is that when you talk about $8.1 billion and then you give us $5.66 billion and quibble about whether I am asking a question about the whole budget, how much money will be spent by the ambulance service providing its services, I think that is a bit rich to complain about. I really do.

Mr REID: I do not believe it is quibbling. I believe the scope of the question that you are asking has moved beyond—far beyond—the scope of the question which was the starting point of these questions.

CHAIR: As a result of the questions raised in question No. 20, can you provide me with a full budget allocation, or is that just going to give me the cash allocation for ambulance services?

Mr BARKER: We can give you the expense. That is what you want—the expenditure budget?

CHAIR: Yes, exactly.

Mr REID: Yes, we can provide that. I have already indicated in *Hansard* that I will.

CHAIR: I presume that if that is the same, it would be equally easy for us to get an expenditure budget for each of the area health services.

Mr BARKER: But that was not the question you asked.

CHAIR: I accept that, and you do not have to take that one on board and do it. I asked whether it is possible.

Mr REID: That is possible, and we will do it.

CHAIR: Thank you. One last question from me is a question about water services which I think is No. 20. However, in No. 14, you have indicated a number of operations that have been done in June and July 2000 for each major hospital or for some of the major hospitals in this State—for the most part, metropolitan hospitals and orthopaedics. Is it possible to split those into urgent and routine? For example, Liverpool Hospital, which is a well-known major trauma centre, may have done 42 operations in June, but those operations may all be totally emergency operations because of the nature of the work of Liverpool Hospital—or is that just routine surgery?

Mr REID: I might have to check this, but I think that would be just routine surgery. In response to the question whether they can be split into urgent and non-urgent operations, I believe they can be split prospectively. If you look at the web site, you have the wait list split into various categorisations but I think they are just planned procedures.

CHAIR: Planned?

Mr REID: Yes, booked admissions.

CHAIR: Somebody such as I can work out how long it will take to get certain things done, but if there are emergencies as well, it is more difficult.

Mr REID: I will check that.

CHAIR: Thank you for that. I want to ask you some questions about water monitoring.

Mr REID: Which question, Mr Chairman?

CHAIR: Question No. 19. My colleague the Hon. J. H. Jobling asked a question about why New South Wales Health breached the May 1999 drinking water monitoring plan by failing to undertake the required

annual sampling typically in Woronora and Potts Hill systems during 1999. Your answer was that New South Wales Health is not responsible for conducting water monitoring under the Sydney Water monitoring plan. Is that not correct?

Mr REID: Yes.

CHAIR: Has New South Wales Health or the public health system any responsibility for water monitoring in Sydney Water?

Mr REID: This is quite a complex answer, Mr Chairman. The question relates to the number of samples collected for analysis for trihalamethane, which is a disinfection by-product. Sydney Water Corporation is responsible for monitoring drinking water distribution systems, as outlined in the water quality monitoring plans provided and agreed to by the department.

CHAIR: So they set a plan and you approve it.

Mr REID: We tick off the plans each year. The Department of Health noted that although six routine samples were not collected in the Woronora and Potts Hill distribution system, an additional 52 samples were taken from the Woronora system and 25 from the Potts Hill system under an additional project. The number of samples is well in excess of compliance requirements. There are no health concerns. All the trihalamethane values are below the 1996 the National Health and Medical Research Council guidelines for Australian drinking water, and all the sample results in Woronora and Potts Hill were well below the guidelines level.

CHAIR: I accept that, but there is an article in the latest "Public Health Bulletin" about sampling done in the Hunter and other holiday areas. The samples were done in 1996 and they were reported this month. Do you do other sampling throughout the State? If so, where do you report them? If you want to rule that out of order, I would be more than happy to take your admonition.

Mr REID: I believe that samples taken in the Hunter do not relate to a question specific to the Woronora and Potts Hill systems during 1999.

CHAIR: Is Sydney Water dealt with differently from how we deal with the rest of the State?

Mr REID: That is correct. They are dealt with under the same guidelines, but there is a Hunter water criteria as distinct from Sydney Water.

CHAIR: It is different from your responsibilities or your actions in terms of, say, Wagga Wagga or Lismore?

Mr REID: It may not be different in terms of our actions, but there might be different guidelines which adhere to various systems.

CHAIR: Has any member any other specific question?

The Hon. Dr A. CHESTERFIELD-EVANS: I will come back to the cost of the effectiveness of the Quit tobacco campaign. On pages 17 and 18 of the transcript dated Wednesday 23 August—

The Hon. R. D. DYER: What is the meaning of referring to the transcripts as distinct from questions arising out of the answers that have been given here?

The Hon. Dr A. CHESTERFIELD-EVANS: My incredible enthusiasm to make sure that everything I say is within the scope of what we discussed before.

The Hon. R. D. DYER: I think it is sleight of hand.

The Hon. Dr A. CHESTERFIELD-EVANS: I will come back to the question number, if you prefer.

CHAIR: Did the director-general take anything on notice following that?

The Hon. Dr A. CHESTERFIELD-EVANS: I will quote the director-general. I said:

> What calculations have you done on the break even point of the Quit campaign cost effectiveness and how much do you anticipate to have spent on the Quit campaign as a result of these calculations? If calculations have not been done, why not and when will they be done? What I am saying is that if you can make money by increasing spending on the Quit campaign, surely you have a moral imperative to do that. Have you done this calculation and what is the result of them?

Mr Reid replied:

> I am not aware of what calculations have been done of the Quit investment versus return. There are some very good calculations on the cost of tobacco use in Australia. I am not provided those figures but this was done in a report by Collins and Appsley.

Mr Reid went on to talk about the Collins and Appsley report. I said there was an 18 per cent increase in smokers health costs versus non-smokers. The Chair said, "It is interesting, is it not?" And Mr Reid said:

> It is, but I can take on notice that question about what analysis we have done for return on our investment in Quit.

I asked:

> Will you undertake that if Quit is shown to be cost-effective in reducing the health budget, the Quit campaign should rise to the point at which it is not cost effective?

Mr Reid then equivocated somewhat.

CHAIR: No, he proselytised.

The Hon. Dr A. CHESTERFIELD-EVANS: Mr Reid said:

> I think any investment we make, it helps to look at cost effectiveness with available data right across the system. I certainly would not give an undertaking on a one-out basis for one program. Investment in a particular program is not solely determined by the cost benefit analysis of that program but by the distribution across a whole range of expenditures of the $7 billion we spent on health.

CHAIR: Effectively he undertook to take a matter on notice.

The Hon. Dr A. CHESTERFIELD-EVANS: I said:

> If that calculation has not been done, will you undertake to do it?

The Hon. Dr A. CHESTERFIELD-EVANS: Mr Reid replied:

> Can I come back on that? I will certainly come back on whether it has been done. If it has not been done I will ask my department to do as best we can.

Mr REID: I take it that is the question?

The Hon. Dr A. CHESTERFIELD-EVANS: The question is: Have you done the best you can, because we are still a bit short on data on the cost effectiveness of Quit and its resultant effect on your spending on the Quit campaign?

Mr REID: I am happy to answer this question.

The Hon. Dr A. CHESTERFIELD-EVANS: Is that all right? Have I covered it sufficiently?

The Hon. R. D. DYER: I am satisfied. However, could I gently suggest to the director-general that a one word answer might suffice?

The Hon. Dr A. CHESTERFIELD-EVANS: No, it would not.

Mr REID: I took the Victorian study, which shows a significant return on investment. I did not need to replicate that study for the New South Wales experience in terms of the benefits of Quit campaigns. Similar campaigns are clearly beneficial, which is one reason why there is significantly additional investment in that area. I stress the point that there are many other areas where there are very good returns on investment. If you check *Hansard*, I made reference to falls by the elderly as one area where there is enormously important return on investment in health promotion programs and safety awareness. There are many similar investments. I do not think I need to replicate a clear benefit analysis compared with the Victorian study. As I said, I take that to be a clear indication that what applies in Victoria would apply in this State.

The Hon. Dr A. CHESTERFIELD-EVANS: I do not have any problem with that. What I am quibbling about is the degree of investment given the return. The degree of investment is small given the high level of return we might expect. You referred earlier today, in answer to a question from the Chair, about your priority being the waiting list. I am concerned that prevention gets left behind at the expense of cure.

Mr REID: I made the point that I talk about waiting times rather than lists. Having a priority in one area of health does not deny priorities in other areas of health. There is a multiplicity of products in the health system. The real trick is how to balance those products and get the best returns for the people of this State. The long-term benefits of health promotion have clearly been well demonstrated. By the same token, people's concerns about their hospital system and emergency care are equally important. It is a matter of balance.

The Hon. Dr A. CHESTERFIELD-EVANS: It may be equally important in perception, but it may not be equally important in cost-effectiveness terms. I would argue that your priority would be more in the area of cost effectiveness than popularity, in the sense that if one is to have expertise, the advantage is that you have the knowledge more than the public perception.

Mr REID: Good emergency care is not a matter of popularity. It is a matter of quality and good clinical practice, just as investment in health promotion activity, whatever it might be—fitness, smoking cessation, alcohol reduction and a range of other areas—is also good clinical practice.

The Hon. Dr A. CHESTERFIELD-EVANS: Often prevention is not seen as demand management. If you saw it as demand management you could actually see it as improving the waiting lists and waiting times, and even resources and other necessities.

Mr REID: Which is why the Government action plan is very much trying to focus on keeping people out of hospitals, particularly those with chronic and complex conditions, and to better manage them in the community.

The Hon. Dr A. CHESTERFIELD-EVANS: The order of spending is nowhere near the Californian data, which suggests that we have spent a great degree of magnitude below the optimum spending to get those returns?

Mr REID: That is a view.

CHAIR: Are there any other questions? director-general, next time we meet, which will be next year for the budget process, I encourage your department—as I have encouraged the Department of Community Services—to answer in a timely fashion the early questions we submit so that we do not have to have these further meetings. Difficult as it is, we are prepared to go through these meetings to give the department the opportunity to explain to the people of New South Wales. It would be more helpful if we could be more concise and deal with specific issues in depth, so that we get some understanding of the depth, width and height of the achievements of the Health Department.

Mr REID: I have two answers. I hear what you are saying about the timeliness of responses.

CHAIR: Thank you for your attendance.

The Committee proceeded to deliberate.