GENERAL PURPOSE STANDING COMMITTEE No. 2

Wednesday 7 June 2000

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 5.30 p.m.

MEMBERS

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

The Hon. Dr A. Chesterfield-Evans
The Hon. A. G. Corbett
The Hon. R. D. Dyer
The Hon. Jennifer Gardener
The Hon. Janelle Saffin
The Hon. H. S. Tsang

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PRESENT

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

Department of Health
Mr M. Reid, *Director-General*
Mr R. McGregor, *Deputy Director-General, Operations*
Mr K. Barker, *General Manager, Finance and Commercial Services*
Ms D. Piccone, *Chief Executive Officer, Corrections Health Service*

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CHAIR: Before questions of witnesses commence, I remind the Committee members that the Committee has authorised the broadcasting of all public procedures. The Committee has determined that, with respect to the time frame for members to lodge questions, any subsequent follow-up questions will have to be in to the Committee Clerk by 5.00 p.m. tomorrow. Minister, I welcome you to this public hearing of General Purpose Standing Committee No. 2. I thank you and the departmental officers for attending today. The Committee will be examining the proposed expenditure from the Consolidated Fund for the portfolio area of Health. As you 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 these guidelines. I emphasise that only members of the Committee and the witnesses before it may be filmed or recorded. People in the public gallery are not considered to be 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 reporting the proceedings of both Houses of Parliament, you must take responsibility for what you publish or what interpretation is placed on anything that is said before the Committee.

While there has been provision in previous years budget estimates resolutions for members of a committee and substitute members to refer directly to their own staff at any time, there is no such provision in the current resolution. Members and their staff are therefore advised that any messages should be delivered through the attendant on duty or the Committee Clerk. For the benefit of members and Hansard and the effective operation of the Committee it is very important that departmental officials identify themselves by name, position and department or agency before answering each question. There is wide latitude allowed in asking questions on any of the budget estimates and related documents before the Committee. However, where a member is seeking information in relation to a particular aspect of a program or subprogram it may will the Minister and the Committee if the program or subprogram is identified.

The Committee has agreed to the following format of the hearing. If a question is asked by a member and any other member of the Committee wishes to follow that question through, they are entitled to do so. I will try to be even-handed in terms of time for all honourable members who wish to ask questions. The only other thing that is different this year is that I have advice from the Clerk urging Ministers to give relevant answers to questions. It is not particularly pointed to Ministers but it comes from our experience last year. The Committee has the power to summons public servants to attend and give evidence and there is nothing to prevent committees from holding additional hearings in the period leading up to the presentation of the first report by the adjournment of the House for the winter recess—that is, 23 June. Public servants should not refuse to provide information to a committee. If they have difficulty providing information they should be given the opportunity to inform the Committee of the difficulty and its nature.

Minister, how much money has been allocated to operate the waiting times web site in 2000-01. Will it be money of value for general practitioners and patients, or will they be confused by inaccurate and misleading data?

Mr KNOWLES: I will ask Mr Reid or Mr Barker to answer that question. I will make some general remarks about the web site. A web site was a relative newcomer to the health system. I had anticipated receiving nothing but support for it because, frankly, in an age of consumerism and information technology almost every industry sector I have been associated with for at least the last 10 years has had some sort of capacity to disseminate information in this way or similar ways. I was therefore surprised when I discovered that there was considerable resistance to the concept of publishing waiting list/waiting time data for a number of reasons which centre around things such as "The consumer won't understand it" or "It is not really accurate" or that it in some way implies some sort of exposure of an individual clinician's business.

I was even more surprised when, on the *Sunday* program a few weeks ago, the then President of the New South Wales Branch of the Australian Medical Association [AMA] made it clear that she had been told by any number of practitioners/clinicians that they were simply not going to cooperate and participate by providing information for inclusion into the web site. That disappointed me. Based on the fact that we have been trying to build up the database for publication I had already been alerted to the fact that there was, in some quarters, nothing short of open hostility to the concept. I can relate a conversation I had at a Sydney hospital not terribly long ago where I was upbraided for having the temerity to publish the information about the waiting times with individual clinicians, and again I was shocked by that.

I was therefore gratified to receive some positive affirmation for what we seek to do from clinicians around the State and, importantly, from the independent commentary position of the editorial pages of the *Sydney Morning Herald*. I refer you to an editorial of 15 May which delves into this issue. It makes the point that Dr Phelps not accepting the need for clients to be given information that might make their choices more informed is wrong. They put the view that there is no merit in the argument. They touch on many of the reasons why waiting lists and waiting times take the form they do: from doctors taking holidays to resource issues.

They make the point that the extent of the waiting times list—how long or how short it is—has become the issue of political debate rather than what measures are needed to make elective surgery processes more efficient. They go on to say that this should be the first of a range of published indicators about the service which we provide using tax payers' money. I make the point that the waiting lists we publish are about the public hospital waiting lists and therefore the procedures that are paid for by tax payers. They urge me in their editorial to make sure I go further and have regard to issues around safety—

CHAIR: Minister, could you answer to the question? How much money has been allocated?

Mr KNOWLES: I will come to that—

CHAIR: I understand the difficulties, but would you answer the question?

Mr KNOWLES: There is no doubt that you understand the difficulties because you are a clinician, and I respect that. I am trying to make the point that, as a person who is not a clinician who has come to this task seeking to provide information to consumers about the nature of the services that they receive, I was concerned at the—

CHAIR: So am I, Minister. Could you provide an answer: How much money was allocated this year?

Mr KNOWLES: I ask Mr Reid to answer that question.

Mr REID: No specific funds were allocated to establish the web site for waiting lists. It was done from within the existing resources of New South Wales Health; it was done using existing technology within New South Wales Health; and all we are doing is putting data we have been collecting over many years on a web site.

CHAIR: How much does it cost to do it, even if it is done internally?

Mr REID: There is no identification of the cost of the web site in the budget year.

CHAIR: Is it $1 million, $2 million, $3 million, $4 million?

Mr REID: I am indicating that there is no identification of the cost. We have not costed it because this is something we have been doing for many years—

CHAIR: So you have no idea?

Mr REID: —as part of the core business of New South Wales Health.

CHAIR: So you have no idea how much it costs?

Mr KNOWLES: We will provide you with a breakdown of that component of that part of the Department of Health.

CHAIR: Could I confirm that you have taken that question on notice?

Mr KNOWLES: Yes. I would like the Committee to understand that, frankly, whatever the cost of the web site we are seeking to make a fundamental move to providing greater access to information and greater choice to consumers. Clinicians have said to me that the biggest problem with this is that it may change referral patterns—general practitioners choosing or having access to a greater amount of information to determine which specialist they choose to refer to on behalf of their patients.

CHAIR: Minister, these are truisms, and I accept that. The thrust of my question is: How much does it cost? Why you have done it or the difficulties of doing it are not the issue; the issue is what you have done is both confusing and inaccurate.

Mr REID: I refute that entirely: it is neither confusing nor inaccurate.

CHAIR: Well, in that case—

Mr REID: You asked the question and I would like to answer it.

CHAIR: You have.

Mr REID: No, I have not. This was evolved in consultation with general practitioners, the College of Surgeons, the College of General Practitioners, the AMA, consumer groups and a range of other clinical people. It was evolved over many months and there was a level of agreement about its evolution. We have made it clear in putting the data on the web that if at any time any clinician in this State had concern about his or her list and the accuracy thereof he or she could contact us and we would take that list immediately off the web site and modify it with the correct data—if they thought it was incorrect—and modify it on to the web site.

CHAIR: If the information on your web site is so accurate, why have some 30 doctors taken the trouble to write to the shadow Minister for Health in scathing terms about the inaccuracies and misleading information contained on the web site about their own practices? Doctor Andrew Lester, of Goulburn, said, "The web site information suggested to my patients that my patients have a 90 per cent chance of having their surgery within seven months. That is not true. A patient booked in today would have to wait for between 15 months and two years."

Mr REID: I cannot verify how many clinicians have written elsewhere. However, since we made that assurance to every clinician only 14 clinicians—out of 2,000-odd who are indicated on the web site—have written to us about the list. Some of those 14 clinicians have not complained about the accuracy of the list but have complained about whether, in principle, consumers should have rights to this information. If clinicians have complained about the accuracy of the list, in the good faith we have established, we have taken it off the site. We have negotiated with the clinicians about the accuracy of that data. Where that accuracy is modified we have put those names back on the list.

CHAIR: Minister, if your web site is so good why did Dr Lester go on to say:

> I have a number of patients who have been unable to walk and have been in constant agony whom I have prioritised as urgent, and it has still taken six months for these patients to have their joint replacement surgery performed.

Mr REID: You are moving on to another issue. This is not about the accuracy of this list; this is about some views they might have about waiting times.

The Hon. JANELLE SAFFIN: I ask a supplementary question. Who provides the information?

Mr REID: The information is provided by the clinicians.

The Hon. JANELLE SAFFIN: So they provide it?

CHAIR: That is simply not true.

Mr REID: Sorry, that is true. The information is provided by the clinicians, it is then provided to us by the hospitals; they are the only ones who have the list. In every instance we have written back to every clinician in New South Wales—not once but twice—and asked them to verify the accuracy of the data.

CHAIR: Mr Reid, not one clinician in this State would have any idea how long it has taken them to clear 50 per cent of their patients.

Mr REID: No, it is about the number of people on the list they have provided. The question was who provided the data and about the list, not about the time, Mr Chair.

Mr KNOWLES: Mr Chair, we can all swap correspondence: you have had one, and I have another one. I have a letter from another clinician, Bill Ross, who has been a very outspoken surgeon in the mid North Coast. He writes to me about waiting times information on the New South Wales Health net. He said this recently:

> Thank you for your correspondence dated 13th November regarding waiting times information on the Health net—

the correspondence that Mr Reid referred to—

> I have looked at this and I am very impressed. I think this is an excellent project and I wish you good luck. If there is any way in which I can help please don't hesitate ...

We have all seen the episodes of *Yes Minister* where one way to devalue an initiative is to try to confuse the issue—that it is inaccurate, that it is inappropriate—if you do not want to do it. We all know—we have seen it on the *Sunday* program—that there is a body of clinicians who do not want to do this; they will do this over their dead body. Mr Reid has outlined to you a process which has been articulated right throughout the clinical workforce where there are, or may be, inaccuracies. They are invited to provide that information to the Department of Health for correction. It is a fairly straightforward process. Nobody is pretending that starting something as large as this is not going to be without some—

CHAIR: If it is so good, why has Dr Michael Neill of St Vincents informed the shadow Minister for Health that the waiting time for him to do a total hip replacement is not two to nine months, as advised by your web site, but up to 18 months? He has been allowed to do only five such procedures since January 2000. Minister, I will table all the letters the shadow Minister for Health has received.

Mr KNOWLES: Could you advise whether the correspondence was also written to the Department of Health?

Mr REID: Dr Neill has not written to the department.

CHAIR: I will table these documents and you can look at them yourself at a later time.

Documents tabled

Mr KNOWLES: One might question why a clinician, faced with an opportunity to correct the public record, might choose to instead write to the shadow Minister for Health, who is not part of the Department of Health and who has no influence over the public record. Certainly it would suggest that those people are perpetuating their concerns about publishing information about their individual waiting lists.

CHAIR: Minister, how do you respond to a surgeon from Mona Vale who describes your web site as:

> An attempt by the Government to be seen as transparent and honest whilst successfully confusing the public with a cloud of erroneous data in a technological medium.

Another doctor writes:

> Realistically there is over two years of waiting for admissions to hospitals for ordinary patients for joint replacements. There is an extremely false impression for people visiting the web site.

Mr KNOWLES: I would respond by referring you back to what I regard as perhaps a more independent commentary about the benefits of publishing this information—that is, the *Sydney Morning Herald*. It stated:

> By opposing the release of the elective surgery waiting lists, Doctor Phelps is trying to ensure that any public scrutiny of the efficiency of doctors is kept from the public. The logic in her argument (or chopped logic) is that the public can't be trusted to understand the nuances behind the information being placed on the Internet.

Some of those points were raised in that most recent letter. It continued:

> There is no merit in this argument. The public can understand that the Internet information needs to be put into context. Doctors take holidays. They have sabbaticals. Some doctors have only limited access to particular hospitals. Some hospitals close during holidays. Other hospitals cut their operating sessions when they run short of money. These are not difficult notions to grasp. Moreover, if some lay people cannot find out these details, their GPs are certainly able to get the information for them.

It is the AMA, then, that is providing a self-serving distraction rather than the State Government. This is clear from the statement made by the Director-General of NSW Health, Mick Reid, supporting the new move. He said, "This is designed to help patients and general practitioners make informed decisions about their surgery ... and to demystify hospital procedures." I can understand that there is a huge investment in maintaining the mystery and nobody pretends these steps will not happen without a struggle, but they are happening.

CHAIR: Minister, do you not have an obligation to the patients and the doctors working in the system to treat them fairly? What do you say to the suggestion that if a patient sees this inaccurate information on the web and asks the doctor, who gives the patient a different waiting time, that it might be seen by the patient that the doctor or you are inaccurate, or worse that the doctor is telling lies?

Mr REID: Before I answer that question, I think it is important to go back to your other question which has not been responded to about the two-year wait for conditions such as hip replacements. There have been claims that:

> For many conditions such as hip replacements, particularly in country hospitals, doctors were reporting that they have patients waiting for more than two years for surgery.

In fact, out of more than 1,600 patients in this State waiting for hip replacement surgery at the start of this year only one patient in country New South Wales is waiting that long for that procedure. I think we also need to balance up the anecdotal evidence with the actual evidence we have before us. That patient you mentioned has since had the operation. So that out of the 1,600 patients in country New South Wales who waited for hip replacements only one waited that long; 95 per cent of patients who wait for elective surgery have their surgery within a year and 99 per cent of people who require urgent elective surgery are treated within the urgent waiting time.

CHAIR: Please answer the question about the difficulty a patient would have if he said, "Fifty per cent of your patients are going to be done in five months" and the doctor said, "Look, I am sorry but you are going to have to wait for a year to get it done." Can you not understand that the patient would say, "Well, the doctor is lying and he is trying to force me to go private"?

Mr REID: That, Mr Chair, is not how the data is presented.

The Hon. JANELLE SAFFIN: We all know doctors would not do that.

Mr REID: If you go to the web site two pieces of data are very useful for GPs and consumers. The first bit of data shows for each doctor the median waiting time for that procedure. The second bit of data shows the length of time it takes to treat 90 per cent of patients who have that condition. Now on any account that provides information to the consumer which reflects either the shortest period of time they might wait or some idea of the longest period of time they might wait. So those two bits of data are on the web site and, as you are aware, the response from GPs and consumers has been extremely positive.

The Hon. H. S. TSANG: Mr Chair, I have a procedural question. I believe that as a member of the Committee I have a right to a say.

CHAIR: Yes, please proceed.

The Hon. H. S. TSANG: Mr Chair, I have been listening very carefully on questions on the budget. I believe the Committee is meeting for two hours. I am looking forward to listening to other eminent members, such as Dr Arthur Chesterfield-Evans, who has some wonderful questions to ask. I think it is only fair that I have a chance to listen to him.

Mr KNOWLES: I think I have a right to respond to the assertions that have been put.

CHAIR: I will rule on the procedural question first. Henry, had you been here earlier you would know that we determined before the Committee met how the questions would go. The questions were to be asked by me, then the Hon. A. G. Corbett, then the Hon. Jennifer Gardiner—

The Hon. H. S. TSANG: But that might take up the whole two hours and I will not get a chance because of everybody else.

CHAIR: There are blocks of questions. If you want to intervene on any of these questions, to follow that question through, you are more than welcome to do so.

Mr KNOWLES: I would like to respond specifically to your commentary about Dr Andrew Lester. I will read this into the record:

> Since December 1994 when Dr Andrew Lester commenced providing a specialist orthopaedic service to Goulburn Base Hospital, to complement the service provided by the general specialist surgeons, over $1.5 million has been spent providing services ranging from major joint replacement to arthroscopy for 786 patients.

> At the commencement of the expanded orthopaedic program over $600,000 was provided in the first 18 months to reduce the significant outflow of Goulburn and district patients to other hospitals outside the boundaries of the area health service.
>
> Over the last three years the total number of orthopaedic patients treated annually by Dr Lester has not diminished. In fact, last year although a service plan identified service to be provided to 140 patients at a projected cost of $254,000, 175 patients were provided with services costing $350,000.

CHAIR: Minister, I appreciate what you are saying.

Mr KNOWLES: You are about to appreciate what I am about to read. This matter was brought to my attention as a consequence of correspondence from, I think, three of Dr Lester's patients being passed on to the Alan Jones radio program. I suspect that it is one of the reasons you have raised it here. We, of course, did some checking. This general briefing note goes on to say:

> The hospital does not dictate to specialists how to proportion the funds available against the various procedures in their caseload. Patients awaiting major joint replacement surgery in Goulburn Hospital are offered a range of allied health services.

CHAIR: I would appreciate it if you could table that letter because it does not go to the issue that Dr Lester raised about the accuracy of the waiting list.

Mr KNOWLES: I want to place on the record that Dr Lester cannot have it both ways.

CHAIR: Dr Lester said, "The web site information suggests that my patients have a 90 per cent chance of having their surgery done within seven months and that is not true. A patient booked in today would have to wait between 15 months and two years."

Mr KNOWLES: At the date of this briefing note, April, Dr Lester's list had a total number of 63 patients. We were told that at that time Dr Lester had just returned from two weeks unscheduled leave—that is, he did not notify the hospital and it had to cancel and reschedule all the patients booked for that time. He is away again in July for two weeks, away in August for a week and away one week in September prior to the theatre closure. He has only 41 operating weeks a year, which translates into 41 joints per year.

CHAIR: Minister, that supports what Dr Lester is saying—precisely.

Mr KNOWLES: The point quite clearly is that there are many features that make up why waiting lists are configured the way they are, including the things that doctors do not tell their elderly patients when they are urged to send their cases to the radios, including taking leave without letting the hospital know and that there are other programs. Everyone knows there is an anaesthetists conference at the Crown Casino in a week or so.

CHAIR: Dr Ronald Clark, from Bankstown, said:

> Since the middle of last year the number of joint replacements performed at Bankstown Hospital has dropped considerably, supposedly for economic reasons. My patients are now awaiting around for 10 to 12 months for joint replacements with some patients being booked for the end of next year. The current data on the Internet is consequently inaccurate.

Mr REID: I would like to make a comment in relation to Dr Clark and Dr Lester. We have made it clear that the policy is if doctors have concern about the data on the site they contact us, we take the data off the site, we liaise with those doctors, we get accurate data and when we agree we put it back on the site. Neither Dr Clark nor Dr Lester has written to us to complain in any way about the data on the site.

CHAIR: Dr Lester gets to do only one hip operation a month. He has 63 patients waiting—if they are all waiting for hips they could be waiting for five years.

Mr KNOWLES: Mr Chair, you are making the point on the accuracy of the web site .

CHAIR: That is right.

Mr KNOWLES: We have a standard protocol for how that is to be rectified. Fourteen doctors have availed themselves of that protocol—only 14 doctors. If Dr Clark or Dr Lester—as you have tabled the data we will approach them—had approached us we would have taken that data off the web site and liaised with them.

CHAIR: Dr Robert Simon, a general surgeon from Lismore, has written to me personally. He said:

> Thank you for your recent letter regarding waiting time information. I have visited the web site and found that there are gross inaccuracies in the information that is presented. My own figures have not been published as I have asked for them to be reviewed before they are published.
>
> I note the current review process allows only 48 hours for the surgeon to review the figures and then resubmit them. I think this is inadequate and I feel there should be potential for a lot of misleading information that could be published.
>
> I am in favour of waiting times being published, however, I think this information needs to be accurate and the current system for registering these waiting times is inadequate.

Mr KNOWLES: How long would the doctor like? What is an adequate time?

CHAIR: I could explain to you later, because we have not got time here, what is required to get the figures to the department. I had a long talk to Dr Nick Shiraev about it. Consequently if you look at it, it is all done in retrospective fashion and a doctor has no idea if a patient who was put on their list a year ago comes off today, how that is dealt with. So it is a complicated arrangement.

Mr KNOWLES: As a doctor, do you support the information being—

CHAIR: I always have; absolutely.

Mr REID: Once again, Mr Chair, if Dr Simon wishes to come back and negotiate the timing for the accuracy of his data in his individual case to go on the web, we are happy to accommodate him. If Dr Lester and Dr Clark would provide us with information about the accuracy of their data, we will accommodate them. As you are aware, 14 doctors out of 2,000 doctors have contacted us about a very new process. In all 14 cases, if the complaint has been about accuracy of data, we have accommodated their requirements. If any other doctors have made representations to you or any other member of the Committee we would be happy to receive those representations and accommodate their requests.

The Hon. JENNIFER GARDINER: I move that the Minister's documents be tabled, and that Dr Pezzutti's documents be tabled.

Documents tabled.

The Hon. A. CORBETT: What is the web site address?

Mr KNOWLES: It is the New South Wales Health web site: *www.health.nsw.gov.au*.

Mr REID: If you want to add waiting times on to that you will find the end result. The New South Wales Health site constantly rates in the top 20 in Australia. We are one of the most popular sites that people access.

CHAIR: People are desperately trying to get to hospital.

Mr REID: It has an extraordinary number of services provided on it. I encourage any member who wants to know anything about health services, not just about waiting lists, to visit the site. As I have said, the New South Wales Health site has an extraordinary range of information on it and it constantly rates in the top 20 sites approached by anyone in Australia.

Mr KNOWLES: When British Columbia, Vancouver, tried to establish a similar site they had exactly the same thing: the exact same arguments, the red herrings. It works fine: the sky did not fall in, the pattern did not change all that much.

CHAIR: Minister, the Hon. A. G. Corbett simply asked for the web site address. We are just wasting time.

The Hon. A. G. CORBETT: If the public have a problem understanding the data on this web site, who do they approach?

Mr REID: They can approach two groups of people. Members of the public will go to their GP, and this will be just another source of information as part of the discussion with their GP about their case.

The Hon. A. G. CORBETT: Let us assume that they do not want to talk to their GP. What if they want to talk to someone on the phone?

Mr REID: If they want to pick up the phone, on the site they will find addresses for waiting list co-ordinators—that is, people who are on the other end of the phone. They can ring up at any time and say, "I want some information about this, I don't understand the site or I don't understand my way through it." In every area health service we have a waiting list co-ordinator, and we also have a statewide waiting list co-ordinator. The name of the statewide co-ordinator in New South Wales Health is Anne Cowling, who can be contacted on 93919000.

The Hon. A. G. CORBETT: The budget overview handout states that there is an additional $500,000 for the Isolated Patients Travel and Accommodation Assistance Scheme [IPTAAS]. However, unlike last year's budget, there is no line item in this budget to provide details. Will the Minister indicate how much was budgeted for this program in 2000-01? Is this greater than the budget for last year? What were last year's budgeted and actual spending figures?

Mr REID: This year the IPTAAS budget is a $500,000 increase on the previous year. That brings our total budget to $7.5 million each year. We have also eased some of the requirements around access to IPTAAS, because they were fairly stringent sometimes about whether you were within 200 kilometre access to another service, and we have eased those restrictions. We think that the additional dollars we have put in would, in an ideal world, pay for 2,000 additional services. However—and this is a very relevant point—IPTAAS will be highly affected by the GST because we pay for the services that people will make out of their own pockets: a train fare, an air fare, a taxi. The GST will have an impact.

The Hon. A. G. CORBETT: What are some of the other restrictions that have been eased?

Mr REID: I would have to take that question on notice. There was a detailed review of IPTAAS, and I can provide you with a copy of that review, and I can also provide you with a copy of the various easing of restrictions to be put in place. They were basically around the type of person who could travel with the client, and the distance travelled, and the access to the range of services and health services.

The Hon. A. G. CORBETT: If people want to pursue this, who do they contact?

Mr REID: If it were a local issue, their best contact would be their area health service; if it were a statewide issue about the review, they should contact New South Wales Health.

Mr KNOWLES: I have met with representatives of communities who would normally be beneficiaries of IPTAAS. Very early in my term they alerted me to what they regarded as the unnecessary rigidity of the rules around the distance requirements, and the issues associated with who might travel, particularly with a younger person, to an urban centre, for example, for treatment. The additional money is obviously designed to deal with more people who might benefit from the scheme, but areas have been instructed to take a more flexible and commonsense approach, and to have regard to things such as hardship. The distance criteria, while still in place, has a degree of flexibility attached to it, such as consideration of other transport options. The Australian Health Ministers Council has taken up this GST matter via the Federal Minister for Health, Dr Wooldridge.

Every State has an isolated transport scheme. Every State needs to move patients to major centres for major procedures. The community has to understand that whilst every State has increased its funding for isolated patients transport schemes much of that money is likely to be instantly eroded by the impact of the GST. It is the unanimous view of all State and Territory Health Ministers that that is simply an unreasonable impact, and probably an unintended consequence of the impact of the GST. It is something that the Commonwealth Government would logically recognise in the items that are subject to being removed from the GST framework, as are other health matters.

The Hon. A. G. CORBETT: So some people may have benefited from this scheme but they will not because of the GST?

Mr REID: That is correct. We estimate that the value of the GST impact on the IPTAAS scheme is roughly equivalent to the additional half a million dollars we are putting into the scheme. As the Minister said, it is probably an unintended consequence of the GST, but it is a consequence that has real impact on country people, particularly the poor, the indigenous, and those who are more remote.

Mr KNOWLES: In fairness to Dr Wooldridge, I met with him just recently in Canberra and. among a range of issues that we discussed, he quite genuinely accepts the need for all jurisdictions, including the

Commonwealth, to try that much harder for the bush, to use that sort of terminology, including access issues. He has clearly read Ian Sinclair's report into the health needs of small country towns, and I do not think he has overtly and publicly endorsed it, but he recognises, as that report does, that transport and access is a fundamental issue to rural communities. I am hopeful, in the best spirit of working together, that what I think is a genuine anomaly will be ironed out. Bear in mind that this issue has probably been on the Commonwealth Treasurer's desk for some time now.

The last time this was formally raised at a health Ministers meeting was in Sydney about three months ago, and it was in the context of GST impact and the FBT impact, which is of particular effect for wage packages for rural work force. The Australian Democrats, as you have been aware, have brought in a range of legislative changes into the Senate associated with FBT but there is not a commensurate adjustment for the GST for this scheme. So it is something that I think we as a community can continue to press. I understand that people like Ian Sinclair continue to be on the trail. Every other State and Territory Health Minister is, and I suspect Dr Wooldridge is too. I would like to think we will get there.

The Hon. A. G. CORBETT: If the money runs out, what will happen to the people who need this assistance?

Mr REID: We have found that the budget we have established pretty much covers the demand within our criteria. We constantly review that. If there are particular hardship cases additional costs are met within area budgets. In the main it has been a budget—anything is slightly elastic—that has accommodated the demand within the criteria.

Mr KNOWLES: On my observations and from representations to me, they are more than satisfied with the approach we are now taking. Although it is fair to say I have not spoken to them since everybody realised the GST impact might bite back into it.

CHAIR: So not before four or five months?

Mr KNOWLES: Four or five weeks.

The Hon. A. G. CORBETT: Minister, I would like to talk about primary community-based services. Will you tell us what the budget is for community-based services? What proportions of these funds is to be spent on primary health care nursing? What proportion is to be spent on post acute care services relating to earlier discharge from hospital?

Mr KNOWLES: Ken Barker is sifting through budget papers, so we might take that question on notice. I make the important point that much of the commentary you find in the report of the New South Wales Health Council goes to your important question—that is, how much effort do we put in as a community to primary care, preventative care, community-based care. As is said in the foreword, there is an almost seemingly total concentration on the hospital end and the acute end of the system. We have endeavoured to demonstrate a commitment to primary and community care, with clinical support.

That is why in the implementation of the health care models—the Health Council report recommendations—we have allocated funds that, for example, go to better treatment of chronic recurring conditions at an earlier stage. We are focussing initially on respiratory illnesses, heart and cancer. We are of the view that if we can get to individuals who have those longstanding lifelong illnesses earlier they will not need to attend the acute end of the system as frequently. So there is a genuine investment there, almost a shift in the way we treat those illnesses. It is similar to the way in which over the last decade the medical community has shifted in the way it treats diabetes and asthma.

The Hon. A. G. CORBETT: Could I have the figures please?

Mr REID: The budget for primary and community services is $564,226,000. We cannot split that budget easily into post acute care and community nursing, but I would be more than happy to take the question on notice and give you some broad estimates.

CHAIR: I note that that question has been taken on notice.

Mr REID: It is about the proportionate amounts going to both of those departments.

The Hon. A. G. CORBETT: I refer to mental health services. There is an urgent need for more mental health services in the community. Can you indicate what proportion of the $36 million of new funding will go to services in the community, and what proportion will go to hospitals and other forms of institutional care?

Mr KNOWLES: At the specific request of the Mental Health Association, the new money that we put in—which, from memory, equates to $117 million over the next three years—

CHAIR: Is it the same as the $2 billion announcement?

Mr KNOWLES: Yes, the same way as Peter Costello does the Commonwealth budget.

CHAIR: Okay, just so long as we understand.

Mr KNOWLES: We are quite explicit about how these moneys are built up, and the community has been taken in. The important part of your question is: How has that money been distributed? My only requirement is that it is on a more equitable basis than it has been in the past, and it is not a criticism of the mental health community; it is a feature of where mental health establishments have been located traditionally, with a preponderance of money going to them, perhaps to the detriment of other areas in our State. There is a desire to spread the money more equitably. To do that, I have asked Dr Marie Bashier, a woman of 30 years experience who is highly regarded in the mental health community—I think it is fair for me to say that she is unanimously supported as the person to chair the Mental Health Implementation Group—to work with consumer groups, clinicians and, of course, people with mental illness to determine the best way to spend that money.

Dr Bashier and Professor Beverley Raphae—who runs the Centre for Mental Health, community-type health, who is well regarded in her field—are overseeing that work. I have a meeting with Dr Bashier later this week to hear some of their preliminary findings. I am told by the advice that the additional funding will provide 700 additional direct care staff, 12,000 new community service clients, resulting in, based on the number of times they would have contact with them, an estimated 450,000 new community service contacts, 45,000 extra emergency department clients, and 192 new acute beds, including 90 in rural areas.

Mr REID: I should add that the focus of the centre for mental health policy, in terms of mental health, is early prevention and community-based services. The vast majority of the moneys will be directed into community-based care.

The Hon. A. G. CORBETT: Can you give me that information?

Mr REID: When the committee has deliberated—it has not yet met yet—and decided how to expend those extra funds, we will provide you with that information. I suspect it will be another month or two before it makes a final decision. Those additional dollars start growing as of 1 July.

Mr KNOWLES: I should correct the amount $36.5million in 2000-01; $28.4 million in 2001-02; $42.6 million in 2002-03. The total of those three amounts is $107 million. It is not cumulative so it is a whole lot more, and that is very exciting.

CHAIR: It is different from the $20 billion beat-up.

Mr KNOWLES: Is that a question?

CHAIR: No.

Mr KNOWLES: Could I have the Commonwealth budget paper please?

The Hon. JENNIFER GARDINER: I refer to the last Auditor General's report, which indicated that in 1998-99 there were substantial movements in funds across the area health services because of patient flows in line with the resource distribution formula [RDF] policy. That data shows that Central Sydney, Northern Sydney and South Eastern Sydney received substantial amounts under the scheme, whilst all other areas lost substantial amounts. Do you anticipate that that will be the same pattern in the coming year and, if so, what implications are there for the rural and regional hospitals in particular?

Mr REID: There are substantial flows of patients across areas. Some of those flows are for logical reasons—the two logical reasons being the provision of high-level tertiary services, which tend not to be

provided in every area health service; and if a hospital is across the border and closer to you. For example, a lot of people in South East Sydney flow into Canterbury Hospital from just across the border.

CHAIR: Or Coolangatta flows into Tweed.

Mr REID: Or Coolangatta flows into Tweed, or the Southern Area Health Service flows into Canberra, or Wodonga flows into Albury, or Broken Hill flows into Adelaide. At the moment there are two things happening. There is an issue in terms of the budget announcements which are coming through Cabinet. There is now equity to be achieved in terms of the resource distribution formula over a three-year period within two percentage points in each area. This is something the Chair has argued strongly and vociferously for for many years and he is equally as pleased as us that this has to pass. This is something which has been on the agenda since 1978.

CHAIR: The Chair will not be verballed. The Chair does not agree it will come to pass in three years.

Mr REID: In that instance, there will be equity funding. However, we have not yet put into place the system of dollars following the patient, which is what you are talking about—whereby South Western Sydney, for example, would get the total amount of its dollars flowing into Central Sydney in the first instance. Once we put the reform agenda in place—which is part of the Minister's announcement, and particularly the aspects in relation to the Metropolitan Health Plan—we will start to establish the appropriate site and location for tertiary services and determine what is appropriate patient flows across borders. We are intending, probably in about three years time, to put dollars into place. There are very minor changes from year to year in terms of patient flow patterns. It has a very strong historical concept around it. I would not expect that even over the next three years there would be dramatic changes in patient flows.

Mr KNOWLES: My discussions around the State tell me that there are those who strongly favour an immediate shift to allow areas to hold their money—that is, to seize control of patient flows, to make the areas that are sending the patients hold the funds. There are those who say, "Please don't do that", and obviously it depends on history. We asked managers to give us a commentary on all that and you will find it is basically a matter of do your planning of your the location of services first and then allow those things to follow.

Mr REID: Yes.

The Hon. JENNIFER GARDINER: What do you say about the fact that the Chief Executive Officer of the Southern Area Health Service, Dr Sherbon, has told the shadow Minister for Health that he would call for tenders from local private hospitals—

Mr REID: Do you mean Illawarra or Southern?

The Hon. JENNIFER GARDINER: Southern.

Mr KNOWLES: It is either Illawarra or Southern; what is it?

CHAIR: Illawarra.

The Hon. JENNIFER GARDINER: He told the shadow Minister for Health that he would call for tenders from local private hospitals to treat his local patients rather than lose those funds to the metropolitan Sydney hospitals. What do you say to his fears about the plan?

Mr REID: I do not think they are fears. As I said to you, there are three reasons why patients flow across borders. One is for very sensible reasons in respect of tertiary services, the other is in respect of where a hospital is closer—that is, across a border—and another reason might be where an area has historically been underfunded. As the additional dollars flow into Illawarra, they will start to make rational decisions as to whether they continue to contract or have those services provided from outside the area—and remember there was a significant increase in the funding for Illawarra. Their increase over a three-year period is going to be 16 per cent. In terms of their budget, that is quite a lot of money.

So they will start to make decisions in terms of those patients who are flowing for inappropriate reasons and are travelling long distances. They will decide whether they will contract out, whether they will have those services provided out of the hospitals within the Illawarra area—and that is a very rational decision that all areas

which gain will make. Northern Rivers, Central Coast, Mid North Coast, Hunter, Illawarra, South West Sydney are all gaining considerable moneys out of the achievement of equity over a three-year period. They will start to make decisions about whether they try to reverse patient flows which are inappropriate, and try to provide those services locally—which is to the good of local employment and, of course, consumers, who do not have to travel the long distances.

Mr KNOWLES: Illawarra has been historically underfunded on an equity basis. It will get a greater increase; nearly $70 million over the next three years

[*Short adjournment*]

The Hon. JENNIFER GARDINER: Minister, in last year's budget you indicated that the Health allocation would be $6.938 billion. In this year's budget papers additional funds have been provided. Can you confirm that the revised 1999-2000 Health budget is therefore $7.126 billion?

Mr KNOWLES: You have obviously raised this issue because Jillian Skinner did so in her contribution to the second reading debate on the budget. She is comparing actuals with budgets; our budget figures are budget to budget. Mr Reid might want to deal with it. While we are looking for that information, Brian, I place on record my apology to you about verballing you in your involvement in the Northern Rivers clinical council. I was advised, and in fact have now shown you the correspondence I had received, that you had replied as one of 35 clinicians to participate and in the process you advised me that you attended a preliminary meeting. I thank you for doing that and for your involvement.

CHAIR: One hundred people turned up and were eventually very enthusiastic.

Mr KNOWLES: Yes, and I can report the same sort of enthusiasm from around the State. I apologise and invite you to be part of that process when it is formalised.

Mr REID: Could you repeat the figures that you quoted, so I can verify them?

The Hon. JENNIFER GARDINER: The revised budget for 1999-2000 was $7.126 billion.

Mr REID: Yes.

The Hon. JENNIFER GARDINER: And this year's budget is $7.416 billion.

Mr REID: I confirm that.

The Hon. JENNIFER GARDINER: So that means that New South Wales Health has $290 million extra to spend than it spent last year?

Mr REID: No, you need to compare the budget figure—which is $6.938 billion with $7.416 billion.

Mr KNOWLES: You did this last year, the year before and the year before. Andrew Refshauge used to do it when you were in Government. It is the old system.

Mr REID: A variety of things occur during the year that may increase budgets, such as awards and drug reform—which was an issue last year. A range of things occur in any single year, and may well occur in respect to the $7.416 billion, which result in budgets above that which is initially allocated. I think that has occurred since time immemorial in the health system, and we would expect it to continue. The only true comparisons one could make at a point in time is between the 1999-2000 initial budget, $6.938 billion, and the 2000-01 initial budget, $7.416 billion.

The Hon. JENNIFER GARDINER: It certainly gives a different picture to the one you tried to create in March this year when you said that New South Wales Health would get $412 million extra in this budget.

Mr KNOWLES: No, let us do away with this nonsense very quickly. Your Treasurers, my Treasurers, every Treasurer and indeed every part of this budget paper and every set of budget papers is compared. I am not going to bore you with the figures, but I have them here right back to 1992-93, when Ron Phillips was the Minister. You compare budget figures to budget figures, that is how budgets are built. Mr Reid has given you a

very sensible explanation about what happens in every budget year, as has been well documented. These things are the stuff of Oppositions when they have not much to say—and I confirm that the New South Wales Labor Opposition probably said it when it was in Opposition.

CHAIR: Minister, stick to the question.

Mr REID: I will relate the actual figures quoted. If one goes to page 10-10 of Budget Paper No. 3, the recurrent appropriation cash flow from Government, the budget in 1999-2000 was $5,476,726,000; the 2000-01 budget, $5,890,859,000. The difference between that is $414 million. Through certain accounting things we actually got an extra $2 million on what was in the ministerial announcement of $412 million and the budgets reflect the announcement made by the Minister on behalf of the Government.

The Hon. JENNIFER GARDINER: I will move on to another public relations exercise. You said in your March media release, "We will allocate $40 million immediately to address rural debt. All debts accumulated over the last 10 years by rural area health services before the end of this financial year will be eliminated. "But, as we all know, the Auditor General has told the Parliament that the debt owed by the regional or rural health services is more than $140 million. Can you now confirm that what you meant by that media statement was that you would be eliminating some rural debt, but not the current amount?

Mr KNOWLES: I refer you to the answer I gave in the House on this matter and to any number of publications in rural New South Wales. The Dubbo *Daily Liberal* discussed this at some length. Of course, in New England—where we wiped $10.5 million of those traditional Department of Health loans—it was well regarded. I have made it very clear.

CHAIR: Poor old Northern Rivers did not get much.

Mr KNOWLES: Northern Rivers did not have the degree of loans.

CHAIR: No, so they were punished for being good managers.

Mr KNOWLES: With respect to you and your colleagues in Northern Rivers, maybe you should have been bright young things with your scalpels and cut faster and more efficiently than the people in New England. That is a matter for congratulations, but I am not trying to be punitive here. I have tried to pick up on what Mr Sinclair advised us to do after exhaustive consultations around New South Wales, reinforced by my conversations around New South Wales: to give the area health services a fresh start. The one thing I will not do—and I make it very clear—is act as a debtor-creditor agency in lieu of what should be good and competent management.

My experience with the health system—over many, many years of observation—is that the budgets seem to be the starting point to grow from rather than something to work within. In response to the requests and recommendations of Mr Sinclair, I have been wiping out those historic loans that have burdened those area health services for so long. I expect them to manage within the context of their budgets; it is not an unreasonable thing to ask. Nobody is pretending that this will happen quickly, that all these new rigours will occur quickly, but they have to start somewhere. The fact that Northern Rivers has been an efficient operator—and there may be other area health services that have been as efficient—does not mean that I should not do something about the less efficient ones, just because you have been good, Mr Chairman.

Mr REID: I shall make some specific comments about the $140 million quoted in the Auditor General's report. That figure not only includes rural health services' level of debt to the department but also includes, as the Auditor General would confirm, payments due to creditors at balance date, which is 30 June 1999. Thus $140 million was not a comparable amount; it is distorted by the inclusion of accounts payable on hand as at that date. The $40 million debt related to a true long-term debt which had been incurred by area health services. The debt eliminated by that process ranged from $0.4 million in Northern Rivers; $10 million in New England; $1.3 million in Macquarie; $7.5 million in Mid-Western; $4.1 million in the Far West; $13 million in the Greater Murray; and $1.3 million in Southern

The Hon. JENNIFER GARDINER: Is that all going to happen on 1 July?

Mr REID: It has already happened. It will happen in the 30 June 2000 statements.

The Hon. JENNIFER GARDINER: Mr Reid, how much money is owed right now by the rural area health services in the form of what you were just talking about: the accounts payable?

Mr REID: I ask Mr Barker to answer that question.

Mr BARKER: There is zero in operating debt as a result of the Minister's announcement. No rural health service has any operating debt to the department.

The Hon. JENNIFER GARDINER: What about creditors?

Mr REID: No, that is another issue. Your question asked about debt owed to the department. The $40 million wiped the debt owed to the department. No area health service owes an operating debt to the department. The creditors are another issue.

The Hon. JENNIFER GARDINER: We will move on to the creditors.

CHAIR: What about last year's overruns? That is a current debt—overruns on expenditure.

Mr REID: Sorry?

CHAIR: You talk about the non-currents, the $40 million. What about the currents which include overruns from last year's budget? The other issue is how much is needed to be paid to creditors?.

Mr BARKER: On the current year basis—which I assume you are talking about, and not cost of services operating results—we still have another four weeks of the financial year. That is moving along and they are all being separately assessed on a regular basis.

CHAIR: How much is that?

Mr BARKER: That varies.

CHAIR: Could you get back to us with that?

Mr BARKER: We will not know until 30 June, to be quite honest.

CHAIR: You must have some idea where they are going to end up at this stage. We are only a few weeks off..

Mr BARKER: It depends on how things pan out.

CHAIR: Can you give us your best guess?

Mr KNOWLES: No, we are not guessing.

CHAIR: That is what he gets paid for.

Mr KNOWLES: No, he does not get paid to guess.

CHAIR: Yes, he does.

Mr KNOWLES: We will not know until the annual reports come out in November.

Mr REID: We will take the question on notice and when we have the information we will come back to you about that.

CHAIR: In November?

Mr REID: No, when we have the information.

The Hon. JENNIFER GARDINER: I refer to the earlier part of the question: the accounts payable. What is the situation with those in terms of each of the regional health services?

Mr REID: In terms of each area health service?

The Hon. JENNIFER GARDINER: Yes.

Mr REID: As you know, we have a policy. Is this creditors?

The Hon. JENNIFER GARDINER: Yes.

Mr REID: Any amount of creditors, over a period of time?

The Hon. JENNIFER GARDINER: Yes. Well, as of now.

Mr REID: Or over 45 days? I am trying to get a clarity on your question.

The Hon. JENNIFER GARDINER: Over 45 days.

Mr REID: We will take your question on notice and come back to you. We do not have the details of the creditors over 45 days with us at the moment. As you know, it is departmental policy that areas clear their creditors as best they can in a 45-day period. We have injected money into the system to help them do that over a period of time. Some areas at the moment, as you are well aware, have a creditor problem over 45 days. We are liaising with those areas, as we talk, about how they can manage their creditors within the timeframe we have set. I should add that there are considerable debtors that are owed to the department, which are of equivalent amount to creditors, which is an issue to us—not least of which are issues in relation to private health insurance payments where they do not appear to adhere to the same policy of endeavouring to clear their creditors, in that case, within a 45-day period.

CHAIR: We will obviously seek advice on the department's cash flow.

Mr REID: Thank you, Mr Chair. The other thing that has compounded it is, of course, the Commonwealth Government's decision in relation to escalation. The Commonwealth has agreed to allow a figure of 0.5 of 1per cent, notwithstanding the independent arbiter identified a figure of—

CHAIR: This was run last year as well. It is the same.

Mr KNOWLES: The important thing to note, in fairness to Mr Reid and the point he is making, is that, yes, it is exactly the same issue that was raised last year. It is still unresolved, despite during the intervening period the Commonwealth Minister, Dr Wooldridge, nominating, and Territory Ministers agreeing to this nomination, Dr Ian Castle, the former Commonwealth Statistician, to determine independently the hospital cost index.

CHAIR: That has not been done.

Mr KNOWLES: My word it has been done. Dr Castle reported back to Dr Wooldridge in November last year, clearly recommending a growth index of 2.2 percent. That, we can only assume, was taken to the Commonwealth Cabinet and bounced out the back door, because the letter we got—not New South Wales, the Territory Health Ministers—was that we will pay you 0.5 per cent, which is the default indexation under the Australian Health Care Agreement. The difference between those two figures in New South Wales in the next four years is $300 million.

Mr REID: It is $300 million, and $1 billion for Australia.

Mr KNOWLES: And $1 billion for Australia. That is a year after the time when it should have been determined. So we are now in the period—or fast approaching the period—when we should be negotiating next year's indexation, but we are yet to determine indexation and we are yet to receive any money. In recent times I have genuinely endeavoured to work with Dr Wooldridge on these matters. These are serious issues that need a national and unified approach, but this is a—

CHAIR: This is a disgrace. We heard this last year.

Mr KNOWLES: It is occurring again this year. In fairness to us all, everyone understands that at the time when they are putting in excess of $2 billion in to prop up the private insurance schemes, it is worth noting that the—

CHAIR: To cut you short—

Mr KNOWLES: No, please—

CHAIR: It is perfectly clear that in the same way as you do not respond to escalation in real costs in your estimates in your budgets, the Commonwealth agrees with you, in the terms of its agreement, that the default was 0.5 of 1 per cent.

Mr KNOWLES: That is simply not true. Your assertion is wrong. No-one agrees, not even Mr Wooldridge's appointed independent arbitrator, with the figure the Commonwealth Government has adopted. That is the point. We simply say whatever we might think is a fair and reasonable amount, whatever the AMA might think is a fair and reasonable amount, let us adopt the umpire's decision, the umpire appointed by Dr Wooldridge. He got the report in November; he has not been able to deliver. That means that New South Wales has $300 million over the period of the Health Care Agreement, and that is something that costs the public hospital system. At the same time, he can find money to continue putting into the private health insurance industry. He can make sure that as a consequence of that the share prices of every private health organisation has increased, the ratings agencies have bumped their credit ratings up and in the end—

The Hon. JENNIFER GARDINER: Who is going to answer my question?

Mr KNOWLES: This is a disgrace to the system.

The Hon. JENNIFER GARDINER: Mr Reid, can you confirm weekly updates of the creditors over 45 days for each of the health services?

Mr REID: We get regular updates on creditors. As I said to you in answer to an earlier question, we are concerned about a small number of areas that are having critical problems over 45 days.

The Hon. JENNIFER GARDINER: There are quite a lot over 90 days, are there not?

Mr REID: There would be very few of those issues over 90 days. We are liaising with those areas at the moment about how to address their creditor problem. One of the great outcomes of the health reform agenda announced by the Government is for the first time we have three-year budgets rolling out, so there is a degree of certainty within the areas about their budgets, so they are able to plan far better than they have in the past. I should add that nowhere else in the New South Wales Government, nor in any other State Government nor the Federal Government, in any agency, is there a guarantee of three-year budgets. Those budgets have real growth factors; those budgets also take account of equity being delivered over a three-year period. We feel far more confident that those issues, such as creditors extending beyond the 45 days, can be addressed in a more rational plan over a period of time.

The Hon. JENNIFER GARDINER: If you have regular updates, could you, while we are waiting for the figures that you have taken on notice for the end of the year—

Mr REID: I will take that on notice, yes.

The Hon. JENNIFER GARDINER: In the meantime, could you provide the Committee, again on notice, but perhaps faster, the accounts payable figure for each of the area health services as at 31 May?

Mr REID: Over 45 days?

The Hon. JENNIFER GARDINER: Yes.

Mr REID: I will undertake to do that.

The Hon. JENNIFER GARDINER: How much money is owed right now with respect to accounts payable and current borrowings for the metropolitan area health services, to follow on from the earlier question, the New Children's Hospital and the Ambulance Service?

Mr REID: The same—I assumed your first question related to everyone, but it actually related to the area health services. I will provide details on all 20 area health services.

CHAIR: So you will take that question on notice.

The Hon. JENNIFER GARDINER: Minister, would you confirm that the Wentworth Area Health Service will receive an additional $8.6 million in 2000-01, but it incurred $31.3 million in increased cost of services in 1998-99? What is the forecast net cost of services for Wentworth for 2001?

Mr KNOWLES: I will take that question on notice. I do not have the figures here.

Mr REID: I can provide some of those details if you wish, Minister. In the five years between 1995-96 and 1999-2000, Wentworth Area Health Service received increased budgets in every year. In 1998-99, its budget was $108.5 million, an increase of $65.2 million, or 63.8 per cent more than in 1994-95. In anyone's language, that is a real increase. In 1999-2000, the recurrent budget, cash budget, was $187.7 million, which is an increase of $4 million over the previous year. And if we go to what they have received in the three-year increase, with the three-year budget running out in the future, the percentage increase for Wentworth over the next three years is 11.9 per cent, which is a real terms increase of 5.2 per cent. In addition to that, there are a range of other things which are not in that where there will be additional moneys flowing into Wentworth in relation to mental health and a range of other services.

CHAIR: We will give you those questions on notice, but they are very specific. They do not talk about 1994-95, nor growth over time. What the Hon. Jennifer Gardiner asked you was, specifically, that Wentworth received $8.6 million this year, although on the last year's budget change it had spent $31.3 million increased cost of services. That was the specific question. We will provide you with those questions on notice.

Mr REID: Thank you, Mr Chair.

Mr KNOWLES: You can expect an invitation to the opening of the new hospital.

The Hon. JENNIFER GARDINER: Minister, I ask a question in relation to the capital works aspects of the budget. With respect to the Rural Health Program, phase 2 and then phase 3, could you list which projects are included in the program? Could you tell us which projects will be multi-purpose health services and which ones will be primary health care centres?

Mr KNOWLES: We will take the question on notice. They are outlined in the documentation, but I will make sure you get an answer to that.

The Hon. JENNIFER GARDINER: Can you indicate why the New South Wales Breast Cancer Centre at Westmead, which should have been completed by now, has been pushed back to 2001? We note that last year the Government allocated $2.4 million for this spin-off project, but spent under $30,000.

Mr REID: Part of the difficulty, Mr Chair, is that Commonwealth-wide we have a Public Health Outcomes Funding Agreement, and the Commonwealth has capped, unfortunately, breast screen funding under that agreement. That agreement requires all States and Territories to work towards a 70 per cent bi-annual screening participation rate for women aged between 50 and 69. The funding currently provided is insufficient to allow the 70 per cent participation rate which is our desired aim. So we have performed significantly more screening than has been allowed under the Commonwealth cap, and that is partly because it would be inappropriate to decline to provide services to people who fall on either side of what is deemed, in terms of evidence-based medicine, to be the group for whom the investment money would get the best return. The unfortunate thing about the breast screening program is that we are very much stymied by the caps that the Commonwealth has placed on this State. This is also an issue in other States, and it is an issue that has been considered in Commonwealth-State forums.

Mr KNOWLES: From memory, it was the subject of discussion at the health Ministers' conference.

The Hon. Dr. A. CHESTERFIELD-EVANS: I am very concerned about the level of the Coffs Harbour and District Hospital.

Mr KNOWLES: It is sinking or something?

The Hon. Dr. A. CHESTERFIELD-EVANS: What year flood level is anticipated being used? What allowance has been made for developments in the catchment above it? And what is the safety level above those levels in metres, that is the floor level of the Coffs Harbour hospital? Do you want to take that on notice?

Mr KNOWLES: No, I will try to answer the question—you do not do 13 years in local government and not be able to talk about flood levels. I will seek to verify this in its entirety, but I had the great pleasure of witnessing the cutting out of the ground, the slabs and the earthworks, and all the activities of the new harbour—which I might add is due to the Government.

The Hon. JANELLE SAFFIN: Did you turn the first sod?

Mr KNOWLES: No, I did not. I think the Minister for Public Works did. In terms of the history of the site, this was the project that Ron Phillips did not get up; this is the project that Ron Phillips steered through Cabinet. It is either the one in 100 or the probable maximum flood [PMF]. We are now constructing the hospital as an $82.5 million, or thereabouts, one-stage project. It was originally proposed as a $53.4 million stage one project, which would have excluded the mental health facilities. When I visited Coffs Harbour—I think it was the third hospital I visited, after Tweed and Lismore, as the new Minister for Health—it became obvious that if that hospital was not built as a one-stage project we would not be fair to that community, and I place that on record.

The Hon. Dr. A. CHESTERFIELD-EVANS: And you could not sell the other one.

Mr KNOWLES: That is hardly the point. The mental health facilities at Coffs Harbour need replacing with some urgency, and I suspect that has been the case for at least 20 years. It goes to the very heart of that region's ability to attract work force and its capacity to provide quality service in a facility that should have been in place a long time ago. In the last budget we took the step, much to the Treasurer's credit, of funding this project in one stage. We have also allocated to the Coffs Harbour region a 29.3 per cent increase in recurrent funding over three years as part of the redistribution of Health dollars. The valuable thing about the site is that it is one site. When I was with the project—

CHAIR: Minister, I ask you to be relevant to the question, not to give us a dissertation about—

Mr KNOWLES: You asked the question.

The Hon. Dr. A. CHESTERFIELD-EVANS: I wanted to know about the flood levels. I also want to know the completion date.

Mr KNOWLES: My recollection, from working on the flood plain management levels in New South Wales in about 1988, is that for a facility of that type it is the one in 100 year flood level, but it may have been updated now to the PMF. It is one of those two, but I will check for you and make sure that you get that information. I understand that the site has historically been part of a creek that borders the boundary or something, and in my discussions with the geotechs and the engineers on the site they were really chuffed about the way that they had come to the hydrological solutions for the management of the site.

Mr REID: The construction work has commenced. It is on time, on budget and will be completed by October 2001, occupancy will be early 2002.If I can make a note, Mr Chair, the last time the honourable member asked about swamp lands around hospitals was last year in relation to Bateman's Bay District Hospital, where he did a tour around the swamplands. He had some concerns, you may recall, about the shade around Batemans Bay hospital, and I undertook that we would address that because it was a slip, slop, slap issue. I would like to table the photographs of the new pergola that we have put in place for the shade at the hospital.

Documents tabled.

The Hon. Dr. A. CHESTERFIELD-EVANS: Is this the public area of the hospital?

Mr REID: Yes.

The Hon. Dr A. CHESTERFIELD-EVANS: Is the Minister aware that the surgery departments in the three base hospitals located at Coffs Harbour, Port Macquarie and Taree—who have had to cut to two surgery days per week—have been informed that they are expected to function in this pattern until August?

Mr REID: I will take the question on notice. The key thing about that area is the enormous growth factor that is going to occur over the next three years in that area. For the first time, as I mentioned earlier, since 1978 and earlier—where it has considerably been undeserved in terms of its growth factor—there is a 29 per

cent increase in the budget. It is the biggest in the State. We have new hospitals, we have new services, and we are rebuilding Taree Hospital.

The Hon. Dr A. CHESTERFIELD-EVANS: But if the numbers have gone up 29 per cent, why would you cut the existing services back to two days a week? It seems a total contradiction.

Mr KNOWLES: We are not accepting the assertion at this stage; we said we would check it. I have had assertions made by, I think, a surgeon who came to see me who works at Manning Base Hospital, Taree, about the draconian cutbacks, only to find that the reason they were cut back was in relation to the reconstruction of the hospital, and the reconfiguration of some of the activities. So we will check. I am not saying it is not happening out there; I am saying we will take your assertions on board. The problems the mid North Coast had in terms of its capacity to deal with demand are not new. It is like Northern Rivers. They have been traditionally and historically grossly underfunded. We have begun to do something about that. No-one pretends that it is an overnight fix. Everybody understands that to make the improvements you not only need the investment in capital—a new hospital at Coffs Harbour, a new hospital or total refurbishment at Manning, Taree hospital - you also need clinical involvement.

When representatives of the medical staff councils from Manning and Coffs Harbour came to see me late last year they asked me to recognise the underfunding of the region and, if I did, they were—as Dr Pezzutti has indicated a willingness relating to the Northern Rivers—willing to work sensibly and systemically through the problems that have manifested themselves in those regions for years. I will not remind you too much that Port Macquarie Base Hospital is not a creature of this Government; it is a creature of the former Government—an heroic experiment in the privatisation of health facilities. I say publicly that both Health Care of Australia and the Government agree that it is not the best model these days. Health Care of Australia, of course, has had to think about the way in which it provides health services, and the models it presently uses are vastly different to what they provided back then.

CHAIR: It has been copied in Tugun by the Beattie Government—you will be paying some of the costs.

Mr KNOWLES: That is a clear indication, Mr Chair, that the problems you raise—assuming your assertions are correct—are part of the contractual arrangements that the then Minister for Health, Ron Phillips, was part of and so proud of. In the end, the way we will deal with those issues on the mid North Coast, the Northern Rivers, the Central Coast or South Western Sydney is with clinical involvement, and there is a planning process going on up there involving clinicians, similar to the one that Dr Pezzutti is aware of in the Northern Rivers. I have had those clinicians say to me, "If you give us the resources, we can demonstrate to you how we can use those resources more wisely and effectively, and cope with the growth."

We have done what we have been asked to do: certainty of budgets for three years, increased funding on an equitable basis, and a real opportunity for clinicians to buy into the planning process—something I think most people would regard as a sensible way to proceed. It is very much as a partnership that we will see improvements in those areas, and I sincerely hope that those individuals who saw me in November, who got what they asked for, are going to be part of the new framework to make sure that whether it is in the privatised Port Macquarie Base Hospital, or the rebuilt Manning Base Hospital, or the brand new one-stage $80 million Coffs Harbour Hospital, that we are delivering services in the best possible way for those communities.

The Hon. Dr A. CHESTERFIELD-EVANS: Can I confirm that the question on the flood levels was taken on notice?

Mr KNOWLES: Yes.

The Hon. Dr A. CHESTERFIELD-EVANS: With regard to the question of the delegation on 26 November, I understand that they asked for an additional $12.2 million, and you have put an additional $46.8 million into the budget this year, according to the budget papers. This sits oddly with the cuts to two days per week, if that is the case, and the 29 per cent increase in load in that area, does it not?

Mr REID: We have not accepted that. As we said, we will come back to you with your assertion about the cuts, but we need to bear in mind that the additional dollars flow from 1 July of this year. Now where there are other areas who are in difficult financial positions, but are receiving quite considerable dollars, we have tried to accommodate them in ways so there is not service cuts, and new dollars enough to flow into those areas. If

there is an issue in those areas in terms of how they are coping between now and the end of June, which as you know is only a month off, then we will obviously look at that as a matter of urgency.

Mr KNOWLES: One of the individuals who came to see me was Bill Ross, who was as adamant as anyone else that we needed to make changes. He is now on the public record—and I have read some of his statements into the record of these proceedings tonight—congratulating us on what we are doing. So I think we can afford to be a bit more positive about the prospects for collaboration and improvement, recognising that none of the tasks that we need to undertake will be occurring overnight, and they will not be without debate within the clinical routes themselves. I addressed the workforce in Coffs Harbour. It was an interesting observation: me talking to them as the Minister, and when they began to talk about what they would do with some of this new money with enthusiasm it did not take long for some of the clinicians, with great respect to all of them, to say "Me, me, me, me—more surgery time for me." Then other people were saying, "Hang on a minute, what about community services, what about primary care, what about other critical services?"

The Hon. Dr A. CHESTERFIELD-EVANS: They always get a bad run, do they not?

Mr KNOWLES: That is right. We have not said, "Here's the money" and be prescriptive about how it will be spent. I have got no doubt you will find surgeons up there who will say, "I could use another couple of theatre days", and all those sorts of things. What we have said is, "You all have to work together, everybody in the room at the same time, at the same table, with the money on the table, and do some serious planning." In relation to your Northern Rivers experience, you said that you were part of a highly cynical—

The Hon. Dr A. CHESTERFIELD-EVANS: I was not part of the cynical—

Mr KNOWLES: No, you were an enthusiast, and I thank you for that enthusiasm. But when people realise and believe that it is the "top down, bottom up" approach, as I think you described it, you do see a bit of a change in attitude, and it is early days. I think the best way to proceed, and how to use—

The Hon. Dr A. CHESTERFIELD-EVANS: This is good stuff, but it is not answering the question.

Mr REID: It is better than good stuff.

The Hon. Dr A. CHESTERFIELD-EVANS: It is good, and I am all for consultation. However, I really want you to answer my questions.

CHAIR: Would you agree with HEO and make the cost comparisons between Port Macquarie Hospital and Nepean Hospital publicly available?

Mr KNOWLES: I would have no objection to that.

CHAIR: You have no objection?

Mr KNOWLES: I have no objection. Wait a minute Brian, don’t get tricky. You have asked me a serious question. I did not sign the contracts and I do not have them in front of me. I do not know what the confidentiality might be. As a matter of principle I am more than happy for that information to be put on record.

CHAIR: I understand that.

The Hon. Dr A. CHESTERFIELD-EVANS: Health research has gone up in the budget. Minister, how much of that research is investigator-driven—say a tender is called to do a specific project? There was a lot of controversy in the Baume report which looked at how Cancer Council research money was done, as to whether it simply said, "Okay, there is this much money put in a project and we will fund the best ones" in which case the investigators were driving the direction of the research in terms of their interests, as opposed to the Cancer Council saying, "These are the questions we want to answer to lessen cancer in New South Wales." What is the Health Department’s attitude to that?

Mr REID: The research grants that were increased in the recent budget, which took us from $11.5 million to $20.5 million in 2001-02, basically relate to infrastructure research. This question arose in similar fashion last year. Seeking research for specific research items is traditionally in Australia a function that is directed through the National Health and Medical Research Council [NH&MRC]. The contribution of the

States to research in all States has historically been to provide infrastructure to assist that research take place. There has been a boost of medical research and bio-technology. We conducted a comprehensive evaluation of a range of bids that came in: the Garvan Institute got $9 million, which was an infrastructure grant; the Prince of Wales Medical Research Institute got $4 million; the Children's Medical Research Institute got $3 million; and so on.

Your question referred to what is investigator-driven and how priorities are set in an Australian context. This issue was discussed in some detail at the NH&MRC meeting in Hobart last week. It relates to a Commonwealth issue. There is a major push in all States and Territories that there should be a far higher proportion of priority-driven research in proportion to what historically in Australia has been predominantly investigator-driven. The priority establishment should be particularly around the area of health services and those other areas which have a high return in terms of better health care, more effective health care. Historically Australia has done fairly poorly in priority-driven research activities and has done very well in investigation-driven research. The Melbourne grouping being a classic example.

CHAIR: Like AIDS?

Mr REID: Yes. The general answer to your question is that none of the research grants in New South Wales went to either investigator-driven or priority-driven research. They were research grants around infrastructure. There is a vigorous debate going on now within the national sphere about the extent to which we can get a greater proportion of research, whereby the priorities are established by government or other key. The review of medical research is also in the Wills report, as you are probably aware. At the end of the day the proportion of priority-driven research will still be a fairly small proportion in the context of the total research budget in the Australian context.

The Hon Dr A. CHESTERFIELD-EVANS: That worries me.

Mr REID: It also worries me.

The Hon. Dr A. CHESTERFIELD-EVANS: How much public health research will there be versus benchtop research? The Wills report tends to be driven by the concept that joint venture to make a profit research gets ahead of public health, which may have a higher payback in public health terms.

Mr REID: I think that is true. This has changed somewhat over the years, but historically in Australia the overwhelming majority of research funded out of NH&MRC was benchtop-type research. People had the greater capacity to formulate a research proposal and get a peer review if it was driven through that benchtop-type research process. Obviously, many more variables enter the fray when it is a population-based research or something which is specific to health services research. Historically, they have been poorly dealt with through the National Health & Medical Research Council. You will recall that the establishment of a public health research and development committee as part of the NH&MRC went part of the way to address that issue, and there has been some counterbalance over the last 15 years so there is a slightly higher proportion of public health research. However, I, like you, share your views that this is still pretty myopic in the total picture of research, and that is why there is healthy debate going on.

The Hon. Dr A. CHESTERFIELD-EVANS: Is the State tied to infrastructure such that it will provide buildings and let other people work the lists out?

Mr REID: No. All States are of the view that there should be one central point. You do not want seven States replicating a range of research activities. It has generally been agreed at all levels of government that the role of the States in research is to assist to attract and reclaim research within that State through infrastructure grants. The way we provide those infrastructure grants—just to make sure it is absolutely transparent and related to quality—is in a fairly tied arrangement to the extent to which there is peer review of the research emanating from those research institutes. It is not a coincidence that Garvan gets the greatest majority of our infrastructure grants; the highest proportion of peer-reviewed research literature comes out of that institute.

CHAIR: The biggest growth band in western Sydney.

The Hon. Dr A. CHESTERFIELD-EVANS: Yes. If publication is the currency of this, it somewhat irritates me. I refer to Corrections health. What consultative mechanisms exist to receive community input on Corrections health services? With what agencies do the Corrections Health Service consult about the health of prisoners?

Mr REID: We would have to take that question on notice.

CHAIR: That question has been taken on notice.

Mr REID: I should just add that Corrections health has been totally revitalised in the State over the last five years, particularly under the great leadership of the recent CEOs.

CHAIR: Deborah Piccone, who is with us this evening.

Mr REID: I would be too scared to say otherwise.

CHAIR: She is the case mix lady.

Mr REID: To correct the Chair, she is the episode funding person inter alia.

CHAIR: So she has moved; that was called case mix.

Mr REID: But there are a range of things whereby the Corrections Health Service undergoes community consultation: prisoner services consultation, liaison between the various bodies that represent the interests of prisons, prisoners and the people who work in those services. We will give you a detailed brief on that.

Mr KNOWLES: Is there anything specific you want to know, or do you just want a general answer on consultations?

The Hon. Dr A. CHESTERFIELD-EVANS: What mechanisms exist? There has been a lot of dissatisfaction from prisoners and prisoner groups, particularly in the women's area, which I have been studying with the committee inquiry into prison numbers.

Mr KNOWLES: In addition to us providing you with what we think we do, would you help us?

The Hon. Dr A. CHESTERFIELD-EVANS: Certainly, there will be transcripts about the inmates' comments.

Mr KNOWLES: It may improve the position.

The Hon. Dr A. CHESTERFIELD-EVANS: We are happy to provide that.

Mr REID: We would welcome that.

The Hon. Dr A. CHESTERFIELD-EVANS: What percentage of the Corrections Health Service budget is allocated to women's issues?

Mr KNOWLES: We will take your question on notice.

CHAIR: That question was taken on notice.

The Hon. Dr A. CHESTERFIELD-EVANS: How is their program evaluated, and by whom?

Mr REID: We will take that question on notice.

The Hon. Dr A. CHESTERFIELD-EVANS: Will those evaluations be made available?

Mr REID: Yes.

Mr KNOWLES: I ask Debbie Piccone to answer these questions.

Ms PICCONE: I can answer most of them for you.

The Hon. Dr A. CHESTERFIELD-EVANS: What consultative mechanisms exist? With whom did the Corrective Health Service consult about the health of prisoners? What formal consultation was there?

Ms PICCONE: There is a formal consultative arrangement with various range of groups that we group into the following categories. There are people who have an interest in the welfare of offenders in custody and who have a direct relationship. I will give you an example: the organisation that represents the children of inmates. There is another organisation that looks after the welfare of women in prisons. Then there is another group that I call the sort of statutory corporations human interest, human rights-type groups. Then there are all the government corporations. I think on last count, and I could be corrected, Mr Chair, that there are more than 32 organisations that we consult with regularly. What used to bring those people in, because they provided valuable feedback on the service, every three months to a group briefing. If there was a particular area of interest, say, the International Jurists have a great interest in the management of forensic patients, we would do separate briefings. It just depended on what the issue was.

The Hon. Dr A. CHESTERFIELD-EVANS: The question was about consultation rather than briefing.

Ms PICCONE: In relation to consultation, we sent policies out, we sent our health plan out, we sent segments of relevant parts of the health plan out, as we developed them, to various community representative groups.

The Hon. Dr A. CHESTERFIELD-EVANS: Do they help you develop it or is it for you to brief them?

Ms PICCONE: I will give you an example. I refer to the Indigenous Action Group, in terms of our Aboriginal health plan. We had a draft and we forwarded it to that organisation and it came in and had quite a lengthy meeting with us. It suggested changes to the approach that we had taken, in addition to the various community control groups, AMSs and various other groups. So each section of it is quite different.

The Hon. Dr A. CHESTERFIELD-EVANS: What form did the consultation take?

Ms PICCONE: There are regular ongoing meetings. I might give you a specific health plan: the Aboriginal one is a good one. We would send that out to the organisations that have an interest in that and invite comment back. If they felt they wanted perhaps closer input they would have a direct meeting with me and the staff member involved, who would make amendments accordingly if it was clinically appropriate to do that.

The Hon. Dr A. CHESTERFIELD-EVANS: What percentage was allocated to women's health problems?

Ms PICCONE: I cannot answer that directly.

The Hon. Dr A. CHESTERFIELD-EVANS: How are the programs evaluated?

Ms PICCONE: We have recently employed a professor for population health, Professor Michael Levi, who is also an international expert in tuberculosis and other areas. He is establishing, in addition to the normal clinical protocols of evaluation, with Sydney University—where we have just formed a collaboration—a formal evaluation of all our program areas.

The Hon. Dr A. CHESTERFIELD-EVANS: What percentage of the budget is allocated to post-release or after care programs?

Ms PICCONE: None of our Corrections Health Services' budget is; the general health fund is, in other area health services.

The Committee proceeded to deliberate.