GENERAL PURPOSE STANDING COMMITTEE No. 2

Wednesday 23 August 2000

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 10.00 a.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. J. H. Jobling.
The Hon. H. S. Tsang

PRESENT

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

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

As members would be aware, part 4 of the resolution referring the budget estimates to the Committee requires the Committee to hear evidence on the budget estimates in public. Under Standing Order 252 of the Legislative Council this Committee has resolved to authorise the media to broadcast sound and video excerpts of its public proceedings held today. The Committee's resolution conforms with the guidelines governing the broadcast of proceedings adopted by the Legislative Council on 11 October 1994. The attendant on duty has copies of those guidelines. I emphasise that only members of the Committee and the witnesses before them can be filmed and recorded. People in the public gallery are not considered part of the proceedings and, therefore, should not be the primary focus of any filming or photographs.

In reporting the proceedings of this Committee, as with the reporting of the proceedings of both Houses of Parliament, members of the media must take responsibility for what they publish and what interpretation is placed on anything that is said before the Committee. The Committee has agreed to the following format of the hearing. Questions will be taken one at a time. If anybody has any follow-up questions on an issue which is before the Chair he or she should not interrupt until that question is finished. Otherwise I will freely allocate time between participants. The Hon. R. D. Dyer has indicated that he might need to ask follow-up questions. However, until then I will simply move from member to member in a fair manner. I understand that we have from 10.00 a.m. until 11.30 a.m.—an hour and a half. Are there any questions before we commence?

Mr REID: No.

CHAIR: The Director-General has indicated that it would be helpful and it would save time if members who are asking follow-up questions on questions that were taken on notice at the last hearing direct the Director-General to the number of the question. Are there any questions?

The Hon. A. G. CORBETT: The areas that I think would be applicable to my questions are to be found in Budget Paper No. 3, Volume 2, program 48.1.1, Primary and Community Based Services and program 48.4.1, Rehabilitation and Extended Care Services. The questions I would like to ask focus basically on those people in New South Wales who, for one reason or another, are unable to attend their local general practitioner [GP] or who are unable to attend specialists; yet they are entitled to co-ordinated health care in their home environment. It seems as though over the last few years there has been an increasing tendency for GPs and specialists to ask patients to attend their offices as opposed to doing home visits. Would you explain to us why that trend has occurred?

Mr REID: I will divide that question into two parts and I will do my best to answer the question. I will look separately at general practice activities and then at the broad range of primary health care. The other major component of home visits would be rehabilitation services and chronic care management. In relation to the general practition component it is fair to say that, over a period, there has been a considerable decline in the extent to which general practitioners either make home visits or provide services in people's homes, notwithstanding what has been a fairly significant increase in the number of general practitioners throughout Australia in that period.

The factors which are causing that decline are many. I think at the second estimates committee hearing we spoke a bit about the circumstances at Dubbo, where three things have occurred. Doctors have closed their books, so they are not admitting more people onto their books. They are no longer doing any care after hours, and obviously that mainly incorporates home visits because that is when most of the after hours care takes place. They have also stopped bulk billing. So there has been considerable strain upon both hospital care through the emergency departments and on other forms of community care, in particular, the home visit type of community care and primary care or chronic care management as a result of those developments.

Sometimes there are good reasons why GPs have done that—reasons which relate to perceptions that they would have inadequate remuneration for home visits and inadequate arrangements whereby they can share after hours care. Obviously the proximity and the availability of emergency services often makes it a more

attractive proposition. This has been rectified in some parts of the State. I draw attention in particular to Maitland and Balmain and, to a lesser extent, Wallsend, where different trials are occurring of GPs coming together across various individual practices and sharing after hours care based in the hospital.

CHAIR: Of course, some of those trials are partly funded by the Commonwealth.

Mr REID: The trials are funded by the Commonwealth and they are funded by the State. So they are co-funders. The Balmain trial was a joint funding arrangement, as indeed was the Maitland trial. Those are really important elements that have arisen. It might be useful to note that the Labor Party announced after hours Medicare at its recent Hobart conference. That is something that the current Federal Government has indicated it wishes to pursue, so it is not necessarily a party issue. So the Government is really trying to address that issue of what happens after hours in relation to home visits or the management of other areas. That is the answer to the first part of the honourable member's question. There is a real problem there. Trials are being conducted in an attempt to rectify this problem. But, at the end of the day, there are far fewer home visits because of remuneration issues and because of the demand on doctors' services, and far fewer after hours services are provided anyway, be that in hospitals, by GPs or in their own practices.

I turn now to primary health care and chronic care management. I make it clear so that members can understand the distinction that the primary care activity predominantly relates around services provided to community health, community health nurses, allied health workers, social workers, and in most places in the State it is provided out of a discrete and identified community health centre, which dates back to 1975 when such centres first evolved. Expenditure in our primary care program budget this year was $564 million, which is 7.6 per cent of total expenditure in primary health care and which was an increase of 4 per cent over the previous year. We have been looking at how to use those primary health care services more effectively and we have been particularly looking at how they can have better linkages to general practice.

It is fair to say that Australiawide the different financing arrangements—this issue was discussed at the Senate hearing in Canberra last Friday—between general practice funds from MBS payments directed to the Commonwealth and our primary care providers has led to fairly disjointed interaction between the necessary back-up support for GPs doing home visits and a range of other things and the activities of GPs themselves. So there are many attempts now to try to bring those two areas back together. Just as a matter of interest, we are trialling a range of activities in primary care called Hospital in the Home. For much of chronic care management, rather than trying to—

CHAIR: When will that trial be completed? It has been going for a number of years.

Mr REID: A number of trials are occurring.

CHAIR: I know. There is a trial at Royal Prince Alfred Hospital.

Mr REID: Are you talking about the one at Bankstown and a number of other trials which have been going for a number of years?

CHAIR: I am referring to the central Sydney trial.

Mr REID: Essentially, they are no longer trials. I should not have used the word "trial". I think you are quite right. They are no longer trials; they are activities which are occurring and which I think need to be extended.

CHAIR: And they are also funded by the Commonwealth.

Mr REID: And they are funded by the State. So health care in the home is provided. If you have to have drips or other things people can be taught to do that in their homes, so it then takes place in their homes. So those sorts of activities are occurring. That is not done for economic reasons; it is done for clinical management reasons. I turn now to chronic care. In an Australiawide context the management of chronic and complex care has been the least developed. There are a range of areas where we can improve chronic and rehabilitation care. Currently chronic care, or what we call rehabilitation and extended care, takes about $1 in every $10 that is spent in the health system. So around $729 million is expended on rehabilitation and extended care. Those rehabilitation services are not just directed towards old people; often they are directed towards working age persons and children. They can cover things such as education programs, respite beds, outpatient clinics and hydrotherapy services.

We have a large budget for the provision of equipment, aids and appliances, community rehabilitation and long-term maintenance. The most common impairment benefiting from rehabilitation is stroke management. People who have suffered strokes comprise about 40 per cent of our rehabilitation beds. So they are the people who have a major requirement for chronic care. The second most common reason is physical recuperation following orthopaedic events, such as fractures and joint replacements. There are also issues around brain injury, spinal chord injury, chronic pain—which is a major area—cardiac and occupational rehabilitation.

That cuts across a number of agencies and is one area where possible silos in State agencies can inhibit people's access to programs, and I am particularly talking about the role of the Department of Community Services, the Ageing and Disability Department, the Health Department and other agencies. The Government, in its announcements on rehabilitation, highlighted this as a major area in which additional dollars are needed and in the action plan for health that came out in the budget last year as part of additional dollars going into the health system, $45 million over a three-year period was set aside for improvement of chronic care management. We have contacted all area health services to ascertain how they intend to expend that $45 million.

CHAIR: Specifically targeted at?

Mr REID: We have targeted it at cardiovascular, respiratory and cancer management. In terms of management we have set up a clinical group called the Chronic Care Clinical Information group chaired by Ron Penny, who is renowned in this area, and Steve Boyages, who is in the department. They have broad terms of reference and their brief is to find the best way to invest the $45 million so in those three areas we can start to get far better management of chronic care. They have received strategies from every area health service in the State as to how those expenditures might take place and at the moment we are looking at mechanisms for expending that money in those areas, which are essentially processes on how we can move chronic care management out of the acute end the spectrum and to have better investment in primary, secondary and rehabilitation areas of management and provide better linkages between general practitioners, primary care workers, emergency departments, in-patient care, rehabilitation services and across the Health Department, the Department of Community Services, the Ageing and Disability Department and other health service providers.

Once that package is put together it will be available on the Internet, together with the other activities around the government action plan. Your question is correct, that is the area we need to invest a lot of time and energy, as well as the dollars we have put in it, because it is a complex area of care. It often involves multiple diagnoses and a true team effort of managing that care and services across agencies and bringing together acute care and community care spectrums, which have not been brought together very well. It particularly involves bringing together general practitioners with other care providers.

The Hon. R. D. DYER: I was interested in what you had to say about practitioners at Dubbo. You used the words, "closing their books to new patients" and you mentioned that bulk billing is not available. Given that Dubbo is a prosperous regional centre, what happens to new residents who come to live and work in Dubbo? How do they undertake medical treatment? Are any measures undertaken to attract new practitioners to Dubbo?

Mr REID: At the moment they have difficulty getting on the list of individual practitioners. I am not too sure if the books are closed today, but they were certainly closed the last time I took notice. The Federal Government announced a range of strategies to try to get more trainees coming through the system who are rural based.

CHAIR: And funded it.

Mr REID: And funded it. It involves people signing up, often at the age of 18, and committing themselves in a bonded way before an occurrence that might occur 13 or 14 years later, so there is a degree of questioning, most people would agree, around whether that bonding arrangement will be successful and major organisations such as the Australian Medical Association and the College of General Practitioners have expressed concern. The Commonwealth is endeavouring to find mechanisms of attracting general practitioners into country towns but that is a long-term process.

In terms of our health services, the Macquarie Area Health Service has taken steps to ensure that the medical staffing levels at Dubbo try to keep pace with the activities and at the moment we are trying to attract a range of additional specialists to the Dubbo Base Hospital because many of these people you have mentioned tend to get managed in the emergency department of the hospital and are funded on a State basis. We are looking at how we can attract more specialists into the hospital but as you know the training and payment mechanisms for general practitioners are the responsibility of the Commonwealth.

CHAIR: I have heard that the Royal Prince Alfred Hospital, Hospital in the Home program has been stopped because they have run out of funds for it, is that true?

Mr REID: I am not aware of that. I would have to take that on notice. I make the point that there are a number of Hospital in the Home programs and my expectation is that over time there will be a blurring in the distinction between hospital walls and the provision of care in the community.

The Hon. A. G. CORBETT: I put it to you that one of the great frustrations for chronically ill people who are stuck at home is that it is immensely difficult to get specialists to visit them. The specialists, quite understandably, have various reasons such as the fact that they are too busy, it will take too much time, there are cost issues and the fact that they will have to put off other patients in order to do a house call. It seems that those who most need this service receive the least service because they are unable to get out of their home and visit the specialist. You refer to arrangements in the pipeline at the moment. Will those arrangements take into account the need for specialists to put aside a certain period of time each month to allow for the provision of home visits?

Mr REID: Once again the responsibilities for specialists in a community setting are a bit divided. If it is a specialist who is remunerated through the MBS arrangements, the State has no influence over how that external contractor, because they are not part of the New South Wales health system, develops his or her work practices. Once again, there are strong disincentives for those specialists to make home visits, mainly strong remuneration disincentives. I do not think they feel they are adequately rewarded.

CHAIR: But they could be arranged through the local hospital.

Mr REID: There are two ways in which they are employed: one through the MBS arrangements and under that arrangement there are disincentives for them making home visits because of the remuneration mechanisms that apply under the MBS payments to deliver home care. Where a specialist is employed through a hospital environment, there is some capacity in some cases for those specialists to make home visits, although it is far more likely that the nature of their employment has them linked to some outpatient service or a person visiting through the hospital environment.

CHAIR: Is it possible for a visiting medical officer under current arrangements at a public hospital to be asked to go and visit a patient in their home by the area health service?

Mr REID: It is possible.

CHAIR: Are they not tied to operating in certain facilities?

Mr REID: That is correct, but it is possible and has occurred.

CHAIR: I would like to comment on the fact that the answers to the questions taken on notice are far below a standard which I would think is reasonable and I reflect the view of a number of members of the Committee that these answers are almost an insult to our intelligence.

The Hon. R. D. DYER: That is an entirely subjective opinion, if I might say so.

The Hon. J. H. JOBLING: It is not reflecting on your intelligence, Mr Dyer.

CHAIR: I draw your attention to a commitment made by the Minister to me at the public hearing. I asked him about the cost comparisons between Port Macquarie hospital and the Nepean hospital publicly available. The Minister said, "I would have no objection about it." He then went on to say:

> 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 and I do not know what the confidentiality is that might be there but as a matter of principle I am more than happy for that information to be put on record.

The Minister came back and answered those questions but was hiding behind the confidentiality agreement.

Mr REID: I think you are referring to question No 25 in the first set of questions. There are two sets of questions.

CHAIR: Yes, the Minister is hiding behind the confidentiality agreement. Did your department seek to see whether Port Macquarie hospital and the private operator would be concerned about the release of that information?

Mr REID: It is true there is a confidentiality clause, which was entered into by the previous conservative Government, in relation the cost comparison component of the Port Macquarie contract and we have adhered to that confidentiality clause since the signing of that contract and we would intend to continue to adhere to it.

CHAIR: In other words, nobody can find out whether there is a yellow book comparison of peer hospitals such as Lismore, Tamworth and Port Macquarie?

Mr REID: You can certainly find out the cost comparisons of the public sector hospitals in the State by reference to the yellow book. I repeat: There is a confidentiality clause, which was drawn up, signed and entered into by all parties—Port Macquarie and all the other hospitals that are part of that cost comparison. That was the agreement and I do not intend to rescind that agreement.

CHAIR: Given that the Minister has no problem with its release and the chief executive officer in a previous inquiry that I undertook has no problem with the release of that information, surely it is time that was reviewed so that people can see what the real cost comparisons are?

Mr REID: I am happy to review the confidentiality clause but as it was entered into by all parties—you are talking about one party—my intention would be that if any party had any concerns about the release of that data, given that they agreed to enter into it in the first place in goodwill on the understanding that it would be confidential information—

CHAIR: But you have no problem with releasing the information and the Minister has not either?

The Hon. H. S. TSANG: Chair—

CHAIR: The Minister says he has no problem with releasing it.

The Hon. H. S. TSANG: Chair, can I—

CHAIR: We have limited time today.

The Hon. H. S. TSANG: I have not asked one question. What I am saying, as a person who has been in business before, is that most of the private hospitals are in debt and most are up for sale, therefore the hospitals need to retain their confidentiality and the director-general must respect that. That is an intelligent enough question.

CHAIR: The director-general can answer his own questions. The Minister has no problem with the release of this information.

Mr REID: I was happy with that elucidation.

CHAIR: Are you happy with the release of the information?

Mr REID: I have indicated that there is a contract and I intend to adhere to the contract. I make the further point that I also do not intend to release the contract. I do not think the signer of the contract would wish the contract itself to be released. Not only do I not intend to release that component of the contract that relates to cost comparisons, I do not intend to release the contract and I am not too sure the hospital to which you are referring would wish that contract to be released, but if it does; if it comes back and suggests possible release of the contract and the cost comparisons, then I will continue to review that. We will look at that but it would have to be an agreement by all parties.

CHAIR: Given that the Australian work force committee has recommended there be an increase in the number of specialist medical training positions, particularly in ear, nose and throat surgery, can you give a guarantee that the New South Wales Government will not allow any cutback in those training positions in our public hospitals?

Mr REID: Just for the information of the Committee, about three years ago there was a multiplicity of committees set up or in operation looking at aspects of the medical workforce throughout Australia. As you would be aware—

CHAIR: You only have to answer my question.

Mr REID: —the responsibility for training and the oversight of those medical specialties is a Commonwealth responsibility. The Australian Health Ministers Advisory Committee [AHMAC] established the Australian Medical Workforce Advisory Committee [AMWAC] which is chaired by John Horvath who is renowned in his field and who happens to be a Sydney-based renal physician at Royal Prince Alfred Hospital [RPA]. Those committees have produced a multiplicity of reports—approximately six or seven I think—into various aspects of the medical specialties and the workforce requirements for those medical specialties. In all cases and in all the reports they have issued to date, they have recommended an increase in specialty numbers and they cut across a range of areas. I think they are about to issue their first report which recommends a decline in specialty numbers in a particular specialty but all the reports that have been issued to date recommend an increase in specialty numbers.

In pretty well every circumstance in New South Wales and the majority of other States, additional training posts have been made available for those specialties. There are one or two cases where some funding in some States has not been made available to accommodate the increased numbers but I have made a commitment in this State to continue to try to adhere to the recommendations which come out of AMWAC and I will continue to do so. Just out of interest, I mention that I was at a meeting yesterday where Sitesh Bhojani from the Australian Competition and Consumer Commission [ACCC] was talking to the combined college chairs about the AMWAC reports in Melbourne. Questions had been asked of the ACCC by the specialist colleges, namely, if they restricted training positions or in some way cut back on training positions—as paediatrics is the next one out—would that constitute anti-competitive behaviour and would the colleges be liable.

Part of the difficulties for professional colleges throughout Australia in terms of some of the AMWAC information is that they rightly claim that they are there for professional reasons, not for workforce number reasons. But as you are aware, there is a kind of greying or blurring of what constitutes an accredited position by a college and how much that contributes to a workforce build up.

CHAIR: I know. I am drawn to this issue because Professor Allan Fels has put out a press release about that particular matter, but I draw your attention to it because I want to get a guarantee from you that, should a hospital attempt to cut back on its training position, the department would intervene to ensure that those positions would not be lost.

Mr REID: I give an undertaking that I am committed to the AMWAC process. I am committed to the number of training positions which are identified in that AMWAC process and the State's endeavouring to achieve that target. That does not mean in every instance that it might occur. There might be reasons, as all members of this Committee would well be aware, for wanting to redistribute some of the positions.

CHAIR: So if one area health service wished to cut back to save money by reducing the number of registrar training positions, you would intervene?

Mr REID: If the audit took it away from the AMWAC recommendations and if it was not recompensed with other positions involved elsewhere—there might be a good reason why one would cut back in some areas and there might be a good reason why one would increase in other areas. If it were not for either of those two reasons, I would certainly be looking at that from a State perspective.

CHAIR: Given that that you increased the Isolated Patients Transport and Accommodation Service [IPTAS] funding, which is another answer to a question here, by $500,000—

Mr REID: Could you just tell me the question that it relates to? I am sorry—it is just so that I know.

CHAIR: I do not know, I am sorry. I cannot find it. I wrote these questions last evening. They were Hon. A. G. Corbett's questions relating to IPTAS—the first questions by Hon. A. G. Corbett.

Mr REID: Yes, I think I have found them so I can probably help you with the question number. It is question No. 4.

CHAIR: That is right. You indicate that there had been enhanced funding of $500,000 on a budget of $6.9 million.

Mr REID: Yes.

CHAIR: Given the general increase for services provided by the department of 10 per cent to cover the goods and services tax [GST], is that a reasonable enhancement? Will you re-examine that enhancement to see that it covers the increased costs associated with the introduction of GST?

Mr REID: You are correct in saying—I will just explain this to the members of the Committee—that the IPTAS dollars are not GST exempt in the context of the cost of the service provided. I think this was a question asked by Hon. A. G. Corbett last time.

CHAIR: It was.

Mr REID: The costs of the service provided are costs which are recompensed for costs incurred in buying a train ticket or buying a plane ticket, whatever it might be, and tickets are, of course, subject to GST. When we increased the budget, that predated the estimates of the GST arrangement. I make the point, however, that it is not just an issue around the $500,000. The IPTAS budget has increased by something in the order of 22 per cent in the last six years, so it has been a substantial increase. In 1995-96, the expenditure was $6.128 million and it is now up to $7.5 million which has been budgeted for 2000-01, and as you know, we have relaxed the rules around some of the scheme, which was the question asked by Hon. A. G. Corbett. I make the point—

CHAIR: I am sorry, in 1999-2000—

Mr REID: I am just coming round to your question.

CHAIR: Yes, but in 1999-2000, it was $6.9 million. Therefore, this year, with the enhancement of $500,000, it should be $7.4 million.

Mr REID: I think there was an escalation factor which gives us another $100,000. It is actually $7.5 million, so the data here was right. Mr Barker might want to accommodate this, but part of the GST arrangement is accommodated by the decrease in tax arrangements, too.

Mr BARKER: I think that the understanding we have from the Commonwealth's new tax system is that while the GST has been imposed on a number of consumable items, that has been offset to the purchase of those services either by reduction in pay-as-you-earn [PAYE] taxes or an increase in pensions.

CHAIR: I understand that.

Mr BARKER: Therefore, those who have to pay out charges which are then subject to IPTAS have received a personal benefit in their weekly income to offset the GST. That is a Commonwealth principle and therefore in the IPTAS reimbursement, we take that Commonwealth approach.

CHAIR: Given that every other non-government organisation [NGO] funding that you receive was increased by 10 per cent, surely it would have been reasonable for this one to be increased by 10 per cent.

Mr BARKER: I do not think that this is an NGO project.

CHAIR: I know that.

Mr REID: I think I have made the point that far more than increases for NGOs, if one is going to draw a comparison between apples and oranges, the budget of this category has increased by 22.5 per cent over that period.

CHAIR: That is over the last six years. I am talking about over the last year while the purchase of the tickets has been subject to GST.

Mr REID: That is quite a substantial increase.

CHAIR: The purchase of the tickets is now subject to a 10 per cent increase or, in State Rail's case an 8.5 per cent increase, and you have barely increased it enough to cover the increased cost of the tickets for the poor people who are using the service.

Mr REID: Yes, but if I can just quote myself from the last inquiry, I think I can probably answer your question. The Hon. A. G. Corbett stated:

> Okay, just my last question on this issue. If the money runs out, what happens to the people who actually need this assistance?

I said:

> **Mr REID:** We have found that the budget we have established pretty much covers the demand within the criteria we have.

I then went on to state:

> We constantly review that.

This is the important bit:

> If there are particular hardship cases, then additional costs are met within area budgets.

I have made it clear to areas that there is a degree of elasticity in this budget. I do not see that IPTAS is a definite component of the $7.5 million but if there are increases above and beyond that, then in hardship cases it should be covered. If I can just go on to point out that I did undertake at the last meeting—once again in response to a question by Hon. A. G. Corbett—that I would send to the area health services a new guideline for the IPTAS arrangements and guidelines particularly for medical practitioners and specialists about how they access the scheme under some of the criteria and the new rules. I would like to table those two documents.

CHAIR: The witness has asked to table those documents and I would appreciate his providing a copy to all members.

Motion by the Hon. J. H. Jobling, seconded by the Hon. R. D. Dyer, agreed to:

> That the documents be accepted for tabling.

CHAIR: Why is it that the Southern Area Health Service has admitted that it does not have money to pay outstanding accounts for IPTAS?

Mr REID: For IPTAS?

CHAIR: IPTAS, the organisation we have been talking about.

Mr REID: I will take that question on notice.

CHAIR: When will the Committee get the answer to that, given that it took seven weeks to get the other answers?

Mr REID: I undertake to give it to you within seven weeks.

CHAIR: Thanks. That is the usual sort of time frame.

Mr REID: I am sorry, I was being flippant. I will get it to you as soon as possible.

CHAIR: Okay. I said that because last time you said you would give me an answer within a week—that was about the comparisons between Commonwealth and State funding for Health in New South Wales—and you said that you would get it to me by close of business the next day. It took about seven and a half weeks to get an answer and it was not complete. So I ask you on this occasion to please answer the question because it is important.

Mr REID: I will get that to you.

CHAIR: Why are area health service board members not been paid for their services? This comes under the question to do with budgets of area health services which was asked but not answered.

Mr REID: I am sorry—to which question are you referring?

CHAIR: Any of the questions relating to area health service budgets—comparing those to last year because this is a new cost.

Mr REID: In my view, subject to some discussion among Committee members, that question would be outside the agreement of this Committee which specifically related to pre-existing questions either in the first round of questions provided on notice or in the second round of questions provided on notice.

CHAIR: Does that mean you are not going to answer that question?

Mr REID: You made it very clear to me in the letter you sent to me that other than the matters that were raised by Hon. A. G. Corbett and other than the matters pertaining to ambulance services, the questions you were going to ask had specific relationship to the questions which had been put on notice in either of the two previous circumstances,

CHAIR: Yes. That means that you are not—

Mr REID: I thought that was our agreement.

CHAIR: I understand. Therefore, given that the budgets of these hospitals and area health services have not yet been published in full—we asked a series of questions about the budgets of area health services in question 3, which is a good example. No, I am sorry, that is about creditors. I will come back to that when I find that tagged question. It is an issue which is being raised because again the area health services legislation will have to be varied to change the nature of the board membership following recommendations of the Menadue committee to include clinicians on the board. Given that that legislation has to be changed—

Mr REID: There is no requirement for that to be changed. Clinicians can be accommodated through administrative arrangements.

CHAIR: So you are not going to answer the question about paying board members?

Mr REID: What is the question? I will see if I can link it back to a question you have asked.

CHAIR: Why have area health service board members been employed on a temporary basis currently? More importantly, why have they not been paid?

The Hon. R. D. DYER: Point of order: My understanding is that Mr Reid has clearly said to the Committee—

CHAIR: I uphold the point of order. I will come back to that issue. Can you reveal the specific budget for the New South Wales Health drug program bureau which was asked about during previous questions?

Mr REID: Which question?

CHAIR: I would have to find it. I did not realise you were going to ask to do that when I drafted the questions last evening.

Mr REID: That is what we discussed, but I think you are referring to question No. 26—

CHAIR: Yes, probably.

Mr REID: —which asks what the specific budget of the drug and alcohol directorate, or whatever you call it, is for 2000-01.

CHAIR: Yes.

Mr REID: I am sorry, what was the question?

CHAIR: Can you reveal a specific budget item now? At the time you answered this question, it had not been determined?

Mr REID: It still has not been determined, but I am happy to provide it to you once it is determined.

CHAIR: When do you expect it to be determined?

Mr REID: As you know, hospital budgets have not yet been issued. We run through a kind of hierarchy of events and the area budgets have been published. The hospital budgets are what we are focusing on now, and the expectation is that the drug and alcohol directorate budget will be finalised within two to three weeks.

CHAIR: Would that be the case, too, for question No. 27, which is the area health service budgets for drug and alcohol treatment and rehabilitation?

Mr REID: That is correct.

CHAIR: Will they be made public?

Mr REID: I can make those available to you. I will make those available as soon as they are published; as soon as they are available.

CHAIR: The other question that related to dental that I would like to follow up on is, can you tell us how many pensioners are currently awaiting public dental treatment?

Mr REID: Sorry, which question was this?

CHAIR: The question on dental, which was in the first series, question No. 30 about public dental services. First of all, I would like a comment on that answer that $5.5 million is provided to Northern Rivers and Mid North Coast, which represents about 10 per cent of the State's population, and therefore is being shortchanged out of the $72 million that is allocated. When are you likely to produce a fairer result for the Northern Rivers and the Mid North Coast?

Mr REID: I will take those questions. The first question, the $72 million—and you will have to excuse me, I will come back about the accuracy of these figures—includes a component for dental education provided through the dental school and Westmead, which are statewide services. In identifying the additional dollars that went to the area health services, and as you know we identified and replaced the money that was pulled out through the Commonwealth withdrawal of dental services, once you had extracted that component that was dental education we provided that on an equity basis. The distribution of dental dollars as provided in the table, which came to you, which included the growth funding of $20 million—

CHAIR: Further $5.5 million would represent 10 per cent, so it is $55 million and $17 million goes into education?

Mr REID: About that. If I can just add there, because there are still some concerns about what makes up that education component, we are reviewing that process about what actually ends up in the academic arrangements out of our dental budget to see whether we are expending wisely whatever that amount is, or whether there should be further identification of statewide services to get a more transparent arrangement about expenditure for teaching and research, but the remaining dollars are provided equitably.

CHAIR: How many pensioners are currently waiting for public dental treatment in each area health service, which is a follow-up question to No. 30?

Mr REID: I would seek the advice of the Committee here, but I would not have thought that it is a bit of a longbow to say that that is a follow-up question to a question about the allocation of dollars to the area health services.

CHAIR: I think it is reasonable, given that the money is allocated. I just want to know how many people are waiting for the expenditure of those dollars.

The Hon. R. D. DYER: Point of order. There must be a very tangential link to say the very least between question No. 30 that is asked on notice about the allocation of money to dental health services to which a detailed response has been given, and the oral question you are now putting about waiting lists. There is no direct link between the two.

CHAIR: No, the number of pensioners waiting is the question, not the number of people waiting.

The Hon. R. D. DYER: Whatever category a person may be, there is no link between that and the question that was put on notice.

The Hon. Dr A.CHESTERFIELD-EVANS: To the point of order. It is all about whether the service is delivered. It is not an unreasonable question. You ask about dental health services, you ask about money and the result. Surely that is the essence.

The Hon. J. H. JOBLING: To the point of order. There will be a number of matters that will relate to questions that were asked previously. From the answers Mr Reid or his colleagues give there will flow subsequent questions. But it would have been my understanding, and I would have expected it of Mr Reid, that if he had the answer he would be more than happy to provide the answer and would not be looking to take the defence that it was not specifically a question. I would think on that basis of money allocated, it is a reasonable question to discuss the question of money and how it is divided and, consequential on that, whom it affects.

CHAIR: I will rule the question in order.

Mr REID: I do not have the information of the amount with me. I make the point that four years ago, when a large amount of money was withdrawn from New South Wales, there were 270,000 people in New South Wales who were disadvantaged as a result. We have now tried to rectify that with the additional dollars that came into the service. We have put that additional $20 million in, and by 2002-03 the recurrent budget for dental health will be $92 million. I will endeavour to find out if we have information about the number of people who are currently on the waiting list.

CHAIR: Are you saying that it will grow to $92 million in 2003?

Mr REID: Yes, up from—

CHAIR: Because the answer you gave us is additional growth funding of $20 million in respect of oral health, this includes $4 million in 2000-01.

Mr REID: Yes, if you add the $20 million on to the $72 million that takes it up to $92 million.

CHAIR: Per annum?

Mr REID: Per annum.

CHAIR: But given the way the Minister presented his $2 billion boost as a parameter thing, I would have thought it would be $4 million one year, $8 million the next year and $14 million the year after that to make a $20 million boost. The Minister is going to use the same argument as he has used before for his wonderful $2 billion boost.

Mr BARKER: It is definitely $20 million on the $72 million by 2002-03 and I think in his announcement he quoted a figure like $32 million over the three-year period.

CHAIR: If we are going to be consistent with the Minister's previous way of doing this parameter thing, that answer should have been $32 million, should it?

Mr BARKER: That is the cash over the three years, but on an annual basis it is $20 million.

Mr REID: Let me put it in the same framework in which the $2 billion was expressed, which is exactly the same framework as the Federal Government expresses its increases.

CHAIR: Hang on. In answer to the question—

Mr REID: No, I am answering your question. There will be an additional $33 million cash invested in dental health services, which will increase the expenditure on dental health from $72 million to $92 million by the year 2002-03.

CHAIR: The 2002-03 budget will be $92 million at this stage?

Mr REID: Through the injection of—

CHAIR: Are they going to be in—?

Mr REID: Sorry, if I could just finish, because you asked me a question. Through the injection of an additional $33 million.

CHAIR: Just to be clear, are those dollars 2000 dollars or are they 2003 dollars? In other words will the $92 million be an absolute amount of money, or will the money—?

Mr BARKER: No, it would have to be escalated. Then there would be an escalation.

CHAIR: So it could be more than $92 million but at the minimum $92 million? But it will be $92 million in 2000 dollars?

Mr BARKER: Correct.

Mr REID: That is correct.

CHAIR: Are all of the other figures you have given us, the budgets that are estimated for each area health service, written in 2000 dollars to be escalated as well?

Mr BARKER: That would depend upon which figures you are referring to.

CHAIR: Looking at the area health service budgets that the Minister has given—?

Mr BARKER: They have got an escalation component in them.

CHAIR: They will have escalation components?

Mr BARKER: They have got. They have got escalation components.

CHAIR: They already include that. In other words the figure Mr Reid has given of $92 million will be escalated, but the figures the Minister gave for his $2 billion announcement will not be escalated? That is what I understand from Mr Barker.

Mr BARKER: No, the figures the Minister used for the area figures included a component for wage escalations and non-salary escalations.

CHAIR: But the figure you are giving us today for the $92 million does not include those two figures?

Mr BARKER: Does not include forward wage movements or non-salary movements, that is correct.

CHAIR: In other words, it could have grown to $95 million in 2003?

Mr BARKER: It certainly could.

CHAIR: These are quite different methods of answering the same question, so you can understand why it is difficult for Committee members to fully follow the answers that are given unless you really understand the dollars you are talking about.

Mr REID: If I could just go back to the question you asked about the number of patients. I should say that the package we announced is designed to double the number of people treated within three years. We anticipate that funding will enable an extra 30,000 people to be treated in 2000-01, which is a 15 per cent increase, and by the end of the three-year period we expect to be treating double the number of patients that we are now treating. I will come back to the specific answer.

CHAIR: For $20 million more you will treat the same number of people you are currently treating for $72 million, is that what you are saying?

Mr REID: No. What I am saying is that the additional funding that has gone in will enable an additional 30,000 people to be treated in 2000-01.

CHAIR: That is different from doubling the number that is being treated at the moment?

Mr REID: Yes.

The Hon. Dr A. CHESTERFIELD-EVANS: My questions relate strictly to the questions asked before. In fact, I can give all of you copies of them so that it is all very clear to which ones they relate, and then we can have a wonderful time. There is one at the end that does not, but I am happy to delete that. At question No. 8 the Minister said that there is $300,000 extra for a specific Aboriginal health care program in Corrections Health. What is that as a percentage of the budget? How does the allocation compare to the percentage of Aboriginals in a correction system as a whole, and how does it compare to the indices of health needs? What indices are used and what are the differences between Aboriginal and non-Aboriginal in those indices?

Mr REID: Sorry, I was still trying to find the question.

The Hon. Dr A. CHESTERFIELD-EVANS: Question No. 8?

Mr REID: Yes, I have found it now. It is the $300,000?

The Hon. Dr A. CHESTERFIELD-EVANS: Yes. That is just a number. What is that as a percentage of the Corrections Health system budget? It is not in the budget papers.

Mr REID: We would have to calculate that, but we can provide you with that information.

The Hon. Dr A. CHESTERFIELD-EVANS: How does it compare with the percentage of Aboriginals?

Mr REID: We can provide you with that information.

The Hon. Dr A. CHESTERFIELD-EVANS: How does it compare to the indices of health needs if their health is poorer? Obviously, it should not necessarily be proportional just to their numbers.

Mr REID: No, and $300,000 actually goes to quite specific health care needs. There is a whole range of other raft of activities that are covered.

The Hon. Dr A. CHESTERFIELD-EVANS: I understand that if they have cut fingers they are treated in the same budget as other people.

Mr REID: Yes, that is right, but also there is a whole Aboriginal health budget that is quite substantial.

The Hon. Dr A. CHESTERFIELD-EVANS: In the Corrections Health system? Not in a general one in the Premier's—

Mr REID: Sorry, I will have to take that on notice, too

The Hon. Dr A. CHESTERFIELD-EVANS: Question No. 8 (iii) relates to intellectually disabled prisoners. How much is spent on the program from the Department of Corrective Services disability support services and Corrections Health for the intellectually disabled?

Mr REID: The first part of that is a question you should direct to the appropriate agency in your next hearing.

The Hon. Dr A. CHESTERFIELD-EVANS: No, Corrective Health Services is under the Health Department, not under the Department of Community Services is it not?

Mr REID: Sorry, you are not doing the Department of Corrective Services today, you are doing DOCS. But the Department of Corrective Services disability support services, from memory, and I will follow this up, is not administered out of the Health budget. It is administered out of the Department of Corrective Services budget. There are components—

The Hon. Dr A. CHESTERFIELD-EVANS: So that it does not come under Corrections Health?

Mr REID: It does not come under Corrections Health at all. It is an issue that should be directed to the Department of Corrective Services.

CHAIR: Why did you answer questions about it the first time?

Mr REID: The first time, if you look at our answer we said that intellectually disabled prisoners are cared for by the Department of Corrective Services disability support services. The issue of how much money is expended in that component is a matter for them, not for us. We would not be aware of that.

The Hon. Dr A. CHESTERFIELD-EVANS: So it does not come under Corrections Health?

Mr REID: No, it does not come under Corrections Health. There are components in Corrective Services that are managed out of the Department of Corrective Services, and components that are more specifically health are managed out of Corrections Health. They are issues around drug and alcohol programs and mental health programs. Sometimes they are one or the other.

The Hon. Dr A. CHESTERFIELD-EVANS: It is not your department?

Mr REID: No, that is correct.

The Hon. Dr A. CHESTERFIELD-EVANS: Question No. 11 relates to drug and alcohol programs in Corrections Health. Who is reviewing the programs? Is that KPMG Management Consultants and the Australian Health Council on Health Care Standards?

Mr REID: That is correct. The review is being undertaken by KPMG, and we have called in the Australian council to help us on some of the indicators. I do not know who the consultant is that is doing the benchmark study, but I will find out that name and provide it to the Committee.

The Hon. Dr A. CHESTERFIELD-EVANS: What indicators are being used?

Mr REID: I will find that out and provide it to the Committee.

The Hon. Dr A. CHESTERFIELD-EVANS: Will the reports be available publicly?

Mr REID: Yes, they will.

The Hon. Dr A. CHESTERFIELD-EVANS: Question No. 13 refers to $36 million of new funding for mental health services in the community. The Minister has said a proportion of the $36 million to community services will not be given until the mental health implementation group deliberates how to spend money.

Mr REID: Yes.

The Hon. Dr A. CHESTERFIELD-EVANS: How is the $36 million decided on in the absence of information as to how it would be spent?

Mr REID: How was the actual amount decided upon?

The Hon. Dr A. CHESTERFIELD-EVANS: Yes. If you did not know what you were going to spend it on, how would you decide the amount to spend?

Mr REID: That is a good question. This came up as part of the budget process, as you are aware, so there was a toing and froing about how we divided up the components of the health sector. But the key thing we looked at here was that the mental health strategy could well expend beyond that $36 million component and we tried to look at a snapshot of interstate comparisons of where other States stood on a per capita basis in the expenditure on the mental health compared with New South Wales. From recollection, this $36 million additional investment—as you know, historically New South Wales has been very low in per capita expenditure on mental health—brought us up to mid range.

I indicated, too, in answer to that committee that the second part of that was how that $36 million was going to be expended, as well as the actual amount. There has been now a meeting of the mental health

implementation group, which I foreshadowed at that meeting. That is chaired by Marie Bashir, who is an eminent psychiatrist from Sydney. It has about 20 other people on it who comprise a range of community-based representative groups, psychiatrists, general practitioners, official visitors—who are quite important in this—area health chief executive officers, Aboriginal mental health service representatives, and representatives of non-government organisations [NGOs]. The committee met recently, on 4 August, and agreed to a work program around the $36 million of the overall management strategies associated with $107 million, because there is a total amount of $107 million we are putting in, and the development of the mental health emergency care department strategies, which are critical.

I think is fair to say that throughout Australia and the western world emergency departments have not handled mental health visitors as well as they have handled fractures and heart attacks and those types of things. The development of eating disorder programs is quite important, as well as in-patient mental health care for children and adolescents. The committee is looking at the component of NGO dollars versus public sector dollars and looking after prevention strategies for consumers and carers of people with mental illness. So that is the broader range of things they are looking to expend that money on over the next three years.

The Hon. Dr A. CHESTERFIELD-EVANS: Will the report be available publicly shortly?

Mr REID: Yes. This is one component of the government action plan for health and, as with all other components, as a report comes out of that medical committee it is referred to the clinical council, which I chair. It then goes to the Minister and, as it goes through that process, it becomes a public document and is available on the net.

The Hon. Dr A. CHESTERFIELD-EVANS: Referring to question No. 15(b), in view of the $284 million in health costs and the 18 per cent extra in health costs for smokers, how many smokers can be expected to quit depending on the Quit program?

Mr REID: We have not announced the actual component of the Quit program. I would draw your attention—I am sure this has already been drawn to your attention—that when Easts win the grand final next Sunday—

CHAIR: How much funding have you put in, in all?

Mr REID: It has been publicly announced there is $600,000, which is a contract that—

CHAIR: That is just for the grand final, is it?

Mr REID: No, that is for the whole finals series.

CHAIR: How much for the grand final?

Mr REID: It was not identified between particular components. It has been for the whole finals series. So we have got coverage out of the "Smoke-free" sign with the New South Wales Health banner across the grounds and around the goalposts. If you saw that try last week, which was not a try and which was replayed several times, when Easts won last week, you would have seen the "Smoke-free" sign quite often around the goalposts.

CHAIR: Are you going to see the match?

Mr REID: Yes, I went and saw the match and I am going to see the next match. It is very coincidental that the first time we have put sponsorship money in is the first time that Easts have made it since 1980, when they lost in the grand final to Canterbury, and 1975 when they won the grand final. There is a beautiful confluence of events here that I am going to reap the benefit of.

CHAIR: I notice you are back in the business of the Rock Eisteddfod again?

Mr REID: Yes.

CHAIR: After getting out of it for a while.

Mr REID: No, we have always been in the business of the Rock Eisteddfod. I have handed out the awards now for the past three or four years. We were going to drop it off but we ended up continuing on.

The Hon. Dr A. CHESTERFIELD-EVANS: What calculations have you done on the break-even point of the Quit campaign cost-effectiveness and how much is it anticipated you will spend on Quit campaigns as a result of these calculations? If calculations have not been done, why not, and when will they be done? What I am saying is if you can make money from the decline in health spending by increasing spending on the Quit campaign, surely you have a moral imperative to do that. Have you done these calculations and what is the result of them?

Mr REID: I am not aware of what calculations have been done on the Quit investment versus a return. There are some very good calculations of the cost of tobacco use in Australia. I do not think we provided that to you last time, but this was a report done by Collins and Lapsley.

The Hon. Dr A. CHESTERFIELD-EVANS: Collins and Lapsley reports have been coming out regularly for some time.

Mr REID: Yes, in 1996, which followed up their 1992 report, which estimated the economic cost of tobacco usage was about $12.76 billion. From this it has been estimated that the cost to New South Wales is around the $4.34 billion mark in the tangible cost of health care—hospital bed days and those types of things—but also the intangible costs, being lost consumption, the decrease in value of loss of life to the deceased, and those types of things. I do not have the information on the break-even point from Quit but I do have studies from that and also from a 1999 American study, which examined the relationship between modifiable health risks and the short-term health-care charges. That revealed that current smokers had medical charges which were about 16 per cent higher—

The Hon. Dr A. CHESTERFIELD-EVANS: You quoted 18 per cent here.

Mr REID: Sorry, 18 per cent higher than those who never smoked, and former smokers 26 per cent higher.

CHAIR: It is interesting, is it not?

Mr REID: It is. But can I take on notice that question about what analysis we have done for what return on our investment in Quit.

The Hon. Dr A. CHESTERFIELD-EVANS: Will you undertake that if Quit is shown to be cost-effective in reducing the health budget, that the Quit budget should rise to the point at which it is not cost-effective?

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

The Hon. Dr A. CHESTERFIELD-EVANS: But generally quitting smoking is the one prevention program that has been shown to be extremely cost-effective in analyses of employment, and so on. It would seem, if we have 18 per cent extra, there is clearly a marginal benefit if you cut the smoking rates, and the Quit studies suggest that certain amounts—$3 or $4 a head or $7 a head—in New South Wales might yield quit rates that would reduce the acute care costs even in the short term. If that was shown to be the case, would you undertake, (a), to do the calculation and, (b), if you are going to save money in the short term to spend the money in order to save that money?

Mr REID: I take the point that I will come back to the Committee with the analysis, if it has been done, and share it with the Committee. I make the point again that there are a range of other interventions, if we had limited budgets, where investments would return rates maybe even well above that. For example, studies that have shown increasing programs on falls in the elderly have an enormous return in terms of decreased utilisation. This is getting their houses ready and having non-slip floors and those types of things. I make the point that any consideration of the budget item is not considered in isolation but if there is a very good economic return for that, that would obviously be in its favour for an increase in budget in future years.

The Hon. Dr A. CHESTERFIELD-EVANS: If that calculation has not been done, will you undertake to do it?

Mr REID: Can I come back on that? I will certainly come back on whether it has been done, and if it has not been done, I will ask my department to do it as best we can.

The Hon. Dr A. CHESTERFIELD-EVANS: In question No. 21 I asked about cuts in surgery departments at Coffs Harbour, Port Macquarie and Taree base hospitals, and there is a general answer about money being provided to the Mid North Coast Area Health Service. It does not actually answer the specifics of my question. Have the surgery departments been cut? If so, is it by two surgery days per week? Did this continue until August? If so, is it still continuing? If the new funding has addressed this, can a guarantee be given that there will not be similar cuts next year?

Mr REID: Subsequent to the answer and more specific to your question, neither Port Macquarie nor Manning Base hospitals have cut their elective surgery days. Elective surgery at Coffs Harbour was reduced by two days a week from 17 April through to 30 June as part of a strategy by the health board. One of the elective surgery days at Coffs Harbour was subsequently restored in July. The second day is now being provided as we talk. The level of elective surgery for the remainder of the year, as with all activities, is subject to clinical and management review. As you know, as I provided in the earlier answer to the honourable member's question, the area is in the midst of that comprehensive strategic planning to look at how best to utilise its growth funding for future years. I emphasise once again that the budget of the mid North Coast, and this has been one of the areas which has been the major recipient of additional dollars, from its 1999-2000 initial cash allocation of $158.8 million by 2002-03 will increase to $205.6 million, and that is an increase of 29.5 per cent. That is the biggest percentage increase of any area health service in the State over that period. So, I think the future is looking pretty rosy for the mid North Coast in addressing what has been comparative underfunding since the 1970s, when the growth in population started in that area. But in answer to your specific question, one of those days was restored back in July and the second day is now being provided.

CHAIR: You use the words "pretty rosy" for the mid North Coast?

Mr REID: In terms of 20 years of the inequity—

CHAIR: "Pretty rosy" is the term you use now?

Mr REID: In terms of the percentage increase in their dollars, a budget growth of 29.5 per cent over a three-year period is not a bad budget growth.

The Hon. H. S. TSANG: I think it is pretty good. I think it is extremely good—29 per cent is real money.

CHAIR: The Hon. H. S. Tsang would say that—without knowing anything about it!

The Hon. H. S. TSANG: Twenty-nine per cent! This is real money.

CHAIR: But, Mr Reid, you said it is going to be pretty rosy.

Mr REID: I make the point that as a component of that are quite substantial additional dollars flowing to the Mid North Coast in the specific areas—not just general growth funding, but in the areas of dental health and mental health funding. But I emphasise once again that it is a budget that will go from $158.8 last year to $205.6 million in 2002-03.

The Hon. J. H. JOBLING: I think my questions should go to Mr McGregor, the Deputy Director-General of Operations. With that in mind, Mr McGregor, could you advise me when the independent laboratory that was appointed to test Sydney's drinking water will actually commence its testing?

Mr McGREGOR: As Deputy Director-General Operations, the issue of laboratories is not within my particular portfolio. The question would probably more appropriately be addressed to the Director-General.

Mr REID: Could you repeat the question? As it was directed to Mr McGregor, I did not listen to the question.

The Hon. J. H. JOBLING: I would have thought operations might have covered the question of laboratories.

Mr REID: No. That is the Chief Health Officer's responsibility. Could I have the question again?

The Hon. J. H. JOBLING: Of course. We had an undertaking that there was to be an independent laboratory appointed to test Sydney's drinking water. When will the laboratory actually commence its testing?

Mr REID: The company that won the tender was an Adelaide-based company called the Australian Water Quality Centre, which was selected to provide the service for the recommended independent laboratory. We signed a contract with them on 13 June of this year. The processing of samples by the independent laboratory commenced on 24 July this year. The samples are transported using priority freight arrangements, and the samples are sealed. To date, two duplicate samples per week have been sent to the independent laboratory. During this time there has been no detection of any pathogens in the processed samples. The laboratory is responsible for checking samples for both cryptosporidium and giardia, and it does that by three mechanisms.

CHAIR: The samples are sent to Adelaide?

Mr REID: Yes. There is rechecking of all samples that are found to be positive in routine testing by Sydney Water.

The Hon. J. H. JOBLING: Thank you. It seems to have been a reasonably lengthy time between the start of the process of seeking an appointment and the actual appointment. Would you care to comment on that passage of time?

Mr REID: It was absolutely essential, in choosing this independent laboratory, that we went through a very detailed process of probity arrangements so that we would not be open to any questioning. The contract for the independent laboratory did stipulate that the laboratory should attain NATA standards—which is the National Association of Testing Authorities accreditation—

The Hon. J. H. JOBLING: One would have expected that as a minimum requirement. Surely that is not a matter of surprise.

Mr REID: — within six months of the commencement of the contract, and only one laboratory has attained NATA standards, and that has been done very recently. The contractor who has been successful is undergoing the accreditation process in August of this year, and we feel it will be successful. But that was part of the reason we put quite stringent requirements in the contract arrangements. Whilst it might appear some period of time, I think the end result, in terms of the probity arrangements in place, will justify that time. As I say, it is now operational.

The Hon. J. H. JOBLING: At the beginning though did you not indicate that you expected it to be a much quicker process?

Mr REID: Like many things, one would hope it would be speedier, but, as I say, it was an important process.

CHAIR: But would it not have been put in the tendering process that the people tendering should be NATA approved?

Mr REID: I make the point that NATA accreditation was used as just one example of many things required in the tender document. I do not resile at all from the fact that we took our time. We examined the tender documents carefully. We examined the responses to those tender documents. We ensured that probity arrangements were in place. The announcements that have been done and the testing which is now taking place will stand us in good stead for many, many years, and I think fully justify the time that went into the preparation.

The Hon. J. H. JOBLING: What is the duration of the contract?

Mr REID: From recollection, it is a five-year contract. But could I take that question on notice and come back to you?

The Hon. J. H. JOBLING: Yes. I follow on from that to a matter that arose from question No. 50 and your answer to that previous question. I would be interested in your response, on behalf of New South Wales

Health, to the question put as to why New South Wales Health did in fact breach the 1999 drinking water monitoring plan? I understand this was by failing to undertake the required annual sampling for trihalomethanes in six consumer properties specifically in the Woronora and Potts Hill systems during 1999.

Mr REID: I am sorry, Mr Chair, I do not have the details of that question. But I will take it on notice.

The Hon. J. H. JOBLING: Which I presume you would be somewhat concerned about though if my information is correct?

Mr REID: I would rather take the question on notice to test the veracity of the question before I expressed any concern one way or the other, or even said I was not concerned about it.

The Hon. J. H. JOBLING: That is a surprising response, if I might say so, Mr Reid. I would have thought you would reasonably have been concerned if my information is correct, or happier if you find it is incorrect.

Mr REID: I would rather test the veracity of the question first before I make any personal comment on the question. I will undertake to test the veracity of the question and—

The Hon. J. H. JOBLING: And, if I am right, I expect to find some concern.

Mr REID: — and provide a response to the Committee.

The Hon. J. H. JOBLING: Thank you. Another matter that came up in an independent committee but is subject to a series of questions that were asked is the famous North Side Storage Tunnel, which I am sure you are familiar with. What studies were commissioned by the Department of Health to ascertain that there were no health risks posed by the North Side Storage Tunnel sewerage vent at Scotts Creek? The reason I ask the question will become apparent.

Mr REID: Mr Chair, once again I think there is no reason at all, even by a longbow, to consider this question to be related to the previous questions submitted about the North Side Tunnel. I would ask the Chair to discuss that with members and to make—

The Hon. R. D. DYER: Point of order: In addition to the response that Mr Reid has just given, one of the General Purpose Standing Committees is about to embark on a detailed inquiry into that very matter. I would suggest that the inquiry should be left to that particular committee, which has extensive terms of reference to inquire into the North Side Storage Tunnel.

The Hon. J. H. JOBLING: To the point of order: The Hon. R. D. Dyer is right; another committee is looking at this question. I would ask, before the Chair rules on whether the question I wish to put is consequent upon the first, that Mr Reid understand why I am pursuing this line. Unfortunately, we were unable to ask Mr Reid this question in the other committee hearing. It is a matter that I think will cause considerable concern. I ask that the question be allowed, because I suspect Mr Reid may wish to answer it.

Mr REID: Mr Chair, I do not wish to answer it. The understanding that I have in coming to this Committee for the third time is that that you were to provide the broad areas of the questions that were going to be asked. Mr Corbett provided three areas in which he wished to ask questions. It was specific that your questions would be in response to the first set of questions or the second set of questions that were placed on notice, and you added ambulance services to that range of items.

The Hon. J. H. JOBLING: I have a series of questions on ambulances services.

Mr REID: If I could just add that Health has provided a range of information to the committee of inquiry, and I would ask the honourable member to take our assurance that that addresses the issues that are Health specific issues.

CHAIR: I understand what the Hon. J. H. Jobling is trying to achieve, and I understand the point of order taken by the Hon. R. D. Dyer. I ask Mr Reid: Is this a question you would simply like to duck today, or is it a question you would like to answer?

The Hon. J. H. JOBLING: I have not put the question. I will take the answer given to me on the previous one.

CHAIR: I understand there are constraints that we agreed to, but it is an opportunity, given that the honourable member has asked the question, for you to answer in the public forum.

Mr REID: I do not wish to provide any information about the North Side Tunnel. The information that Health has provided has gone to the committee as part of the processes of that committee.

The Hon. H. S. TSANG: Could I point out to the Hon. J. H. Jobling that on 13 September a report will be submitted by Sydney Water to the Department of Urban Affairs and Planning on specifically those issues.

CHAIR: What is the question that the honourable member wants to ask?

The Hon. J. H. JOBLING: Mr Chairman, I understand all of that. The question I was coming to is a matter of concern. The question that I was proposing to ask—and I will rest on the determination of the Chair—is: Dr Stephen Corbett, the head of the Department of Health's Environmental Health Unit, stated in evidence before the other inquiry to which reference has been made, the North Side Storage Tunnel, that the Department of Health was bypassed by the Department of Urban Affairs and Planning in the assessment process surrounding the approval of the Scotts Creek vent. I sit on the other committee. That statement concerned me sufficiently that I wanted to put to Mr Reid the question as to why that happened, in an attempt to find an answer to the question. That is the question that I was ultimately leading to.

The Hon. R. D. DYER: Further to the point of order: Mr Reid has clearly said that New South Wales Health has made a submission to the other inquiry. Surely the matter should be pursued at that forum.

The Hon. J. H. JOBLING: I will accept the Chairman's ruling.

CHAIR: Since the opportunity for the Director-General has been given, and as I have been asked to rule on the question, I rule it out of order.

The Hon. J. H. JOBLING: I accept that.

The Hon. Dr A. CHESTERFIELD-EVANS: Mr Reid has not answered this particular question. He has answered the previous one.

Mr REID: I could not find a relationship between the particular question and any of the 96 questions that were placed on notice.

The Hon. J. H. JOBLING: If I could proceed to the Ambulance Service. Am I correct in this case that the question should go to Mr McGregor?

Mr McGREGOR: No.

The Hon. J. H. JOBLING: Does it go to Mr Reid?

Mr McGREGOR: It depends on the nature of the question.

The Hon. J. H. JOBLING: Can I receive some clarification on the question of whether the New South Wales Ambulance Service has in fact received a three-year budget allocation? If it has received a three-year allocation, can I be supplied with some details, please?

Mr REID: The answers are yes and yes. In fact, we can probably provide you with the details now. This question goes to Mr Barker.

The Hon. J. H. JOBLING: Thank you. If the question is fairly lengthy, the information could be tabled, to save time.

Mr REID: No; I can read them out to you, if you would bear with me for one minute. The 1999-2000 cash allocation for ambulance services was $145.8 million; for 2000-01 the cash allocation is $153.7 million; for 2001-02 the cash allocation is $160.7 million; and for 2002-03 the cash allocation is $167.7 million. I am trying to follow the blue line that underlines these items across the page. That represents a 15 per cent increase in 2000-03 from the initial cash allocation for 1999-2000.

The Hon. J. H. JOBLING: To Mr Reid: I presume the maintenance budget also is available from that particular document?

Mr REID: I am sorry. That is the overall recurrent maintenance budget. It excludes any capital allocations to the Ambulance Service, and that only takes place on a year-by-year basis.

CHAIR: Is the honourable member seeking that the document be tabled?

The Hon. J. H. JOBLING: Is it a document that you find yourself in a position to table for the Committee?

Mr REID: I can table the document on the increase in ambulance services, yes—Not this document, but I will table a document on the increase in ambulance services. I will provide that to the Committee.

Motion by the Hon. J. H. Jobling agreed to:

That the document be tabled.

The Hon. J. H. JOBLING: Mr Reid, it is my understanding that last year the Ambulance Service was in fact in a situation that could be described as perhaps desperately underfunded and that many of the local ambulance stations could not have their vehicles serviced or could not replace worn tyres. Are you aware of those practices? What steps have you taken to overcome that matter?

Mr REID: Certainly we have been endeavouring to enhance ambulance services across the State. The Ambulance Service has received a considerable cash injection, as I have already indicated. I quoted the amounts for you. I would expect that that cash injection will provide additional staff—there is already a commitment of the Government that there be additional numbers. We now employ approximately 2,500 uniform officers, compared with 2,200 at June 1995 and another 108 ambulance officers are to come on board this year. We have introduced patient transport officers to transport non-urgent cases. They are available from 13 ambulance stations across the Sydney metropolitan area.

The Hon. J. H. JOBLING: If I might interrupt. I appreciate the information you are providing to the Committee, but I am trying to confine you to the question because we are under a time constraint. If, in fact, vehicles were not being serviced on a regular schedule, or if worn tyres were not being replaced, it should have been a problem that concerned you greatly as a safety matter concerning your officers. Would that be a reasonable conclusion to draw, if the vehicles were not being properly serviced?

Mr REID: I have not evidence that they were not being properly serviced, but I will take that question on notice and examine that matter.

The Hon. R. D. DYER: Mr Chairman, could I draw your attention to the fact that the time allocated for this meeting has expired. It is now after 11.30 a.m.

The Hon. J. H. JOBLING: If Mr Reid could spare the Committee another five or 10 minutes I would be grateful. We have not asked any questions about the Ambulance Service and I would appreciate the opportunity to ask a couple of questions.

CHAIR: What is your view, Mr Reid?

Mr REID: I have been here for an hour and a half and I have tried to answer every question to the best of my ability. I call upon the Chair to make a ruling. I understood that I was required for an hour and a half.

The Hon. H. S. TSANG: I suggest we should take the questions on notice.

CHAIR: In that case, I think I should close the meeting.

The Hon. J. H. JOBLING: Before you do so, Mr Chairman, I indicate that I have some specific questions relating to the Ambulance Service. I will pass them up, to be conveyed to Mr Reid with the Committee's concurrence.

CHAIR: Does any member of the Committee have any other questions?

The Hon. Dr A. CHESTERFIELD-EVANS: Might I ask one additional question on notice about whether the Department of Health is a self-insurer. I refer the witness to question seven?

Mr REID: I will take that question on notice, together with the other questions. I presume we are to take them all on notice, Mr Chairman?

CHAIR: We will have to.

The Committee proceeded to deliberate.