GENERAL PURPOSE STANDING COMMITTEE No. 2

Monday 19 June 2000

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 5.20 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 Gardiner
The Hon. H. S. Tsang

_____

PRESENT

Department of Health
Mr M. Reid, *Director-General*
Mr R. McGregor, *Deputy Director-General, Operations*
Dr A. Wilson, *Chief Health Officer*

_____

CHAIR: I advise that the Hon. Jennifer Gardiner will replace the Hon. D. F. Moppett on the Committee today. I welcome those present to this public hearing of General Purpose Standing Committee No. 2, particularly the departmental officers attending. At this meeting the Committee will examine the proposed expenditure from the Consolidated Fund for the portfolio area of health.

Before questioning of witnesses commences some procedural matters need to be dealt with. 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 them 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, media representatives must take responsibility for what they 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 officers identify themselves by name, position and department or agency before answering a question. Wide latitude is allowed in 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 will help departmental staff and members of the Committee if the program or subprogram is identified.

The Committee has not agreed to this procedure but I propose that questioning starts with the Hon. Jennifer Gardiner. The Hon. A. G. Corbett will follow I will then ask questions. I hope that the allocation of time for questions will be fairly even but if questioning on an issue is begun I would ask members to conclude questioning on that issue before moving to the next issue. Two hours have been set aside for the public hearing today. At the conclusion of the hearing if members have not exhausted their questions the Committee may decide to hold additional hearings before reporting on 23 June. I propose to have a short break at 6.25 p.m. and to conclude at precisely 7.30 p.m. or earlier if questions have been exhausted. I declare the proposed expenditure open for examination.

The Hon. JENNIFER GARDINER: Mr Reid, when we last met we discussed creditors whose accounts were outstanding for more than 45 days. You said that you would get back to us on how many such creditors there were. Have you been able to find out that information?

Mr REID: No, I do not have it with me. I will provide it as promised to the Committee.

CHAIR: What sort of time frame are we talking?

Mr REID: It would be very soon after the end of the financial year. I am sorry to ask a question, but what is the time frame of the Committee?

CHAIR: We report on 23 June but our final report is not until August.

Mr REID: It would be very early in July.

The Hon. R. D. DYER: What sort of detail is being sought? The New South Wales health system is a vast empire, if I may use that expression. I would have thought that it would require a lot of work to produce the detailed information sought.

The Hon. JENNIFER GARDINER: As Mr Reid has previously spoken to this Committee about reports to—

Mr REID: I have given an undertaking.

CHAIR: It is a report on each area health service, of which there are a number. But we are talking big numbers.

Mr REID: I have given an undertaking that I will provide details of creditors for 20 entities, so there are 17 geographic area health services, Corrections Health, the Ambulance Service and the New Children's Hospital and essentially it will be one figure for each of those at a point in time.

CHAIR: Will the figure be for 30 June or 31 May?

Mr REID: It will be for the end of June, the end of the financial year, and we will provide it to the Committee as soon as that data is compiled as at that time.

CHAIR: Even knowing that that might have to be adjusted before the annual reports are written?

Mr REID: The final audit, but I imagine it would not be any more than probably two weeks into the July period.

The Hon. JENNIFER GARDINER: Since the earlier hearing the Minister has visited the New England area and has been reported as giving an undertaking that the creditors of that area health service who have been owed funds for more than 45 days will be paid within the next week, that is, by Friday of this week.

Mr REID: Yes.

The Hon. JENNIFER GARDINER: Can you confirm that they will be paid before the weekend?

Mr REID: I can confirm that the undertaking the Minister gave in relation to the New England Area Health Service will be adhered to. I should make it clear that there are two issues here. One is the provision of money or the sourcing of money to cover the level of creditors over 45 days. The second issue is the payment of that money by the area health service and receipt of that money by the creditor concerned. There might be a very short time lag between the provision of money by the department to the area health service and the actual receipt of that credit over 45 days by the creditor concerned.

The Hon. JENNIFER GARDINER: So the department is allocating to the New England Area Health Service some funds specifically for this purpose, is it?

Mr REID: There are still discussions with the Minister about the source of the funding. I did not say "the department." I said the source of the funding. We are having discussions around the source of funding but the undertaking given by the Minister will be adhered to.

The Hon. JENNIFER GARDINER: Is it being discussed that the New England Area Health Service may need another cash injection over and above anything else that has been mentioned until last Friday?

Mr REID: That is the matter we are discussing at the moment. The only undertaking I can give you is the undertaking that the creditors' issues as discussed by the Minister will be adhered to. The source of that funding and those types of things are still in discussion.

The Hon. JENNIFER GARDINER: Will priority be given to those creditors in the New England Area Health Service who have been owed money for more than 90 days?

Mr REID: Priority will be given to the long-term creditors but the commitment as he gave it was a commitment over 45 days. I should add, of course, that we are holding many debtors well in excess of 45 days as a health system, often from private health insurance funds and a range of other payers. So I think it is a very good commitment that has been given and one we will adhere to.

CHAIR: What steps are you taking to rein in the cash flow problem. These are public funds. You said this last year, of course. What have you done between last year and this year to try to rein in that long period of time between providing the service for a private patient and the money coming in?

Mr REID: The whole rationale which led to the underpinning of the health council dollars, the reform agenda, was based on providing certainty to area health services about their long-term funding arrangements. It

was based upon providing a considerable growth factor within that injection and for those areas that had historically—I am not trying to verbal the Chair—since 1978 been underfunded in an equity sense. It provides those dollars over a three-year period to achieve equity.

CHAIR: That was not the question.

Mr REID: No, but I am saying it is that certainty of funding over a period of time that enables area health services to better plan the provision of services. The second point is there has been a significant reduction in creditors over 45 days over the period of the last year. The third point in terms of rural debt, which is the other point relevant to rural area health services as distinct from metropolitan, is that the Government has allocated $40 million to remove rural debt, which is significant.

CHAIR: Some rural debt, the non-current rural debt.

Mr REID: Let us go back to the Auditor-General's figures. Three figures are quoted. One is $40 million, one is $63 million and one is $140 million. The $40 million is the debt we have wiped out. The $63 million quoted from the Auditor-General's report by the shadow Minister for Health relates to the previous financial year, which shows the level of gain that has been made in the period. The $140 million of rural debt relates to the totality of debt, including debts at a point in time as at 30 June. So the true rural debt that has been the cause of concern for many people for many years in rural areas relates to that core element of $40 million, bearing in mind that we have adjusted that $63 million—

CHAIR: What the Auditor-General calls non-current?

Mr REID: That is correct.

CHAIR: The question I asked was what steps you are taking to make sure that health funds pay earlier than they are currently paying?

Mr REID: I do apologise.

CHAIR: Just because you do not have the money in your hand does not mean it is not public money.

Mr REID: No, I do apologise. I was following on from the honourable member's question about creditors and I assumed that question was about creditors, not about debtors. The majority of debts owed to the health system are related to patient fees and they totalled $63 million as at 30 April. We have put in place things like simplified billing trials to try to get those things through the system more quickly with a view to streamlining the billing process, as well as a single bill for a period of hospitalisation. Simplified billing approaches are being introduced now by a number of area health services.

We are looking at a whole range of reforms around compensable patients, which is a major source of our debt, as you are aware—$25 million or around 40 per cent of patient fee-related debts as at 30 April, subject to insurance related claims, workers compensation, motor vehicle, spinal, brain injury, related public liability and those types of things. When a legitimate insurance claim is recognised it can take between four and eight weeks and in cases where litigation is involved it can take between nine and 12 months for the debt to be recovered. We are trying to reform that. We are having discussions with the various bodies involved in that compensation arrangement to try to get a more streamlined approach to enable money to come back into the health system more rapidly rather than over a long period, particularly in those cases involving litigation.

CHAIR: And repatriation?

Mr REID: The repatriation arrangements tend to be relatively not subject to long-term debtors. The payments out of DBA tend to be quite rapid as they come into the health system, so I would not categorise repatriation in the same arrangements.

CHAIR: There is $100 million outstanding over 45 days at any one time from your debtors.

Mr REID: I did not say over 45 days. I said they are some of the indications of the long-term debtors in the health system. I do not know which of those are over 45 but the rate of chargeable patients, compensable patients and ineligible patients results in considerable difficulties.

CHAIR: Were those moneys outstanding for a week, day, a month?

Mr REID: As you know, some of the cases in relation to compensable patients have been outstanding for years.

CHAIR: I know that, but I am talking about private funds. If a private hospital had those sorts of debts it would go broke.

Mr REID: It would not be unusual for private health insurance companies to have debts outstanding with us well in excess of 60 days.

CHAIR: What are you doing to rein that in?

Mr REID: We go constantly to those insurance companies and seek their more rapid payment. The hospitals go to them directly as well. We do not control those private health insurance agencies. In the ones where we have influence, relating to compensation, the ineligibles or chargeable patients, we put in place systems that simplify billing and other arrangements of that kind.

The Hon. A. G. CORBETT: I have a question about improving health services in rural communities. Mr Reid, I refer you to a brochure entitled "Royal Far West Children's Health Scheme and Services for the Aged", which states:

> The Royal Far West receives funding from the Government, however more than $3 million in additional funds is needed each year to keep this much needed service alive.

What assistance are you providing to the scheme this year and is it an increase over last year? Why is there the $3 million deficit to which the brochure refers?

Mr REID: I will take that question on notice, but I will try to answer it from recollection, if the Hon. A. G. Corbett will bear with me. There are two sources of funding for the Royal Far West Children's Health Scheme: one relates to the Department of Education and Training and the other relates to the Department of Health. Those who have visited the service, which is based in Manly, will know that there is a school, which is Education funded, and health services, which are Health funded. There have been considerable communications between the Department of Education and the Royal Far West Children's Health Scheme about the funding of the school-based services. From recollection, New South Wales Health provides funding, in a health service context, of about $2.3 million a year to Royal Far West. That sum has not decreased over any period: it has been escalated like any other non-government organisation [NGO] service. I will check that figure, but my recollection is $2.3 million. It is one of our largest—from recollection, it is our fifth largest—NGO recipient. Our NGO budget is about $70 million a year, so it is a substantial player in the NGOs stakes and is treated like any other service.

There have been considerable discussions with the Royal Far West about the continued appropriateness of bringing young children to metropolitan areas for a range services rather than endeavouring to provide services more appropriately, with support mechanisms for them and their families in their rural communities. The Royal Far West Children's Health Scheme has been responsive to the call for more outreach services based in rural areas. It has sought additional dollars for the provision of services at Manly, but that is not unusual—it would relate to other NGOs. As I have said, the Royal Far West received an escalation like any other NGO and it is one of our largest recipients of NGO dollars—from recollection, $2.3 million from a $60 million or $70 million budget. I think only three or four other agencies receive more money.

The Hon. A. G. CORBETT: Are there any concrete plans to move the provision of services to where people need them?

Mr REID: Yes. I think the Royal Far West Children's Health Scheme has been quite responsive to the idea of looking at how it might provide better outreach services. Parents were concerned that, as an NGO, the Royal Far West Children's Health Scheme—not us—no longer funded the support mechanisms to enable parents to travel with their children to receive services and then return home. I will check this information and come back to the Committee, but I think the Royal Far West decided about 18 months ago to no longer fund support mechanisms. That has caused some disgruntlement among its support base.

The Hon. A. G. CORBETT: What is the status of that?

Mr REID: I will undertake to give you both the level of the budget and the nature of the changes that have been mooted, which have caused these concerns.

The Hon. A. G. CORBETT: Under the heading "Dentists", the brochure states:

> There is a waiting list for Orthodontic treatment and assessment. Children who have turned 13 years of age are not usually accepted for Orthodontic treatment. Children showing poor hygiene and a lack of co-operation with their treatment will not be accepted for Orthodontic treatment.

Why is there a cut-off at age 13? Should children with poor hygiene who showed a lack of co-operation with their treatment not be helped to become more co-operative and to improve their standard of hygiene rather than being ruled out categorically?

Mr REID: This question relates to the issue that I raised regarding the appropriateness of providing services locally in rural areas or providing them in Manly, where children may be advantaged by travelling to receive them. As you are aware, the Minister's recent budget announcements referred to a considerable increase for dental health services in the State. The majority of that expenditure will go to rectifying the $34 million that the Commonwealth removed from dental health services funding three years ago.

CHAIR: Mr Reid, you were on solid ground until you got to that point.

Mr REID: This is important. Under the dental reform package, $33 million will be spent in New South Wales over the next three years, and the vast majority of that funding will go into rural health services. I think it is more appropriate to try to re-establish services in areas where people are rather than necessarily providing orthodontic services for children over 13 years of age based in metropolitan areas. The injection of dollars mainly into public dentistry in rural and remote areas, into Aboriginal medical services—where there is considerable injection of dental dollars—and into rural hospitals provides a better response. I will give one example. The rural provision of dental health services in the Southern Area Health Service—

CHAIR: The issue is specifically about orthodontics.

Mr REID: The issue is: Why do we not provide orthodontic services for people aged over 13 through the Royal Far West Children's Health Scheme. My point is that we are trying to provide those services where people live. We have put an additional 25 per cent into the Southern Area Health Service, an additional 27 per cent into the New England Area Health Service, and 28 per cent into the Northern Rivers Area Health Service. That provides an example of the growth in rural areas. It is not one or the other; it is a matter of—

CHAIR: Can you get back to the Committee with information as to why children over the age of 13 are not eligible and provide figures regarding orthodontics, which is what the Hon. A. G. Corbett asked for?

Mr REID: I am quite happy to come back to the Committee with that information. That is a local decision taken by Royal Far West Children's Health Scheme; it is not our decision. I am happy to go to the Royal Far West Children's Health Scheme with that question on your behalf; it sets the parameters and policies regarding its funding arrangements.

CHAIR: Can you provide the allocation of money to each area health service for public dentistry?

Mr REID: Yes, I would be delighted to. I have been advised that there is a clear distinction between orthodontics and dental hygiene services. Orthodontic services are expensive and it would appear that the Royal Far West Children's Health Scheme has introduced the over-13 years limitation. That limitation is not imposed by the conditions of its grants. The additional $33 million over the next three years will provide not only a range of basic dental services but a range of specialist dental services, including orthodontics in rural areas. I am happy to provide the total amounts that will go to each area health service.

CHAIR: And please explain the rationale behind the choice of age 13, which is the Hon. A. G. Corbett's specific question.

Mr REID: Yes. The Committee asked about the isolated patients transport and accommodation service [IPTAS], and I am happy to provide—

CHAIR: Would you like to table the answer?

Mr REID: I can give you the answer, but I will table the discussion paper that was requested and a new brochure, which is about to be released. If honourable members have comments about it, I will happily receive them as they might assist in educating people about rural services. I indicated last time the changed arrangements for IPTAS, which makes it a more flexible form.

Documents tabled.

I have some comments that are relevant to your question. We have reduced the personal contribution of $40 to $20 for patients and/or escorts who are pensioners or health care card holders; so we have extended that support mechanism.

The Hon. JENNIFER GARDINER: What was the rationale behind the $40 in the first place?

Mr REID: I cannot tell you the rationale in the first place because it was many years ago. It may be spelled out in the report. But the rationale for these changes came out of the consultation process that took place very extensively throughout rural communities into how it could be more flexible. There is a standardisation of the rate of reimbursement for travel by private car up to 12.7¢ per kilometre. One of the questions was about the degree of variability. Someone living in New England may have a different arrangement from someone living in the Far West. We have now standardised it across the State to that rate. We had the strict criteria of 200 kilometres before IPTAS could be accessed, but patients and guardians who are pensioners or health care card holders in remote areas who live within 180 to 200 kilometres are now eligible. Patients with chronic medical conditions who need to travel between 150 and 200 kilometres are now eligible to access IPTAS.

The fourth change was the introduction of a private accommodation allowance for patients who are pensioners or health care card holders and who receive ongoing long-term outpatient treatment who might wish to stay with their family or friends during that process. Those issues came out of the review that I have tabled. The issues are explained in the brochure that is going to rural communities throughout New South Wales. The brochure is not finalised. Any comments the Committee wishes to make about the brochure would be welcomed.

CHAIR: Previously I asked you about patient flows and the money that went with them. I draw your attention to Part 2 of Volume 3 of the Auditor-General's Report for 1999. In regard tor the Mid Western Area Health Service, which includes Bathurst and Orange, the report states:

> Goods and service expenses including other expenses increased from $31.2 million in 1997-98 to $51.8 million primarily due to the recognition for the first time of inter-area patient flows of $19.4 million—

that is an outgoing of $19.4 million in expenses—

> largely because of recognition of revenue associated with inter-area patient flows, again recognised for the first time, of $3.8 million.

At the moment the Mid Western Area Health Service is paying out $19.4 million and receiving $3.8 for patient flows. These are book entries, as I understand it. Is that correct?

Mr REID: Yes. The issue of patient flows has major ramifications, particularly around the northern rivers and greater Murray cross-area patient flows.

CHAIR: That is what I am talking about.

Mr REID: Yes. The northern rivers, greater Murray, southern and far west area health services are treated as book entries. So there is not a transference cost involved. By that I mean that the Northern Rivers Area Health Service does not actually receive the dollars or pay out the dollars for a patient who flows from the northern rivers to Queensland, but it is a book entry for calculation at the end of the year. It is only at the end of the year, or during the year, that we receive the bills from Queensland for northern rivers patients. In the calculation of the resource distribution for more equity we took that factor into account.

CHAIR: But the Auditor-General is working from operating statements. The operating statement does not say that they are just book entries, but money that is moving now. Is that not so?

Mr REID: Yes.

Mr McGREGOR: Under the accounting standards they are non-cash adjustments that occur with the knowledge and approval of the Auditor-General. He is making an observation about the value of them.

CHAIR: Last year they were identified for the first time?

Mr McGREGOR: Yes.

CHAIR: Does it go to whether they owe, or are over, their budget? Are they just book entries?

Mr McGREGOR: They form part of the accounts for record purposes. That is what they are for: to show the public the value of the transfers. As you may recall, that issue was identified by the health council; that is, the question of inter-area flows and how they should be dealt with.

CHAIR: For example, this could look like money allocated by the State Government. A contribution goes to Orange, or to the Mid Western Area Health Service, and instantly comes out again so that the budget, the Government contribution, to that area looks very grand, but the service does not have the advantage of spending it locally.

Mr REID: No, if I could just explain. This is a complex issue.

CHAIR: I understand that.

Mr REID: I am not trying to obfuscate in any way. Two things are occurring here; one is cross-area flows, and the other is interstate flows. I will deal with—

CHAIR: I am not talking about interstate flows.

Mr REID: I am sorry, I thought you were. I will deal with the cross-area flows. At the moment we do not give to an area the totality of dollars for the health services used by that population. In essence, their budget comprises the dollars spent within that area health service and the dollars that might be spent on a range of other health services

CHAIR: Just to clarify that, the budget for the mid-western area includes a number of book entries.

Mr REID: Yes.

CHAIR: Book entries state that there will be an outgoing of $19.4 million, for example, but that will also be allocated against the income budget of $3.8 million—assuming those figures are correct.

Mr REID: That is essentially correct. I am talking in the longer term.

CHAIR: Just a moment. That means a growth in the budget for the Mid Western Area Health Service could simply be a growth in the budget for them to buy services elsewhere?

Mr REID: If I could just take it in two steps.

The Hon. H. S. TSANG: Chair, would it be possible for you to let the witness finish his explanation, because I started to understand what he was trying to say and then you cut him off.

CHAIR: I can assure you that if Mick Reid wants to beg for mercy he will.

The Hon. H. S. TSANG: I am serious.

CHAIR: Am I badgering you or simply moving things along?

Mr REID: It is a complex answer that I would like to give in steps.

The Hon. H. S. TSANG: Would you give me a chance to understand him?

The Hon. R. D. DYER: I support the remarks of the Hon. H. S. Tsang, Mr Chairman. I notice that Mr McGregor was cut off rather abruptly and did not have the opportunity to complete his answer. I ask you to pay the witness the courtesy of allowing him to complete his answers.

CHAIR: I am asking questions within my allocated time. I am trying to understand the system. If I can clarify where the Mr Reid is coming from that will move along the discussion, rather than being discursive. However, if the director-general would be a little more economic, that would be helpful.

Mr REID: As I indicated at the start, this is a complex issue. I will endeavour to be as economic as I can while giving full clarity to the answer. At the moment the issue is that we have area health services and a strong perspective of a population-based focus for those area health services. In many area health services there is a considerable degree of cross-border flows. For example, each year there are $78 million worth of patient flows out of south-western Sydney into other area health services. That could be for three reasons, as I indicated at my last appearance before this Committee. It could be because people live closer to hospitals and other areas, and they are quite appropriate flows. A person may go to Canterbury in the Central Sydney Area Health Service, although that person lives in the South Western Sydney Area Health Service, because that is the closest hospital. Another reason is appropriateness, because a person may not want tertiary services. So some of those flows are appropriate. The third reason is that it may well reflect on the historic imbalance in service provision.

You will find the greatest outflows occur for those areas that received the least amount of dollars on a per capita basis. The things that are to occur over the next three years are an endeavour to get equity back into our system. For the first time the Holy Grail will be achieved. In three years time our health services will have equity on a population basis. Each area health service will tend to have its dollars for that population which is equal to other area health services. Those dollars will be used to reverse a number of inappropriate patient flows, where people have travelled long distances because of inadequate funding to receive health services that can more appropriately be provided locally.

It is probably our intention that in three years time—although a final decision has not been made by Government—the areas will hold the totality of dollars for their population and there will be some contractual arrangements for transference of those dollars across areas. To get there, we first need to have matters in place, such as the metropolitan planning approach, the development of new hospitals at Coffs Harbour and the Manning region, and those other types of hospitals where there has been historical underfunding, and a shift of those dollars to achieve this equity over the next three years. At the moment those flows occur in area budgets as book entries.

CHAIR: They are still announced, for example, as the budget for the Mid Western Area Health Service.

Mr REID: But it is the budget for the population covered by the Mid Western Area Health Service, because the population of the Mid Western Area Health Service used those services to those dollar amounts.

CHAIR: Can you understand why the Auditor-General made it clear that these are folded in for the first time? I will come to Northern Rivers in a moment. South Western Area Health Service has outgoing costs of $6 million and incoming costs—because of interarea flows—of $29 million. Again that is a disincentive. Are you proposing that in three years time when you give them the money each area health service will require a certificate for a person to be treated out of area?

Mr REID: I indicated two things. One is that the final decision has not yet been made by the Government as to whether areas will hold the totality of dollars in the first instance or for how long it will continue to be a book entry. Initial thinking is that at the end of three years the areas will hold the totality of dollars. If they do, the key point is to minimise the transaction costs to accommodate patient flows across areas. There would not be individual transaction costs; there would be broad contractual arrangements between areas based upon the history. More importantly, they will take into account the differentiation between tertiary services and appropriate flows where hospitals or health services are close to each other, compared with the services that are being modified on the basis of service developments we are putting in place over the next three years in order to get to that equity of funding.

CHAIR: I am concerned that the big winners will be the Central Sydney and South Eastern Sydney area health services because they have established services—unless you put in place some form of system that requires a doctor referring a patient from, say, Liverpool to Royal Prince Alfred Hospital to obtain approval from the area health service.

Mr REID: As you know, historically those areas—central Sydney and south-eastern Sydney, have been favoured by a funding mechanism which is not equitable. They have been favoured by a funding mechanism that has the dollars flowing to them in the first instance.

CHAIR: They still are favoured.

Mr REID: Remember that three things have already happened and the fourth will occur. Firstly, there is equity in the funding to be delivered over a three-year period. Secondly, there is a three-year budget. Thirdly, there are growth factors for every area health service in that funding. On top of that, if at the end of that three-year period dollars are held with the areas, it will be the areas decision within the parameters of the broad metropolitan plan as to how services will be provided locally and what other services they will contract and buy from central Sydney, south-eastern Sydney or far west Sydney.

CHAIR: I understand what you are saying. In other words, you are continuing to adhere to the principles involved in the RDF plan that was put in place by the Government in 1996 or 1997, although it has taken more time.

Mr REID: Correct.

CHAIR: At the end of the day, an area will have the money and this whole process of moving the money around will go. I am being very fair about this. They will get comfortable with the idea of how much they have to spend so that they can plan their own services, and will do a metropolitan health plan. Where is the rural health plan that goes with that in terms of providing tertiary services in places that are ready, such as Lismore, Dubbo, Orange, Wagga Wagga, and Albury? Where are the tertiary services there?

Mr REID: The Hon. Jennifer Gardiner has Ian Sinclair's report in front of her. If you read that report and the Health Council report, you will see they are specific about the development of hospital-based services in the major regional centres. I have no doubt that in 10 years time, probably considerably less, there will be a considerably greater range and greater complexity of services in Lismore, Bathurst, Orange, Albury, Wagga Wagga, Tamworth, Dubbo and Armidale, and even out of Broken Hill, for the provision of services. If you look at the report—I cannot recall if it is in the Sinclair or the Health Council report—the specialist services which were initially identified as being required to develop into tertiary range services, as the honourable Chairman has mentioned, relate to acute psychiatry, orthopaedics, renal and radiotherapy services. There has been general agreement in the planning processes that that range of services should be developed.

CHAIR: What is the timetable for the rural health plan that was going to be developed—I hope, at the same time as the metropolitan health plan? I presume you will decide where you will put tertiary services before you complete these book entries and make it real dollars?

Mr REID: Yes.

CHAIR: When do you think that will be completed?

Mr REID: You will recall that last time I handed out to Committee members working paper No. 1 on the implementation of the government plan of action. That was handed out to each member and, Mr Chairman, you indicated to me that you had received an earlier copy in the mail.

CHAIR: I had.

Mr REID: I handed it out to all Committee members on the last occasion. Within that paper is a range of a dozen or so committees that have been established. One of those committees is the rural health committee, which is chaired by a rural chief executive officer and a rural board chair. They have in place a detailed working plan as to how they will roll out the recommendations of the rural health strategies. In addition, much of the metropolitan health planning work will be looking at the network arrangements between metropolitan areas and rural health services. I am more than happy to provide you with the detailed work plan of the rural health committee so that you will get a flavour of the timing and roll out of the rural health service issues—which are raised in both the Sinclair and the Health Council reports—over the next two to three years.

CHAIR: How much recurrent funding has been allocated to Auburn District Hospital and what plans are in place for the future of that hospital within the metropolitan health plan?

Mr REID: I do not have the internal funding for individual hospitals with me. I will take that question on notice. If I could answer the earlier question before you go on to your next question. The metropolitan health plan will consider the range and division of tertiary and secondary services throughout metropolitan Sydney. As you would expect, it will look at renal, oncology, cardiology and neuroscience services.

CHAIR: These are all tertiary services.

Mr REID: We will also look at a range of services that relate to obstetrics, paediatrics, emergency departments and those types of areas. We will probably release a series of planning documents. The first ones might be in services where considerable work has already taken place, such as burns and spinal services. I would consider that they would be progressively released from the next few months onwards over a period of two years.

Issues such as the role and the mix of services that will be at Auburn will be influenced by two things. One is the metropolitan planning process, which will look at trauma networks and those sorts of things. The second will be the role of the Western Sydney Area Health Service and the board and how it perceives the relationship between Westmead, Mount Druitt, Blacktown, Auburn and the community-based services within that area.

CHAIR: We are expecting that when, the next 18 months or two years?

Mr REID: Yes, I would expect the major one to be done in the next 18 months. I should make it absolutely clear on record that Auburn Hospital will not close; that Auburn Hospital will continue as part of the network of health services in this State.

CHAIR: That is not an answer to the question I asked, but I am pleased to have that reassurance.

Mr REID: No, but if you were leading to another question I thought it could save you some embarrassment.

CHAIR: We have done the cross-flows and we looked at the specifics of a hospital—Auburn. In respect of cross-border areas such as Albury, Moree, Broken Hill, Queanbeyan to some extent and the Northern Rivers, when do you intend to fold their cross-border corrections—which, I understand, are currently government-to-government—into the budget?

Mr REID: This is an extremely significant issue for New South Wales because New South Wales is a net exporter of health services. If I look at a couple of areas, one is international health services, we are a significant net importer and the cross-border flows out of areas where we are a significant exporter. To give you a flavour of the dollar amounts so that you can realise their significance, at the moment about $5.5 million annually flows from Northern Rivers to Queensland.

CHAIR: That is less than it used to be.

Mr REID: That is compensated by something like $4.6 million that flows from Queensland to Northern Rivers, but the dollar amount is quite different.

CHAIR: You are talking about the number of patients?

Mr REID: That is total separation, that is patients. But the dollar values for those two numbers is $19 million flowing north and only $11 million flowing south. For the Southern Area Health Service, into that doughnut of Canberra, something like $12 million flows out of the Southern Area Health Service, which is Queanbeyan down the coastal fringe and around the back of Canberra up into the snow—to the value of about $39 million. In respect of the Greater Murray Area Health Service, from the Albury-Wodonga areas there are 10,000 patients flowing from Greater Murray into Victoria, reversed by about 3,700 patients flowing back, the two dollar components being $25 million and $8 million. The Far West Area Health Service is interesting because patients flow to South Australia and Victoria in quite considerable amounts. Because the Far West area comes down across that western side of the border, there are about $5 million of patient flows to Victoria and about $4 million of patient flows to South Australia.

CHAIR: And not much flows back.

Mr REID: And very little flows back in those areas. On top of that we have something like $29 million estimated cost of patient flows into New South Wales from overseas countries, much of which is quite difficult in a recoverable sense over a period of time. The largest countries for flows into New South Wales come from our Southern Pacific partners, particularly New Caledonia, Fiji, China, Indonesia, New Guinea and the USA.

The Hon. H. S. TSANG: Would they seek services and pay fees?

Mr REID: No. Two things are involved here. One is that there is probably a considerably greater amount than $30 million that flows internationally into New South Wales where it is often difficult to identify the patients to count. The second is that of the patient flows that come in some of those pay and others do not—although it is often difficult to recoup.

CHAIR: It often does not identify entirely the humanitarian aspect, for example when a team from Royal Prince Alfred Hospital goes to the Solomons to do some humanitarian work.

Mr REID: That is right. For example, the Chairman has connections through East Timor and other countries. Some services are provided on a humanitarian basis for those countries. We have a situation of considerable net outflows particularly affecting broader areas and large international flow arrangements. The one that concerns us most has been the Southern Area Health Service into the Australian Capital Territory because it has the most expensive health service in Australia by a mile. We have been in disputation with the Australian Capital Territory about it health service. As I said, something like $39 or $40 million worth of flows occur, so it is quite significant to the health system. We ended up going to arbitration where the arbitrator fixed an agreement as to what the health service flow should be, what should be counted in it, what should be benchmark price, what should be the opportunity cost per capita, which is a key issue, and how those things are taken into account.

I am coming to the answer to the question. There is now a memorandum of understanding between the Southern Area Health Service and the Australian Capital Territory. There is also another memorandum of understanding being proposed where there will be a public tendering for services to be provided at Broken Hill, and what should flow out into Adelaide and Victoria where there is agreement taking place at the moment. Currently we do not, as you say, have an automatic transfer of dollars and the dollars are not held at an area level for the provision of interstate patient flows. The reason for that is that it is often difficult to get the counting back from the other States. It is a timing issue as to what has flown into those areas and what has not flown into those areas. However, we are working with those States to try to get a more rapid exchange of information. It would be ideal if those dollars were held in the area so that they can start some discussions with their clinicians about whether those flows should occur. For example, the vast majority of Northern Rivers—

CHAIR: When will that be reflected in the budget of Northern Rivers and the other area health services? Is it next year or thereafter?

Mr REID: My expectation is that it will come around the same time as the inter-area patient flows, within that three-year period.

CHAIR: Will this be on top of the $2 billion that has been allocated, or is it already included in that?

Mr REID: It is already included in that figure.

CHAIR: At least $9 million of the increased expenditure for Northern Rivers will be the cross-border flow?

Mr REID: No. The identification of equity for Northern Rivers, and the time frame and the dollar flows to get that equity, which have already been announced, includes adjustments—which already occur for patient flows just as they do for inter-area health services—and relates directly to equity for population groups regardless of where they get that service, even if that service is a cross-border service. Bear in mind that many of those cross-border areas are absolutely appropriate patient flows. The Gold Coast is a particular example.

CHAIR: Further to that and part of the same question, this year I noticed that the Northern Sydney Area Health Service will buy some services from the Mater hospital. Can we expect to see, areas making their own decisions, or is buying from the private sector part of a big change for New South Wales Health? Or is this a one-off instance?

Mr REID: We need to bear in mind that contracting to the private sector for the provision of services for public patients has been a feature of the health system for 15 years. If you go to the Illawarra Area Health Service, 15 years ago under a previous administration the provision of urology services was from the private sector.

CHAIR: Barrie Unsworth did that.

Mr REID: That is correct. If you look at the deal with the Mater hospital, which was the direct question, it is an interim arrangement to contract for the use of 20 beds for public patients over the next three months. It is a one-off issue. I do not see it being replicated more broadly in the health system. There are one or two examples where similar things are occurring now. The urology issue is one example, but also the Hunter Area Health Service has an arrangement with a private sector nursing home provider to deal with long-stay nursing home-type patients.

The Hon. Dr B. P. V. PEZZUTTI: This is not something that other areas can look at with confidence?

Mr REID: If other areas wish to do that as a one-off event, they can look at those arrangements. I do not expect it to be a major issue, but areas are free to look at those options. It was something that the Health Council considered. The Health Council's recommendation states:

> There should be serious effort to involve other sectors in health service planning in order to encourage more flexible use of all health resources. That is, a private or non-government hospital may be able to assist with peaks in demand, or to provide a particular service as part of a wider network of public, private and non-government services (eg the management of patients with chronic and complex conditions).

The Hon. Dr B. P. V. PEZZUTTI: That is why I asked the question, given the response from Dr Sherbon, in the Illawarra. Is it going to be a modus operandi in New South Wales Health, or is it just a one-off situation?

Mr REID: I made it clear that there has been something in place for 15 years. It will be used in a flexible arrangement. It is also operating at Tugun for the provision of services, as the honourable member is well aware—a very sensible, logical, cost-effective provision of services in the public sector and private hospitals.

The Hon. Dr B. P. V. PEZZUTTI: Will it be extended across the system?

Mr REID: Where it is appropriate it should be done. I do not see that it will have wider application.

The Hon. Dr A. CHESTERFIELD-EVANS: Are there no other publicly owned beds in the northern region at Manly, Mona Vale or some other publicly owned hospital?

Mr REID: The issue here was a short-term requirement, particularly over a winter period, when it is deemed more appropriate that those services would be provided. We have bed closures at Royal North Shore Hospital because of the redevelopment we are putting in place at the moment. This issue was brought on stream not because we are unable to provide a full range of public sector beds we already have in the system, but because of the redevelopment proposals that are in place.

The Hon. Dr A. CHESTERFIELD-EVANS: What about Manly, Mona Vale and other hospitals in the area? Are there not other hospitals in the public sector that could have been used?

Mr REID: All areas look at the range of options, and will continue to do so. This was an issue of a constraint of beds at Royal North Shore and the capacity to attract new staff for a short period. Remember, we are putting a whole range of additional beds into place over winter, and trying to accommodate that peak in demand, so it involves the difficulty of attracting new staff over a short period of time coupled with the fact that the Mater indicated that it had spare capacity and was willing to enter into a very favourable contractual arrangement.

The Hon. Dr A. CHESTERFIELD-EVANS: How much was that contract?

Mr REID: The contract has not yet been finally signed; it is still in negotiation. The announcement was in the media prior to the contract being signed. I make the point that the nuns themselves saw that this entirely filled their mission; that this was in line with their mission as nuns. The Private Hospitals Association, as you know, came out in full support of the arrangement. The Government said this is the normal course and is commonsense. The Health Council recommended it. It has been in place for 15 years. It will continue to happen when and as required.

The Hon. Dr A. CHESTERFIELD-EVANS: Will the contract be made public when it is signed?

Mr REID: That is not a matter for me. That is a matter for the area health service and the board, but I can see no reason why it would not be made public. Most of these are.

The Hon. Dr A. CHESTERFIELD-EVANS: As you know, there has been controversy about the closure or downgrading of Auburn hospital, such that its theatre equipment is being exported, the number of sessions it is working has dropped, and casualty is therefore unlikely to remain supported in the medium term; Port Kembla emergency department is picketed, as you may know—

Mr REID: No, it is not.

The Hon. Dr A. CHESTERFIELD-EVANS: Have they stopped the picket?

Mr REID: Yes, they stopped about a month ago.

The Hon. Dr A. CHESTERFIELD-EVANS: Did they give up?

Mr REID: No. They reached agreement with the area health service about the appropriateness of the actions that had taken place. There is no longer a picket at that hospital.

The Hon. Dr A. CHESTERFIELD-EVANS: Is casualty still working or is it running with one general practitioner, as it was?

Mr REID: It is working as has been proposed, not as it was originally. It is not a full-level service, as it was originally.

The Hon. Dr A. CHESTERFIELD-EVANS: In cases like Auburn and Port Kembla, where the hospital is a satellite to another hospital—I suppose Auburn is to Westmead roughly as Port Kembla is to Wollongong—it is difficult to get transport at night to the major hospital, and waiting times are often very long. Years ago registrars or senior housemen ran casualty departments and if there was a problem they transferred the patients. Often there is quite a lot of staff at the major hospital. Why can they not be diversified, giving a better geographically spread service, because most episodes of service do not require high-tech intervention anyway?

Mr REID: That is correct, and there will always continue to be a mix of high level tertiary and district hospitals in any health system, which I believe is appropriate. If the question is leading to a downgrading of district hospitals, I would not support that contention. They have a viable role to play in our health service.

The Hon. Dr A. CHESTERFIELD-EVANS: Though they tend not to have casualty departments, which is what people are concerned about.

Mr REID: The rebuilding of the hospital at Canterbury, the rebuilding and development of Blacktown Hospital, the whole Macarthur strategy, Tamworth accident and emergency [A and E], and the Camden strategy are all evidence not of pouring money into tertiary hospitals but of providing an appropriate range of support services for those tertiary services, as you rightly say, and trying to get a clear distinction with it. If I can give you one example, the paediatric networks—which we are looking into at the moment throughout western Sydney—are networked to try to relieve the pressure on the New Children's Hospital, now called the Children's Hospital Westmead, by developing a bear logo arrangement in a range of other paediatric wards in district hospitals throughout western Sydney.

It will also have staff rotation, which is the very thing you are referring to, to get the network of clinicians—the nurses and doctors—who will rotate through those other hospitals and provide a service so that parents feel comfortable about taking their children to those hospitals and receiving the same quality of service by the same range of people as they would if they travelled to the New Children's Hospital. I believe that is a classic example of providing a network service which recognises the importance of district hospitals, which develops a district hospital so it upgrades the standards in those hospitals where appropriate, and which links the networks of specialist services with the major tertiary hospitals, and as a downstream effect increases access to services for parents of children and decreases the workload on the major teaching hospital.

The Hon. Dr A. CHESTERFIELD-EVANS: Is that actually happening? I remember that there was a fuss when the Blacktown Hospital paediatric ward was being downgraded. I do not know if that has been

rectified. There was an A and E controversy at Mount Druitt, there were problems in the maternity section of Shellharbour Hospital, problems at Port Kembla with emergency, and problems with orthopaedics in Mona Vale and Manly, as well as Auburn, I believe. What is the strategy to keep a service maintained? When people refer to service they usually mean having an operation or going to casualty, particularly heart attack patients, who seem to be attached to coronary care facilities. If they want specialty surgery they do not mind; but for routine surgery, which is done in private hospitals half the size of these district hospitals quite economically, they then say the district hospitals are not economical. It is usually keyhole surgery: the surgeons come in, do it, and go. The support is not often rocket-science support.

Mr REID: You have raised a range of questions and I will try to answer them one by one. You listed a number of hospitals—Auburn, Shoalhaven, is that right?

The Hon. Dr A. CHESTERFIELD-EVANS: Shellharbour maternity.

Mr REID: I think Shoalhaven was another one, which is in the same boat, and Manly and Mona Vale.

The Hon. Dr A. CHESTERFIELD-EVANS: Blacktown and Mount Druitt. The same applies to Batemans Bay, if you are talking about maternity.

Mr REID: We will come to Batemans Bay. You are adding questions to the earlier one.

The Hon. Dr A. CHESTERFIELD-EVANS: It is the same principle. The district hospital is getting the services, is it not?

Mr REID: I do not accept that district hospitals are not getting services. There is a range of strategies for the redevelopment of Blacktown Hospital, as you know, which is due to be formally opened shortly. There is a whole planning process going on around the appropriate role and level of services on the northern peninsula around Manly-Mona Vale. What should evolve out of that will not be the removal of services but a better range of services in defined communities supporting the services provided at a teaching hospital. Shoalhaven hospital is being redeveloped at a cost of $28 million. It will provide a new emergency department, medical triaging and the range of services that you are saying are being somehow lost to the system—day surgery, a day-only centre.

I have already mentioned that Auburn hospital will not close. There will continue to be a range of services at Auburn hospital. But its correct role I think appropriately comes out of a planning process as to what is the relationship between the hospital and its big brother or big sister hospital that you mentioned. There will continue to be a viable role at those small hospitals. There are some fundamental questions that need to be asked when we examine those hospitals. They include whether the services can be provided safely with the same level of care at those hospitals. And where it can, I think we should continue to provide them.

The Hon. Dr A. CHESTERFIELD-EVANS: There is a tendency for the temples, if you like, the big ones, to have huge resources and large numbers of doctors, but they are very difficult for everyone to get to in an emergency. An emergency seems to be defined now as something requiring an ambulance. But the hospitals are a long way away for people who have to travel to them by public transport, which is very poor in that it does not usually even centre around the hospitals.

Mr REID: Yes. I take the point that there are a whole range of issues around that. I was merely trying to emphasise that there is no overall plan to diminish the importance of district hospitals. There are plans to improve their networked arrangements with the major teaching hospitals. There are a range of confounding factors in place at the moment. For example, as you well know, there is a considerable shortage of junior medical staff throughout Australia, which is making it difficult to provide the whole level and mix of previous services. There will always be a role for the district hospitals, appropriately networked, with the major services and providing the secondary range of services. We are trying to put in place that those services should be of high quality and that people in those hospitals should have good access to clinical care when required from their networked arrangements. That is the emphasis of a planning process and the networks that we are putting in place, as I have already indicated in terms of paediatric services.

At the last hearing the honourable member asked a question about Coffs Harbour hospital and floods. I have documents to table for the Committee. Mr Chairman, if I might have your indulgence, the floor height of the new hospital is set above the November 1996 flood level, which was assessed as being in excess of a one-in-500-year event, and estimated to have been up to a one-in-2,000-year event. According to council records the

1996 flood covered the site at its highest point by 50 millimetres. It is understood to have resulted from a spillage of water that had built up on the Pacific Highway embankment upstream of the site. There have been a range of activities on the site which should rectify the problem.

The Hon. Dr A. CHESTERFIELD-EVANS: Fifty millimetres above the height of the 1996 flood?

The Hon. R. D. DYER: Mr Chairman, I would like to clarify something. I understood Mr Reid to say a moment ago that there have been earthworks at the site.

Mr REID: Yes, I am just about to talk about them. The earthworks at the site raised the building levels to above the November 1996 flood levels, which was a one-in-500-year event and estimated to be a one-in-2,000-year flood event. The building platform is 0.8 of a metre above the one-in-500-year event and more than 1.5 m above the one-in-100-year level. Construction of a swale affords a level of protection to the adjacent property as well. The yellow area on the diagram shows the area of the Coffs Harbour hospital site that could have been subject to one-in-100-year flooding. As I said, the hospital platform is almost a metre above the level of the 1996 flood event. The one-in-2,000-year event is demonstrated in green. There are also photos of the site showing the earlier works. The 1998 aerial photo shows the building platform. It has been built up over a period. It will be a spectacular hospital, well received in the community and providing a very comprehensive range of health services. There is a May 2,000 photo of the work to that stage. It is an $80 million project.

Documents tabled on motion by the Hon. R. D. Dyer.

The Hon. H. S. TSANG: Have the questions asked by the Hon. Dr A. Chesterfield-Evans resulted in any additional costs? After the questions you raised the platform. Did that cost the State any more money?

Mr REID: We did not raise the platform as a result of the question asked by the Hon. Dr A. Chesterfield-Evans.

[*Short adjournment*]

The Hon. Dr A. CHESTERFIELD-EVANS: Why is there such a shortage of junior resident hospital doctors?

Dr Wilson: The shortage of junior medical staff comes about through several factors. First, the Commonwealth Government has reduced the intake into medical schools. That occurred some four years ago at the same time as provider number restrictions were introduced. As well as that, the impact of the changes in the medical training programs in New South Wales with the introduction of post-graduate training programs will have their maximum effect over the next three years, so we will see a major deficit occurring over the next three years in terms of junior medical staff entering the scheme. The demand for junior medical staff has always been higher than the supply that is available and that is being exacerbated with the expansion of services everywhere.

The Hon. Dr A. CHESTERFIELD-EVANS: Is there not, though, a shortage of training positions for general practitioners? Is it not the fact that one-third of graduates do not have any post-graduate training? Taking into account all the specialist training programs and general practitioner training programs, one-third of graduates do not have further post-graduate training and is that not silly if one is short of junior medical staff?

Dr Wilson: As you are aware, the number of general practitioner positions is determined by the Commonwealth under the provider number restrictions that were introduced. There is a limit both on access to provider numbers and access to provider numbers as determined by being able to complete training as a general practitioner, which is very appropriate I think, but there is a limited number of training positions for general practice. We are seeing at the moment some evidence that the predictions of the number of general practitioners Australiawide were probably underestimated, so we are starting to see some concerns being raised about general practitioner availability in areas which were previously thought to be likely to be reasonably well supplied by the Central Coast.

The Hon. Dr A. CHESTERFIELD-EVANS: So we have a shortage of general practitioners, an excess of graduates with no training, and a shortage of junior resident medical officers. Is that not an absurd situation?

Dr Wilson: One of the intents of the provider number restrictions was the hope that it would drive young doctors into specialty areas that traditionally had trouble recruiting people, areas such as rehabilitation, and that junior medical staff would be retained in hospitals for a longer period of time.

CHAIR: You strongly supported that.

Dr Wilson: It was a spin-off that the public sector would have liked to see, but in fact we have very little evidence that either of those have occurred so far. We have seen a massive expansion in training, in that people are electing to go into the College of Physicians training program because that has no limits on it. It does not define the number of training positions that are available. One can basically apply to have any position potentially accredited, so there has been a massive expansion in the number of people who are going into that program, but not particularly great expansions in the areas of need.

The Hon. Dr A. CHESTERFIELD-EVANS: I have seen physicians capable of putting in a stitch. Could these people not function as junior staff in casualty departments?

Dr Wilson: They do. They still continue to staff emergency department services. Is that what you mean?

The Hon. Dr A. CHESTERFIELD-EVANS: Yes. These people presumably are not stepping out of the public sector to be unemployed, without provider numbers and without higher training, to go into the taxi industry or whatever?

Dr Wilson: Well, they are not appearing in the public sector.

The Hon. Dr A. CHESTERFIELD-EVANS: Are they simply disappearing?

Dr Wilson: No, they are being taken into areas like the private hospitals, for instance, which in the past did not employ medical cover but now employ junior medical staff. We are seeing a growth in the number of salaried doctors in places like specialist medical clinics, such as the impotence clinics and areas like that, which are employing people on a salaried basis.

There has been an expansion in a number of other opportunities. We suspect a number of people are delaying their decision by, for instance, going overseas for a period of time before they decide to enter the work force. That is very difficult to document. There is no way of tracking junior doctors at the moment to work out where they are going, but every State and Territory in Australia has now reported that they have this problem. We are fortunate in many ways in that we have three medical schools, but any additional medical staff we may have here are offered opportunities to go wherever they like in Australia. It is an open field.

The Hon. Dr A. CHESTERFIELD-EVANS: So at least to some degree junior resident medical staff are being lost from the public sector to the private sector.

Dr Wilson: That is one of the areas in which there has certainly been an increased uptake of people.

CHAIR: But you signed off on this wonderful initiative by Dr Wooldridge, which I objected to from the beginning, and it has been the disaster that everybody predicted it would be.

Dr Wilson: That was actually signed off during the previous Minister's period. He did not support it during that period of time. He supported the junior doctors at the time because he was concerned about the impact that would have on junior doctors' training opportunities.

CHAIR: But the department thought it would be good for the department?

Dr Wilson: The department was hoping that one of the spin-offs from it would be an increased number of junior medical staff available to us. We were also hoping that areas that traditionally had problems attracting registrars would, in fact, be able to get registrars—areas like rehabilitation, drug and alcohol, et cetera.

The Hon. Dr A. CHESTERFIELD-EVANS: What budget do you plan to use in the Quit program this year, given the new legislation that is in place? It would be a shame to do that without some sort of Quit program to reduce the prevalence and incidence of tobacco smoking?

Mr REID: As the honourable member says, there are some fundamental changes in terms of legislation coming into place, which I am sure the honourable member welcomes, in terms of sites for smoking in various places. In 1999-2000 the Government committed direct funding of $1.833 million for the purpose of

tobacco control in New South Wales, but I should point out strongly that that does not reflect the totality of the extent of government funds used in tobacco control activity. Outside the Health portfolio, a number of other agencies, such as WorkCover, the police and the Department of Gaming and Racing, have particular roles to play. Tobacco prevention expenditure does not occur wholly within New South Wales Health. There is environmental health and health promotion—

The Hon. Dr A. CHESTERFIELD-EVANS: These rationalisations were not used in earlier times, were they?

Mr REID: —and epidemiology and Aboriginal health. When the legislation is passed, there will obviously have to be a mechanism for community consultation, which will be provided in addition to those dollars.

The Hon. JENNIFER GARDINER: I wish to move to a new topic. This year there have been several unintended incidents in hospitals, such as food contamination, use of incorrect drugs and procedures, and use of potentially contaminated equipment. What funds have been allocated for quality control measures?

Mr REID: I must state at the outset that I do not accept the hypothesis that things happened this year that were of greater or lesser importance than incidents in previous years.

The Hon. JENNIFER GARDINER: Do you have a benchmark?

Mr REID: We do incident management in the health system. We do not have a particular benchmark: for instance, a lining up of food contamination with other incidents that might occur in the health system. However, before I answer, I make the general point that I do not believe anything occurred this year that had not occurred in the past few years.

In terms of quality issues and how they are addressed, a quite comprehensive quality framework has evolved in New South Wales. I am happy to make that document available to the Hon. Jennifer Gardiner. It tries to map how we will improve—we are constantly striving to improve—the quality of our health services over the next few years. The quality framework evolved out of the national study conducted in 1995, which indicated that there were about 14,000 avoidable deaths in our hospital system Australia-wide—

CHAIR: This question is important. The Hon. Jennifer Gardiner asked what funds have been allocated this year for quality control measures.

Mr REID: She actually asked about funding in relation to particular incidents and I was trying to make a point about those incidents. From memory we allocate about $600,000 per annum to the development of a specific quality framework. However, the point is that it is a microcosm of what truly occurs. In every one of the 220 hospitals across New South Wales there is a range of quality activities, which occur through peer review, quality committees and area health services. There is no single amount. In terms of implementing the quality framework—to which I just referred and to which it is important to relate this issue—a budget of about $600,000 has been determined.

The Hon. JENNIFER GARDINER: How much did the rat eradication program at Gosford Hospital cost?

Mr REID: We do not have separate itemisation in our accounts for rat eradication; the money would have come from the normal recurrent funding for the hospital system. It would not be identifiable as a separate item.

The Hon. JENNIFER GARDINER: Do you know whether any other hospitals had to introduce a rat eradication program?

Mr REID: I do not have those details at my fingertips. Other hospitals might have had rat eradication programs. Those who live in rural parts of the State will know that there are often mice plagues that affect a range of buildings. Eradication programs are a normal process for many hospitals, schools, courthouses and private homes.

The Hon. JENNIFER GARDINER: Is it fair to say that there is no overall monitoring of such incidents; it occurs on a hospital-by-hospital basis?

Mr REID: Rat eradication?

The Hon. JENNIFER GARDINER: Yes.

Mr REID: There is no overall monitoring. If it proves to be a critical incident and something occurs as a result that is detrimental to health, we would monitor that incident. We do not put such occurrences together and label them "rat critical incidents".

CHAIR: Did not Gosford Hospital, which had the rat incident, also have a problem with fruit salad?

Mr REID: That would have been identified as a critical incident and, as such, there would have been a full investigation and a full report.

CHAIR: Do you know how much the rat program cost?

Mr REID: No, it would be a normal part of the recurrent budget of the hospital. The question was: Do we systematically monitor rat eradication programs throughout all 220 hospitals in the State? The answer is no.

The Hon. JENNIFER GARDINER: How many critical incidents of that nature have there been in the past 12 months?

Mr REID: In terms of rats?

The Hon. JENNIFER GARDINER: Yes.

Mr REID: I will have to take that question on notice.

The Hon. R. D. DYER: Mr Chairman, could you elucidate the connection between fruit salad and rats? I am interested to know.

CHAIR: Yes. The fruit salad problem was identified as a problem of food preparation and the kitchen—

Dr Wilson: I am sorry, that is not correct. We must be absolutely clear about this. The problem was not associated with the hospital kitchens. The fruit salad is prepared outside the kitchens—it is preprepared fruit salad—and the problem was traced back to the manufacturers. It has been identified as a national issue for which a new control program is being introduced. We must be absolutely clear about this matter.

CHAIR: During the investigation of that matter, were not Gosford Hospital's kitchens found to be very substandard?

Dr Wilson: But that was not the issue in relation to the listeria incident to which you referred and to which the problem was traced.

CHAIR: I did not say that. I said that, as a result of that investigation, you found that the kitchens at Gosford Hospital were substandard.

Dr Wilson: As part of the inspections that we carry out on a range of hospitals, we found things that needed to be upgraded in that hospital kitchen.

The Hon. JENNIFER GARDINER: Mr Reid, how much additional money has been allocated to New South Wales Health for services provided specifically to cater for the additional burden on the system as a result of the Olympic Games?

Mr REID: I have the honour of chairing the Olympic medical and health committee, which has been meeting regularly over the past three years to plan a range of services for the Olympics. Two categories of services have evolved. Many of the services that have been developed relate to health services provided for the athletes within the village. That is a component of SOCOG's budget rather than that of New South Wales Health. The range of activities—I will come to the dollar amounts—relating to the New South Wales Health budget include a health surveillance system, which is important in detecting infectious disease outbreaks and

unusual patterns of illness or clusters of injury; and food and environmental health monitoring, which will be very important and entails a co-ordinated program of food safety inspections and a strategy for the prevention of legionnaire's disease, in particular.

Hospital care, as required, will be provided through a network of hospitals, which will play specific roles. We are designating hospitals with particular roles on the basis of their location in the context of venues. There will be interpreter services and the Ambulance Service will be a major contributor to the Games. It will provide ambulance support to the competition and non-competition venues and training sites. We are now conducting training and qualifications for a range of those services. There is a budget to counter disasters, which are a little unpredictable. We obviously hope that there will not be a major disaster, but we must bear in mind the potential for emergencies.

The budget to support the Olympic and Paralympic Games has been allocated as a separate item from Treasury over and above our budget. We were allocated $2.263 million in 1999-2000 and $4.755 million for 2000-01, which is the sum total in terms of our activities for the planning and implementation of the health plan. We have a comprehensive health plan that has been signed off by all agencies but I do stress that that relates to those activities I spelled out, Mr Chairman, as distinct from activities that might take place inside the fence.

The Hon. JENNIFER GARDINER: How many hospitals will be shut down for the purposes of elective surgery during the Olympic Games?

Mr REID: This is a very interesting question because there is a perception that—and Dr Wilson might bring me up to date on some of the figures if I get them wrong, because I do not have a brief on it—there is a heavy demand on the hospital system as a result of the Games. The evidence from Barcelona and Atlanta, which were the two previous Olympic venues, is that there is an absolute minimal usage of the hospital system by Games-related people. I think, from recollection, at Atlanta there were in total something like 23 in-patient admissions throughout the whole period of the Games. So the answer to your question is that it is expected that there will be absolute minimal increased hospital admissions from the Olympics family or from the other people who are in town.

CHAIR: That was not quite the question that was asked.

Mr REID: No, but I am coming to the other question.

CHAIR: Please do.

Mr REID: Just as we are trying to plan our services in terms of staff movements and those types of things, there will be, just like with any other services, an impact upon some of our service providers which will be caused by the difficulty of workers accessing sites; people who are part of the Olympics family or who are going to work for the Olympics and, of course, providing the back-up services, particularly with the ambulance arrangements. But in terms of the moving or closure of elective surgery as a result of people being admitted for Games-related reasons, that will be minimal.

The Hon. JENNIFER GARDINER: Minimal?

CHAIR: How many hospitals will be shut down?

Mr REID: No hospitals will shut down. No hospitals will shut down over the period. There might be some downturn of some activities for the reasons I have said. The question actually was, Mr Chairman, if I—

The Hon. JENNIFER GARDINER: I will read it again.

Mr REID: Yes.

The Hon. JENNIFER GARDINER: How many hospitals will shut down elective surgery during the Olympic Games?

Mr REID: Yes, read on.

The Hon. JENNIFER GARDINER: And which ones are they?

CHAIR: That is it.

Mr REID: No, you have left something out there.

CHAIR: No, she did not.

Mr REID: Well, no hospitals will shut down.

The Hon. JENNIFER GARDINER: Will they shut down any elective surgery?

Mr REID: There may be some downturn in elective surgery, but I would be very surprised if there is any full-on closure of elective surgery. Those hospital plans are being evolved at the moment.

The Hon. JENNIFER GARDINER: But I thought you said that those plans had been signed off. I thought, Mr Reid, you said that the health plan for the Olympics had in fact been signed off; but now you are saying that it is all being talked about.

Mr REID: No, no. I am sorry. The plan for the Olympics in terms of the range of activities that I have mentioned has been signed off. There is a comprehensive health plan for the Olympics. There will be some closures, not because of the Olympic Games but because doctors in health services will not be on duty and will not be able to provide those services. So there will be some closures of elective surgery but it is not because of the Olympic Games.

The Hon. JENNIFER GARDINER: I wish to go back to two quick follow-up questions from our earlier discussion about creditors who are outstanding for 45 days plus. If the New England Area Health Service creditors are to be paid within the next week or so, what is the time frame for the other area health services with that chronic problem of outstanding payments? Is there another health service which is the next cab off the rank, for example?

Mr REID: No decision has been made on that. In answer to the earlier question, I said I would provide by the second week of July information on the creditor arrangements.

CHAIR: I am sorry, the Minister has announced—

Mr REID: If I can just answer the question, Mr Chairman. As yet, we do not know the details of the roll-out of that between now and that period.

The Hon. JENNIFER GARDINER: With respect to the discussion that is going on and that you are having about sourcing and the provision of those funds to the New England Health Service, do they go beyond the creditor resolution issue to address the cash problem that they have had in buying surgical gloves and X-ray film, for example?

Mr REID: The discussion with New England has been around its creditors.

The Hon. A. G. CORBETT: Mr Reid, I am not quite sure if you are aware of a story which was published in the *Daily Telegraph* on Wednesday 14 June headed "Circumcised baby almost died". It refers to a doctor who has been before a tribunal, and the Health Care Complaints Commission having alleged certain things about the way this doctor has performed some circumcisions. What sort of protocols are in place, or should be in place, to ensure that a child does not suffer during and after a routine male infant circumcision?

Mr REID: I think it is probably best if I take that question on notice. I do not have the details with me, Mr Chairman, so I am quite happy to provide the details. A protocol is in place. The Chief Health Officer might want to add something.

Dr WILSON: I only say that, in relation to that specific case, we will have to get some additional information. There are guidelines relating to circumcision and particularly around the pain relief: addressing the issue of pain relief for children in a situation which has been an issue and which had substantial coverage in the medical press last year. As a result of that, we set some specific guidelines in relation to that.

The Hon. A. G. CORBETT: I can remember having conversations with members of New South Wales Health in 1996, and as a result of those discussions I think the Division of Paediatrics or whatever it was

called had certain procedures and they were adopted by New South Wales Health. It obviously concerns me when I see something like this occurring. Could you also find out for me what the cost of a routine male infant circumcision would be and what the numbers are for this year or for the last financial year?

Dr WILSON: Yes, that is no problem. That is an identifiable item in the hospital morbidity collection so we have comprehensive data from all public hospitals in New South Wales going back over many years. We can give you some estimates of the costs involved in that. There is an average cost for the provision of those services. I will take that question on notice and come back with an answer. I should add that the case you are referring to—just so that it is on the record, Mr Chairman—was, from recollection, a private hospital case, not a case which occurred in a public hospital.

The Hon. A. G. CORBETT: That was not mentioned in the article.

Dr WILSON: No.

The Hon. A. G. CORBETT: We have heard in recent months about the overuse of antibiotics. Firstly, is this of concern to the department? I am sure it is. Is it a concern? What has been done to educate both doctors and the public on the proper use of antibiotics?

Dr WILSON: Mr Corbett, you have identified a very important issue in the health care system at the moment in relation to antibiotic use—one that is of national or international concern, really, in terms of the growing resistance to antibiotics. You may be aware that there is a national report on antibiotic use, particularly in relation to antibiotic use in veterinary areas which is one of the major concerns arising at the moment—the growth of not so much unregulated but relatively uncontrolled use of antibiotics in the animals sector and the concerns that may hold for the development of cross-resistant organisms in human beings.

As a result of that, the National Health and Medical Research Council [NH&MRC] is currently developing a national proposal or program which is aimed at trying to lead to more appropriate use of antibiotics in the veterinary sector. Hopefully that will have some flow-on benefits into the human sector. In the hospital sector we have also been looking at this in terms of the use of antibiotics, particularly in teaching hospitals. In most teaching hospitals, if not all—I cannot tell you exactly; I will have to take on notice whether it is all, but I am pretty certain that it is all—now have in place policies on restricting the use of antibiotics, particularly the very broad spectrum antibiotics, to situations where they are absolutely necessary.

As well as that, the other major area where there is use of antibiotics in the community particularly is in the general practice area. Again, the national prescription service is looking at this through a number of strategies. For instance, the Commonwealth is either just about to release or has released a program for use in doctors' surgeries which computerises antibiotic guidelines—they have been around for a long time—to try to facilitate their use within general practice. That is one of the strategies that is being used to try to achieve the more appropriate use of antibiotics in general practice. We have actually taken that program onto our Clinical Information Access Program site, which is a program on the New South Wales Health intranet that is accessible by all doctors.

The Hon. A. G. CORBETT: It continually amazes me that doctors are still prescribing antibiotics for the flu, coughs and colds. It appears that patients pressure doctors to prescribe antibiotics. What has been done to educate both doctors and the public on the obvious superfluous nature of antibiotics for those sorts of conditions?

Dr Wilson: The national prescriber service recently released a survey on that issue. It surveyed consumer expectations in relation to the use of antibiotics, which confirmed the view you just put. As part of its program into looking at the appropriate use of medications, it is proposing to run a national education campaign for the community. However, having said that, it is interesting that the effects are not necessarily as easy to tease apart as that. A study has just been completed which looked at the impact of a Health Insurance Commission program which was aiming to reduce the use of Augmentin, a broad spectrum antibiotic. All general practitioners in Australia who were above a certain percentile of users of Augmentin were sent a note stating that they appear to be overusing Augmentin, et cetera.

Sure enough, it documented a very substantial reduction in the use of Augmentin. I have not seen the full report, only a letter from the investigators. Interestingly, they found that the patients of doctors who were targeted in the mail-out that did not receive antibiotics showed a substantial increase in complications. Also, as a

consequence, there was a substantial increase to the health care system. We have to be very careful about the sorts of approaches we take to try to get people to more appropriately use antibiotics. That was a fairly blunt instrument, which did not tailor the message appropriately to the doctors concerned.

The Hon. A. G. CORBETT: We are all aware of the death of a Federal member of Parliament, apparently from depression. Mr Reid, what measures have been taken within your department to prevent mental illness and mental health problems, given that the budget paper talks about preventative approaches?

Mr REID: The honourable member asked me a question about this at the last Committee hearing. You might recall that I indicated that there has been a considerable increase in the amount of dollars spent on the major strategy announced by the Government regarding mental health. New South Wales has lagged behind other States in per capita allocation for mental health services. The spending on mental health services will grow by $36.5 million in 2000-01, $28.4 million in 2001-02, and $42.6 million in 2002-03. I indicated at the last Committee hearing that a mental health implementation group has been established as part of the National Health Council reform agenda. It will be chaired by Professor Marie Bashir, from the Central Sydney Area Health Service. She has an extraordinary capability in the area of mental health. It will be co-chaired by Professor Beverley Raphael, the Director of Mental Health for New South Wales Health.

Much of the work history that Beverley focused on concerned how to develop more health preventative activities and early intervention and identification for mental health services. We will have to wait for the findings of this committee to see where the focus of those additional mental health dollars will go. It is my expectation that they will be very heavily focused around early intervention and early prevention. Over the past two years we have had major initiatives in suicide management, and we have put in place a range of tremendous strategies for suicide prevention, with large dollars attached to them. We have run a major suicide prevention campaign in conjunction with the Commonwealth. We could probably expand those.

In the case that you mentioned for New South Wales Health staff, we have put in place comprehensive employee assistance programs. We have the support mechanisms in place. We are issuing updated guidelines to our health system on mental health issues amongst some of the staff. As you know, the 100,000 people who work in New South Wales Health are just as prone to mental health illness as is the rest of the community. There is a national mental health promotion strategy, which has been signed off by the Commonwealth and the States. It is geared to developing mental health awareness in the community. There are preventative activities, and that is a joint Commonwealth-State initiative.

At the end of the day the suicide levels in Australia are one of the highest in the world. From recollection, Finland has the highest rate and Australia ranks second or third. Worse, among the Aboriginal community the suicide rate is four times that of the rest of the Australian community. This particularly impacts upon young Aboriginal males from 18 years to 25 years; that group has a distressing level of suicide. Today I returned from Broken Hill, where I attended a dinner last night. Midway through the dinner a person had to leave because one of his relatives, a 26-year-old male from Wilcannia, committed suicide last night. It is a sad feature of the Australian health system if we cannot tackle youth suicide, particularly in our Aboriginal community. If we cannot, we have failed our nation.

CHAIR: How much money intended for mental health has come out of the $2 billion announcement?

Mr REID: The figures I quoted are included in the additional $414 million that flowed into the system this year.

CHAIR: The money that was announced for mental health was included in the Minister's initial amount. How much of that will go to non-government organisations [NGOs]?

Mr REID: That is undecided. We have established a committee under the chair of Marie Bashir and allocated dollars to the area health services as part of the budget we put out.

CHAIR: You do not have a figure?

Mr REID: It is up to the committee to give guidelines, and it is up to the area health services to give some input into the mix between public sector services in the non-government services.

CHAIR: I think I would rather have the Minister here; his answers are a bit shorter.

The Hon. H. S. TSANG: I think his answers are adequate.

CHAIR: The McClellan report insisted upon an independent testing laboratory that must be identified without delay. How long after the water crisis from July to September 1998 were tenders invited for the role of an independent testing laboratory for Sydney Water?

Dr WILSON: I will take that on notice. It was the second half of last year, after the task force looked at the different options that were available, but I cannot remember the exact date.

CHAIR: How many tenders were submitted?

Dr WILSON: It was a two-part process. First, we went out to see who had the capacity. We put out an expression of interest and asked people whether they had the capacity to do it. From that, five or six groups put in an expression of interest, but I will take that on notice as well. Of those, only three could have realistically delivered and they were asked to put forward a tender. AWT was one of the groups that put in for the original expression of interest. It is obviously the group that was being accessed so it was not assessed for the final.

CHAIR: Recommendation 50 of the final report on the Sydney Water inquiry asserted that a suitably qualified independent laboratory should be established to provide adequate data for regulatory authorities. The laboratory must be adequately resourced. When will the independent testing laboratory actually begin operation?

Dr WILSON: The contract for independent testing was signed last week. We will commence straightaway the process of actually getting the process to work properly.

CHAIR: Will the independent testing laboratory test Sydney's water every day of the year?

Dr WILSON: There are two parts to the water testing program. I am happy to give you complete details of that.

CHAIR: Will you come back to us with those details? Will the independent testing laboratory test every site that is tested by AWT on a daily basis?

Dr WILSON: The independent process will assess all testing of Sydney water that is carried out by AWT at the moment. Wherever they are testing, we will test.

CHAIR: Has the laboratory been accredited for testing for cryptosporidium and giardia?

Dr WILSON: The only laboratory in Australia at the moment which is accredited for cryptosporidium testing is the AWT laboratory.

CHAIR: The new laboratory you are setting up will not be accredited?

Dr WILSON: It will be accredited. As part of the contract there is a requirement that it achieves accreditation within a period of time. I will have to get back with the correct time.

CHAIR: Currently the laboratory that has got the tender has not got accreditation?

Dr WILSON: The NATA process has been introduced. Remember there is only one laboratory which is being accredited, that is the AWT laboratory. That reflects the enormous efforts that it has put into improving the quality control processes over this period of time.

CHAIR: What incidence of possible corruption, including fraud and breach of statutory requirements, misconduct and financial or other types of irregularities, is the Department of Health experiencing?

Mr REID: I do not have a comprehensive list of all the possible areas of corruption the department is possibly experiencing. Those allegations can go to a variety of sources. As you are aware they go to ICAC, for example, direct from New South Wales Health. There might be things being investigated by the Ombudsman's Office or the Health Care Complaints Commission.

CHAIR: Are you aware that the department put out for expressions of interest for people to come and investigate for you? I am using your words from your advertisement. You went out to contract to get some investigators to take matters from ICAC, as I understand it?

Mr REID: No. We did go out to contract. I now understand the question. We put an advertisement in the newspaper.

CHAIR: What drove you to do it? What problems were you facing?

Mr REID: Quality.

Mr McGREGOR: On a number of occasions where allegations may be made to the Independent Commission against Corruption it is not uncommon for the commission to refer those to the department for investigation. It has been our experience during a long period of time that quite often it is far better in terms of the perception of the investigation for it to be undertaken independently. The department has consulted with the Independent Commission against Corruption and with other agencies about this process of using a panel of independent investigators. As I said, we have found that to be an issue that gives us quality results in terms of investigations.

CHAIR: What is the budget for that?

Mr REID: If the question is leading to an implication that there have been a range of specific instances or a growth in this area which causes—

CHAIR: I did not say that. I was using your words in the advertisement.

Mr REID: We are going out in a contracting arrangement on the basis of going to a panel arrangement. That is doing exactly what we have been doing for many years to ensure that there are more explicit quality standards in those arrangements. I think that is something to be applauded.

CHAIR: I did not make any inference. I simply used your words. What budgetary allocation is being put aside for that?

Mr McGREGOR: There is no specific budgetary allocation. Again it is the department's experience that it is quite often more efficient and economical for the investigation to be conducted externally rather than using people internally who have to be released from duty and the associated cost attached to that.

CHAIR: Could it be $500,000, $1 million, $2 million or $5 million?

Mr REID: We do not have a budget allocation. In some cases these budgets are covered by the department and in other cases they might be covered as a normal course of events by an area health service.

CHAIR: Will the people that you acquire help with the checks on staff and new staff as part of the implementation of the recommendations of the royal commission into paedophilia?

Mr REID: No, this is an entirely separate unit to a unit which has been operating for many years in the department since the royal commission. That is the staff records management unit, which for a long period of time has been doing not only comprehensive staff checks but checks to assist in terms of NGOs with health connections or students who come and work in our health system.

CHAIR: Contractors?

Mr REID: Or contractors as part of fulfilling the requirements and recommendations of the royal commission. The panel is a separate entity.

CHAIR: Who won the contract for Sydney Water's independent laboratory?

Dr WILSON: It is an Adelaide group whose name escapes me at the moment.

CHAIR: What is the value of the contract?

Dr WILSON: The testing regime is linked to the number of tests that AWT does. The contract that has been awarded relates to the volume of testing which goes on, which will go up and down as demand requires.

CHAIR: What is the big number?

Mr REID: We are probably looking at something about $1.5 million for the totality of the activities. We need to wait to see what the end result will be.

The Hon. Dr A. CHESTERFIELD-EVANS: Dr Alex Wodak said in a recent talk that since 1986 there had been an agreed policy of harm minimisation for hard drugs. He pointed out that of the money spent on hard drugs, 10 per cent is spent on research, 6 per cent on treatment and 84 per cent on police in gaols. Would you comment on those figures?

Mr REID: No. They are issues which to some degree are outside the portfolio of Health. They are whole-of-government decisions. I am happy to comment on my portfolios area of interest.

The Hon. Dr A. CHESTERFIELD-EVANS: If the policy is harm minimisation and, in fact, it has fundamentally been law enforcement and not harm minimisation, is it not in your department's bailiwick, particularly as Dr Wilson points out that it is not quite what was intended and what the rhetoric says?

Mr REID: No, I re-emphasise that the estimates committee relates to the portfolio and expenditures—

The Hon. H. S. TSANG: I would like to endorse what the director-general said. According to the rules of the Committee, policy areas should be referred to the Government and not to public servants.

CHAIR: I thought it was a pretty straightforward question. You can follow it up if you like.

The Hon. Dr A. CHESTERFIELD-EVANS: If the policy is to do one thing and something different is done, can the recommendation of the department—

The Hon. H. S. TSANG: Mr Chair, you have to rule whether my objection is relevant.

CHAIR: The question related to the implementation of policy rather than whether the department was changing the policy. Was that the thrust of your question?

The Hon. Dr A. CHESTERFIELD-EVANS: That the policy as stated is not the policy as implemented.

The Hon. R. D. DYER: Mr Reid's response was to the effect that this is a whole-of-government matter and that many of the aspects raised fall outside the health portfolio.

Mr REID: I am happy to answer the question. I am not happy to answer a question about the relative allocation of dollars outside the Health portfolio. I do not think that would be an appropriate question to ask me. I was asked to make a comment about the proportion of distribution between Corrections, Justice and Health. I am not willing to make a comment on that. That was the nature of the question. I am willing to say that we have been asked in relation to the government plan of action to look at the implications of the flow-on of health activities into other portfolios. We have a comprehensive strategy of looking at, for example, the flow-on of the extension of methadone maintenance programs into gaols or the flow-on of a range of other activities. I am not willing to comment on the relative distribution because it is outside my scope and knowledge.

The Hon. Dr A. CHESTERFIELD-EVANS: The McArthur Drug and Alcohol Youth project was not funded, although it seemed to fall within the guidelines. Is that correct?

Mr REID: I am not aware of that. I would have to take that question on notice. I have been advised that the McArthur Drug and Alcohol Youth project has received notification that it will be funded. The only point of context which is yet to be resolved is the source of funding for that service, whether it comes out of the broad drug reform dollars—you correctly said that you thought it did not fit within those parameters—or from the area health service as part of its normal activities.

CHAIR: Mr Reid, on the last occasion I put a number of questions on notice about all area health services receiving extra money but incurring extra costs in the previous year over and above their allocation and the forecast net cost of services for Wentworth in 2000-2001. I remind you that those questions are still outstanding. I thank you for your attendance and I wish you a good evening.

The Committee proceeded to deliberate.