GENERAL PURPOSE STANDING COMMITTEE No. 2

Wednesday 20 June 2001

Examination of proposed expenditure for the portfolio area

HEALTH

The Committee met at 6.30 p.m.

MEMBERS

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

The Hon. Dr A. Chesterfield-Evans
The Hon. R. D. Dyer
The Hon. Jennifer Gardiner
The Hon. R. S. L. Jones
The Hon. J. R. Johnson
The Hon. H. S. Tsang

PRESENT

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

New South Wales Health
Michael Reid, *Director-General*
Ken Barker, *General Manager, Finance and Commercial Services*

CHAIR: I welcome you to this public hearing of General Purpose Standing Committee No. 2. First, I thank the Minister and departmental officers for attending today. At this meeting the Committee will examine proposed expenditure for the portfolio area of Health. Before questions commence a couple of matters need to be dealt with. Part 4 of the resolution referring the budget estimates to the Committee requires the evidence to be heard in public. The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. A copy of the guidelines for the broadcasting of proceedings is available from the attendants.

I point out, in accordance with Legislative Council guidelines for the broadcast of proceedings, that only members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, the media must take responsibility for what you publish and what interpretation is placed on anything that is said before the Committee.

There is no provision for members who are at the table to refer directly to their staff. Witnesses, members and their staff are advised that any messages should be delivered through the attendant on duty or the Committee clerks. For the benefit of members and Hansard, I ask departmental officers to identify themselves by name, position and department or agency before answering any questions referred to them.

When members are seeking information in relation to a particular aspect of a program or subprogram, it would be helpful if the programs or subprograms are identified. The Committee has agreed to the following format for the hearing. The Hon. Jennifer Gardiner will commence for the Opposition, followed by the Hon. Dr Arthur Chesterfield-Evans and then the Hon. Richard Jones, each for about 20 minutes. We will then have a break in which refreshments will be provided in the anteroom. After the break the Government may wish to exercise its right to ask 20 minutes of questions, I will ask 20 minutes of questions and the remaining time will be divided on the basis of any member having urgent questions. Minister, does that create any problems for you or your officers?

Mr KNOWLES: My understanding is that this is a two-hour session. What you have outlined is essentially two blocks of three lots of 20 minutes.

CHAIR: Yes.

Mr KNOWLES: If the Government does not ask questions, do you propose to fill that up with other questions or are you going to compel me to do Dorothy Dixers?

CHAIR: I have to ask whether you are prepared to take questions on notice at the conclusion of the hearing?

Mr KNOWLES: Yes, as we usually do.

CHAIR: The timing for answers to be given to the Committee has yet to be decided by the Committee. We will have to do that at the conclusion of the estimates hearing and notify you. At this stage the usual guidelines would be approximately 20 days. As the lower House is sitting, could you advise whether you will need to attend divisions this evening.

Mr KNOWLES: I understand I am paired.

The Hon. JENNIFER GARDINER: Budget Paper No. 3, Volume 2, subprogram 48.2.2, relates to overnight acute inpatient funds. Can you tell the Committee why you underspent the overnight acute inpatient budget by $250 million last year when there are now nearly 68,000 people waiting for elective treatment?

Mr KNOWLES: We did not. I will ask either Mr Reid or Mr Barker to go into detail; but I can say that the assertion in Mrs Skinner's press release is wrong. If you look at the total range of programs, we are spending $58.5 million more. Quite clearly, as we continue to reallocate funds between programs and as we continue to fine-tune programs over time there are always adjustments.

That comes from about 1994 when funds were allocated in an unidentified block grant. Since that time the system has attempted to break down the allocation of funding into the range of program areas shown in that allocation—everything from primary care, to teaching and research and including a large number of areas within the schedule. If we look at their cumulative total, we will see an increase of $58.5 million. I might add that a reduction of $250 million in acute overnight care—essentially operations—would equate to roughly 125,000 operations. I think we might have heard about that.

The fact is that the change in classifications—for example, dialysis was once classified as acute inpatient and cancer treatment was once classified as acute inpatient but is now classified as an outpatient service—has seen the adjustments in those numbers. It is a rational approach. Of course it is also supported by the clinical changes that were announced a year ago in the context of the Health Council report and have been further endorsed since through the work of the chronic care committees and acute care committees of the Health Council

They were endorsed most recently a week or so ago by the metropolitan planning group, which recognised that the nature of and changes in medicine saw a great shift into primary care models—outpatient-type services and so on. As a consequence, the assertion that has been made—I do not know whether it was in a press release but there was certainly a quote from the shadow Minister for Health, the honourable member for North Shore, in this morning's *Daily Telegraph*—is simply wrong.

Mr REID: I should add that there are very good clinical reasons why we are trying to shift the balance in the proportional distribution between programs. As the honourable member knows, we have 10 different programs in the health sector and progressively over time we have been trying to relatively increase the proportion of those areas that have historically been underfunded in our system. That is the first point.

CHAIR: The Hon. Jennifer Gardiner's point is—and I have the relevant page in front of me—

Mr REID: If I may finish my point, the areas where we are progressively trying to increase expenditure are mental health, Aboriginal health and community health. Trends in those program areas over the past 10 years show progressive increases. As the Minister indicated, at the same time we are actively trying to reduce admissions to hospitals for areas such as chronic care in order to have better management of those patients in the community.

CHAIR: The bottom of page 9-23 shows that $3,351,647 million was allocated in the budget for 2000-01 and that $3,101,543 million was spent. In other words, is the figure here rubbery as well?

Mr KNOWLES: What you see is the budget; the revised figure. If you quote figures in isolation, you can tell any story. If you want to look at the total picture, I refer you to the bottom of the same table from which you just quoted and the figure of $7,416, 867 million.

CHAIR: We are not arguing about that. The question is specific.

Mr KNOWLES: We have given you an explanation for the shift in program spending, which shows that under that total area of the budget there has been a $58 million—

CHAIR: In other words, you are saying that area health services can allocate the money however they like.

Mr KNOWLES: Brian, we can have an easy night or a long night. We can interrupt each other all night or we can take turns at speaking. There is a $58.5 million increase in this program as published. You fail to recognise or acknowledge the shift in program identification—for example, a $94 million increase for primary and community-based hospitals; a $76 million increase for emergency services; a $54 million increase for outpatient services; and a $106 million increase for rehabilitation and extended care—and models of care.

CHAIR: It will be a difficult process this evening unless you are more concise. The specific issue is that this budget allocation was passed by Parliament. We want to know whether the moneys that were allocated will be spent. The Hon. Jennifer Gardiner pointed out that under this form of arrangement Parliament allocated $3.3 billion last year, of which $3.1 billion has been spent. That is $250 million less than you were allocated in the budget. We are now asking why you underspent by $250 million on the line item that was identified in the budget. That is the question, and it is the sort of question that is asked in an estimates committee hearing.

Mr KNOWLES: The total allocation for this range of programs encompassed under this part of the budget has shown an increase of $58.5 million with variations between the various programs within the overall program budget. Of course, that is as it should be and that is as it has been every year. If we went back to the 1994 budget papers, for example, we would not see these variations because all that ever happened was one block fund was allocated to an area health service, and it was divided up as the service saw fit.

This is a more sophisticated model that recognises that over time, particularly given the changes in the methods of treating people, there is a shift in the way in which funds are allocated. That is an entirely legitimate and highly transparent method of providing the community with information about their expenditures in this particular part of the health budget.

CHAIR: Minister, since you have not answered the question, I will ask the Hon. Jennifer Gardiner to move on.

Mr KNOWLES: I have answered that question.

The Hon. RON DYER: Point of order: It is entirely gratuitous of you, Mr Chair, to say to the Minister that he has not answered a question. You may find his answer unsatisfactory. However, he has responded to the questions that were asked.

CHAIR: I take the point. The point I was trying to make was the same point I made earlier. It will be in the transcript.

Mr KNOWLES: The point you are really making is that Jillian Skinner tried to do a beat-up in today's *Daily Telegraph* that went nowhere. You are trying to do it again and you are going nowhere. No-one with any credibility or understanding of these things would pursue it. That is a matter of fact. If you are unhappy with that, I am sorry. However, if you are pretending that we cut elective surgery by $250 million, I do not know where you are living. That implies a cut of 125,000 operations. Do you think that 125,000 operations can suddenly disappear out of the system without clinicians going berserk? I am not sure what you are trying to assert.

CHAIR: They are.

The Hon. JENNIFER GARDINER: Minister, can you advise of the total acute inpatient hospital budget, the percentage allocated to elective surgery and the percentage allocated to elective medical treatment? Can you give us that breakdown?

Mr REID: The information in the budget papers on a program basis does not differentiate between elective surgery and elective medical programs. We have some information about the volume of elective surgery and the volume of elective medical procedures, but it is not split in the budgetary context either in the budget or in any area health service.

The Hon. JENNIFER GARDINER: You do not have that at all?

Mr REID: It is not split in a budget context, no.

The Hon. JENNIFER GARDINER: For the budget papers or for the department generally?

Mr REID: There is no differentiation in any accounting procedures in a budgetary sense at hospital level, area health service level or State department level of the monetary split between elective surgery and elective medical procedures. We have information, which we could provide to the honourable member—it is available on the website—which shows the volume of elective services that are undertaken. You could deduce, if you wish, on the basis of a value of diagnostic-related groups the cost associated with those two pools of money. It is not identified in any accounting procedure anywhere.

The Hon. JENNIFER GARDINER: Minister, can you provide information about the 2000-01 budgeted and revised allocations to each of the 10 health budget programs you referred to earlier for each of the area health services?

Mr REID: I would like to make a point here. When we send out a budget allocation letter to area health services, we do not send out a budget allocation according to the programs that are listed here. This is a mechanism in response to questions from this Estimates Committee some years ago to try to seek some further clarification about how we split the money between the various program areas. We now provide the information post hoc according to the program classifications.

The allocation letter which goes to the areas indicates, as I and the Minister have told this Committee, that some areas are fenced off in terms of not having any reductions in the budget. At the moment they relate to aboriginal health, mental health and community health. In terms of their accounting procedures, the area health services come back to us and indicate those areas to ensure that they have not removed money from them.

In fact, you can see from the trends over time in the program allocation that there has been a substantial increase of money into those areas. For example, aboriginal health has gone up from 1989 to 2001 in percentage terms. Mental health has gone from 6.81 per cent of the budget up to 7.2 per cent of the budget. Aboriginal health

has gone up from 0.29 per cent of the budget to 0.35 per cent. They are specific designated areas. Of course, we spend money on aboriginal health in a variety of other areas. There is not a specific allocation letter that spells it out.

CHAIR: It might help if the annual report of the department reported by line item on expenditure, which is what the Hon. Jennifer Gardiner is trying to elicit. She wants to find out what percentage of the money is spent on emergency admissions and what percentage is spent on routine booked admissions. That would tell us a bit about the way the system operates, how much money is spent on the acute overnight area, how much demand and pressure is put on the system by emergency admissions, and how much is available within the budgetary arrangements.

Mr KNOWLES: If you want to ask that question you can, but that was not the original question. The question was can we provide a breakdown in the programs in each of the 20 controlled entities.

CHAIR: No, it was not.

Mr BARKER: In the mid-1980s the Public Accounts Committee [PAC] reviewed how hospitals had their budget set. Around 1988-89/1989-90 the principle of global budgeting was introduced in the New South Wales Government generally. That principle has been followed ever since. In the context of building up an expense budget—which is built up upon the basis of government cash, non-cash items and own source revenues—the areas can work out their expenses budgets across the programs. As the Director General said, some specific programs have quarantines in place and there are other sub-components in a small area where there are quarantines which are subject to separate reporting. They have a legal obligation to meet the demands of their communities. Therefore, they are required to move the money between the programs to satisfy those demands.

CHAIR: They are also required in their annual reports, in exactly the same way your annual report is written, to show their expenditure against different items. As I understand it, the department and the area health services have an agreement on how much money is allocated to each of those line items. These services then have the ability to move their money, again by agreement with the department, between one program and another. Is that not true?

Mr BARKER: That is true, they have the ability to move. They do not—

CHAIR: Why did you approve a movement across the system of $250 million from acute overnight to other programs?

Mr BARKER: As the Minister said, we used to have a program called 2.3 support for area health services. It had over 77 to 78 per cent of the budget. We were constantly criticised and asked why Health did not dissect this amount of money. In the 1995-96 budget papers the process of refinement and distribution into a more meaningful way of how health services delivered their programs was introduced. The process has been maintained. The reforms in both the clinical area and other reforms have meant that the budget papers have gradually improved in respect of showing where the appropriate services have been delivered.

I would imagine that the acute area will further improve as episode funding continues its roll-out, because areas are going to have to justify where they are over benchmark levels and what is causing that. They are looking more closely at their budgeting and costing and their overall scope of services within the defined program areas.

CHAIR: These budget figures, as they are reported in these papers, are totally rubbery and able to be moved and changed?

Mr BARKER: I did not say they are rubbery. They are estimates based upon the best current information we have available. As from 1 July episode funding has been introduced for emergency departments and intensive care units. That will increase the refinement in those areas. The episode funding next year will have a different focus compared to this year's focus. One must expect that these figures will continue to move within the global funds we have available and will improve our understanding of where the money is being spent.

Mr KNOWLES: That, of course, is entirely legitimate, given that this is a budget estimates committee and we are dealing with the estimates for the forthcoming year. In terms of area allocation, I can advise that the following amounts have been allocated to the area health services.

They are consistent with the three-year budget announced on 8 March last year when the Government responded to the Menadue and Sinclair reports and the Health Council reports. They are entirely consistent with the

agreements we have reached both at an administrative level and a clinical level with the various groups that have been involved in the planning for the disbursement of these funds ever since.

Central Sydney received $604.6 million and Northern Sydney received $510 million. I will round the figures off. Western Sydney received $562 million, Wentworth $213 million, South-Western Sydney $515 million, Central Coast $205 million, Hunter $475 million, Illawarra $245 million, South Eastern $818 million; Northern Rivers $218 million, mid North Coast $194 million, New England $148 million, Macquarie $97 million, mid Western $161 million, the Far West $56 million, the Greater Murray $194 million and Southern $133 million. Then we had the remaining specific area services.

A point about those allocations is that they continue the Government's announced policy of redistributing health funds to a more resort distribution formula. That is one of the reasons we have mustered support at a clinical level for these changes: they send the money to where the communities are and to where the population has been shifting for some years. That is why, in proportional terms, areas like the mid North Coast again gets a very substantial percentage increase of 12.7 per cent and other areas are growing in not dissimilar amounts. We recognise the long-held view that health funding was disproportionately skewed to the urbanised areas and inadequately supporting the growth areas, particularly the northern region areas from the Central Coast to the Hunter and up through the mid North Coast—

CHAIR: You have given this answer before. I am aware of the—

Mr KNOWLES: I have never given those figures before, ever.

CHAIR: They were in the budget when you launched your $2 billion—

Mr KNOWLES: I am sorry, that is not correct.

CHAIR: They are consistent with that. You said so when you started to answer the question.

Mr KNOWLES: I would hope they would be consistent with that.

CHAIR: Exactly. We have asked each year when that will be completed, and we found out from Mr Reid last week that it will not be completed until the year 2002-03.

Mr KNOWLES: Which is what we announced a year ago.

CHAIR: We will not ask that question again until that time.

Mr KNOWLES: You may not seek to ask that question because it underlies the fundamental cornerstone of the Government's policy, which is the distribution of health funds on an equitable basis. Whilst you may not like to hear this, that is what has gained the attraction in the health system of clinical groups all around the State over the past 18 months, seeing them get their fair share.

The fact is that we announced a three-year health budget for the first time ever on 8 March last year. That was predicated on additional funds being injected into the health system and, despite the best efforts of one of your colleagues and an interesting access economics reports that was debunked in about a week, no-one argues now, particularly clinical groups, that there is no money, new money and growth money, in the system.

Of course, that money is being distributed on a fairer basis and, most importantly, based on the principles that we have outlined, and I keep repeating them because they are worth repeating: the opportunity for clinicians to have a real say in how that money is spent. That is why a whole lot of people have signed up, including the shadow Minister for health, for the announcement we made last week about the metropolitan services plan, which finally has bipartisan support.

CHAIR: If you keep your answer concisely to the question you are asked we will actually get through some questions this evening. I would appreciate your being concise. That is one question out of the way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I refer to Budget Paper No. 3, Volume 2, page 9-31 Why was less money allocated to population health services compared with last year? It seems that most of this was due to the cut in staffing. Can you tell me why there was such a large cut in the population health services budget?

Mr KNOWLES: We have that here. I think there is a rational reason for it.

Mr REID: I am on population health. Which figures are you talking about, just so that I know?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is a huge drop in the average staffing on page 9-31 of Budget Paper No. 3, Volume 2.

CHAIR: The funding is on page 9-32.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would appear from the fact that other items have not been cut much that the cut—

Mr KNOWLES: I am on page 9-31. I am looking at average staffing EFT with—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is right, it goes from 2,456 to 1,5722.

Mr KNOWLES: No, it has gone up. It has gone from 1,545 to 1,572.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sorry, it comes before.

Mr KNOWLES: It has gone up from 1,545 to 1,572.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the budget has gone down.

Mr REID: No, the decrease from 1999-00 to 2000-01, which may be the figure you are talking about, 2,433 to 1,545, is that the figure?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Mr REID: The decrease in staffing numbers did not result from any staffing decreases, but resulted from a program environment.

Mr KNOWLES: It is the same thing; it is a shift in the program

Mr REID: Yes. The reduction of 888 is fully offset by the increase reported in the primary and community-based services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has just moved across?

Mr REID: It has just moved across.

Mr KNOWLES: If you go to the primary and community-based services component of this program you will see the commensurate increase in the same numbers, which is a good example of the furphy that has been run about acute services with the shift up and down.

Mr REID: I should emphasise for the purposes of the Chair that we are projecting, again, an increase for 2001-02, as the Minister has already indicated, which is consistent with the increased funding provided in that area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is, however, still a decrease in that area. What is responsible for that?

Mr REID: The decrease in the money?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Mr REID: It relates to the same thing. You have shifted a number of staff, you have shifted components of the program and you have shifted component of the dollars

Mr KNOWLES: I am looking at the proposed budget and there is an increase—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: An increase from the revised. I see what you are saying.

Mr KNOWLES: Yes, that is right.

Mr REID: Again.

CHAIR: But what are we likely to see if the question is the one we asked before? What are we likely to see next year? That figure next year could be $160 million, could it? You have $214 million down to $135 million. This year you have $183 million.

Mr KNOWLES: I guess we will just have to wait until next year.

CHAIR: Are you likely to see that next year?

The Hon. JOHN JOHNSON: We are not discussing next year's budget estimates.

Mr KNOWLES: We will have to wait until next year, will we not?

CHAIR: This is a gross drop, and he tried to explain that. But the actual expenditure—

Mr KNOWLES: No. The Director-General has indicated that there are commensurate changes in other program areas as they adjust, and as the programs are refined they predict a further increase next year.

Mr REID: As you would move 888 staff in their associated program areas you would expect you would move an amount of dollars related to that staff.

Mr KNOWLES: For their wages, for example.

Mr REID: The totality of the combined population in health and community health, where the shift has occurred between those two program areas, has increased and it is projected to increase further, and it is fenced off.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note that you have a pretty modest change in the smoking rates. Do you think that is satisfactory? What level do you think is satisfactory? I notice that female smoking rates have not dropped at all, and that male smoking rates are dropping quite slowly. Is a 1 per cent drop in male smoking rates over four years satisfactory?

Mr KNOWLES: On a personal level I do not believe so. But, as you well know, and you know much more about this than almost anyone else in the room, if not the State, we are now getting to that core group of individuals who are more difficult to get off smoking. In addition to that there is this increase in the number, particularly of young females, who are taking up smoking. It is a combination of those two factors that are leading to a slowing down in the rate of decline in smoking.

That is why, as you are well aware, we continue to work with organisations like the Cancer Council to try to further refine and target the message to these key groups. That, backed with the various legislative packages targeted at young people, retailers selling to underage people purchasing and so on, not to mention our smoke-free environment bill, is all part of a suite of initiatives.

I believe that any community would argue—with the possible exception of the Treasurer, who is in the room—that this is one of these areas where there is always work to be done. However, it is fair to say that there have been substantial amounts of work done, with more to do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The quit rates are very much proportional to the quit advertising if you are selling a product. A lot of research is available from California, and the rates that they were looking at were much lower and falling much faster than ours. You say that the hard core smokers would not be consistent with the Californian literature, but the spending rates in Australia are absolutely derisory by Californian standards. The cost-benefit analysis in the health service would suggest that you are going to make money from doing that, yet you are not doing it. Why is that?

Mr REID: If I could make comments on both the first question and the second, you will recall that the Chair asked a question during a previous estimates committee meeting—I am sidetracking a bit here—as to why tobacco packages did not actually carry a warning that smoking causes blindness. On the day following that estimates committee meeting we wrote to the Commonwealth and sought its support for putting that on cigarette packages. You will be pleased to hear that tobacco packages now carry a warning that smoking causes blindness.

But I digress. The national tobacco campaign "Every cigarette is doing you damage" has been the most successful anti-smoking campaign aimed at current smokers. It has been promoted in New South Wales, on our estimate, for the past 15 years. Indications are that it has resulted in a significant reduction in smoking prevalence, perhaps of the order of 1.4 per cent. That might seem a small amount but, as the honourable member would know and as the Minister has indicated, we are coming to the hard core of smokers at the moment, in terms of the decline in tobacco usage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not answering my question. California had a much lower rate than this and it was still falling faster. It showed that the more you spend on quit programs, the faster your numbers drop, even at levels well below what we have here.

Mr REID: I am advised that direct comparisons with the Californian program funding estimates are misleading, because in New South Wales additional education in schools is provided by the Department of Education and Training and is not costed in our own sector. That is one point. Second, additional investments in tobacco control—which are not included in the $3.3 million, which is the published figure for our expenditure in this area—occur throughout all of our 19 area health services; we can probably exclude the children's hospital.

They have a range of personal activities that involve promoting smoking cessation, assisting smokers to quit, monitoring and enforcing tobacco legislation, educating various groups and communities about the health effects of both active and passive smoking, and research and monitoring various tobacco control activities. Also not included in the State figures is the fact that, under the auspices of the national public health partnership and the Australian Institute of Health and Welfare, work is progressing nationally and in New South Wales to get more consistently reliable estimates of population and health investments. At the moment we do not, unfortunately, have disaggregated area health data for tobacco control.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there money to be allocated to the community participation strategy, as it relates to the Government action plan health council reforms? If so, where in the budget papers is there reference to that?

Mr REID: I should point out where we are with the implementation of the Government action plan [GAP]. You will recall that we had three sentinel events: in November 1999, Treasury, in its wisdom, gave us three-year budgets, growth funding and equity allocations; in March 2000, we released the Health Council Report and the Ian Sinclair Report; and we have had a year of moving forward on the implementation of that into the GAP program. That brings us forward to March 2001.

The budget papers you are looking at are not reflective of any specific aspects that have come out of the implementation, other than the initially announced figures for intensive care, emergency departments and best practice. Budget considerations in relation to, for example, the greater metropolitan health plan, the consumer participation area, information technology strategies—I should note, however, there were significant enhancements in capital works for information technology—and the various other components are within the normal growth factors of the health budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With respect to community participation, is it true that New South Wales Health engaged a company, PPK Environment and Infrastructure Pty Ltd, to conduct community consultations in the period March to May 2000 at a cost of $90,000, with responses from 400 people? Why was that done when the health consumers network sought $30,000 to run a pilot project to demonstrate how statewide independent consumer groups could work, and was knocked back?

Mr REID: It is true that PPK Environment and Infrastructure Pty Ltd was hired. I think it is also correct to say that the amount funded to the company was $90,000. An extremely important component of the reports of both John Menadue and Ian Sinclair was that having a stable, clinically effective and involved community in our health sector required better participation by the community in our planning process. PPK, as you rightly indicated, consulted with a large variety of people. Turning to your question, there are considerable differences among consumer organisations and individual consumers about the appropriateness of any individual body—at the commencement of this process—receiving an allocation of $30,000 in order to act on behalf of all consumers.

It has been brought home very bluntly to those involved in this consumer participation that many consumers, particularly those in rural areas, do not regard peak bodies, and the body you mentioned, as the type of body to whom you would necessarily allocate money to in order for them to represent consumers. For that reason an external PPK process was decided on. One very important outcome from that will be the extent to which there should there be a peak body selected from existing bodies to represent consumers in this State in this process—

whether there should be disaggregated consumer representation or a new body formed. That discussion is proceeding, I believe even as late as a few hours ago.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not true that the PPK report dealt mainly with health service providers and area health service employees, rather than the public?

Mr KNOWLES: That is not what I believe. In fact, one of the joint chairs of the committee who is in the gallery is shaking her head vigorously.

CHAIR: Would you state the name of that person?

Mr KNOWLES: Yes, Deborah Hyland. The other joint chair, Julie McCrossin, also briefed me on these matters. I believe that they and their group should be commended for the extent of their consultations with a range of community groups. What we have here is, in my view, not an unexpected divide between those who presently have a deal of control and status as auspiced consumer representative bodies and those, for example in small country towns, who do not necessarily belong to organisations such as NCOSS, or whatever the organisation might be, and feel that they are marginalised when issues of consumer and community participation are discussed.

From the briefings I have received, there was very vigorous debate during this particular segment of the Government action plan process around what would constitute a fair and reasonable model that would retain the existing and historic organisations—the organisations that governments traditionally liaise with—but also seek to involve those individuals who feel they are disfranchised because the views of particular organisations may not necessarily represent their particular personal view. That does extend also—

CHAIR: Could you bring your answer to a close, Minister?

Mr KNOWLES: I was going to say that also includes regional and rural organisations. For example, I have received representations from the Country Women's Association, which felt that it was not traditionally part of the consultation framework and urged us not to be throwing money at a specific body until all those issues were teased out and sorted out. I was very happy to agree, especially with the Country Women's Association's representations, on those issues.

The Hon. RICHARD JONES: Minister, why has the department failed to recognise the importance of multiple chemical sensitivity [MCS] as a potentially serious public health issue? Why has the department only quoted the positive statement by the American Academy of Allergy and Immunology when there are other scientific papers asserting the very real problem of MCS?

For example, I refer to "On Recognition of Multiple Chemical Sensitivity in Medical Literature and Government Policy" by Albert Donnay, which was published in the *International Journal of Toxicology* in 1999, in which he states "a psychogenic etiology specifically rejected in the 1994 consensus statement of the American Lung Association, and the American Medical Association, the US EPA and US Consumer Product Safety Commission"?

Is it not a fact that Germany listed multiple chemical sensitivity in its edition of the World Health Organisation's international classification of diseases [ICD] in November last year? Will your department wait until Australia lists MCS in its ICD before recognising the importance of this syndrome? Finally, do people who suffer from MCS in New South Wales have equal and adequate access to medical facilities? If not, why not?

Mr KNOWLES: For the Luddites in the room, including me, this was the disease of the twentieth century—

The Hon. RICHARD JONES: The twenty-first century.

Mr KNOWLES: And it is now the twenty-first. We changed.

The Hon. RICHARD JONES: It is recognised in the twenty-first century.

Mr KNOWLES: Yes. It is the one that relates to the partner of a member of the upper House, if I remember correctly.

The Hon. RICHARD JONES: Who would be sitting here if it were not for multiple chemical sensitivity.

Mr KNOWLES: That is the thing you are talking about.

The Hon. RICHARD JONES: That is why I am asking the question specifically.

Mr REID: The department is very aware of issues surrounding chemical exposure and we constantly confer with what we believe to be reputable immunological, allergy and other experts to obtain the relevant information in this area. Current advice on this condition is that it is an extremely complex issue and it is a condition characterised by quite diffuse and relatively non-specific symptoms which are difficult to relate to any specific chemical or to any known toxicological profile.

There has been, and remains, extensive debate in professional circles. It has been occurring over many years. No consensus has yet emerged. Given the lack of consensus, the most appropriate strategy for treatment still remains unresolved. There is no obvious remedy that specifically addresses the concerns of those with the condition. It is very unfortunate but it is true at the moment.

Position statements have been put out by the American Academy of Allergy, Asthma and Immunology and the American College of Occupational and Environmental Medicine, which were released in 1999. They reflect the current status of multiple chemical sensitivity as documented in the published scientific literature. The other specific question, which flowed from the honourable member's first question, I would—

The Hon. RICHARD JONES: About Germany listing it on its ICD.

Mr REID: Yes, your implication that we would not consider it as a condition until it was ICD listed would clearly not be the process. ICD stands for international classification of diseases. That is more a process measure by which you record information. If a consensus in the literature was found and a consensus of treatment modalities was found that would be an area in which the department would act rapidly. But our discussions with our immunologists, our allergy experts and a variety of other experts involved in this—and there are many—indicate that it is still quite diffuse with relatively non-specific symptoms and hence it is difficult to treat.

Mr KNOWLES: I understand that the German model is based on an iterative algorithm of building up the rationale for listing. I guess based on what Mick has said, particularly with the positions of the American academy and the college being unresolved, there is no obvious remedy and I guess we are still in the formative process. It is a fascinating area though.

The Hon. RICHARD JONES: But you are aware that it may certainly exist? It is a generally recognised condition?

Mr REID: Yes. People are certainly saying that it does not exist. Clearly, it has a lexicon: it is in the literature. What people are saying is that the symptoms are extremely diffuse and hence the treatment modality is very difficult to pinpoint. Until that is done it is really difficult to know how we involve the clinicians in the appropriate treatment modality.

The Hon. RICHARD JONES: Do you have anyone investigating it or are you just waiting for other people to do the work?

Mr REID: I will ask the Chief Health Officer to liaise with the honourable member about the experts we are dealing with, what their information is to us about the symptoms, and the treatment modalities. That would be Dr Andrew Wilson.

The Hon. RICHARD JONES: And he will do it now or later?

Mr REID: I cannot do it tonight but I will have that person call you in the morning.

The Hon. RICHARD JONES: Thank you very much. What is the Department of Health planning to do to implement the recommendations of the sick building syndrome report of the Standing Committee on Public Works, which I am sure you are aware of?

Mr KNOWLES: Are you aware of the sick building report?

Mr REID: I would have to take that question on notice, Mr Chair. Could the honourable member elaborate a little more? I will just see whether I have anything more on it.

The Hon. RICHARD JONES: It is a report the Standing Committee on Public Works brought down within the last 12 months on the sick building syndrome. There are a number of recommendations that it asked the Department of Health and other bodies to take action on.

Mr KNOWLES: Richard, I confess that I am unaware of the report.

Mr REID: Was it showing the health consequences of sick buildings?

The Hon. RICHARD JONES: Yes. It came out fairly recently, about two months ago.

Mr KNOWLES: Given that the report is apparently eight weeks old, you can have my assurance that we will assess it properly and will obviously form a considered view. No doubt the Chief Health Officer will oversee the Health Department's response to it. My assumption would be that more than one agency would be involved in preparing a response to a report of that nature—everybody from the EPA through to the Health Department and all points in between. One would therefore assume that the considered responses of individual agencies would find their way most likely to a Cabinet-type consideration for a whole-of-government response.

The Hon. RICHARD JONES: Many of us believe that this building is a sick building.

Mr KNOWLES: I have heard it called many things.

Mr REID: I point to an article in the *British Medical Journal* of about three issues ago. It referred to a survey done internationally of the health consequences of poor housing. It showed that particularly for children under five there were significant decreases in instances of respiratory illness, gastrointestinal illnesses and—the countries referred to were South Africa and those around Malawi—decreases in malaria as a result of improvements in what we call health housing habitat.

The Hon. RICHARD JONES: Minister, are you aware that many vital provisions of the Food (General) Regulation have not being included in the new Commonwealth food safety standards such as the New South Wales code of practice for kangaroo meat for human consumption—

Mr KNOWLES: Could you repeat the question, Richard?

The Hon. RICHARD JONES: This is the Food (General) Regulation, the Commonwealth food safety standard. They have left a number of matters out of that new regulation, including the sale of perishable food at temperatures between 50 and 60 degrees and so on. What can you as a State Minister do to ensure that the pieces left out of the regulation that can have a significant impact on a number of health areas will be reinstated?

Mr KNOWLES: I can abide by the agreement that exists between all States and the Commonwealth, at the Commonwealth's request, that health Ministers and food Ministers, which in some States may be the agriculture Ministers, continue to progress detailed consideration of each and every one of those areas that are either presently removed from the regulation or have been proposed for inclusion in the regulation. The national food standard is just that; a national standard recently introduced under the auspices of the Australian and New Zealand Food Authority [ANZFA], which, if my memory serves me correctly, certainly preceded my time as Minister for Health. It has been in preparation for at least five years.

Frankly, it is one of the things that the Commonwealth Government can take some credit for at a national level. It has managed to get all jurisdictions, including New Zealand, to agree on so much of what should constitute a national food standard. In the end, no-one would pretend at ANZFA level—whether it is Senator Grant Tambling, who chairs those meetings on behalf of Michael Wooldridge, or any State Minister or the New Zealand Minister for Health—that there is no more work to be done. It is one of those extraordinarily complex and large processes.

In my time with that group we have predominantly focused on genetically modified food, as the honourable member might assume, and food labelling. That has taken up the great bulk of the work of health Ministers and/or agriculture Ministers in the context of ANZFA considerations.

The Hon. RICHARD JONES: Minister, are you or your department aware of a paper entitled "Australia's Preparedness for Emerging Wildlife Diseases—A Model for a National Health Network", prepared by Heddy Bryant and Dr Chris Bunn? Are you aware of the concerns that have been raised by scientists about emerging wildlife diseases, such as orbivirus, which are inadequately monitored?

Do you or your department know that we have an obligation to assure the Office International des Epizooties that there is evidence of absence of any wildlife diseases in exported meat from wildlife, for example kangaroo meat, and that we are unable to do that at present? If so, why has the department not informed the people of countries to which the meat is exported of the risks associated with eating kangaroo and other game meat? What research is the department doing into new and emerging wildlife diseases?

Mr KNOWLES: Most wildlife disease research is done through very large research programs either within or in co-operation with the Department of Agriculture. I ask that that question be referred to the appropriate Minister. In relation to the notification of receiving countries on the basis of export of kangaroo meat, the States do not have control over the issuing of export permits or licences. And of course I would be very happy to find out for the honourable member what the Commonwealth does with notification procedures relating to export permits and to provide specific information on the matters that have been raised.

The Hon. RICHARD JONES: I assure you that we are not in a position yet to assure the Office International des Epizooties that there is evidence of absence of diseases.

Mr KNOWLES: With respect, I will have to take your word for that. This is not within my jurisdiction; it is a Commonwealth consideration.

The Hon. RICHARD JONES: It is a health issue.

Mr KNOWLES: Yes, but it is a matter for Commonwealth health.

The Hon. RICHARD JONES: Is the department doing any work to correlate the exposure of country people to pesticides with rates of illness, including cancer clusters and increasing rates of multiple cancers? If so, how is it progressing?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a matter for the Cancer Council.

Mr KNOWLES: Yes, the Cancer Council and Jeff Angel.

Mr REID: Did you ask whether the department is aware of or undertaking any research in relation to pesticides?

The Hon. RICHARD JONES: Is the department doing any work to correlate the exposure of country people to pesticides with rates of cancer in those same areas, for example, Gunnedah?

Mr REID: Yes. We have information on hospital utilisation of people with various conditions and we often analyse that information to see whether any trends are geographically related to hospital usage. Through our public health units located in every rural area health service we monitor, as normal public health procedures, air vectors and those types of things for pesticide usage. On research in that area the Department of Health does not undertake specific epidemiological studies. That question might best be directed to the Cancer Council, which is a separate agency, or the National Health and Medical Research Council.

Mr KNOWLES: I recall, and the Hon. Richard Jones would know from his involvement in these areas, that the Environment Protection Authority was working on cotton pesticides with various non-government agency groups in the Namoi Valley. Again, that would be more appropriately directed to the Environment Protection Authority.

The Hon. RICHARD JONES: What is the department doing to monitor the incidence of chemicals and metals in breast milk? Is it a fact that breast milk contains DDT, dioxins, PCBs, various pesticides, fire retardants such as PentaBDE, metals such as lead and mercury, and endocrine disrupting chemicals? What can the department do to advise mothers to reduce their intake of dangerous chemicals and metals? Does the department, for example, advise future mothers to lower the risk to their babies by eating food grown without pesticides? Will the department advise what it is doing in this area?

Mr KNOWLES: Are you suggesting that mothers should not breast-feed their children?

The Hon. RICHARD JONES: I am saying that mothers who breast-feed their children are giving them a dose of DDT, dioxins and lead in their very first feed.

Mr KNOWLES: Maybe we should invite the breast-feeding association here, and I suspect that they would take you to task.

The Hon. RICHARD JONES: This is about to become an issue, so you might as well address it.

Mr KNOWLES: It has probably been an issue for some people for many years, but when these matters are raised at national health Ministers conferences, which there are from time to time, the overwhelming advice of all the professionals who bring evidence to the table to advise people such as myself, continues to re-endorse the very high value of breast-feeding in the context of better nutrition, better prevention of downstream illness, and all the things that are frankly well-documented and in the literature.

I could give you a long answer, prompted by Mr Reid, but in the end the people who would have these matters raised have an obligation to ensure that they are raised properly within a forum so that the assertions can be properly tested.

The Hon. RICHARD JONES: I am aware that there is no testing taking place now, because of the controversy.

Mr KNOWLES: The great fear is that the opportunity to scare the living daylights out of mothers, particularly young mothers, is very real. To assert that breast-feeding is in some way dangerous—

The Hon. RICHARD JONES: Do you hide the problem, do you?

Mr KNOWLES: I beg your pardon?

The Hon. RICHARD JONES: Is that what you do: you hide the problem?

Mr KNOWLES: I did not say that, and I take offence at the suggestion that I might be saying that. I am saying that if assertions are being made, they should be put in a forum where they can be properly tested. The appropriate place for that is at a national level involving all State, Territory and Commonwealth health Ministers. If the Hon. Richard Jones cares to check, he will find that this issue is perennial, a bit like cadmium in peanuts and all those sorts of things. Every time this matter is looked at, overwhelmingly the evidence is in support of the use of breast milk. It is a bit like immunisation of one's children—there are people with philosophical objections to that.

The Hon. RICHARD JONES: What is the Department of Health doing to ensure that the incidence of pesticides and metals is reducing? How is the department advising mothers to reduce pesticide and metal loads? That is the point behind my question, not that breast milk may be damaging children now, but how can we in the future make sure that that damage is less?

Mr REID: I have two comments to make in response. First, it is really important to place on the record that all epidemiological evidence points to the beneficial health consequences of breast-feeding, and that is the best available evidence of international clinicians and researchers.

CHAIR: Not to mention the psychological benefits.

Mr REID: Yes, thank you. International research has indicated that if the current level of breast-feeding is increased from 60 per cent to 80 per cent, an amount of well over $11 million would be saved on an annual basis through the reduction in severity and volume of childhood illnesses, and a reduction in maternal absenteeism. Second, Australia should be very proud that one of the fundamental cornerstones of the Australian health care system, which has existed since 1909, has been our baby health centres. They really set us apart from many other countries in the world, because of the extraordinary emphasis we place on antenatal care and antenatal education.

I assure the honourable member that any material that is evidence based and justifiable in terms of any deleterious consequences of anything mothers do in the antenatal years is very much passed on to educate mothers during that period. I think that is extremely important.

[*Short adjournment*]

The Hon. HENRY TSANG: Minister, would you please provide an update on multipurpose services?

Mr KNOWLES: Multipurpose services is the name given by the Commonwealth Government, because of its funding guidelines, to facilities what most people would call a small country hospital where the small country

hospital, traditionally based around acute services, has become combined with aged care facilities, principally nursing home beds, all under one roof. In my view they are, in the right location, an excellent model to provide health services and aged care services locally to allow the elderly to age and live their final years in a dignified manner in a location as close to where they spent their lives raising their families. That, of course, is an objective of all governments of all political persuasions.

Traditionally, there were problems with the model because of the Commonwealth funding rules, which prevented the amalgamation of some aged care facilities with small State-run hospitals. To his great credit, the Rt Hon. Ian Sinclair, who chaired the review of health services in small country towns on behalf of the Government, to which we responded on 8 March last year, saw opportunities to break down some of those stifling rules and to establish a new environment in which more work could be done to bring those services closer together, bearing in mind that the acute part of the facility was traditionally provided by the State while the aged care facility was provided by the Commonwealth or a non-government organisation provider—an RSL club or a local council.

Off the back of the Sinclair report we proposed to establish over the three years of our program, which we announced on 8 March last year, 34 multipurpose services on a published timetable. I can report to the Committee that the multipurpose services program is going very well. The facilities are largely both on time and on budget. Where there have been some slight increases in budget, it has been as a result of the community consultation process, which has been part of the development process. A typical example is where a small town might say, "Look, not only would we like a little hospital and the aged-care facility brought under one roof, but we think it is also pretty clever if we can move the ambulance station from the main street under the same roof as well." That has an additional capital component and, in that context, a legitimate expenditure to achieve better integration of services.

The program in its first stage has seen the following sites endorsed by the Commonwealth in terms of its commitment to the provision of aged care beds: Collarenebri, Holbrook, Coolah, Rylstone, Nimbin, Lightning Ridge, Coolamon, Gilgandra, Emmaville, Brewarrina, Jerilderie, Boggabri, Lord Howe Island and Blayney. Tenders closed in relation to all of those programs today.

Mr REID: Yesterday.

Mr KNOWLES: Yesterday, on 19 June—and that is good because it meets our timetable. There is a slight hiccup with the Denman facility because of a hiccup at the officer level by the Commonwealth. I think, frankly, that one part of the Commonwealth Government did not know what the other was doing because when it published its program, which omitted Denman, the Hon. George Souris recognised that he might have a little bit of a political problem. I would like to have been a fly on the wall in terms of the phone calls that must have been made through to Canberra. However, that matter seems to be getting back on track as well as it should, because Denman, of course, is a site ideally suited for a multipurpose service. The remaining sites continue to meet their timetables.

The out-year programs are presently in the process of consultation with local communities, developing their service plans, establishing local advisory committees and going through the site selection process, depending on the phase of planning. It is fair to say that the multipurpose service program has produced a very important shift in attitude in rural communities to the provision of local health services. It is a model that demonstrates quite fairly how well health services can be provided when governments work together. It is a great credit to those involved in the development of the program, and particularly to the towns and communities that have worked very hard to establish their facilities in which they take a great deal of pride.

I recently attended the opening of the Lake Cargelligo MPS and the entire town was there. Ian Armstrong and the Federal member of Parliament Tony Lawler, who was there on behalf of Dr Wooldridge, were also present. It was a great day to celebrate not only the opening of a health facility but re-establishing the status of that town, which had felt under threat for many years. The stamp of that new building—a big capital investment worth many millions of dollars—on a town such as Lake Cargelligo, the ability to provide age care beds in the town so that the elderly may be cared for by highly competent nursing staff, and the ability to attract medical staff to the town is a terrific model, which the Government will continue to progress.

The Hon. RON DYER: Minister, I understand that you have provided quite a large amount of money to the Hunter region of the State. Can you explain to the Committee how that money will be spent?

Mr KNOWLES: I would love to. The Newcastle strategy is a terrific piece of community-based work developed by health professionals and the community in the Hunter. When I first became Minister I was told that there was a plan, subject to funding—that is always the magic component—to redevelop and add to existing facilities in the Hunter region. This essentially involved upgrading Belmont District Hospital and the Mater

Misericordiae Hospital, establishing a new polyclinic in Newcastle to replace the Royal Newcastle Hospital—which has largely closed except for some specific elective, mostly orthopaedic, surgery—and establishing a new bone and joint institute, ambulatory care centre and parking station at the principal teaching hospital in the Hunter, the John Hunter Hospital.

The total cost of that strategy is estimated to be about $234 million and, by endorsing that major capital works program, the Government has created an opportunity for the people of the Hunter to have new health services and to participate actively in their development in the next few years.

This is a very clever way of encouraging change in the sense that it involves a shift of services to specialist units—such as the bone and joint institute, which will allow a totally integrated approach to the treatment of bone and joint disorders. It will not be just an orthopaedic or hip replacement shop; it will link the entire range of services that treat bone and joint disorders.

The Belmont hospital upgrade will see that facility enhanced in line with its level four delineation. It will increase the amount of locally accessible care and bring about a flow adjustment between John Hunter and the local precincts that Belmont serves, which are situated principally around Lake Macquarie. It is a fine hospital that will play a vital part in providing health services in the Hunter, particularly in the context of the work that has just been announced off the back of Professor Goulston's report about the better networking of health services and seeing a role for the big and the little hospitals.

This announcement was greeted with a great deal of joy if the correspondence that I have received is any indication, and equally important is the Government's agreement to incorporate the redevelopment of the Mater hospital in the overall package. That will cost an estimated $75 million to $80 million, from memory. There was an attempt by the order that runs the hospital and by the board, which is chaired by Mr Brian McGuigan, to determine whether it would be possible to obtain funding from other than government sources, principally other religious orders—bearing in mind that there has been a fairly substantial national shift to amalgamate the various religious orders that provide care. St Vincent's, the Mater in North Sydney and the Mater in Newcastle are just three examples of such facilities.

Unfortunately, despite the very considerable efforts of those groups, they were not successful, which gave me the opportunity to incorporate the Mater Hospital into the overall Newcastle strategy. The polyclinic will be a great boon for central Newcastle. It really represents contemporary health care. A city precinct with a not insubstantial—

CHAIR: The time for that answer and the time for Government questions is complete. I want to ask a question specifically about John Hunter Hospital. Is it reasonable for John Hunter Hospital to be forced to postpone some operations, specifically a pacemaker operation, to the end of the financial year because it did not have any more money in its budget?

Mr KNOWLES: My understanding is that six pacemaker operations have been rescheduled. That has been with clinical agreement. One of those cases was reviewed by clinicians and will be conducted in the very near future. I am advised that the total number of pacemaker operations performed at John Hunter Hospital will be about 222, representing a 22 per cent increase in the total number of pacemaker operations performed over the last year. It is also the highest number ever performed at John Hunter in a single year. Waiting times for elective pacemaker insertion are between three and six weeks. I am advised that all patients waiting to be seen for pacemaker surgery are being seen within the appropriate clinical guidelines.

CHAIR: Is it reasonable that Mrs Patricia Smith, whose pacemaker operation was scheduled for 12 June, will not have the operation until August, which is more than six weeks?

Mr REID: The information we have is that the number of operations has gone up significantly. The highest number of pacemaker operations ever performed at John Hunter Hospital have been performed in this financial year. Waiting times for pacemaker insertion are between three and six weeks. They are being seen within the appropriate clinical guidelines. We are advised that all patients are being seen within the appropriate clinical guidelines.

CHAIR: My next question relates to the Northern Rivers Area Health Service.

Mr KNOWLES: Before you go on—

CHAIR: I am happy with the answer.

Mr KNOWLES: I am not happy with the total response. What is not reasonable is an assertion you have made. If you care to provide us with details of an individual case we will check it. If history proves itself to be correct, you have been given half information and I am sure there is a total story.

CHAIR: Mrs Patricia Smith was scheduled to have her operation on Tuesday 12 June. She will not have the operation until August because, she was told, at the end of the financial year the hospital did not have any more money in the budget.

Mr KNOWLES: As you well know as a medical practitioner, there are a lot of reasons doctors give people for why they can or cannot have their surgery.

CHAIR: Blame and shame.

The Hon. JOHN JOHNSON: From 12 June to 1 August is six weeks.

Mr KNOWLES: That is about right. Irrespective of that, these are matters for clinical decision. If the clinician dealing with this person believes that more urgent priority should be given, that is totally open to the clinician and totally available for the clinician to have that matter scheduled, as you well know.

CHAIR: I would not agree.

Mr KNOWLES: As you well know.

CHAIR: I do not have to agree with that and I do not need to be verballed.

Mr KNOWLES: Are you suggesting that a clinician's view would be overridden by an administrator?

CHAIR: As to the Northern Rivers Area Health Service, you indicate the budget this year will be $218 million. On the paper you have before you, what is the increase over last year's budget?

Mr REID: It represents a cash allocation of $218.8 million, which represents an increase of 11 per cent over the 1999-2000 allocation of $184 million. What is important is not only that dramatic increase but the fact that over a three-year period the Northern Rivers Area Health Service in the year 2002-03 for the first time since the 1970s will have parity in access to dollars of the health budget. Of the $8.1 billion that will be allocated to Health in 2002-03, Northern Rivers Area Health Service, like every other area health service in the State, will be on target for equity allocation.

CHAIR: That extra money this year includes money to pay for flows across the border to Queensland, is that correct?

Mr REID: No, that is not correct. The current allocation to the area health service does not include flow dollars.

CHAIR: I am talking about this year's budget allocation.

Mr REID: Are you talking about the year we are currently in?

CHAIR: Yes, starting 1 July.

Mr REID: That is next year.

CHAIR: That is the budget amount. Does that budget now include flows across to Queensland this year?

Mr REID: No, that cash allocation I have just quoted to you does not include the flow figures across the border.

CHAIR: Is the $218 million the cash allocation or not? What is it?

Mr REID: It is the cash allocation. It does not include the interstate border flows which, from memory, are something like $10 million or $12 million. I will get the exact figure for you.

CHAIR: I am interested in whether it flows into this year's budget.

Mr REID: You are misleading what I am saying, and I want to answer. The cash allocation which we have published to you does not include cross-border flows. However, from 1 July this year we are proposing for areas which are on borders to have access to those dollars, which currently flow directly from 73 Miller Street, North Sydney, through to the Queensland Department of Health. If I give you the figures for Northern Rivers, there is an inflow into Northern Rivers which predominantly comes into Tweed Hospital because there has been considerable capital investment in Tweed Hospital over the past few years. The inflow into New South Wales from Queensland totals $11.417 million. The outflow from Northern Rivers into Queensland totals $17.498 million. That gives a net outflow of $8.080 million of Northern Rivers residents into Queensland.

CHAIR: The figure must have been $19 million, because 11 plus eight is 19.

Mr REID: I apologise, $19.498. It is proposed that the interstate flows for that area and for New England, Far West, Greater Murray and Southern areas from 1 July will be managed at the area level. I emphasise again that $218 million does not include—

CHAIR: The $218 million allocated this year does not include the flow?

Mr REID: That is correct.

CHAIR: When will mental health funding be subject to the resource distribution formula [RDF]? When will Northern Rivers get its fair share of mental health money? I have not asked how much it has increased this year. I have simply asked when will it happen. With the current estimates in the 2002-03 budget, which has been allocated, including the mental health announcements, Northern Rivers was still about $4 million short of the average of approximately $80 per head per year.

Mr REID: That is correct. As part of the Government action plan implementation, you will recall I have spoken to you previously about the committees we have set up around acute care, chronic care—

CHAIR: I am asking when?

Mr REID: The growth moneys going to area health services as part of the $107 million, which is being invested into mental health, the additional dollars, are progressively going to ensure equity in mental health resource allocation. The actual date, the year at which equity will be achieved, is a question I will take on notice. Progressively the dollars are flowing to achieve equity.

Mr KNOWLES: We have done that specifically—

CHAIR: I am happy with that answer. I understand that it has taken longer than the other idea. The question of—

Mr KNOWLES: I do not want you to be misled into thinking that anyone is going slow on this. This is a specific recommendation.

CHAIR: No. I am simply asking it as a question—

Mr KNOWLES: I am simply trying to answer. You ask questions. We have a right to answer them.

CHAIR: But I have the answer from the director-general.

Mr KNOWLES: You have part of an answer. We are entitled to place on record what we believe is a full exposition of the facts. The issues around mental health funding are being considered by a group which, until she became Governor of New South Wales, was headed by Marie Bashir. When she became—

CHAIR: I am aware that we have been informed by the director-general—

Mr KNOWLES: Excuse me!

CHAIR: And this is a question that I had specifically asked of me by the practitioners up in that area as a result of—

Mr KNOWLES: They will be interested to read *Hansard* and get the full answer.

CHAIR: They are aware of the briefing papers.

Mr KNOWLES: They will be interested to get the full answer, and I put on record to your friends who will read this that you are trying to stop the department from providing a full answer to their question.

CHAIR: There are a number of questions I have to get through tonight. If we keep going at this rate I will get no answers.

Mr KNOWLES: That is fine.

CHAIR: I am asking the questions.

The Hon. JOHN JOHNSON: Put them on notice.

Mr KNOWLES: You are asking questions and I am trying to answer them.

CHAIR: No, I will get this sort of answer if I put them on notice. The next question I have is: Why is the Northern Rivers Area Health Service funding not adequate to maintain the operation of the mothering unit built in Lismore; a 10-bed individual room specifically for early childhood management of some 1,500 mothers in Lismore?

Mr KNOWLES: I will take it on notice, but the press clipping I saw, from your local paper up there, reported that it has been reopened.

CHAIR: It will continue to be opened?

Mr KNOWLES: I just said that I will take it on notice, but the press clipping I saw was that it has been reopened.

CHAIR: Apart from mental health, I am happy that you say you are now delivering a plan to get fairness across the system.

Mr KNOWLES: But you will not let me answer the questions, so you do not know what I am trying to say.

CHAIR: The next question I have is: What is the status of the tender process for the establishment of a community health service located at the old Western Suburbs Hospital site? Will that be subject to private operation?

Mr KNOWLES: My understanding is that the Central Sydney Area Health Service has been endeavouring to obtain an operator for the nursing home component, or the aged care component. I would say aged care, not nursing home, because that was the verbiage that was historically the case. In that context we will seek to ensure, as we do, that we provide the community health facilities that are integral to those undertakings. I am advised that tenders for that process have closed. There are now negotiations being undertaken with our preferred tenderer.

Mr REID: Which is not yet announced until we go through the process.

CHAIR: I understand.

Mr KNOWLES: For probity reasons.

CHAIR: Are the tenders in?

Mr REID: The tenders have closed, and we have selected our preferred tenderer. We are negotiating with that preferred tenderer now.

CHAIR: Can you provide details of the minor works, miscellaneous works, in the capital budget of some $99.35 million? Is it possible to provide us with a list of those miscellaneous works?

Mr KNOWLES: Yes.

CHAIR: It seems like a lot of money.

Mr KNOWLES: I will answer your question, if you will let me. In a budget of just under $2 billion over the next four years, including $532 million this year, all of it articulated there, the health system also maintains a minor works program, which is in the order of the relativities that are consistent with the numbers you have read out. They range from everything from fixing up the shelf at the ladies auxiliary stand at John Hunter Hospital so that they can sell lollies at the counter through to maybe relocating a door in an intensive care unit to make it more accessible for patient flows. I am happy to give you those programs chapter and verse, if you wish them, but I would suggest to you—

CHAIR: If we could just have the major ones.

Mr KNOWLES: Hang on! Which ones do you want? Do you want the shelf—

CHAIR: I asked the question because it is obviously one-fifth of the total capital works program for the State budget. I am wondering whether there are some major projects within that under miscellaneous which might be under $1 million, but are significant.

Mr KNOWLES: I will do it now to save the poor people sitting behind me the extraordinary work that would go into answering that request. I am reading off a minor works sheet.

CHAIR: Perhaps you could simply table it?

Mr KNOWLES: No, I prefer to read it onto the record. Hospital building infrastructure, $1.793 million; admin, plant and equipment, $3.255 million; ambulance minor works, $8.1 million; BTS equipment, $4 million; Corrections Health, $551,000; dental health/fluoridation, $500,000; health technology program, $5.609 million; Illawarra Area Health Service site purchase and IMT strategy annual provisions of minor works, $1.286 million; mental health strategy stage 2.1, $310,000; rural health, $2 million; laboratory services, $1.5 million; preplanning and site acquisition for the Hawkesbury, $8.15 million broken down into preplanning $3.65 million, site acquisition $500,000 and facility fees $4 million; Port Macquarie facility charges, $7.016 million—

CHAIR: Is that the rent on Port Macquarie Hospital?

Mr KNOWLES: No. Capital is capital. Rent is recurrent. I am sorry, Mr Barker says it is the availability charge.

CHAIR: That is, in fact, a sort of rent on the facility?

Mr BARKER: That is correct.

CHAIR: So rent is rent, but that is capital.

Mr KNOWLES: Yes, it is an availability charge. RM and R greater than $5,000, $76 million.

The Hon. RICHARD JONES: What about Concord?

Mr KNOWLES: No. Concord is a major project under the $350 million major capital program—

CHAIR: That is not part of this answer.

Mr KNOWLES: Can I not respond to interjections?

CHAIR: It was my question and the question relates to the minor works in the budget. You are about to answer a question on major works.

Mr KNOWLES: Is that satisfactory?

CHAIR: Yes, if we could have those works that would be great. The next question I have is how much money is owed, at this time and on 31 December, by rural area health services in the form of accounts payable under current borrowings? Is it possible to have that by area health service?

Mr KNOWLES: Borrowings nil.

CHAIR: Borrowings are the sort of advances that the department gives, which they need to pay back over various time schedules.

Mr BARKER: The Minister, in his 8 March 2000 announcement, waived all operating loans that rural health services had with the department, and they have been eliminated in the financial records as at 30 June 2000.

CHAIR: Is that all of them? Initially the Minister's announcement was $40 million worth. They were more than that. All of them have been waived as of—

Mr BARKER: The Minister's $40 million announcement covered all rural health operating loans held with the department. If you look at any rural health service's annual account you would see—

CHAIR: They have no borrowings?

Mr BARKER: They have no operating loans. Some may have some capital loans, which are subject to normal business case approach.

CHAIR: I understand that. They have no operating loans.

Mr REID: I should mention that the $40 million quoted was different from the $200 million which you had quoted in some press releases. Those figures were somewhat rubbery; I guess a bit like a latex aeroplane. They did not quite stack up. But today—

CHAIR: If I go to a rural area health service there will be no borrowings?

Mr REID: That is correct. And the $40 million—

Mr BARKER: The rural health service would have no operating loans, but some of them will have loans with which to invest in some form of plant, equipment or building, which will give them an operational benefit.

CHAIR: What sort of dollar figure would they need across the State?

Mr BARKER: Immaterial across the State.

CHAIR: How much across the country areas?

Mr BARKER: I would say it would be less than $10 million.

CHAIR: None of the accounts payable are outstanding? They would not have large outstanding debts for accounts payable?

Mr KNOWLES: Accounts payable as in people to whom we owe money?

CHAIR: Yes.

Mr KNOWLES: I am assuming that a business that has a $7 billion expenditure budget has a few accounts payable today. I think we pay about $5 million a day in bills. I am assuming there are a few.

CHAIR: Were there any over 45 days as at 31 December or 31 March?

Mr KNOWLES: There may be.

Mr BARKER: There could be. It is a variable thing.

Mr KNOWLES: As we did last year, we will provide the Committee with a list. What you are really asking is how many creditors we have over 45 days. Let me help you with your question. You are trying to find out how broke the Department of Health is. That is what you are really trying to get at. It is a fallacious question because the department is not broke. What you are really asking—which you asked in a much better form last year—is: How many creditors do area health services have over 45 days? I will take that question on notice and provide that information.

CHAIR: Could you provide the Committee with the department's recurrent allocation, budgeted and revised, for 2001-02 for each area health service?

Mr BARKER: The Minister has quoted those figures.

Mr KNOWLES: I have just given them.

CHAIR: You did not give all of them.

Mr KNOWLES: I did. Your assistantant may not have been listening, but I did. You should read *Hansard.* If they are not all there I will be happy to provide them.

The Hon. HENRY TSANG: Mr Chair, I draw to your attention the fact that your 20-minute block of questions is now completed.

CHAIR: Thank you very much. I have taken your comment on board.

Mr REID: I think there are three areas that may not have been provided, which we will provide. They are the children's hospital, corrections health, and the ambulance service. We will take that question on notice and provide the answer.

CHAIR: What percentage of New South Wales Health—

The Hon. JOHN JOHNSON: Fair crack of the whip!

CHAIR: What percentage overall is—

The Hon. JOHN JOHNSON: Mr Chairman, fair crack of the whip! You have cracked the whip and we are cracking it back.

CHAIR: This is my last question.

The Hon. RON DYER: The Hon. Henry Tsang drew your attention to the fact that the allocated time for your period of questions had expired.

Mr KNOWLES: Would it be fair to say that you are now in breach of your own standing orders?

CHAIR: No. We have now gone over the 20 minutes. Since the Hon. Henry Tsang has drawn my attention to it, the remaining time is for people who have important questions to ask. I propose to ask one of those.

The Hon. HENRY TSANG: The Hon. John Johnson has not had an opportunity to ask a question yet.

CHAIR: What percentage of the New South Wales Health work force would you classify as administration? Following that the Hon. Richard Jones has a question.

The Hon. RICHARD JONES: I do.

Mr REID: I think when you asked this question two years ago during estimates committees we were able to indicate to you that we had been the subject of a comprehensive study by the Council on the Cost of Government [COCOG]. Professor Walker chaired COCOG at that time and he undertook a study of all government agencies. From recollection—I am sure Ken Barker will correct me if I am wrong—New South Wales Health had the lowest proportion of administrative staff of any government agency. It is difficult to know what constitutes administrative staff, but I think our current estimate is between 2 per cent and 3 per cent.

The Hon. RICHARD JONES: I refer you to Budget Paper No. 3, Volume 2, page 9-12. Under the line item "Proceeds from sale of property, plant and equipment" there is a figure of $62,986,000 for 2001-02. Can you tell the Committee how much of that is related to the relocation of Rozelle hospital patients to Concord? How much will be raised from the sale of part of Callan Park? Can you guarantee that no green space will be sold or leased, and that the European and Aboriginal heritage on that site will be respected and protected?

Mr KNOWLES: Do you want me to give you the press release, or do you want me to repeat it?

The Hon. RICHARD JONES: I want you to be totally honest with the Committee and tell us how much of the green space will remain for public use?

The Hon. JOHN JOHNSON: The Minister is always honest.

The Hon. RICHARD JONES: I absolutely hope he would be. We had a big meeting the other night, as you would be aware, Minister. Chris Puplick was there. Questions were asked at that time but no answers were given.

Mr KNOWLES: I am very keen to answer your question.

The Hon. RICHARD JONES: Please answer. The Committee would be delighted to hear how much of the green space will be left after you finish carving it up.

Mr KNOWLES: I am advised that, so far as the program you quoted is concerned, none of those dollars relate to the proposed sale of a portion of Rozelle hospital—because, as you might imagine, the sale of any land at Rozelle will not occur in the forthcoming budget year because there is a funny thing called a planning process between now and then.

The Hon. RICHARD JONES: It can be rammed through, of course.

Mr KNOWLES: I beg your pardon?

The Hon. RICHARD JONES: It can be rammed through.

Mr KNOWLES: No, it cannot. I drafted State Environmental Planning Policy No. 56 when I was Minister for Planning, and I drafted it so that it could not be rammed through. Have a copy! There is a process that will be undertaken by the Minister for Urban Affairs and Planning, not by me. What I have made very clear is that, as a minimum, there will be a new park, not an old hospital; and the land area available for that park will be more than is presently available for parkland—something of the order of 80 per cent. But the final determination, as it should be, will be resultant on the outcome of the planning process under that State environmental planning policy.

CHAIR: Do you wish table that document?

Mr KNOWLES: Yes, I table SEPP 56.

Document tabled.

Mr KNOWLES: In the context of the heritage items, we have made it very clear—very clear—that we intend to preserve all of those items of heritage, as of course we should. They are part of the public domain. While we are talking about Rozelle, I know you have an interest in it because you attended the public meeting—

The Hon. RICHARD JONES: There are many other questions. We might not need that. I mean, I have a great interest in it—

Mr KNOWLES: So do I, because there is an important point to be made. We are talking about repatriating a small amount of the value captured in a 125-year old hospital site used for the mentally ill to re-establish a new mental facility in more contemporary and clinically appropriate surroundings at Concord Hospital. This nonsense that I read about instant experts saying we should redevelop a psychiatric hospital at Rozelle, in isolation, to take the treatment of the mentally ill back to the early part of the last century, is just that: nonsense! You will not find too many clinicians—any clinicians, I would assert—who would argue for anything other than integration of mental health treatment into mainstream facilities.

That is precisely what we propose to do in the relocation of Rozelle to Concord. It is entirely appropriate to repatriate some of the asset value in that site, subject to all of the proper conservation, heritage preservation, access to open space, access to foreshores, as has been precommitted; and a proper planning process. Precedents for that move have been the relocation of the children's hospital at Camperdown to the children's hospital at Westmead; relocation of the Royal Women's Hospital at Paddington to the Royal Women's Hospital at Randwick; relocation of Rachel Forster Hospital to a new bone and joint facility at Missenden Road; and any number of others you might remember in history. Frankly, those who assert themselves to be experts on the management of people with mental illness—when what they are really saying is, "Not in my backyard"—should be ashamed of themselves. I will not read this, because I know that members of the Committee have other questions to ask.

I seek to table a photocopy of a letter headed "Relocation will be boon to mentally ill", written to the *Glebe and Inner Western Weekly* by Mr Charlie Linsell, who happens to be the staff elected member on the Central Sydney Area Health Board. More importantly, he is a psychiatric nurse at Rozelle and has been for a generation. I think his letter says 25 years. He is certainly not portrayed as a friend of mine. He states that he fought the good fight over many years and he urged people in that community to wake up to themselves and recognise that what the Government seeks to do, in an attempt to look after the mentally ill, is the appropriate way to go. I urge those of you who have some compassion for people who are unable to speak for themselves to actually stand up and say that what is going on there is nothing more than precious self-interest by a tiny minority of individuals.

Document tabled.

CHAIR: The Hon. Jennifer Gardiner.

The Hon. JOHN JOHNSON: Mr Chair, I have sat here for two hours and have not even caught your eye.

Mr KNOWLES: I think Johno should have a question—

CHAIR: I have given the Hon. Jennifer Gardiner the call. I will call you next.

The Hon. HENRY TSANG: It is just not fair.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We can come back.

The Hon. JENNIFER GARDINER: Yes, we can have an extra sitting.

The Hon. HENRY TSANG: We can come back but you have to be fair. If you want to be chairman you have got to be fair.

CHAIR: I have been fair.

The Hon. JENNIFER GARDINER: Minister, what is the total budget of the New South Wales Ambulance Service for this year? Can you advise whether the directive that the director-general issued to hospitals last year which threatened budget cuts if a hospital went on LTO is still in force? How much did the Ambulance Service raise in fees last year? How much money does the Ambulance Service raise in fees each day on average?

Mr KNOWLES: Today I do not think it is raising any fees because there is a paper ban by the unions as a consequence of the industrial action over the workers compensation legislation. I do not believe the director-general issued any such directive but he can speak for himself. As far as the budget is concerned, I am sure he will tell us the details. But before he does I make the point that to get a question like that from you lot just staggers me. When Ron Phillips was the Minister and for the five years prior to our coming to government there was a net reduction in real terms to the Ambulance Service budget. We have a former head of the Ambulance Service sitting right behind me who, if he could speak openly, would say that the administration by you lot of the Ambulance Service was an absolute indictment. The machines were falling to bits. You put no investment into the service.

When we came to power Andrew Refshauge, to his great credit, began an escalation program of enormous proportions that we have continued. I can give you the large increases in the ambulance expenditure that we have made over not only the last year but also over the previous five years to rectify the mess that you created and left behind. That involves major investments in capital, a new fleet. You see a whole lot of new Mercedes ambulances running around at the moment. They were desperately needed and overdue. There have been new uniforms for the staff and all those things. Of course, we recognise, as I said in answer to the Parliament yesterday—

The Hon. JENNIFER GARDINER: You are a bit sensitive on ambulances.

Mr KNOWLES: No, I think you should be ashamed of yourself for asking such a question.

The Hon. JENNIFER GARDINER: In the wake of the Auditor-General's report it is you who should be ashamed.

Mr KNOWLES: We endorsed it entirely and it has been the great trigger to begin a cultural change in the Ambulance Service. I announced in the Parliament yesterday that it is early days yet but the service has seen a 25 per cent improvement in response times from April last year to this year.

The Hon. JENNIFER GARDINER: Will you put a non-metropolitan person on the board?

Mr KNOWLES: I will come to that. These questions are great. That was the second question, which I will answer and I will take my time, Mr Chairman. With regard to response times, it is early days. After 17 goes in the Industrial Commission to start a three-station trial out of 228 stations—

CHAIR: The answer in the Parliament that you gave yesterday was 11.

Mr KNOWLES: Eleven what?

CHAIR: Eleven visits to the Industrial Commission.

Mr KNOWLES: No, I said 17. I will send you my script. I do not know what is recorded in *Hansard,* but I said about 17. Whether it was 11 or 17—I think it was about 17, which is what I said in the Parliament yesterday—it demonstrates just how hard it was historically to get cultural change when all we were trying to do was shift some roster times in three of our 228 ambulance stations. Surprise! Surprise! At the conclusion of the 10-week trial—only a couple of weeks ago—there was a 30 per cent improvement in response times in those three ambulance stations. What is even better, ambulance officers themselves are wanting to be more involved in some of these more creative rosters and to better utilise their highly professional skills.

I place on record my great appreciation of the men and women of the Ambulance Service for their dedication and commitment. After the Auditor-General's report, which the Government embraced, we could have expected them simply to say, "We are not interested in participating in these changes." But they have not done that. Between them and their industrial association, the Health and Research Employees Association, they have worked hard with the service to effect change in the knowledge that change was desperately needed.

With respect to the board, I deliberately sought to change the board structure following the former chairman, Mr Ducker, telling me that he was unable to continue as chairman because of his other board commitments with a number of private organisations that he remains involved with. That gave me the opportunity not only to make the change at the board level but also to give the symbolic message to everybody who was interested that I was serious about effecting change at every level in the Ambulance Service—not only, as I was being accused of that the time, by picking on the union or by picking on the workers but by going right through the organisation from top to bottom to effect change.

That is why, for example, we have imported a fellow from the UK with specific experience from his former workplace in Durham in the north-east of England on the implementation of CAD systems. He has been in place for some months now and has been on a very extensive tour of ambulance services. The reorganisation of senior management at that level is beginning to prove effective.

At the board level, I have deliberately left positions vacant and established a very small core group of individuals for two reasons. One is to focus their attention on the detail that is required to implement the Auditor-General's findings, and the other is to recognise that their appointment is on an interim basis only, as I indicated when I responded to the Auditor-General's report. I have appointed Barrie Unsworth as the chairman and I have appointed Mick Reid and Bob McGregor to the board. I have kept on Jon Isaacs and three others whose names escape me for the moment, including the staff-elected representative.

There are still vacancies, but when we have completed the interim task we can then move to re-establish the board on a more formal, representative basis, which I am more than willing to do. But for the moment the problems with the New South Wales Ambulance Service require focused and determined action, and that is what is occurring, by the preliminary results I was able to announce in the Parliament yesterday.

I make the point, though, that these changes will be maintained and we will see continued improvement only if we maintain the co-operation of the work force. That is manifest in the very co-operative arrangements that exist, at least for the moment, in the peak consultative councils, which are chaired by the Director-General of Health and attended by the Secretary of the Health and Research Employees Association and the Labor Council to make sure that at the most senior levels of the labour force and the management of the system we are focusing on real improvements in the delivery of services.

The Government has put an enormous amount of money into the Ambulance Service. We had to re-establish and reinvest in ambulance capital services particularly because of the absolute scorched earth policy that you implemented when you were last in government. And that is a matter of fact and documented record. Look at any budget paper. We are now rebuilding the morale, the culture and the level of professionalism in that organisation, delineating roles, establishing opportunities for change and making sure that the focus is on quality improvement. That is where we will see the benefit of that investment. The taxpayers have paid for a very good Ambulance Service. They now want to see the return on what they have paid for.

Mr REID: If I can answer the specifics of the question about the budget. Over the past three years the Ambulance Service has received a cash injection of almost $45 million. The recurrent budget has increased a massive 65 per cent to over $160 million in five years. Its initial cash budget allocation in 2000-01 was $153.7 million, which was an increase of almost 5.5 per cent. There will be a further 9.2 per cent increase in 2001-02. In relation to the question asked about revenue—these are estimates because we do not have the actual figures here—our best estimates are that the revenue is currently running at around $50 million per annum, of which $23 million comes from interhospital transfers, that is, patient transfers. The capital budget, which relates to the other part of the question, for 2001-02 is—

CHAIR: So the income is about $50 million a year?

Mr REID: Total revenue is around $50 million per year but the specific question related to patient revenue, if I recall, and that is around $23 million a year.

CHAIR: So it is about half a million a week?

Mr REID: That is correct.

The Hon. JOHN JOHNSON: Minister, the people of Western Sydney in the past have been disadvantaged with regard to health care. Can you explain what the Government is doing to right this injustice?

Mr KNOWLES: I appreciate that question very much because again it addresses—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has already been answered at the previous briefing by Mr Reid. He talked about the RDF at some length.

The Hon. JOHN JOHNSON: I asked the Minister the question, Arthur. I can talk to you at any time. I can only talk to him once a year.

Mr KNOWLES: Did you talk about this?

Mr REID: I apologise, Minister, but I did make some mention of western Sydney, but I am sure not in the detail in which you will outline the strategy of the area health service.

Mr KNOWLES: Did you talk about rebuilding Westmead Hospital?

Mr REID: No, probably not, Minister. No, I did not.

Mr KNOWLES: Did you talk about the upgrade of Blacktown Hospital?

Mr REID: No.

Mr KNOWLES: Did you talk about the upgrade of Auburn and District Hospital?

Mr REID: No.

Mr KNOWLES: Well, there is a lot to talk about then. As the Hon. John Johnson well knows, because he was there when it happened, the last real substantial shift of resources to western Sydney was when Laurie Brereton established the Beds to the West program.

CHAIR: Oh, really!

Mr KNOWLES: The Chairman said "Oh, really", and that should be recorded.

CHAIR: Now Labor says it built Liverpool Hospital and Nepean Hospital, the kids hospital, et cetera.

The Hon. JOHN JOHNSON: Brian, you are the Chairman, stop it.

CHAIR: He is just baiting me, Johno.

Mr KNOWLES: It is not hard to do, Brian. The Labor Party regards it as a symbol of its efforts to redistribute health funds. I am very pleased that Mr Reid has already elaborated on the resource distribution formula.

CHAIR: Beds to the west, I love that.

Mr KNOWLES: Beg your pardon, Mr Chairman?

CHAIR: I love Laurie Brereton's beds to the west, I thought that was the best.

Mr KNOWLES: A lot of people in western Sydney did, too. So you think that that is a joke.

CHAIR: It was a joke.

Mr KNOWLES: With respect, I know people who used to travel very long distances to the eastern suburbs because they could not get heart surgery or cancer treatment. I take it as offensive to call the provision of services to where people live a joke.

CHAIR: I did not say that, I said that Laurie Brereton's beds to the west, which never happened, was a joke. The idea was a good one, and I supported it, and we have supported it.

Mr KNOWLES: The idea was a good one.

CHAIR: We supported it, and we did it.

The Hon. HENRY TSANG: Mr Chairman, I would like to hear the Minister's answer, please.

Mr KNOWLES: This is a fascinating conversation. Every time the Government does something the Opposition wants to take credit for it. Last week when we announced the metropolitan strategy, the next iteration of resources moving to western Sydney, Jillian Skinner said across the Chamber, "This is our plan." I do not mind who claims the plan, but I am interested in where the allocations of resources go. We have been able to incorporate funds off the back of some very large increases in recurrent expenditure for areas that have traditionally been underfunded, such as western Sydney, south-western Sydney, and Wentworth, and backed them with enormous capital allocations that will see, for the first time in 25 years, about $178 million allocated to upgrade Westmead and Auburn hospitals.

That is a great tribute to the efforts of all the people in the past who have either properly or improperly claimed success for moving resources. I pay tribute to Laurie Brereton for his work, and I recognise the wonderful work of the enormous number of clinicians who, over the past 12 months, have built a model to allow that work to continue. I do not seek to claim credit for that work, because it has been the work of the system and the clinicians, equally sharing the objective of a better distribution of health services. When people such as John Dwyer from the Prince of Wales Hospital in the eastern suburbs acknowledge that it is high time to put down the cudgels and break down the parapets of the various institutional castles that hospitals have represented for many generations and actually network systems to deliver health services to where people live, we must all recognise that something is happening.

What is happening is that people in the system understand that there is an equity argument here. On 8 March 2000 we were able to establish the foundations of that with a three-year health budget. We drove an equity and social justice agenda for the redistribution of services. Goulston's report last week—not mine, not Laurie Brereton's, and certainly not Jillian Skinner's—was the basis for one of the most fundamental reform processes this State has seen since beds to the west. Full stop! I do not care what you say, Mr Chairman, because it is a matter of fact.

The fact is that that is occurring by clinicians for clinicians on behalf of patients, and putting services where people live. We can get away from those offensive statements that I just heard from the Chairman about the joke of moving services to the west. Previously people could not get cancer services or heart treatment at Liverpool, and

could not get dialysis at Nepean, so this is a great tribute to those men and women, and a great shame on the Chairman for his attitude.

Amongst the medical establishment there has been a patronising attitude that all roads must lead to some place away from where people live, because that is where doctors want to be. For the first time in a long while, that has changed. Some great men and women, led by Kerry Goulston, and the 42 people on the metro strategy group have funded, built and supported the distribution of clinical services.

CHAIR: Who built Liverpool Hospital? Who built Nepean Hospital?

Mr KNOWLES: I do not mind whether your party built Nepean Hospital or not.

CHAIR: Thank you. I referred to Liverpool hospital.

Mr KNOWLES: But if you did build it, you did not put dialysis out there. But we will! If you did build Liverpool, and I do not think that you did, you did not put cancer services or heart services there. Bricks and mortar do not fix people, my friend, clinical services do. The fact that we are delivering clinical services to places where they have never been delivered before is what health service delivery is all about.

Mr Chairman, you can rattle on about your great heroic results in health service delivery, but the proof of the pudding is in the eating. At no stage were the Greiner or Fahey administrations able to achieve a massive redistribution of clinical services. But we were able to announce that last week with western Sydney being at the heart of it. Of course, that is what this is all about; that is what the delivery of better services to where people live is all about. But in response to the Hon. John Johnson, this is not just about western Sydney, south-western Sydney or the Central Coast, it is about all the regions that have been typically and traditionally underfunded. That is where our model leads us.

Whilst we announced that metro strategy last week, which in large part deals with the 43 per cent of the community who live west of the Glebe Island Bridge and gives them a better deal for their taxpayer funded health services for the first time ever, it also links that to a rural strategy, which is coming down the pipeline. The clinicians and administrators, the 3 per cent of the massive work force re-engineering the system, should take credit for this work, not Jillian Skinner, not Craig Knowles, and not Brian Pezzutti. I pay tribute to every single man and woman in the work force. When one talks to them, one find that it is obvious that they have a new-found pride in what they seek to do, because they own it.

It is terrific that I can stack John Dwyer from Prince of Wales Hospital, with Graham Stewart from Westmead Hospital, with Pat Creegan from Nepean Hospital, with Sue Hodgkinson from Liverpool Hospital, and people from the Hunter and the Central Coast—the gang of 21—all in the same room and get the sort of response that we got to the program last week. We knew that we were on a winner.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask a couple of questions?

Mr KNOWLES: When I finish answering.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is becoming a bunfight.

The Hon. JOHN JOHNSON: It is not a bunfight as far as I am concerned; he is answering my question.

Mr KNOWLES: Concerning the redistribution of services, I will read from the press statement issued by the 21 chairpersons of the medical service committees of each hospital in the greater metropolitan region. In support of the Government's plan and Kerry Goulston's plan, last week they said:

> Most importantly, we would like to emphasise that uniquely these plans have not been generated by Government nor its bureaucracy—

this is John Dwyer commenting—

> The plans have resulted from long deliberations by hospital commissions, other health professionals and consumers. As such we have every right to expect bipartisan support for these overdue and exciting reforms to bring to the people of Sydney the modern integrated hospital service they deserve and expect.

When the narks in this room start raising questions about why there are no services at location X, my answer is that it is because they have not been there for a damn long time; but we are making changes. We send copies of *Hansard* to people, and it is read at medical staff meetings. They ask, "Why don't these people just get off it, and get onto a decent program of reform that we would like implemented, or, alternatively, propose something better." That is my challenge to those who would claim credit for this.

If it is really theirs, they have to sign up for it. But if it is not, which bits of this would they not do? Which bits of this program would they jettison? I do not think they would jettison any of it. I think they are caught between a rock and a hard place. To their sole luxury they now have their own little domain—the nark end of the business; the mean and nasty, nitpicking bit of the business—whilst everybody else is out there getting on with the job of rebuilding health.

The Hon. JOHN JOHNSON: Thank you for that comprehensive answer, Minister.

CHAIR: Minister, with your approval could you answer one last question from the Hon. Dr Arthur Chesterfield-Evans?

The Hon. JOHN JOHNSON: Mr Chair, I will draw you a picture. When the big hand is on such and such and the little hand is on something else, it is way past the time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The allocation for mental health NGOs increase was 1.2 per cent. Given that the inflation rate is approximately 2.5 per cent, this is actually a decrease in real terms. According to the National Medical Health Report 2000, mental health NGOs in New South Wales are funded at 68 per cent below the national average. Does this mean that you do not want to use NGOs for the delivery of mental health?

Mr KNOWLES: No, as you well know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In which case, what are the reasons for this relatively low funding level of mental health NGOs?

Mr KNOWLES: I will give Mick a chance to get blue 19 out of the folder. I might just quickly conclude the answer I was trying to give to the Chair a while ago. I deliberately added more money to the mental health pot, I think from memory $107 million over three years real money. Because we were effectively trying to improve the levels of funding for mental health, I was also concerned that dropping large amounts of money into the pot at any one time could see it dissipated and not spent wisely.

As a consequence, as I did with the metro plan, I asked the clinicians to give me a hand in working out how to spend it. The first chairman was, as matter of fact—and I do not put this as anything other than a statement of fact—was Marie Bashir, who until her appointment as Governor was chairing a group of clinicians from around the State in giving me advice as to the best way of dispersing that money, and that work is continuing. In that sense there is a lot of money in the pot and they are continuing to work through as rural groups, acute groups and chronic care groups in developing a funding model and a programming model that will inevitably and properly incorporate NGOs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Clinicians may not have good liaisons and relationships with NGOs who may be less professional.

Mr KNOWLES: I use the concept of clinicians in its generic sense. It incorporates, as do all the clinical groups, consumer representatives, NGO representatives, nurses, administrators, in this case psychiatrists and people with a range of qualifications. Their appointment is not necessarily on an industry sector representative basis; it is on their ability to network and to have contact with those various groups. In that sense I am satisfied that the fairly diverse range of individuals on that group covers the landscape. For example, I recall an individual who happens to be on the board of a Steiner based NGO dealing with people with mental illness. He is not there because of the Steiner background but because he is a financial expert. He works in a fairly large private sector organisation in the city and is currently giving his time to the task.

That is a bit of background information to assure you that people who have always said they wanted to have their say are now having a say. That is a funny look, Jillian. I had the opportunity to tour many of our mental health facilities with representatives of consumer groups about a year ago and I have had some repeat visits with them. It is fair to say that they have been most supportive of the Government's program and our efforts to incorporate them into the system.

Mr REID: Ken has a specific answer.

Mr BARKER: There are two parts to the question. The first part is that in the budget last year we had an assumption of how much would go to NGOs but there has been an entry into employee-related payments, so we are employing more staff than we anticipated. You will notice that in next year's budget we are expecting an increase of 9 per cent, which is an inflationary increase plus a real increase over six years revised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are not talking about voluntary organisations and NGOs.

The Hon. HENRY TSANG: Point of order: Mr Chair, I draw to your attention to the fact that we are now way past 25 minutes.

The Hon. RON DYER: To the point of order: You said quite clearly to the Committee a short time ago that you would allow the Hon. Dr Arthur Chesterfield-Evans one last question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: These are supplementary questions on the subject.

The Hon. JOHN JOHNSON: There are no supplementaries.

Mr KNOWLES: I am happy to go through those questions outside. Can we give them in writing to you afterwards?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

CHAIR: Minister, thank you very much for your answers. I have an apology to make to you: There were in fact 17 trips to the Industrial Commission. I congratulate you on your persistence. I was reading this late last evening and with my new glasses—

Mr KNOWLES: The numbers blur, don't they? Sevens become ones. It is a bit like when Jillian reads budget papers—sevens become ones.

CHAIR: Minister, if you cannot accept an apology with greater restraint than that I will never do that again, I promise you. I am sure you would never do that.

Mr KNOWLES: I apologise.

CHAIR: Thank you for your attendance. You have said that you will take some questions on notice and I will confirm their response time with the Committee. Would three weeks be an adequate response time?

Mr REID: A bit longer, about five weeks if that is possible.

CHAIR: The questions on the notice paper could be answered in five weeks. Is three weeks adequate or not?

Mr REID: For the questions you raised tonight?

CHAIR: No, for the questions that are still to be tabled.

Mr REID: We do not know how many questions there are. You tabled 163 last year.

CHAIR: There are about 80 questions altogether.

Mr REID: Well then, we need longer than three weeks.

CHAIR: The Committee will have to deliberate and see whether they are prepared to accept that.

Mr KNOWLES: I would ask the Committee to recognise that at the last estimates committee the director-general came back four times. We responded to 160-odd questions on notice and whilst we are very happy to do that, many of those questions, as the Chair just suggested, could easily have been put on the notice paper. I just

make the observation that this is a terrific process of scrutiny and it is important to the parliamentary process, but it is also very expensive. There is a cheaper way of doing it, which is asking some of the questions on notice.

The Hon. JOHN JOHNSON: Do you know how much it did cost?

Mr KNOWLES: I could do an estimate for you, if that is a question on notice.

The Hon. JOHN JOHNSON: It would be a help.

The Hon. JENNIFER GARDINER: Rubbish!

The Committee proceeded to deliberate.