HOUSE OF ASSEMBLY

Wednesday 29 September 1982

ESTIMATES COMMITTEE A

Chairman:
Mr G. M. Gunn

Members:
Mr L. M. F. Arnold
Mr H. Becker
Dr B. Billard
Mr R. E. Glazbrook
Mr T. H. Hemmings
Mr G. R. A. Langley
Mr T. M. McRae
Mr I. Schmidt

The Committee met at 11 a.m.

The CHAIRMAN: I have examined the minutes, and if there are no objections I will sign them as being a correct record of proceedings.

I welcome the Minister of Health and her officers to the Committee. As this vote is somewhat different from the votes of other departments, in that we have only one line, I understand that the member for Playford wishes to make a few opening comments before members start asking questions. I will then permit the Minister to reply and make any comments that she thinks appropriate.

Mr McRAE: I am endeavouring to set out the basic critique of the Opposition of the South Australian Government's health budget in this financial year. In order to fully comprehend what has occurred, I think it is necessary to refer to the primary Budget documents. I think it is quite clear from the Financial Statement of the Premier and Treasurer that Commonwealth funds play a critical role in relation to State finances. In fact, that statement is absolutely trite, because if one looks at recurrent funds almost exactly 50 per cent of all funds received by the States come from the Commonwealth; and if one adds recurrent funds and capital funds the total received from the Commonwealth is about 42.5 per cent.

Page 3 of the Financial Statement of the Premier and Treasurer refers to a feature of recent Commonwealth Budgets being much slower in growth of payments to the States than in other areas of Commonwealth expenditure. According to the statement, Commonwealth payments to the States are expected to rise by 2.1 per cent in real terms in this financial year, compared with 4.1 per cent real growth in Commonwealth outlays for their own purposes. The significant feature over the last five Budgets is that payments to the States have declined in real terms by about 5 per cent, whereas expenditure by the Commonwealth has increased by 19 per cent.

Therefore, we are looking at plus 19 per cent in real terms total Commonwealth expenditure, and minus 5 per cent funding in real terms received by the States. I believe that the Premier quite properly concluded that portion of his remarks by saying:

> In other words the States have borne the full brunt of the Commonwealth's cost-cutting exercise.

In fact, this cost-cutting exercise has played a very real role in the health area, and we will examine it in some depth as the day goes on. Page 4 of the Financial Statement of the Premier and Treasurer notes:

> The trend in Commonwealth payments to the State remains adverse and has added greatly to our budgetary problems. Regrettably, given the lopsided nature of Commonwealth-State financial powers, this is something that South Australia and all other States must contend with.

The Premier then outlines the strategy of his own State Budget for this financial year.

The Premier's basic strategy is that his Government was elected because of its commitment to a policy of lower taxation, and he refers to the tax cuts that we already know about. Later in the Financial Statement it is noted that the estimated expenditure for the Minister of Health blew out or exceeded estimates by $36 500 000. I will pull these statements together in summary form in a moment: I think it is fair that I provide specific references, because it is with this background that the Opposition approaches specific areas. I refer to Attachment II of the Financial Statement, prepared by Treasury officers. Page 18 refers to the figure that I have already mentioned. There is also a table which sets out in money terms and in real terms the percentage in Commonwealth Budget outlays over previous years, and the figure that I mentioned of plus 19 for the Commonwealth and minus 5 for the State is there justified. In the pages that follow, there is a major statement on developments in Commonwealth-State financial relationships.

Pages 20 to 23, inclusive, set out the Treasurer's comments in relation to tax sharing grants and their results. For instance, page 20 states:

> For 1982-83, the total increase in the tax sharing grants is 16.2 per cent, reflecting a corresponding growth in Commonwealth taxation collections in 1981-82.

It goes on to mention that we enter the health area specifically at this point, as follows:

> In 1981-82, a new form of general purpose (untied) revenue grants was introduced, namely what are termed 'identifiable general purpose health grants' which replace the former hospital cost sharing grants of the four States other than South Australia and Tasmania and certain other specific purpose payments for health which had been provided to all the States. The new health grants arrangements are apparently intended to be an interim step towards the absorption of the health grants into the tax sharing grants.
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> In the case of South Australia, the hospital cost sharing agreement remains in place, and the identifiable health grants cover only assistance in lieu of payments formerly made under community health and school dental programmes.

On page 21, the Premier outlines South Australia's submission to the Commonwealth. Among the points emphasised was the following:

> South Australia should retain the financial benefits, relative to other States, which it was receiving as a result of the continuation of the hospital cost sharing agreement with the Commonwealth. The application of the commission's fiscal equalisation methodology without qualification would result in a reduction in the State's assessed tax sharing relativity because of the receipt by the State of per capita grants for hospital running costs which exceed the average of those of the other States. This, the State argued, would be in contravention of clause 7.1 of the agreement.

The commission's response is also set out, and in relation to health it is stated:

> on the same basis, it did not consider its assessed factors should reflect the retention by South Australia of the financial benefits of the hospital cost sharing agreement . . .

Finally, on pages 23 and 24 a summary is given of the consideration of the report of the Grants Commission at the Premiers' Conference in June 1982. The loss that would have accrued to South Australia had the Grants Commission report been accepted in full is set out on page 23. The loss was—$52 000 000 and the actual result was—$11 000 000, and there is a projection into the future from there.

It is the Opposition's view that, to get this matter into perspective, one must clearly identify the factual material as opposed to the ideological or philosophical material: I shall do that so that objectivity, I trust, will reign. The basic underlying submission of the Opposition is, first, at both Commonwealth and State levels, Governments follow a monetarist policy. The Opposition believes that that policy has not yet proved its worth. In fact, everywhere it is being

used, far from producing benefits, it has produced disaster upon disaster.

The second point is that, even putting aside that ideology in total, the Premier was perfectly correct (and is supported by the Opposition) in criticising Commonwealth tactics that are designed to increase its own expenditure by cutting State grants. In other words, increasingly the Commonwealth is handing programmes to the States (and one can see this in other Treasury material), thereby imposing obligations on the States and their taxpayers, without providing the States with funds to meet those obligations. For instance, page 26 of Attachment II shows a summary chart entitled 'Specific purpose payments to States and Northern Territory, Summary of recent changes'. In the Estimates Committee yesterday the Premier agreed that this was a patchwork quilt effect. Health is mentioned specifically. The total level of payments in 1980-81, from the Commonwealth's point of view, was $1 408 000 000 the payment to this State in 1981-82 was $205 000 000; and the Budget estimate for this year is $222 000 000.

The comment made by Treasury is that this is a result of major changes in federalism direction, towards absorption into general purpose funds. What is happening is that, within the monetarist policy, which is a philosophical position on which the two parties will not agree, there is also a new federalism policy on which, equally, we will not agree, but certain facts do and must emerge whether or not we agree on the philosophy which produced it. A regrettable part of this patchwork quilt, in the submission of the Opposition, is the transfer of health funding into the new agreements. We maintain that the agreement signed last year, no doubt at the point of a gun (I would not dispute that), no doubt under threat from the Commonwealth that worse might follow if it was not signed, has cost South Australia dearly and has and will lead, in our submission, more and more to flat rate taxation in this State. Tied with that is the notion of the 'user pays' principle, again a philosophical position with which the Opposition cannot agree, but again something on which we can find hard facts.

In the view of the Opposition, the hard facts are that, as a result of the Commonwealth's dumping this programme into the State without providing adequate funding back-up, what has happened, particularly in the hospitals area, is that three categories of person have emerged. The first category is reasonably protected, and that category is those persons whose bills are met by the Commonwealth and are no burden on the State. The second category is those persons who are members of funds, and a large proportion of the community are members of funds. The third category is persons who fall in the middle, who are not members of funds, either because they cannot afford to be, because of the enormous cost of health insurance, or because quite frankly they have just taken a punt on their own health. But the reality of the situation, in the Opposition's submission, a clear fact which arises from all this, is that, because there is this short-fall of funding, the State is put into this position: either it can resort to taxation to make up the short-fall, or flat rate taxation will and must come, to the detriment of those South Australians who are members of the funds.

Again, in terms of fact, let me make quite clear that the Premier states (and I accept his statement) that his philosophy, he being the Premier of the Government of the day and having the support of this House, is that taxation will not be increased. If that is so, there can be only one other means of the Government's financing its losses in the hospital areas, and that must be to pass on the cost to the health funds and, as a direct result, the average householder will pay more and more. The Opposition prediction is that, as a result of all that I have said (and people in the community can form their own views of the philosophy behind it), facts show that in this coming year the ordinary householder who is sensible and who can afford to be in a fund is going to be faced with an increase of $3 or $4.

The Opposition also anticipates, as surely as night follows day, that hospital bed charges will increase markedly as the financial year goes on. As the estimated expenditure blew out by $36 500 000 last year, we suggest that there is every likelihood of the same happening this year. This flat rate taxation is invidious, because it is a fact that—

The CHAIRMAN: We really are not discussing the taxation policies of the Government; we are discussing the health line. I realise that it is a broad subject in view of the fact that the subject is covered by only one line, namely 'Miscellaneous'. However, the Chair has given the member for Playford considerable latitude and I hope that his remarks will be related to the health line.

Mr McRAE: Indeed they are, Mr Chairman. The fact is that, unless the Government resorts to taxation, it must resort to pushing the cost across to the funds, which in turn must increase their fees. The ordinary householder on an average wage will be paying as much as the extremely wealthy person which would be a most invidious situation, in the view of members of the Opposition, and I think in the view of any right-minded person. The Opposition will be pressing for information during the day concerning what specific steps are proposed by the Government concerning these matters.

The other matter that arises from this is that, because of the short-falls, there have been obvious difficulties, which have been adverted to by the Auditor-General, in collecting moneys. To me, it seems quite obvious that a mistake has been made either by the Commonwealth Government, the State Government or has been made by both, in calculating the categories of persons who are covered by the Commonwealth. It would take some argument to convince me that the $16 000 000 due to public hospitals in this State from patients is all money due from rogues and scoundrels: that just cannot be the case. Retail stores and other merchants base their debt strategy on the calculation that only 2 per cent of the community will refuse to pay their debts if they can afford to pay them. If one multiplies that figure by five, and assumes that the percentage of people who refuse to pay their debts is as high as 10 per cent, real problems emerge.

During the course of the day the Opposition will want to find out about what has happened to the internal audit structure of the commission. Apart from that matter, even if the internal audit structure of the commission is as clear as crystal, and there are no troubles at all, the Opposition will be asking about what will be done in relation to the recovery of moneys. In other words, if there are claims of an outstanding amount of $16 000 000, how on earth is it expected that these moneys will be recovered in the law courts? The Opposition will be suggesting to the Government that it will find that the courts will simply make no order, because there is no basis on which they can make an order. Having dealt with the broad area of taxation, I now turn to the next heading.

The CHAIRMAN: The honourable member has had just over 20 minutes to make his comments. The Chair has been fairly tolerant, and I now ask the honourable member to round off his remarks.

Mr McRAE: In that case I will leave the various headings to my colleagues. However, there is one matter of complaint which I feel obliged to bring to the attention of the Chair. As usual, the Opposition is faced with difficulties in the health line. It has tried to accommodate its desperate need for information in various ways. First, the Hon. Dr Cornwall, in the Legislative Council, placed a comprehensive series of

questions on the Notice Paper in relation to hospital statistics, acute health care hospitals, hospital bad debts, health salaries, psychiatric hospital statistics, mental health statistics, domiciliary care services, occupational health, the Central Board of Health, and Strathmont Centre and its annexes.

All of those statistics were vital to the preparation of our effort today, but the Government's standard answer to all of those questions was that the time and effort required to provide answers to them was not considered to be warranted. The Minister's representative in another place has said consistently that these figures could be found in the Health Commission's annual reports, in Parliamentary Budget papers, the Auditor-General's Report or other publications.

We did not formally object at the time. What we did was to ask Mr Robin Prior, a member of the research staff of the Parliamentary Library, in the normal course of business (and I stress this) and in a thoroughly proper fashion, to contact the Health Commission and research the matter for us. He did that: he contacted the appropriate officer at the Health Commission and set about the task of compiling the statistics. I want it clearly noted that nothing was sought in relation to confidential files or any matter of confidentiality; nothing was sought as to Ministerial documents; nothing was sought as to Cabinet recommendations or anything that could be classified as confidential by any standards. The Library staff collated the data in the same perfectly legitimate way in which they collect all relevant material as requested by members from all other Government agencies, departments and instrumentalities.

There was never a suggestion of impropriety from the Presiding Officer, from the Librarian or from anyone else. When the material had been collected, but before it could be handed to the Opposition, I am informed (and I accept that) from the Parliamentary Librarian that the Minister of Health went to the Library and caused acute distress to the Librarian and his staff by demanding that these figures should not be given to the Opposition. She demanded that they be handed to her. That officer took the very correct course of saying that at that stage he would remain completely neutral, that he would place the papers in a safe place, which he did, and seek advice from the Presiding Officer. Eventually all the material except two documents was released.

We want that complaint noted because it is something that is quite extraordinary. It is something that causes a worry to the Opposition and to members of the public when normal information (and I give my word that that is all it was) was attempted to be censored and when such acute embarrassment was caused to officers of this Parliament. If for no other reason than the protection of Mr Robin Prior and Mr Stirling Casson, we are placing on record that never at any time did we ask them to do anything improper, nor did they do anything improper; in fact, on the contrary, everything they did was correct. With your ruling, Sir, I close my remarks there.

The CHAIRMAN: The honourable member has had approximately 27 minutes. I invite the Minister to make any comments she may wish to make in relation to what the member for Playford has had to say or in relation to any other matter which she deems appropriate. I point out to the member for Playford that this Committee has no control over the way in which these votes are laid before the Committee. That is a matter entirely for the Treasurer and in no way can action be taken to rectify any problems which he believes the Committee may or may not have.

Minister of Health, Miscellaneous, $226 848 000

Chairman:
Mr G. M. Gunn

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Mr R. E. Glazbrook
Mr T. H. Hemmings
Mr G. R. A. Langley
Mr T. M. McRae
Mr I. Schmidt

Witness:
The Hon. Jennifer Adamson, Minister of Health and Minister of Tourism.

Departmental Advisers:
Mr B. McKay, Chairman and Chief Executive Officer, South Australian Health Commission.
Mr E. J. Cooper, Executive Director, South Australian Health Commission.
Dr B. J. Kearney, Deputy Chief Executive Officer, South Australian Health Commission.
Mr R. J. Sayers, Executive Director, Southern Sector, South Australian Health Commission.
Mr D. Williams, Executive Director, Western Sector, South Australian Health Commission.
Dr W. T. McCoy, Executive Director, Central Sector, South Australian Health Commission.

The CHAIRMAN: I declare the vote open for examination.

The Hon. Jennifer Adamson: I respond briefly to some of the points that the member for Playford has made. He spent considerable time referring to the Premier's comments and obviously there is no room for dispute over his statements about the reduction in Commonwealth grants over the last five Budgets. The effect that that has had on the health budget needs to be seen in the context of not only the reduced grants but also in the context of the new financial arrangements which the Commonwealth introduced in September last year.

The member for Playford criticises the so-called monetarist policy of the Commonwealth and the State Governments, and states that nowhere in the world has it been seen to work. He somehow equates that policy with the Government's general health policy and its efforts to achieve improved financial management in the health system in South Australia. I make the point that, if his comment is valid, and I would certainly dispute it, it is certainly valid to say that there is no proven correlation between increased spending on health and improved health in any given community. In fact, there is evidence to suggest that increased spending can actually have an adverse effect on health if it is the result of over servicing and inappropriate forms of care. Be that as it may, I do not necessarily accept that improved financial management and reduction in costs in the health services leads to any disadvantage to anyone; in fact, there is evidence that it leads to considerable advantage to the patient and certainly undisputed advantage to the taxpayer.

The criticism of transferring certain programmes to the States in my opinion is unfounded if it relates solely to permitting a State to have not only the responsibility for delivering services, but also the authority to determine how the services are delivered and in what way they are funded.

I would not, however, dispute that the Commonwealth has chosen to hand over certain programmes to the States at a time when those programmes are about to face a period

of expansion and expanding need. The programme was handed over at what one would call a base level immediately prior to the State's having to expand that programme to meet emerging needs. A good example of that would be the handing over of the women's shelter programme to the States at a time when the Commonwealth would have well recognised that there was an emerging need for more shelters. Similarly, the community health programme was handed over at a time when the Commonwealth recognised that in the next few years the States would need to find expanding sums of money to meet the demands of that service.

The member for Playford then went on to refer to insurance take-up rates. I do not have the figures with me but the Commonwealth Health Minister has on numerous occasions outlined the very high take-up of health insurance, the very large numbers of Australians who are eligible for free health care, and the comparatively small number of people who choose too or who are unable for financial reasons to take up health insurance. If that information can be brought into the Committee later in the day I will be happy to provide it to the Committee.

The member then went on to suggest that the consumer is bearing the brunt of the Commonwealth policy through increased hospital charges, and on that note I would like to make several points. South Australia's hospital charges have been contained more effectively than have the charges in any other State. It is interesting to observe the fact that charges have gone up in all States, and that they are highest of all under the Labor Government in New South Wales. A private bed in New South Wales costs $160 a day compared to a flat rate of $105 a day in South Australia for both private and public beds, and that is the lowest cost of all States. That has been achieved in part through efforts by the Health Commission and the hospital boards in South Australia to improve financial management and to keep costs down. We are much more cost efficient in the hospitals system in 1982 than we were when the Government came to office in 1979.

This is reflected not only in the charges, but also in the insurance rates. Insurance rates for Medibank Private, which operates in all States, show that in South Australia the cost of contributions to the basic hospital table is 23 per cent lower than in New South Wales. That refutes any suggestion that South Australians are paying more in hospital insurance than people in other States are paying. So we have in this State the lowest hospital charges in Australia and among the cheapest basic hospital insurance rates in Australia, and the combination of that means that, both as patients and as taxpayers, South Australians are better off than their counterparts in other States.

The reference by the member for Playford to what he described as an anticipated blow-out, the cost of which would have to be met by the consumer, ignores the fact that there is provision in the round-sum allowances which are held by Treasury to meet the cost of wage increases and inflationary cost increases in services. I will ask the Chairman of the commission to be specific about the internal audit issues that were raised in his question referring to the remarks by the Auditor-General about the collecting of moneys, but in reference to the Commonwealth estimates I can simply agree with him that they were over-estimates. All States argued that the Commonwealth over-estimated the capacity of the States to raise revenue, and not one single State was able to meet the Commonwealth estimates of revenue in the first year of operation of the new arrangements. We believe that that was solely on the basis that the Commonwealth had used unreal estimates which did not have a solid basis either in experience or in information which the States provided, so I do not dispute that the Commonwealth estimates were over-inflated, and we simply were not able to meet them.

As to the amount of information made available to members of Parliament and to the Budget Estimates Committee, I have said in each year that the Estimates Committees have sat that we, as a Government, have made available infinitely more Budget information than any previous Government has done, and the presentation of what we will call the blue book with hospital figures makes available to the Committee a wealth of information which has never previously been available in this Parliament. I would conclude by dealing with the member for Playford's allegations about the work of the Parliamentary research assistant in obtaining information for the Labor Party.

Mr McRAE: For the Opposition.

The Hon. Jennifer Adamson: For the Opposition. At no stage did I come down to the Parliamentary Library and demand that information be returned. When the Parliamentary research assistant approached the Health Commission for information on behalf of an inquirer (and the inquirer, of course, was not identified), the commission explained to that officer that some of the information sought was too time-consuming and difficult to obtain, the reasons being not only that an officer would have had to be made available to go through annual reports but that in some of the circumstances information of the kind being sought simply was not kept. In future it may well be on computers, but in the past, including periods when the Opposition was in Government, that information just was not recorded and would not be possible to find.

However, the commission officer indicated that some of the material was available in a report entitled 'Hospitals in South Australia', to which anyone could have access; I am not sure whether it is not even available in the State information offices. It certainly has been made available to hospitals, and on that basis any member of Parliament would be entitled to have it. However, having obtained that information, the research assistant then sought further manpower and financial information which had not been made public, and still has not been made public, by the commission. The officers who were providing that information were not authorised officers. In fact, the appropriate officer was not available; he was on leave.

At no stage have I suggested that either the Parliamentary research assistant or any member of the Opposition was behaving in an inappropriate fashion in seeking this information. On the contrary, the commission officers who were providing information that is not public were unwittingly—and I stress at that level—unwittingly—providing information which would not be appropriate, simply because it had not been verified with the health units. It will, in due course, be verified, audited and provided through annual reports.

So there was no intention on my part to thwart either the Parliamentary research assistant in his proper course of duties, or any member of the Opposition; it was simply to ensure that any information that was made available was appropriate to be made available publicly and had been verified with the health units. The information which was retrieved was that which had not and has not been verified with the health units. It will in due course be verified and published in annual reports.

The ACTING CHAIRMAN (Mr Glazbrook): Before calling on questions, I seek the Committee's direction as regards the programme for today, bearing in mind that the Minister is also Minister of Tourism and that the tourism vote is also scheduled for debate and questioning today. Can the Committee indicate a time schedule for the health vote so that the Minister may make arrangements with her officers regarding the tourism vote?

Mr McRAE: So far as the Opposition is concerned, we would propose that we cease questions on the health line at 8 p.m., whatever the circumstances.

Mr BECKER: I think we need a bit of flexibility in that. I would say 8 to 8.30, leaving about an hour and a half for tourism.

The ACTING CHAIRMAN: The Committee, of course, holds its own destiny and accepts the indication of 8 p.m., with that flexibility.

Mr HEMMINGS: I can understand what the member for Hanson is getting at, but there has been some concern in the past that tourism deserves a little more time (in this case, more than an hour or an hour and a half), and that is the reason why my colleague the member for Playford said that regardless of that the Opposition would cease questions on health at 8 o'clock, which would then give the Committee dealing with the matter of tourism at least two hours, and I think that is fair.

The ACTING CHAIRMAN: I think the Chair recognises that the Department of Tourism officers will not be required before the dinner adjournment, and I think the Minister can have that indication.

The Hon. Jennifer Adamson: Thank you. Because of the breadth and complexity of the health lines and my wish to make available officers to answer specific questions that cover that breadth and complexity, I would appreciate if the Committee could give some indication of whether it wishes to deal with hospitals in the morning, afternoon or the evening, and at what stage in respect of public health. The principal commission officer, who is also Chairman of the Central Board of Health, has to leave Parliament this afternoon to attend a National Health and Medical Research Council meeting interstate, so if public health matters could be dealt with this morning the principal commission officer would be available to answer specific questions. If the Committee wishes to pursue that matter this afternoon, other officers could be made available.

Mr McRAE: The Opposition is perfectly happy to go along with the suggestion that public health matters be dealt with forthwith.

Dr BILLARD: Could I suggest that, if we follow the pattern as set out on page 1 of the blue book (which lists a number of areas), dealing with general funding issues first, followed by general issues so that we would not be jumping all over the place and without setting a time limit on any area, we could gradually move through.

The ACTING CHAIRMAN: I believe that the Minister has explained the difficulty in regard to some of the officers who are involved.

Dr BILLARD: Public health is shown as the third item, and the two items above that are the Office of the Minister and central office.

The ACTING CHAIRMAN: It depends on how much time is taken on those matters. Opposition members have indicated their willingness, and I think that in this instance, because of the constraints upon the Minister's advisers, it may be worth while pursuing that subject forthwith as suggested.

Mr McRAE: Do I understand that the member for Newland is suggesting that we deal with the fourth topic on the first page of the blue book, and proceed from there?

Dr BILLARD: No: I was suggesting that we deal with general funding and overall issues first (which may have already been dealt with) and then gradually, during the day, instead of jumping all over the place, we could follow that listing simply as a guide so that we have some cohesion on the subject.

The ACTING CHAIRMAN: The honourable member is referring to the first nine items on the first page.

Mr McRAE: Basically, we would not object to that, provided that, as my colleague points out, it is understood that the general questions on funding (and I understand what the honourable member is saying in that regard), involving point 4, would be considered first and public health generally be dealt with after that.

Dr BILLARD: Does the honourable member want to deal with recognised hospitals first?

Mr McRAE: That seems to be a fairly logical progression, or perhaps we could deal with general funding and then public hospitals.

The Hon. Jennifer Adamson: I believe that the thread has been lost. I would like the public health services dealt with this morning, because the principal commission officer will be available. If we follow the suggestion of the member for Newland and use as our programme guide page 1 of the blue book, on which is listed the statement of actual and estimated payments and receipts, that would enable a general approach, and then listed in order from 1 to 9 are the Office of the Minister first and central office second (which I doubt would take a great deal of time), with public health services third. After that, we could discuss the fourth item, recognised hospitals. If we proceeded in that order, my officers would know when to be available progressively, and we would certainly cover the whole health system in an orderly fashion.

Mr HEMMINGS: These Estimates Committees have been set up by this Government (and I am not trying to be facetious) so that members can question in depth the Minister, and senior public servants can answer on behalf of the Minister. Now we have a situation where certain officers might not be available later on in the afternoon. I base my remarks on the precedent that has been set in the Federal Parliament. One would have thought that, where a Minister is listed to be questioned until a certain time, all public servants involved should be available to assist the Minister.

It may be that I have a number of questions. I do not place much credence in the blue book: the basis of my questions is what I cynically call the joke book (the yellow book). It may be that a public servant might have to sit here until 5 o'clock before a particular question I ask involves him, but that is what it is all about—that is what this Government has decided. The Government went away from the examination of the lines and adopted Budget Estimates Committees.

The Opposition has already agreed that our questioning on health will cease no later than 8 p.m. I, as a member of the Committee and as the spokesman in the House for my colleague the Hon. John Cornwall in another place, will not be bound by the fact that the chief executive of the Health Commission is entitled to go off after lunch. It is now nearly 12 o'clock: we have only one hour and 10 minutes before we break for lunch.

Mr BECKER: What is wrong with that?

The ACTING CHAIRMAN: Order! If there is not total agreement in the Committee, we will proceed by asking questions in the normal pattern.

The Hon. Jennifer Adamson: I would like to clarify the position for the benefit of the member for Napier. The Chairman of the commission will be here for the entire proceedings: I was referring to Dr Keith Wilson, the principal commission officer who, as the State representative, attends meetings of the National Health and Medical Research Council. Those meetings are set well in advance of the time when the dates for the Estimates Committees are set. Any finance question on public health and any questions relating to clinical matters, at any stage of the day, can be answered by another officer. However, Dr Wilson will not be here after lunch.

Dr BILLARD: I refer to the general funding levels, and I preface my question by recalling that last year allegations

were made that there had been massive cuts, particularly in funding for recognised hospitals. In fact, there was a motion on the subject, which alleged that there were cuts of 22 per cent. At that time we responded by pointing out that the funding allocation had increased by 14.4 per cent: in the event (as we see from the figures), it increased by 14.7 per cent. This year there have been allegations of heavy cuts in health funding. What is the true position?

The Hon. Jennifer Adamson: The health budget this year is a stand-still budget. The actual expenditure on health is estimated to be almost $500 000 000, plus approved wages increases, as against $457 000 000 last year, when an overall increase in health expenditure of 12.6 per cent was recorded. There was certainly no reduction of 22 per cent. I will ask the Chairman of the commission to explain to the Committee the figures in appendix 1, because the matter is complicated. It is very easy to leap to false conclusions unless one has a full picture not only of State and Commonwealth cost-sharing arrangements but also of revenue figures.

I certainly refute any suggestion that the health budget has been cut this year: it has not been cut, it is a stand-still Budget. That is well recognised by the boards of all the hospitals, and they understand that they are receiving stand-still budgets, not cuts as has been suggested. I will ask Mr McKay, using the statement of actual and estimated payments, to identify the factors which demonstrate that this is a stand-still budget and not a reduction, as has been claimed by the Opposition.

Mr McRAE: It seems to me that we would save time if we could put our question, and Mr McKay can deal with both matters at the same time. Under the hospitals cost-sharing agreement, the Commonwealth met 50 per cent of the budgeted net operating costs of recognised hospitals. Under other legislation and programmes, the Commonwealth met 50 per cent of the net operating costs of community health, domiciliary care, school dental and drug education services, and the full net cost of Aboriginal health services; together they represent approximately 80 per cent of the commission's total operating expenses. That information was contained in the commission's report of 1978-79. Looking at page 1 of the blue book, it can be seen that receipts from patient contributions will rise from $59 800 000 in 1980-81 to an estimated $125 000 000 in 1982-83. Does this not show that a far greater burden is being placed on the consumer, and does it not necessarily and logically follow that that will cause the funds to increase rates generally?

The Hon. Jennifer Adamson: I wonder whether the Opposition appreciates that the figures in this year's Budget are based on 12 months revenue and not nine months, which is the comparison with last year, that they are also based on increased fees which were determined at the end of last year, higher than those of the previous year, and that there will be benefits from direct billing and the pursuit of accounts which has not been undertaken as effectively as it might have been because Government hospitals have simply not been accustomed to collecting accounts in the past. I will ask Mr McKay to elaborate on those three points.

Mr McKay: Dealing with the question of finance and the explanation: it is a confused picture, and unfortunately we cannot make it any simpler because of the Commonwealth involvement in the cost-sharing agreement and, therefore, the impact on recognised hospitals. Last year the Health Commission spent $435 900 000, and the estimate for this year is $467 000 000. That estimate represents the flow-on of wage increases and other activities associated with last financial year. They are impacts flowing to this year, we know what they are, and they can be measured. Also, in negotiating that figure with Treasury, we have looked at items which we agreed will impact on this year's budget and which, again, we know will add to its cost. We also took off items which will not carry on into this year—one-time items in last year's Budget.

On the receipts question, last year the new arrangements started from 1 September. In fact, you could receive treatment in a hospital in South Australia and throughout Australia until October without any charge. That was the date of operation of the new health scheme. Our receipts for last year of $82 000 000 reflected nine months experience under the new arrangements whereby any persons not eligible under the Commonwealth arrangements are required to pay for their health care. In addition, hospital charges in South Australia rose from 1 July by 20 per cent. As regards those factors, in reaching the estimate of $125 000 000, we have looked at the impact of the 12 months of the new arrangements, of the 20 per cent increase in fees, and what we believe will be an improvement in our financial collection because of a number of activities which we have entered into. The main activity involved is an arrangement with the funds whereby we can actually receive payment for hospital charges from the funds direct whereas you cannot by introducing a system of assignment of benefit by the patient to the hospital and that will quicken our current turn-around time for hospital charges, which is something up to eight to 10 weeks.

Moving to net operating costs, which is the subtraction of receipts from payments, we arrive at the Commonwealth contribution, and there are various Commonwealth contributions there, and that is why I said it is very confusing. For example, in the nursing home area we receive nursing home benefits from the Commonwealth for places like the Hampstead Centre. Under the cost-sharing arrangements, the figure that the Commonwealth will contribute is an actual estimate. In other words, it is not like our expenditure figure: it is a figure that includes an estimate for anticipated wage increases this financial year. That again complicates the matter, but the Commonwealth is interested in not what the estimate is plus wage increases: it actually looks at anticipated wage increases in reaching that figure.

We then arrive at the net cost to South Australia. One of the difficulties we had last year in talking to the Committee was the understanding of that net cost to the South Australian figure because, although we have Commonwealth anticipated wage increases, we do not have the State anticipated wage increases. I think that Treasury has anticipated about $26 000 000 this financial year for round-sum allowances, which will be added to the net cost to South Australia. Therefore, in looking at our costs for this financial year, we will be looking at a figure of about $226 000 000.

Dr BILLARD: You did not give any percentage movements.

Mr McKay: If you look at the last two financial years, total health costs in South Australia have risen by almost the same figure, about 12.5 per cent in those two years.

Dr BILLARD: What impact would wage and salary increases have on this Budget? How much do wages and salaries increases contribute to the overall Budget figures?

The Hon. Jennifer Adamson: Is the honourable member referring to last year or this year thus far, for the first quarter?

Dr BILLARD: I was referring to last year, but comments about this year would be welcome. As an example, we know that in education 90 cents in every dollar goes in wages and we know that if there is, for example, an increase of 13 or 14 per cent most of it will be consumed by salary increases. I would like some indication as to the percentage of the overall budget spent in salaries, and the impact salary increases had in the last year.

Mr McKay: I do not have the percentages, but wage increases last year were $19 500 000 in a budget of

$400 000 000. This is where the problem exists, because the flow-on from other wage increases impacts on the budget outside of that; that is, the new wage increases. They start at various times during the year. For example, the nurses' increases commenced from 1 January. Most of the staff have received a 12 to 13 per cent increase; the medical officers received the lowest increase, with 8.2 per cent; nurses were between 12 and 13 per cent; the general administrative staff between 12 and 13 per cent; and the domestic and other category staff received a wage increase of approximately that figure.

The gross wage figure alters due to the timing of a wage increase and its impact on the Budget. Actual wage rates over the past 12 months have risen by about 13 per cent. By far the greatest percentage expenditure (in fact, over 80 per cent) is on wages. In relation to the other part of the honourable member's question concerning rising insurance rates, I point out that the current insurance rates have been set on the existing charges and the funds' actuarial anticipation of funds that their members will use at the existing rates. If their assessment is correct, the rates charged by funds should remain as they are, as long as charges remain as they are at present.

Mr HEMMINGS: I do not want to belabour the point made by the member for Playford about the information that was sought by the Parliamentary research assistant, although it seems that the Opposition's story and the Minister's explanation do not really gel. If the Minister has no complaint, why was all the information locked in the Parliamentary Library's safe? Why were only certain documents released (leaving two documents in the safe)? I would not go so far as to say that the Minister has misled the Committee; I am attempting to find out the facts. I do not have a key to the Parliamentary Library safe, but I am sure that the Minister has the information that I require. First, how many bad debts have been incurred in all major South Australian hospitals for the years 1978-79, 1979-80, 1980-81, and 1981-82?

The Hon. Jennifer Adamson: I am not sure whether the member for Napier was listening carefully when I responded to the member for Playford's comments. I did not say that there was no complaint; I said that I did not go down to the Parliamentary Library. I contacted the Parliamentary Librarian and asked him to ensure that the information on the public record was separated from the information that had been unwittingly provided by Health Commission officers who were not aware that some information was not on the public record and had not been verified by the health units. I am certainly not in a position to provide immediately the information sought by the honourable member in relation to bad debts. However, if my officers have that information I am happy for it to be provided.

Mr McKay: It is difficult to answer that question. Without any problem at all we could provide the Committee with the details of bad debts written off between 1978 and the current financial year. We experienced difficulties during the past year (which caused comment in the Auditor-General's Report), which is why we started a new system on 1 October whereby people not eligible for Commonwealth benefits are charged for their health care. Prior to that time it was simply a matter of choice by the patient when presented with an account whether or not he would pay it. The introduction of the new arrangement has caused problems in hospitals in relation to their work loads and a number of actions have been taken, including reviews by both hospital administrations and by consultants. At the moment a number of new arrangements for billing systems are before the commission.

However, the figure for outstanding accounts should not be regarded as the bad debt figure. I think that is important, because the figure for outstanding debts includes the amounts for bills raised and accounts not yet finalised. In the health system at present there is a situation whereby a patient receives a bill some time after discharge from hospital. The patient then takes that bill to his health fund which processes the account and posts the cheque back to the patient who then forwards it to the hospital. That process can take up to 10 weeks if everyone does their best to expedite the matter. In other words, the process entails the hospital sending out its account, the patient forwarding it to a health fund for processing, and the health fund posting a cheque to the patient who then forwards it to the hospital.

Further, there are remission cases under the present hospital arrangement where patients are charged, and on receipt of a bill question their eligibility because they are not insured. Those involved contact Social Security and many of them receive cards because they are eligible for benefits. If a person then produces that card at the hospital, the hospital is required to remit the debt.

Another matter is compensation. As the honourable member would know, compensation cases take a long time to process through the legal system and hospitals do not necessarily know for quite some time whether a charge will in fact be recovered. These matters are complex issues. The real test of a bad debt occurs when a hospital cannot collect and is forced to write off the debt. The information sought by the honourable member in regard to this matter could be provided.

The Hon. Jennifer Adamson: While Mr McKay has been speaking further information has been provided. In 1981-82, $666 000 was written off in bad debts. That sum includes remissions which neither the commission nor the hospital boards classify as bad debts; in other words, people who have been judged by a board to be in circumstances that warrant the remission of their hospital accounts. If our quick calculations are correct, that amount of $97 420 000 represents (as a percentage of actual receipts for the 1981-82 financial year) a figure of less than 1 per cent of receipts written off as bad debts.

Mr McKay: Many of the amounts written off would be minor amounts. For example, the out-patients fee is $20, and the various hospital boards make a judgment about whether an amount is worth pursuing.

Mr HEMMINGS: In regard to bad debts written off, the Minister has supplied a figure of $666 000 for 1981-82: will the Minister provide figures for the other years that I have mentioned. I point out that this is simply a supplementary question.

The CHAIRMAN: It was framed as a question.

The Hon. Jennifer Adamson: I will endeavour to provide those details if they are available.

Mr HEMMINGS: I have learnt a lesson; one must never ask a supplementary question.

The CHAIRMAN: Order! Before proceeding any further, I point out that the Chair has been most tolerant this morning. If the honourable member reflects on the Chair, I will name him and he will not remain as a member of this Committee. I had discussions with the member for Playford this morning before the commencement of proceedings and, because this vote has only one line, it was decided that the Chair would be as tolerant as possible to ensure that the Committee operated in an effective manner. The Chair takes strong exception to the reflection made by the member for Napier and I ask him to withdraw. The honourable member would be aware that any member named by the Chair is removed from the Committee. Under no circumstances will I tolerate reflections on the Chair.

Mr HEMMINGS: I apologise, Mr Chairman, and I do withdraw. The other document in the Parliamentary Library safe relates to nurses salaries for 1981-82. Could the Minister

supply the Committee with the nurses salaries paid at the Royal Adelaide, Queen Elizabeth, Modbury and Mount Gambier Hospitals?

The Hon. Jennifer Adamson: They are not available at this stage. If they can be extracted, I have no objection to them being made available. In relation to my undertaking to provide information about so-called 'bad debts' for previous years, I point out that when a so-called 'free hospital system' is operating there is no such thing really as a debt. It is only when a user-pays system is introduced that 'debt' becomes meaningful. I hope that explains why it is not possible to provide those figures for those years.

Mr HEMMINGS: The Minister stated that this is a stand-still health budget and, therefore, it has not been reduced. Page 7 of the yellow book states:

> The proposed total expenditure for the 1982-83 financial year is $505 500 000, which represents an increase of 6.2 per cent on the 1981-82 actual expenditure of $475 800 000. This represents a 'stand-still' allocation . . .

Does the Minister disagree with the Treasurer's comment that his estimate of the Federal Treasurer's projection of an 11.3 per cent inflation rate for 1982 represents an overall reduction in real terms of about 5 per cent?

The Hon. Jennifer Adamson: The statements in the yellow books are not made by Ministers; they are prepared by the Treasury. The member for Napier seems to ignore the fact that the $505 500 000 mentioned does not include the round-sum allowances for salaries, wages and inflationary cost increases in goods and services for health. When those sums are added, obviously inflation is taken into account.

Mr GLAZBROOK: I refer to the agency overview objectives, issues and strategies on page 6 of the yellow book. Why does that overview refer only to voluntary organisations being used in the provision of health services to complement or substitute for Government-operated services? Does the term 'voluntary organisations' really refer to deficit-funded hospitals or to the overall medical services provided?

The Hon. Jennifer Adamson: The words, 'effective use of voluntary organisations' embrace the whole range of organisations, not only those provided with specific Government grants to enable their operating costs to be met, including St John Ambulance, Minda, Julia Farr Centre, the Royal District Nursing Society and a wide range of voluntary organisations, some of them of a quite local nature. Through its various operations the Health Commission tries to ensure that those organisations provide a more cost-effective, more human and appropriate service for people requiring health care.

The honourable member would know that the Government is absolutely committed to the involvement of voluntary organisations in the health system. South Australia is unique in Australia in the extent of that involvement. The South Australian St John Ambulance Service is without doubt the most cost-efficient ambulance service in the whole of Australia; that is substantially due to the very large involvement of highly trained volunteers. The Royal District Nursing Society is a voluntary organisation which provides a State-wide service. Another important State-wide service is provided by what was formerly known as the Mothers and Babies Health Association; it has now been incorporated under the Health Commission in association with the School Health Service and the Child Adolescent Psychiatric Services to form the Child Adolescent and Family Health Services. In this State we are extremely fortunate in the extent of voluntary-based services, because the voluntary component helps to keep the costs down and, in the past, the community-based management has also reduced costs to taxpayers. The Government's policy of community-based management for all health units will ensure that we receive expert advice and community knowledge in an honorary capacity at no cost to taxpayers.

Mr GLAZBROOK: I refer to 'Strategies' on page 6 of the yellow book, as follows:

> The South Australian Health Commission continues to press the Commonwealth Government to devolve more of its existing financial and regulatory controls on hospitals and nursing homes to the State.

Which Commonwealth financial and regulatory controls does the Health Commission believe must be devolved to allow the State more flexibility in its planning?

The Hon. Jennifer Adamson: I will ask the Chairman of the commission to answer that in specifics. Under the present system nursing homes are controlled by the Commonwealth and the States are responsible for the delivering of health care to the aged (mainly in hospitals). Therefore, we do not have the flexibility of a global health budget to transfer resources from one area to another, either across the board within South Australia or in individual country towns or major cities. Because there is a division of funding responsibilities, the patient often falls between the two and there is duplication in some areas and there are severe gaps in other areas.

If the State Government through the Health Commission had the responsibility and the authority to manage these funds, we believe that they could be used much more efficiently, transferring funds where appropriate from one area to another. I will ask Mr McKay to elaborate on how that can be achieved. Certainly, in the past we have suffered as a result of that divided responsibility.

Mr McKay: I think the main areas are, first, the Commonwealth programme for the construction of nursing homes (mainly in the voluntary sector) and, secondly, the operational funding through nursing home benefits. I think the State believes that, having been given responsibility for the community health programme (the domiciliary care arm of this system), to be cost effective we should be building up those services which will prevent our growing aged population from having to be placed in institutions. At the moment, the institutional side of that arrangement is outside of our control. It does result in some vertical situations, because a number of country hospitals, through the efforts of people in the community, have gone ahead and built nursing homes on hospital grounds. Those homes must be run as separate institutions, so there is some duplication of costs.

The Commonwealth does not particularly trust the State and feels that we might be using nursing homes to syphon funds off. That is the difficulty when two funding agencies are involved in a particular area of care. The absorption of the dental health programme and the school dental programme into general funding was mentioned earlier. That will now allow us to combine the services of the dental hospital and the school dental service at State level and provide a State-wide dental service without the descriptions which apply to particular funding programmes.

Mr GLAZBROOK: I refer to the last paragraph under 'Strategies', as follows:

> Development of a number of analytical tools to aid decision-making by the Commission on the type and level of health services to be provided in South Australia.

When the Health Commission refers to analytical tools to aid decision-making, what provisions have been made to allow for input from both consumers and providers of health services and health care in South Australia?

The Hon. Jennifer Adamson: The member for Brighton has raised a very important question. The Executive Director, Mr John Cooper, will describe the analytical tools. They could be described as consultancies and role and function studies for hospitals, several of which have been undertaken

in the past year by the South Australian Health Commission. The commission ensures that the local community plays a very large consultative part in those studies. An excellent example is the intellectually retarded persons project, which commenced in 1980. That project will determine the extent and need for services for the intellectually disabled and the manner in which parents, families and health and other professionals believe that those services should be delivered. That was an enormous fact-gathering exercise, an epidemiological study and a study of services. It involved extensive consultation. A large consultative network was established and the outcome, as the honourable member knows, was a new organisation designed to provide a co-ordinated and integrated service to be headed by a community-based board. Other studies have been conducted in the Riverland, in Port Augusta and in country towns. Mr Cooper will describe two or three of those studies and the manner in which the commission enlists the involvement of local community groups and any relevant professionals or health workers.

Mr Cooper: I suppose two general approaches can be discussed under this heading: first, the availability of information and analysis to appropriate consultative and consumer representative groups. That approach was adopted in the intellectually retarded persons project which had a steering committee with wide representation. We also had a parent consultative committee and a whole series of seminars during the course of that project. Information was made available to people and analyses were presented.

The Riverland study, which was conducted by a consultant, was very similar, because it involved analysing data and presenting it to public meetings, meetings of health professionals, and so on to assist them when making decisions. I point out that work being done by the Royal District Nursing Society and a large psychiatric service that we are introducing can include the use of mathematical models to take consumer input. In fact, members of our research staff are developing a technique to incorporate value judgments made by professionals and consumers into a linear programming model.

I note that one member of the Committee is laughing, but it does work. It is a wellknown technique called the Delphi technique, and I guess that is what has been referred to. The commission recently established a steering committee to begin a large review of psychiatric services in the State on a similar basis as the intellectually retarded persons project. That project was completed last year, but its implementation is still in the early stages. The steering committee has met once. Two task forces have been established consisting of clinicians and people from organisations such as SACOSS and the Mental Health Association. This slightly esoteric technique will be used in relation to child, adolescence and family psychiatric services and in relation to services for the aged suffering psychiatric disorders.

The Hon. Jennifer Adamson: In the conduct of these studies the commission would normally identify everyone in a given area, be it State-wide (for a service delivery area) or geographically for a specific location. Everyone who has any interest whatsoever in the provision of health care, including consumers, voluntary agencies, health providers (such as the local G.Ps, and community nurses), local government, boards of various voluntary bodies (such as child and family health services), the Royal District Nursing Society (and any other organisations that may not provide a State-wide service including school organisations, and parent bodies) are all brought together to exchange information and seek advice in relation to the best way of proceeding with a certain course. I am finding exactly what resources are available. In fact when this is done we find that local people themselves are unaware of the extent and nature of the resources that are available in their local district. Quite often there is a big challenge and an opportunity to simply enable those resources to be co-ordinated in the best interests of the patient and consumer.

Mr McRAE: I repeat (because we have not got on record a clear acknowledgement one way or the other on this) that the result of the new strategy as indicated by the increase in payment contributions of some $60 000 000 this year does in fact represent a transition to a user-pays principle.

Obviously, either the Minister favours that principle or she does not. In the first instance, does the Minister favour the user-pays principle, and, if she does, does she then acknowledge that I am right in saying that quite clearly that introduces flat rate taxation in that, apart from the Minister's own Government taxing the community at large, the burden is being shifted from Commonwealth graduated taxation schemes to flat rate taxation in the form of fund levies?

The Hon. Jennifer Adamson: I am rather at a loss to understand the honourable member's question. He would know that I am on record many times as supporting the user-pays principle; in other words, those who can demonstrably afford to pay for health services should do so, and everyone who is capable of doing so has an obligation to protect himself or herself and the family against the cost of those services by being insured. At the same time, this Government recognises, as indeed the Federal Government recognises, that there is a proportion of needy people in the community whose needs cannot be met in any way other than by the community itself, through the Government making available resources to them. That is what occurs in regard to a very large proportion of Australians. I believe that about 20 per cent of the population is entitled to receive free health care.

As I have said on many other occasions, the concept of a so-called free health system has been thoroughly discredited, and I do not believe that it will be embarked on again in Australia. There is broad community appreciation of the need for people to accept financial responsibility and all of the self-imposed controls that go with it, including a consideration of the use of services and a reduction in the overuse or the abuse of a so-called free health scheme. Figures from a survey of the Australian Bureau of Statistics just provided to me indicate that 70.4 per cent of South Australians were covered for basic hospital cover as at March 1982: translated into numbers, that figure represents 920 000 people. About 300 000 people in South Australia are eligible under the Commonwealth scheme, and about 80 000 people, or 6 per cent of the population, are not covered, a large proportion of whom would be healthy young people who choose to take the risk. Of course, that is a matter for their own judgment.

Mr McRAE: The point I am making and the sting in the question (and surely the Minister will agree that it follows as surely as night follows day, as I agree that one gets nothing in this world without paying for it) is that, under the previous system, people paid under graduated taxation scales so that the wealthy paid more than the less wealthy. Under this system, surely the Minister will admit that, in reality, there is a flat rate taxation system. Whether a person is earning $250 per week or $10 000 a week (as do some medicos around the place), he will pay the same rate for health insurance. That is the point that the Opposition draws to the attention of the Minister.

The Hon. Jennifer Adamson: The honourable member's point must be seen in the context that those who are earning at the rates he describes are also paying a very large proportion in personal taxation, which then goes to support those people who are eligible for Commonwealth benefits and who obtain free health care at no cost to themselves. It is quite spurious for the honourable member to draw attention to charges and describe them as flat rates of taxation

while at the same time ignoring the whole basis of personal income tax and the way in which it is paid in this country.

Mr McRAE: I draw attention to another major topic that alarms the Opposition—the question of nursing in this State. We are very concerned indeed that there has been a cut of almost 25 per cent in the nursing establishment. We are alarmed at the undermanning of the big public hospitals. The information provided to members of this Parliament, from members of staff and from parents of staff members, and the complaints received from our constituents are quite alarming. Quite clearly, the number of nursing students and trainees has been cut by some 500. This so-called economy has had a drastic effect in the hospitals.

We are told (and we have no reason to disbelieve) that the situation in the major hospitals is so bad at present that a patient could lie for some time in a bed which he has fouled: if he seeks assistance from a nurse, she may say, 'Yes, I will be there in a minute,' knowing full well that she cannot be there for an hour because she is so over-worked. At times three nurses might be rostered for a night, but one cannot turn up, and one may have been transferred elsewhere. We have had various statements from the Minister, who has said that trained people should be used, but two facts are emerging.

First, on the commission's own estimates, 750 nurses a year must be trained to maintain the supply, and, obviously, that is not occurring at present. Even if that matter were picked up now, there would be a short-fall in five to six years, and if the matter is not picked up very shortly, we will face a disastrous situation in years to come (as, indeed, we face now). It is very interesting to note that one of the documents that my colleague said was nestling in the Parliamentary Library safe is, in fact, not nestling in the safe but has gone to the shredder—to its ultimate destruction—and that is the document that deals with figures in this regard. In fact, after making a few phone calls, we were able to obtain some figures, but that is not a very satisfactory way of going about it.

Will the Minister and her officers say exactly what is going on? What has been the decrease in the number of trainees over the past five years? Am I correct in saying that there has been a decrease of 489 trainees, or almost 25 per cent? Am I correct in saying that, while the establishments of all other sectors of staff (and I refer to hospital porters, medical officers, para-medical officers, and so on) have been adequately maintained in the major Government hospitals, the number of nursing staff has been cut uniformly across the State? Am I also right in saying that the Minister has received complaints from the public and from those involved in the establishments that people in the community who end up as patients in hospitals are being hurt because of the inadequate supply of staff in this area?

The Hon. Jennifer Adamson: I expect that the member for Hanson, as a member of the Public Accounts Committee when the Fourteenth Report was brought down, may have questions to ask on this subject, also. In prefacing my remarks and specific answers to the member for Playford's questions I refer the member to the Fourteenth Report of the Public Accounts Committee regarding the financial management of the Hospitals Department and to references in that report to excessive staffing levels in Government hospitals. Page 17 of that report states:

> The Auditor-General has been very critical of the Hospitals Department over the past five years for its failure to control staff establishments. These criticisms refer to deficiencies in controls over the number of staff employed and the additional hours paid as a result of the numerous rostering systems used or the overtime worked.

Referring to that last comment, I believe that it is an enormous credit to the Royal Adelaide Hospital, to the Health Commission which assisted it, and to the union which co-operated with it that, simply by changing the nature of cleaning rosters (not reducing but just changing the rosters), an amount of $2 000 000 was saved over the period 1980-81. Needless to say, that was without adverse effect on patient care and without adverse effect on the cleanliness of the hospital.

The report went on to discuss a number of issues, one of which was the excessive nurse staffing, particularly in central service, sterile supply departments, domestics, nursing, and especially student nursing and resident medical officers at the Royal Adelaide Hospital. At the Queen Elizabeth Hospital there was criticism of the excessive number of domestics. At Glenside there was criticism of the excessive number of nurses and pantry maids, and at Flinders Medical Centre there was criticism of excessive numbers of nurses and pantry maids. The previous Government recognised the need to address these questions and had initiated action to reduce staffing and certainly to reduce the number of trainee nurses at Government hospitals before we came into office.

That policy has proceeded under this Government and, as a result of the pursuit of that policy, the efficiency of hospitals has improved. Nursing staff studies have been undertaken at the Adelaide Childrens Hospital, the Flinders Medical Centre, and the Royal Adelaide Hospital, and the whole question of nursing manpower has been addressed by the commission in consultation with the Nurses Board and the nursing profession. The profession itself was rightly worried that too many nurses were being trained for jobs which would not be available.

The number of students and trainees at Government metropolitan hospitals in 1978 was 2 949; in 1982 it was 1 749. At the same time the number of qualified nursing staff in 1978 was 3 682 and in 1982 it was 3 869, an increase of 187. In other words, the number of trained staff has increased with a consequent improvement in patient care.

Regarding the complaints that the member for Playford alleges are being made, there will always be complaints in a health system which is dealing with human beings in all kinds of situations ranging from birth to death, and all that can occur in between. We are dealing with human beings and there is no way that any of them, either staff or patients, can be perfect. However, I would like to refer to the number of letters received by hospital boards, by the commission, and by me, as Minister, praising and expressing admiration for the very high standard of patient care in South Australian hospitals. That standard is recognised throughout Australia and, indeed, internationally.

I conclude by making reference to the fact that the Australian Grants Commission, at its hearings earlier this year, was critical of the fact that South Australia has a higher ratio of nurses to patients than the national average. The Grants Commission believes that the nurse-patient ratio in this State should be more in line with the national average; in other words, that there should be further reductions.

Mr BECKER: Page 7 of the yellow book outlines the objectives and the issues and states:

> The proposed total expenditure for the 1982-83 financial year is $505 500 000, which represents an increase of 6.2 per cent on the 1981-82 actual expenditure of $475 800 000.

I wonder whether that confounds the member for Playford. The total proposed expenditure represents, as the Minister said, a stand-still allocation to the South Australian Health Commission. The yellow book continues:

> However, the S.A. Health Commission anticipates achieving sufficient savings in 1982-83 to enable it to continue reallocating resources to high priority health programmes and to fund the introduction of several major new initiatives in accordance with Government policy.
>
> The new initiatives are:

Establishment of the Intellectually Disabled Services Council and provision of $500 000 additional funds to this area for improvements in services.
Introduction of a pensioners' spectacle scheme ($500 000).
Development of the pensioners' dentures scheme ($250 000).
Increased daily subsidies to the owners of psychiatric hostels ($180 000).
Absorption of additional costs stemming from the commissioning of the Leigh Creek and Streaky Bay Hospitals, the new Hillcrest Psychogeriatric Unit and the Windana Nursing Home ($560 000).
Extension of the after-hours nursing service offered by the Royal District Nursing Society ($130 000).
The major areas towards which existing resources continue to be reallocated are:
community health and domiciliary care service;
environmental and occupational health services;
health promotion services.

In what areas will the savings be made? When will these new programmes or initiatives be introduced?

The Hon. Jennifer Adamson: I will try to take those questions in turn as they relate to the projects listed, and I will ask the Chairman of the commission to elaborate. The establishment of the Intellectually Disabled Services Council took place formally on 1 July this year. The additional funding of $500 000 cannot be commissioned immediately. The council must determine its own priorities; that is the job it has been given. It must advertise, establish people in posts and work out its priorities. I would expect that that might take some months, but the Government believes that the funds allocated for the council will be spent within the current financial year.

I shall deal with each matter and then ask the Chairman to identify where the money for them will be coming from. In regard to the pensioner spectacle scheme, I hope to be able to announce its introduction in a short time, as soon as negotiations with the various professional and provider bodies have been concluded. The allocation of $250 000 for the pensioner dental scheme is in addition to the amount of $500 000 already spent.

Perhaps a good example concerning where the money is coming from is the matter of the extension of the after-hours nursing service offered by the Royal District Nursing Society, which has been allocated an additional $130 000. The cost per patient per day of the after-hours nursing service is a very small amount, $8 a day (and I am talking about the cost, not the charge) compared to the cost of caring for a person in a hospital, which is about $180 per day for a general ward at the Queen Elizabeth Hospital—the change being $105 per day. The honourable member may care to imagine the number of patients who can be kept out of hospital by the extension of that after-hours service and the number of patients who can be discharged earlier than they would have been, in the knowledge that there will be a home support nursing service provided for them. That provides a very graphic example of how costs of institutional care can be decreased and how the savings can be used for providing a very much expanded community-based support service for very much less cost, consequently covering a much larger number of people. In regard to other areas of savings, I ask the Chairman of the commission to elaborate.

Mr McKay: As the Minister has said, basically there has been a transfer of funds from the hospital sector to other areas of health service, which practice will continue this year. To put that into perspective, I point out that the initiatives we are talking about are worth $1 700 000, which is about .5 per cent of the recognised total expenditure of hospitals. It represents something like the cost of 1½ medical or surgical wards. Over the past 12 months action has been taken within the hospital system to rationalise facilities, and some of the savings will come from the institutional side of hospital activities.

The Hon. Jennifer Adamson: To reinforce Mr McKay's comments, I point out that for the year 1979-80 and the current financial year (and statistics in the blue book will demonstrate this), the average length of stay in hospital has been reduced. At the same time as bed capacity has been reduced percentage occupancy has increased. Details in the blue book indicate that bed occupancy in our hospitals is not nearly at the level that it should be. To operate at less than 80 per cent occupancy, in nationally and internationally accepted terms, is not efficient operation. Therefore, by increasing the bed occupancy rate and by increasing the throughput hospitals can be made more cost efficient and the money thus saved can be used to provide improved community-based services.

Mr McKay: In answer to the last part of the question, the Royal Nursing District Society's service extension has already started and money allocated for that purpose will be spent this year. The Streaky Bay Hospital is due to be opened: the Leigh Creek Hospital has been opened. The allocated expenditure for those will be in the current financial year, and the subsidy for psychiatric hostels has been negotiated with the owners and, thankfully, they have left some of that money, with the patients, and so the patients' real income will increase as a result of those negotiations. That will be introduced shortly. The pensioners' dentures scheme began last year, but the allocation of $250 000 is in addition to the amount spent last year. At present the spectacle scheme is being negotiated with the appropriate professional bodies.

In regard to the Intellectually Disabled Services Council, some of the allocated money has been spent for the establishment of the council and the rest of it will be for other services. The new C.E.O., who will take up duty next month, has a number of priorities for which money will be spent, particularly in developing more skills in the domiciliary services area in assessment and maintenance of people within the community.

[Sitting suspended from 1 to 2 p.m.]

Mr BECKER: I was interested to note that it costs the Royal District Nursing Society an average of about $8 a day to look after a person once he is discharged from hospital compared to the cost of keeping him in hospital. The Minister has said that we have to look more closely at the bed occupancy rate and the length of stay in our hospitals. I note that the average length of stay in hospitals is now 7.5 days at Royal Adelaide, 5.8 at Queen Elizabeth, 5.8 at Flinders, 3.9 at the Children's and 5.5 at Queen Victoria.

I can understand the reason for the Royal Adelaide Hospital's average being a little higher than that of the other hospitals because of the nursing home component and other specialist services it operates such as the spinal injuries unit, where I believe the average length of stay is just under six weeks, and the other wards attached to the hospital. I would have thought that the average of 5.8 days at Queen Elizabeth and Flinders would be almost the ultimate, and I wonder whether it could be reduced any further.

I understand that the bed occupancy rate at the Royal Adelaide is 83.5 per cent (which is a significant improvement), Queen Elizabeth 73.3 per cent and Flinders 85.7 per cent. I have been told that at the Flinders Medical Centre the occupany rate is sometimes 100 per cent because of emergencies and there is a tremendous amount of pressure on that hospital at times. I wonder how the hospital managements expect to achieve lower average lengths of stay and higher bed occupancy rates.

The Hon. Jennifer Adamson: I will ask Mr McKay and then Dr Kearney to respond directly to the member for Hanson. First, I would like to correct a mistaken impression that the Hampstead Nursing Home is contained in the

figures for the Royal Adelaide Hospital. The Hampstead Centre is not included in the hospital statistics: it is separate. The reason for the greater average length of stay at the Royal Adelaide compared with the other hospitals lies in several areas. First and historically, the age of its patients tends to be greater than that of patients at other hospitals. It attracts a higher pensioner population. Secondly, the spinal injuries unit, to which the honourable member referred, the neuro-surgery unit and the cardiac units are all super speciality units which contribute to the increased length of stay.

With regard to increased utilisation of hospitals through increased bed occupancy and decreased length of stay, not to mention the avoidance of admissions where possible by treating people at home through such agencies as the Royal District Nursing Society, I will ask Mr McKay first and then Dr Kearney to elaborate.

Mr McKay: It becomes difficult once one starts to get into these figures. Royal Adelaide has an aged population but I think better assessment of those patients could provide some opportunity to treat them outside the teaching hospital area. I think that the commission at the moment is looking at the possibility of using perhaps cheaper hospitals, and by that I mean the community ones. I think that is the area we now have to look to. Having achieved a reasonable occupancy and length of stay, we now assess whether or not teaching hospital beds are being used appropriately and whether or not some of the patients using those beds could be treated in other areas. We are looking at that issue. Dr Kearney might like to talk about the average length of stay, because it does relate to the mix of cases, and this is the most difficult area. Just having an average length of stay does not tell the story: it is what is involved in that length of stay.

Dr Kearney: I think it would be difficult to expect too much of a further drop in the average length of stay, because it literally would be pushing patients rapidly in and out of a hospital when they are receiving major treatment. I think the changes that are likely to happen in the future are avoidance of the admission, as the Minister indicated, particularly better development of out-patient services so that many of the procedures that are carried out now as an in-patient service will be on an out-patient basis. There has been a move towards day surgery, and I suspect that hospitals will continue to develop that aspect of treatment.

In addition, some of the more sophisticated investigatative services are improving to the extent that they also will be able to be done on an out-patient basis, thereby avoiding admission. I think that in the long term the commission will be looking at the rate of utilisation of hospital services overall, and there is probably scope within a long-term plan to reduce the total number of admissions a thousand of population by better consultative services in the community and better use of out-patient services or alternatives to admissions.

Mr BECKER: On page 7 of the yellow book reference is also made to the ability of the boards of management of incorporated health services and units to continue to achieve the level of savings achieved in recent years. It states:

> It is important to note that South Australia's health services have achieved savings in excess of $45 000 000 over the past four years, while also expanding the range of health services and maintaining their traditional high quality. This has been achieved by the steady introduction of better management techniques and much higher productivity by all health services staff.

I do not think anyone could argue that the quality of patient care has not been maintained. The decrease in spending of $45 000 000 in the past four years must have had some impact on the cost to the consumer. Have you any idea what benefits that has had on persons who take out private insurance? What savings have been gained by them as a result of these achievements?

The Hon. Jennifer Adamson: I am not sure whether the honourable member was in the Chamber when I answered a question earlier this morning about the increased efficiency of South Australian health services and the beneficial effects that has had on costs, the consequent beneficial effect that has had on charges, ours being the lowest in Australia, and the relationship between those lower charges and health insurance rates. In fact, in the Medibank Private table the charges in South Australia are 23 per cent lower than the charges in New South Wales. Those figures indicate the direct relationship between improved financial management efficiency at the hospital level and the lowering of costs, with no adverse effects on the standards of patient care and in some instances a markedly beneficial effect on the standards of patient care, as well as indicating the relationship of costs to charges and of charges to insurance premiums. On all those scores, South Australia rates among the best, if not the best, of all States.

Mr BECKER: How does South Australia compare with other States in respect of the level of health insurance? Does the $45 000 000 in savings mean that South Australian people are $3 or $4 per week better off than the people of other States?

The Hon. Jennifer Adamson: I am given to understand that these tables can be compiled. I do not have them here, but I will arrange for them to be brought into the Committee within a short space of time.

The CHAIRMAN: I take it that the Minister will provide those tables today or on a subsequent day so that they may be incorporated in *Hansard*.

Mr HEMMINGS: The member for Playford said earlier that there had been a reduction of 489 nurses in South Australian hospitals, but that figure relates only to the Royal Adelaide Hospital. The total reduction has been over 1 000 nurses, and the Minister's figures bore that out when she was replying. Despite what the Minister says, and in support of the statement by my colleague, all the criticism being levelled at the major public hospitals in South Australia concerns the lack of attention. No-one criticises the nursing staff, but it is obvious to members of this Committee, to members of the Health Commission and to the Minister herself that the wholesale drop in the number of nurses in public hospitals is causing a real problem.

At the R.A.H. there has been a reduction of almost 25 per cent; at the Adelaide Children's Hospital, 23.4 per cent; at Mount Gambier, 23 per cent; and at Port Pirie, 22 per cent. A similar reduction is being experienced at all other South Australian hospitals. Replying to a question tabled by the Hon. John Cornwall in another place, the Minister agreed that the number of nursing students and trainees had been cut, but said that the slack had been taken up by qualified nurses. However, the figures given by her this morning do not bear that out.

There has been only a nominal increase in the number of registered and enrolled nurses in this State. Unlike the member for Hanson, who is Chairman of the Public Accounts Committee, I place more credence on the figures contained in the final report of the nursing manpower study produced by the Health Commission. At page 2 of chapter 4 it is recommended that there be 750 trained nurses a year to meet the demands of the major hospitals in this State. However, Sturt C.A.E. this year had only 112 acceptances for its nursing course, leading up to the Diploma of Applied Science (Nursing). There were 110 acceptances last year and 103 in the previous year. So, in no way can the major hospitals expect to meet the demands for registered and enrolled nurses if the number of nursing trainees and students in public hospitals continues to be cut. Does the Minister

still stand by her statement this morning that systematically reducing the number of students and trainees in our major hospitals will not result in a major fiasco over the next two or three years?

The Hon. Jennifer Adamson: The honourable member correctly said that the Nursing Manpower Study had recommended a graduation of 750 trained nurses a year. In effect, that is exactly what the commission is doing: the graduation rate is 750 per year. The intake across the State is about 900 and, when those who leave for some reason or other during their training are taken into account, the commission is implementing virtually to the letter the recommendation of that study, which was undertaken as a result of criticism by the Public Accounts Committee and in close co-operation with the nursing profession and the Nurses Board. The commission's obligation to match the training programme with projected manpower requirements has been extremely carefully monitored and implemented.

Mr HEMMINGS: It will be interesting to see whether the Minister's statement will in effect come true. She may find that it is the most damning statement she has made to this Committee today, because there will be a real disaster if the number of trained nurses in our public hospitals continues to fall over the next few years. The Minister says that the training programme is being carefully monitored and that the 750 graduates recommended by the Health Commission will be forthcoming. I shall be the first to congratulate her if that proves to be the case, but, if it does not, I shall be the first to indict her on what is happening.

If one looks for the real reason why there has been a reduction in the number of students and trainees in our public hospitals, one must look at the salaries paid. Perhaps this factor is connected in some way with the reason why the information that Parliamentary Research Assistant Robin Prior tried to get has been placed in the library safe.

An examination of the salaries paid to nurses in our public hospitals over the past three years shows the real reason why the Health Commission, and the Minister in particular, are so keen to cut the strength of the nursing staff in those hospitals. In 1978-79, $20 760 000 was paid in salaries and wages to nurses at the R.A.H., and that represented 28.33 per cent of total budget. In 1979-80, that amount rose to $21 170 000 or 28.09 per cent of total budget. That was the first year when, as a result of Government policy, there was a marked reduction in the nursing staff.

They found then that they had to pay the nursing staff a decent wage, so their answer was rerostering, retrenchment or reduction in staff. In 1980-81, with further reductions of nursing staff, the figure was $22 900 000, or 27.49 per cent of the annual budget, and that is the real reason—not because we are training too many nurses or because of increased efficiency—it is this Government's intention to cut the budget to the major public hospitals, so again I ask the Minister whether she still stands by her statement that patients in public hospitals in this State are adequately served and covered by the nursing staff, or whether this is just another reason for this Government to cut its health budget in the major public hospitals.

The Hon. Jennifer Adamson: The member for Napier has indicated a lack of understanding of the relationship between training nurses and the provision of trained nurses to patient care, and I will ask the Chairman of the commission in a moment to outline the effect that a nurse-training programme has on a hospital, and the way in which nurse rosters can be organised to ease the burden on nurses and improve the standard of patient care when trained nurses are provided instead of trainee nurses—the double benefit that that has for both the patient and the nurse. In reference to the honourable member's statement about increases in nurse salary costs in 1976-77, it was in the years 1974 to 1977 that the full effect of the equal pay awards were felt in hospitals, and I again refer to the Public Accounts Committee Report which demonstrated that the Royal Adelaide Hospital was training excessive numbers of nurses.

I should also point out that in other States where that policy of excessive training of nurses has been pursued the profession itself has rebelled against it, taken industrial action and lobbied Governments in the same way that this Government has been lobbied by the medical profession and the dental profession to try to convince the universities to reduce their intake of students because there is an oversupply of doctors and dentists in South Australia. There was, towards the end of the 1970s, very great evidence of over-supply of nurses. That was certainly doing no kindness to the patients, and it was certainly doing no kindness to the nurses themselves who had very little prospect of employment because excessive numbers of them were being trained.

I have been advised since I responded to the earlier question about the commission's implementation of the recommendation to produce 750 trained nurses per year, and the commission acts on the advice of many people, including the profession and the Nurses Board. It does not just dream up these figures out of fresh air, nor does the Government invent figures to suit it. We seek the advice of the commission, and in this instance we have taken it. The intake last year allowed for the graduation of not 750 but 800 in this current year, but in the previous year since we have been in office the relationship between the recommendation and its implementation has been fairly precise, namely, 750 trained nurses per year. I would like to ask Mr McKay to explain the impact that a nurse-training school has on a hospital and also the impact of increased numbers of trained nurses on patient care and on the nursing rosters as distinct from training large numbers of nurses in a nurse-training school.

Mr McKay: There are a number of impacts. A nurse in the first year of duty really adds little to the work force other than as a manual labourer. That is offset, I think, really by their attendance at block schools when they are not actually in a work situation (they are, in fact, in a tertiary training situation within either a hospital or a college). Within the wards themselves, there is also, when you have a large proportion of trainees, a burden on the qualified staff within the ward who act of course as trainers of trainee staff. There are other factors in that sort of four-year period. One is the changes that have happened within the hospitals themselves. The others are that some of the duties of nursing staff that were undertaken five years ago are now undertaken by people like ward clerks, and some of the duties in the domestic area have also been transferred away from the nursing staff.

I think the Health Commission believes that the only way to determine what is an appropriate level of nurse staffing is to undertake as scientifically as possible a survey of the needs of individual units. Those sorts of studies have been carried out over the last two years at the Royal Adelaide, at the Children's Hospital and the Flinders Medical Centre. At the Royal Adelaide, what showed up was that some departments were under-staffed and some were over-staffed, depending on the relationship of patients within that ward and the dependancy of those patients. That has been accepted by the nursing management at the Royal Adelaide, and there has been an overall reduction in nursing staff. At the Flinders Medical Centre, that is still being discussed with the hospital and with nursing management there, but the same situation arises, especially in the intensive areas.

The intensive care and neo-natal units of the hospital did come out of that survey as being under-staffed. Theatres and some of the other ward areas were over-staffed, and

overall I think there is still a reduction. There is still room for a reduction in nursing staff, and I believe, and the Commission believes, that the only way to assess the requirements for nurses is to actually look at a hospital on the basis of the individual units within that hospital to determine what are appropriate levels of nurse staffing by a very intensive study of what is actually required within the unit. At the Children's the same thing applied: overall, the nursing staff were sufficient and there were some excesses, and the hospital has agreed to reduce its nursing staff as well.

Mr HEMMINGS: It seems rather strange that when one talks about an over-supply of nursing staff one tends to get rid of them. When we are talking about the medical profession and about the excessive demands being made on the public hospital sector, the Government just caves in, but that is not really my question. I refer to page 31 of the blue book. The Minister, in her first term of office, when we came up with the one-line entry in the Estimates of Payments, made a promise to the Committee, which I had the honour to lead on the Opposition side: it was a rather futile exercise and in future further information would be forthcoming. The second year introduced what is known as the blue book, and when the Opposition attempted to ask questions about it there were replies from the Minister, not at the time (I give her due respect for that), that it had been hastily put together and there were some inaccuracies.

I do not have the *Hansard* report but, basically, that was the Minister's reply. She said that there could be some inaccuracies in the blue book, and we all accepted that. One would have thought that, because my colleague in another place, the Hon. Dr Cornwall, has questioned through our research assistant, the statistician employed by the Health Commission, this year's blue book would be accurate (or at least 99.9 per cent accurate). I refer to only one item on page 31—bed capacity, daily average occupied beds, and percentage of bed occupancy.

I was at Mount Gambier about four weeks ago, and because of the trouble that is occurring in the local hospital, and because some concerned citizens have said that there have been drastic cut-backs in bed capacity, I made inquiries, and I can pretty well vouch for the information that I received. I stress that I am picking out just one item, and if necessary until 8 o'clock tonight, I will refer to the other hospitals that are listed. There is a glaring discrepancy in regard to bed capacity at the Mount Gambier Hospital. We are told that the bed capacity as at 30 June 1982 was 193 beds; however, I have it on very good authority that, as at May 1982 (and there is nothing to suggest that the figures for May differ from the figures for June 1982), the bed capacity at the Mount Gambier Hospital was 146. That is a glaring discrepancy.

The reason why there has been a reduction from 193 to 146 beds is fairly obvious, and I believe it should be fairly obvious to members of the Health Commission and to the Mount Gambier Hospital board of management, because the board made the decision. That information would have been transferred to the Health Commission, which, being very helpful, would have transferred that information to the Minister, and I am sure that the statistician who provided this information in the blue book would have inserted the correct figure. The children's ward was closed in May 1982, and the men's and women's wards were amalgamated.

I notice that some of the Health Commission officers are nodding their heads, so I must be on pretty safe ground. If the Minister disputes my figure of 146 and maintains that 193 beds are available, will she say why, if her information is correct, I was deliberately misinformed when I was in Mount Gambier?

The Hon. Jennifer Adamson: I draw the member for Napier's attention to the words at the head of that column 'Approved bed capacity as at 30 June 1982'. That refers to the number of beds approved by the Commonwealth for payment of hospital benefits. I will ask the Chairman of the commission to tell the Committee how that figure is determined. The sector director for the southern sector, which includes Mount Gambier, will then outline the situation at the Mount Gambier Hospital. I believe that the answers to those two questions will save the honourable member further questions, because clearly he is under a misapprehension as to the meaning of 'approved'.

I refute the somewhat gratuitous statement made by the honourable member when he attempted to show that somehow the Government treats doctors and dentists differently from nurses. The honourable member alleged that the Government had caved in to doctors' demands. I point out that, when it comes to determining the number of nurses in training, the State Government, through its health authority, has the responsibility and the authority: we do not have the same power to exercise that right in respect to the training of doctors and dentists, who receive their education through the universities. The State Government has no control over intakes to universities.

As to the Government's caving in, it is interesting to note that the demands of the salaried medical officers last year resulted in an increase in salary of 8 per cent, but the demands of nurses resulted in an increase of about 14 per cent. Mr McKay will now outline the difference between approved beds and actual beds to demonstrate the accuracy of the figures in the column on the left-hand side of the page.

Mr McKay: The Commonwealth approves beds in both the private and public sectors for the payment of benefits. The figures in that column refer to approved bed capacity. We make changes in the number of beds required to serve a given population. Mr Sayers will give the history of the Mount Gambier situation. He will also describe how many beds are provided and how many are used. We talk to the Commonwealth regularly, usually on an annual basis, about the number of approved beds, and we make adjustments. In the past, more than 193 beds may have been approved at Mount Gambier, but Mr Sayers will provide more detail.

Mr Sayers: The Mount Gambier Hospital has 213 beds, of which 20 have not been opened or staffed since 1963. That is, 193 beds have been approved by the Commonwealth and were open from 1963 until the end of April 1982. The board of management closed 47 beds as an efficiency measure, reducing the number of open beds from 193 to 146, and that was the position as at 30 June. Since that time, six beds have been reopened, making a total of 152, and the board plans to open an additional five beds in the next few weeks.

The decision to close the beds was made by the board of management and not by the Health Commission. It was an efficiency measure, based on the very low occupancy of the hospital and the available nursing staff at that time. Basically, the efficiency aspects of the entire management process caused the board to make that decision.

Mr HEMMINGS: I accept that, in part, if we use the words 'approved bed capacity' we are not talking about the number of beds being used. However, when one compares that figure with the number of daily average occupied beds, the percentage of bed occupancy, the occupied bed days, and the gross cost per daily occupied bed, the first column becomes rather meaningless. I thank the officer who, in effect, confirmed my statement that only 146 beds were available when I visited Mount Gambier (although that has since been changed).

Could the Minister supply the Committee with a list of all the available beds, as listed in pages 29 to 33 of the blue book, as opposed to the approved beds for these hospitals? That should provide us with a better appreciation of where we stand in this State in relation to bed availability. I am not a very clever man, I am just an ordinary politician, but the blue book states that the Lyell McEwin Hospital, in my own area, has a total of 184 approved beds. That number has remained static for the last three years.

I have highlighted one area where only 146 or 151 beds are available, depending on the particular time of the year. Obviously, that information has been given to the press: it will give the public a false impression in relation to the available number of approved beds for persons wanting to go into a public hospital. As I have said, there has been no change at the Lyell McEwin Hospital over the last three years. I have just checked with my electorate secretary and I am informed that 185 beds (one extra) are made available to the public. However, in Mount Gambier we are talking about approved beds—beds approved under the Commonwealth-State agreement. Could the Minister supply the Committee with details in relation to all available beds for all hospitals listed on pages 29 to 33?

The Hon. Jennifer Adamson: We also are talking about approved beds, and the Chairman has explained that background. If I provided the Committee with those figures, they would be out of date within hours or certainly days of their being provided. However, I assure the honourable member, on the advice of the Chairman of the commission, that the approved beds in virtually every hospital listed on those pages represent actual available beds.

The explanation for Mount Gambier has been outlined. I am happy to ask each of the executive directors of the central, southern and western sectors to come to the table and provide the Committee with a general analysis of the relationship between the numbers identified in that left-hand column as approved bed capacity, and the actual numbers of available beds. In some hospitals there may be a small variation; in others no variation; and in a very few (such as Mount Gambier) there may be a significant variation for various historical reasons.

I stress that the health system is not static; it is dynamic and changes from day to day and bed occupancy changes from day to day. While waiting for the executive directors of the sectors to come to the table the Chairman will outline why the approved bed capacity numbers do not affect the daily occupied bed costs and, therefore, the validity of those right-hand columns.

Mr McKay: We use an occupied bed rate, because if we used the approved bed rate we would have a situation where a hospital with 50 approved beds, because of occupancy rates, could open only half of them; and if one multiplied that figure it would be a very cheap bed rate. The occupied bed rate provides a reasonable comparison.

As the Minister has said, most of the figures reflect the available beds as well as approved beds, but there are individual differences. We are presently undertaking what we call roles and functions studies at individual South Australian hospitals to determine the appropriate number of beds for a particular hospital (we hope that will be the approved number as well as the available number).

The Hon. Jennifer Adamson: Mr Williams, Executive Director of the Western Sector of the South Australian Health Commission (whose central teaching hospital is the Queen Elizabeth hospital) will provide information in relation to his sector, which includes the western suburbs, Yorke Peninsula, Eyre Peninsula, and the north-west area of South Australia.

Mr HEMMINGS: I am pleased that the Minister is going to provide this information and I am happy to receive it, but could it be read out slowly in relation to each hospital?

The Hon. Jennifer Adamson: I do not expect the directors to give individual figures for each hospital: that could only be done if they telephoned each hospital. Their knowledge of the hospital system and the fact that they are visiting these hospitals regularly will enable them to give the Committee a general assessment of variations of any significance between the number of approved beds and the number of beds in use. As I explained, it would be impossible and indeed fruitless to give the Committee today's bed occupancy, because tomorrow it would be out of date.

Mr HEMMINGS: I am perfectly willing to wait for a telephone call.

The CHAIRMAN: The manner in which the questions are answered is entirely in the hands of the Minister and, if the Minister delegates that responsibility to an officer, that is in the hands of that officer. I do not think the Chair can insist that the Minister provides fine technical details. If the Committee requires further information and the Minister agrees, she can furnish it at a later date.

Mr Williams: Generally, there are no variations between the approved bed numbers provided in the blue book and those beds actually operating in the hospitals in the western sector. That situation is flexible. For example, I refer to a major capital works programme being undertaken at the Whyalla hospital at the moment: as new units are commissioned some adjustment in bed capacity is necessary. That was necessary recently in the commissioning of a maternity unit but, in general terms, the beds indicated as being approved are those available for use and are presently in operation.

The Hon. Jennifer Adamson: Dr Bill McCoy, Executive Director of the Central Sector of the South Australian Health Commission, will provide information in relation to his sector which includes the Royal Adelaide Hospital, the northern suburbs of Adelaide, the Mid-North and Far North of South Australia.

Dr McCoy: A number of changes have occurred. The Adelaide Children's Hospital approved bed capacity is shown as 274 and the present number of beds being used is 225. The commission and the board of management are conducting detailed discussions and negotiations about the future number of beds to be used at that hospital.

The 274 beds provided at the Children's Hospital represents a major reduction in relation to the number provided in past years. At one stage there was a total of 350 beds, but 50 of those beds at the Estcourt House Annexe were removed and sold to the Government. They are now being used by the Intellectually Disabled Services Council. There have been further reductions: first there was a reduction of 26 beds and now a reduction of a further 24, and there are likely to be further reductions at that hospital.

One of the reasons for this is that there is a paediatric department at Flinders Medical Centre: therefore, whereas previously there was only one children's hospital in Adelaide, there are now two major paediatric centres, which has had a significant effect on the bed requirement at the Adelaide Children's Hospital. There has been a minor change at the Queen Victoria Hospital: I do not remember the exact figure involved, but it is slightly lower than the figure of 182 beds mentioned in the Programme Estimates.

In regard to the country areas of the central sector, a number of changes have occurred. Balaklava Hospital is shown in the Programme Estimates as operating with 40 beds, but it is in fact operating 30 beds. The Blyth Hospital is shown as having 20 beds, but it is the view of the commission that a lesser number of beds are required at that hospital and detailed negotiations are proceeding with

the board of that hospital concerning that matter. The number of beds at Crystal Brook has been reduced from 40 to 30, and the number of beds at Peterborough is 35, not 51 as shown.

The Hon. Jennifer Adamson: I now ask Mr Sayers, Executive Director of the southern sector to expand on what he has already said in relation to the Mount Gambier Hospital. The principal teaching hospital for the southern sector is the Flinders Medical Centre. The southern sector covers the southern suburbs of Adelaide and the South Coast to the Victorian border.

Mr Sayers: There are 494 beds at the Flinders Medical Centre, which is both the approved number of beds and the number of beds that are open and staffed at present. In regard to the country areas, all the southern sector hospitals, with the exception of two hospitals, have the same number of beds open and operating as is indicated in the bed capacities shown in the Programme Estimates. The two exceptions are the Loxton Hospital, which is operating 36 beds and not 42, and the Renmark Hospital, which has 38 beds, not 42 beds as indicated. Both those hospitals have had nursing homes and hostels built adjacent to them. The need for acute hospital beds has lessened in the past two years. There should be further reductions in relation to those hospitals.

In regard to the mental health facility, Glenside Hospital is shown as having 557 beds, but the hospital has now been reduced by one ward. That was a very old ward and it is no longer needed. That represents a reduction of about 20 beds plus or minus, say, two beds.

The Hon. Jennifer Adamson: In summary and by way of analysis of the information that has been provided, the Committee will recognise from the figures that have been given that the percentage bed occupancy in hospitals, which have been mentioned as having reduced the number of beds in use, is at a thoroughly inefficient level; in other words, well below the rate of 80 per cent which is considered to be an efficient use of beds. In some cases it is below 70 per cent, or even below 60 per cent. In other words, it is a very wasteful use of beds. In many of the country areas, as Mr Sayers pointed out, the provision of nursing home beds has enabled the transfer of long-stay patients from hospital beds to a more appropriate and more economical form of care.

In addition, the considerable expansion in community based health services in the country areas, through domicilary care, day care centres and other support services has enabled two things to occur: avoidance of admission in some cases, and in other cases a discharge earlier than otherwise would have been possible.

This indicates that the health care system in South Australia is responding to the challenges outlined in the Jamieson Commission of Inquiry Into the Efficiency and Administration of Hospitals in Australia. The Government is attempting (and I believe is succeeding) to provide much better and more appropriate care, particularly in regard to non-institutional care. In so doing we are relieving the cost to the taxpayer and providing a more humane health care setting in which people can be looked after in the place that they like best, namely, their own homes.

Mr GLAZBROOK: I refer to 'Objectives, Issues and Strategies' on page 6 of the yellow book. 'Implication for resources' states:

> Increased share of resources from institutional care to non-institutional and preventative care services.

I ask the Minister to address this question of redirecting the increased share of resources from institutional care to non-institutional care and to indicate whether it refers to the Government sector or the non-government sector?

The Hon. Jennifer Adamson: The Government's policy clearly indicates that home care is preferable to institutional care and that we must place greater stress on preventive services. In identifying the implications for resource use, the commission is literally responding to Government policy. As a statutory authority, the commission's policies in relation to certain specific matters are determined by part-time commissioners, as distinct from overall Government policy. However, those policies are very much in line with the Government's policies. There are health authorities in Australia which are perhaps not so closely in line with the policies of their respective Government policies, or vice versa. In other words, unlike South Australia, some Governments in Australia nave not consistently grappled with the need to reallocate resources to non-institutional care.

The example that I gave earlier about the comparative cost of providing community nursing through the Royal District Nursing Society, as distinct from the cost of providing full hospital nursing (difference of between about $10 per day and $180 per day) is also graphically illustrated when one considers the health promotion and health education campaigns that have been undertaken by the commission.

The immunisation campaign conducted by the commission last year, which I have mentioned in Parliament, resulted in a 57 per cent increase in immunisations for Rubella and measles. The media costs associated with that campaign amounted to about $35 000. Of course, that figure does not include staff costs, preparation time, consultation time, and the extensive co-operation sought with health authorities and health professionals.

That $35 000 should be seen in the light of that same sum being the cost of treating a single patient for tetanus in the intensive care wards of the Royal Adelaide Hospital. In other words, by increasing immunisation we have undoubtedly saved (and no-one can say how many) hospital admissions, and thereby saved a considerable sum. If the breast self-examination campaign, which is about to be launched and which has been foreshadowed in the press, prevents a number of operations for cancer on women we will have saved a hundredfold, a thousandfold the cost of the campaign as well as sparing a great deal of pain and heartache to women.

Mr GLAZBROOK: Understanding the severe limitations that all Government departments have on their spending due to budgetary situations and the inability of the State Government to raise more money at the present time to increase services, I would like to ask a question about the ability of the boards of management of incorporated health services and units to achieve the savings of more than $45 000 000 in the past four years. Could the Minister indicate in a general way where the saving of $45 000 000 was effected in the past four years, particularly while expanding the range of services provided and maintaining the traditionally high quality of patient care. Perhaps some indication could be given of the direction of those expansions.

The Hon. Jennifer Adamson: In the first instance, again, I refer the honourable member to the Fourteenth Report of the Public Accounts Committee, which identified savings of $14 000 000 that it believed could be made in the first year of the implementation of its recommendations and that in fact was what occurred. Those same initiatives have been followed in subsequent years. Broadly speaking (and this process started under the previous Government, which had planned to extract about that figure from its 1979-80 Budget), the areas that were tackled first were in relation to cleaning costs and rostering and that resulted in a saving of $2 000 000 alone in a single hospital and staffing. As the honourable member knows the Government's no retrenchment policy has meant that any staff reductions have been made through attrition. Savings have also been made on goods and services and more efficient management and through the transfer of Public Buildings Department

employees to the direct employment of the hospital boards, who were then able to determine their own priorities for maintenance and upkeep work.

By pursuing all those initiatives, many of which were achievable only through improved management information which has been made available to the boards, the overall saving has been achieved.

I stress that the $45 000 000 is the amount which would have been spent had the rate of increase in the 1978-79 Budget spending been maintained. Had that rate of increase been allowed to continue this current year's Budget would have been not in the region of $500 000 000 but $550 000 000 plus. I would like to ask the Chairman of the commission and perhaps Mr Cooper who, as Director of the corporate sector, has been much involved in the planning for improved management, to elaborate on what I have said by way of the detail of the savings.

Mr McKay: I think all areas are involved in the savings. There has been a reduction in the staffing generally in most categories of staff which has brought South Australia from having a highly staffed hospital system to having a less highly staffed system, while it is still in most categories well up with Australian averages and in advance of most. I think the other things have been improved management within hospital systems, for which the boards and administrations have to be congratulated. They have introduced a lot of new techniques. A lot of money has been saved in the system just by better rostering of staffing generally.

The Minister spoke about savings in cleaning. There has been a lot more automation rather than the mop and bucket system that probably operated previously so they have been able to maintain cleaning standards but with much less manpower. In relation to laundry, rather than just changing a bed, decisions were made on a more efficient use of the laundry. I could refer to food and other things when talking about how savings have been made. The savings have been made by a much better system of management within the hospitals which have been achieved and that is where the real costs have been saved.

There has been a movement in the last couple of years of about $5 000 000 from the health system as well as a decrease overall from the hospital system to the domiciliary and community health areas. It is not just a saving over that; there has been a switch of resources from the hospital and institutional system into those community systems, so the achievements are quite significant.

The Hon. Jennifer Adamson: I would like to round off what the Chairman has said, and Mr Cooper has said that it has virtually all been covered and there is no point in adding to what has been said. I believe that the management achievement, to which the Treasury pays a tribute on page 7 of the yellow book, is largely due to the fact that the Government's policy requires boards to exercise the greatest possible degree of independent managerial responsibility consistent with overall health, economic and industrial policies. When we came to office the hospital boards received budgets were designed centrally in the commission office. That is not this Government's policy. The Commission provides block allocations and grants to the hospitals and the boards themselves determine the priorities of spending within their hospitals, involving the heads of departments and enabling the people who work in the hospitals to assess priorities and how the budget should be spent.

That means that if money can be saved through efficiencies in one area it can be expended in another. It provides inbuilt incentives to good management. The positive results of that policy are really demonstrated in last year's Budget results which show that the majority of the hospitals came in on budget. Mr McKay would like to add something further to what was said earlier.

Mr McKay: The other major factor is a much better utilisation of hospital beds. The reduction in lengths of stay has already been mentioned, and Dr McCoy talked about the Children's Hospital, which has brought its length of stay from five or six days down to almost half of that. That is good paediatric care, because children should be at home with their parents rather than in hospitals if it could possibly be avoided. That has had an impact on the hospital, because it has been able to reduce beds and staff, and some of the other teaching hospitals have also been able to do that.

Mr GLAZBROOK: Pages 9 to 13 of the yellow book refer to policy development and service planning, aged and physically disabled living at home, adult psychiatric problems, services mainly for schoolchildren, specific services for the Pitjantjatjara community, special services for non-metropolitan Aboriginal communities, special services to metropolitan Aborigines, and health promotion and health education programmes as being programmes partially funded from Commonwealth sources. Can the Minister indicate what level of funding is available from the Commonwealth for those programmes?

Mr McKay: In relation to the policy development and service planning programme, seven years ago the Federal Government started to encourage the States to put some effort into research and planning by providing grants to the States to establish research and planning units within health systems. Our grant is about $70 000 but it has recently been discontinued. I think the aged and physically disabled living at home programme relates mainly to the Commonwealth subsidy to the District Nursing and Home Nursing Services and also to what are called the Commonwealth grants to domiciliary care services. I am not surome of the amount.

The Hon. Jennifer Adamson: I will get that information to the Committee either later today or by letter subsequently.

Mr HEMMINGS: I was astonished to hear the Minister say earlier that the programme set out on page 7 of the Programme Estimates had been put forward by the Health Commission. However, the Programme Estimates, although produced by the commission, are the result of direction received from the Minister on behalf of the Government. Page 6 of the document deals with the objectives, issues and strategies endorsed by this Government as a matter of policy. They include the promotion of health and life, with which I agree, and the promotion of greater emphasis on non-institutional care. At the bottom of page 6 reference is made to the implications for resources and the document states:

> Increased share of resources from institutional care to non-institutional and preventative care services.

That represents the main plank of this Government's policy on health care. On page 7, the document states that the major areas towards which existing resources continue to be reallocated are as follows: community health and domiciliary care service; environmental and occupational health services; and health promotional services. All that sounds very grand, but when one studies the contents of the document from page 17 onward, one realises that it is pure rhetoric because, if one believes we are to promote the greater use of non-institutional care and take resources from institutional care for use on non-institutional care, as well as promoting the three items I have just referred to, one finds no support for the statement on page 7.

Except perhaps for a few minor items in respect of which a little more money is to be allocated, there is no way possible that the aims and objectives in the major areas can be achieved. Under the heading 'Major Resource Variations—1982-83—1981-82' reference is made to a 'proposed increase of $251 500 in programme expenditure associated with the following major factors: inclusion of the Mental Health Research and Evaluation Unit previously included

in programme sector 4'. However, no manpower variation is proposed for that project.

At page 18 of the support document, the same full-time staff is proposed this year as for last year to implement the co-ordination of and planning for the health programme. At page 19, there is no variation in staff for the various projects listed, and the same applies in respect of the programmes listed on page 21.

At page 23, last year's staff level of 29.5 in respect of the strategic planning for computing remains the same this year. In respect of the budgeting and reporting functions, which are dealt with at page 27, the staff of 19 last year remains the same this year. The Minister made so much play about services for the old and the physically disabled, and one would have thought that this would have been an area for an increase in staff. However, under this heading on page 29 the staff for this year remains at last year's figure of 479.1.

In respect of services mainly for the aged suffering from mental and behavioural disorders, last year's staffing figure of 497.6 remains the same this year, and the same sorry story is repeated over and over again throughout the document. Yet, this area of services for the aged and the physically disabled is one about which the Minister made so much play as to the need to provide services for these people at home, so that they need not be taken to an institution for treatment. One would have expected an increase in staffing in this area.

However, there is no increase in staff whatsoever. One can go right through this yellow book, and there has been no increase in staff whatsoever. How does this Government, with its dramatic shift this year to spending more money in non-institutional care for the people, expect to provide that extra staff? We cannot provide extra services, unless we make the present staff work much harder. Pages 72 and 73 deal with primary care services. Let us look at community health centres. There has been a marginal increase in money, but there is no increase in staff; the level for this year remains the same as it was last year.

Although we can go right through this book, there is no indication of increases in staff. However, I refer to one important aspect. Last session Parliament passed the radiation protection Bill, which the Minister said was the most important Bill to have come before the House. She made predictions and promises of increases in this area, and on page 80, in the right-hand column, we see that additional staff and equipment are proposed for the Radiation Control Section. That area relates to protection for patients and for workers, not only from radiation, but in all other areas of occupational health. One would have expected a dramatic increase, but the figure is the same this year as it was last year. I know that this is a long preamble but rather than waste the Committee's time asking questions on page after page, I am trying to cover the complete book in one go.

The ACTING CHAIRMAN (Mr Glazbrook): I trust that the honourable member will reach his question shortly.

Mr HEMMINGS: I will reach my first question. If the Minister was correct and sincere when the radiation protection legislation was before the House, and when she promised that there would be additional staff in the Radiation Control Section, how does she substantiate the fact that there is no increase in employment levels and that the figure proposed remains at $104 300 000?

The Hon. Jennifer Adamson: I realise that the examination of this Budget requires very meticulous searching of the papers, but I would like to suggest to the member for Napier that, before he embarks on another oration condemning the commission and the Government, he seek his information first and analyse it afterwards. Pages 21 to 26, to which he referred, berating the Government for not increasing the staff, referred to the central office of the South Australian Health Commission and its health planning functions. The Opposition cannot have it both ways. They cannot beat the Government and the Health Commission around the ears, saying it is a bureaucratic, top-heavy organisation perpetually increasing its central office staff. It is not a bureaucratic top-heavy organisation, and in fact there has been a reduction in staffing in the central office of the commission consistent with the commission's policy of removing itself from service delivery functions and placing service delivery in the hands of the health units under community based boards.

So, there certainly has been no increase in the corporate sector of the South Australian Health Commission which undertakes those health planning functions. The honourable member's peroration in regard to pages 21 to 26 should be satisfactorily answered by the fact that he was apparently not aware that he was talking not about health services, but about the planning functions of the commission.

In respect to the other pages (and I was not able to make notes on every point that he made), I refer him to the fact that the increase to the service delivery bodies are such that they determine their own staffing priorities. When inflation is taken into account, the increased grant to the Royal District Nursing Society amounts to about a 20 per cent increase. Obviously, the society's costs are substantially, if not almost exclusively, in the area of staff, and quite obviously the society will spend those funds on increased staff to provide, among other things, the after-hours domiciliary care referred to in the yellow book.

The increased sources virtually throughout all the pages to which he referred are provided to various agencies which then engage their own staff. That goes for community health, for domiciliary care, and for all the other community based health services. The radiation section of the commission has an increase, on my calculations, of 29.3 per cent and adequate staffing is being provided through those increased funds to ensure that the Radiation Protection and Control Act is administered properly.

Mr HEMMINGS: One thing I can always guarantee, Sir; when the Minister and I are crossing swords, I always praise the Minister and she always calls me ignorant.

Members interjecting:

The ACTING CHAIRMAN: Order! The honourable member has a question to ask?

Mr HEMMINGS: Yes. Page 80, on the right-hand side under 'Major resource variations 1982-83', states:

> The proposed increase of $465 000 in the programme expenditure in 1982-83 is associated with the following major factors . . . (3) improved staffing as a result of governmental policy to increase resources in the general area of environmental and occupational health services.

There is also a reference to the provision of full year effects on salaries, wages and price increases. In line with my earlier comments, again no increase in staffing is shown in the Programme Estimates. Could the Minister please inform the Committee what is the improved staffing and how many people are to be employed? If more employees will be appointed, why is that not shown on page 81?

The Hon. Jennifer Adamson: I take it that the question relates to increased staff for radiation protection.

Mr HEMMINGS: I dare not answer, because my comments might be seen as my third question.

The Hon. Jennifer Adamson: I did not understand the import of the honourable member's question.

Mr HEMMINGS: The Minister castigated me by saying that I did not understand pages 18 to 26.

The Hon. Jennifer Adamson: I can give the honourable member a specific answer. Two additional staff were appointed late last year, two more have recently been

appointed, and a further two positions have been created, making an increase of six full-time staff in that section.

Mr HEMMINGS: That is not shown.

The Hon. Jennifer Adamson: It may not be shown, but I refer the member for Napier and, indeed, all members of the Committee to the column on the left-hand side of page 7 of the yellow book, where it is stated:

> The further allocation of resources by boards of management to component parts of their agencies will occur during September. The accurate reaggregation of allocation on a programmes basis is therefore not possible until mid-October. The programme allocations contained in this document have therefore been prepared largely on a 'best estimates' basis.

It is certainly not possible for me to tell the Committee other than in broad terms how many additional staff the Royal District Nursing Society, for example, will employ with the additional funds that we have provided. That is for the society to determine. It is not possible for me to indicate with any degree of accuracy at this stage what individual community health centres will do with their increased resources. I can provide staffing numbers in relation to specific sections of the commission over which I exercise an immediate information-gathering role, but that is not possible in regard to health units, other than to say that resources have been increased in order to permit the appointment of additional staff.

In response to the preliminary statement of the member for Napier alleging that increased staffing has not occurred in community based and preventative services in comparison with the institutional component of the health budget, the reality is that a health system cannot be turned around overnight, especially when a Government has a no-retrenchment policy. Even if the Government did not have such a policy, it would be very difficult indeed to effect massive transfers of resources from the institutional system to the non-institutional system in a space of three years. We have progressively and logically worked towards reallocation of the resources on a programme-staged basis that enables the system to be responsive to community needs, and that is what the increased allocations for the community-based health units indicate.

Mr HEMMINGS: The yellow book (page 92) under '1982-83 Specific/Targets Objectives' states:

> Establish and commence an internal audit programme.

In October 1980, during the Estimates Committee, you, Mr Acting Chairman (a very able member of the Committee), asked the Minister a very impertinent question, as follows:

> Has the commission a system of internal audit of both fiscal and manpower resources and, if so, how many employees are involved in conducting those audits?

The Minister replied:

> Yes, the commission has a system of internal audit, and I will ask the Senior Finance Officer to outline the details.

Mr Bansemer replied:

> The commission is in the process of establishing a system of internal audit.

A few more words were said, and after the luncheon adjournment, you, Mr Acting Chairman, were obviously not happy with the answer, and in relation to internal audits asked:

> How many will eventually be appointed to the position of internal auditor?

The Minister replied:

> Five positions have been created for that Internal Audit Unit, one of which has been filled. I will ask the Chairman to explain the role foreseen for that unit.

The Chairman went on to say:

> The necessity for internal audit is well known and well recognised. It is proposed that a five-man unit will be established, and one position has been filled. The Auditor-General has drawn the attention of the commission in previous reports to the need to strengthen internal audit, and the introduction of this establishment is in response to that request. In addition, a Management Review Unit has been created within the commission which has been looking at the development of the management efficiency orders, and especially looking at reviewing programmes as they develop. In other words, we do not just introduce a programme and let it roll on; there is a regular review of its development. In addition, the individual hospital units as they are becoming incorporated and accepting responsibility are also developing their own internal audit functions.

That was in 1980: we now see that in 1982 an internal audit programme is still a specific target and objective. My colleague the Hon. John Cornwall took up this matter at some length with the Minister, and it seems that, notwithstanding that promise in 1980, the unit never really got off the ground. We were talking about a five-man unit, and as of April 1982 only two positions have been created, that of Chief Internal Auditor and Internal Auditor. Advertisements have appeared in the press and I suppose internally in the Health Commission. I understand that, after a short stay, the Chief Internal Auditor resigned (apparently his appointment lasted only a matter of weeks), and that position has not been refilled.

Therefore, in effect, despite a promise made in 1980 and despite very true statements being made by the Chairman that the Health Commission required an internal audit programme, it is still only a specific target in 1982. My colleague wrote to the Minister of Health in May 1982, and the Deputy Premier (who was then the Acting Minister of Health) replied, in part (and I will not quote out of context but only the relevant details), as follows:

> It was unfortunate that the officer appointed to the position of Chief Internal Auditor resigned so soon after taking up his position but he received and accepted a significantly more attractive offer, from a financial point of view, to take up a similar position in another organisation.
>
> It is important to recognise that there are members of the Auditor-General's staff continuously examining the financial operations of the South Australian Health Commission and also those of the major ex-Government hospitals in the metropolitan area. In addition, within the sector organisation or the commission, personnel are monitoring the activities of all health units under their jurisdiction as part of their routine responsibilities.
>
> It is intended, however, that the vacant position of Chief Internal Auditor shall be filled as soon as possible and, in the meantime, work is proceeding on the completion of an internal audit charter for the commission, which will be implemented as soon as the necessary staff member has been recruited.

Despite the fact that the original appointee resigned, and despite the fact that in October 1980 the Minister, the Chairman and the Chief Finance Officer felt it was important that there should be an internal audit programme within the Health Commission, why is it still listed as a specific objective?

The Hon. Jennifer Adamson: I think that the member for Napier has in effect answered his own question in quoting from the letter from the Deputy Premier to one of his colleagues earlier this year, but I will ask Mr McKay to elaborate on that.

Mr McKay: The question of internal audit has been addressed by the commission internally. As mentioned in the letter read by the honourable member, the Auditor-General does audit the Health Commission: he has a team full time within the commission, and he also audits the major hospitals. The other hospitals have their own auditors. We did appoint a senior internal auditor, and he looked at the issue of what an internal auditor would do within the Health Commission.

We have a situation now, because of the organisation that has been established since last year under the sector arrangements, where we now have more Health Commission officers within health units than we have had in the past. Under the sector arrangements, we have assistant directors, in charge of the financial aspects and financial sections, who

are spending a lot more time than ever before in health units, looking at the financial aspects of health units. What we now need to determine is the internal audit charter we require and the relationship between that internal audit group and the sectors. The sectors are an unusual sort of organisation, and they carry out a management review function which I think we originally envisaged for this particular unit. That is the issue now being debated within the commission, before we actually fill that job again, so that we have an understanding of the way we want to go with our review and audit functions.

The CHAIRMAN: I believe that the Minister has some answers to questions previously asked by the member for Hanson. If the Minister would like to respond to those now they can be incorporated in the proceedings.

The Hon. Jennifer Adamson: The member for Hanson asked whether the commission had information indicating the savings per week for South Australian families in regard to health insurance as a result of the efficiency and cost effectiveness of the South Australian health system. I have a table, which I seek leave to incorporate in *Hansard*; it is purely statistical and sets out the health insurance arrangements, basic hospital cover, and weekly contributions on a State-by-State basis for family rates.

Leave granted.

HEALTH INSURANCE ARRANGEMENTS
Basic Hospital Cover: Weekly Contributions ($)
Family Rates[1]

	N.S.W.	Vic.	Qld.[2]	S.A.	W.A.	Tas.	A.C.T.	N.T.[2]
Medibank Private	9.00	7.10	6.20	7.30	7.50	7.90	9.00	6.20
M.B.F.	6.80[2]	—	5.30	—	—	7.10	6.80[2]	5.30
H.B.A.	—	6.64	—	—	—	—	—	—
M.H.	—	—	—	7.00	—	—	—	—
H.B.F.	—	—	—	—	7.00	—	—	—
H.C.F.	8.00	—	—	—	—	—	8.00	—
A.N.A.	—	6.74	—	—	—	—	—	—
N.H.S.A.	—	—	—	7.00	—	—	—	—
St Luke's	—	—	—	—	—	8.10	—	—

Notes:
1. Single rates are half family rates.
2. To be increased shortly.

As at September 1982

The Hon. Jennifer Adamson: In explanation of the table, I should add that I believe Queensland should be excluded from comparisons with other States because of the continuation of its free hospital system: that obviously has an effect on its insurance rates. I also point out that the Northern Territory rates which are listed at $6.20 a week are about to rise.

Taking those two considerations into account, I indicate the variations from the South Australian rate for Medibank Private, which is the only fund operating across Australia: New South Wales is $1.70 per week more expensive than South Australia; Victoria is 20 cents per week less than South Australia; Western Australia is 20 cents per week more than South Australia; Tasmania is 60 cents per week more than South Australia; and the A.C.T. is $1.70 per week more than South Australia. On those rates only Victoria is cheaper than South Australia, and it should be borne in mind that bed charges in Victoria are more costly than those in South Australia.

Mr SCHMIDT: Several weeks ago I had the pleasure of attending the accreditation of a private nursing home at Christies Beach. I believe that it is the first home in South Australia, and the second in Australia, to receive such accreditation, and I refer to the Christies Beach Private Nursing Home. Is it correct that the standard of care and accommodation in nursing homes in South Australia is above that in other States? Can the Minister explain how those standards are determined? If there are no standards, will she say why not? If there are standards, by whom are they determined? Are there any further standards to be applied by the Health Commission to the private nursing section?

The Hon. Jennifer Adamson: I would like to comment on the accreditation of hospitals and nursing homes and say that the Government and the commission firmly support the concept and, indeed, encourage hospitals in South Australia to apply for accreditation.

We have seen, from the Government and private hospitals that have applied, the beneficial effect that even the application has on the hospital, in ensuring that management and staff work in concert to ensure that staff work towards standards and that they are meeting them. Probably the most notable example of that would be the effect upon the Modbury Hospital of seeking and achieving accreditation: it had a very beneficial effect on all involved with the hospital. It also led to a marked increase (and a well justified increase) in the confidence of the local community in its hospital.

In regard to nursing home standards in South Australia, certainly I believe that South Australia ranks well on a national scale. Staffing levels in South Australian nursing homes are significantly higher than staffing levels in other States. Indeed, the Commonwealth has criticised South Australia on the ground that, because it pays medical benefits and because costs in our nursing homes are affected by staffing, we should examine the staffing levels more closely on a State level. The Commonwealth believes that in some areas costs are too high. I shall have to check whether there is any material present that can be used to make comparisons between South Australian and interstate nursing homes, or whether there is an officer present who can provide that information. Overseeing of nursing homes is undertaken by local boards of health and the Central Board of Health. As I explained earlier, the Chairman of the Central Board of Health had to leave in order to attend a very important interstate meeting of the National Health and Medical Research Council.

Having conferred with officers to see whether anyone can provide the information sought by the member for Mawson, I point out that apparently this cannot be provided in the specific sense. However, I shall make sure that it is available to the Secretary of the Committee for distribution. Mr McKay has indicated that he will speak to that issue in general terms.

Mr McKay: It is an issue that affects two levels of government, more so than the State Government, namely, the Commonwealth Government, which is responsible for providing approval for nursing home beds, and local government, under Central Board of Health regulations which provide for licences. They are the two bodies that deal with the standards of accommodation. The Central Board of Health has regulations which lay down minimal staffing standards. It is my understanding that the staffing standards in South Australia are higher than in most other States. The Central Board of Health has been compiling figures on

staffing in South Australia and requirements for staff in a nursing home-dependent situation in order to determine an appropriate staff standard.

Mr SCHMIDT: If the standards, particularly the staffing ratios, are significantly higher in South Australia than elsewhere in Australia, one could assume that that would add to the cost of running nursing homes and that such costs could be passed on to patients. A survey conducted on 28 August this year, which involved some 2 821 beds of the tax-paying nursing home sector in South Australia, revealed that 1 764 of those beds were above the standard State fee, which I believe is set at about $37.85. It was also found that between 70 per cent and 80 per cent of the total operating costs of these homes are direct wage costs. Therefore, if the standards in these nursing homes are that much higher than they are in other States, what is the Government doing to alleviate the situation in relation to the operating costs of those nursing homes, particularly in regard to staffing levels?

I refer to page 33 of the blue book, where reference is made to the Hampstead Gardens Nursing Home and to Ru Rua Hospital. Whilst my argument cannot be applied directly to Ru Rua because of the specific nature of that hospital, it does apply to the Hampstead Nursing Home, as it is a general nursing home. It is indicated in the blue book that at that nursing home the gross cost per daily occupied bed is $80.22 (that is at 93 per cent efficiency). One wonders, therefore, why that home is not running at a 100 per cent efficiency level, when one considers the demand supposedly in the community to have these hospitals filled, particularly the demand for people to receive nursing care accommodation.

I refer particularly to the cost per day per bed. When one considers that the lowest standard fee charged by a private nursing home is about $37 and the highest fee about $51, almost $52, and relates that to the amount of $80 charged by the Hampstead Nursing Home, one wonders why it is that a Government-run hospital should be so significantly more costly to operate per day than is a privately run hospital.

The Hon. Jennifer Adamson: The additional cost inherent in a teaching hospital situation (the Hampstead wards of the Royal Adelaide Hospital are part of a teaching hospital) is significant and is reflected in the differing costs involved. I ask the Deputy Chief Executive Officer of the commission, Dr Brendon Kearney to elaborate.

Dr Kearney: The regulation on staffing for nursing homes is covered under the Health Act and is administered by the Central Board of Health. Those regulations are presently under review in respect of nursing homes. There are several differences between Hampstead, although recognised as a nursing home, and a private nursing home. First, the type of patient in a nursing home is assessed. The patients there are regarded as being more heavily dependent patients, that is, the more sick patient who requires heavier care, particularly nursing. Some of the nursing beds are also described as slow-stream rehabilitation beds.

An active rehabilitation programme is aimed at getting patients occupying those beds back to non-institutional care. That fact is reflected in the average length of stay (some 68 days) in those 125 beds, whereas in private nursing homes the expected average length of stay is about two or three years. Apart from providing nursing care and hotel services, the Hampstead Nursing Home also provides medical and paramedical services to its patients because of the nature of the patients at that home.

The Hon. Jennifer Adamson: I now ask Mr McKay to add to Dr Kearney's comments.

Mr McKay: The cost allocation study taken at the Royal Adelaide Hospital and the Hampstead Nursing Home raised exactly the same questions as those raised by the honourable member. It was considered that if Hampstead was to be considered a nursing home it should operate closer to nursing home standards. The studies undertaken at the Royal Adelaide Hospital on the North Terrace site and Hampstead site showed, in fact, that the Hampstead Nursing Home was appropriately staffed for the dependency of its patients.

As I have pointed out, there was overstaffing at the North Terrace site which is indicated by the figures. That is why the commission undertook a detailed study of nursing requirements at Hampstead which constitutes the major component in that bed day cost, and the requirements were determined as being appropriate, whereas on the North Terrace site they were found to be above those recommended.

The Hon. Jennifer Adamson: Another consideration that needs to be taken into account concerns the charges levied for the various nursing home situations, and I ask Mr Cooper to discuss those.

Mr Cooper: The only point that I want to make relates to the charges that have been quoted. First, there is the charge to the patient and, in addition, there is the payment of Commonwealth nursing home benefits to people in all nursing homes (which amounts to about $20 a day). The deficit financed nursing homes, the large organisations such as Helping Hand, receive a subsidy direct from the Commonwealth Government. The overall nursing home cost structure is not as different as is immediately suggested in relation to Hampstead Centre when one compares minimum charges with the full costs of that centre.

Mr SCHMIDT: Table 15 of the Commonwealth Department of Health's submission to the Senate Select Committee on Private Hospitals and Nursing Homes states that the estimated cost to the Federal Government for the 1981-82 financial year for South Australian Government nursing homes, was $9 114.36 per bed; for deficit financed nursing homes, $11 801.98; and for participating nursing homes (private), $8 566.78. Therefore, the funding provided to private nursing homes by the Commonwealth Government is far less than is paid to participating and Government nursing homes. We have just indicated that, in relation to long-term patients, it is more so for private nursing homes, particularly in relation to slow-stream rehabilitation. When was slow-stream rehabilitation introduced at Hampstead? Why was it introduced and how does it relate to what is provided in the private sector?

The Hon. Jennifer Adamson: I stress again the different types of patient who are accommodated in these two different types of nursing home. It is not uncommon for private nursing homes to refuse to accept very dependent patients who must rely upon the public system for care, along with all the additional costs that are imposed, as mentioned by Dr Kearney and Mr McKay. I refer the question to Dr Kearney to elaborate further.

Dr Kearney: The slow-stream rehabilitation activity associated with the Hampstead nursing home has been present for some three years. It is associated with the location of the Eastern Region Rehabilitation Service, which is also based at Hampstead Centre. It was introduced to complement the range of activities of that rehabilitation service and to show that it is possible to rehabilitate large numbers of patients who are presently resident in nursing homes.

One of the important factors in the dependency of patients going into nursing homes is the prior assessment of those patients. I think it is generally recognised that there are many patients in South Australian nursing homes who have not been fully assessed as to their true needs for nursing home care. It may be inappropriate for many of those patients to be in nursing homes.

The Health Commission and several of the rehabilitation units believe that the assessment of the patient should be

on the basis of being able to provide the best and most appropriate type of care for the patient. The simple solution of putting patients into nursing homes may not always be appropriate. That is the activity that is practised at Hampstead Centre, through the rehabilitation unit, in relation to the patients who are generally regarded as being more heavily dependent than those in general nursing homes.

The Hon. Jennifer Adamson: In effect, the member for Mawson is pointing out that nursing home care in the private sector is cheaper than it is in the public sector. Certainly, there is no disputing that point, but there are sound reasons for the additional cost. However, it certainly is not as great as it appears to be on the basis of the comparison of figures, as explained by Mr Cooper. Mr McKay will identify some other factors which contribute to the costs at Hampstead Centre appearing to be greater by comparison than the private sector costs. Mr McKay will elaborate on the inbuilt costs and the nature of the centre.

Mr McKay: The Hampstead Centre is not only a nursing home; it also incorporates a spinal injuries rehabilitation unit and a neuro-surgery rehabilitation unit. It has overheads which are shared amongst the various services provided. They would not normally apply if it was a free-standing nursing home, and that brings the figure down. As the Minister has said, I do not think we can argue that nursing homes in the private sector do have some capacities to run at lower costs than does the public sector, but they do not have the same kind of overheads that we necessarily have.

The Hon. Jennifer Adamson: I also stress that, where possible, the Government's policy is to refer people to private sector nursing homes or private hospitals in order to relieve the pressure on the public sector, but at the same time there is a cost to the patient involved in relation to some private nursing homes. When a patient cannot afford to meet that cost there is no alternative but to refer that person to a nursing home in the public sector. In addition, there is the question of the medical care provided at Hampstead direct to the patients. In a private nursing home that would be provided by a private practitioner and it would not be shown in the overall costs in the way that it is shown here.

Mr McRAE: As I said some five hours ago in my opening statement, and on this occasion it will not be a 27-minute opening statement, the health care area is terribly difficult for any Opposition, particularly when it is confronted by a Minister and an agency quite determined to hold back any information that they can. I must congratulate the draftsmen of this yellow book, particularly pages 6 and 7 where, having dealt with the overview of the Premier's Financial Statement, it becomes a masterpiece of what George Orwell termed 'non speak'. It is also a document of self-congratulations and anticipated self-defence. All three components are to be found in this absolute masterpiece of a document. It begins by setting out the laudible objectives of the agency, with which no-one could quarrel, any more than they could quarrel with motherhood. It then goes on, for reasons known to the Minister (because she is surrounded by the 12 apostles from the agency), but which the Opposition does not know, to explain that the vast majority of South Australia's health services are now managed directly by the boards of management of incorporated health agencies. It also states that, because they will not get their act together until September, the later figures in the yellow book should really not be heeded because they can all be changed.

This is a repeat of last year's performance and one can only assume that it foreshadows what will happen again next year. It then goes on to the total expenditure, which proudly refers to the substantial allocation. However, anyone with half a wit, blind Freddy, would know it is slashing 5.1 per cent in overall expenditure. The figure in the left-hand column of page 7 is 6.2 per cent, which represents a standstill allocation and an actual increase of 6 per cent. Actual terms are not dollar terms so, taking inflation into account, the increase is really −5.1 per cent.

The descriptive information under 'Implications for Resources' is a sheer masterpiece of drafting of which any lawyer could be proud. Then there is the possible reallocation of possible funds depending on possible events that might or might not occur depending on whether something does or does not happen. That is a magnificent anticipated self-defence.

No wonder the Opposition, confronted with this incredible document, had complaints to make and, when further antagonised by the Minister, became a little upset. Nevertheless, we have been objective and kind in our approach throughout the day, so I direct my attention to a proud boast of the Minister to see what sort of anticipated self-defence we draw this time.

The member for Napier drew attention to the story under 'Implications for Resources'. The Minister has proudly boasted that the major areas to which existing resources continue to be reallocated include community health and domiciliary care services. She may well be proud if the system works well but, looking at the facts, we find that the 1981-82 allocation for the western domiciliary care service was $1 369 000 and that this year it is $1 407 000 which, when indexed in real money terms, represents a slash of 12.7 per cent. That is hardly an encouraging thought for those who are interested in this area.

For the eastern domiciliary care service, $915 000 was spent in 1981-82 and this year $966 000 is being allocated which, in real terms, represents a slash of 0.68 per cent. The allocation for the northern domiciliary care service (formerly Para region) is an example of a real increase, in this case 2 per cent.

In future, will the Minister see that her agency prepares a support document that means something so as to save the Opposition, as has been the case over the last few years, trying to make sense of the figures? Further, will she do her best to prevent friction between the Opposition and the Government by making officers freely available to discuss issues of fact (not Government policy and not confidential matters), and will she do so in a ready fashion instead of behaving as she has done in the past two years? In the light of the figures to which I have referred, how can the community believe that the Government really intends to do anything substantial about domiciliary care.

The Hon. Jennifer Adamson: I am absolutely disgusted at the thoroughly offensive manner in which the honourable member has referred to officers of the Health Commission, and I do not intend to answer any of his questions until he withdraws his offensive remarks about the 12 apostles.

Mr McRAE: I withdraw that remark immediately. I counted about 12 people behind the Minister. It is an offensive reference. I withdraw it and apologise to the Minister, to the officers referred to, and to you, Mr Chairman.

The Hon. Jennifer Adamson: I accept that apology on behalf of my officers and am grateful that it has been offered. However, I resent the implied and deliberate criticism of officers who cannot speak for themselves. The honourable member has alleged that I and the commission are determined to hold back information, but I believe that no Minister of Health has been more generous than I in providing information for the Parliament and for individual members. I have extended to the Opposition spokesman on health every courtesy he has sought, including free access to the hospitals and to the chief executives of those hospitals. In reply to Questions on Notice, I have given the Opposition untold quantities of information. Each year the Estimates Committee has been given an increasing quantity of information. The allegation that the commission will not get its

act together until September is an unjust one, and it is especially unjust when one notes the performance of this Government which has improved dramatically on the performance of the previous Government, which could not get its budgets out to the hospitals before November.

The honourable member has fallen into a trap, that he cannot apparently see, of refusing to make allowance for some of the round-sum figures when determining the effects of inflation. Regarding the request to make officers available from the Health Commission to the Opposition so that they might explain the contents of the Budget, I would have gladly done that had I received a request in time. However, I understand that a request came from the Treasury to my office on the morning of the day on which Treasury officers were to meet with Opposition members. By the time I received that request and was willing to make officers available, I understand that the meeting had taken place. If the Opposition wants a reasonable time in which to have information available to it so that they might consider it, I will see that such provision is made.

Mr McRAE: The Minister has not answered the main thrust of my question: how does she expect the community, in view of the cuts to which I have referred, to believe that the Government is serious in its protestations as to its concern for domiciliary care services? The Minister claimed that I had not taken account of the round-sum figures. What nonsense! Of course I did, because the allocation for last year had indexed to it a round-sum figure and the allocation for this year has indexed to it a round-sum figure. Therefore, I am comparing like with like and am being purely objective.

If the Minister looks at page 7 of the support document, she will see that the proposed total expenditure for this year is $505 500 000. Last year's support document similarly had a figure for proposed total expenditure, but indexed to that figure in the Financial Statement of the Premier and Treasurer was a round-sum allocation. So, in other words, if we are talking about fairness, I maintain that I am being fair in comparing like with like. The Minister has thrown in a red herring. My analysis is correct in taking into account all the relevant facts.

The Hon. Jennifer Adamson: I will ask Mr McKay to elaborate on this point, but I point out that the 6 per cent increase in wages this financial year will increase the allocation by about 13 per cent which exceeds the anticipated c.p.i. and I acknowledge that it is not easy to arrive at the commission's figures, as outlined by the Chairman, because of the cost sharing arrangements and the different way in which the Commonwealth takes into account inflation as distinct from the States. I assure the honourable member that reference to these documents demonstrates that the resources allocated to community health represent a real increase. Mr McKay will explain as simply as he can the manner in which that increase can be demonstrated.

Mr McKay: As I have said, it is confusing. If one looks at page 7 one can see that it is not comparing like with like, because the actual expenditure for last year was $475 800 000. The estimate of $505 000 000 for this year does not include the amount held by the Treasurer in round-sum allowances for both wages and the proportion for inflation. In fact, our figure includes 4 per cent for inflation. There is additional money in the round-sum allowances. We anticipate that, if wage rises proceed as expected, it will probably reach about $30 000 000. Therefore, one must add $30 000 000 to the $505 000 000 when comparing it with the $475 000 000 which gives a rate of about 12 per cent, but we are anticipating that the system will probably move. In relation to community health centres, if that figure holds, as I believe it will and it is used for community health, it will produce a figure of about 14 per cent.

Mr McRAE: Plus 14 per cent in real terms?

Mr McKay: In other words, the actual expenditure for 1981-82 will be increased over the actual expenditure for 1982-83 by about 14 per cent, if the wage and salary movement amounts to about $30 000 000. That is one of the confusing things about this area, and that is also why the Commonwealth Government estimates what it will be. Rather than keeping it as a round sum in the Treasurer's fund, they add that figure of $30 000 000 to the actual expenditure. The estimated figure for this year will include that wage and salary component of $30 000 000.

The Hon. Jennifer Adamson: I refer the member for Playford to page 39 of the yellow book and the programme title 'Services Mainly for the Aged and the Physically Disabled Living at Home'. The total programme expenditure under recurrent expenditure for 1981-82 was about $8 400 000. The proposed expenditure for 1982-83 is about $9 900 000 and on top of that one adds the round-sum allowances. The actual figures represent an increase of 18.2 per cent. When one adds the round-sum allowances that is an increase of about 20 per cent, which is a substantial increase in relation to the reallocation of resources.

Mr McRAE: I am glad that we now have an understanding that in future we need a breakdown, otherwise we get these areas of friction. If that background information is not provided it is no wonder that the Opposition becomes confused.

I return to the topic of domiciliary care; because that is what we are on about. I still do not understand Mr McKay's explanation, in light of the fact that the actual sum expended last year would have included wage increases. This year the actual sum proposed must include wage increases. Honourable members may shake their heads, but they cannot have it both ways; we either do it by line estimates or by comparing the actuality of last year, by saying 'Last year we spent X dollars on domiciliary care. This year we have allocated X dollars, and we anticipate a certain percentage wage increase.' I will not be so impertinent as to ask what that anticipation is, but I think that one can reasonably assume that if inflation is 11.3 per cent, any wage increase is likely to be in that area. I think the Minister can see that I am being completely fair. Will the Minister provide the Committee with the actual expenditure last year (including all the wages and associated costs) and the sum actually allocated this year (including the projected allowance for wages) in relation to the western domiciliary care service, the eastern domiciliary care service and the central northern health service?

The Hon. Jennifer Adamson: I will ask Mr McKay to provide that information. Certainly the actual sum includes the amounts spent last year and that, of course, includes progressive salary increases which are then built into the base figure for this year. As he rightly says, we cannot anticipate what increases will be incurred. Indeed, it would be industrially unwise to do so and one cannot attempt it. Therefore, I do not think that I can indicate that there would be any likelihood of that occurring in the future, because it is just not the way a Treasury or any responsible Government operates. Mr McKay will explain how the inflationary component is anticipated and built into the allocation.

Mr McRAE: I am not seeking information about the method; I understood Mr McKay's explanation the first time around. I am looking for the actual figures by way of comparison between last year and this year.

Mr McKay: In relation to the western domiciliary care service it was $1 360 000 last year and it is $1 400 000 this year, which is an actual increase of 2.74 per cent on that economic estimate. The Executive Director of the western sector has explained the situation to me. The western domiciliary care service has been amalgamated with the Queen

Elizabeth Hospital, which proposes to start a domiciliary care rehabilitation service and assessment rehabilitation service. Therefore the $150 000, for domiciliary care in the western sector is earmarked for the Queen Elizabeth Hospital.

In addition to the 2.7 per cent increase one must add an increase of about 6 per cent to achieve an actual figure which amounts to about 8.8 per cent for western domiciliary care. The Executive Director of the western sector might like to enlarge on what is happening in relation to the Q.E.H. in terms of the actual resources going into domiciliary care in the western sector. They are also affected by the district nursing service which provides a district nursing service to domiciliary care services, and as we pointed out there is a very large increase in their capacity which will impact on that service. The same thing applies in relation to the eastern sector. It raises the allocation for the eastern sector from $915 000 to an allocation of $966 000 which is an increase of about 5.5 per cent.

One would add to that a figure of about 6 per cent. The Director of the central sector may be able to provide more information. Overall, in regard to domiciliary care, we anticipate an increase of a little over 6 per cent, to which must be added a further 6 per cent, making a total of about 12 per cent. In regard to community health centres, there would be an increase—$16 200 000 to about $17 500 000, or 7.9 per cent. If 6 per cent is added to that, there is an increase in that area of nearly 14 per cent.

Mr McRAE: Does that include wages?

Mr McKay: Yes, the 14 per cent includes wages. Last year, $406 000 was allocated for the central northern region, against the allocation this year of $443 000, an increase of 8.9 per cent. If a sum for wages is added to that, there is a total increase of about 14.9 per cent for the central northern region.

The Hon. Jennifer Adamson: Does the member for Playford want the sector directors to provide detail in response to his question?

Mr McRAE: We would be only too pleased to receive additional figures.

The Hon. Jennifer Adamson: I presume that Mr McKay went into as much detail as the member for Playford wanted. I do not know that the sector directors can provide additional figures, because I believe that all of the figures have been cited; however, the directors could give an elaboration of the nature and extent of the services.

Mr McRAE: I would be pleased to have in tabulated form what Mr McKay has set out. I am sure that that would make the position much clearer.

The Hon. Jennifer Adamson: That information can be provided to the Secretary of the Committee.

Dr BILLARD: Charges were made today and last year in regard to recognised hospitals and 12 months ago we spent 1½ hours in this Committee debating allegations made by the member for Playford (who moved a motion) that there had been a 22 per cent cut in funding to recognised hospitals. The honourable member absolutely insisted in that debate that there had been a 22 per cent cut, and he could not see the difference between the actual spending of the previous year and the proposed spending for the coming year. There was a debate about round-sum allowances last year and the year before.

If one compares page 1 of the blue book to page 1 of last year's blue book, one finds that the actual spending on recognised hospitals last year, compared with actual spending on recognised hospitals the previous year, was 11.7 per cent higher, which can in no way be construed as a 22 per cent cut. Having waited 12 months for the documents to be produced this year, we now have the proof of the pudding, which is that the alleged 22 per cent cut in funding to recognised hospitals simply did not take place.

Regarding budgetary controls in the larger hospitals, particularly the Royal Adelaide Hospital (because that is the largest hospital), I was concerned at what Mr McKay said about the staffing study on several of the major hospitals that found that there was understaffing and overstaffing within the same hospital. I was concerned that those two situations could exist side by side. What standards are set for staffing in various sectors of hospital operations? Given that a staffing study examined the situation recently, what continuing mechanism is used to prevent such disparities from arising in the future?

The Hon. Jennifer Adamson: The whole question of nurse staffing is extremely complex, and I will ask Mr McKay to identify some of the factors that affect it. The principal factors are obvious, and include the degree of dependency of the patient being treated (and that is the most important factor affecting the requirement for nursing care) and the nature of the design of the nursing unit. Architects have quite a lot to answer for in relation to the design of hospitals. If a hospital is well designed, it is easier to staff it adequately considering patient care, but if it is poorly designed, with the same number of patients of the same degree of dependency, more staff are required because of the geographical lay-out of the nursing units.

I will ask Mr McKay to outline the reasons why in the one hospital there could be understaffing in one area and overstaffing in another, and also the mechanism that the commission and the health units will use to overcome those difficulties in the future.

Mr McKay: As the Minister has said, this is a very difficult area, because the work loads change according to the number of patients in an area. The dependency of individual patients also causes a problem. Another issue is the staffing standard required to nurse a patient in a certain situation, and an update of those standards was probably lacking. That has now been overcome by the staffing studies.

There has been an assessment of what is required in terms of nursing care to patients in particular situations and in certain areas of the hospital. That assessment provides one tool: the second tool is the measure of dependency of the patient. Daily assessments of the dependency of patients have been undertaken in ward situations, and those assessments are linked to the standards for care. I believe that the hospitals are doing a good job of moving those around. We are trying to establish standards, and, as the Minister said, this must be undertaken in individual institutions.

In fact, the Health Ministers asked a group of State officials to try to achieve national uniformity so that all of the States could follow the same criteria for nurse staffing. Unfortunately, that committee reached the conclusion that there is just too wide a variation in the components making up the staffing arrangements to apply a general system throughout the States. Each individual unit must be considered. The answer to the question is a regular, almost daily, assessment of the dependency of patients and the standards that have been adopted to ensure that there is no deviation or change in the pattern of patient care that would mean more or less staffing.

The Hon. Jennifer Adamson: I would like to reinforce what Mr McKay has said from the point of view of a layperson who receives, as Minister, letters from patients (the majority of which are complimentary) about hospital care. It is quite clear that some patients and their families would not necessarily understand the nursing policy (if you like) and the rehabilitation basis of the way in which some patients are treated. Years ago possibly a patient whose fingers had been severed might have had his total needs attended to by a nurse, on the basis that he could not cope. The modern concept of rehabilitation is to get that patient

feeding himself, washing himself where possible, and clothing himself as soon as possible, the day after an operation on his hand.

Similarly, sometimes there is criticism in childrens hospitals that the mother feeds the child and not the nurse, and that there should have been a nurse available to do that. However, the approach to paediatric care is that, the closer the bond can be maintained between the mother and child while the child is hospitalised, the less the trauma for the child. Very often there are sound nursing reasons for employing the assistance of either the patient or the patient's family in the care of the patient. These should be understood for what they are—a genuine and soundly-based policy, rather than an automatic knee-jerk reaction, that there cannot be enough nurses because the mother is having to feed the child or the baby or the grandmother.

That concept of self care and family support for people in hospitals should be, I think, better understood and more widely proclaimed by health professionals than it is. When that occurs there may be less emotionalism surrounding this subject of nurse-patient ratios.

Dr BILLARD: I appreciate that answer. It appears to me that the public will be reassured if they can see that sort of study of the appropriate staffing levels and the appropriate care is continuously reviewed. It would concern people if the situation could have drifted over the years into a state where there were quite large disparities as to what was appropriate. The real thrust of my concern was that there be some continuing monitoring of the situation through management, so that that situation does not arise again.

Pages 11 and 12 of the blue book contain details of the performance of the major hospitals. I have compared the receipts this year with the receipts last year, and, whilst recognising that there is a different health scheme in operation which has obviously impacted that area, I have noticed that the different health scheme operation has impacted receipts of different hospitals to different extents. For example, the Royal Adelaide Hospital has had its receipts boosted by 29 per cent. The Flinders Medical Centre, at the other end of the scale, has had its receipts boosted by 69 per cent. That is a big disparity and it appears to me that the hospitals which have had their receipts boosted by a larger percentage are those in the outer metropolitan areas. For example, Modbury has increased by 64 per cent, the Lyell McEwin Hospital by 52 per cent and so on. Is there any reason for the disparity between the hospitals?

The Hon. Jennifer Adamson: Yes, and the reason relates to the comment I made earlier about the different clientele of the hospitals. The Royal Adelaide Hospital has traditionally drawn its patients from an aged population, the pensioner section, and a large proportion of that hospital's patients are Commonwealth eligible patients. By contrast, the Flinders Medical Centre and Modbury Hospital draw their patients from an area of largely young families who are insured, and that different clientele is directly related to the differing impact on the various hospitals as a result of the changes in health-financing arrangements.

Dr BILLARD: My final question relates to the community health centres and their performance, as summarised at pages 23 and 24 of the blue book in statement 5. Again, I have drawn comparisons between the expenditure by the community health service this year and last year and I note that net operating expenditure was $15 980 000 in the last year, an increase of 122 per cent on the previous year. I note the Child, Adolescent and Family Health Service was included last year but, if we extract the $6 200 000 for CAFHS, there is still a 36 per cent increase in expenditure over the previous year, a pretty hefty increase for community health services.

I have looked through some of the individual centres, particularly the one that serves my electorate, which is St Agnes, and that centre had an increase of 49.5 per cent in its net operating expenses over the previous year. I have noticed that increases for individual centres vary quite markedly. Who makes the decisions as to whether funds go to community health centres? At what level are those decisions made? What criteria are used in deciding where the funds will go? By way of comparison, the community health centre at Ingle Farm has had a 58 per cent increase, which is 18 per cent more than that of St Agnes. I would have thought that if any area was growing more rapidly it would be St Agnes.

The Hon. Jennifer Adamson: The member for Newland has correctly identified the very substantial increases in community health, and specific answers to his questions will be provided by Mr McKay. However, I would like to refer back to an earlier question which I believe you asked, Mr Chairman, near the beginning of the Committee: namely, the consultative process that the commission undertakes before making decisions. I would like Mr McKay's answer to be seen in the context of the consultative process and the very broad discussions that take place between the commission and local organisations, providers and consumers, prior to decisions being made about resource allocation.

Mr McKay: As to who makes the assessment, under the rearrangement of the Health Commission organisation, the sector director basically makes the decision about the distribution of resources within his sector. Taking the two examples cited by the member, both centres lie within the central sector and the decision on the resources applied to each would have been made by the sector director. However, there are a number of issues in that. There will be one-time expenditure, so that at times one community health centre may be purchasing equipment or having repairs done which is a one-off expenditure and this does not necessarily enable a true comparison.

St Agnes has been going through a review of its activities and its management structure and how it should operate, and it has not been operating at the level of Ingle Farm. That is the reason for that discrepancy last year: until they had worked out their management structure there was no increase in positions, and that was the reason that that budget was less than that of Ingle Farm. It may be also that some minor works or equipment purchased skewed the results somewhat.

The sector directors are also establishing advisory committees at sector level to give them advice both on the consumers in the community and the providers, to establish priorities for both community health services and domiciliary care. The committees will be advising sector directors what should be happening. Therefore, decisions will not be made in complete ignorance of what those in the community and the providers would like to happen.

The Hon. Jennifer Adamson: The question really poses another question, concerning the value of the information sources of the commission and the statistics available to the commission. It further raises the matter of the quality of our epidemiological information throughout the commission and the knowledge of the social background in regard to the provision of health services. All those things point to the need for decentralised provision of health services and community-based management, because it is only when management and resource allocation decisions are made close to the point of delivery of health services that those services will be truly responsive to the needs of local people.

The Government's policy, which is strongly based on a policy of decentralised management, is one of the reasons

why the commission has divested itself of service delivery functions. Its role now is co-ordination, planning and integration of services. It is the people at Ingle Farm, St Agnes, Christies Beach, Noarlunga, Balaklava, and Snowtown, for example, who we believe are best equipped to identify the needs of their local population and to ensure that those needs are met.

At the same time, they need access to good information: the commission's information gathering capacity has certainly improved quite dramatically over the past three years, and I hope it will continue to improve. Statistics such as morbidity and mortality are being refined and other information is being gathered by health surveys. I recall surveys having been made at Ingle Farm and Morphett Vale. Also, there was a survey in the central northern area conducted by the Para Districts Health Advisory Committee. These surveys are undertaken at the ground level; people go out to individual householders and ask them what their needs are and their opinion of the services provided. In that way health services are becoming more and more responsive to the perceived and actual needs of people in local communities.

Mr LANGLEY: I refer to a matter that concerns those in my district, as it is an older area. Under section 34 of a Commonwealth Act the Whitlam Government provided an opportunity for State Governments to provide beds for pensioners in community hospitals. As this service is no longer available, having been repealed by the Fraser Government, does the Government have any plans to institute a similar service? People in the Unley district were more likely to go to the Ashford Hospital, where 50 beds were allocated, but now there has been a change in the style of the running of that hospital because, after all, the hospital must keep operating, whatever the circumstances. However, at one stage the hospital appeared to be in serious trouble. There has now been an improvement, but the number of people using that hospital now is not as great as it was during the time in which that Commonwealth provision was in force.

The Hon. Jennifer Adamson: I thank the member for Unley for a thoughtful question on a matter which has a profound impact on individuals and also on the State health budget. The withdrawal by the Commonwealth Government of the provision of section 34 beds was a decision it made on its own account; certainly, not with the support of the South Australian Government. The Government was very concerned about the effect that the change would have on the hospitals that had a large proportion of their beds identified as section 34 beds. Ashford hospital fell into this category as did the Western Districts hospital. It is a tribute to the management of both hospitals that they weathered an extremely difficult period and came through it.

The answer to the honourable member's question is 'Yes'. The Government recognises (and the Health Commission is very conscious of the fact) that it is better to care for people, especially the aged and the young, in locations close to home, family and neighbourhood. Such an arrangement is better for the patient and better for the patient's family. Very often the level of care that can be provided in such community and religious hospitals is more appropriate and is certainly cheaper than the same service being provided from a metropolitan teaching hospital, the function of which is really not to provide that general hospital care but to provide specialised services.

At this stage it is not possible for me to be more precise, other than to say that I intend that the commission should investigate ways and means of making use of the unused capacity in the non-government sector and the community sector, both to relieve the pressure on public hospitals and to improve the viability of non-government hospitals, while at the same time providing a service that the member for Unley has identified as being a very important one. We recognise the problem and we want to do something about it.

Mr LANGLEY: I can assure the Minister that the people in my district are frightened about what has happened as a result of the change. The Minister said before that the user pays; I could quarrel about that, but after all I am not running a Government. However, people now must pay on average about $12 per week to ensure that they can get into a hospital. This is hurting people who, over a period of years have budgeted their income for their retirement. I think the Minister explained that this matter has hurt people, and I agree with her comments. One of the problems now is that there are long waiting lists for those wishing to go into a Government hospital, and I know of people in my district who have needed urgent medical attention but who have had to wait for several months before going into hospital or have had to go elsewhere. In some cases these people have not taken that extra second precaution. Everyone knows the cost of hospitalisation, but people get into an awkward position when they must pay rent and other living expenses, and so on.

The Minister indicated that the Government is considering the matter, but I stress that there are cases where people are really not in a position to enter a hospital for the simple reason that they cannot pay and they are on a waiting list. Is there a service provided by the Government to which people can go and explain the precarious position that they are in?

The Hon. Jennifer Adamson: The member for Unley has raised several issues regarding eligibility for free health care. I take it that the honourable member is suggesting that that eligibility should enable patients to have some choice as to whether they attend a public hospital or a local community hospital. I have said that I believe that there is great merit in making use of local community hospital beds for eligible patients, and I am sympathetic to the idea of making arrangements of our own.

Obviously, that would have to be with the Commonwealth's approval because we are still part of a cost-sharing agreement. The question of waiting lists at public hospitals for people needing urgent attention raises another issue, and that is that there needs to be an understanding by the Committee, and certainly by the general public, that there is plenty of unused capacity in the public hospital system as well as in the private hospital system. In fact, South Australia has among the highest number of beds a head of population of any State in Australia and certainly a much higher number than is generally accepted internationally.

We have 6.4 beds a thousand head of population, other States have less and are working towards less, and other countries, such as the United Kingdom, Europe and North America, regard somewhere between three and four beds a thousand head of population as being acceptable. In other words, we have what could be considered as twice the acceptable number of available beds a thousand head of population.

Where patients are placed on waiting lists, I think the management of public hospitals need to exercise more directives to staff to ensure that those patients are referred to other hospitals. For example, I have heard of waiting lists at Flinders for certain operations but there is no reason why anyone should have to wait in the Adelaide metropolitan area for an operation at Flinders when that operation could be readily undertaken in an unused bed at the Queen Elizabeth Hospital. It is quite wrong to expend resources in one geographical location when we have unused resources in another. It is extremely important, and I think that the

Government, health professionals and management of health units, have an important obligation to the community to explain. The resources are there, and it is up to those concerned to use them in the most effective manner.

Certainly there is no reason why people should be required to wait for operations. They may not be able to be admitted immediately to the hospital of their choice, but if it is an emergency the operation could be undertaken anywhere immediately. If it is an elective operation, it could be undertaken, although perhaps not necessarily at the hospital of first choice, but with undue waiting time. I would ask Dr Kearney to elaborate on that, because it is an important truth that needs to be understood by the community.

Dr Kearney: Waiting times do vary between the teaching hospitals. Generally over the last decade waiting times for discretionary or elective surgery have decreased significantly because of the development of the facilities in the metropolitan area. Waiting times are perhaps longer in some areas, and they would be in the areas of elective orthopaedic operations particularly at the Flinders Medical Centre and also of E.N.T. surgery and plastic surgery.

As the Minister has indicated, anyone requiring urgent or emergency surgery is able to be accommodated immediately in all public hospitals at the moment. The variability between the hospitals in those areas I have mentioned where there are slight increases in waiting times is such that certainly the waiting time, say, at the Queen Elizabeth Hospital for orthopaedic surgery is very much less than it is at Flinders Medical Centre, and a shift of patients between the hospitals would be possible. However, compared with interstate and overseas countries, the waiting times for elective surgery in the teaching hospitals in Adelaide are very acceptable.

Mr LANGLEY: I am a little surprised at the answers that have just been given. People in my district have been on a waiting list for so long that they have ended up paying for the operation to be done. I do not believe that there is no waiting list. I believe that that is not true because people have told me that they have had to wait. Dr Kearney has just said that there are waiting lists in some areas and no waiting lists in others, but nonetheless people are having to wait, and that worries me to a great extent.

People are always put on to a waiting list, and I have never heard anyone in my district say that they had been given the opportunity to go to another hospital where there is no waiting list for that type of operation. It is news to me that patients are being told that the waiting list is shorter at another hospital to which they could go if they so desired. I have never heard that said; I would be surprised if that is the case, but I will look into this matter with the people concerned.

The Hon. Jennifer Adamson: They have never been told by the doctors.

Mr LANGLEY: I hope they have been told by the hospitals to which they have applied in the first place. I have never heard of anyone being told by a doctor that they could go somewhere else where there is a shorter waiting list.

The Hon. Jennifer Adamson: I think the member for Unley is making a good point. I am not disputing anything he is saying. I am saying that the patients should be told, and they should have information made available to them that indicates that there is a place for them at another hospital if they want it. There may be reluctance on the part of some doctors to provide this information. My assertion is that that message has to be hammered home to the whole community, as does the understanding that it would be irresponsible to the point of negligence to expand beds in one hospital in order to meet temporary needs for elective operations whilst leaving unused empty beds in another hospital.

Mr BECKER: I am a bit concerned about the Opposition's allegations of the user-pays system in our health services. This seems to have come up this afternoon in the examination of this vote. I wonder whether the Opposition is playing on the misfortunes of others, particularly as we know that some illnesses can frighten people, especially the aged.

I regret that the whole of the health debate has been turned into such an emotional issue, and the Opposition should be reminded of the problems facing the New South Wales Health Commission recently in this field. What is the subsidy per hospital bed, and what is the general all-up cost of the health services to the taxpayers of Australia in general and this State in particular?

The Hon. Jennifer Adamson: The basic difference is to be found on page 1 of the blue book, which indicates the difference between payments and receipts to give the net operating cost. Under the user-pay principle the charge for a patient is $105 a day in South Australian hospitals, whereas the cost can vary from $180 in a general ward to about $1 000 a day in intensive care. That gives some idea of the cost of the subsidy that must be borne by the taxpayer under the user-pay principle.

Mr McKay: Last year's figures may help in this regard. Out of the $467 000 000 paid for health services in South Australia, $83 000 000 was received from the public by way of health insurance and other charges. So the net cost to the taxpayer, both Commonwealth and State, was $384 000 000. It is hard to relate that to the cost per bed because of the way in which the service operates, but it is $300 a head for South Australia.

The Hon. Jennifer Adamson: That merely demonstrates that the more effective we are in keeping management costs down the more effectively we can relieve the taxpayer of what is a great burden, despite the operation of the user-pay principle. Without that principle the burden would be much heavier.

Mr BECKER: I hope that that statement puts to rest the emotional arguments being used by Opposition members to frighten South Australians regarding the cost of our health services. The following article appeared in yesterday's city-State edition of the Adelaide *News*:

Some privately insured patients are having heart operations in public hospitals in preference to health card holders, an Adelaide specialist claims. The doctor said today a scandalous situation had developed with expensive public hospital equipment being used for private patients, enabling surgeons to charge private fees of up to $1 000 a case. It was possible for two surgeons to do 25 heart bypass operations a week to share $25 000.

'I would be surprised if they made less,' the specialist said. He was commenting on a story in The *News* in which the Heartbeat Assistance Group said patients could be dying each week because of lack of post-operative ward beds at Royal Adelaide Hospital. Professor Lou Opit of Monash University, Melbourne, backed the Adelaide specialist's claims.

'The last figures made available showed that 70 per cent of all private work done by doctors was being done in public hospitals using public equipment,' Professor Opit said. Some medical authorities tried to ensure insured patients had an advantage over uninsured people.

'A certain number of doctors are allowed to take private cases in public hospitals as well as taking cases from public patients,' said Professor Opit, a crusader for a better deal for community medicine. 'If patients are on a health card, the doctor is not entitled to raise a fee, but he can do so for privately insured patients.'

The Adelaide specialist said that unless a dramatic change took place the situation would continue with private patients taking priority at the expense of the public. Adelaide doctors could be sharing about $1 000 000 a year from heart operations, according to Professor Opit. General practitioners referred patients to the specialists using public hospitals, he said.

'The problem of the waiting list could be solved instantly if all private patients were forced to have their operations in private hospitals,' the specialist said.

I understand that the heart unit at the Royal Adelaide Hospital is regarded as the best in the world. This opinion was confirmed when I was overseas on study leave last year. In other places I visited universities and hospitals making inquiries on another subject, and wherever I went I was asked how certain doctors were getting on and I was told that our open-heart surgery unit was recognised as the best in the world. Therefore, I am amazed at this scandalous press article, which is a terrible slur on the R.A.H. I understand that some specialists in this unit are incensed at this article, especially as the statements are attributed to an unknown so-called specialist. The members of the unit are distressed and wish to have the issue clarified.

I understand that the unit has three surgeons, and in the first six months of 1982 performed 603 open-heart operations, 408 of which involved private patients. This proportion (67 per cent) represents the number of patients carrying private insurance in the community, and there has been no preference for privately insured patients. The unit was expressly set up in 1960 as a single State service to treat both adult and child patients, irrespective of their level of medical insurance. The single unit service has been extremely cost effective, and it is recognised world wide for its competence and efficiency.

The cost effectiveness was borne out when the Public Accounts Committee looked into the health services, and the competence and efficiency of this unit is indeed acknowledged. The unit established a second surgery, I think for only a few thousand dollars, compared to the original quote from P.B.D. of about $2 000 000, so full credit goes to the Royal Adelaide Hospital there. I understand that the Adelaide specialist quoted in the *News* is not a cardiologist and would therefore have no intimate knowledge of the running of the unit (of course, he does not make his name known). The surgeons working in the unit do pay service charges to the Royal Adelaide Hospital, for both clinical and secretarial services, and the P.A.C. report referred to the specialists in Government hospitals who were allowed to take in private patients.

This particular unit contributed more money to the hospital than all the other specialists combined. As a matter of fact, Dr Sutherland contributed massive amounts to the hospital for the use of services, and that is in the P.A.C. report. Therefore, I am very concerned about this matter (and I note the allegations made by the member for Unley), and I was wondering what can be done to rectify the situation as outlined in that article. I am incensed to think that anybody would reflect on this unit or our hospitals, because as far as I know there is no discrimination of any kind in respect of patients seeking any kind of treatment.

The Hon. Jennifer Adamson: I share the member for Hanson's concern about that article. If the doctor concerned had had the courage to identify himself, I have no doubt that by now legal action would be taken against him, because his allegations were libellous and defamatory of a unit which is pre-eminent in Australia and, as the member for Hanson has said, internationally recognised. There was a series of false statements and gross misrepresentation in that report in the *News*, and there was an almost incredible lack of understanding, on the part of the doctor who made the allegations, of the nature of heart surgery. The suggestion that it should be undertaken in private hospitals is so grotesque as not to be entertained, because not only could no private hospital afford the capital equipment required in the first instance: if heart surgery is to be effective, there needs to be a high throughput which ensures a level of clinical competence on the part of all members of the team, because it is not an individual effort; heart surgery requires a very highly disciplined team effort.

I would like to ask Dr Kearney to make reference to each of the allegations in turn and set the record straight, and I hope that when the record is straight it will be published, because South Australians deserve better by way of information through the media than they got by medium of that article in yesterday's *News*.

Dr Kearney: I think it is true to say that the quality of care provided at the cardiac unit at the Royal Adelaide Hospital is equal to any in Australia or internationally. Its results in terms of operative mortality and improvement to patient care are equal to the best anywhere, and so it does have a very high reputation as a unit. In addition, it is fair to say that the rate at which these operations are provided to the community is high by Australian and international standards. Approximately 600 people per million have coronary artery by-pass operations, which form about 75 per cent of the type of cardiac surgery now performed, and that is an operation which is basically done to relieve angina caused by ischaemic heart disease. That rate of operation is nearly equalled by Western Australia, but not anywhere near equalled by the other States in Australia, so that the availability and quality of that service to South Australians is presently unequalled in Australia.

In addition, the patients selected for surgery have to be first assessed by a primary care practitioner, usually the family practitioner, and are then investigated and assessed by a cardiologist, and then, in turn, assessed by the cardiac surgeon prior to surgery. So that the process and the mechanisms leading to placement on the operating list are such that the medical condition indicating the operation is more important than the patient's insurance status, and that selection is made at an open conference setting, where many people attend.

The high percentage of patients who have insurance and are private patients in the cardiac unit reflects the insurance status of the general population, and it is approximately 65 per cent. That is higher than the private patient load in the general hospital, that is, at the Royal Adelaide Hospital, but that is partly because of the age mix of the population going to the cardiac unit. More middle-aged people are having cardiac surgery and not so many elderly people. It is true, however, that most patients who are insured are private patients in that unit.

The waiting list at the moment is of the order of four to five weeks, and that is not considered excessive. Normally the operation of coronary artery by-pass surgery is offered for angina, and modern medical treatment certainly is able to tide people over for that period. Of the 25 or so by-pass operations done each week, there are several kept free during the week for those patients who require urgent cardiac surgery, and there is no delay for patients in specific categories where it is known that performing the operation urgently has an effect in reducing mortality from that disease.

So that, from my knowledge of the health system and the cardiac surgery unit, the report in the paper is incorrect in many respects. There are three cardiac surgeons. The service is of high quality, and the waiting times are acceptable. No overt discrimination has ever been sustained over many years of operation in that unit, and those cardiac surgeons do pay facilities charges.

Basically, the charges are threefold: first, in relation to employment of office staff where the surgeons are responsible for employing their own staff; secondly, they are required to pay commercial rent for their offices in hospitals; and, thirdly, there is a fee of about 20 per cent of the charge of the operation in relation to each private patient.

Mr BECKER: The Public Accounts Committee Report of 1979 (No. 14) shows the figure for that year, which illustrates the contribution made by Mr Sutherland.

Dr Kearney: I should add that, since that report, the cost allocation study at the Royal Adelaide Hospital in 1980 identified the cost of cardiac surgery at $4 000 for each operation. That contrasts with a range of between $7 000 and $11 000 in other cardiac units in Australia. It is a very efficient operation, because a small number of surgeons and nurses, having a progressive attitude towards patient care, work principally within the one unit.

The length of stay tends to be shorter than the average for cardiac surgery, and there is an active pre-operative and post-operative rehabilitation programme. I point out that the present unit was established by Mr D'Arcy Sutherland, who is a cardiac surgeon of some international note. I believe that we are fortunate that Mr Sutherland is a South Australian who had the foresight to establish the unit.

Mr BECKER: I have asked my next question in every Committee of which I have been a member, so the Minister need not be offended. Nothing is listed under assets in the programme performance budget papers in regard to the number of motor vehicles owned by the department. This information is given under fixed assets in relation to some departments, but not others. The programme performance budgeting for the Health Commission is still being developed, and I hope that it does not go any further. I believe that most departments have gone far enough: if it went any further we would be counting pins, stamps, stationery, and so on, which becomes a very expensive exercise. The system has gone about as far as it can go without becoming too expensive.

I believe that information on fixed assets is important, and I am particularly interested to know the number of motor vehicles under the control of the Health Commission, the department, or both? To whom are the vehicles issued? What is the policy of the department and the commission in regard to issuing motor vehicles? Where are the motor vehicles stored overnight?

The Hon. Jennifer Adamson: I will ask Mr McKay to respond.

Mr McKay: A number of issues are involved. One of the problems is that the health area is very large. We have taken the view that motor vehicles that are issued to health units are the responsibility of those units. Does the question relate to vehicles under the control of the health units or under the direct control of the commission?

Mr BECKER: I would like to know how the economics are controlled. There must be an overall policy.

Mr McKay: Basically, the overall policy is similar to that adopted by the Government generally. Cars are not issued on a personal basis except in specific instances where the officers concerned require the use of a vehicle to undertake their duties. The majority of vehicles are garaged in various places; for instance, the Health Commission has a garage in Pirie Street where vehicles are housed overnight. Vehicles are allocated to health centres. Approval for an officer to continuously take home a vehicle under the control of the commission is given by me as Chairman or by individual health units in regard to the vehicles under their control.

Generally, the vehicles are stationed at the headquarters of the organisation. The same rules apply as in regard to the overall system. The commission has recently agreed to reduce its directly controlled motor vehicle fleet by about 15, from a total of 50 vehicles, as a result of the Government's decision to reduce its vehicle fleet by at least 10 per cent.

The Hon. Jennifer Adamson: I am not sure whether Mr McKay's answer covered, to the satisfaction of the member for Hanson, the broader question of how far we pursue programme performance budgeting down to the last paper clip. I will ask Mr McKay to address himself to that issue.

Mr McKay: The Health Commission has found it very difficult, as the honourable member can understand, to go very deeply into defined programmes of programme performance budgeting because of the health institution system. Problems arise in an institution such as the Royal Adelaide Hospital, which conducted a cost allocation study that identified nearly 280 individual cost centres that perform different functions. We are continuing to develop the programme and it has still to be finalised. Mr Cooper, who has been closely involved with Treasury in the development of programme performance budgeting, may like to comment.

The Hon. Jennifer Adamson: I will ask Mr Cooper to elaborate in that regard, but for the information of the member for Hanson I point out that, while the extraction of this information primarily for the purpose of examination by the Budget Estimates Committee may appear to be pursued to the nth degree so that one might wonder whether it is justified, I am assured by Health Commission officers that, as the year progresses, the information that is extracted in programme form is of inestimable value to the commission in its planning functions. Mr Cooper, as Directer of the Corporate Sector responsible for the planning division, may like to elaborate on how that occurs.

Mr Cooper: Three points are worth making. At present, our fixed asset information involves only buildings or institutions; we have not gone beyond that. Earlier in the day reference was made to difficulties in regard to manpower figures, and so on. Although the format of these documents must be consistent across Government, they are largely designed to suit a Government agency that is providing a direct service. That creates difficulties for us, because we are a funding agency, in turn passing on money to other people. Certainly, when preparing these documents, we, at most, make preliminary allocations to other agencies, and at that point those agencies must decide precisely what they will do in terms of employing staff, and so on.

We encounter difficulties because of the sheer size of the commission. We try to incorporate all cost information, but we can go no further than that. Some other Government departments try to go beyond what we would regard as a cost centre. The members of the commission make great use of the information throughout the year. It is a way of analysing, describing and monitoring the purposes for which commission money is allocated and spent. We have not previously done that. It is much more useful in a management sense to think about the provision of services to the elderly than it is to think about the provision of recognised hospital services which traditionally provide all sorts of things.

The Hon. Jennifer Adamson: It is of great value for a Minister to be able to monitor the manner in which a Government policy is implemented. Without that monitoring it is virtually impossible to identify the Government's success in expanding resources for community health and preventative health, because those services are provided through a multitude of agencies. Without this sophisticated programme performance system, there would be no way that a Government could effectively monitor the manner in which its policies are implemented and the manner in which its resource allocation priorities are fulfilled.

Mr BECKER: It is a matter of where one draws the line.

The Hon. Jennifer Adamson: We are a long way from paper clips.

Mr LYNN ARNOLD: I am conscious of the short time left, so I will ask my question in three parts. First, I refer to the Health Commission's policy and the policies of individual hospitals with regard to people who, for financial reasons, have difficulty meeting bills from hospitals. A constituent who was an outpatient at the Royal Adelaide Hospital approached me with a final notice for prescriptions that he had filled by the Royal Adelaide Hospital, in relation to a tumor condition and epilepsy. He has suffered from

these complaints for a long time. I presume that there must have been a policy change, because he has not approached me before.

My constituent was required to fill out a questionnaire to which he does not object. The first part refers to his status (he is an invalid pensioner) and his wife's status (she is a part-time teacher), and he accepts that. However, he found the next section personally intrusive and objectionable, because it asks for expenditure details in relation to rent, mortgage, household insurance, food, clothing, loan repayments, vehicle expenses, electricity and gas, and so on.

His contention is, quite rightly I believe, that an invalid pensioner receiving an invalid pension (his wife only works part-time, but not enough to upset his invalid pension) is obviously in financial need, given the expensive payments he has to make for the prescriptions. He also objected to the end of the document which requires a declaration but does not offer one an opportunity to say how much one can afford to contribute in payment of the amount. That part of the document states:

I declare that I will contribute the rate of fees prescribed by the board.

There is no option for one to make an offer and for that offer to be entertained. He found the form intrusive and he also found it highhanded. I gather, because he has approached me, that it is a change in what he has previously had to submit to.

My next question relates to people potentially in need. I asked the Minister a question in the House about multiple births and the billing policy. A multiple birth mother is billed, the first child gets in free, and the second child and beyond are billed as full patients. I think that the term 'user pays', when considering how much use they make of resources, is hardly correct. The Minister's reply was that there seems to be no cases of financial disadvantage. I am worried about those people who cannot take out health insurance because they cannot afford it, who are not eligible for free hospital service and who, by virtue of circumstances well beyond their own control, have a multiple birth on the way. If they have a multiple birth on the way they cannot take out insurance, because the waiting period for pregnancy accounts is, understandably, nine months. I am concerned that these people could suffer some financial disadvantage. It should be remembered that one birth in 80 is a multiple birth. I am fully insured privately, but I am conscious that the health insurance that I am paying doubtless is partly paying these costs to hospitals. I become concerned for those who could not afford health insurance and who, therefore, could end up paying the bill.

My last question relates to mentally retarded children. I have a constituent who has tried to care for a mentally retarded son at home. The family has attempted to arrange integration of the child into a normal school and, after 14 years of considerable difficulty and stress on the family, they feel now they must have some support, either by short term residential care or, unfortunately, permanent residential care.

They have been led to believe that there is a shortage of beds in Strathmont and that they would not be able to get their child admitted. They also lament the fact that short term residential care is not sufficient in its availability. I acknowledge that places like Downey House in my electorate have been created under this Government, and I commend it for that. However, as I have said in the House, I believe that service should be extended. It is an insufficient answer to my constituent to say, 'Well, there's a programme and it's very good, except you probably can't get in'. That does not answer their particular problem.

The Hon. Jennifer Adamson: The answer to the honourable member's first question about the Government's policy in relation to the recovery of fees (which was also covered in his second question) is provided in *Hansard* by my colleague the Hon. Mr Burdett, in reply to a question on notice of 10 August this year. That reply summarises the Government's policy in relation to hospital charges as follows:

- no patient is to be denied treatment through inability to pay;
- authorises Hospital Boards of Management to remit accounts in full or part in cases of financial hardship; and
- permits charges to be waived for preventive health services in respect of uninsured patients where such charges would seriously inhibit people taking advantage of those services.

In regard to invalid pensioners, if the honourable member's constituent was an invalid pensioner he is automatically eligible for free health care as a Commonwealth cardholder. I am wondering whether the member's constituent might be confusing the questions posed by the Department for Social Security with questions that he thinks have been addressed to him by the Royal Adelaide Hospital. If the honourable member can give me the form, I will pursue the matter on his behalf. In relation to multiple births, the Committee recognises that the honourable member would know better than anyone else the cost associated with that type of birth. That question is really answered in the Government's policy document.

In regard to the intellectually disabled and their needs, the establishment of the Intellectually Disabled Services Council and the allocation of an additional $500 000 to that council is recognition by the Government of the needs of people like the member's constituent, and our determination to provide much more by way of community based care instead of institutional care. In other words, we want to establish many more Downey Houses. The member has identified a prime example of the kind of thing that the Government intends to do by way of policy, and intends to ensure is done through the provision of additional resources.

A great backlog must be cleared, but the cost of providing that community based care is much less, and, in most instances, is much more appropriate than institutional care. Much more education is required in relation to the community, families and the professionals engaged in institutional care who are reluctant to see the status of that care in any way diminished.

There is a shortage of beds in institutions and there is no denying that. The only way that that shortage will be effectively overcome is by transferring resources to community based care, which will enable us to provide many more places at a much lower cost than is presently the case. One cannot undertake such a turn-around quickly, but that is the direction in which we are going.

[Sitting suspended from 6 to 7.30 p.m.]

The CHAIRMAN: Before calling the member for Mawson, I indicate that in view of the time constraints I will call for questions from either side on a one-for-one basis.

Mr SCHMIDT: I refer to community health service programmes. I note that there has been a substantial increase in the allocation of funds for the Christies Beach Community Health Centre and the Morphett Vale Community Health Centre. I realise that the figure for 1981-82 in relation to the Morphett Vale Community Health Centre is due to the fact that it was open for only a short period of time before the end of the last financial year. However, this year the sum of $222 800 has been allocated. Will the Minister outline where those funds will be used, and can she say what expansion of services have been provided in regard to the community health service line?

The Hon. Jennifer Adamson: Mr Ray Sayers, Executive Director for the southern sector, who is responsible for that area will give those details.

Mr Sayers: In relation to the community health centres at Christies Beach and Morphett Vale, there will be an expansion of services during the coming year. For the Morphett Vale service, the commission has already approved additional positions: one full-time psychiatric psychologist, one full-time social worker, and a part-time speech pathologist. In regard to the Christies Beach centre, further funds have been allocated for expansion, but at this stage the board of management has not addressed that matter. No doubt, it will be employing more staff in that centre. Also, additional funds have been made available for further research programmes in the southern area of Adelaide. An additional $8 000 has been made available to assist the research officer who currently works from the Morphett Vale centre. Therefore, in both cases the increased allocation of funds reflects an increase in service provision.

Mr HEMMINGS: I refer to the programme 'Environmental and occupational health services' outlined on page 80 of the yellow book. The Minister would be well aware of the problems at the east wing, levels 7 and 8, of the Royal Adelaide Hospital, where I understand a ban has been placed on all work in that area. There was an unfortunate incident in this House some two weeks ago in relation to blue asbestos. Whilst I fully recognise that the Industrial Safety, Health and Welfare Act is not under the Minister's jurisdiction, I point out that certain bulletins are issued by the South Australian Health Commission that attempt to ensure that people working with blue asbestos do so under certain safety codes.

I understand that, in regard to the work being carried out on levels 7 and 8 of the Royal Adelaide Hospital, no-one from the occupational health branch has been to that area. Will the Minister tell the Committee exactly what part her department has played in ensuring that workers in that area are protected? I have inspected the area and I understand that the work being carried out entails the removal of asbestos in riser ducts. I have only one bulletin with me, but it details the practice for safe disposal of waste asbestos insulation, which practice has not been carried out in the area to which I referred. Will the Minister tell me whether any of her officers have been to that area, and whether the code of practice has been adhered to?

The Hon. Jennifer Adamson: I assume that the member for Napier has read the response to questions directed to the Minister of Industrial Affairs which is provided in the *Hansard* report of the relevant Estimates Committee. That report covers the general points that the honourable member has raised. In regard to the specific points raised, I mentioned earlier that Dr Keith Wilson is not available, because he is attending a meeting interstate, although he was available until mid-afternoon to answer questions such as the one the honourable member has raised. Therefore, I shall have to ask the indulgence of the honourable member to take the question on notice.

Mr GLAZBROOK: I refer to the subprogramme 'Chairman's Office' on page 18 of the yellow book. Will the Minister provide the names of employees holding positions in that office, in relation to mental health, medical co-ordinators, and perhaps the position of principal nursing officer? Will the Minister provide details of the job specifications, where they were formulated and details in relation to annual salaries? The only reference I have been able to find is on that page.

The Hon. Jennifer Adamson: It is not the normal practice to identify employees by name.

Mr GLAZBROOK: I am sorry, I was referring to their positions.

The Hon. Jennifer Adamson: The Chairman will respond to that question.

Mr McKay: A number of positions, especially those of advisers that existed under the previous organisation are now contained within what is called the Chairman's Office, following the reorganisation of the Health Commission into sector organisations. Within that office there is the Director of Mental Health Services. It is a requirement under the Mental Health Act that there be a Director of Mental Health Services. I am quite happy to provide the job descriptions to the honourable member later rather than go into detail on that matter now. In regard to the other two consultant advisory positions, one position concerns child and maternal health for which a specialist is employed, and the other is in relation to aged care and geriatrics. The Chairman's Office also comprises myself, the Deputy C.E.O., as well as a number of support staff, and the secretariat to the commission. The part-time commissioners also come within that office. If the honourable member would like a detailed organisational chart of the Chairman's Office as well as job descriptions I am happy to provide that information.

Mr McRAE: I would like figures in relation to bad, doubtful and outstanding hospital accounts as at 30 June, which figures were supplied to the Parliamentary Library research staff but which were subsequently withheld and shredded? Will the Minister give an undertaking to supply those details to the Committee?

The Hon. Jennifer Adamson: I explained earlier that the information which was unwittingly provided and later retrieved has not yet been verified with the hospitals. As soon as it is verified that information will be provided in the annual reports. If that verification should occur within the next few weeks (in other words, during the time of this session of Parliament, which presumably would be prior to the publication of annual reports) I would certainly be very pleased to make it available to the honourable member. I now ask the Chairman of the commission to outline the procedures by which that information is verified between the health units and the commission.

Mr McRAE: On a point of order, Mr Chairman, we have only 20 minutes left. I am not seeking such information. There are many other questions we wish to put in the next 20 minutes. I would ask that we proceed on a one-for-one basis across the table.

The CHAIRMAN: That being the case, I take it that the honourable member does not wish any further information?

Mr McRAE: No, Sir.

Mr HEMMINGS: I would like to return to the question of blue asbestos at Royal Adelaide Hospital. I understand that the Minister has said that the competent officer who could provide me with the information is not now available, and she is going to give me a reply later. Returning to the question of the work on levels 7 and 8 of the East Wing of the Royal Adelaide Hospital, I refer to the reply given to the Deputy Leader of the Opposition by the Minister of Industrial Affairs on 10 August 1982, where he said, in part:

> It was only yesterday that the Minister of Health issued a public statement pointing out the exact circumstances of the so-called problem that had arisen at the Royal Adelaide Hospital. First, the maintenance work at the Department of Community Medicine at the Royal Adelaide Hospital has been carried out under the supervision of the University of Adelaide Safety Officer and has been inspected by a technical officer of the Occupational Health Branch of the South Australian Health Commission. The maintenance work involved the removal of ceiling tiles to get to electrical connections and was not an asbestos removal job. Because there was a potential to disturb in-house asbestos, the area has been sealed off for protection and no-one has been endangered in any way.

Has a member of the Occupational Health Branch of the Health Commission been present in the areas of levels 7 and 8 to ensure that the provisions under bulletin 22 have been complied with? To my knowledge, gained from all the people to whom I have spoken working on that area, no-

one from the South Australian Health Commission has ever been present on those levels at any given time.

The Hon. Jennifer Adamson: In order to ensure that the answer is absolutely accurate, I would prefer to take that on notice and provide it in writing, because I do not have an officer here who can verify that one way or the other.

Mr BECKER: I refer to page 20 of the yellow book, under the heading '1982-83 Specific Targets/Objectives: (Significant Initiatives/Improvements/Results Sought)', the following comments appear:

Additional private hospitals are to be included in the South Australian Hospitals Morbidity Collection.

Redesign of monthly summary data collections from hospitals and formulation of appropriate indicators of hospital performance.

Development of guidelines for assessment of levels and types of dysfunction of disabled, handicapped, or elderly frail persons.

That is the sentence that throws me. Who will collate the data and who will be responsible for the development of the guidelines for assessment of levels and types of dysfunction of disabled, handicapped, or elderly frail persons? Whose responsibility is that?

The Hon. Jennifer Adamson: I will ask Mr Cooper to provide the specific answer, but I preface that by saying that the need for the commission to have accurate information about the level entitled 'dysfunction and disability in the elderly' is becoming more critical as each year passes and, as we face what could almost be described as an epidemic in health terms of diseases associated with ageing over the next two decades—

Mr BECKER: Yes, 15 per cent of the number.

The Hon. Jennifer Adamson: Yes. The number of people aged 75 years and more will double in Australia in the next 10 years. I will ask first Dr Kearney, and then Mr Cooper, whether they have anything to add.

Dr KEARNEY: That relates to the assessment of patients requiring nursing home-type care. As part of the development of the concept of assessment, we are attempting to introduce the levels of classification of disability which are now internationally recognised in I.C.D., which are international classification codes. It describes the various levels of disability, and we could certainly table that, although we do not have it at the moment. It is not fully implemented, but, as part of the education of all health staff involved in disability, we are attempting to ask staff to complete that when they are seeking admission of patients to nursing homes, first in the Government area in relation to the nursing home-type patient arrangements, the recognised hospital system and, in the longer term, we hope as a general classification to be used in assessing a person's disability and needs for long-term institutional care.

The Hon. Jennifer Adamson: I think Dr Kearney's answer has covered the question.

Mr McRAE: May I, in the last 10 minutes of this session, clarify the Opposition's position on one point raised by the Minister during the course of the day and that was that we were in the game of battering public servants around the ears. We are not. We are professional politicians, accustomed to being battered around the ears, and so we should be. We expect the same high-level performance from our own public servants, so there should be no reflection of ill will, animosity, or anything less than objectivity, so far as the Opposition is concerned.

The CHAIRMAN: I do point out to the honourable member for Playford that the understanding is that all questions are directed to the Minister; it is not the role of the Minister's advisers to be cross-examined, and no reflection should be made on them. All criticism must be levelled at the Minister.

Mr McRAE: I accept the ruling. Having said that, I would like to put the final question on notice. It appears to the Opposition that the number of people who would qualify for health cards was grossly underestimated in relation to the agreement which was signed last year. Indeed, as I understand it, the Minister earlier today drew attention to the fact that the Commonwealth forces are somewhat hard-headed on this matter. Whether it was or was not, a plain fact is being sought. The Opposition is now seeking an estimation as to the number of South Australians who qualify for a health card or a pensioner health benefit card in our system. I accept that that must be given on notice, and I ask only for an assurance that an answer be given in due course.

The Hon. Jennifer Adamson: I think the member for Playford may have been out of the Chamber when I did provide the specific answer earlier in the day. He will find the record in *Hansard*. I draw his attention to the fact that the number of people who hold health insurance is not necessarily a guide to the number of people who will use the system. The number of card holders who, by their very nature, embrace the elderly and the disadvantaged, are more likely to be heavy users of the system than are the numbers of people who are insured, or even those who are not insured. In other words, we can expect the eligible people to be the greatest users of the system, and in fact that has transpired.

Mr McRAE: Will the Minister in due course say how many South Australians qualify for a health card or pensioner health benefit card?

The Hon. Jennifer Adamson: Earlier I gave an approximate figure of 300 000 as at March this year, but I will seek a precise figure from the Commonwealth Department of Social Security.

Mr SCHMIDT: The bed occupancy rate at Northfield during 1981-82 was 77 per cent, whereas for this year it is expected to be 93.4 per cent, which would seem to indicate a substantial increase over the past 12 months. Over the same period the average length of stay at Northfield has fallen from 96.4 to 68.8. Can the Minister say why the average daily cost of feeding a patient at Hampstead is $4.57, whereas the daily cost of feeding a patient in a comparable size nursing home is $1.83 and at Ru Rua $2.66. Why should the average cost of meals be so much higher at Hampstead?

The Hon. Jennifer Adamson: I will see whether I can get that information.

Mr HEMMINGS: I have a further question concerning blue asbestos at the Royal Adelaide Hospital. Regulation 39 of the Industrial Safety Code Regulations made under the Industrial Safety, Health and Welfare Act provides:

(1) *(a)* The occupier of industrial premises shall ensure that the mineral crocidolite (blue asbestos) is not used in or upon such premises.

(b) Where crocidolite has been used before the date of operation of this regulation on or in connection with any plant, equipment or installation the alteration, dismantling, maintenance or repair of which causes or is likely to cause asbestos fibres to be given off, such alteration, dismantling, maintenance or repair shall not be commenced or continued unless approved by the Chief Inspector.

(2) No worker shall be exposed at any time to concentrations of asbestos fibres in excess of 10 fibres separately longer than five micro-metres, per millilitre of air, unless such worker is wearing approved protective clothing and a full face piece or helmet type air line respirator conforming to the relevant requirements of Australian Standards 1715 and 1716 'Respiratory Protective Devices'.

In effect, that regulation places the onus on the occupier, in this case the Royal Adelaide Hospital, and the South Australian Health Commission has been given the responsibility of ensuring that the workers employed in these areas will not be exposed to the danger of blue asbestos. Can the Minister say whether at any time on levels 7 and 8 of the East Wing at the R.A.H. inspections have been made by

the Occupational Health Section to ensure that the workers on those levels are not exposed to asbestos fibres in excess of 10 fibres separately longer than five micro-metres per millilitre of air?

The Hon. Jennifer Adamson: A reply to that question will be provided along with replies to other questions related to that matter.

Mr GLAZBROOK: What was the outcome of the survey conducted of all nursing home patients in connection with the Health Commission's census? What was the relevance of the survey to the area of policy making? How many nursing homes were surveyed?

Mr Cooper: The survey covered all people receiving care in South Australian nursing homes on the census day last year. I forget how many were surveyed, but the number would be about 6 000. The relevance of the survey to this programme area is that within private and deficit-funded nursing homes many patients are suffering degrees of mental or behavioural disorders which the census identified for the first time. As the number identified was large, it was an important piece of information.

Mr HEMMINGS: I have asked the Minister three questions about blue asbestos and I expect that, as she has not the expert advice available here, I will receive her reply later. If the Minister finds that the Occupational Health Division of the Health Commission has failed in all three areas to which I have referred, what action will she take?

The CHAIRMAN: The honourable member is getting close to asking a hypothetical question.

Mr HEMMINGS: No, with great respect, Mr Chairman. I consider that this subject is a serious one. Even though, without the advice of a competent officer in this area at present, the Minister cannot reply now, I expect to receive replies from her later. If the report on the protection of workers, monitoring of blue asbestos in levels 7 and 8 of the East Wing of the R.A.H., and the removal of asbestos dust is not satisfactory in that it shows that protective work has not been carried out, what does the Minister intend to do about this matter?

The CHAIRMAN: Although the Minister may certainly answer the question, I have given my view on it.

The Hon. Jennifer Adamson: Certainly, at this stage the question is hypothetical. If it proved to be a question that needed to be dealt with, I would take whatever action was necessary to ensure that in future the regulations were adhered to, but I have no doubt that that is already occurring.

The CHAIRMAN: In accordance with the arrangement entered into earlier today, I take it it is still the wish of the Committee that we finish this vote now and proceed to Tourism. There being no further questions, I declare the examination of the vote completed. I thank those officers who have patiently assisted the Minister in what must have been a fairly long day.

Tourism, $4 088 000

Chairman:
Mr G. M. Gunn

Members:
Mr H. Becker
Dr B. Billard
Mr R. E. Glazbrook
Mr T. H. Hemmings
Mr G. R. A. Langley
Mr T. M. McRae
Mr I. Schmidt
Mr J. H. Slater

Witness:
The Hon. Jennifer Adamson, Minister of Health and Minister of Tourism.

Departmental Advisers:
Mr G. J. Inns, Director of Tourism, Department of Tourism.
Mr L. J. Penley, Director, Development and Regional Liaison, Department of Tourism.
Mr A. B. Noblet, Director of Marketing, Department of Tourism.
Mr D. E. Packer, Chief Administrative Officer, Department of Tourism.
Ms A. E. Rein, Chief Planning and Research Officer, Department of Tourism.

The CHAIRMAN: I have to report that Mr J. Slater has replaced Mr L. Arnold. That is the only change, and I welcome those officers who are assisting the Minister. I declare the expenditure open for examination. Does the honourable member for Gilles wish to make any brief comments before any questions?

Mr SLATER: I think I can incorporate them in the first question, if I may. I want to ask the Minister if she is aware of the latest statistics released yesterday by the Australian Bureau of Statistics in relation to the South Australian hotel and motel room occupancy rates for the June quarter of 1982. The figures show a decline of 6.2 per cent over the March quarter figures. The Minister may recall that she made some significant comments, both in this House and publicly, relating to the difference between the March quarter figures and, if I remember correctly, the December figures of 1981. The comment that was made was that it was significant, to her anyway, that it appeared that there was a great tourist boost for the State when we recorded these figures in March.

I do not wish to delay the Committee unduly, by quoting from what was said in *Hansard* at that time and in reply to a question from the member for Brighton, the Minister did make quite extensive comment in regard to those figures. I did make the point that they were selective figures and that they were used in an endeavour to indicate, as I said before, that some great tourist upsurge had occurred in the State. In actual fact the figures need to be considered not on a quarterly basis, but over a much longer period, and I have a comparative statistical table of the Australian Bureau of Statistics figures over a two-year period, and I wish to quote these figures for the benefit of this Committee and the Minister, to show that there has not been a significant change when we use what I believe are significant figures, regarding tourism, in South Australia, and relating to the room occupancy rates of licensed hotels and motels over the past two years in this State.

In the March quarter of 1980 the occupancy rate was 56.8 per cent; in the March quarter of 1981 it was 57.1 per cent and in the March quarter of 1982, it was 60.1 per cent. In the June quarter of 1980, it was 53.6 per cent; in the June quarter of 1981 it was 53.5 per cent; and in the June quarter of 1982 it was 53.9 per cent. In the September quarter of 1980 it was 53.6 per cent, and in 1981, it was 50.7 per cent, and of course, the figures for 1982 are not yet available. In the December quarter of 1980 it was 53 per cent; in 1981 it was 53.5 per cent.

I believe those figures indicate that the upsurge in tourism that was claimed by the Minister in a statement in this House and publicly has not come to fruition; it is more myth than reality. It is noticeable from the figures that I quoted that every year the figures for the March quarter are higher. In 1982 there were two reasons for that: the March quarter (which incorporates, January, February and March)

is the busiest tourist season, and this was accentuated in 1982 by the Adelaide Festival of Arts. Will the Minister comment on the comparison between the figures for March and June 1982? The formula that the Minister used previously shows a decline of 6.2 per cent. Is the Minister prepared to comment, in the light of that decline, on the position of tourism in South Australia?

The Hon. Jennifer Adamson: I am certainly prepared to do that, and I will ask Miss Rein to elaborate. The member for Gilles is confusing the occupancy rate with the number of rooms sold. I point out that the number of rooms sold in hotels and motels in South Australia in the June quarter increased by 3.7 per cent in 1982 compared to the same quarter in 1981. It is reasonable to compare like quarters with like, that is, to compare the March 1982 quarter with the March 1981 quarter. That comparison shows a substantial increase in 1982.

No-one disputes that the Adelaide Festival of Arts is a contributor to increased room occupancy. That festival occurs every two years, and at no time since its inception and since figures on room occupancy have been kept by the Bureau of Statistics has there been such a record of growth in that quarter as there was in the March 1982 quarter. Incidentally, that reflects the situation throughout the State, not only in Adelaide. One would expect that the majority of direct beneficial effects of the festival would bear on Adelaide. Miss Rein will elaborate on the relationship of occupancy rates and rooms sold, and will interpret the figures that were released yesterday by the Australian Bureau of Statistics and, indeed, the figures that the honourable member has cited to the Committee.

Ms Rein: The occupancy rate, as shown from the Australian Bureau of Statistics quarterly accommodation survey, is a ratio of the number of rooms sold to the number of rooms available. Consequently, changes in occupancy rate can be attributed to either increases or decreases in the number of rooms sold or, alternatively, to increases or decreases in the number of rooms available.

Mr SLATER: And length of stay.

Ms Rein: That is basically the number of rooms sold. The figures to which the Minister referred in terms of rooms sold take the occupancy rate and calculate the changes in the number of rooms sold, which is a better indicator than the occupancy rate, although, as the honourable member said, one sees from the table that the occupancy rate has been increasing at the same time. In most quarters there will be not only an increase in the number of rooms sold but also an increase in the number of rooms available. When the rate of increase in the number of rooms available exceeds the rate of increase in the number of rooms sold, there is a decline in the occupancy rate, although more rooms might have been sold and there might have been an increased turnover, and vice versa.

In terms of the June quarter, the number of rooms sold in hotels and motels increased by 3.7 per cent. Sites sold in the State's caravan parks increased by 5.3 per cent over the number sold in the June quarter of the previous year and, because the industry is seasonal, comparisons are made with the comparable quarter of the previous year, rather than with the immediate preceding quarter. Therefore, the combined results for the 1981-82 financial year in relation to rooms sold in hotels and motels show that there was an increase of 3.9 per cent over the 1980-81 figures, and an increase of 5.5 per cent in sites sold in caravan parks over the 1980-81 figures.

The Hon. Jennifer Adamson: I will round off those remarks by drawing to the Committee's attention the fact that a pleasing feature of the year, which in terms of rooms and sites sold was the best since the survey commenced in 1975, is the good growth record in the traditional off-season months, of which June is the most significant. In June an increase of 6.4 per cent was recorded in the number of rooms sold and 10.1 per cent in the number of sites sold, and that is a quite dramatic turn-around in regard to caravan sites in South Australia.

Mr SLATER: I worked on the room occupancy rate figures: I thought that they would be the obvious figures on which to calculate statistics, but I will consider the significance of that later. I draw the Minister's attention to a comment made in the book *South Australia, A Strategy for the Future.* The State Development Council (page 43) states:

> The potential of the local industry has been regarded as promising for many years but its growth rate has been poor and overall results disappointing. Reasons given for the stagnation have included inadequate marketing, lack of international air services, the high cost of domestic air fares, local apathy and a lack of top class attractions.

Is the Minister aware of that comment?

The Hon. Jennifer Adamson: I have read it, and I believe that if the honourable member reads on he will find some positive comments. The statements to which he refers rightly apply to that period from 1973-74 to 1978-79, when the levels of domestic tourism in South Australia barely grew, at an average rate of 2 per cent per annum, which was the lowest rate of growth of any State in Australia. It is interesting to compare that rate with the percentage increase in growth since the Government came to office.

Measuring that percentage increase by trips with the main destination in South Australia, in 1978-79 (taking that as the base year and recognising an average annual growth of 2 per cent in the previous six years), there were 3 412 000 trips; in 1979-80 there were 3 627 000 trips, an increase of 6.3 per cent; in 1980-81 there were 3 879 000 trips, an increase of 7 per cent; and, on the basis of the figures that we have (although it is never wise to project), we are expecting that the 1981-82 figures will represent a continued improvement on that 7 per cent. In other words, we will be edging up towards an annual growth rate of 10 per cent, and that is our target every year for the next five years. If we can achieve that, there will certainly be a very high degree of job creation and economic development resulting from tourism in South Australia.

Mr SLATER: I refer the Committee to page 102 of the Programme Estimates and the commentary on resource variations between the years 1981-82 and 1982-83, in particular the following:

> A reallocation of funds within the programme 'Marketing the State as a Tourist Location' as follows:
>
> Funds of $108 000 will be spent in general planning and promotion offset by reallocating funds from intrastate and interstate promotion and $122 000 in international promotion.

Page 110 gives some indication of where this $122 000 will be spent and states:

> A rescheduling of financial resources reflects the planned international promotional thrust by the department in New Zealand, Asia, Europe, and North America . . . showing an increase in expenditure of $122 000 with no increase in manpower levels.

Will the international promotion be conducted in association and conjunction with the Australian Tourist Commission? The charter of the Australian Tourist Commission is to sell Australia overseas; it is not usually the prerogative of State Tourism Departments. We should certainly ensure that there is no duplication of effort and resources in endeavouring to promote international visitors to Australia. There certainly is a need to develop the international market, but not to the detriment of the intrastate and interstate market which is, and I believe will always be, the largest sector of the tourist market in Australia, particularly in South Australia.

It may be of interest to the Minister and the Committee that the Commonwealth census conducted on 30 June 1981 showed that there were 52 400 overseas visitors in Australia

at that time, and South Australia had only 2 800 of those overseas visitors. South Australia's share of tourists was 5.3 per cent at the time of that census. Where will this $122 000 be spent, and will it be in conjunction with and with the assistance of the Australian Tourist Commission?

The Hon. Jennifer Adamson: We certainly do work in close co-operation with the Australian Tourist Commission in selling South Australia overseas: indeed, our own Director of Tourism has the honour to be the Deputy Chairman of that commission. I would challenge the honourable member's statement that the States do not have a responsibility to sell themselves overseas.

Mr SLATER: I did not say that; I said it was in conjunction with the Australian Tourist Commission.

The Hon. Jennifer Adamson: In that case, I must have misunderstood what I believe I heard the honourable member say. We work in conjunction with the Australian Tourist Commission, and there is a responsibility for the States to ensure that they are included in the package tours of the various tour wholesalers. The primary means we use for ensuring that is by attending the International Tourismus Bourse held in Berlin in February each year. I will ask the Director of Marketing, Mr Noblet, to elaborate on the ways in which we use promotional funds to market South Australia as a destination for international tourists.

Mr Noblet: The amount of $122 000 is an increase over the amount provided last year and is principally directed towards the New Zealand market. Other amounts which will be expended in overseas markets the same as last year will be spent in the United Kingdom and Europe for the International Tourism Fair held annually in Berlin. The appointment has been made of a preferred agent, almost a general sales agent but a preferred agent on a small retainer, to represent South Australia in the German-speaking markets and involving some assistance to the travel trade in the United Kingdom. The principal amounts will be spent in New Zealand, and all are being spent in association with the Australian Tourist Commission. That A.T.C.'s responsibility is to promote Australia as a destination and the A.T.C. invites individual States to participate with it for individual State promotion.

The amount of $120 000-odd in this current financial year will principally be utilised for a media campaign involving television and print media (and that campaign has commenced in New Zealand); for support for an officer of the Department of Tourism who will take up duty in Auckland on Monday week, working as a secondment officer to the Australian Tourist Commission in Auckland; to fund familiarisation programmes, bringing travel agents from New Zealand to South Australia to familiarise them with the product; and to provide some assistance to the travel trade in New Zealand in the production of brochures that will include travel programmes to South Australia. All activities are undertaken under the auspices of and in conjunction with the Australian Tourist Commission and at their invitation.

The Hon. Jennifer Adamson: I round off those remarks by reminding the Committee of figures with which I have already provided Parliament, namely, the international visitor survey figures which were released in about the middle of this year and which indicated that the growth rate of international visitors to South Australia over the two-year period, taking in 1979-81, was in the region of 23 per cent, which is tremendously encouraging to us when you consider that it occurred without any international airport facilities and that it was by comparison with an Australian national growth rate of only 18 per cent. That is the first time ever that South Australia has exceeded a national average visitor growth rate, and it certainly provides a magnificent basis for the work being done by the department now which will undoubtedly bear some very worthwhile fruit as the result of the establishment of international airport facilities.

Mr GLAZBROOK: I refer to an objective detailed on page 101 of the Programme Estimates concerning generally improving knowledge about the industry. Although the Minister is probably well aware of it, I bring to her attention articles which appeared in Monday's *Advertiser* and Wednesday's *News* concerning the amount of $6 900 000 000 spent by Australians each year for the purposes of seeing their country. The article states:

> A survey of the Federal Government has shown that domestic tourism has a great impact on the nation's economy, acting Industry and Commerce Minister, Mr Fife, said.

The article further stated that the amount spent was perhaps far more than anyone has ever envisaged being spent on tourism. Mr Fife was reported to have said that the result of the survey conducted by the Federal Government suggested that tourism was of greater significance to the economy than had previously been thought. If one considers that figure and the gross national product return, it is apparent that one could expect that South Australia should have received between $650 000 000 and $660 000 000, plus what would have been spent by international visitors coming to South Australia; so we could say it would be about $670 000 000.

It is indicated in the Programme Estimates that the direct economic value of tourism to the State is conservatively estimated to have been $320 000 000. Does the Minister agree that there is a tendency to grossly under-estimate the value of tourism? Further, what does the department intend to do to engender a greater awareness of the economic value of tourism to this State, both in economic terms and in the provision of jobs?

The Hon. Jennifer Adamson: Several important issues are embraced in that question. The first concerns the way to improve knowledge about the tourism industry generally. Previously I have outlined to Parliament the need for a tourism awareness campaign and the way in which the department has evolved in regard to the development of such a campaign along somewhat different lines from those originally envisaged, and I refer to a campaign directed to the public. I shall ask the Director of Tourism to outline the manner in which that tourism awareness campaign is to be conducted with initial emphasis on target groups. I shall also ask him to outline to the Committee the proposal to undertake individual case studies of communities in South Australia in order to identify the economic, social and cultural benefits accruing to those communities as a result of tourism. I think people can readily relate to something they know and can understand. Those case studies will have a beneficial effect on not only the communities themselves but also the rest of South Australia, because most South Australians will be familiar with those communities.

In regard to expenditure by tourists, I agree that it is under-estimated. For example, such calculations do not include day trips, which are an enormous source of revenue for a large number of businesses. I ask the Director to make reference to the tourism awareness campaign, and then I shall ask the Chief Planning and Research Officer to outline the survey that is being conducted for which the Department of Tourism is allocating funds to identify more accurately expenditure on tourism in South Australia.

Mr Inns: The Tourism Development Board recognises that one of the greatest needs of the State at present is the conduct of an awareness campaign or programme to make the various sectors of the public in South Australia much more aware of the value of tourism to South Australia both in economic terms and in terms of visitation to key destinations and resorts. As the Minister indicated, it was orig-

inally planned to undertake a campaign which was to commence with a broad thrust. That campaign would have commenced at about this time. However, on reflection and on taking advice, the Tourism Development Board agreed that the whole programme must be sequentially approached and that, rather than attack all the sectors of the public, we should divide them into their logical groups and commence an ongoing programme which not only would have one single thrust but would be a continuing programme.

Such a programme must begin with those in industry; in the initial stages it must also involve State Government departments, which must pe persuaded that tourism is one of the State's most valuable industries. Further, operators and employees in the tourism industry must be equally persuaded before beginning the broader thrust to the public sector itself.

The Department of Tourism and the board believes that the industry itself, which is made up of small businesses not operating in any cohesive fashion, probably does not recognise the value of tourism in the industry. Therefore, beginning at home, one might say, is the first target in such a programme. Financial institutions, local government and the media must all be approached in this programme in a build-up fashion. Then in the mid-part of the programme, or perhaps in about March or April next year, it is planned that it will become something of an on-going public campaign to dove-tail in with what will be the main thrust of our advertising campaign on television, etc.

Therefore, what was initially to be a burst of an awareness campaign, which would have had perhaps two, three or four months intensive approach, is now to comprise on-going programmes tackling the various sectors of the public, beginning with the tourist operators themselves, and eventually leading up to a climax in the form of a campaign directed to the public itself.

The Hon. Jennifer Adamson: I now ask Ms Rein to elaborate.

Mr SLATER: We have only an hour for this section. Government members are stalling for time: a Dorothy Dix question was asked and the Minister gets five people to answer it!

The Hon. Jennifer Adamson: I indicate that I would be happy to have that information put in writing, if the member for Gilles objects to the present course of action.

Mr SLATER: I object.

The ACTING CHAIRMAN (Dr Billard): The Minister has the right to answer questions in any way that she sees fit.

The Hon. Jennifer Adamson: Ms Rein can outline briefly the survey that has been conducted nationally which will provide the Committee with further information.

Ms Rein: As was pointed out earlier, the study—

Mr SLATER: This is a propaganda exercise.

The ACTING CHAIRMAN: Order!

Ms Rein:—is being undertaken by the Bureau of Industry Economics. The figures referred to were from the preliminary results of the 12-month survey. The Department of Tourism has contributed finance for the study to enable the department to generate expenditure figures at the regional level, which we believe we would not have been able to do otherwise. The department expects that the State and regional figures will be available early next year and that they will show a substantial increase over current estimates.

The ACTING CHAIRMAN: I remind the member for Gilles that the first 25 minutes devoted towards this subject was occupied by questions from him: the last 15 minutes has been occupied by questions from the member for Brighton.

Mr GLAZBROOK: I refer to the summary of the programme structure for the Department of Tourism on page 103 of the Programme Estimates. The second part deals with tourism and development and marketing of the State as a tourist location. I am rather concerned about this area. What roles do the department and the Minister play in trying to develop an understanding of the value of tourism at local government level, particularly in view of the lack of understanding of the benefits of tourism in local government areas in relation to employment and what those areas can offer tourists from interstate? Whilst the Minister has provided a lot of information in the House about the development of tourism, liaison with local government has not been pursued and incorporated into planning strategies. Without local government involvement the development of tourism may largely founder.

The Hon. Jennifer Adamson: I agree, and I believe that the Local Government Association and certain metropolitan and country councils would also agree. The fact that the association conducted its own survey was a first step towards obtaining facts upon which awareness can be based. One of the strategies in the tourism development campaign deals with the role that local government can play and its importance in influencing development through its response to planning in local government areas. Specific information in relation to local government's role, particularly through regional associations, can be provided by Mr Les Penley, Director of Regional Development and Liaison.

Mr Penley: Certainly, this subject is taken up in the awareness programme, which has already been described. In fact, local government plays a major role in that awareness plan. It is also fair to say that the appointment of five regional managers in the field, who took up their positions in January this year, will assist in creating a greater awareness amongst local government in relation to the value of tourism and the need to be aware of the planning processes that must be observed. The Local Government Association at the end of last year put together a working party, in conjunction with the department, to outline to its member councils the objectives that they might care to adopt to assist them in the orderly planning of tourism within their areas. That document was adopted by the Local Government Association and is currently in circulation. The subject also gets quite a hearing in the tourist development plan where, again, the awareness of local government in relation to the areas I have mentioned is highlighted. The case studies which were mentioned in relation to the awareness campaign will play a great part in proving to local government exactly what tourism means at an economic level within their own regions. We look forward to those case studies becoming an ongoing proposition.

Mr GLAZBROOK: In relation to the marketing of South Australia as a State, I was interested to hear comments made relative to efforts we made in New Zealand. Will the Minister give an indication of the part that the private sector is playing in funding projects in the joint participation of State publicity, bearing in mind the comments regarding implications for resources in the Budget preparation. The yellow book states:

> The department is at a critical development stage where it requires additional resources to fully implement Government policy in relation to tourism.

I believe that, as awareness comes about, one would expect a greater participation by the private sector in funding projects or in joint projects and joint funding of efforts if we are to achieve the maximum potential in relation to marketing the State.

The attendance to this subject in this Chamber is indicative of the awareness of tourism and what it means to South Australia. We have to go beyond what we have within Government or the Parliamentary system to the wider retail field and the awareness throughout.

The Hon. Jennifer Adamson: I heartily endorse those last remarks. If one monitored the questions addressed to me as Minister of Tourism over the past three years, one would find that the majority of questions have come from the member for Brighton. I regret the apparent lack of interest demonstrated at the Parliamentary level. In relation to private sector involvement in joint promotions, that is an area which the Government has tried to encourage. I pay full tribute to the Director of Tourism and the Marketing Director for the manner in which they have enlisted the co-operation of the private sector and the way in which that sector has responded.

The biggest contributor to the New Zealand project was Qantas with an input of $80 000, with $50 000 for media advertising and the remainder for tickets to enable people to travel to participate. The wineries made a considerable input into the New Zealand promotion, as they did into the South-East Asia food and wine promotion which the Premier took by way of a trade and tourism investment seminar. I believe that Safcol was another major South Australian industry involved in that seminar. We hope to undertake many more joint promotions, as experience has proved that they are good for the State and that they also reap considerable rewards for the operators who participate and who put in funds collectively with other private operators and, together with the Government, they gain group strength and have a more effective impact on their target market.

Mr SLATER: In March 1981 the Minister announced that the Government had approved the provision of Loan capital up to $5 000 000 to be provided through the State Bank for the development of tourist projects. Could the Minister advise the number of loans that have been made by the State Bank under the Tourist Loan Development Scheme, who were the recipients, what amounts were involved and the terms and conditions of the loans for projects involved?

The Hon. Jennifer Adamson: That announcement was made following Cabinet consideration of the recommendations of the Tonge report. It was not made in precisely the terms that the honourable member has outlined but rather with the qualification that up to $5 000 000 had been approved in principle for Budget consideration. The honourable member and the Committee will recall that it was shortly after March of that year that the Federal Government announced substantial reductions in Loan funds to the States and our intention to proceed with low interest loans was thwarted as a result of that reduction.

We consequently turned to alternatives that would enable us to encourage tourist operators who wanted to embark on new developments. In doing so, we discussed the matter at Cabinet level and developed what in effect was an expansion of the Government guarantee for approved loans. With the co-operation of the Industries Development Committee, loans have been approved and, as a member of that committee, the honourable member would be familiar with the details. I have not the information with me, but it could be provided for the Committee.

Mr SLATER: The Minister was correct when she said that there was an expansion of the Government guarantee for approved loans and that such loans would be available, through the Industries Development Committee, for potential tourist projects. Will the Minister indicate details of such expansion?

The Hon. Jennifer Adamson: I said that the committee had previously concentrated largely on the manufacturing industry.

Mr SLATER: Our committee concentrates on anything: we get all sorts of reference.

The Hon. Jennifer Adamson: Nevertheless, a substantial part of the guarantees provided by the committee would be for manufacturing industry. The Department of Tourism developed a booklet to ensure that the tourism industry would be aware of what was available by way of loan guarantees recommended by that committee. I understand that three guarantees have been provided, including one for a motel at Marla and another for motel accommodation at Mannum.

Mr SLATER: How many tenders were received for the department's advertising agency for the period of 18 months commencing 1 July 1982 and who were the unsuccessful tenderers?

The Hon. Jennifer Adamson: I understand that 26 tenders were received. It is not the policy of any Minister, nor has it ever been, to provide details of tenderers, so I do not intend to answer that part of the question, as it would be improper for me to do so.

Mr BECKER: What criteria were used in renegotiating the contract for the advertising agency? When tenders were being considered, was it stipulated that the successful tenderer should be a wholly-owned and controlled South Australian company?

The Hon. Jennifer Adamson: The latter is always a consideration, I suppose, but certainly not a prime consideration. The department was looking for an agency that could best serve it in all areas, including the creative area and the capacity of the department to buy space effectively and to advise on marketing strategies. The Director of the department, with the help of the Marketing Director, may wish to comment on the areas the department considered important in its consideration of tenders for what is, I understand, the largest Government account and, indeed, the second largest advertising account in South Australia.

Mr BECKER: It is considered to be a plum.

The Hon. Jennifer Adamson: Yes.

Mr Inns: The committee appointed by the Minister to examine the tenders that were received (and besides that of the successful tenderer 26 tenders were received) judged each tender on the basis of, first, the creativity put forward in the original documents; secondly, a knowledge of the product that the advertising agents would be required to advertise, promote and market; thirdly, the size of the professional staff, that is, the numbers of professional staff in the precise areas of relevance that were required; and, fourthly, the track record of the various advertising agents that applied.

Many advertising agents that applied had their headquarters in another State but had a small professional staff in Adelaide. The reviewing committee appointed by the Minister considered that it was preferable, given the size of the agency and the advertising required, that we should have a company with its prime professional and creative staff in Adelaide. They were the main areas that we reviewed. The Director of Marketing, with the Minister's permission and the permission of the Chair, Sir, may expand on some of the detail if it is wished.

Mr Noblet: Two other criteria were probably covered by the broad aspects mentioned by the Director, but we were interested, first, in the media purchasing power of the advertising agencies, that is, in their ability to buy media time and space at the most advantageous rate to ensure that our funds would be spread as far as possible. Secondly, we were interested in the ability of the agency to develop a spirit of team work with officers of the department in Adelaide.

We were concerned to ensure that the level of experience and the standard of staff at the agency was such that a good team spirit could be developed for the future, particularly as we were faced with the task of developing a new corporate identity for the State, which has required constant liaison in recent months.

The CHAIRMAN: The normal procedure has been for the Committee now to take a short break.

The Hon. Jennifer Adamson: Unless any officer or member would like a break, I am willing to continue.

Mr SLATER: I complained a moment ago about the time factor as far as tourism is concerned; we only have two hours.

The Hon. Jennifer Adamson: Then let us proceed.

The CHAIRMAN: Order! All the Chair is doing is putting forward the normal arrangements. I point out to the member for Gilles that his colleagues set the time.

Mr SLATER: My colleagues did not lump health and tourism together, so that we have—

The CHAIRMAN: Order! That is not a matter for debate.

Mr SLATER: I simply made that statement.

The CHAIRMAN: If the honourable member is going to argue with the Chair I assure him that the Committee will come to an abrupt end, and he will not be in the Chamber. I have heard the honourable member, over the speaker, arguing in a manner that I did not think appropriate. I am not going to have the rulings of the Chair questioned under any circumstances. If the honourable member is not happy with the rulings of the Chair, he has a course of action open to him. Are there any further questions?

Mr BECKER: I wish to continue on the line I pursued a minute ago and that was that, of all the criteria, I was concerned with the media purchasing power of an agency and the spirit of team work. I admit that I have a limited knowledge of the workings of advertising agencies, particularly in relation to the Travel Centre.

What I want to know now is what expertise did Clemenger have, or what expertise does Clemenger have, over the previous advertising agent, particularly in the media purchasing power, the spirit of team work and a professional track record, because I was under the impression that the previous advertising agency did a pretty good job in the circumstances when they came in. They had to start from scratch to some degree to try and boost up a totally new image and new package in promoting the Travel Centre in South Australia and tourism in South Australia, and even though it was a heavily increased budget, my own observation was that this was an area that had been let run down for many, many years, and it was not on the previous Government's high priority list as regards expenditure.

In view of that and in view of enthusing the people of South Australia to visit their own State, I would have thought that the previous advertising agency had done a pretty good job, because since Clemenger have come in I have not seen anything locally at all; I have not noticed anything in the paper, and not that I watch television very often, but I have not seen anything at all promoting the State, and I was wondering whether the previous advertising agency lost the business because of that television commercial with a person who was promoting the various names of towns and having a glass of wine half-way through it. I quite liked it myself, but I just wanted to know, because I thought they were doing a pretty good job and I would have thought in this field that you would need several years experience before you really became the master of this promotion. Just what credentials do Clemenger have? What previous experience have they got, and do they have connections representing other travel centres or organisations involved in the tourist industry?

The Hon. Jennifer Adamson: Certainly there is no doubting the fact that a good job was done by Wearne Australia Pty Ltd and that has been well recognised and acknowledged by me publicly several times. In terms of media purchasing power, Martin Kinnear Clemenger is a much larger agency with consequently expanded purchasing power. In terms of creativity and capacity to do the job, I will ask Mr Noblet to comment on that, but because it is such a large and important account and one that is rightly regarded by the advertising world as an important account, the Government believed that it was desirable to tender in accordance with accepted practice when the contract expired. The fact that the honourable member has not seen any advertising as yet is no reflection on the agency which was appointed in June and has developed what I would consider to be a superlative campaign, and I am happy to invite any member of the committee who wants to attend a background briefing on that campaign to do so at a session which will be held very shortly and which members of Parliament are invited to attend.

The agency has developed a campaign which is based on a corporate image for the State which was recognised as being an essential part of our future marketing, and I am glad that those little South Australian place name commercials inspired the honourable member. I hope he took a holiday at Port Victoria or one of those other places. I will ask the Director of Marketing to refer to the purchasing power and team work creativity aspect of the agency's capacity.

Mr Noblet: I do not think it is appropriate for me to make comparisons between the purchasing power of the two agencies, but to speak about the purchasing power of Clemenger Adelaide or Martin, Kinnear, Clemenger, as it was at the time of the appointment. It is normal for advertising agencies to use their purchasing power to block book or bulk buy time, particularly on radio and television stations, in their own name, and allocate it to their clients later, as required.

Television and radio air time involves quite significant discounts in relation to the amount of time bought and the unit cost of any particular radio or television commercial is reduced quite considerably. Clemenger, because of its range of clients who spend quite considerable sums in South Australia, has very high purchasing power, probably the second highest of any agency in South Australia. It demonstrated ably to the selection committee that it would be able to buy radio and television time and newspaper space, ignoring rate increases that happen anyway on an annual basis, at a better rate than we were able to achieve beforehand.

Preliminary indications for the new campaign indicate that to be so. We are also keen to develop a spirit of teamwork with agency representatives, particularly with those who had experienced work on travel accounts before. Although the account, and the agency, is based in Adelaide, Clemenger is part of a national network with the ability to draw on expertise in other offices. The key staff of Clemenger Adelaide working on the Department of Tourism account have come from interstate to work in Adelaide; two have worked on tourist accounts before, including the account service director for the agency who spent some time on the Australian Tourist Commission account when he was stationed in Melbourne. Other tourism accounts Clemenger has handled include Western Australia, T.A.A., and the South Australian S.A. Great or Mates of the State Campaign, which that agency operates on a voluntary no-charge basis. The department has been well satisfied to date with the spirit of team work that has been developed. Last year the advertising campaign for the pre-summer period was launched on air by the department in September 1981. The new campaign, which has been developed by the new agency, will be launched on 3 October, next Monday.

Mr SLATER: I ask the Minister a question relating to page 101 in the yellow book where in the final paragraph, under 'Corporate Management Objectives', the final sentence reads:

It is proposed to encourage the development of a number of key major tourism projects which can act as a catalyst for further investment in tourism plant.

I ask the Minister, what does that mean? Does it mean that the Government presently has any particular project under consideration? Is the Government considering assisting a project involving a large international convention centre, estimated to cost $30 000 000, at the West End brewery site in Hindley Street, or any other site in the metropolitan area?

The Hon. Jennifer Adamson: To address a broad thrust of the question, that sentence refers to the development of investment portfolios, which provide information which developers would be likely to seek before they proceed with selection of site or determination of the nature of a project. The department intends to undertake a programme which will commence with the identification of development needs on a priority basis. In other words, where in the State, given the nature of our attractions and the manner in which they are regarded by our target markets, do we need more accommodation for example, more attractions or improved infrastructure?

Recognising that investors will not proceed unless they have a good data base, the department will identify worthwhile projects and prepare investment portfolios that can be offered to potential investors. Those portfolios would allow us to place specific development ideas and proposals before local or overseas investors, and in that way we will be one step ahead of the eight ball if someone wants to spend money and asks how he can spend it. We will be able to present a range of options.

Regarding the convention centre, to which the member for Gilles referred, certainly the Government is actively examining ways and means by which Adelaide could be supplied with a major convention centre of international standard. I am not in a position to comment on any site or to give details whatsoever, other than to say that the Government regards a convention centre as a very high priority.

Mr BECKER: The yellow book (page 113) shows that $167 000 is proposed for international promotions. On what will that money be spent? I would have thought that that sum would not buy very much at all.

The Hon. Jennifer Adamson: The honourable member was not present when the Director of Marketing provided a break-down of that sum and the justification for its expenditure. The answer to the honourable member's question is already on the record.

Mr BECKER: Is it likely that that sum will be increased if the Adelaide international airport proves to be successful?

The Hon. Jennifer Adamson: As to the latter, I have no doubt that that will be the case: as to the former, I would expect the sum to increase progressively on an annual basis, but I believe that that sum is sufficient for this year's needs, if one can ever say that anything is sufficient in terms of tourism marketing allocations. Every Minister of Tourism would obviously like a lot more.

Mr SLATER: Will the Minister provide details of the number of consultants and marketing and advertising agents who undertook work for the Department of Tourism in 1981-82? Who were the consultants and agencies, what was the nature of the work undertaken by them, and what amounts were paid to each consultant and agency?

The Hon. Jennifer Adamson: I would prefer to take that question on notice, because it is quite specific. As far as the officers can ascertain, there were only two consultants—Rob Tonge and Peter Gardner and Associates (in relation to a survey on the number of day trips). I believe that the aggregate sum for the amounts paid is to be found in the Estimates of Payments. I shall be happy to provide the individual sums in writing.

Mr GLAZBROOK: In response to a question from the member for Gilles, the Minister referred to the appointment of principal agents overseas. How many agents will be appointed overseas, either as principal agents or general sales agents, for South Australia? What use is made of the agencies established under the State Development Office through the Agent-General in London and through the agents in Tokyo, the Philippines and Hong Kong?

The Hon. Jennifer Adamson: I will ask the Director of Tourism to answer that.

Mr Inns: The only agent to be appointed outside Australia to work on behalf of the department in this coming financial year will be Hans Lees, who will work through German-speaking Europe. We will not be appointing any other agents besides him, and he is working as a preferred agent, not as a general sales agent. In regard to any other agents who want to do contractual work for specific aspects, we will consider their applications but, at this stage, we are appointing only one.

In regard to South Australia House in London, we are certainly receiving strong co-operation from the Agent-General who is working on our behalf in the promotions that are being put together by British Airways and Qantas out of London to launch their flights to Adelaide. The Australian Tourist Commission in various parts of the world where we are concentrating our marketing efforts, particularly South-East Asia, and through Singapore, New Zealand and Japan, is working specifically on our behalf. We are in constant liaison both directly with those officers overseas and through head office in Melbourne.

Mr SLATER: In relation to overseas activities, particularly in the United Kingdom, is the previous departmental Director, Mr Joselin, undertaking consultancy work on behalf of the department? What payments, reimbursements or emoluments have been made to him in regard to any of his U.K. consultancy work? Are the results of his U.K. work available for the Committee? I refer to a reply that I received last year indicating that Mr Joselin was paid a retainer of $20 000 a year for four years. In addition, there were a number of other possible costs, for example, telephone calls, telex charges, travelling, accommodation and the like. Has the Minister any information about his activities?

The Hon. Jennifer Adamson: The specific details are provided in the answer to Question on Notice No. 179, which was given on 20 September.

Mr SLATER: The Question on Notice has not been answered.

The Hon. Jennifer Adamson: I am sorry, I signed the answer on 20 September, and I will give it to the honourable member now. The former Director of Tourism, Mr Joselin, has investigated the operations of a number of British airports as part of a general review that the Department of Transport is making on the economics of airport ownership and operation. He has represented the Government and participated in the preparation of promotional material for a number of companies in connection with the introduction of direct flights from the U.K. into Adelaide. In addition, he attended and assisted with the setting up and maintenance of South Australia's booth at the International Tourismus Bourse at Berlin. He has undertaken an analysis of the tourist market in the U.K. as it apples to South Australia and prepared recommendations for its servicing, and he has prepared a report on a possible general sales agent for South Australia in the United Kingdom.

The Minister of Transport and the Director-General of Transport can provide more specific information as to the first two undertakings, and I understand from the Director of Tourism that the Director-General of Transport has plenty to keep Mr Joselin busy, in fact, more than the Department of Tourism would have.

Mr GLAZBROOK: Continuing with the promotion aspect and the use of overseas offices, the Minister and the Director may be interested to know that, in response to a question yesterday, the Premier indicated that we must promote tourism even more vigorously than we have up to the present. That statement was made in conjunction with the question of having an agent in Tokyo. The Premier said that the potential for tourism will be quite enormous and that access to the Japanese tourist market will increase tremendously. He also referred to the Wine Train that went to Sydney as a promotion. What co-ordination is there between the department and the State Development Office in the promotion of South Australia as a tourist destination?

Mr Inns: There is continuous co-operation and co-ordination between the State Promotions Unit and the State Development Branch of the Premier's Department relating to work being undertaken in Tokyo. Indeed, during the Premier's own visit to Tokyo he did a considerable promotion, and the department had a sizable input, briefed the Premier's delegation and asked the Australian Tourism Commission representative in Tokyo (Mr LePage) to represent the department from a tourism point of view. Certainly the department agrees with every word that the Premier said: that there is a vast potential in Japan and Tokyo on a number of fronts. Much of the efforts we are now generating within the department take that into account.

Of course, there is a limit to the number of international fronts that the department can work on at any one time, and during this current financial year we have concentrated on three particular markets—the New Zealand, South-East Asian and United Kingdom-European markets. I have no doubt that the Japanese market will loom very much prominently in the very near future.

Mr SLATER: Two letters appeared in the *Advertiser* column 'Letters to the Editor' on 6 September 1982 headed 'Travel Centre Apathetic'. The complaints were associated with the availability of brochures. In part, one letter states:

> The brochure contained small paragraphs on a few beaches in the Christies-Aldinga-Moana area which my friend copied but while standing at the counter.
>
> Before she had finished, the pamphlet and generously supplied pen were virtually snatched from her because someone else was waiting for them.
>
> The total lack of professionalism and apathetic attitude displayed by the staff was disappointing and annoying.
>
> If this is the type of treatment that people from other States face when they approach the centre for help, it is little wonder the S.A. tourist industry is in such a lousy state.

In part, the other letter writer states:

> I obtained a brochure from the South Australian Travel Centre, chose a tour and booked and paid my fare approximately a month before the departure date.
>
> I awaited notification of the itinerary from the tour operator until several days before the departure date, then contacted them and discovered they had no knowledge of any application form or money from the South Australian Travel Centre. Fortunately the problem was sorted out and I was able to join the tour. Tourism in this State should be promoted further and used by more Australians, but incidents of this kind should not occur.

The letters were both signed, so the persons concerned could obviously have been located. Were the complaints investigated and were the correspondents contacted? Does the Minister believe that that ought to be the procedure, and are the complaints contained in those letters justified?

The Hon. Jennifer Adamson: I understand that it is an automatic procedure for these matters to be investigated. It is certainly my experience from observation of correspondence being attended to that any complaint of whatever kind is followed up with scrupulous and painstaking care. I am sorry that the remarks that appeared in those letters to the Editor have been read into *Hansard*. I wish that those allegations could be counterbalanced by the vast number of complimentary remarks received at my office and by department officers.

The Committee may be interested to know that the number of inquiries dealt with in the Travel Centre on a monthly basis range from 25 736 in January, 1981-82, to 9 660 in June, 1981-82. That is an enormous number of customers. It would be quite unreal to expect that every single one of those thousands of people would be absolutely satisfied with the service they received. Equally, I think that the member for Gilles would acknowledge that it is devastatingly disappointing to a staff who are doing their utmost (and doing it extraordinarily well) to have the one fault or slip which may from time to time occur, human nature being what it is, highlighted in the manner that those two complaints were highlighted.

I am pleased to take this opportunity to place on record my tribute to all of the staff in the department, not only the staff on the gound floor of the Travel Centre, whose patience, enthusiasm and courtesy is legendary, but also the staff at all levels in what is a small Government department for their absolute dedication and for the quality of service that they supply to the people of South Australia and to visitors from other States and countries. I am sorry that the member for Gilles raised those particular complaints, although I certainly accept the validity of the question 'Are they followed up?'. Yes, they are followed up, and I am glad that I have had an opportunity to put on record a tribute to the exceptionally fine officers working in all departments of the South Australian Department of Tourism.

Dr BILLARD: To what extent is the promotional programme conducted either through television or through the daily press co-ordinated with material distributed through the office? Comments and suggestions have been made to me that improvements could be made if the material handed out relating to different districts in South Australia was co-ordinated so that it was of a uniform standard. The comment that came to me was that one gets roneoed material for some districts and high quality glossy material for others. There may be some benefit if the quality of the material was co-ordinated.

The Hon. Jennifer Adamson: The department and I recognise that there have been deficiencies in this area. The South Australian Association of Regional Tourism Organisations, which is responsible for the production of much of the literature relating to specific locations, also recognises this problem, which was being discussed as recently as last week. We discussed how we can progressively upgrade this information to give a more co-ordinated presentation, thus linking that promotional campaigns. I will ask Mr Noblet to outline how it is proposed that that should be done.

Mr Noblet: Last year a start was made on the campaign by the Department of Tourism with the *Hit the Trail* campaign of South Australia and the 'Many Worlds of South Australia' campaign that was conducted interstate. There was a relationship between the advertising on television and in the newspapers and the brochure material that was made available. The promotion on television in South Australia conveyed the suggestion of the *Hit the Trail* campaign to South Australians who were able to come in and collect a *Hit the Trail* kit, which suggested to them places in South Australia they might like to visit. Interstate advertising took the theme of discovering the many worlds of South Australia, and the promotional book titled *The Many Worlds of South Australia* was launched and matched that theme.

Since the appointment of the new advertising agency a few months ago, the department and the agency collectively have been working on the development of a new corporate identity, or umbrella image, for tourism promotion for South Australia. That work has now been completed, and as new brochures are being printed they are being styled to conform

to that corporate identity of this State. In future, all material that is produced by the department and, where possible, material produced by individual tourist associations and individual operators within the industry, will also conform, so that the travelling public will see some uniformity between the various pieces of literature made available to them.

Mr SLATER: I do not think the question that I asked previously was adequately answered. I asked whether there had been a follow-up to the two complaints made in writing to the press, and whether those complaints were justified. I indicate to the Minister my personal experience in this matter in regard to a constituent and the availability of brochures at the Government Travel Centre. Early this year a constituent asked me about brochures. On her behalf, I offered to obtain some brochures in relation to the availability of various tourist opportunities in the metropolitan area of Adelaide. The person concerned did not want to go too far into the country areas because she was visiting from interstate.

I took the opportunity to go to the Travel Centre and was rather amazed about the lack of brochures available, many of which were stamped 'Not to be taken away'. This occurred early in the year, probably in February, March or April. However, I want to know whether the persons who were signatories to the letters in the press were ever contacted by the department and if things were ever made right, and whether the complaints were justified and the matter followed up.

I doubt whether the staff can be blamed for the problem: it may have been because of an organisational problem or an internal situation. Who knows? It could have been due to a number of things. It might have been due to the general atmosphere that prevails in the Public Service. I originally asked the Minister whether those two people were ever contacted by anyone from the department in an endeavour to ascertain whether the matter could be rectified.

The Hon. Jennifer Adamson: I understand that one of the correspondents was contacted, that her problems were discussed at length with her by an officer of the department, and that the difficulty was resolved. I understand that no contact was made with the other correspondent other than a general response through the same medium that the correspondent chose, namely, by way of a letter to the Editor.

In terms of what the honourable member describes as a Public Service response, it is fair to say that the Department of Tourism tends to reflect the rather sensitive service standards that are associated with the industry at large. In other words, it knows that it is there to please customers. It is definitely a service-oriented department, many of the people in which come from the private sector and are accustomed to following up complaints. I take the honourable member's point: if an address is on the bottom of a letter in the paper, that person should be contacted. The customer is always right, and we should try to ensure that, if one was not happy in the first instance, one is thoroughly satisfied with any follow-up treatment that one gets.

Mr GLAZBROOK: I refer to page 115, programme title 'Advice and support to tourism development', and to subprogramme 'Identification and evaluation of new opportunities for tourism development'. Does the department keep a register, or has it made a register, of opportunities relative to available sites of land owned by Government agencies which may not be being utilised or which may be up for disposal, and does it also register sites with potential so that it can advise on any inquiries that are made regarding development for projects? Alternatively, do we go out seeking developers to look at the development establishment of those sites?

The Hon. Jennifer Adamson: The member for Brighton has raised a very important point, in other words, the requirement for the Government to use initiative to make every post a winning post in relation to development and investment. I will ask Mr Penley to answer the question. The broad answer is that the department has undertaken so many new responsibilities since its reorganisation. This is one that I would recognise as being important. How far it has been addressed, I am not sure, but Mr Penley can advise the Committee.

Mr Penley: The department has, as the Minister has indicated, over the past four months commenced a register of available land sites throughout the State, utilising the resources of other Government departments. For example, the Highways Department and the E. and W.S. Department have computer print-outs of such land and advise us regularly. We have commenced such a register. It is not as complete as it might be, but as we get our feet on the ground we hope to fine tune that. Also, and more important, we have recorded a list of actual developments in the State and are trying to relate those developments to jobs, employment, and dollars invested in the industry. We are attempting to record available land sites and that will become an integral part of the investment portfolio programme that was described earlier.

Mr SLATER: I notice on page 109 of the Programme Estimates book the subprogramme entitled, 'Policy advice, Tourism Development Board', involving expenditure of $15 000. How is that expenditure made? Who are the current members of the Tourism Development Board? Have there been any changes? Do they receive remuneration and, if so, how much?

The Hon. Jennifer Adamson: I am advised that that sum of $15 000 allocated on a programme basis is that portion of the time of Miss Rein as Director of Research and Planning in servicing the board and providing it with the information that it needed as a background to its decision making. I will ask the Director, who is also Chairman of the board, to elaborate further on that sum.

Mr Inns: That sum also includes board fees of $2 000 per annum that are paid to board members, as well as any expenses that are involved in country visits. The board has made two country visits during its 12-month period of operation. I think the honourable member also asked for names.

Mr SLATER: I asked whether there had been any changes in membership. I believe some of them would have been for a term of one year. Have there been any alterations or changes to membership?

The Hon. Jennifer Adamson: Yes, there have been. I announced those changes by way of a public statement. I cannot recall whether there was any coverage given to that statement, but of the two new members of the board the first is Mrs Elizabeth Manley, who has special expertise in the area of marketing and promotion. She is a director of Birrell, Manley and Cawrse advertising agents, and she is a former Businesswoman of the Year. The other board member is Mr John Sharman, Managing Director of the Grosvenor Hotel. The committee may recall that, in establishing the board, I indicated that I regarded it as important that there should be both continuity achieved by terms exceeding one year, up to three years, and a reasonable turn-over to ensure that the various component parts of what is a very diverse industry had the opportunity to make an input on that board. Another change in appointment was Mr Jack Kew, of T.A.A., who replaced Mr Bob Hardy, a former Manager for South Australia of Qantas, who was transferred interstate prior to the expiration of his term. I should add the Chairman of SAARTO who last year was Mr Cornelius Van Dalen and who this year is Mr George Murphy, and that is an *ex officio* position.

Mr GLAZBROOK: On page 117, regarding Tourist Agency Services, the third paragraph states:

Information and booking services are provided through the agency's offices and the private sector.

I wonder whether the Minister and advisers could tell me how many outside representatives the department has and the delivery mechanism to ensure that the private sector agencies are fully equipped with information and material on South Australia.

The Hon. Jennifer Adamson: That is making reference in terms of the department's agencies. It would be the interstate offices in Melbourne and Sydney. As for the private sector, I will ask the Director if he can elaborate on what I have just said.

Mr Inns: The method by which the private sector is serviced, both in Adelaide and the two interstate offices, Sydney and Melbourne, is the appointment of sales officers in each office and their job is primarily to service the industry with literature, brochures and leaflets.

Mr GLAZBROOK: Are the various locations of the different agencies covered and kept up to date?

Mr Inns: Yes.

Mr SLATER: I refer to co-operation with other States in regard to package tours. On 16 August this year a press statement attributed to the Minister announced that a joint study of the possibility of promoting combined South Australian and Northern Territory tourist packages would be evaluated. It stated that a preliminary evaluation had been suggested for tour packages combining the attractions of both South Australia and the Northern Territory and that it could be extremely popular. What, if anything, is likely to come of that? I was intrigued by a press notice, probably late last week or early this week, which stated that the Queensland Tourist and Travel Corporation and the Northern Territory Tourist Commission announced that they were undertaking a joint and positive measure to promote the north of Australia as a tourist destination. It would appear that, while South Australia has been evaluating the matter, Queensland and the Northern Territory have got together. In view of the situation that has arisen, will a study still be considered and, if so, will it be possible for us to join with the South Australian and Northern Territory tourism people in promoting a package to our mutual benefit?

The Hon. Jennifer Adamson: It certainly will be possible. There is nothing to preclude one State or Territory from having co-operative arrangements with more than one other State. For example, South Australia is working on proposals with the Northern Territory. We are also wanting to develop proposals with the south-west of Victoria in order to develop ring routes. As the honourable member will know, visitors do not like to backtrack—they like to keep on seeing new country and get back to their original location without covering the same ground twice and yet seeing as much as possible. I will ask Mr Noblet to elaborate on the Northern Territory proposals and the stage we have reached with them. Certainly, the Northern Territory could quite profitably work co-operatively with Queensland, Western Australia, South Australia, and possibly even New South Wales.

Mr Noblet: Discussions have taken place for quite some time between the Northern Territory and South Australia over the possible development of package tours linking the two States. In discussing the matter it became obvious that there was a real danger that the States might duplicate the work that was already being done by a number of individual tour operators who were packaging tours up the centre of Australia, starting in Adelaide, or down the centre strip, starting in Darwin. So, we (by 'we' I mean South Australia and the Northern Territory, through our respective Departments of Tourism) decided to make a close study of the existing tours being conducted to ascertain their current viability, look for ways in which the operators could be assisted, also look for gaps that might be evident in the range of tours currently available, and then look for ways to fill those gaps.

We advertised for consultants who would like to undertake that work on behalf of the Northern Territory and South Australia, and we have had a response from 18 different consultants who have experience in that kind of work. A short list of seven has been prepared, but no tender has yet been let. A tender will be let by South Australia because we are acting as the co-ordinating body, although it will be jointly funded by the Northern Territory and South Australia. That tender is expected to be let within a matter of days or, if not, within a week or two.

We are also examining the possibility of joining with New South Wales and Victoria to promote the use of the coastal road from Sydney to Adelaide through Bega, Mount Gambier and the Coorong, and return. We are discussing circle routes with other States, especially with Victoria, for a route from Adelaide through Broken Hill and Mildura. We strongly believe that the pooling of resources with the adjacent States is long overdue because the traveller has no real interest in State boundaries, and the States should combine in the interests of the traveller if not in the interests of avoiding wasteful duplication.

Mr GLAZBROOK: What help does the department give to entrepreneurs who promote their area by developing low-cost accommodation such as school camp sites? How does such help compare to help given to the private sector in respect of other projects, and is it related directly to school holiday operations?

The Hon. Jennifer Adamson: The short answer is 'Not a great deal'. As a matter of policy, however, I believe that this is an area to which resources should be devoted because, although there is little immediate financial return, it must be given a priority because, in spending money in this way, we are encouraging and establishing an interest and awareness in tourism among young people who will one day have their own income to spend on holidays and trips. Today, they are seeing their State and one day will want to see it again, and their appetite for travel will be whetted by their experience as young people. Mr Penley will refer to the low-cost cottage accommodation that the department is helping provide in the Adelaide Hills. This is a pilot scheme in low-cost accommodation.

Mr Penley: True, the department over the past six months has been helping the Adelaide Hills Regional Tourism Association in monitoring the demand for the cottage-type accommodation similar to that provided in England. The work is being done in anticipation that this type of accommodation will be in demand when the International Airport commences operations. We have already produced a brochure and the association has provided a co-ordinator for bookings, etc., and the project is proceeding satisfactorily. It will certainly provide an alternative style of accommodation.

Mr SLATER: Has the Minister approached her Commonwealth colleagues for a firm undertaking that the current curfew at the Adelaide Airport will be maintained? There have been approaches by major airlines to the Department of Transport, particularly in relation to wide-bodied aircraft, concerning the opportunity of coming not only into Adelaide but into other airports (Sydney, for instance), outside of what are now considered the normal curfew hours. Can the Minister ensure also that no action has been taken to expand the airport beyond its present boundaries?

The Hon. Jennifer Adamson: As I recall it, the Commonwealth Public Works Standing Committee gave that assurance. I know that it was sought by the State Government, and I seem to recall the Minister of Transport standing in

this House on various occasions and reaffirming that that is a requirement of the State Government and that it will occur. I simply add that, if we were to be seen to be falling down on ensuring that that continued to occur, I have no doubt whatsoever that the member for Hanson and the member for Morphett would be on our backs very smartly. To my mind there is no doubt that that curfew will remain and that the boundaries will not be extended.

Mr GLAZBROOK: Regarding low-cost accommodation, is the department encouraging local government to look closely at its strategy on planning and zoning regulations to permit the greater use of private accommodation for guest house accommodation? In its policy of pursuing local government in this manner, is it also deciding to adopt a policy on the standards of accommodation to be set for purposes of guest house, boarding house or low-cost tourist accommodation?

The Hon. Jennifer Adamson: The short answer is 'Yes'. I understand that the department has circulated all the hills councils with a view to alerting them to the importance of this. As to the policy on standards, I understand that that is a pretty ticklish area, as the honourable member would know, yet it is an area in which the policy and guidelines that the department has formulated in regard to caravan parks has worked very well and been genuinely observed, showing what a co-operative effort and self-regulation will do in a way that I think is preferable to actual statutory regulation. Obviously, this is an area which would have to be addressed because when one is looking at low-cost accommodation there have to be minimum standards, otherwise travellers can be badly disappointed and the whole thing becomes counter productive.

Mr GLAZBROOK: And safety?

The Hon. Jennifer Adamson: They should be insured under existing health and other regulations. In addition to that, I think there needs to be a set of guidelines. If they are not already in the process of being formulated, I should think that that will occur in the normal course of events.

Mr SLATER: Is the $50 000 grant announced by the Minister in Mount Gambier last week for the relocation of the Mount Gambier Tourist Office contained in this year's Budget?

The Hon. Jennifer Adamson: Yes.

The CHAIRMAN: It is now 10 p.m. I thank the Minister and all officers who have accompanied her during the day for their assistance and co-operation. As I will not be present tomorrow it will be necessary for the Committee to elect an Acting Chairman.

ADJOURNMENT

At 10 p.m. the Committee adjourned until Thursday 30 September at 11 a.m.