HOUSE OF ASSEMBLY

Thursday 15 September 1994

ESTIMATES COMMITTEE A

Chairman:
The Hon. H. Allison

Members:
Mr M.J. Atkinson
Mr M.K. Brindal
Mr M.R. De Laine
Ms J. Greig
Mrs D.C. Kotz
Ms L. Stevens

The Committee met at 11.5 a.m.

Witness:
The Hon. M.H. Armitage, Minister for Health.

Departmental Advisers:
Mr Ray Blight, Chief Executive Officer.
Dr D. Filby, Executive Director, Policy and Planning Division.

The CHAIRMAN: The Committee will be conducted under Parliament House Standing Orders, not Sessional Orders. The normal rules of debate and conduct apply. If the Minister undertakes to supply information at a later date, it must be in a form suitable for insertion in *Hansard*, and two copies must be submitted to the Clerk of the House of Assembly no later than Friday 30 September.

South Australian Health Commission, $669 840 000.

The CHAIRMAN: I declare the proposed payment open for examination. Does the Minister wish to make an opening statement?

The Hon. M.H. Armitage: It is with great pleasure that I present the Estimates for the South Australian Health Commission. On 11 December 1993 the people of South Australia gave an overwhelming endorsement to the Liberal Party's plans to rejuvenate South Australia. The Liberal Government was elected with three main objectives: to eliminate State debt; to create jobs for South Australians; and to improve the quality of public sector services. This budget represents significant progress on all three of those objectives.

Within the budgetary context the broad strategy for the Health Commission for 1994-95 is based on the following:

· the need to return $34.3 million to Treasury as the health system's contribution to debt reduction. This represents 2.5 per cent of the Health Commission's total payments budget.

· the introduction of casemix based funding for hospital services under which hospitals will be paid for the work they do at a standard price. This will ensure that efficient hospitals are rewarded and the inefficient required to make the level of savings necessary for them to meet the statewide benchmark price.

· the exemption of disability services and mental health services from making any contribution to the debt reduction target in 1994-95, in recognition of the relative need for funding in these areas. However, both will be expected to make efficiency gains which will be reinvested in new and expanded services.

· the introduction of an element of competition into the provision of health services through implementation of the contestability policy. Under these arrangements the private sector will be given an opportunity to provide public services if the existing public sector providers choose not to meet the benchmark levels of price and quality.

The major elements of the Health Commission's budget for 1994-95 are as follows. An amount of $34.3 million will be carried forward from the Health Commission's 1993-94 budget allocation. The Committee should be aware that 68 per cent of this carried forward amount ($23.5 million) relates to known commitments as at 30 June 1994 and the balance of $10.8 million relates to provisions set aside by health units to meet future cost pressures—in other words, sound financial management. The net funding arrangements in place with the Department of Treasury and Finance provides for this flexibility and has encouraged improved financial management throughout the health system.

We have provided $11.5 million for three incentive funding pools under the hospital service improvement strategy, a primary health care pool, a booking list bonus pool and an additional throughput bonus pool. The Health Commission received funding of $10.4 million for a twenty-seventh pay at several health units in 1993-94, which will not occur this year. Funding for social justice carries by St John Ambulance has now been transferred to the Minister for Emergency Services from 1 July 1994. This represents a reduction of $6.1 million in the net allocation to the Health Commission for 1994-95. As has occurred over the past three years, health units will be expected to absorb wage and salary increases and price inflation within their budget allocation through increased efficiency or staff reductions.

I am confident that the health system will, once again, meet the budgetary challenge whilst maintaining services. It is worth noting that, despite reductions in the net draw on the State budget by health over the past three years, admissions to recognised hospitals last year increased by 3.4 per cent. It is important to note that it has been possible in this budget to provide additional funding in some areas. Increased funding has been provided for palliative care services, mammography screenings and the cervical screening program.

The capital works program has been increased to $81.5 million, which will include projects targeted to achieve savings from better designed facilities. Major projects to be funded include: $6 million to complete the construction of the Women's and Children's Hospital; the new 86 bed hospital at Gawler, which will also be completed this year, with a further expenditure of $8 million; the commencement of work on upgrading the Accident and Emergency Department at the Flinders Medical Centre, for which $2 million has been allocated this year; $6.6 million to continue the South Australian Mental Health Service decentralisation program; $7.2 million for upgrading country health facilities; and $1.9 million for a new aircraft for the Royal Flying Doctor Service.

I commend the budget to the Committee as a responsible budget in difficult times. In order to assist members of the

Committee to consider the budget details, I have circulated a copy of the blue book with information supporting the 1995 estimates, and I look forward to responding to members' questions about these important health budget lines. I look forward to questions from the Committee.

Mr ATKINSON: I refer the Minister to page 276 of the Program Estimates and the program titled 'Community based services'. The City of Marion operates a community transport service for frail aged residents. This service utilises a contract with a private company (the Minister will be pleased by this outsourcing) for two buses, which are fitted with a hydraulic lift to assist wheelchair access. Since 1987 this service has received a contribution from the Health Commission and last year this was $58 400. Part of this service provides for a paramedical aide for Southern Domiciliary Care clients to meet the special needs of wheelchair bound people. The Marion council has now received a letter from the Health Commission, the relevant parts of which state:

> The Health Commission has been required by Government to reduce its net draw on State finances by $65 million over three years and this has led to an extensive review of all funding provided by the commission. You will be aware from media reports of a number of decisions that have been made. In the general area of community services a significant savings requirement is being asked of most health units. The Marion transport program is one of the services that has been included in this grouping. I regret to advise you that the Health Commission will be unable to contribute any financial resources beyond this financial year and indeed in 1994-95 can only make available $48 000 to your council. This amount has been included in the Health Commission's advice to Southern Domiciliary Care Service and you should liaise with them for release of funds.

The Minister's decision has left the council facing such unpalatable options this year as increases in charges for users of the service or cut-backs in the number of trips available to clients. When all funding is cut in 1995-96, the future of the service itself must be in jeopardy. For many clients this service provides the only contact with the world outside their homes. Does the Minister understand the fundamental importance of community transport services for wheelchair bound people; is there any other group of people more disadvantaged than the wheelchair bound paraplegics and frail aged clients of this service who have had their funds cut by the Minister; and is this the most callous decision yet by the Brown Government?

The Hon. M.H. Armitage: As I said in my opening remarks, this is a responsible budget in difficult economic times. Without wishing to go over old ground or rake over old coals, we all know that difficult decisions are having to be made because of past financial mismanagement, not because we take pleasure in making difficult decisions. However, the budget has been framed in that context specifically as part of the Liberal Government's plan, which it took to the people of South Australia during the months of November and December last year. The member for Spence will probably recall that the people of South Australia gave the Liberal Party 36 members in the Lower House and the Opposition 11, and that was a very clear endorsement of the fact that the State's finances needed to be brought back under some measure of control. Hence, the responsible budgeting in difficult times. This is the budget of the health portfolio. In essence, the honourable member has asked about a transport, not a health, matter.

Mr ATKINSON: It is in your line.

The Hon. M.H. Armitage: Transport matters are not specifically the portfolio responsibility of the Minister for Health. Over the past few years I have been approached by many people, particularly rurally based people, who have complained that access is difficult. I recognise that access to some services is very difficult, but our responsibility is to provide appropriate health services. The honourable member mentioned a unique service provided in one local council area; it is not provided anywhere else in the State. In difficult financial circumstances, we have to take decisions that we may not be able to provide all services in all areas. We cannot provide them around the State, so one could ask why people, particularly in the Marion area, should receive this particular service.

Mr BRINDAL: Pork barrelling.

The Hon. M.H. Armitage: The member for Unley says that it may have been a previous example of pork barrelling. I do not make any judgment as to the relevance or otherwise of that.

The CHAIRMAN: The member for Unley will refrain from prompting the Minister.

The Hon. M.H. Armitage: A large number of councils provide their own transport services. For example, two of the three which I represent provide their own transport services. The health budget has been framed in difficult economic times. We are specifically asking areas to ensure that they cut administration, not services. I hope that members of local government which have had areas pared will look constructively at providing services just as other local government areas do.

Mr ATKINSON: Referring to the Program Estimates, page 272, relating to country health services, did the Minister authorise a payment of $250 000 to the Onkaparinga Hospital as settlement of legal claims made by the hospital against the Health Commission; if so, on what conditions was the payment made; and where is this payment concealed within the financial statements?

The Hon. M.H. Armitage: I am pleased that the member for Spence has asked me this question. It will save me having to write a letter to him later, because I had agreed to answer this matter in response to a question in Parliament. As I indicated in Parliament, this settlement is subject to confidentiality agreements, but I am happy to give the following details. Let us be clear that this is solving a problem not of our making but of the previous Government's making, the Party which is represented by the member for Spence. In trying to solve the problem—and we have been doing a lot of this since we have been in Government—it was estimated that the legal costs of the Health Commission, including Crown Law, to fight that case would have been $200 000 with absolutely no guarantee that if the Health Commission won the case we would be able to collect the money.

So, a commercial decision was made that it seemed a very reasonable way out of the problem, given that the problem had been caused by the previous Government, that the $200 000 and $22 000 legal costs for the Onkaparinga Hospital be combined into a payment, and that was done. As I say, that was a commercial decision to stop further costs in an effort to cause further decay in the budget. They are the figures that I am at liberty to tell the Committee and the financial figures for which the honourable member was asking. I am informed that the amount is debited to the corporate administration costs in the head office line.

Mr ATKINSON: I find it remarkable that the Minister can try to get away with answering so little on this question. The Opposition is advised that the case that the Onkaparinga Hospital had against the Health Commission was unsustainable and had no merit whatever, and that the threat to sue the

commission was entirely empty. What the Minister is saying is that, if someone with no case threatens to sue you and the cost of defending the case will be $200 000, you give them a quarter of a million dollars. It does not seem to me to be very good reasoning, and it seems to me that the case would have been struck out at first instance. Did the Minister seek legal advice on the case before making the payment, and will he release this legal opinion and the Crown Law opinion sought by the former Government which clearly rejected the hospital's claim as being without merit and politically motivated?

The CHAIRMAN: Before the Minister responds, the Chair would ask whether this matter is still *sub judice*.

The Hon. M.H. Armitage: No longer, Mr Chairman.

The CHAIRMAN: The question is permitted.

The Hon. M.H. Armitage: If the honourable member had been listening to my answer instead of thumbing through his papers, he would have heard me say we took Crown Law advice and we acted on it. The simple fact is, and this applies in any of these types of legal cases, that the Government was trying to extricate itself from a situation caused by the previous Government at the smallest cost and pain to the taxpayer. When one assesses any of those things, there is always a risk that the case will be lost. As I said in my previous answer, which I reiterate, if we had lost the case, our advice was that we would have had little opportunity to collect the money.

Mr ATKINSON: I agree you would have had little opportunity to collect the money, but essentially this is a payment from Consolidated Revenue to political allies—

The CHAIRMAN: Is the honourable member posing another question or entering into debate, in which case the Chair will have to intercede? The honourable member asked for a supplementary question. I assume he is about to ask his third question.

The Hon. M.H. Armitage: In dealing with the matter of a payment to political allies, first let me deny that. Secondly, if they were our political allies, they would have hardly leaked stuff to the Opposition.

Mr ATKINSON: We did not receive the leak from the Onkaparinga Hospital. My third question is about wages within the Health Commission. Is Government policy still as stated in the financial statement on page 1.7, as follows:

> Budget sector agencies will be required to absorb the cost of wage increases, if any, during 1994-95 and 1995-96.

The gold book at page 2 reports that the Health Commission achieved a net cash surplus of $34.3 million in 1993-94 which will be carried forward to meet, among other items:

> . . . cost pressures expected to arise during 1994-95 as a result of further wage claims and other factors.

This includes $10.8 million to assist in meeting unfunded cost pressures in 1994-95, and $3 million for award increases expected to occur in 1994-95. Which award increases are expected in 1994-95? How does the Minister rationalise Government policy for a two-year wages freeze for the public sector with this budgetary provision?

The Hon. M.H. Armitage: The answer to the first question is 'Yes.' It has been Government policy for the past three years, as I indicated in my opening remarks. The honourable member also did not hear in my opening remarks that the $34.3 million is to be carried forward from the Health Commission's budget allocation. Of this, $23.5 million relates to known commitments as at 30 June, and the balance of $10.8 million relates to provisions set aside by the health units to meet future cost pressures. In other words, it is sound financial management. The honourable member went on to ask which award increases may be expected, and that has also been the subject of a question in Parliament.

The ANF is seeking an 8 per cent wage increase. The trainee medical officers' award, which is still being negotiated, could be a cost to the system of $3 million. A large percentage of the health budget is for wages, and I point out that a 2 per cent wage increase would cost the sector $20 million. So, given the award increases in this area—just one of those that may occur this year—I do not see it as anything but good financial management for the health units to set aside $10.8 million.

Mr ATKINSON: May I ask a supplementary question, Mr Chairman?

The CHAIRMAN: If it is brief. I do not propose to allow five successive questions.

Mr ATKINSON: Is the Minister saying that the Health Commission is exempt from that announcement in the financial statement that budget sector agencies will be required to absorb the cost of wage increases?

The Hon. M.H. Armitage: No, not at all, because a number of the provisions which have been set aside for health units have been for award claims that have been building up for some time. The units have been prudently managing their affairs. They will be expected to pay those award increases and any that occur in the future. For instance, the trainee medical officers' award has been around for two to three years. As I say, it is prudent financial management.

Mrs KOTZ: First, I congratulate the Minister for the health budget that has been presented on behalf of the South Australian Government. Most people in South Australia would be aware that it has been extremely difficult, under all the circumstances inherited from the previous Government, to put together a budget that is not only financially responsible but does look at a whole range of services within our community with a degree of compassion.

I am also well aware that the Minister for Health has an unique range of knowledge of the health services that is necessary to present to our community in South Australia. So, I congratulate him. Page 271 of the Program Estimates refers to the completion of the private hospital proposal for Modbury. The Minister would be aware that there is a degree of discontent within the Modbury community at the moment because of the public debate which has been initiated through a public scare campaign and which has been assisted by the member for Spence and union executives in some of the unions that purport to support the area of health. This has caused quite some alarm within the community sphere. What is the likely impact of the Modbury Hospital private development on the provision of services to the community? What is likely to happen to staff working at that hospital?

The Hon. M.H. Armitage: First, I thank the member for Newland for her words at the beginning of the question; I am very grateful. We are bringing to fruition this exciting proposal—and I would emphasise 'bringing to fruition' because, as I demonstrated in the House of Assembly in Question Time some time ago, a number of attempts had been made by the former Labor Government to dip its toes in this water.

The current proposal for the Modbury Hospital has three main parts: first, the provision of a 60 to 65 bed private hospital to be built alongside Modbury Hospital and linked to it; secondly, the provision of private sector funding for the upgrading of a number of areas within Modbury Hospital for

public patients, which obviously will benefit public patients; and thirdly, the private sector management of public patient services provided through Modbury Hospital facilities, with the Government retaining ownership of the facilities.

The likely impact of the developments is that there will be improved access to a greater range of services for both public and private patients at the Modbury Hospital campus, significantly with a considerable reduction in costs to the Government. Obviously, if the same or better services can be provided at a significantly reduced cost, it is to everyone's benefit. The provision of the private hospital services will improve access for the local community and overcome the necessity for many people in the north-eastern community to travel outside the region for private hospital services. The proposal, which has been submitted to the Government by the board of Modbury Hospital with regard to public patient services, is based on the full current range and level of Modbury Hospital services for public patients being maintained, together with all current medical education, staff training, research and other programs. So, in other words there is retention of the vast majority of facilities, which people are using as hooks on which to hang a campaign of negativity in relation to this exciting opportunity for the people in the north-eastern area.

Indeed, on the basis of the proposal submitted, it is expected that the range and level of services and education programs will be increased in the public hospital under the private sector management, as has been experienced in similar ventures interstate. The tender submissions, which we have received from Benchmark Mutual Hospital Group and Healthscope Pty Ltd, both allow significant substantial savings without a reduction in the range, level or quality of public patient services. There may be additional funds for new and expanded services in those suburbs.

The officers of the Health Commission are holding discussions with representatives of the Coalition for Better Health, to whom I have extended an invitation for a written submission regarding the Modbury Hospital Board's recommendations. And that is a prime example of the contestability policy of the Government. I had a meeting with two senior people from the ANF less than a week ago, and I made available to them and to the Coalition for Better Health access to persons intimately involved within the Health Commission with the preparation of the submission, so both those organisations are provided with relevant information.

We hope that a decision on the private development can be taken in the next four to six weeks. Under any scenario, the State's finances indicate that there will be some changes necessary in staffing levels and arrangements at Modbury Hospital, but we believe that the private option is the most palatable of all those in relation to the provision of services being maintained. If the Government proceeds with the option of private sector management, the current staff will have a number of options, which include a transfer of their employment from the public to the private sector, to work with the new hospital operator; a transfer within the public sector to another hospital or other public employment; or the acceptance of a separation package. Both the private tenderers have already indicated that they would choose the vast majority of their employees from the present staff in Modbury Hospital. This is what happens; a private operator cannot suddenly set up a hospital with the number of beds that the combined public-private exercise might have without needing vast numbers of staff, and they are not available in the market place unless one goes to the present staff. So, in other words the staff need have no particular concern.

I indicate also that the Government is currently negotiating with representatives of the union movement a transfer agreement to be applied where public sector staff transfer to the private sector in circumstances such as these, and the terms of the agreement will most likely be applied in Modbury Hospital should this process go ahead. In summary, it is an exciting opportunity for the constituents of the member for Newland and similar electorates, and staff need have no concerns.

Mrs KOTZ: Page 274 of the Program Estimates refers to the South Australian Mental Health Service realignment recommendations. I know that the report which was requested by the Minister some five months ago and which was prepared by independent consultants, KPMG Peat Marwick was specifically commissioned because of widespread concern that the previous Government's plans for mental health were fatally flawed. What is the progress in resolving the issues that have been identified in this report?

The Hon. M.H. Armitage: When the Liberal Party came to office it inherited a Mental Health Service with considerable budgetary difficulties, and the service was grappling with a complicated process of change, which had been around for a couple of years, known as the Areas Project. Briefly that project is to develop a number of local multi-disciplinary community services, including such facilities as emergency teams to respond to patient crises in the community, continuing care involving the coordination of ongoing care, supported accommodation, clinics and consultancy services, and importantly, community rehabilitation services.

It also entails a service philosophy of seeking to maintain the client in the community, admission via community teams, encouragement of consumer participation, putting in-patient facilities into local general hospitals, devolving responsibility for those matters to the local general hospital—that goes under the jargon name of mainstreaming—and improving the remaining specialist mental health facilities. The Government certainly supports these changes and, in particular, the creation of the community services from savings in the ancillary costs of running the Hillcrest Hospital campus. The disruption, which had been caused by the earlier removal of the board and the CEO, the appointment of a CEO and so on, led to South Australia Mental Health Services (SAMHS) experiencing considerable difficulties in achieving the financial goals set by the previous Government.

I felt that the unrest in the sector was sufficient for some, if you like, pegs to be put in the ground in relation to the finances, and accordingly I appointed KPMG Peat Marwick as a result of the competitive tender process. In case anyone wishes to know the cost of the realignment project, it was $52 000. This realignment project examined the implementation of mental health reform, its timetable and the budget. Unfortunately, what this realignment consultancy identifies is that the supposed $11 million of savings to be generated, which the previous Government had identified, were just illusory. The consultant suggests that those savings were totally unattainable and ought to be discarded as an expectation.

This presents a number of dilemmas, not the least of which is that many people in the mental health community have an expectation that that $11 million of 'pie in the sky' savings could be applied to service provision: it is simply not the case. What we have been able to do with this realignment project is to develop a four year timetable, which is logical

and budgeted appropriately, and which will provide greater certainty for SAMHS in the completion of the transfer of beds to the general hospitals and the Glenside campus, and the creation of community based teams. The value to the community is that the services are provided where there are cultural, social, family bonds, and so on, hence greater support systems locally for people who need that sort of care.

To that end I am able to say that, coincidentally, patients went into the Noarlunga Hospital psychiatric mental extension of 20 beds literally yesterday. That is a very positive thing for the people in the southern area, as I am sure the member for Reynell would recognise. Earlier this year we opened 20 beds in the Lyell McEwin Hospital, which I am sure the member for Elizabeth would recognise and be grateful for. There is tangible evidence that the process is working and providing facilities where required, but it is unfortunate that the savings which were expected under the previous Government were simply not there and so we have had to realign and re-jig the process. I am confident that the financial program, which has been put down under the realignment project, is attainable, and I am certain that better facilities and health care in the mental health area will result.

Mrs KOTZ: I refer to page 271 of the Program Estimates. The Minister may recall that I made certain comments in a previous question with regard to hospital services when talking about Modbury and the fact that there was a great degree of public alarm brought about by negative comments of members of the Opposition. I refer now to the amalgamation of the Lyell McEwin Health Service and the Queen Elizabeth Hospital. I indicate that the same type of public alarm has been utilised throughout the press in the northern regions as well as in the north-eastern regions. With that in mind, will the Minister outline the service and the budget impacts of this amalgamation?

The Hon. M.H. Armitage: Again, the Government believes that this is a very creative response to what was a considerable difficulty for the health sector. People who have read the Audit Commission report, and in particular people either involved in management or service provision or as consumers of services at the Queen Elizabeth Hospital, would realise that the Queen Elizabeth Hospital was faced with a sword of Damocles since the Audit Commission, given that it was faced with the possibility of a significant reduction in beds and downgrading of its teaching status.

The process of potentially amalgamating the Lyell McEwin Health Service and the Queen Elizabeth Hospital have put those concerns to rest once and for all. The actual amalgamation is designed to address a number of pressing issues with public hospital services in the Adelaide metropolitan area. The essence of the amalgamation sees a commitment to the expansion of the Lyell McEwin Hospital from 180 to about 300 acute beds, together with additional facilities for same day services—surgery and medical procedures—and step-down accommodation to ensure that patients can be sent home in an appropriately planned fashion. It also entails the redevelopment of the Queen Elizabeth Hospital as a full teaching hospital with 425 acute beds, step-down care facilities, same day surgeries, and so on.

Very soon, we will be calling for expressions of interest from the private sector to provide a 60 bed hospital on the QEH campus, as well as the provision of private funding for the upgrading of public health facilities and the possible involvement of public patient services, not dissimilar to what has evolved at Modbury. At the same time, as in the Modbury exercise and as we are committed by our contestability policy, the Queen Elizabeth Hospital's management and staff will be given an opportunity to submit proposals for efficiency gains under the present public sector management and dictates. The redeveloped campuses of the Lyell McEwin and Queen Elizabeth Hospitals will be designed to enable each campus to meet the considerable current and future demands in their areas.

Importantly, the newly amalgamated North-west Regional Hospital Service will be a full teaching hospital with the capacity to attract and retain experienced clinicians, academics, nurses and junior medical staff to both campuses. This will certainly enhance the ability of the Lyell McEwin to provide additional specialist staff, which will be required when the new facilities are commissioned sometime in 1996-97. In the context of that amalgamation, the Queen Elizabeth Hospital has agreed to pursue a number of reforms in the finance and management area, which will yield a significant budget dividend, which will assist us in meeting our budget targets, and which will also provide a source of funds for the provision of equipment, purchases and so on at the Queen Elizabeth Hospital.

To make sure that that process is bedded down properly, we have announced the establishment of an amalgamation steering committee under an independent Chair, Mr Ron Barnes. The steering committee comprises nominees from the board and staff of both hospitals together with representation from the University of Adelaide, given that one of our major intents in this process was not only to preserve teaching hospital status at the QEH but also to upgrade the Lyell McEwin to teaching hospital status, and also from the Health Commission. I hope to receive an interim report within the next six to eight weeks, and the target date for the amalgamation formally is February 1995. Again, it is an exciting project which will see benefits in the north-western area.

Ms STEVENS: I want to pursue a number of questions in relation to mental health services (Program Estimates, page 274). Will the realignment report be made public and, if so, when?

The Hon. M.H. Armitage: I am more than delighted for the report to be made public, and I will organise for members to be given a copy immediately. The reason I am delighted for it to be made public is that it contains the important features of how this process will occur over the next four years, how it will be budgeted, what services will be provided and how. So, I am only too delighted for it to be made public.

Ms STEVENS: Has the timetable for implementation of the devolution process of mental health services been altered as a result of this report and, if so, how?

The Hon. M.H. Armitage: The timetable has been altered, there is no question about that. The process will finish in 1997-98. It has been altered because the savings of $11 million, which are needed to provide the facilities, are not there.

Ms STEVENS: I understand that, but in what way has it been altered?

The Hon. M.H. Armitage: The process has not been altered at all, but the end result of closing Hillcrest (other than for psychogeriatric services) and James Nash House, of Glenside being the focus for acute intensive mental health beds and of having beds in local hospitals and community teams, and so on, involves the same process. The present Government has always been supportive of the process of devolution. Since 1991, when this process was first announced, it said that this is the right process. The difficulty will be if you go too fast and discharge people into the

community without appropriate facilities being provided. All this process does is ensure that those facilities in the community are available for uptake by patients who will be discharged.

Ms STEVENS: What new funding targets, if any, were set by the consultant, and have those been accepted by the Government?

The Hon. M.H. Armitage: I am more than happy to say that the member for Elizabeth will see everything set out on page 27 of the consultancy report. However, I should indicate that the targets were discussed as late as last night at a meeting between the Executive of the South Australian Mental Health Services, the CEO of the Health Commission (Mr Blight) and me. It is agreed that the budget targets are eminently achievable and we are happy with them. They have certainly been accepted by the Government.

Ms GREIG: I would like to commend the Minister for the budget that he has presented. I concur with the statements made by the member for Newland, and I would like to add my appreciation of the way in which the Minister has managed to address the needs of the community, including the clinical and environmental health aspects, involving not only the views and advice of his department and the bureaucracy but also the concerns and needs of the wider community, to which he has paid attention. Of particular interest to me is women's health. Page 276 of the Program Estimates refers to the investigation of the integration of women's and generic community health services. What is the likelihood of a women's health focus being maintained within the integrated regional community health service?

The Hon. M.H. Armitage: I thank the member for Reynell for the remarks she made. As a Minister preparing a budget for the first time I recognise the value of input by local constituents to their members of Parliament and the representations that those members make to me. Government members here today have certainly done that and, in a true bipartisan spirit, the member for Elizabeth and the member for Price have both had input to me on matters of concern to them in their electorates as well. Budget framing is, in many instances, a response to local needs as well as to overall budgetary targets.

In relation, in particular, to the likelihood of a women's health focus being maintained within an integrated regional community health service, as a Government we acknowledge the importance of women as consumers of health services. Indeed, they are the predominant users of all health services in this State, and women's health continues to be a priority within the South Australian health system. It is, however, a fact that, as I have said before on several occasions, we have framed this budget in difficult economic circumstances. In view of those contributions which the health sector was required to make to the overall State's debt reduction strategy, a decision was made that women's health and community health sectors could no longer be sheltered from budget cuts as they have been in the past. We believe that efficiencies which legitimately could be made within women's and community health areas without reducing the level of services provided are predominantly in the areas of administrative and accommodation infrastructure.

For example, some of the staff to client ratios of women's health centres and community health centres are as follows. The Adelaide Women's Community Health Centre has a staff to client ratio of one staff member to every 67 clients; the Dale Street Women's Health Service, one staff member to every 101 clients; and the Elizabeth Women's Health Centre, one staff member to every 127 clients. In the community health area, the Eastern Community Health Service has a staff to client ratio of one staff member to every 20 clients; the Noarlunga Community Health Service, one staff member to every 47 clients; and the Parks Community Health Centre, one staff member to every 62 clients.

By way of further example, recognising that a number of the services provided are vastly different—I do not want anyone to assume that I am making a direct comparison—the Family Planning Association, which provides an area of women's health service which is not, if you like, in the medical model (a view which many consumers of women's health and community health services want to get out of), has a staff to client ratio of one staff member to every 1 029 clients. So, we believe there is an opportunity to capitalise on some administrative efficiencies which can be made.

To that end, a proposal for the future of women's health and community health services is being prepared and will be released next week. It proposes the integration of the three smaller metropolitan women's health centres into a regional health service while maintaining the Adelaide Women's Community Health Service as a statewide service. This particular option gives credence to the priority for women's health in rural areas. It is seen as the best option to increase links with mainstream agencies while ensuring that a women's health focus is maintained within each region. The discussion paper addresses a number of issues pertaining to women's health, including the safeguarding of women's health philosophy and operational autonomy for women's health programs, which will be assured within the regional service frameworks via service agreements and management delegations; the quarantining of women's health program funding, which could be extended to facilitate a redistribution of community health funding into regional women's health initiatives, if necessary; and a separately located and identifiable women's health space feature, which could be accommodated within a regional service concept by developing creative reception or strata title configurations or other options.

Ms GREIG: I refer to page 276 of the Program Estimates and particularly the regionalisation of community health services. What benefits will accrue to the community as a result of this initiative, other than achieving efficiency gains in administrative infrastructure?

The Hon. M.H. Armitage: Again, this is a very important question because, whilst we are keen to achieve efficiency gains, we are also looking to other benefits to accrue. Benefits which might be expected to accrue from a totally integrated regional community health service include the ability for smaller venues to access specialist professionals within a regional service structure rather than attempting to recruit them part-time (and there has been an acknowledged difficulty in attracting professionals to some of these roles in the past); the opportunity to devote more resources to service delivery, as a result of regional administrative infrastructure; the opportunity to rationalise recurrent costs associated with accommodation; and the ability to access a range of venues rather than being limited by service delivery models on a particular site. An integrated primary health care focus would be on a par with other health services within the regional health management framework.

An analysis which we performed of the distribution of community and women's health funding across the metropolitan area revealed quite a large inequity when resources across regions were compared on a *per capita* basis. The

central region currently has a significantly higher proportion of the community health dollar relative to the other two regions. So, to address these inequities across the northern, central and southern metropolitan regions we made the following decisions. The northern and southern community health services would be sheltered from any efficiency cuts in 1994-95 and the central region services would bear the community health service contribution of efficiencies for 1994-95, which equated to an average of 6.7 per cent per unit. The central unit's community health resources are allocated disproportionately across the region, and redistribution will be facilitated to areas of greatest need within the region in developing this regional approach to service planning. So, a number of other benefits accrue as well as the obvious financial ones.

Ms GREIG: Again on page 278 of the Program Estimates, additional funding is identified for screening women for breast and cervical cancer. What are the major developments planned for 1994-95 in relation to these screening services and what are the expected outcomes for South Australian women?

The Hon. M.H. Armitage: In 1994-95 an additional $1.6 million is identified to fund the planned additional screening of women for breast cancer. Our South Australian program is part of the national program for the early detection of breast cancer, and that program is cost shared with the Commonwealth. The program commenced on a pilot basis in 1990-91 and is expanding. Women are screened on a two yearly basis. The projected number of screens for 1994-95 is 55 000, which comprises a mixture of new women recruited to the service and women coming back for rescreening. This number represents a 35 per cent increase in screening activity over the past year, which is certainly a very positive feature for South Australian women. To meet this target, new community-based clinics are to be established at Arndale in the western suburbs and at a site in the northern suburbs, and these will replace part-time clinics at the QEH and Lyell McEwin. The lease at the Arndale site is about to be finalised, and we expect it to open in October.

In addition to the existing mobile unit for screening country women, another mobile unit is to be commissioned shortly, which I am pleased to say has access for the disabled. Funding has been provided in the capital works budget for this financial year for purchasing and equipping this unit as well as equipping the two new community clinics, and that is a $600 000 commitment. In line with the national program's objectives, the South Australian Breast X-ray Service's target is to have 70 per cent of women aged 50-69 years in its screening program. To date we have achieved a rate of 45 per cent in that age group, which is double that achieved elsewhere in South Australia. The service is achieving its expansion without compromising quality or efficiency and it is the only fully accredited breast cancer screening service in Australia. Pleasingly, its cost per screen is well below the figure used by the Commonwealth for funding purposes.

Whilst it is too early to measure the success of the program in relation to its primary performance indicator of reduced deaths of women due to breast cancer, indications are that the program should have a significant positive impact. From the 120 000 screens performed so far, 670 cancers have been detected and, of those, 75 per cent have been small tumours. As most people sitting in this Estimates Committee would realise, the earlier that breast cancer is treated the greater is the likelihood of a successful outcome, so the fact that 75 per cent of the identified tumours have been small is very positive. In relation to cervical screening, again, our program in South Australia is part of a national program and receives Commonwealth funds. The budget for the program this year is $1.4 million.

The program seeks to target women who, whilst they are at risk, are less likely to have regular Papanicolaou smears. These include older, rural and Aboriginal women and women from a non-English speaking background. The screening continues to be provided through the normal service providers, but in some areas these may be supplemented to improve access or to overcome any barriers women may experience in having a regular smear test. The program includes providing information and training for service providers to improve the reliability of pap smears, their interpretation and the treatment of abnormalities. It also promotes reminders and recall systems to increase the level of regular screening, which is so important.

An Aboriginal women's program coordinator has been appointed and in the first stage programs were funded at Ceduna-Koonibba, Nganampa, Port Pirie, Port Lincoln and through the Aboriginal Community Recreation and Health Service. The second round of these negotiations is being finalised and a metropolitan-wide strategy for Aboriginal women is being negotiated. A statewide media campaign is commencing in mid-September which will run through to mid-November. With increased screening the incidence of invasive cancers of the cervix will be greatly reduced. During the period 1989-93, 28 per cent fewer invasive cancers were diagnosed in South Australian women than would have been expected from previous incidence rates, and this is attributed to increased screening activity directed at early detection and treatment. Further reductions might well be expected from the publicity program which we are giving it.

Having had previous experience as a general practitioner, I often hear people talk about prevention of illness. It does not necessarily mean high technology or anything like that. It always impressed me that, if we could get women to have regular smear tests and breast examinations, decrease their smoking and increase their exercise, many of the problems in my portfolio area would be solved. Here we have two immediately concrete examples of good screening programs.

Membership:

Mrs Geraghty substituted for Mr Atkinson.

The CHAIRMAN: As promised, the Minister has very promptly made available the KPMG management consulting report 'Realignment of timetable and budget for the areas project' by the South Australian Health Commission and Australian Mental Health Service. A copy is being provided to both sides for perusal.

Ms GREIG: As a supplementary, when is the commissioning of the second mobile screening caravan to be undertaken?

The Hon. M.H. Armitage: October.

Ms STEVENS: I refer to SAMHS on page 274 of the Program Estimates. In your budget statement and again this morning in your introductory statement, you said that the South Australian Mental Health Service budget was quarantined from any cuts. However, an analysis of that and subsequent information reveals that SAMHS must absorb all CPI increases and any TSPs that it will need to use to achieve any savings in its recurrent budget; that the realignment report, which recommended a strategy to deal with its deficit

over four years, thus avoiding any cuts, has been ignored; that SAMHS will need to find $3 million in savings to come in on budget; that the Government has expressed a commitment to achieving community-based services but no money has been allocated to implement them, including no new money from non-Government sector services; and that the Government has used new Commonwealth national mental health money to maintain expenditure levels from last year rather than create any new services to deal with the Burdekin inquiry recommendations. Will the Minister explain his assertion that there have been no cuts to the SAMHS budget?

The Hon. M.H. Armitage: I am more than delighted to do so. As the member for Elizabeth knows, there is an expectation across the system that wage increases, salary pressures, CPI increases and so on will be met within the budget. That is the standard practice—business as usual. If she, with her connections with the Labor Party and the unions, is able to help us in decreasing those wage pressures, I am sure that people in the health sector will be only too delighted. There is nothing new in saying that. Those budgetary changes will be expected of all sectors.

I discussed the $3.1 million as short a time ago as yesterday evening with the Chief Executive Officer, Jennifer Bowers, of SAMHS and other people. There is an agreement that we all understand where the Government is coming from in this exercise. It has always been the Government's intention to commit $2 million of Commonwealth funding for adult psychiatric services to SAMHS—that was part of the deal—but the money has not yet arrived so that is not part of the budgetary process in the first instance.

Regarding the extra $1.1 million, again, there is an understanding that the Health Commission will utilise its best endeavours to provide from Commonwealth funding, which is still to be identified, an amount that will go to make up that $1.1 million. As yet we are unclear whether the Commonwealth will put any conditions or provisos on the use of that money. Whilst we can guarantee the first $2 million of the $3.1 million difference, the other $1.1 million is more problematical, but we will use our best endeavours in that area.

In the discussion yesterday it was also quite clear that the Government is enthusiastic that the SAMHS board is embracing the seven quick strike projects identified in the KPMG report. I recognise that the member for Elizabeth will not have had time to see it yet, but it includes looking at rostering options which will not only be more efficient but, more importantly, provide services when the patients need them. According to the report there is universal agreement that rostering at present often has high numbers of staff when there is low demand from the patients and *vice versa*. That will change. As well as being good for the patients, we are told there will also be a financial benefit. Rostered days off, which at present are extant in the system, is another feature which may well glean many opportunities for financial savings. Contestability options are again identified in the KPMG realignment project, and the SAMHS executive is enthusiastically embracing them. There are four other areas which are identified in the report, all of which may mean that there will be no pressure for that extra $1.1 million. We had a forthright discussion with SAMHS and it understands the Government's position, just as we understand its position.

Ms STEVENS: As a supplementary question, I gather from what you have said that your use of the word 'quarantined' was an over-simplification of the situation and a little misleading. Does it mean that SAMHS will have to find savings of over $3 million in the next three years?

The Hon. M.H. Armitage: The answer is that it will not, for the reasons I have just identified: the extra $2 million Commonwealth money that we are guaranteeing; our best endeavours to make sure that if in the next round of funding there are no preconditions, we will sort that out with SAMHS for the extra money; the quick strike projects; and, lastly, which I forgot to mention earlier, a commitment in SAMHS to make up its budgetary overrun from last year over the next three years. Whilst that appears to be a large financial commitment in the first year, it is normal bookkeeping practice which, with net funding, SAMHS can repay according to an agreed schedule over the next three years. The specific answer to the question, 'Does it mean that SAMHS will have to look at $3.1 million?,' is 'No.'

Ms STEVENS: Is there a new deficit reduction strategy which has not been announced? Can you provide more details about the quick strike projects, the business about Commonwealth funding and what you have just mentioned as part of that?

Mr Blight: SAMHS overran its budget last year by about $900 000. The realignment project recommended that that amount be repaid, if you like, over a period of three or four years. The Metropolitan Health Services Division has indicated to SAMHS that it is happy for that amount to be repaid over three or four years. However, the method of dealing with it in accounting terms has been to put the whole of that overrun amount into its 1994-95 budget. Looking at the situation in a strictly accounting sense, it would appear that SAMHS was being asked to repay the whole of its debt from last year in this financial year. However, under the rules of net funding that we have been operating for several years now, it is possible for a health unit to carry a deficit from one year into the next.

The Metropolitan Health Services Division has an agreement with SAMHS that, if it wants to absorb only part of the debt this year and carry a block of it into the next financial year, that is satisfactory. That means that SAMHS now has the option of repaying all of its debt this year, and that may be possible if the quick strike projects produce early results. Alternatively, it can carry over a portion of that debt into the next financial year or, indeed, the year after. It is a mechanism which honours the recommendation in the KPMG report that it can pay off that debt over three or four years if it wishes.

Ms STEVENS: Does the Minister still say that SAMHS will not have to find savings of over $3 million over the next three years in various ways?

The Hon. M.H. Armitage: I do not think I can do anything other than repeat myself, and say 'Yes', with the understanding that the member for Elizabeth and I will work on the unions to diminish the wage increases, and other such cost pressures will have to be covered. Other than that, no.

Ms STEVENS: SAMHS is required to fund targeted separation packages out of its budget allocation. What is the projected number of staff that have either taken TSPs or will take TSPs and the total cost that that will entail?

The Hon. M.H. Armitage: Can I clarify that—do you mean within SAMHS specifically or across the health sector?

Ms STEVENS: In SAMHS.

The Hon. M.H. Armitage: In 1993-94, 94 SAMHS employees took TSPs. I will take the question on notice and provide a specific answer as to the cost. The approximate cost is $2.8 million.

Ms STEVENS: What about 1994-95?

The Hon. M.H. Armitage: I am not sure how many will be involved in the future.

Ms STEVENS: So, $2.8 million at least.

The Hon. M.H. Armitage: I will provide the exact figure later, but I am informed that in 1993-94 it is of the order of $2.8 million to separate the 94 employees, who represent 90.5 full time equivalents.

Mr BRINDAL: I refer to page 270 of the Program Estimates and the introduction of casemix funding. Will the Minister explain why he has moved to this system of funding? What are its up sides and, if there are any down sides, what are they?

Membership:

Mr Atkinson substituted for Mrs Geraghty.

The Hon. M.H. Armitage: I am very pleased to address this extremely important question in relation to the funding of the health system. As I think most members would realise, the South Australian hospital budgets had been based on historical expenditure with neither funding to them nor expenditure by them based on their outputs. This payments system, which is still utilised in many States—Lord only knows why—gave no rewards or incentives for efficiencies, and importantly no encouragement for resourcefulness and innovation. The hospital budget levels have built up over decades with a recognised capacity to consume considerable extra funding, not necessarily related to the expansion of service or an improved standard of care.

Maintenance of open-ended funding would have meant moving money from other areas of Government expenditure or making people pay more directly for health services. The Government felt that some measure of hospital performance needed to be developed so that hospitals could be reimbursed for the work and services they provide. We believe that hospitals that are more productive within reason should receive funds for that extra output. Equally, hospitals striving to be more efficient than the industry standard should receive some incentive in the form of savings which can be channelled into further improvement of services.

On 1 July 1994 the system of casemix funding as part of the Hospital Services Improvement Strategy was introduced to drive what is indeed a most fundamental reform of hospital financing. South Australia had been establishing the capacity to undertake casemix funding for some time, and since 1989 a modified form of casemix had been used to adjust the budgets at the margins between three of the metropolitan teaching hospitals. Casemix funding is aimed towards patients receiving a more efficient and higher quality service, booking lists will be considerably reduced and waiting times kept to a minimum. Hospitals are being encouraged to coordinate their services more effectively with community agencies and GPs to improve continuity of care.

As a result of the model, hospitals fall into one of three groups during 1994-95: first, those with fixed budgets either because they are paid by grant or have a rural access grant, and there are 24 of those; secondly, those required to make savings based on their base work load, and there are 24 of those; and, thirdly, those which will receive an efficiency payment based on performing their base work load, and there are 27 of those. We have established two bonus pools to fund additional throughput within the hospital system because the Hospital Service Improvement Strategy, as its name implies, is based on improving services as well as just being more efficient.

The objective of the booking list bonus pool is to provide an incentive to reduce the elective surgical booking list, which is defined as the register of people waiting for elective surgery at the six major metropolitan hospitals. Hospitals will be able to access this pool only if they still have people in urgency category 1—waiting more than 30 days—or category 2—waiting more than 90 days. A non-booking list hospital, either metropolitan or country, can access this pool only if it has contracted with a booking list hospital to undertake procedures from the booking list hospital's list—in other words, if it is directly decreasing the booking lists.

The objective of the throughput pool is to provide a hospital with payment for activities over and above its agreed base workload. All hospitals can access this pool, provided they have a net increase in activity—that is, net of the booking list pool—above the base workload. The payment for this is to be set at 80 per cent of the booking list pool price. As at July 1994 the number of people on the booking list has reduced by 209 from the baseline of March 1994. In the Victorian system, which introduced casemix funding a year prior to South Australia, the first results are that a number of those hospitals are reporting profits, unaudited at this stage, and preliminary indicators are that there is a great reduction in the booking lists, with nearly all urgent cases being removed from the lists and, generally, a noted increase of activity across the system. In essence, we have moved to the system of casemix funding to provide incentive in the system and, in so doing, to reduce costs, improve quality, increase throughput and reduce waiting lists.

Mr BRINDAL: Casemix is, indeed, impressive. By way of information, was the Minister aware of the enthusiasm that the previous Minister had for this and the fact that the Federal Government seems desperate to push other States into casemix, as the Federal Government suddenly has become convert to your cause.

The Hon. M.H. Armitage: I am aware of the fact that the previous Minister (now in Canberra) indicated, when we made a media release that we were moving to casemix funding, along the lines of, 'We would have done it, but not so quickly,' which, I guess, means that he was committed to it. In the valedictory speech of the former Federal Minister for Health, Dr Neal Blewett, he was glowing in his praise of the casemix system. He was also glowing in his praise of the Victorian Minister for going down that path. I was a little offended, as his local member of Parliament, that he was not quite so glowing about the fact that we had taken that path too but, nevertheless, I will speak to him about that at some stage.

Mr BRINDAL: Regarding page 279 of the Program Estimates, Support services, specifically the implementation of service agreements with health units, will the Minister explain what are service agreements and will they impose limits on the range of services provided by hospitals and health centres?

The Hon. M.H. Armitage: Service agreements document the understanding of the Health Commission and health units regarding the funding and the provision of services by that health unit. In general terms, they document the level of resources that the Health Commission will provide and the agreed range and level of services that the health unit, whether it is a hospital or a health centre, will provide in return.

We anticipate they will have a lot of functions, including the definition and clarification of roles and responsibilities of both the commission and the health unit. They will improve

accountability at all levels of the health system for the use of public funds. They will provide a mechanism for ensuring a fair and reasonable geographic distribution of health services. They will provide a mechanism for monitoring, reviewing and reporting progress, so that the achievement of health outcomes can be looked at. They will further devolve responsibilities to health units to provide services, whilst the Health Commission sets strategic directions in achievement of Government policy, and they will provide a mechanism for emphasising continuity of care through coordination of services between the various units.

In particular, service agreements describe the performance commitments of health units; the legislative Health Commission and Government policy requirements to be met; financial competency requirements; evaluation, monitoring and reporting requirements; the level of funding, both capital and recurrent, provided by the Health Commission; and the Health Commission's responsibilities.

In developing these agreements, it has been necessary to be quite specific about the service profile of units. Casemix funding, which requires the determination of the base workload of each hospital, has been a very significant factor in requiring the commission and hospitals to be clear about the work to be undertaken for the resources which we provide.

Implementation of these service agreements has raised some issues for smaller country hospitals. Clarification of workload has identified some hospitals as providing services outside previously agreed service profiles, and sometimes in conflict with the overall regional service strategy. Whilst this has resulted in some hospitals no longer being funded to provide a very small range of services, in the vast majority of services the recent service mix will be maintained. In addition, a provision of $2.5 million by the rural access grant, arrangements within the casemix funding model, will ensure that the 14 country hospitals which have low levels of activity can continue to provide those services.

As at 12 September, the Metropolitan Health Services Division had received four signed agreements. Health unit boards of directors are considering those agreements at their monthly meetings, so the remainder of these agreements are expected to be received during September. Country Health Services has received five signed agreements, and the country health units have received an extension of 14 days to sign them, given the dilemmas of distance or the tyrannies of distance. We anticipate that the vast majority of the remainder will be received by then.

Mr ATKINSON: Regarding page 278 of the Program Estimates, 'Public and Environmental Health Services', has the South Australian Health Commission granted TNT Air Couriers exemptions to carry radioactive freight without signs on the outside of its aircraft and vehicles as required by legislation and, if so, why?

The Hon. M.H. Armitage: I am informed that there are no exemptions.

Mr ATKINSON: How often in the past financial year has the South Australian Health Commission issued notices under section 17 of the Public and Environmental Health Act entitled 'Control of Offensive Activities'? How often has the commission been asked to act under this section in the past financial year?

Additional Departmental Advisers:

Dr K. Kirke, Executive Director, Public and Environmental Health Service.

Dr M. Jelly, Acting Executive Director, Metropolitan Health Services Division.

Dr Kirke: The Health Commission does not issue notices under that part of the Act. The Public and Environmental Health Council, which is established under the Act, hears appeals against notices issued by local government under the Act. In the past 12 months the Public and Environmental Health Council has heard of the order of 10 such appeals from all over the State.

Mr ATKINSON: In relation to the Program Estimates, the funding of programs for hospitals contains nominal cuts of 1.2 per cent for teaching hospitals, 0.9 per cent for metropolitan non-teaching hospitals, 0.9 per cent for country health services, 0.1 per cent for services to Aboriginal people and 4.8 per cent for mental health services. Cuts of a similar magnitude in dollar terms are proposed by the Minister over the subsequent two years and will have much greater impact when the expected rates of inflation of 2.9 per cent for 1994-95 and 3.5 per cent in 1995-96 are taken into account. I refer the Minister to page 11 of Economic Conditions and the Budget, table 3.1—'Economic Assumptions'.

As salaries and wages are the major component of the health budget, the major burden of cuts will fall upon health workers, including nurses and doctors, whose salaries the Government wishes to freeze for two years—with a reduction of 6.4 per cent in real terms and closer to 10 per cent when compared with the likely growth in average weekly earnings. The Audit Commission determined that the current earnings of nurses were on a par with other States. Does the Minister believe that a real wage reduction of up to 10 per cent in relative wages for South Australian nurses, doctors and other health workers is sustainable?

The Hon. M.H. Armitage: I remind the member for Spence that we are framing a budget in order to return the State's finances from the perilous state in which his Party left them. The Liberal Party made that quite clear to the people of South Australia prior to the 1993 election, and the difficulties experienced today by the honourable member of having to run between committees is a direct result of what the people of South Australia thought of our respective financial plans.

In relation to the expectations of wage increases and so on within the sector, there is nothing new in that. It has been the case for the past three years that those cost pressures would be expected to be gleaned from within the budgets of the units. Looking at the total South Australian economic picture, I am informed that, in the private sector, large companies and enterprises are making returns to the sector of about 5 per cent on an annual basis. In other words, they have to make 5 per cent efficiency gains merely to stay in business because it is such a competitive world. I am informed that, if we were able to achieve a 5 per cent efficiency dividend across the sector, not only would we return the $65 million in efficiency dividends, which we are returning to the Treasury, but we would have another $65 million on top of that to spend. So I do not believe that, where the private sector—

Mr Brindal interjecting:

The Hon. M.H. Armitage: If we made a 5 per cent efficiency return across the sector, we would have $65 million to return to Treasury for our budgetary component and another $65 million to spend. So I am happy for the public sector to look at those sorts of figures, particularly given that in all of our policies, such as contestability, we are asking them to meet private sector benchmarks. They are

given first opportunity to meet those private sector benchmarks.

Mr ATKINSON: What reduction in wages paid to health workers in South Australia relative to those interstate does the Minister wish to achieve? Will the wage freeze announced by the Government apply to all staff, including specialists and visiting medical staff?

The Hon. M.H. Armitage: I have absolutely no responsibility for wage increases paid interstate.

Mrs KOTZ: I refer to page 276 of the Program Estimates, which relates to community-based services. I have commented previously on the different tactics which have been used to provide our communities with misinformation and which have occurred in the north-eastern and northern communities. Unfortunately, the scare campaign, including the misinformation, is not related specifically to one portion of the State; it is apparently travelling across the State at quite a rate, and the Messenger Press is being used as a purveyor of doom by Opposition members. The lead article on the front page of the *Portside Messenger* published on Wednesday 7 September was headed 'Health lobby fights budget cuts in west', with another item on the same page being headed 'Western suburbs a low priority for Liberal. . . ': what budget cuts have been applied to the community health and women's health services, specifically in relation to the western suburbs, and on what basis were those budget cuts made?

The Hon. M.H. Armitage: I am aware that the community health and women's health services have been sheltered in the past from significant budget cuts but, as I have said, we have inherited a budgetary situation which means that all parts of the health portfolio must at least have an expectation that they will contribute to the attainment of efficiency gains. In the metropolitan community health area those efficiency savings have been identified for 1994-95 as $0.7 million and for both 1995-96 and 1996-97, $1.35 million. Services have been told that they are expected to achieve the efficiencies in non-service areas, such as administrative infrastructure and accommodation, and so on, and that existing levels of service provision are expected to be maintained.

An analysis of the distribution of community health and women's health funding across the metropolitan area reveals an inequity when resources are compared between regions on a *per capita* basis, and the central region has a significantly higher proportion. The proportion of total community health funding allocated by region before and after the budgetary situation can be compared to the proportion of the population in each region. For example, the central region has 39.7 per cent of the population with 51.22 per cent of the budget for 1994-95. Prior to the budgetary situation in 1994-95, 39.7 per cent of the population took 52.7 per cent of the budget.

The northern area had 27 per cent of the population and took 24.95 per cent of the 1994-95 budget, compared with 24.16 per cent in 1993-94; the southern region had 33.33 per cent of the population and 23.8 per cent compared to 23.1. So, there is clearly an inequity, and even the minor changes we have made have addressed to some extent that inequity. The central region is being required to bear the community health service budget cuts on a population basis, and even after those cuts considerable inequities still exist.

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

Membership:

Mrs Geraghty substituted for Mr Atkinson.

Mrs KOTZ: Prior to the luncheon break I asked the Minister a question about services provided in the western suburbs. I outlined the fact that the reason my interest was being directed to this area was certain media headlines which had been quite negative. The questions that we are asking today are obviously eliciting very positive responses from the Minister and the Government. Page 271 of the Program Estimates refers to a dedicated inpatient rehabilitation unit in the western region: will the Minister advise the details of rehabilitation services to be provided in the western suburbs following the closure of inpatient rehabilitation services at the Queen Elizabeth Hospital?

The Hon. M.H. Armitage: I am happy to do that and, picking up on the theme of the member for Newland's question in relation to the western suburbs, I point out that as a Government we were faced with a number of health services decisions in the western suburbs involving our budgetary position as a State, not the least question of which for the Government was the Queen Elizabeth Hospital, its provision of services and the retention of its status as a teaching hospital. Recognising the facts from the social health atlas, which indicated that the western suburbs have a number of high priority needs, we are making plans accordingly. This is a good example of considering the provision of health care across metropolitan Adelaide in this instance, but across South Australia as well, in a planned and organised fashion in response to identified needs. One of those needs, not only in the western suburbs but elsewhere, is rehabilitation services.

The inpatient rehabilitation services at the QEH were closed in September 1991 and then St Margaret's Hospital board proposed the establishment of a 10 bed rehabilitation unit at St Margaret's Hospital. The commission at that stage made available $300 000 annually to cover the increased costs related to staffing, goods and services and so on for the provision of services in that extra 10 bed unit. The sum of $288 000 has been provided for capital works which includes a small extension to the hospital, demolition of the old nurses home and provision of on-site car parking. The nurses home has been demolished. Building work on the extension has commenced and is expected to be completed by early December 1994. During building work the total bed availability at the hospital has been reduced by only three beds.

As a measure of the success, for the period 23 September 1993 to 31 July 1994, 50 patients were admitted to the unit and 43 were discharged, with 95 per cent of those patients making functional improvements in their health. Considering the importance of rehabilitation after injury, stroke, or whatever, it is significant that 95 per cent of patients made functional improvements in their health. Once the new facilities are completed, which as I indicated before is expected to be in early December, the number of patients admitted to the unit will clearly increase. It is a success story, and the collaborative approach which involves St Margaret's, the QEH and the western domiciliary care services as an important component in the western area will result in improved continuity of care for clients in that area and better coordinated inpatient, outpatient and domiciliary services.

Mrs KOTZ: I refer again to community based services and relate that to page 276 of the Program Estimates. The Minister would be aware of certain illnesses that are apparent throughout South Australia. Asthma and other respiratory illnesses are certainly a growing problem. Will the Minister advise what steps have been taken to ensure that our health services respond to these concerns (once again relating this

to the western suburbs where I believe there is a significant, growing concern about this problem), and how will those measures be implemented as part of this budget?

The Hon. M.H. Armitage: A western region respiratory health plan was developed to respond to concerns that the western area of Adelaide had apparently elevated hospital admission numbers for respiratory illness (particularly childhood asthma), elevated levels of the dread smoking, and some community anxiety about air quality. The respiratory health plan is an initiative of the Western Health Services Planning Group and was developed during 1993 by the Western Health Services Planning Unit and the Metropolitan Health Services Division as a national pilot with funding from the Commonwealth Medicare Agreement Incentives Program. The plan was supported in the western area by GPs, the QEH, consumer groups, community groups, local government, community health services, and so on.

It identified strategies for improving respiratory health in the region, including health service reforms for the management of asthma and chronic obstructive airways disease and a program to involve community members in reducing tobacco usage, particularly among young people. In that area all members would realise that the Parliament has taken an attitude whereby a number of legislative changes have been introduced to provide tougher laws in relation to young people having access to tobacco.

One of the strategies is action to better monitor and improve air quality. The plan highlights the need for better coordination of health services to address asthma and a greater focus on primary care. It aims to ensure that every person who is diagnosed as having asthma promptly receives a thorough assessment, an appropriate educational program, a personal written management plan and regular recall and review. As someone who has seen, particularly in the Adelaide Children's Hospital, the dilemma of recurrent asthma and the difficulties which that can present for children because of the large amounts of time they spend withdrawn from their studies—although, obviously efforts are made in hospitals to improve that—anything that is able to improve asthma management is obviously to be greatly encouraged.

The key elements of the plan have been included in the service agreements, which we have discussed before, confirming budgetary allocations. Units involved include the Queen Elizabeth Hospital, the Women's and Children's Hospital, the Parks Community Health Service, the Port Adelaide Community Health Service, the Dale Street Women's Health Centre, Western Domiciliary Care, CAFHS and the Royal District Nursing Service. It has also been used as a model for the development of a State-wide asthma strategy, currently in draft form, and it is the subject of wider consultation pending an approach to the Commonwealth for funds for further development and implementation. So the specific answer to the question as to what steps have been taken is 'lots', and the results are very encouraging.

Ms STEVENS: My question relates to page 276 of the Program Estimates regarding women's health centres. While community health services in the most disadvantaged regions of Adelaide (the northern and southern regions) have suffered a funding freeze, the Southern Women's Community Health Centre and the Elizabeth Women's Community Health Centre have had their funding slashed by 5 per cent, as have the Adelaide Women's Community Health Centre and the Dale Street Women's Health Centre. The three regional women's health centres have been told that their funding will be slashed by a further 5 per cent during the 1995-96 and 1996-97 financial years. They alone have been given cuts over this period, making it clear that regional women's health centres have fared worse than any other area of the health budget and perhaps the entire Brown Government budget.

Will the Minister confirm that the cuts for each women's health centre were based on the net funding allocation for 1993-94 from which the 5 per cent was taken? I wish to put on the record that included in this figure from which the 5 per cent has been calculated are: first, one-off items such as grant moneys received on a one-off basis from the Federal Government (for example, $168 000 for the national women's health program and $90 000 for the alternative birthing services program); secondly, considerable amounts of money which centres were asked by the South Australian Health Commission to put through their accounts—these moneys were not connected to any programs which the centres were running; thirdly, workers' compensation lump sum payouts; and, lastly, a budget carryover from the 1992-93 financial year. Does the Minister agree that the cuts are, therefore, far greater than the stated 5 per cent?

The Hon. M.H. Armitage: Prior to answering that question, I now have further figures on SAMHS regarding a question which the member for Elizabeth asked before. In 1993-94, 90.5 FTEs accepted targeted separation packages from SAMHS. The total cost was $4.651 million of which $3.548 million was funded by Treasury. The cost to SAMHS was $1.103 million, and the annual salary savings from staff taking TSPs was $2.47 million. In July 1994, 22 FTEs from SAMHS staff have taken TSPs, and we are awaiting work force plans from all health units, so the potential for TSPs for the whole of 1994-95 is not known.

In relation to the substance of the question, work which has been done in the north in relation to administrative savings in community health areas indicates that savings which can be made will more than cover the costs of the cuts which are being made. So, as I have said on many occasions before, we are not keen to see services cut. We believe that, particularly in this instance, there are administrative and accommodation savings which can be made, and we are confident on the figures we have that they are achievable. In particular, I have been advised that, because in many instances they are quite small units, they have a high percentage of administrative costs.

As we have targeted for improved administrative costs rather than service costs, we believe that if there were amalgamations of centres with other units (whether that be with women's health centres, community health centres or whatever)—and there are advanced plans in a number of areas to do just that—the savings we are asking for could well and truly be made from administrative costs. In relation to some of the specific Commonwealth programs which the member for Elizabeth mentioned, I should identify that we are not planning to make cuts in specific areas related to Commonwealth funding, but to clarify that I will ask Dr Jelly to speak to the Committee.

Dr Jelly: I met with the directors of the women's community health centres last week. They raised a number of issues about their funding, including that related to Commonwealth funded programs. I indicated to them that I was prepared to review the matter. Having reviewed the matter, although it has not yet been formally put to the directors, we will not apply any cuts to Commonwealth programs, so some money will be provided to those units instead of the cuts which were proposed to those programs.

Ms STEVENS: With regard to the issue which the Minister just raised in relation to women's health centres, of making savings by cutting administration costs, I have some information which has been provided to me by women's health centres regarding a breakdown in the use of total staff time. I wish to read it out because it relates to what the Minister just said. They say that approximately 70 per cent of their total staff time is utilised in direct women's health service delivery, that approximately 12 per cent is spent on administration that directly supports service delivery (for example, maintaining the library, making appointments, managing case notes, typing referral letters, etc.) and that, without spending this time on administrative activities, service delivery could not occur. They say that approximately 14 per cent goes into administrative activities required by the South Australian Health Commission (for example, providing activity, financial and work force data, etc.) and that the remaining 4 per cent of total staff time is spent on other administrative duties. So, they say that they have pared it down as far as they can without impacting on service delivery. I ask the Minister to comment.

The Hon. M.H. Armitage: Yes, I can: I do not believe they are right. As I said before in answer to a question prior to the lunch break, the simple fact of the matter is that a number of these centres have staff to client ratios of 1:100; I cannot remember the exact figures. Some of the community health centres were 1:20. Thanks to the budgetary situation with which we have been left, that is unsustainable. We are faced with the fact that we have to pay for the services. We are unable to provide services for nothing. We do not expect people to work for nothing, and we cannot provide them for nothing; we have to pay for them. We do not have the money to provide for administration costs at the level of those staff-to-client ratios.

In answer to your previous question, I said that we believe that, if people look constructively at amalgamating with community health or other services, those administration costs can be cut dramatically. Let us face the question of women's health centres. I will provide for you later the exact number of staff in those women's health centres, but they have four directors; each one of those centres has a director. In a Rolls Royce society that may be fine but, unfortunately, you lot left us with a Holden budget.

Ms STEVENS: I was trying to clarify something with you, because you mentioned that the staff-to-client ratio was about 1:20, but the figures you mentioned this morning indicated that Adelaide had 1:67, Dale Street had 1:101, Elizabeth had 1:127 and Noarlunga had 1:47. That is a lot more than 1:20, which is what you just said.

The Hon. M.H. Armitage: You are implying that I am trying to hoodwink the Committee and that is not right. I specifically said that I do not remember the figures but that the figure for the community health sector was about 1:20. I also said I would provide the figures for you later. Now I do not have to: you have given them to me. Let me assure you that a staff-to-client ratio of 1:150—if that is the rough area that you are talking about—is unsustainable when we know that efficiencies can be made from amalgamating services. We cannot afford these services, and the taxpayers of South Australia do not want us to afford them, when we can provide the same services for less money.

Ms GREIG: I refer to page 271 of the Program Estimates, in relation to implementing primary health care initiatives in conjunction with community-based agencies. How much money has been spent on these initiatives, and would the Minister also provide details of the initiatives that have been funded and the agencies that have received funding?

The Hon. M.H. Armitage: The primary health care initiatives program of $1.5 million is one of the components of the service improvement pool, which is part of the Government's hospital services improvement strategy. It is supportive of the establishment of some demonstration projects which are innovative and which seek to improve and extend the links between hospitals and community-based services. The object of the exercise is to make sure that we have a smoother link and more integrated and continuous quality care for people who are already ill, as well as to increase our emphasis on health promotion and illness prevention within the system. That is certainly one of the strategies that featured prominently in our pre-election health policy.

As the program funds will be generated from hospital efficiency gains, the major proportion of funds will be available to hospitals themselves as the auspicing bodies for continuity of care and to discharge planning projects, and that entails $1 million. However, we are expecting that hospitals will enter into partnerships with community-based and consumer organisations and groups to carry out a number of the projects. Some other funds—$500 000—will be available to health units and organisations which receive a substantial portion of their funding from the Health Commission, and that will be put towards health promotion and illness prevention projects. We have approved 18 projects for funding from pool 1, which is known as 'continuity of care'; and 17 projects for funding from pool 2, which is for health promotion and illness prevention. I would like Mr Blight to tell the Committee some of the details of those projects.

Mr Blight: A sample of the projects will give an idea of the diversity that is being promoted through this program. One is the senior surgical care program being operated between the Western Domiciliary Care Service and the Queen Elizabeth Hospital. This program aims to educate patients before they go into hospital for hip replacement surgery to prepare them as far as possible for the procedure through such things as education about the procedure itself, what they can expect, what their carers can expect; and engagement in appropriate exercises before the procedure just to build up general body fitness that will assist in the patient's recovering quickly after the operation.

After the operation, the program aims at providing therapists to monitor the patient's progress in hospital and to take a leadership role in ensuring discharge planning so that the patient is properly fit before they are discharged from hospital; then, once the patient is at home, following that up with home visits where they are thought to be necessary. That is a good example of a home-based care service operating within an acute teaching hospital before and after the surgical event, all in the interests of the most effective care of the client.

Another example is in the country. The Naracoorte Hospital and Naracoorte Community Health Service have put up a rural midwifery practice project. Again, this is aimed at improving the continuum of care. In this project a half time community midwife will interact with the client and the client's family antenatally, intrapartum and post-delivery. Again, the idea is to coordinate and integrate all the services around that patient to ensure that the patient is well prepared prior to the service and that discharge planning is done effectively and sensitively in accordance with the patient's needs.

Another example in the area of Aboriginal services is the No Violence, No Shame project being operated between the Port Augusta Hospital and the National Aboriginal Family Violence Project. This project is aimed at developing culturally appropriate and relevant educational programs. They can be used for Aboriginal men who have difficulty controlling their violence. In this project we have cooperation between Aboriginal elders and community members of the Adynamathanha, Kokatha and Pitjantjatjara groups. They will all be involved in pilot testing the program, and we expect that in time that will become a program of national significance. A final example would be the adolescent suicide prevention program. This is centred on the development of an educational video and resource package for use by general practitioners. It has been developed between the Child, Adolescent and Family Health Services and Flinders Medical Centre.

The purpose of the program is to ensure that general practitioners have the support to enable them more readily to recognise young people at risk, to improve their knowledge of how to deal with adolescents and the trauma of a suicide, and more ably to assist young people and their families to access support services when required. This is targeted at both metropolitan and country general practitioners and will flow into the continuing medical education program being run by the Royal Australian College of General Practitioners and the Child and Adolescent Mental Health Service.

Ms GREIG: The Program Estimates, at page 270, refer to the nursing convalescent unit at the Flinders Medical Centre. Will the Minister inform the Committee of the outcome of the evaluation and advantages of this type of step-down care for patients?

The Hon. M.H. Armitage: The nursing convalescent unit at Flinders Medical Centre was established in February 1993 for a trial period of 12 months. We are only too happy to extend funding to enable a full evaluation to take place. The aim of the unit is to provide a period of convalescence for patients who do not need acute medical treatment but who do require a period of nursing care before they can return to their home or previous residence.

The philosophy of the unit at Flinders is centred on the provision of individual patient care with the patient being involved in decisions relating to their own care, as they will be when they are discharged. Nurses work in partnership with the patients to plan the day and to facilitate treatments and education as required. Visiting hours are flexible. Families and friends are encouraged to work with the patients towards independence and a satisfactory return to their home and familiar surroundings.

The evaluation report of the unit, which was provided to the commission this week, identifies a very high usage—up to 93 per cent occupancy; a 35.8 per cent reduction in costs for a range of orthopaedic patients when compared with acute ward costs (that is a very significant factor) and an average of 17 per cent reduction in costs for other categories of patients when compared with acute ward costs. A great deal of satisfaction has been expressed by staff and patients in relation to quality management indicators.

When talking about a saving involving a 35.8 per cent reduction for orthopaedic patients and 17 per cent for other categories of patients, I should remind the Committee that the cost of an acute bed is about $600 every day. If we are able to save those percentages, they represent a substantial saving as well as being good for the patients, who are better prepared for their own recuperation.

The unit at Flinders is part of an overall approach to continuity of care, which provides choices for patients while ensuring the most cost efficient services. The unit works in conjunction with the Hospital at Home service to provide improved continuity of care. The Hospital at Home scheme operates for 24 hours a day, seven days a week, and allows selected adult patients the option of recuperating at home under the care of Flinders nurses and general practitioners. Approximately 120 patients have elected to make use of the service since funding was made available in May 1994. Preliminary figures show that Flinders Medical Centre is saving approximately $40 000 per month through this service—a very significant saving. It is the first scheme of its type in South Australia. Recently I was very pleased to present the unit with the community Outreach award after its being judged top of the Metropolitan Health Service category by the Hospitals and Health Services Association of South Australia and the Australian Hospitals Association award category. It is a significant financial saving, it is better for patients, and obviously it frees beds for additional elective surgery in the acute setting.

Ms GREIG: The Program Estimates, page 277, refers to the establishment of a multipurpose service in the Pitjantjatjara lands. Will the Minister inform the Committee of the details and advantages of this proposal?

The Hon. M.H. Armitage: I am very pleased to inform the Committee about the potential establishment of an MPS, as it is known in the Pitjantjatjara lands, because of my commitment as Minister for Aboriginal Affairs as well. By way of background, multipurpose services are joint Commonwealth-State initiatives in which Commonwealth and State health and aged care funds are rolled together or cashed out, and local communities use these funds in a flexible manner to meet their health and aged care needs. There are two other multipurpose services in South Australia. Indeed, at a recent Health Ministers conference that I attended, it was quite clear that we are leading the way with this innovative method of providing care.

Negotiations have commenced with a view to establishing one of these multipurpose services to cover the Pitjantjatjara homelands, which would be auspiced by Nganampa Health, which is an Aboriginal-controlled health service. To date the Health Commission, the Federal department and Nganampa Health have reached an in principle agreement to proceed, with a probable start date of 1 January next year. The various officers, whom I mentioned earlier, met the ATSIC Regional Council on 30 August at Leigh Creek. We are still awaiting the view of the ATSIC Regional Council, but I am optimistic that this will progress.

At the moment we fund Nganampa about $1 million annually and ATSIC about $3.4 million. The Commonwealth Department of Human Services and Health will now contribute $1 million in one-off capital and $.44 million recurrent. This is, if you like, new aged care money as at the moment the Department of Health and Human Services funds no aged care services in the Pitjantjatjara lands. There are a number of things about this of which South Australia can be particularly proud. First, it will be the first multipurpose service in Australia with an Aboriginal community-controlled health organisation, and it will certainly be the first aged care service on the Pitjantjatjara lands. Those are two major elements. If ATSIC becomes a signatory to the MPS agreement, nearly all funding sources for the auspicing body, Nganampa Health, will be included. It will have a single three-year funding and service agreement with all its major

funding bodies. The agreement will detail services to be provided and total funds to be supplied by the funders. The significance of this is not only for Aboriginal people in the services that they will be able to provide to members of their own community: as Minister for Aboriginal Affairs, I believe its major importance is that it will be under Aboriginal control. As I go into Aboriginal communities, it is clear that they wish to have control over their own destiny. This is an innovative way of allowing that whilst at the same time providing improved services.

Mrs GERAGHTY: I refer to page 271 of the Estimates of Receipts and Payments. In July a public meeting was held at Modbury Hospital to protest at privatisation of the hospital. The Minister was represented at the meeting by the member for Wright, who all but ruled out full privatisation of the hospital. In his Address in Reply speech on 3 August, the member for Wright referred to the Modbury Hospital meeting in the following terms:

> I stated that the Minister had indicated that the likelihood of the total privatisation of the Modbury Hospital was virtually zilch . . .

We now know that the Modbury Hospital Board, carefully chosen by the Minister, has recommended that the entire hospital be run by the private sector. Did the Minister approve of the speech given on his behalf by the member for Wright at the public meeting at the Modbury Hospital and did he say that total privatisation of the Modbury Hospital was most unlikely?

Mr BRINDAL: On a point of order, Mr Chairman, I seek your guidance as to whether the Minister is responsible for the comments of the member for Wright.

The CHAIRMAN: The Chair listened to the question. The question was really addressed to whether the comments made by the member for Wright were appropriate to the Minister's future intentions for the hospital. As such, I believe they are quite in order. It is really a question of ministerial policy and future direction that the member for Torrens was addressing.

The Hon. M.H. Armitage: First, I would say that the meeting, at which a number of people voiced a number of opinions, was called by the Coalition for Better Health. The speakers included the ANF, whose representatives 36 hours later indicated to me that they were implacably opposed to any privatisation of public services. Another speaker was a representative from the ACTU who is not well recognised as being necessarily friendly to the aims of a private enterprise based Party. Another speaker came from the Evatt Foundation, which has obvious links with the Labor Party. So, I guess it is fair to say that, given those speakers, I was not particularly amazed to find that some of the motions passed opposed privatisation and demanded certain things of the Minister.

In relation to that meeting, I have seen a number of copies of the local Messenger newspaper in which people have identified themselves as having been appalled at the fact that they felt so used for political ends by that meeting, given that they went along ostensibly to learn what they could about the potential for change at Modbury Hospital. I should also indicate that, if the member for Torrens would like to read the Messenger newspaper of, I think, last week or the week before, she would see that the plans which the Government has announced for Modbury Hospital have been given an absolutely ringing endorsement by local residents. So, certainly the views of the meeting—

Mr BRINDAL: And her electors.

The Hon. M.H. Armitage: Precisely. So, as to the views of some people at the meeting, I am realistic: not everything we do pleases everybody, but equally there are plenty of people who are pleased with what we are doing. I will relay to the hospital board some of the comments of the member for Torrens, but it is the board's job to administer the hospital without fear or favour, which it does. Indeed, as a number of former Health Ministers have commented, and as I have found, sometimes boards have flexibilities and opportunities that Ministers, Health Commissions and so on are not necessarily in favour of, but they are autonomous. It is their job to administer the hospital. They have looked at the reports from the tenderers. They have come to me with an option which includes the provision of a private bed hospital on the same campus.

I think the honourable member was absent earlier when I indicated that the Government is still maintaining all the assets of the hospital, so it is not a full privatisation option. As I said before, we are very pleased that we are able, following the tenders being looked at, to guarantee that the services will continue to be provided at the same or better levels with potentially better infrastructure. The way the Government perceives it, it is a win-win situation.

Mrs GERAGHTY: There are a couple of points that I will raise again later. How does the Minister propose to privatise beds at Modbury Hospital when regulations made under the Health Commission Act put a limit on the number of private beds in South Australia?

The Hon. M.H. Armitage: As previous Labor Health Ministers identified in these sorts of exercises—for example, the private development at the Flinders Medical Centre and the potential private development at Modbury (which I would remind the honourable member was certainly initiated and fully investigated on a number of occasions by the previous Labor Government, so this is not breaking new ground, but we are very pleased that it is happening)—private beds will need to have private bed licences, and we are as specific as the previous Government in that regard. The 60 bed licences will have to be provided by the tenderers, so there is no expansion of private bed licences in South Australia.

Secondly, we do not need to have any change. We are under a contract. We are having public patients treated in those beds, but the prime thing is there is a complete expectation by the Government that there will be no change in the private bed stock in South Australia under this proposal.

Mrs GERAGHTY: As a supplementary question, you are ruling out that there will be a change in the number of public beds at the Modbury hospital; will you also rule out any additional costs being passed on to public patients treated at the Modbury Hospital, if privatisation proceeds?

The Hon. M.H. Armitage: I am very happy to do that because, under the Medicare agreement, one of the agreements is that public patients are offered services at no cost. They are not charged now, so that will be the end result of the deliberations.

Mrs GERAGHTY: What agreements have been made between the potential operators of the Modbury Hospital and the board or Health Commission in relation to public hospital accommodation being preserved, community participation, staffing matters, default procedures and penalties, and asset protection?

The Hon. M.H. Armitage: As I indicated in an answer to a question from, I think, the member for Newland—and perhaps the member for Torrens was not here—at the

moment we do not have the final offers from the two tenderers. The deliberations are still continuing, and we expect that that final result will be available in about six weeks, but, as in a previous answer, the Government's expectation for either of the tenderers, whichever one is successful, is that all those things, such as public services, standards and so on, will remain or will improve.

Mr BRINDAL: In relation to the question of contestability (page 279 of the Program Estimates, referring to the 'development of strategies to assist the implementation of the contestability policy'), can the Minister describe the process involved in the contestability policy he has recently announced?

The Hon. M.H. Armitage: I am pleased to elaborate on the contestability policy and the processes because it is a linchpin of the Government's expectations of the hospital and health services providing more efficient and effective services. The process is actually quite straightforward, but I will give a brief background to start with. Contestability is the introduction of the potential for competition into public health services which previously have held a monopoly position, or which have operated in a regulated or tied market. It is quite consistent with our objectives as a Government of ensuring that services are efficient and effective and that the community needs are met within our existing financial constraints, which I have mentioned on a number of occasions already today.

The contestability policy is consistent with one of the recommendations of the Commission of Audit. It is also quite consistent with one of the major measures announced in the Government's June financial statement and, certainly, with the competitive focus of the casemix funding model. The policy introduces competition into the system, but it takes a sensitive approach by providing an opportunity to the current service providers in the first instance. This is a direct result of a pre-election commitment given by the then Leader of the Opposition, now Premier. Once that opportunity to the current service providers has been offered, if the competitive benchmark is not met a competitive process involving private sector contractors is undertaken.

There are 14 steps in the policy guidelines to make sure that all the i's are dotted and the t's crossed. The first nine steps enable the existing in-house providers of a service to meet the established targets and benchmarks, to sign a performance agreement and implement improved in-house services consistent with the agreement. If that does not achieve a successful outcome, the final five steps involve matters such as detailed service specification, calls for tenders and awards of contracts. It certainly featured very strongly within our pre-election health policy, where we talked a lot about competitive tendering. I would indicate to the Committee that considerable interest has been shown from the private sector and, as Minister, I certainly intend to drive the processes as far as I can, but it is ultimately in the control of the CEOs and of the system. But, certainly, as I mentioned before, it is a linchpin of the Government strategy.

Mr BRINDAL: My second question relates to the metropolitan hospitals strategic planning study (at page 270 of the Program Estimates), specifically referring to the development of a hospital master plan for each metropolitan hospital. What are the financial and service implications to metropolitan hospitals of the planning study?

The Hon. M.H. Armitage: The metropolitan hospitals planning study allows us, in a most sophisticated way, to project the demand for public hospital services in Adelaide up to the year 2006. The study method itself used very complex modelling techniques, and I am pleased to say it involved intensive consultation with hospital planners, administrators, medical practitioners and other health professionals. The study showed that the demand for hospital services will increase significantly. I have mentioned this in Parliament before, and I am sure everyone realises, that as the population ages and as the population numbers increase, and with the introduction of new technologies and new treatments, it obviously sets up an expectation in the community.

The model allowed us to say that increase in demand between 1991 and the year 2001 has been estimated at around 17 per cent, and 29 per cent between 1991 and 2011. If we made no change, based on 1992 admission rates and average length of stay, this would translate into a demand for an additional 900 beds over the next 15 years. Clearly, that is not acceptable—or unachievable—and the planning study recommends the redevelopment of the major metropolitan teaching hospitals to provide low dependency care and step-down accommodation, increased same day medical and surgical capacity, and enhanced rehabilitation services.

By making these changes the metropolitan hospitals will be able to meet service demands in a more efficient and effective manner than is possible with their current facilities. In answer to a previous question, I indicated with step-down facilities and those sorts of innovative approaches that at present Flinders Medical Centre is saving $40 000 a month. With these proposed new facilities and continuing changes in patient management, it is our estimation that the metropolitan hospitals will be able to reduce by 600 acute beds by the year 2001, although a number of low dependency beds will take their place. The metropolitan hospitals facilities plan indicates that by the year 2000 there should be 4 700 public and private hospital beds in Adelaide, representing a rate of about 3.6 acute beds per 100 000 population.

It also recommends the expansion of Lyell McEwin Health Service to around 300 beds; expansion of Noarlunga Health Service to around 200 beds; and a substantial redevelopment of infrastructure and patient amenities at the Royal Adelaide and the Queen Elizabeth. It also supports the collocation of private hospitals on public hospital campuses and the use of private sector financing.

It is estimated that around $430 million will be required to develop public hospital facilities over the next decade, and on recent patterns of public works that is a shortfall of about $100 million in funds. We are optimistic that this will be provided via the private sector, mainly via the joint public/private hospital developments in the public hospital system, which we have talked about already. It is a well researched facilities plan indicating, in response to changing needs, that we will certainly be able to meet the demands for health care.

Mr BRINDAL: I refer you to page 270 of the Program Estimates where reference is made to completing the amalgamation capital development project involved in the amalgamation of the Women's and Children's Hospital. As the Minister will be aware, I come from a teaching background and, by and large, I found the budget documents very easy to read and self-explanatory, but I have noted that one aspect of that project involves the installation of a cogeneration plant. Could the Minister explain to me what a cogeneration plant is—I am really quite mystified—and say what the benefits of that plant are?

The Hon. M.H. Armitage: Co-generation is the process of generating two different sources of energy (electricity and

heat) using the one fuel source, which is generally gas, and economies are gained where on-site generation enables the electrical and thermal energy to be used in a local fashion. That is particularly so of many hospitals which, from all our experience, have large numbers of energy requirements for heating, cooling, equipment sterilisation, catering services and so on.

Mr Blight: This co-generation work is the result of ongoing discussions between the commission and the Office of Energy Planning over many years. It has been aimed at evaluating the installation of co-generation facilities in hospitals for a number of purposes: first, to bring about a net reduction in operating expenses through reduced energy costs; secondly, to assist with other Government objectives, such as reducing the peak workloads experienced by our power stations; and thirdly, to assist in achieving environmental objectives, such as reducing greenhouse gas emissions. The Women's and Children's Hospital project is the first of our co-generation projects and will cost about $4.4 million in capital, but savings of the order of $650 000 per annum are expected to flow from that investment.

Work has already been completed at the Royal Adelaide Hospital and the Flinders Medical Centre, and tenders for similar plant at those two hospitals will be called within the next few months. Savings at the Royal Adelaide Hospital are expected to be $1 million per annum off an investment of $5.3 million, and at the Flinders Medical Centre the saving will be $430 000 per annum off an investment of $2 million. So, these co-generation initiatives are very worthwhile investments which provide very good ongoing recurrent savings. Co-generation is also being investigated at the Queen Elizabeth Hospital; plant is being installed as part of the new Gawler Hospital redevelopment; and the opportunity to use co-generation will also be investigated as part of the new Mount Gambier Hospital.

Mr De LAINE: I thank the member for Newland for her assistance, but I point out that questions in relation to the western suburbs can be quite adequately handled by the shadow Minister and me. I refer to Pages 276 and 279 of the Program Estimates. Community health services have suffered particularly badly in the Brown budget of broken promises, with the inner southern, Port Adelaide, Parks and Eastern Community health services all receiving real cuts of between 7 per cent and 9 per cent. The South Australian Community Health Research Unit has also received a 7 per cent real cut. In view of these huge cuts in community health services, why should anyone take seriously objectives for 1994-95 such as those stated under the support services program, as follows:

> Develop strategies to support community participation in health, planning and services. . . Establish Youth and Women's Health Councils.

Why is the Minister bothering to investigate the integration of women's and generic community health services, which is stated as one of the objectives for 1994-95, when the financial cuts he has forced upon women's health services leave them with very little alternative? Who will conduct this investigation and when will they report?

The Hon. M.H. Armitage: First, in relation to the matters of substance raised by the member for Price, I attended a number of meetings in relation to both community health matters and women's health services, one of which was attended by the member for Spence and was held at the Parks Community Centre. Also I attended a meeting in relation to women's health, which occurred on a Saturday afternoon. At both of those meetings and at every other opportunity I suggested to people in those interest groups that I would be more than willing to receive input from them. Some people provided input and others did not. In particular, there was a considerable amount of input in relation to the women's health centres. So, we had all that input, together with the following policy directions: we wish to have all sectors make a budgetary contribution; we expect services not to be cut; and the administration is to provide the budgetary benefits. The Metropolitan Health Service looked at the matter and prepared a position paper, which will be released early next week. So, we look to input in respect of that paper.

Reiterating a previous answer, the paper into women's health and community health services proposes the integration of the three smaller metropolitan women's health centres into regional community health centres whilst maintaining the Adelaide Women's Community Health Centre as a State-wide women's program. The savings will be generated from the integration of those smaller metropolitan centres, which have high administration costs merely because of their staffing structures.

Mr De LAINE: Will the Minister promise to suspend future funding cuts to women's health centres if the investigation recommends their retention as separate entities?

The Hon. M.H. Armitage: I will not guarantee that.

Mr De LAINE: As the Minister would be aware, the Port Adelaide Community Health Service has received a 7.5 per cent budget cut, which equates to $65 000. This will greatly disadvantage the Port Adelaide community. The Port Adelaide Community Health Service has by far the smallest budget of all the regional centres. It has a large geographical area of responsibility with high levels of poverty and disadvantaged groups throughout the area. The poor health status of the people of the Port Adelaide council area and parts of the Woodville council area, including Seaton, Hendon and Royal Park, has been documented and is widely recognised. I take in an answer to a question prior to the luncheon break where the Minister quoted that the criterion for these budgetary factors was population. In my view, that criterion is almost irrelevant.

There are many other major factors that impact on the budgetary needs of certain areas, and I have highlighted some of them there with disadvantaged groups and other social atlas problems in those areas. In my view, the size of this cut must adversely affect service delivery to the community and, as an observation, if the Health Commission budget decision had been based on the needs of the community and the health status, Port Adelaide should have been recognised as having equivalent needs to the northern and southern suburbs. In this scenario the Port Adelaide Community Health Service would be looking at a cut of the order of $18 000, not $65 000. Why has the Port Adelaide Community Health Services received a deeper cut than the northern and southern community health services when the social atlas shows the west as the most needy area?

The Hon. M.H. Armitage: I referred to the social health atlas previously when I indicated that a number of the factors that the member for Price has referred to in his question were direct factors in the Government's decision to ignore the Audit Commission report, which would have seen the Queen Elizabeth Hospital lose its teaching status. That was quite specifically one of the Government's major factors in providing appropriate care in the western area. I reiterate that to indicate that the Government is fully aware of the social health atlas and of the needs of people in the west. However, it would appear that the member for Price has misunderstood

something I said before in that I was not only talking about population but dollars spent per population, and it is quite clear the member should look at that.

The central region, in relation to community health, has 39.7 per cent of the population. After we have made our budgetary adjustments in that area, whilst maintaining funding in the north and the south, 39.7 per cent of the population receives 51.22 per cent of the budget. Whilst I recognise the member for Price's concerns as the local member, I put it to him that the member for Elizabeth would be enthusiastic about our attempt to spend the dollars where the need is. The simple facts of the demographics are that the growth areas are the north and the south. We have made a small, and we believe perfectly achievable, cut in the centre, and we have distributed to the north and the south where the growth areas are. I reiterate that, after our budgetary adjustments, the central region, which has 39.7 per cent of the population, is receiving over 51 per cent of the budget.

[Sitting suspended from 3.20 to 3.45 p.m.]

Membership:

Mr Atkinson substituted for Mrs Geraghty.

Mr De LAINE: How will these community health services cut their budget without reducing services? How was the level of each of the amalgamating services' administration efficiencies determined? How was the percentage of the cut that would not impact on the services determined? What consultation has been carried out with the health centres to investigate the services and the potential savings, if any, within the centre's administrative functions?

The Hon. M.H. Armitage: Regarding the first question, we in the commission are only too happy to allow administrative decisions to be made in the field. That is one of the things that we are looking at the sector to do, namely, to provide services according to local needs and local responses, in which case it is not appropriate for a central body to be making specific decisions as to how money will be spent. We give global budgets and allow managers to make those decisions. We are not determining how services will be provided once the budgetary adjustments have been made.

With regard to how efficiencies were measured, as I have indicated on a number of occasions—and I can be quite specific, given that the member for Elizabeth pulled me up before—in at least one of these community health centres the staff to client ratio is 1:20. As I have said previously, we are unable to fund those sorts of staff to client ratios. In looking at efficiencies that could be made, we were able to determine that the administrative area is ripe for those.

Regarding how these consultations might be achieved, as I have indicated in answer to a question from the member for Elizabeth in the House, a region in which there were three typical community health services began testing the water on a voluntary basis as to how they might provide an increased component of services by amalgamating their administrative structures. I repeat: that was a quite typical region, it had typical community health centres, and so on, and they came up with a figure in excess of $250 000 that could be removed from administration to provide extra services for the local community. I ask all community health personnel: if one area can do it, why not all the others? I am sure they can.

Hence the expectation of the Government that the community health sector would not be immune from the same types of budget cuts as we are asking all the other areas, other than disability and, as we have said before, mental health, to make. It is across the board: we are not singling out community health at all. We are saying that we have concrete examples of how money can be saved by administrative efficiencies. The Government needs to balance its books for the good of the State, and we would expect all areas to achieve similar sorts of rationalisations of administration, not of service provision.

Mrs KOTZ: Prior to the afternoon tea break, the member for Price took the opportunity to thank me for being concerned about the western suburbs area, then assured the Committee that both he and one other member of the Committee were quite capable of looking after that area, which I am extremely pleased to hear. For the record, I would point out that the member for Price has been in this Parliament long enough to know that this is a Committee of the Parliament representing all the areas of South Australia and not necessarily the individual electorates, so I think it is quite fair to state that the question is definitely in order. As we started at 11 a.m. and it took until 3 p.m. before the member for Price asked a question, I was beginning to wonder whether the western suburbs were being represented.

The CHAIRMAN: The honourable member is only adding more heat than light, as the co-generation scheme referred to, and I would prefer the light to be the dominant part.

Mrs KOTZ: I refer to page 279 of the Program Estimates, which refers to the establishment of initiatives for youth. As the Committee would recognise, the major thrust of this Government's budget has been job creation across all areas of our economy. As the Health Commission is the largest public sector employer in South Australia, what contribution has the South Australian Health Commission made to foster the training and employment of young persons in this State?

The Hon. M.H. Armitage: I guess this is one of the real ways in which the Health Commission is addressing the criterion which I mentioned before and which is to increase job creation in South Australia as one of the election goals of the Liberal Government. Within the commission we have made a significant contribution to youth training and employment over the past 12 months, focusing since the election in particular.

Additional Departmental Advisers:

Mr R. Bishop, Executive Director, Human Resources Division.

Ms C. Johnson, Executive Director, Disability Services Office.

Mr P. Davidge, Executive Director, Finance and Information Division.

Mr Bishop: The Health Commission has participated in the Government's training and employment strategy for young long-term unemployed people using the Commonwealth's JobSkills program and Career Start traineeship program. In August 1994 participation in the programs reached a peak, with 149 people being placed throughout the health system, including 18 in country health units. The focus of the program includes not only the traditional clerical and administrative functions but also health systems functions, such as paramedical aides, dental assistants and assistant community health workers. By concentrating on these health functions, however, the number of placements is not equal to available opportunities, as the Commonwealth Employment Service has been unable to provide the required number of suitable potential trainees. Therefore, demand exceeds supply.

Based on previous programs run within the Health Commission, it is anticipated that 60 per cent of the participants will obtain either permanent appointments or further temporary appointments within the public sector at the completion of their training programs. The South Australian Health Commission executive has endorsed further participation in the Government's youth training and employment strategy throughout 1994 and 1995. It is anticipated that further uptakes will occur on an ongoing basis during that financial year.

I will quote two cases as typical examples. Case A was a 22 year old female graduate who had completed a Bachelor of Business in Administrative Management and who was unemployed for 12 months prior to commencing a JobSkills program with the Health Commission. At the end of her training program, she was successful in gaining a permanent clerical unit within a health unit. Having been unemployed for such a long time, she was obviously delighted to see her study and job efforts rewarded.

Case B involved a 20 year old Aboriginal male who had been unemployed for six months and who was unsure of the career path he would like to pursue. He was encouraged to participate in the Career Start traineeship program, and through that program he was able to secure work experience in the clerical field and to be exposed more broadly to other occupational categories. On completion of his training, he was successful in gaining an Aboriginal youth health worker position at the Lyell McEwin Health Service. So, the program provided him with a foundation to pursue a career which he had previously not considered, and no doubt he will have further career opportunities. He is also delighted to have gained that position.

Mrs KOTZ: Page 275 of the Program Estimates refers to the establishment of options coordination agencies. What are the benefits of options coordination for people with disabilities and their carers?

The Hon. M.H. Armitage: We believe that the establishment of options coordination agencies is a great leap forward and will be of considerable benefit for people with disabilities and importantly the carers of those people. The function of options coordinators will be to act as agents for people with disabilities and their carers. The prime goal is to assist people with access to the variety of things which they might need for support. At the moment, the system is a bit confusing and intimidating and there are lots of entry points and so on, so we have recently announced the goal of having five options coordination groupings. To be more specific about the role of those options coordinators and how they will function and make things better for people with disabilities, I will hand over to Colleen Johnson from the Disabilities Services Office.

Ms Johnson: The options coordinators will act as agents for clients and their families, and they will help people get out of the system the services they are looking for. They will purchase services on behalf of clients. They will be closer to the clients, they will be able to work out what sort of support people need and they will be best placed to obtain quality support in a very efficient manner. The disability sector over the next three to five years will be expected to achieve a 3 per cent efficiency dividend, and these efficiencies will be used to increase service delivery. Because they are purchasers, the options coordination agencies will be key factors in achieving these efficiencies. Options coordination in itself will eliminate multiple assessment, multiple access points to the service system and overlaps and inefficiencies in case management, including the allocation of resources, as well as providing an access and coordination point to clients. No longer will individual clients have multiple case managers, multiple assessments and multiple points of access through an array of agencies in the system.

The options coordination agencies will also be well placed to facilitate efficiencies within the service delivery sector. We currently have over 80 service agencies in the disability area in this State, and this is not necessarily the most efficient arrangement. So, those options coordination agencies will be looking for efficiencies by identifying service overlaps and gaps for particular disability groups and working with service agencies to address those; by developing unit cost and bench marking approaches, which will include looking at direct service costs, administrative overheads and asset use and management; and by implementing standards in monitoring the quality of services.

The options coordination agencies will also facilitate other developments, which will help with efficiency and effectiveness, because they will assist clients in getting better access to mainstream services, thereby again ensuring effective and efficient service delivery. They will also develop existing community resources to make better use of existing informal networks available to individuals and existing community services available to the entire community, such as local church groups, family members, local community recreational groups, local government services and so on. The options coordination agencies will be able to facilitate these efficiencies, because they will be separate from the service delivery system. They will a point of access, they will provide assessment and case management, and then they will negotiate with the service delivery system to make sure that that system is providing services in the way that clients want them and in an effective and efficient way.

Mrs KOTZ: My last question relates to page 276 of the Program Estimates which deals with community-based services to the general population and refers to the Rape and Sexual Assault Service. I think most members will be aware that those services available to rape and sexual assault victims have been consolidated at Norwich Centre, North Adelaide. Will any additional crisis counselling services be provided to victims out of this centre?

The Hon. M.H. Armitage: This is an important matter which is of concern in the community. As the Minister with responsibility for this area, I am pleased that there are growing thoughts within society that rape and sexual assault are unacceptable. That is my own view, but as I visit various organisations I find that view becoming more prevalent. Personally, I think it is a pity that it even needs to become more prevalent.

The Health Commission engaged a consultant from New South Wales in 1991, Ms Moira Carmody, to review the services provided to adult victims of rape and sexual assault. Her report, entitled 'Strategy for Change,' outlined a number of gaps in the services provided in South Australia. One of the key issues identified was the lack of a 24-hour crisis counselling service for victims. It was recommended that immediate action be taken to establish such a service for the adult victims of rape and sexual assault to reduce any negative impact which is often present on the recovery of the victim. The importance of providing counselling to victims of rape was emphasised, provided that that counselling was as close as possible to the time of assault. That need had been identified a number of years before.

In this financial year the Health Commission has made available $78 000 to commence a 24-hour crisis counselling

service. The Rape and Sexual Assault Service would staff the service during office hours and would have a number of on-call counsellors available after those 9 to 5 hours. A telephone number would be advertised which would be answered by staff from the Rape and Sexual Assault Service during the day and it would be switched through to Crisis Care units for the period 5 p.m. to 9 a.m. on weekdays, weekends and public holidays. The trained Crisis Care staff will screen the after-hours calls to assess whether an on-call counsellor should be contacted.

There are cost and service benefits with this model. Using the resources of Crisis Care, considerable establishment costs will be saved. It is a very good opportunity for the two agencies, Crisis Care and the Rape and Sexual Assault Service, to collaborate in providing services to clients who are often in need of both services. Obviously clients will have the benefit of a 24-hour service available when it is needed. In addition, the Rape and Sexual Assault Service has opened an 1800 telephone number for country residents. Indeed, there are a number of additional counselling services to overcome an appalling situation.

Ms STEVENS: My first question is about magnetic resonance scanners. In a letter to the Minister for Health dated 20 January 1993, as Opposition health spokesperson you wrote:

> I believe that the Women's and Children's Hospital in fact has a larger neurosurgical work load than Flinders Medical Centre and consequently I would be interested in being provided with reasons for the Flinders Medical Centre being the site for the second MRI scanner.

In a letter to Mrs Helen Barr dated 24 November 1993, you wrote:

> I would be more than happy to make a contribution from the State, such that all savings generated from within the hospital budget by the provision of a scanner at the Women's and Children's Hospital would be applied to the costs of the scanner.

That letter concludes with your statement:

> I look forward to advancing this line of thinking further after the election.

Mrs Barr wrote to you again on 22 June 1994 in relation to this matter, but she has not yet received a reply. Does the Minister still support the installation of an MRI at the Women's and Children's Hospital?

The Hon. M.H. Armitage: Since I wrote that letter, or even at that stage, an MRI scanner was put into Flinders Medical Centre. I cannot reverse the decision. I am sure that the taxpayers would not want me to expend money unnecessarily on reversing a decision relating to the placement of something as expensive as an MRI scanner. Since then the Government has made a commitment to provide capital funding to put in a replacement MRI scanner at the Royal Adelaide Hospital. Indeed, within the past 48 hours I was discussing with the Director of Organ Imaging at the Women's and Children's Hospital another matter, during the course of which we discussed the potential for private sector provision of expensive capital items of equipment such as MRI scanners and other things which are available for high cost.

In an ideal world, we might provide these everywhere; but the facts are that the costs for the patient are limited by the Commonwealth. Your colleagues in Canberra have limited the number of scans which can be done on the basis that supposedly rich and avaricious doctors would overservice clients with these machines. I do not believe that is the case. However, the fact is that the number of services which will be paid for these MRI scanners are limited by the Commonwealth.

Ms STEVENS: Do you still support the installation of a scanner at the Women's and Children's Hospital?

The Hon. M.H. Armitage: As I said, I have discussed the matter within the past two days with the Director of Organ Imaging at the Women's and Children's Hospital. He recognised, in relation to our discussions, that we do not have the funds to do all these things; but we will be looking at this and I would support it in an ideal world.

Ms STEVENS: When will you look at it?

The Hon. M.H. Armitage: I am prepared to look at it tomorrow, if the Director of Organ Imaging wishes to discuss the matter with me, with perhaps private sector funding. I reiterate that, even if we were to provide another MRI scanner with private sector funding, the Commonwealth still limits the number of free services which are provided, and they are very expensive for people unless they are receiving that service.

Ms STEVENS: My concern is that your undertaking to Mrs Helen Barr was to continue that line of thinking in relation to the Women's and Children's Hospital. Why has it ended up in the RAH?

The Hon. M.H. Armitage: It was already in the RAH. We are providing an updated one at the RAH. We are replacing the one that is already there.

Ms STEVENS: What is happening to the old one?

The Hon. M.H. Armitage: To add light to this, short of suggesting we might put it out for a garage sale, I will ask Dr Jelly to respond.

Dr Jelly: The Commonwealth provided funds in 1993-94 initially to buy a machine for the Flinders Medical Centre and an additional amount of $300 000 to upgrade the Royal Adelaide machine. When that was proposed, it was found that technically they could not upgrade it to any satisfactory level. A total of $300 000 was paid as part of the Flinders Medical Centre purchase because the amount of money provided by the Commonwealth did not cover the full cost at that time. In this year the Commonwealth proposes to spend $1.9 million on a replacement machine at the Royal Adelaide Hospital. That will not cover the full cost of the machine, so a relatively small amount will come out of the capital works program of the Health Commission, and some Royal Adelaide Hospital sourced funds may be used to complete that purchase.

The Hon. M.H. Armitage: If we use this as an example, it is one of the dilemmas for the Health Commission and for the provision of health services that, as I indicated in a previous answer, because of modern technology, there is an expectation in the community that all these services will be provided. Accordingly, they expect the most up to date machinery. A large number of highly technical machines which we are using just adequately at the moment are literally unable to be updated. The parts that go wrong or potentially cause dilemmas are sometimes not even manufactured any longer. That is the sort of dilemma we are having. As we heard with the MRI scanner, it is simply impossible to update that one.

Ms STEVENS: I just want to indicate that these are your words that I was quoting in relation to having one at the Women's and Children's Hospital. My next question relates to waiting lists. The Minister and the Premier have claimed that waiting lists will be halved by the end of the Government's first term. Does this commitment mean that the Government promises to halve the waiting lists for each

major procedure, such as ear, nose and throat, and will the Minister provide details of the actual numbers of people on waiting lists on which this commitment is based?

The Hon. M.H. Armitage: As to looking at halving each waiting list for each operation, the answer is clearly 'No', but we have addressed a number of these matters I believe very constructively, and I detailed a number of those strategies in an answer to a question from, I think, the member for Unley in relation to casemix funding. Certainly we would recognise that with throughput pools and waiting list pools, bonus pools and so on, there are a number of opportunities for efficient and effective hospitals to access extra funding to provide extra operations from the waiting lists. As I was detailing in that answer, we regard a number of hospitals as non-booking list hospitals that can access various pools of money if they are performing procedures from the booking lists of the booking list hospitals.

We believe that a number of the strategies within the casemix funding model will help us address the waiting list problem, and I draw the attention of the member for Elizabeth to the facts that I quoted in relation to the Victorian experience of casemix funding which has been operative for 12 months when the first pass of results were being looked at, indicating that the effect of casemix funding on waiting lists is nothing short of staggering. We would expect ours to be the same.

Ms STEVENS: You are probably aware of the statements of the member for Giles in the House in relation to the Whyalla Hospital where he has mentioned on a number of occasions that that hospital never had waiting lists until recently. Would you comment on that situation?

The Hon. M.H. Armitage: I am informed that there are no waiting lists at Whyalla, or we have not been informed of any waiting lists. I guess that is the first bit of information. Secondly, whilst they do provide fantastic services at the Whyalla Hospital for people in that area, they do not provide a full range of services and I believe that about 10 per cent of their patients actually come to Adelaide for their operations. This is a prime example of the sort of manipulation, if you like, we may well get through the pools I was addressing in response to your previous question, in that Whyalla may choose innovatively and creatively to provide those operations by having relevant specialists or whatever at Whyalla to provide those services there. They will be able to access the booking list pools because patients from Whyalla will be on booking lists here. The people concerned will benefit by obtaining their services in Whyalla and the numbers on the booking lists will drop here, and that is a very positive thing for everyone.

The casemix funding model has quite frankly proven that Whyalla Hospital has been very generously funded (and let us leave it at that) for many years, and we have quite a considerable expectation of a savings component from Whyalla. There are a number of reasons for that, not the least of which is the geography of the hospital. It is very difficult to run modern, efficient, best practice type services in some outmoded hospital designs. We have some expectations of Whyalla, but that is a good example of how creatively we might well be able to address the dilemmas of people coming to Adelaide to have their operations. But, as I am advised, there is no waiting list at Whyalla.

Ms GREIG: My question relates to page 276 of the Program Estimates and palliative care services. Will the Minister provide the Committee with details of recent initiatives on palliative care services?

The Hon. M.H. Armitage: It has always been my view that many people in need of hospice and palliative care services are perhaps overlooked. My view in that was formulated when, as a medical student between first and second year, I worked as a nurse attendant at the Magill wards at the Royal Adelaide Hospital. The first ward I walked into as a bright eyed and bushy tailed young medical student had 33 patients, 30 of whom had terminal cancer. It is certainly something which young minds are jolted by.

Mr BRINDAL: An ordinary ward?

The Hon. M.H. Armitage: It was in the Magill wards of the Royal Adelaide Hospital and, basically, it was a ward where people were sent in their last days, but palliative services had not been dreamed of—I was a medical student quite a long time ago. It is an area in which I have a personal commitment. The expansion of hospice and palliative care services has been quite significant in the past year as a result of increased State and Commonwealth funding. A four year palliative care program will run between 1993-94 and 1996-97 from the Commonwealth, of which South Australia's share is about $1.1 million. This is in addition to the palliative care funding under the previous Medicare agreement.

A statewide plan for palliative care services was completed in January 1994, and it identifies some gaps in service provision and a number of strategies to address the inequities between the regions. It was developed in association with the various providers, both public and private. Funding was allocated from the palliative care program to expand the metropolitan palliative care services in the north, and the west in particular, and to each region, to ensure support for the network of palliative care service providers, who are certainly worthy of support. The initiatives under the palliative care program include the establishment of bereavement programs, support for a medical registrar position in the south, and recognition of the role of domiciliary care services in the provision of palliative care.

In looking at the metropolitan area a clinical nurse position, previously piloted by the RDNS, has been established within the RDNS in the four metropolitan regions to become an integral part of the palliative care teams. Looking at the north, in 1989-90 and 1990-91 additional Health Commission funds were provided to establish a dedicated six bed hospice unit at Modbury Hospital and the Lyell McEwin Health Service in May and December of 1990. Further expansion of palliative care services has occurred, including the establishment of a respite care counselling and bereavement program at both hospitals and increased nursing and medical staff for the palliative care team.

In the west the annual grant provided to Southern Cross Homes as a contribution towards the hospice unit at the Phillip Kennedy Centre has been renegotiated to increase bed numbers from seven to 12. The palliative care service in the west has been significantly expanded, allowing staff increases to enable the team to provide a more comprehensive service. In the south, in keeping with net funding of health units, the Health Commission has channelled revenue from the hospice back into service provision, which has allowed the hospice to use the maximum bed capacity of 15. In the east there is a close association between the 17 bed Mary Potter Hospice at Calvary and the Royal Adelaide, and the Director of Palliative Care at the RAH is located at Mary Potter Hospice. The Royal Adelaide also has four dedicated hospice beds.

The commission provides an annual grant to Calvary as a contribution towards the care of pensioner and uninsured patients at the Mary Potter Hospice, which has been increased

to provide for additional uninsured or pensioner bed days. In 1993-94 that was $476 000. In the country, the additional Commonwealth funding enabled the Health Commission to establish new palliative care services, with most regions now having a specifically funded palliative care program and, in addition to the project funding, palliative care is generally provided through hospitals and domiciliary care. As I have visited a number of country hospitals in the past few months, I have been impressed by the facilities which a number of them provide so that people from their immediate area are able to access hospice care in areas where their families are able to visit. Outside metropolitan Adelaide, RDNS services are available in Iron Knob, Whyalla, Port Pirie, Port Augusta, Port Lincoln, Marree and in the Hills area. It is a particularly emotive area and there is certainly some good news.

Ms GREIG: On page 278 of the Program Estimates reference is made to immunisation. I would like to mention that it is pleasing to note the establishment of the South Australian Immunisation Forum which, I understand, has wide membership. Could the Minister advise the Committee about the rates of vaccine preventable diseases?

Dr Kirke: Previously there was a committee which was shared between the Health Commission and the Child, Adolescent and Family Health Service. It was an immunisation advisory committee. That has been expanded, and Professor Kevin Forsythe from the Flinders University, who is Professor of Paediatrics and Child Health, is the independent chair of an immunisation forum, which has membership from local government, the AMA, the College of General Practitioners, CAFHS itself, the Health Commission and so on. So, all the potential purchasers and providers of immunisation services are represented. The role of this forum, which was established in December last year, is to develop strategies and provide advice to the Health Commission in relation to achieving the best possible immunisation coverage of South Australian children.

A State immunisation strategy is being developed in concert with a national strategy. I believe that it is likely that CAFHS will be given responsibility for the overall management of the statewide immunisation program. The role of this forum is to provide advice to CAFHS as well. The role of the Health Commission continues to be to monitor the incidence of vaccine preventable diseases and the overall immunisation coverage, and provide reports as required by the Commonwealth.

The second part of the question related to vaccine preventable diseases. I think people would know that we recently had a number of cases of whooping cough. This is an illness that appears every three or four years. Unfortunately, the vaccine that is available to us at the moment is not 100 per cent effective; in fact, only 80 per cent of people immunised against whooping cough in childhood develop immunity, and that immunity lasts for only a few years. So, there will always be susceptible people in the community until we get a better vaccine. Measles is another vaccine preventable disease which, from time to time, causes minor outbreaks. In some cases this is in groups of people who are no longer immune—either their immunity has worn off following immunisation or they were never immunised in infancy. It is interesting to note that most of the recent cases of measles have been in adolescents or adults. So, that reflects our good figures. In fact, our immunisation coverage for measles, mumps, Rubella and so on is about 95 per cent in this State, and that is certainly as good as any other State in the Commonwealth.

Ms GREIG: In relation to page 270 of the Program Estimates, 'Teaching Hospitals,' what initiatives have occurred in the past year in the area of minimal access surgery?

The Hon. M.H. Armitage: In asking Dr Michael Jelly, as both Acting Chief of Metropolitan Services and also Chief Medical Officer, to answer this question, I indicate that Peter Rice, my media person, is, at this moment, recovering from minimal access surgery, so I feel very strongly about this area.

Dr Jelly: There has indeed been a number of initiatives in the past year in relation to minimal access surgery. Mr Tony Williams, who is head of the Unit of Gastro-intestinal Services at the Royal Adelaide Hospital, has introduced day surgery, using minimal access surgery, to undertake a number of cholecystectomies, and that has been a great initiative with many savings. As a result of that, the Royal Adelaide Hospital was able to clear the backlog of people who were suitable for that sort of surgery from its booking list, and indeed it asked the Lyell McEwin Health Service to identify people who would be suitable for that type of surgery from its booking list. Seventeen patients were transferred from the Lyell McEwin Health Service to the Royal Adelaide Hospital for minimal access surgery as a result of that.

In addition, an initiative with respect to day surgery, which covers minimal access surgery amongst other things, has been the development of 'Guidelines for the Conduct of Day Surgery in South Australia. A Best Practice Initiative'. We believe that that is a very good initiative in terms of identifying for the people who work in the health units how day surgery and minimal access surgery should be conducted.

Mr De LAINE: The Western Region Respiratory Health Plan has been written, but no budget allocation has been made to fund it. What is the status of this plan?

Mr Blight: The planning work to get the document to its current state has been achieved by using existing resources, partly from the central office of the commission and also from the staff resources of the Queen Elizabeth Hospital. The project is at a stage where it requires some further investment in technology to help drive the plan. On that score, it is the subject of a so-called 'quick-strike' project bid under our Info 2000 Information Technology Strategy, but the work that has been done to date is of such a calibre that it has attracted the interest of some outside investors in the form of Telstra, the holding company for Telecom. Telecom has approached the Queen Elizabeth Hospital and has indicated that it would be prepared to invest in one area of the technology requirements, that is, the transfer of patient data from the hospital to general practices in the region. So, we are currently working through its contribution to the project.

Mr De LAINE: In the Liberal Party policy speech the Premier promised South Australians that a building program would renew essential facilities at our major hospitals, including the Royal Adelaide and Queen Elizabeth Hospitals. How much has the 1994-95 budget allocated to the QEH to fulfil this promise?

Membership:

Mr Caudell substituted for Ms Greig.

The Hon. M.H. Armitage: I have talked previously about the Metropolitan Hospitals Facilities Study, in which there was consultation with large numbers of hospital administrators, planners, health professionals, doctors and so on, and that would indicate that we can plan differently for the needs

of health care in the future. Because of the advances in techniques of medicine and in care, such as the step-down facilities that I mentioned previously, we will be able to plan much more smartly to provide health care in the future. In relation to the re-jigging of facilities in the South Australian health sector, a considerable interest has been expressed by private sector developers.

The Flinders Medical Centre and Modbury Hospital are well down the path of re-jigging some of their infrastructure with private sector contributions, and plans to have a North-western Regional Hospital Service, under the amalgamation of the Lyell McEwin and Queen Elizabeth Hospital, entail the calling for expressions of interest for a 60 to 65 bed private hospital at the Queen Elizabeth. So there is considerable interest from the private sector in the first instance.

As I have indicated, the facility study is now under way and, once it has been finalised, there will need to be a master planning of facilities, in particular at the Royal Adelaide and the Queen Elizabeth Hospital. Once that has been done, a more specific plan for capital infrastructure can be provided.

Regarding the Metropolitan Facilities Strategic Review, I can say that we are looking, over consecutive years, at providing $31.85 million in 1995-96; $50.3 million in 1996-97; and $51 million in both 1997-98 and 1998-99. That is a considerable boost for the metropolitan hospitals which, as I say, will not be re-jigging beds just as they are but will be doing it in a cleverer fashion. That totals $180 million and, because of the distressing state of some of the infrastructure, we will need a contribution from the private sector, which may well even match that amount of money. However, the facts are that the private sector has indicated interest, and we recognise that with this sort of commitment of money we will be able to provide a much better hospital infrastructure.

Mr De LAINE: In spite of the success of past Labor Governments in vastly improving the dental health of young South Australians, the Minister would be aware that there are segments of the secondary school population where dental problems are still common. In particular, students from non-English speaking backgrounds or from areas where water supplies are not fluoridised are more likely to experience poor dental health. Was any attempt made by the Minister to determine the social implications of his decision to end the free dental scheme for secondary students who are not on the school card, or was the decision purely driven by cost? When will restricted access to the school dental scheme for secondary school students commence, and why was the starting date not given in the budget papers?

The Hon. M.H. Armitage: The decision was made not totally on cost but, as I have said on a number of occasions, and I repeat, the Government was charged with the responsibility of reducing South Australia's debt. Whilst it was not made totally on cost, I do not back away from the fact that it was partly a cost driven decision. In the 1993 calendar year there were 208 027 patients under care through the School Dental Service. In addition, there were approximately 6 000 patients who received care through capitation schemes with private dental practitioners in remote areas: in other words, the Government paid on a per capita basis for private dentists to provide services because it was too expensive for us to provide those sorts of services in remote areas.

The Government is looking to achieve savings from SADS by restricting eligibility for school dental care in secondary schools to only school card holders. As the member for Price indicated, there are particular areas which are more disadvantaged than others. I point out to the honourable member that I am sure that, if we looked at those statistics, exactly the sorts of groupings which he mentioned are more likely to be the people who are school card holders. The proposal is anticipated to reduce patient numbers by about 34 000 based on the number of non secondary school card holders in the 1993 calendar year. SADS estimates that the proposal would achieve savings of $.5 million in 1994-95 and $1 million in a full year. This represents an 8.8 per cent reduction in the School Dental Service budget of $11 364 074, which includes the central administration costs, which would be there no matter what.

As the member for Price would recognise, non school card holders are given, if you like, a safety net of buying into the School Dental Service by paying an annual subscription of $35 which equates to our average annual marginal costs plus the administration costs. We do not make any money on that deal. The rationale for the reduction in eligibility for School Dental Service clients being targeted at the group we have mentioned, in other words secondary school students who are not school card holders, is, amongst other reasons, as follows: school dental research indicates that, of the age group surveyed, approximately 60 per cent of those School Dental Service high school patients have private dental insurance anyway. We have made a value judgment that parents of non school card holders are more able to afford private dental care than the parents of school card holders. We also consider that those same parents (parents of non school card holders) are more likely to be able to afford the annual $35 subscription fee for continuing access to school dental care for that group.

Interestingly, the research also indicates that the children of parents with a higher income are more likely to seek dental care. More importantly, it is quite clear that the level of dental disease is lower in high school students compared with primary school students. I will provide two examples. Over 80 per cent of patients over the age of 12 years did not present with dental decay when they were examined in 1993. The average decay incidence for 6 year old primary school children is twice that of 16 year old children. We consider that the age group we have identified is in a better position to accept self responsibility for its own dental welfare. There are a variety of rationales why we have targeted budgetary restrictions at one particular group.

The South Australian Dental Service has suggested that 1 January next year be the commencement date for this. We are yet to confirm that. It is my view that that would be an appropriate time. Equally, it will have to be factored into a number of things such as the beginning of a term and a variety of other things like that. As I indicated, savings of $.5 million can be generated in 1994-95 and $1 million in a full year.

Mr BRINDAL: I commend the Minister on his answer about dental health. His department has obviously thought through the matter very well. Can I assure the Minister, in collaboration of his statements, that nobody from, as the member for Giles likes to say, 'the leafy suburbs of Burnside' or in my case the 'leafy suburbs of Unley Park' has actually rung to in any way protest against the actions the Minister has taken, because most people view them as sensible. I refer to the Program Estimates (page 279) and the implementation of recommendations for the waste management review. What are the details of the recommendations?

The Hon. M.H. Armitage: I am happy to provide details of the recommendations. In doing so, I will defer to Dr Michael Jelly who will, in answering, provide a summary of a number of environmental initiatives based in hospitals

which I think are exemplary and which indicate excellent waste management.

Dr Jelly: In 1989 a waste management working party developed a number of guidelines and as a result of that there were significant changes in hospitals in the practice of handling waste management. Included amongst its recommendations were that each institution should implement a wide policy that emphasises the five Rs: reduce, reuse, recycle, rethink and re-educate. They should correctly categorise waste as per the recommendations of that report which included: making sure that biological products were properly categorised (because they are the most expensive to get rid of); minimising double containerisation; renegotiating charges with waste contractors and suppliers of consumables; and implementing procedures that reduce consumables used in waste collection.

In 1993 it was decided to review what had happened across the system and it is interesting to summarise some of the issues that have been going on in hospitals. For example, at Flinders Medical Centre, general waste was reduced by 50 per cent and medical waste by 35 per cent. It implemented recycling programs throughout the hospital resulting in 34 per cent of waste being recycled. It used recycled paper as hospital policy; replaced the disposable bed pan system with reusable sanitisers, saving over $130 000 per year; eliminated polystyrene cups for staff tea and coffee, and disposable plates and so on in the staff restaurant; undertook an energy audit; completed a survey of staff transportation needs; installed secure bicycle lock-up facilities; replaced single use soap impregnated tissues with cakes of soap, saving $50 000 per year; introduced reusable linen protectors in place of disposables, reduced line usage and the generation of waste; and achieved total savings under the project of approximately $300 000 per year. It was also the recipient of a KESAB environment award in 1992-93.

The Women's and Children's Hospital also implemented recycling programs for paper, glass and cardboard; commenced a comprehensive education campaign to reduce inappropriate disposal of waste as 'medical' (and has already reduced that by 65 per cent); installed the co-generation energy plant (also saving energy); and investigated potential for water conservation.

The Queen Elizabeth Hospital has reviewed waste management with a view to enhancing recycling. It is enhancing recycling cardboard and pursuing energy conservation. The Modbury Hospital changed its waste contractor to facilitate waste minimisation, undertook a waste audit to identify improvements, established cardboard recycling and reduced medical waste volumes. The Royal Adelaide Hospital has placed its waste management contract out to tender with a view to minimising waste and implementing recycling programs. From that, you can see there has been significant improvement in the way waste is managed at the hospital level, and it is estimated that at least $400 000 is being saved per year across the system.

Mr BRINDAL: On behalf of Government members, I congratulate Dr Jelly on that answer. I also ask him to congratulate the Flinders Medical Centre. It is a remarkable saving and shows what can be done in this area.

The Hon. M.H. Armitage: I thank the honourable member. In preparation for this Estimates Committee, as I indicated to Mr Blight, that is an exciting answer with regard to the sorts of initiatives being taken. I am further told that an environmentally friendly book for hospitals and health services has either been prepared or is in the final stage of preparation. We intend to give it a lot of publicity, because that sort of thing is an unsung story in the health sector.

Mr BRINDAL: I refer members to the Program Estimates (page 279), where there is a reference to implementing a specialised purchasing agency. In his time as shadow Minister, I know the Minister had reason to worry about and question purchasing practices at various hospitals, and I believe the whole Cabinet has looked at Government purchasing with a view to both tightening up and making sure best and most efficient practice takes place in Government. I would have thought that this would concern the Opposition, but apparently it does not. Can the Minister give further details on this?

Mr Blight: This initiative had its genesis in a meeting of hospital CEOs about 18 months ago where they became acquainted with the concept of channel management. That is a philosophy of materials management which says that you can get the best economy in your materials purchasing if you have a look at all stages in the manufacture, purchase, distribution, storage and actual usage of the products. The CEOs of the major hospitals supported the commission's engaging consultants to study the application of channel management in our hospitals, and subsequently a consultancy was let at the Queen Elizabeth Hospital.

Incidentally, that consultancy was carried out by a very experienced US materials manager who remarked that he thought that the general inventory control practices at the Queen Elizabeth Hospital were equal to anything he had seen in the US. However, it was identified that one area of materials, specialist medical and surgical items, would be very amenable to the channel management approach. Across the metropolitan area $15 million *per annum* is spent on these specialised items, and the review showed that very conservatively a net 10 per cent could be saved on those costs—in other words, a very conservative benefit of about $1.5 million *per annum*.

Following that, it was agreed that a specialised purchasing office should be created that would serve all the metropolitan hospitals but, because of the importance of maintaining good working relationships with the hospitals, it was decided that the office should be independent of any one hospital and of the commission. Therefore, it was recommended that the Hospital and Health Services Association, a body which has representation from almost all our South Australian hospitals, would be the ideal focal point for such a purchasing agency. That was agreed by the association. Just recently, Cabinet gave approval to the setting up of a specialist purchasing agency within that association to buy specialised medical and surgical items on behalf of the metropolitan hospital system.

This agency is a first for the South Australian health system and, although the initial target in this area of medical and surgical supplies costed at $15 million, there is ample evidence to suggest that this technique could be applied to other areas of purchasing, with the final scope being around $30 million *per annum*. So, the potential benefit is expected to increase beyond the initial benefit of $1.5 million *per annum*. The specialised purchasing agency will be very small in an administrative sense: it is expected to involve no more than two people, and its costs will be recovered outside the net benefit of $1.5 million *per annum*. This agency is expected to be up and running this calendar year, and it should deliver the majority of those benefits from the 1995-96 financial year and beyond. It is a good example of how literally millions of dollars can be saved with no reduction in the quantity of patient services provided, and in

fact with an increase in quality of patient services, as prostheses and other specialised products are more closely tuned to the needs of the patient.

Membership:

Mr Rossi substituted for Mr Caudell.

Mr BRINDAL: I refer members to the Program Estimates (page 279), where reference is made to a strategy called INFO 2000. The Minister will be aware that, in the past couple of days, there has been a great deal of excitement in South Australia over the Government's announcement concerning the EDS. How will the South Australian Health Commission's INFO 2000 project fit in with Government strategy of outsourcing its responsibility for computing? Is it part of EDS or is it something separate?

The Hon. M.H. Armitage: I am pleased to address that question because, as the member for Unley has quite rightly observed, there has been a deal of excitement about the extraordinary announcement by the Premier two days ago in relation to the possibility of South Australia being an information technology hub for Asia and so on.

Mr Davidge: Before I answer the question specifically, some background on the strategy might assist. The INFO 2000 project was established to prepare new information policies and strategies to assist the South Australian Health Commission and its health units through to the year 2000. It has been adopted as the framework within which individual health care units and strategic implementation technology plans will be coordinated.

The project commenced in February 1993 and the final report was completed in November 1993. Consulting assistance was part of the project, and a well recognised national consultant was selected from seven firms of consultants on the basis of the quality of their submission in terms of developing the strategy and the fact that they had undertaken similar studies for a number of other health authorities around Australia. They also had access to international best practice through their consulting network overseas. In developing the strategy, an information policy and strategy committee was formed comprising CEOs of a range of health units, executive directors from the Health Commission and also clinicians. A very interesting part of the project was that, in addition to public sector consultation, the strategy included divisions of general practice as part of the development of the strategy. General practitioners are very important in the information technology sense and the way in which we operate our health sector because of their interfaces with the health system.

The plan proposes a priority for clinically oriented systems and the replacement of the majority of existing health unit information systems with new common systems over a five year period at an estimated capital cost of $76.5 million. This represents a significant increase to this area of expenditure, and I think in percentage terms it represents just under a doubling of expenditure in that area at the present time. An emphasis on the innovative use of information technology to fundamentally change the way in which clinical services are provided will deliver significant benefits from this investment.

With respect to how this relates to the wider Government strategy, the strategy was developed in close consultation with central agencies, and since its completion it has been appraised favourably by the Office of Information Technology. Cabinet endorsed the strategy on 22 August 1994. Having been developed late last year, prior to the Office of Information technology been created, the strategy has been sufficiently robust to incorporate all the elements of the new direction imposed by the Government. Implementation of the strategy will be on a phased basis, with individual components planned, costed and approved.

One other important aspect of the strategy was that it proposed the delivery of information technology processing services through outsourcing. The EDS proposal basically fits within that category, so it was always and is quite consistent with that. The Health Commission and its health units will participate in the due diligence process to be undertaken by EDS over the forthcoming months, and all existing and future computing infrastructure needs will be sourced through EDS. That is common across all Government agencies. Some existing hardware supply arrangements—and we have some existing arrangements through our small country hospital computing systems—may need to be renegotiated, but once again they are part of the plan.

At the applications level, there are further opportunities for outsourcing and economic development throughout South Australia. The Minister has already announced an in-principle agreement between the Government and McDonnell Information Systems for the development and supply of a new generation of clinically oriented patient management systems. Such initiatives meet the objectives of the Government to increase the economic base of the State and those of INFO 2000 to provide the health system with high quality systems at an affordable price. All systems implemented will be required to meet stringent data security and patient confidentiality criteria. In summary, the INFO 2000 strategy is consistent with the Government's policy on the outsourcing of information technology processing and priorities for the application of information technology.

Mr ATKINSON: Casemix funding is based on the product of the number of weighted patients in each category and the relative cost weight. What percentage reduction in cost weights from 1993-94 is necessary in 1994-95 to absorb the cut in hospital expenditure, and how was this percentage cut in cost weights determined? Was it arbitrarily based on making the required savings in hospital expenditure, or was some scientific study of hospital costs made to estimate the possible savings?

The Hon. M.H. Armitage: The cost weights were not decreased at all. The process about which the member for Spence asked was that we looked at a balanced price and then there was an expectation that the hospital sector would make a contribution. I can provide the details of the total hospital expenditure later, but the contribution required of the hospital sector *in toto* was $15 million, most of which has been reinvested as efficiency pools, through the bonus pool, the throughput pool and so on. Instead of historically funding hospitals which were providing services inefficiently, most of that money is a magnet to get the efficient hospitals to provide more services.

Mr ATKINSON: The report from consultants Van Konkelenberg and Hemmings, entitled 'Responding to the needs of older patients following the introduction of casemix funding in public hospitals', recommended an increase in the range and resourcing of community and home based services. Given that the Government has accepted the report in principle, what is the allocated expenditure on community and home-based services in 1994-95; what was the expenditure in 1993-94; what is the increased expenditure on these services; and where will it be allocated?

The Hon. M.H. Armitage: Before answering that question, I now have the information relating to the previous question. Hospital budgeting was $773 million, from which we asked for $15 million, most of which we reinvested in the efficiency pool. I am informed that the answer to this specific question is that there was no cut in home-based care. Indeed, we have added $1.5 million to a number of community care programs about which we have talked before.

Mr ATKINSON: The same report recommends that the Government should 'increase the provision of specialist discharge planning staff in hospitals to facilitate continuity of care and provision of care in appropriate settings.' How many extra staff to perform these functions have been or will be employed in 1994-95, and what additional funds have been allocated to hospitals to give effect to this recommendation?

Dr Filby: No specific allocations have been made to hospitals to provide for discharge staff. Our expectations are that hospitals will make their allocations on their own in the light of their own decisions about what they need to do. However, under the home and community care program there will be a little over $750 000 of additional money provided to domiciliary care this year to support home-based services.

Mr Blight: The Konkelenberg report recommended the development of sub-acute facilities, estimated at approximately 120 beds. The master planning studies, which are presently under way at the Royal Adelaide and the Queen Elizabeth Hospital, will bring on stream step-down beds of at least that number. The report recommended that another $1.1 million of additional community-based care should be put in place. David Filby has just mentioned the hundreds of thousands of dollars of extra HACC funds, but the hospital service improvement strategy has provided $1 million for projects linking hospitals and community-based care consistent with the Konkelenberg report. The other recommendations relating to the refinement of casemix will be taken up, we expect, with the release of version 3 of the Australian National DIG Classification System, which is due to be implemented for the 1995-96 financial year.

Mr ATKINSON: I refer to support services on page 279 of the Program Estimates. As the Liberal Party spokesman on health before the last election, the Minister promised 'to allocate an additional $6 million annually to public hospitals and retain within the health system all savings generated so that increased funds can be provided for direct patient services and for initiatives announced in this policy document.' The May financial statement announced that health expenditure would be cut by $65 million a year over four years with all savings to be returned to Treasury. Why has the lion's share of budget cuts in South Australia been imposed on the health lines?

The Hon. M.H. Armitage: The booking list pool has in it not $6 million but $7.5 million, and in addition there is $2.5 million in the throughput pool. If savings over and above casemix demands are made by health units, we are quite happy for them to be retained. This budget was framed in the context of South Australia's parlous economic state—

Mr ATKINSON: Which you knew about at the time.

The Hon. M.H. Armitage: Which not only I knew about but which the Government of which the member for Spence was a supporter was hiding from the rest of South Australia.

Mr ATKINSON: I refer to page 275 of the Program Estimates. Is the Minister aware of the 133 South Australians with an intellectual disability who are at risk because the Intellectual Disability Services Council cannot fund support services that would reduce these people's exposure to harm in boarding houses and the like which cannot offer services that comply with the Disability Services Act? What does the Minister intend to do to reduce the exposure of these people to harm?

Mr Brindal interjecting:

The Hon. M.H. Armitage: The member for Unley suggests that I might give some historical background, and I had intended to do that. I am delighted to indicate to the member for Spence, as I have on a number of occasions, that the disability area is quarantined from cuts. We are not making one cut in that area. Clearly the situation which was extant during the decade of the previous Labor Government has not been altered at all. I do not recall the member for Spence making one parliamentary contribution in the past four years criticising that matter. I will look through *Hansard*, but I do not recall his doing that. This is a dilemma which needs to be addressed. We are looking at a number of creative solutions to it in what are tight budgetary circumstances. I will ask Colleen Johnson from the Disability Services Office to give some detail.

Ms Johnson: There is, as the honourable member has said, a difficulty in providing adequate accommodation services. That is a situation that will get worse over the next year because we do have many people living with ageing parents. In fact, we have over 1 000 people living with parents, clients who are aged over 50 years in fact, so this is a problem for the future. However, we have had some money coming into the State over the past couple of years through the signing of the Commonwealth-State Disability Agreement. In the last financial year, $1.615 million was allocated to IDSC to provide an expansion of intensive accommodation support services. An additional $1 million is coming into the State this year under the same agreement. That $1 million is to go across all disability groups for all disability types. The allocation of that money has not yet been determined for the current financial year. However, it is recognised that supported accommodation and intensive support services for people in crisis is a priority area, and funds will be allocated to that program.

In addition to that money coming into the State as a result of the Commonwealth-State Disability Agreement, the Intellectual Disability Services Council (IDSC) has also been looking at other measures to try to solve some of these difficult problems. It has been identifying one-off savings, and those one-off savings have been used to patch together supports for people who are in worse situations. That is only a short-term solution, of course. It has admitted four additional people to Strathmont Centre since November 1993. There is no choice other than for people to go there, despite the unsuitability of Strathmont Centre as an accommodation option.

Two to three vacancies exist in houses where people have been accommodated as a result of crisis and, where possible, people in the most urgent situations will be considered first. A total of nine vacancies for people with severe and multiple disabilities will be filled in IDSC group homes in the near future, now that money has been made available for day options through efficiencies within its own operations.

SCOSA has identified savings from its reorganisation with the Crippled Children's Association, and discussions are being undertaken regarding people who have urgent needs and could be accommodated or provided with day options within SCOSA. Discussions are also being undertaken with metropolitan health services of the Health Commission regarding funds for one client who has temporal lobe epilepsy

and a dual diagnosis of intellectual disability and psychotic behaviour. IDSC is trying to free up funds which can be redirected to provide respite service for families in northern suburbs and the Murray Bridge area where there are significant gaps. It is more difficult to respond to urgent needs especially for accommodation in country areas, and group homes are urgently required in the South-East and at Port Augusta to meet the needs of several homeless people. At this time, IDSC has not been able to identify funding.

IDSC is also investigating the feasibility of purchasing a motel or hostel to set up single unit accommodation for vulnerable clients who have a marginal lifestyle and require supervision and support intermittently rather than constantly. However, some capital funding will be required for that. Strathmont Centre is investigating its capacity to close a villa by moving people into adult foster care or home board situations, and this will also free up funding to cater for a number of people currently living in tenuous situations.

IDSC is piloting an arrangement called the Host Scheme which is, in effect, an adult foster care arrangement for people who are willing to have a boarder with an intellectual disability in their own home. They are paid an amount of money to provide some supervision and some very basic personal care services. That scheme will proceed and, if successful, should allow the dollars to stretch further and provide the capacity to accommodate people in urgent need.

Mrs KOTZ: The Minister may wish to take this question on notice. It relates to an answer given earlier in the day on the second mobile caravan that will be commissioned in October for breast screening and mammography. Which area of the State will the second caravan initially service?

The Hon. M.H. Armitage: I will ask Kerry Kirke to respond.

Dr Kirke: The second mobile unit is almost complete, and we are hoping to commission it in October. It is booked on the ferry to go to Kangaroo Island immediately it has been proven up in Adelaide, and it will service Fleurieu Peninsula and other places that have missed out in the round so far. There is a formal program and, if the honourable member wants details, I can provide that.

Ms STEVENS: With respect to the Lyell McEwin Health Service, recent announcements concerning the amalgamation of the Queen Elizabeth Hospital and Lyell McEwin should result in significant benefits for health services in the north, and we welcome that. Earlier in the day the member for Newland mentioned there had been considerable scaremongering in relation to that situation throughout the northern suburbs. As the Minister knows, a lot of genuine concerns were expressed by members of the Lyell McEwin board, the staff of that hospital and members of the community arising out of—and I think the Minister would acknowledge this—the speed with which those things occurred.

I acknowledge also that the Minister has addressed many of those concerns that were channelled through the board to him, and I was pleased to hear him say again earlier today that the steering committee was up and running, that an interim report would be released soon, and that the time line for February was still firm. Will the Minister guarantee that the people in the north will have equitable access to services at the Lyell McEwin Hospital that have not been available in the past in areas such as orthopaedics, urology and ophthalmology, and that the extra benefits that accrue from the status of a teaching hospital will also be equitably shared at the Lyell McEwin Health Service?

The Hon. M.H. Armitage: I can guarantee that those matters will be addressed by the implementation steering committee and, as I indicated before, there are representatives from both hospital boards and staff on that committee.

Ms STEVENS: I refer to the Mental Health Services unit at the Lyell McEwin Health Service and the 20 bed unit that was opened earlier this year. There have been problems in relation to having all those beds available. The problems relate to obtaining professional staff for the unit. Will the Minister comment on that and on whether that problem has been addressed and, if not, what strategy does he see in relation to ensuring that we use the 20 beds?

The Hon. M.H. Armitage: I am informed that there are shortages of medical staff and again I would ask the Chief Medical Officer to address that.

Dr Jelly: Undoubtedly, the whole of the South Australian Mental Health Services has had major difficulties in maintaining the appropriate level of staffing and is still about six full-time equivalent psychiatrists-specialists short of their target. It has attempted to fill some of those gaps by additional trainees in the system, but there are problems in recruiting professional psychiatrists to the public Mental Health Services. My understanding was, at least initially at Lyell McEwin, there was difficulty in having a psychiatrist available to undertake those legal steps necessary to have someone retained under custody when they were mentally ill. I think they have been mostly allayed by now, but I am not absolutely certain of that and I would have to check it.

Ms STEVENS: I appreciate what you have said in relation to shortages of psychiatrists in the system. What strategies are you thinking about in relation to remedying that?

Dr Jelly: Every attempt has been made to try to recruit staff by advertising both locally and interstate and, indeed, there have been a number of people who have, under limited registration, been recruited into the South Australian Mental Health Services to try to fill the gaps. The psychiatrists are under the same terms and conditions of employment as other specialists within the system, but they choose not to work in the public health system for a number of reasons, some of which relate to work conditions, which are a hangover from the past in many cases.

The Hon. M.H. Armitage: At this moment SAMHS is undergoing a national recruiting program to appoint a Chief Psychiatrist, and discussions that I had with the CEO and others from SAMHS yesterday evening indicated that the morale in SAMHS, which was certainly low after all the dilemmas between 1991 and the release of the realignment report today, is improving—they suggested considerably—but there is still a long way to go. But, we believe that that is part of the problem in identifying why psychiatrists were leaving the service. We believe that those two measures will see a number of them happy to be part of SAMHS again.

Ms STEVENS: In relation to the re-use of instruments, you would be aware of the concerns raised recently on the ABC's *7.30 Report* about the widespread practice of recycling single use only instruments, including cardiac catheters. The dangers associated with this practice were recognised under the previous Government, and the South Australian health authorities played an important part in drawing up recommendations for the National Health and Medical Research Council for safe practice and the recycling of such devices in Australian hospitals.

However, the Audit Commission criticised the high cost of medical supplies in South Australian hospitals. The

Minister's budget cuts have placed unprecedented pressures on our hospitals to cut corners and reduce costs. Given these cost pressures, how will you ensure that the widespread interstate practice of recycling single use instruments does not spread to our hospitals; and how will you ensure that guidelines on re-use are adhered to?

Mr BRINDAL: On a point of order, Mr Chairman, not an hour ago I clearly asked a question on waste management, and the issue of recycling was dealt with then. I, therefore, contend that this a repetitious question.

The CHAIRMAN: The Chair was listening and the Chair did not recall this specific item being referred to. I may be wrong, but I did not recall it. It is single use instruments that we are discussing at this stage.

Dr Jelly: This issue is clearly very topical around Australia and was highlighted on the television show that the honourable member cited. That show, as I understand it—and I did not get to see it, unfortunately—highlighted the use of minimal access surgery instruments in particular. I am informed that within the public hospital system in this State—I cannot speak for the private hospital system—those items are not re-used. However, there are a number of single use items which are used throughout the hospital system and have been for many years, such as those associated with haemodialysis, some endotracheal tubes and the like. The issues are very clear: if you are going to do that, there are some obligations on the organisation to work through a very formal process of approval.

The sorts of questions to be addressed are, first, a guarantee about the sterility of the reprocessed product; the addressing of the engineering aspects (whether it will break or not break); the cleaning aspects; and the addressing of adequate guidelines on quality control and reprocessing of items. My understanding is that the National Health and Medical Research Council is right now drafting guidelines on single use items and, of course, this State is participating in that, in fact in many ways taking a lead through our infectious disease clinical program. So, we would certainly wish to make sure that the quality use of those items is maintained, and we will be working with the NH&MRC to develop those guidelines. I would also like to add that cardiac catheters, which I saw highlighted on one snippet of that program, are not re-used in South Australia.

Mr ATKINSON: I refer the Minister to the capital budget. In his budget press release, the Minister lists one of the areas targeted in 1994-95 as being to realise savings with 'reduced capital works expenditure against previously agreed funding; $7 million'. What are the capital works projects ($7 million) he has cancelled?

The Hon. M.H. Armitage: Both the RAH and QEH redevelopments, stage 2, are in the master planning phase that I mentioned before; Clare redevelopment has been deferred; and SADS, Munno Para Community Health and Millicent redevelopments have been deferred indefinitely. I have had discussion with the Women's and Children's Hospital about other ways of funding the cardiac angiography unit as a priority. Stage 1 of the Mount Barker Community Health redevelopment is still continuing, but others will be slower.

Mr ATKINSON: I refer to page 279 of the Program Estimates—'Support services'. The Commission of Audit recommended:

> Given the size of Adelaide, one, two or three regions would be workable for the metropolitan area.

The report then found:

> Regional boundaries should be determined after further study of the characteristics of local populations, consideration of service requirements of current and likely future local populations and appropriate consultation.

The report concluded:

> The future of QEH is relevant to the strategy for regionalisation.

The Minister announced his decision on the Queen Elizabeth Hospital on 2 August and spoke of services in the north-west, which he described as the area around the Queen Elizabeth Hospital and the Lyell McEwin Hospital. However, two days later he referred to the potential amalgamation of community health care in the north-eastern region when discussing women's health services. How does the Minister intend to regionalise health services in the State and how has he determined regional boundaries? If he has not yet reached a decision on the boundaries of health regions, why did he pre-empt this decision by merging the Queen Elizabeth Hospital and the Lyell McEwin Hospital?

The Hon. M.H. Armitage: The Government was not slavishly committed to all recommendations of the Audit Commission, and the member for Spence knows full well that, if it had been, the teaching hospital to which most of his constituents go would have lost its teaching hospital status. So, I would have thought that he was pleased that we looked creatively at the recommendations of the Audit Commission. The announcement for the amalgamation of Lyell McEwin and Queen Elizabeth Hospitals was announced to, first, retain the Queen Elizabeth Hospital's teaching status and, secondly, to improve the services in the north.

We are putting the finishing touches to a discussion paper in relation to proposals for regionalisation boundaries, and that will be announced early next week. We are looking for input and consultation from the community, just as we did with casemix funding, and we would expect that that would be forthcoming, given that people certainly are expecting a regionalised system so that the benefits of the funder/purchaser/provider split can be gleaned. When the Liberal Party was in Opposition it was quite specific about that. One can have different boundaries for different services depending upon how the amalgamation efficiencies can be generated.

Mr ATKINSON: Will the regions for hospital services be the same as those for community or other health services and, if not, will the Minister provide details of how interaction between, say, hospitals and home and community care services will occur across different boundaries?

The Hon. M.H. Armitage: The answer to the first question is: not necessarily. The answer to the second question is: it will be the purchaser's duty to purchase the cheapest and best quality services for the purchasing authority it is representing.

Mr ATKINSON: I refer to page 271 of the Program Estimates—'Metropolitan non-teaching hospitals': when will the Minister reply to my letter of 19 May about the Southern Districts War Memorial Hospital? In a letter to Mrs Pam Howard of 7 September 1993, the then Leader of the Opposition wrote:

> I would like to confirm the commitment I made verbally to the Friends of the Southern Districts War Memorial Hospital at a meeting at McLaren Vale in July that the Liberal Party will restore the hospital funding to its original level before the State Government's decision to reduce its financial support.

Will the Government honour its election promise to restore the funding of the hospital to the real levels before the previous Government's 60 per cent cut to its budget? Why

did the Minister take 10 private-bed licences from the hospital?

The Hon. M.H. Armitage: Many representations were made to me by members of Parliament from that area as well as from the board, and the upshot of those long and fruitful discussions has been announced in a public meeting and has been publicised in the Messenger Press, to which I refer the honourable member. The hospital has now gone to casemix-based funding; hence historical funding is a thing of the past.

Mr ATKINSON: I refer to pages 278 and 279 of the Program Estimates—'Public and environmental health services' and 'Support services': when will the Minister reply to my letter of 2 February 1994 on behalf of the Ackan family of Crittenden Road, Findon, asking whether the Government intended to license natural therapists in disciplines such as naturopathy, herbalism, homoeopathy and acupuncture? Does the Minister think the provision of ancillary benefits covered by the health funds to cover the costs of consulting natural therapists may be lost if the State Government does not license natural therapists, or that natural therapists will be unable to prescribe remedies under the Federal Government's Therapeutic Goods Act unless they are licensed by the States?

Mr BRINDAL: On a point of order; the Chairman has been very gracious to both sides today, but this is an Estimates Committee and I fail to see the relevance of the honourable member's question. The honourable member did not refer to a budget line.

The CHAIRMAN: The honourable member referred to the budget pages, although not to a specific line. Could the honourable member relate it to any specific section rather than just delivery of health services?

Mr ATKINSON: I think the Minister is pretty keen to answer this question.

The CHAIRMAN: Is the Minister happy to respond?

The Hon. M.H. Armitage: Yes, I am happy to respond. The Therapeutic Goods Act is a Federal Government matter, and naturopaths and so on have had a lot of input into the Federal Government. As to whether health funds ought to provide those benefits, that is a matter for the private health funds, and I am informed that the Government does not license naturopaths.

Mr ATKINSON: Has the Government any intention of licensing naturopaths? I quite understand it if the Government does not, but I would like to know its intentions?

The Hon. M.H. Armitage: That matter has not been contemplated.

Mr ATKINSON: I raised it with the Minister on 2 February this year.

The Hon. M.H. Armitage: It saves me a stamp then.

Mr ATKINSON: I refer to the Program Estimates at pages 270 to 279. A section of the Program Estimates, headed 'Commentary on major resource variations between the years 1993-94 & 1994-95', includes the comment:

> Carryover of funds from 1993-94 for commitments and to assist in meeting 1994-95 savings and cost pressures.

What is the total amount of funds carried over from 1993-94 to prop up this budget, and does this mean that the cuts which the Minister has foreshadowed for future health budgets when carryover funds are not available will be even deeper than they are this financial year?

The Hon. M.H. Armitage: The answer to that question was in both the opening statement and a question that the honourable member missed while he was away.

Mr ATKINSON: That may be the answer to the first question but it is not the answer to the second. Would the Minister care to answer the second question?

The Hon. M.H. Armitage: That bears no relationship.

Mr ATKINSON: I refer the Minister to the Program Estimates—page 279 'Support Services': what restraints has the Minister imposed or what direction has he given to the boards of public hospitals on the privatisation of hospitals and their services? Will he rule out the privatisation of all or any part of Flinders Medical Centre, Lyell McEwin Hospital or Royal Adelaide Hospital? Are there any particular services provided by our major public hospitals which he will not allow to be privatised?

The Hon. M.H. Armitage: The answers to those questions are 'None', 'No' and 'No'.

Mr ATKINSON: In view of the Minister's announcement on 2 August that a private hospital will be built at the Queen Elizabeth Hospital and that additional private sector involvement at Queen Elizabeth Hospital would be sought, will he rule out the sale of all or part of Queen Elizabeth Hospital? Will he say what services now provided by Queen Elizabeth Hospital are up for sale?

The Hon. M.H. Armitage: That announcement included, as I said in relation to another question answered earlier, the concept of offering for tender (and expressions of interest are about to be called for) a 60 bed private hospital at Queen Elizabeth Hospital. In relation to the second question, as I have indicated on a number of occasions, if private provision of services is able to be accommodated within quality guidelines and there is a price benefit to the taxpayer of South Australia, this Government is particularly interested in looking at them.

Ms STEVENS: I refer to the Program Estimates at page 279—'Support services'—relating to computer systems. On page 469 of the Auditor-General's Report it states:

> The commission was advised in June 1994 that it was unable to proceed with the purchase and implementation of its assessed tender option. . . for replacing its financial accounting and management systems. . . as the Government had approved in May 1994 the selection of a financial management system for the whole of Government.

Who was the tenderer accepted by the Health Commission and who was accepted in the whole of Government tender? Is the commission liable for any costs associated with the then unsuccessful tender, and, if so, what are the details? How much money was wasted on this futile tender exercise as a result of the Government's information technology decision?

The Hon. M.H. Armitage: I will refer that question to Mr Davidge.

Mr Davidge: The financial system spoken about was a financial system purely for the central office of the Health Commission, so it was not a health sector-wide financial system. The system selected was Oracle Financials. The system mandated by the Government is CA Masterpiece. There will be no costs and no penalty payments associated with the mandated decision. The work that was done in selecting Oracle Financials was a necessary piece of work that had to be done and will benefit us when we implement the CA Masterpiece system.

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

Membership:

Mr Scalzi substituted for Mrs Kotz.

Mr Wade substituted for Mr Brindal.

Mr ATKINSON: I refer to page 24 of the blue book. Is Commonwealth recurrent funding to South Australia in this year's health budget up by $24.8 million and Commonwealth capital funding up by $3.5 million? As the total State budget allocation to health is $32 million less than last year's estimate, does this mean that the State's contribution to health is actually $60 million down on last year's budget? Does the Minister believe that the Commonwealth will continue to increase health funding to the States if the States themselves reduce funding by twice the Commonwealth increase?

The Hon. M.H. Armitage: Whilst those figures and percentages are correct in the Commonwealth versus State total application of the program, the figures are the Federal draw, if you like, or our contribution from the Federal Government, as the honourable member has correctly identified. However, the State budget is made up of a number of other things which contribute to that, including—in addition to the Commonwealth receipts—the receipts from patient fees, which is a significant amount, the sale of any land and buildings which we might sell, interest on the special deposit account, and so on. All those matters put together are factored into the total budget. This is the Commonwealth position, but there is a greater continuum of fees from those sorts of things that I have mentioned.

Mr ATKINSON: The Minister will recall that he was questioned in Parliament about the late appointment of the Flinders Medical Centre Board. Who are the new members of the board, and when did they have their first valid meeting? Given the difficult resource decisions facing hospital administrators and boards as a result of the Government's budget cuts, is the Flinders Medical Centre at a disadvantage in preparing for these budget cuts without a validly appointed board?

The Hon. M.H. Armitage: I will supply the names of the people who have been appointed to the board later, but I can indicate their professions. The four appointments that I have made are as follows: one of Adelaide's leading architects with experience and an interest in the health area; a person involved in the occupational therapy area; a lawyer; and a financial expert from Mitsubishi. I was speaking recently with the Chief Executive Officer of Flinders Medical Centre who indicated that he intended to have an orientation meeting with those new board members within the next couple of weeks so that they will be *au fait* with the demands of being a board member of a major public hospital. He has spoken to me confidently about those board members and the make-up of the new board. I am very confident in the skills that they bring to the board and, as far as disadvantaging Flinders in any way, it is simply not true.

Mr ATKINSON: In answer to a question from the member for Newland just before lunch, the Minister justified cuts to Western Community Health Services on the basis of population ratios. Does this indicate that other health units and public hospitals will not be funded on a *per capita* basis rather than a needs basis, and does he accept statistics in the social health atlas which indicate that people with chronic health problems tend to be aggregated in the northern, southern and parts of the western suburbs because of factors such as the availability of public housing? If so, why does he believe that these communities should not receive additional resources to deal with their health problems?

The Hon. M.H. Armitage: If the member for Elizabeth sitting beside you were asking that question I would assume that in response to her constituents she would be saying, 'Why is such a large percentage of the budget dollars applied to a small percentage of the population?' We are not distributing money on a population basis and, if that is the impression you have received, that is incorrect. What we are doing is looking at a dollar per population basis. We are attempting to identify the clearly extant areas of need, which are the north and south—the growth areas—and we believe that the provision of services in those areas is equally as important. We also believe that the commitment to the maintenance of the Queen Elizabeth Hospital in particular as a teaching hospital to allow the standards of health care which follow from that commitment is a clear example of the recognition by the Government of the effects which are noted in the social health atlas in the west.

Mr ATKINSON: I refer the Minister to 'Support Services' on page 279 of the Program Estimates. Which hospitals have reached agreement with unions over outsourcing, and why have chief executive officers of some major hospitals refused to negotiate over contestability?

The Hon. M.H. Armitage: My advice is that we do not know particularly of CEOs who are specifically not choosing to negotiate with unions in relation to contestability policies. If the member for Spence has any advice about that we would appreciate knowing it so that we can take action to rectify it. I am advised that, in relation to the Modbury Hospital exercise (in which, as you would recognise, I have asked the Coalition for Better Health to be a player in providing opportunities for it to be part of a bid to help us provide services more effectively and more efficiently), because of the confidentiality of the agreements at Modbury Hospital at the moment there are some business reasons for that non-negotiation at this moment.

Mr SCALZI: Page 279 of the Program Estimates indicates that the Health Commission will encourage the export of health services from South Australia. I have had a strong interest in this area, as I mentioned in one of my speeches. Can the Minister give some examples of opportunities that may be pursued in this area?

The Hon. M.H. Armitage: The whole concept of the export of health services has been a matter which has interested me personally for a long time, recognising the excellence of the services that are provided within the South Australian system. Certainly, members of the Opposition bench who have so carefully perused the Liberal Party policy from the 1993 election campaign would recognise that the potential for the export of health services form the major part of that policy. There is no doubt that it is an opportunity for us to create wealth in South Australia through the use of our expertise. We are pursuing that opportunity down every avenue. I ask the Chief Executive Officer, Mr Ray Blight, to give further examples of initiatives in that area.

Mr Blight: Some 12 months ago the commission entered into cooperative arrangements with SAGRIC International, the Government owned commercial vehicle for the export of Government services, and as a result of that relationship we are participating in two projects. One is a $6.5 million project in Vietnam for the prevention of iodine disorders, and we are providing epidemiological expertise to that project. The second one is a $7 million hospital improvement program in Papua New Guinea. We are working with SAGRIC to source hospital administrators to work in the country in PNG and to provide health worker training.

In Malaysia we have been active in promoting our capabilities. Two officers recently attended an Australian

health services and equipment display in Kuala Lumpur. We promoted our capabilities in public health information systems and primary health care, biomedical engineering services and health facility planning. Partly as a result of that effort, we participated in a joint tender, in conjunction with a Malaysian company, for the supply of biomedical engineering services to hospitals in Malaysia. That project is still active. We have recently been asked to provide further detail on the scope of the biomedical engineering services that we can provide, and we have also been invited to offer capabilities in laundry services, waste management and an IT network to support those three projects. We have also made representations to the Malaysian Ministry of Health for the provision of a management training program. That issue appears to be of high interest to the Malaysian Ministry of Health at this time.

We have also responded to a request by the United Arab Emirates for proposals to carry out a review of health system management in that country. They particularly wanted a proposal which combined public sector expertise with commercial expertise. In that proposal we worked jointly with KPMG and Health Futures International, a local South Australian company.

We also have an opportunity in China to participate in the development of a 500-bed county hospital. We are working on that jointly with Woodhead Australia, an architectural firm which has hospital design as one of its interests. We have assisted with a feasibility study to outline the service profile, but it is possible that we will be invited to play a role in the management of that facility if we so desire. We have yet to decide its feasibility.

They are not all the projects on which we have been working over the past 12 months, but they are samples. We are trying to use the substantial medical, scientific and management expertise that we have within the South Australian health system to add value to the efforts of South Australian or Australian companies as they pursue opportunities in the health industry overseas. We will also be looking for opportunities to develop our own tradeable services and products for direct export.

Mr SCALZI: As a supplementary question, will the Minister outline some of the benefits to the South Australian community and economy in general if those initiatives come to fruition?

The Hon. M.H. Armitage: A variety of benefits may accrue. As I said before asking Mr Blight to elaborate, it has always been my belief that the health sector can play a large part in rejuvenating South Australia's economy. Obviously there will be a variety of economic effects which will flow from these types of alliances in other countries, not the least of which will be jobs in South Australia to allow the expertise to be developed or to prepare the equipment that we are exporting, or whatever.

There is also the potential for large numbers of people to come to Australia to learn what we do very well in Adelaide —such things as training of nurses, doctors and other paramedical staff. In view of the populations of some of the countries which are expressing interest in the South Australian health sector, large numbers of people may need appropriate training, and that will be a benefit in itself. There are definite advantages to the economy.

I would like each individual South Australian to focus on the fact that, if we are to compete in an international health market, the only way is if the services that we provide (be they teaching, training or direct clinical services) are equal to the best in the world. By having a focus within the commission and Government policy on health export, we are focusing on world best practices. There is obviously a flow down effect within the system. If everyone aims to export a particular product in the health sector, there will be a flow on effect. South Australian taxpayers will benefit from the improved practices within the South Australian health sector if they are unfortunately in need of our services.

Mr SCALZI: The Program Estimates, at page 276, indicate that a child abuse prevention strategy for Elizabeth is to be developed. Will the Minister indicate the initiatives that might be pursued under this strategy.

The Hon. M.H. Armitage: Again, this is a very important question, and I am sure that the member for Elizabeth will be interested in the answer. I will ask Dr Jelly to provide the details.

Dr Jelly: This is a combined Department for Family and Community Services and South Australian Health Commission initiative. It recognises that the things that we do to prevent child abuse are less than effective, and we are looking at a strategy which may be developed to improve that situation. There have been a number of such strategies worldwide, including some which have been looked at in Hawaii, New York, the United Kingdom, Newcastle in New South Wales and Newpin in the United Kingdom.

Gayle Breakey, the Director of the Hawaiian Family Stress Centre, visited Adelaide in July and presented the Healthy Start Model to key players in metropolitan Adelaide. The effectiveness of that strategy, as demonstrated by Ms Breakey, validated the view that this was the preferred model for adoption in devising a home visitation service to suit new parents in Adelaide. It has therefore been resolved to develop a home visitation strategy for Elizabeth based on the Hawaiian model.

This model is considered the most appropriate in setting up the home visitation strategy for new parents in the northern region. Its strengths are that the model has been extremely well evaluated and cost benefit analyses have reinforced the effectiveness of the strategy; that improved health outcomes for the whole family and a significant reduction in the incidence of child abuse have been clearly demonstrated; that a mixture of professionals and para professionals provide services to each family; that all members become clients of the home visitor; and that inter-agency agreements have increased the efficiency and effectiveness of the home visitor in providing much needed services to families in crisis.

It is intended to offer the service to all families delivering their first baby at the Lyell McEwin Health Service. Those families considered to be 'at risk' will have services provided relative to their needs. The home visitor will maintain contact with the family and provide services as needed until the child reaches the age of five years.

A detailed strategy is currently being developed by a planning group with representation from the Child, Adolescent and Family Health Services, the Department for Family and Community Services, the South Australian Health Commission, the Lyell McEwin Health Service, the Health Promotion Unit and the Women's and Children's Hospital. Funding of the strategy is currently being negotiated with those agencies that will become players in implementing the strategy. The Health Commission endorses the piloting and evaluation of the strategy with a view to making the service available to all parents metropolitan wide should it prove successful.

Membership:

Ms Greig substituted for Mr Rossi.

Additional Departmental Adviser:

Mr J. Blackwell, Executive Director, Country Health Services Division.

Ms STEVENS: The Minister has announced that the 100 per cent ambulance fee concession for pensioners in country areas will be slashed to 50 per cent. When will this measure take effect? Why was the starting date not announced in the budget or in his press release? What steps is the Minister taking to advise country pensioners of the fact that they will now be liable for ambulance fees?

The Hon. M.H. Armitage: I will ask Mr Jon Blackwell to provide that information.

Mr Blackwell: The decision has not yet been made as to when to implement the change in the concession from 100 per cent to 50 per cent. Negotiations have been commenced with St John Ambulance, which obviously has an interest in this. The situation is that 65 per cent of country pensioners are already covered by the ambulance subscription scheme. Therefore, this will have no effect on their own pockets, if you like, and the ambulance subscription scheme is very cheap for pensioners. It is approximately $17 for a single person and $30 for a family of a pensioner. Members should also note that the 50 per cent concession applies only to cases where a pensioner is transported from home or elsewhere to hospital in the first instance. Any transport for anybody, whether pensioners or not, from hospital to hospital, is still covered 100 per cent by the Health Commission.

The Hon. M.H. Armitage: In answer to the other question in relation to how this might be publicised, first let me say that a number of people know about it anyway, having read budget papers or publicity about it. Certainly, there have been a number of comments on radio. Once the details are formalised according to the information that has been provided, we undertake to advertise in rural press and rural radio.

Ms STEVENS: As a supplementary question, what investigations of the social impact of this decision did the Government undertake in coming to this decision?

The Hon. M.H. Armitage: I guess there are a number of social justice, if you like, criteria which can be looked at in this instance. We are equalising the rural people with those in the metropolitan area in that we are allowing the 50 per cent concession to be statewide rather than only in the metropolitan area. Equally, the fact that there was an ambulance subscription scheme available and the fact that 65 per cent of eligible people are already members of that scheme seemed to us to indicate that there was a good sound basis for making this decision on the understanding that there was a cheap safety net if people chose to take that option.

Ms STEVENS: I refer to a project which has been operating in the Inbarendi College and which began in July last year, called the Inbarendi Health Team. It is a project where health personnel are situated in the five secondary schools in Inbarendi College. Will the Minister provide information about whether this project will continue?

The Hon. M.H. Armitage: What is the reference in the Program Estimates?

Ms STEVENS: I am not sure of the page. I expect it would come under community based services. The program certainly exists.

The Hon. M.H. Armitage: It may well exist but it may be funded through the Education Department. That is why we are having some trouble putting our finger on the reference.

Ms STEVENS: It was opened by the Minister of Health last year. I will put the question on notice.

The Hon. M.H. Armitage: If it is within my budget line, I will provide an answer.

The CHAIRMAN: Otherwise, the question could be asked under the Minister for Education's lines.

Mr WADE: The Program Estimates (page 278) states that the Health Commission will take an active role in the South Australian Centre for Public Health consortium. Will the Minister provide this Committee with more information about this consortium and its functions?

Dr Kirke: The South Australian Centre for Public Health consortium comprises the Health Commission, Adelaide University and Flinders University. It was established in 1993. Training in public health at masters level has been supported at a number of universities around Australia under the Commonwealth Public Health Education and Research Program since 1987. Prior to 1987, there was just the one School of Public Health and Tropical Medicine in Sydney. The current funding for the Adelaide University's Master of Public Health concludes at the end of this calendar year. It will be replaced by an annual grant to the South Australian Centre for Public Health, from 1995 until 1999.

The amount for 1995 will be $550 000, shared between Adelaide and Flinders Universities. The Adelaide University will continue to provide an MPH program. Flinders will provide a Master of Primary Health Care and a Master of Science in Primary Health Care under the aegis of the South Australian Centre for Public Health. The centre has also been funded by the same Commonwealth program to provide education and research in the special area of environmental health. It is the only centre in Australia to have been so funded. The amount of the funding is $100 000 per year.

The consortium arrangement between the three partners will allow students from either university to take elective units at the other university and/or choose work placements with the public and environmental health service of the Health Commission for hands on experience. We believe it is appropriate that closer links have been forged between teachers and researchers, on the one hand, and practitioners on the other. The University of South Australia is represented on the board of management of the centre and is very likely to become a full consortium member in due course. The Health Commission will chair the board of management of the centre and also will act as the host institution from the point of view of receiving funds from the Commonwealth.

Mr WADE: Page 279 of the Program Estimates, under the 1994-95 specific target objectives, indicates that the Health Commission will produce a second edition of the Social Health Atlas of South Australia. Can the Minister indicate the benefits which he expects will be achieved through this process?

The Hon. M.H. Armitage: Yes, we believe the benefits will be quite considerable. The first edition is something we have referred to on a number of occasions already today and it has been quite influential in our policy setting in relation to this budget. For specific detail on the preparation of the second edition, I would ask David Filby to speak to the Committee.

Dr Filby: The second edition, as the Minister identified, will build up on the first edition and, in fact, on the National Social Health Atlas that was produced within South Australia

for the Commonwealth Government. We expect to have completed our work on the second edition in the second half of 1995. This edition will expand the range of statistics included within it for useful planning management and policy development purposes and, in particular, we anticipate being able to significantly add additional work in health status and on hospital outpatients. We anticipate that the main use of the atlas will be for regional planning exercises. Its primary value is to describe the distribution of a number of factors relating to health, and to allow for the ready identification of associations between those factors. It will, of course, become of primary importance in assessing the health needs when you move to a more formalised separation on the roles of purchasers and providers.

Mr De LAINE: The Minister promised before the last election to dismantle the Health Commission. He claimed on page 3 of the Liberal Health Policy that the present centralised system of administering the service in South Australia is unduly cumbersome and beset with serious problems. On 10 February 1994 it was reported in the *Australian* that the Minister would proceed with axing 300 Health Commission jobs as part of an overhaul of the health system. The Program Estimates, page 268, indicate that in 1993-94 254 average full-time equivalents were employed in support services, compared with 248.9 FTEs in 1992-93, as indicated in the 1993 Program Estimates. What are the only areas of the health budget which recorded a rise in employment? Given this increase and the greater administrative and monitoring requirements associated with the introduction of casemix, does the Minister still plan to dismantle the Health Commission, and does he still plan to cut Health Commission staff? If so, what is the estimated number of staff in support services for 1994-95?

The Hon. M.H. Armitage: Let me assure not only the member for Price but also the members of the Health Commission that we are certainly not going to cut 300 members from the Health Commission, as the article allegedly said. That is a clear example of the exuberance of some journalist. The problems which have beset the administration of the Health Commission, and by that I mean the total health portfolio, have been well recognised. Indeed, the previous Government made a number of attempts to alter the way the health system is administered via a variety of papers of different colour and so on. There was also a select committee into the administration of health, and the shadow Minister for Health and I were members of that committee.

There was a large amount of input from people across South Australia, and it would be fair to say that there is a general agreement that that can be improved. We have made no secret of the fact that we believe there are efficiencies which can be generated if one looks at a true funder/purchaser/provider split (an expression I hesitate to use, given its jargon nature). It is a way of stimulating competition between providers, so that the taxpayer receives best value for his or her dollar and the consumer of health receives the best quality service. It is in relation to that administrative change, as I indicated earlier, that we are releasing a paper early next week—it will be put out for discussion—and those sorts of opportunities for altering the administrative structure, capturing the benefits of the funder/purchaser/provider split, and so on, will be part of that. So, the plans are still well in train, and we believe that it will be yet another major reform that will see a more efficient service provision within the health sector.

Mr De LAINE: So, you are not going to dismantle the Health Commission?

The Hon. M.H. Armitage: It would be fair to say that the new administration we will have will be vastly different. There will be a requirement for a change of the Act; some of those changes will be extremely significant, and there will be no question that it will be a vastly different organisation at the end of that process.

Mr De LAINE: How many jobs in the Health Commission has the Minister axed, and how many does he intend to axe in the future? The Minister can take that question on notice if he wishes.

The Hon. M.H. Armitage: I will give the figures for the last four years. At the end of the financial year 1991, there were 241.9 FTEs; 1992, 218; 1993, 219.3; and 1994, 219. So, that is where we have been standing at this stage. Last year the central office had 29 employees who took TSPs, which equilibrated with 27.7 full-time equivalents.

Ms GREIG: My first question is from page 270 of the Program Estimates, and it involves an area of particular interest to me. Page 270 indicates that a review is to be undertaken of biomedical engineering services. Can the Minister indicate what the review is intended to cover?

The Hon. M.H. Armitage: I realise this is a matter of concern for the member for Reynell. She has been assiduous in her representations to me over the last few months in relation to the matter of biomedical engineering. Again, I ask Dr Michael Jelly to give us some detail.

Dr Jelly: A proposal was put forward by the Bio Medical Engineering Advisory Group, which is a group of professionals working in the area who from time to time meet and give advice to health units and to the commission. It said that this proposal would identify cost effective and timely service provision to all customers, meet world best practices and support the Government initiatives and policies for the export of health services. The review, which will cost about $40 000, is to be undertaken by internal consultants of the Health Commission and will cover matters related to casemix; contestability of organisational changes within the South Australian Health Commission as they apply to Bio Engineering Services; and examine commercial opportunities and export markets.

It is possible that the improvements which flow from the review will include: savings through the purchase of shared service contracts; savings through bulk purchasing of components and consumables; savings through shared purchasing of health care equipment; the establishment of uniform policies, practices and procedures; the application of a uniform interpretation of Australian standards, relevant legislation, regulations and codes of practice; the sharing of test equipment and technical information, thereby reducing resources; sharing expertise; the development of a common computerised asset and workload management system; the development of standardised occupational health and safety and work protocols; the minimisation of duplication of resources; shared, and therefore reduced, spare parts inventories; and the provision of a consistent input into the capital equipment program. It is therefore germane that the Health Commission pursues this review, and it will be set in place very shortly.

Ms GREIG: Page 278 of the Program Estimates refers to injury prevention initiatives being undertaken in relation to falls by older persons, house fires, schools and children and unsafe public places. What are the initiatives we are likely to see in relation to injury prevention?

The Hon. M.H. Armitage: The Government regards these matters as very important aspects of its health policy, as it has indicated in a number of the manoeuvres and funding mechanisms where it has put money into primary health care initiatives to stop people having to go to hospital in the first instance—prevention, in other words. These sorts of things fall into that category.

Dr Kirke: An injury surveillance system is in place. It collects information about people presenting at accident and emergency rooms in two major hospitals in Adelaide, and that data has been collected for a long time. That database contains in excess of 120 000 entries, and that means that we are able to identify priorities for intervention. Injury is the single greatest cause of hospital admission in this State, and it accounts for approximately 10 per cent of all admissions. Injuries resulting from road, occupational, recreational and domestic accidents are the leading cause of loss of life from birth through middle age.

Approximately 4 500 older persons are hospitalised each year in South Australia following a fall in the domestic environment. That number exceeds the total number of people admitted to hospital following car accidents. Hospital costs associated with older persons suffering injuries from falls at home have been calculated at $20 million, without considering the domestic care, social and other costs. The Government has approved funding of approximately $100 000 a year for a three-year project to demonstrate that the number of falls among elderly people at home can be significantly reduced. This project is in its second year and is currently serving about 1 000 households each year of the project.

On the basis of a pilot scheme, which we ran about four years ago, we expect that the present program, by providing grab rails, floor treatments to stop bathroom floors being slippery when wet, night lights and safety advice, will reduce the risk of falls by 50 per cent in those people participating in the project. An analysis of the hospital costs associated with fall injuries has indicated that South Australia stands to save as much as $2.50 for each $1 invested in this program. These savings will be realised only after several thousand people have participated in the program to build up the pool of low risk homes.

Surveillance and intervention activities are in place to identify and address hazards in shopping facilities, where older people fall; play grounds, which are not up to modern safety standards—particularly in relation to the depth of soft floor material under climbing apparatus; public swimming pools; and other places of public recreation which require physical or procedural modifications to ensure the safety of the public.

In relation to house fires and hot water scalds, a program is under way to collaborate with both the MFS and the CFS and with private sector safety agencies to encourage the use of smoke detectors and devices to limit the temperature of bathroom tap water in private houses. Such safety items have proven to be effective in this country and abroad in reducing injury and death from house fires and fires in schools.

Mr ATKINSON: In relation to contestability, the Audit Commission found at page 210 of Volume 2:

> Experience in other States such as New South Wales shows that problems can emerge over the scope of the contractor's responsibilities and the quality of the work performed. Australia's largest private hospital operator, Health Care of Australia, will not use contractors. . . for those reasons.

Why is the Government embarking on its policy in view of these reservations expressed by the Audit Commission? What specific measures has the Government put in place to guarantee the quality of work performed by contractors? Will the Government establish a register of contractors?

The Hon. M.H. Armitage: Having spoken with people in New South Wales, including a succession of Ministers, my advice is that the quality of service in whatever area the contract is let is obviously of prime importance. They have indicated to me that there has been a number of examples where the quality of service has been suspect, and those contracts have immediately been terminated with financial penalties for the providers of those services. So, I think that considerable import is placed on the contract that is written. Also, we have very strict guidelines and policy documents to which I referred earlier and which would indicate the exact services and quality of services that are to be provided by the competitive tendering process.

New South Wales, which has been competitively tendering and which has had many of the elements of contestability for some time, indicates annual savings of $83 million, of which $7.5 million is external contracts which have been let, and that means that about 75 per cent are let to the same people who are carrying out the services now. That has always been my theme in pushing the competitive tender line—that the vast majority of contracts are let by the same people who are doing the service now. So, I think the question of standards is obviously important, but if we end up with figures similar to those of New South Wales and we have tight contracts I do not foresee any particular problem.

The commission is running a seminar on 14 October in relation to this matter, and that will be for health sector managers and will deal with matters relating to contract specification, contract management and so on; in other words, the nuts and bolts of the types of issues to which the member for Spence refers.

Ms STEVENS: I refer to 'Delivery of Disability Services' on page 275 of the Program Estimates. What contribution has the Government made to the Supported Accommodation Assistance Program and Community Housing Program to address the housing needs of people with disabilities? How does this allocation compare with that in last year's budget?

The Hon. M.H. Armitage: In answer to the member for Elizabeth, I can say that the Supported Accommodation Assistance Program is a FACS program, not a Health Commission line. In relation to the second part of the member's question, I think that may be a Housing Trust line and not a Health Commission line.

The CHAIRMAN: Does the Minister wish to make a closing statement?

The Hon. M.H. Armitage: In closing I would like to publicly acknowledge all the work that the officers of the Health Commission have done in preparing the budget over the past several months. In particular, I refer to the work that has gone into preparation for Estimates Committee's answers. I would like to thank them all very much for that work.

The CHAIRMAN: There being no further questions, I declare the examination completed.

[Sitting suspended from 8.35 to 9 p.m.]

State Aboriginal Affairs, $3 876 000.

Membership:

Mr Clarke substituted for Mr De Laine.

Departmental Advisers:

Mr Ric Starkie, Senior Project Officer, State Aboriginal Affairs.

Mr David Rathman, Chief Executive Officer, State Aboriginal Affairs.

Mr Peter Campaign, Senior Project Officer.

Ms Julianne Cirson, Finance Officer.

The CHAIRMAN: I declare the proposed payments open for examination and refer members to pages 108 and 109 in the Estimates of Receipts and Payments and to pages 283 to 287 in the Program Estimates. As the State's first sworn Minister for Aboriginal Affairs, who was vitally involved in the Pitjantjatjara and Maralinga land rights legislation back in the 1979-82 period, I would like to say that I am appreciative of the progress that has been made in South Australia under both Governments over the past 15 years. I also appreciate the work and commitment of the current Minister and his staff: a commitment which I know is shared by members of the current Opposition.

The Hon. M.H. Armitage: I will make some extremely brief introductory remarks. In doing so, I will reiterate the Government's commitment to the advancement of the Aboriginal people. We are determined that the Aboriginal community of South Australia will continue to develop to be full participants in the South Australian economy and in South Australian society. As part of this commitment, the Department of State Aboriginal Affairs is a key agency. In my view DOSAA, as it is known, is the focal point of a two-way flow of information between the Aboriginal community and the State Government.

In my view DOSAA has perhaps been unfairly criticised this year in particular in the context of the Hindmarsh Island bridge decision. I pay public tribute to the dedication of the staff at DOSAA and particularly to the leadership provided by David Rathman. It has not been an easy year for DOSAA and for the Aboriginal Affairs portfolio, which has faced a number of challenges. I have been impressed by the flexibility of the department in meeting those challenges and in refocusing on the new challenges brought by the new Government and, indeed, by the issues which have arisen in the past few months and by the new challenges of the future. I welcome the opportunity to appear before the Committee to ensure that we all make certain that the State's efforts to advance the welfare of Aboriginal people are as focused and as effective as they can be.

Mr CLARKE: I am particularly pleased to be here this evening, because it is my first Estimates Committee hearing as the shadow spokesperson for Aboriginal affairs. On doing some research of Estimates Committees in past years, I found that one of the pleasing features in South Australia, as you, Mr Chairman, alluded to in your opening comments, is the strong sense of bipartisanship in South Australia with respect to Aboriginal affairs which, in the first instance, led to the Pitjantjatjara lands rights legislation under a Liberal Government in 1981, and that followed a considerable amount of groundwork under the leadership of former Premiers Don Dunstan and Des Corcoran.

That type of bipartisanship stands South Australia extremely well not only in the Australian community but also overseas. Speaking for the Opposition, I very much want to continue that bipartisan approach. I know there will be differences between us from time to time but I also know that the major political Parties in this State would totally refrain from playing the race card—if I can put it that way—that is, from playing to the lowest common denominator.

I pick up a theme on which I made a speech recently in the House: I encourage the South Australian Government to talk to its Federal counterparts in Canberra with respect to having them adopt a similar bipartisanship approach to that which we enjoy in South Australia and in particular towards the Commonwealth Native Title Act. That would go a considerable distance with respect to the reconciliation process in Australia. Last week, together with the Premier, the Leader of the Opposition and representatives of the Minister's office, I attended functions when the Council for Aboriginal Reconciliation came to Adelaide. Indeed, it met in this very hall last Friday evening as part of a significant conference last weekend.

Mr ATKINSON: I refer to the Program Estimates (page 287) in relation to the maintaining and updating of an Aboriginal sacred sites register. It is stated that one of the goals of the Department of State Aboriginal Affairs is to protect Aboriginal sites of significance, but I would have thought this goal must be maintained by appropriate means. However, there is grave concern in the Opposition at the Minister's methods, given that an officer of the Minister's staff this week telephoned Mr Justice O'Loughlin's associate to put the Minister's point of view—an action which the Minister then defended publicly. Who from the Minister's office rang Mr Justice O'Loughlin's chambers recently, and what position in the Minister's office does this person hold?

The Hon. M.H. Armitage: First, let me clarify for the member for Spence exactly what the circumstances were. We in my office were informed that, as part of the legal denouement of the Hindmarsh Island exercise, a number of reports had been deposited with the Federal Court under the jurisdiction of Mr Justice O'Loughlin. One of those reports was a report known as the Draper report, which was prepared by Neil Draper from the department. The State Aboriginal Heritage Act requires the authorisation of the Minister for the release of that report in particular and, for the Minister of the day to release that report, he or she requires the authorisation of the Aboriginal informants.

Accordingly, I was a little surprised that this had occurred. So, at my direction, Mr Wade from my office rang the courts—not Justice O'Loughlin—to inquire what the circumstances were—whether authority had been given and also whether a Federal court would supervene the Aboriginal Heritage Act requirements. I am not certain of the time that the phone call was made (I can determine that) but the Master of the court (I think was the person) was unavailable and Mr Wade was put through to the assistant of Justice O'Loughlin whereupon an inquiry in relation to those matters that I have mentioned was made.

The associate indicated that inquiries would be made and that a phone call would be returned to us indicating the answers. From our point of view, that was the end of our inquiry for information, which at no stage was directed to go to Justice O'Loughlin himself. What then happened was that the learned judge chose publicly to indicate that he had been contacted in this matter and he made a number of inquiries of the court staff, which included the inquiry as to whether I as the relevant Minister had been contacted about these matters, to which the transcript of the court quite clearly will identify,'No.' He also indicated that he was intent upon maintaining the integrity of his court, just as I would expect him to do, but he sought information from counsel as to what he believed should happen.

At that stage, the Draper report had been supplied, amongst others, and they had been put into a sealed envelope. I am told that no-one had seen those reports. At lunch time in the court yesterday, one of the counsel contacted me, as he indicated to Justice O'Loughlin he would do, and said that counsel wanted to make clear to me that he had the assurance that nobody unauthorised had seen the documentation and that to all intents and purposes the integrity of this matter under the State Aboriginal Heritage Act was intact. Obviously, the intent of my inquiry in the first instance was to make sure that that was the case.

The counsel who contacted me also indicated, given that he was appearing for the Lower Murray Aboriginal Heritage Committee, that he would forward to me information which indicated that authorisation by the Lower Murray Aboriginal Heritage Committee would be forthcoming to me to allow, on their authorisation, the Draper report to be released to certain members of the court staff. On receipt of that information, I forwarded a letter to Justice O'Loughlin indicating that I was attempting to facilitate in every way the release of these reports, as I have been doing since I first received them, and that, as I had received relevant authorisation, the release to the people nominated by the original Aboriginal informants to the Draper report was authorised.

Mr ATKINSON: Would the Minister not agree that it would have been the proper and better course to brief counsel on the matter or to contact counsel for one of the parties? Does the Minister believe that he or his staff have breached the separation of powers, albeit perhaps in a technical way, and, if not, what does the Minister understand by the doctrine of the separation of powers?

The Hon. M.H. Armitage: Given that it was an attempt by the relevant Minister, *id est*, me, to ensure that the Aboriginal Heritage Act was being upheld and that it was nothing more than an inquiry as to how that was occurring, I believe that the approach was perfectly legitimate, and that is exactly why I authorised it. Regarding the question whether I believe that I have in any way offended the doctrine of the separation of powers, I clearly do not believe that. The doctrine of the separation of powers involves the three powers of the judiciary, the executive and government, and in no way have I as a Minister of the Government offended that doctrine, which I believe is one of the most important in the Westminster tradition.

For those of you who do not realise it, we see the perfect example of it every opening day of Parliament when we have the executive of Parliament to the right of Her Majesty's representative; we have the judges sitting in the middle of the Chamber; and we have the elected members of Parliament on the benches. That is a clear indication to anyone who wants to know what are the three powers, none of which I have offended.

Mr ATKINSON: In fact, the separation of powers is not so much a Westminster doctrine as an American doctrine; indeed, the independence of the judiciary came in only after the 1688 revolution, and Westminster had existed for a long time before then. Acts of Parliament are not upheld by representations from Ministers' staff: they are upheld in the courts by an independent judiciary which hears evidence and argument from counsel, not over the telephone from Minister's staff. Does the Minister feel even slightly repentant about this episode?

The Hon. M.H. Armitage: I am amazed. As Minister for Aboriginal Affairs, I will do whatever is within legitimate bounds to make sure that the legitimate Aboriginal informants to reports are given their rights under my Act, and if that entails making a simple phone call seeking information of the court system, not of Justice O'Loughlin, I am more than happy to do it, and I indicate to every member of the Aboriginal community that I will continue to do it.

Mr ATKINSON: Does the Minister agree that it would have been a little better had his staff member not persisted, the Master not being available, in contacting the judge's chambers and instead made his inquiries through another means?

The Hon. M.H. Armitage: No.

Membership:

Mr De Laine substituted for Mr Atkinson.

Mr CLARKE: The South Australian Government's decision to intervene in the challenge to the High Court's Mabo judgment, more particularly the Commonwealth Native Title Act, or some sections of it, has been met with disbelief by representatives of the Aboriginal community. Why is the Government intervening in a matter which we believe the Government's advisers are saying that it has little chance of winning, and how much is this action costing the taxpayers of South Australia at a time when the Government is cutting services which Aboriginal people use, such as the provision of free public transport for school card holders to attend schools, health services and suchlike?

The Hon. M.H. Armitage: It is very important for all members of the Committee, particularly the shadow Minister for Aboriginal Affairs, to understand the difference between the approaches that have been taken by the Western Australian Government and the South Australian Government to the challenge to the Native Title Act. The significant difference is that the Western Australian Government is challenging the existence of native title; in other words, it is challenging the very tenets of the Native Title Act.

It is quite clear from statements made by the Premier and the raft of legislation we have introduced in relation to this matter that the South Australian Government is acknowledging the existence of native title. Indeed, nothing could be clearer than the Premier's statement to the House of several months ago in relation to this matter when he specifically detailed that commitment. However, there are a number of potential difficulties in the administration of the relevant Federal and State Acts. They are differences not in substance as to whether or not native title exists; they are matters of small import but, nevertheless, the last thing that anyone here wants is to see an Act like this making a lot of money for lawyers in challenges.

When we first put our legislative response together we realised that there were some discrepancies between State law and the Native Title Act. In fact, we identified them in a letter to the Prime Minister and in considerable correspondence with his department. The Prime Minister had indicated that he would not contemplate making change; he believed that the appropriate thing to do was to allow the Act to be utilised and to see what happened—in other words, let it all shake out.

The State Government's view was that that was not appropriate, so we told the Prime Minister, 'We don't think the two Acts are compatible in some respects. If you don't allow those small changes to be made'—none of which, I repeat, challenge the thesis of native title—'we may contemplate joining, not issuing, a challenge on a limited number of items.' Mr Keating's original response was 'No'. However,

shortly after our challenge was joined on those small topics—not on the substance of native title—Mr Keating admitted that there were some dilemmas with the drafting that potentially might need change. That was what we had been saying in all of our correspondence with the Prime Minister's Department and with the Prime Minister himself.

If I can indicate as an example of the commitment of the State Government to the principle of native title, we have already allocated the money required to set up the tribunals and so on under the Act, so we are totally committed to the principle of native title. We just want to make sure that the State and Federal Acts are compatible.

Mr SCALZI: With reference to page 287, media attention has recently been given to staffing movements in the Culture and Site Services Branch within the Department of State Aboriginal Affairs and the resultant impact on its role in administering the Aboriginal Heritage Act. Can you indicate to the Committee whether the number of staff in this branch has fallen to a level where it can no longer maintain the Aboriginal Heritage Act?

The Hon. M.H. Armitage: This is a very important question because of recent media speculation. I would like to assure the member for Hartley and members of the Committee that DOSAA is very much committed to addressing the role and functions of the Culture and Site Services Branch as they relate to the Aboriginal Heritage Act. It must be recognised that the branch is established principally to concern itself with the operations of the Act and the support of the Aboriginal Heritage Committee, and it is. A number of officers within the branch are concentrating on tasks which require review as to their relevance to the abovementioned commitment. It will be necessary to regroup and direct the limited resource to ensuring best practice is adopted in promoting the function of the Act to the community.

In relation to some of the staffing movements, I would particularly like to identify the sorts of things that happen which get into the public arena and then get misunderstood. There is an officer who, in August 1994, commenced six months leave without pay. At face value, that may be taken as a decrease in service provision, but what the media did not choose to highlight was that that officer was taking leave without pay to complete her Master's Degree in Anthropology which would obviously be of great benefit to the work of the department in that instance. A number of other officers have been reinstated and so on.

I have discussed the staffing concerns with Mr Rathman, and action has been taken to ensure the effective management of the Aboriginal Heritage Act. There have been some suggestions by people not in this Committee that only one officer remained in that branch. In fact, the current staffing of the Culture and Site Services Branch is as follows: Manager, Margaret Hampton; Senior Project Officer, Peter Campaign (who is with us); Senior Archaeologist, Dr Neil Draper; Project Officer, Christo Stoyenoff; with two other archaeologists, two liaison officers and a clerical officer. Any suggestion that the staffing in the Culture and Site Services Branch is putting at risk the actions of the department in relation to the Aboriginal Heritage Act is clearly fallacious.

Mr SCALZI: How many TSPs have been granted in the Department of State Aboriginal Affairs?

The Hon. M.H. Armitage: During the financial year 1993-94 eight TSPs were accepted and thus far in 1994-95 one has been accepted.

Mr CLARKE: What was the cost of the action in the High Court?

The Hon. M.H. Armitage: It is a matter that is committed to the Attorney-General's lines, not to mine. I do not know the answer, but I suggest you write to the Attorney-General.

Mr CLARKE: Will the State Government contribute to the review of the Federal Liberal Party's policy on Aboriginal Affairs and, if so, what submissions will it make? I draw some comfort from your response earlier to my first question with respect to the State Government's acceptance of native title. Of course, the Federal Liberal Party's position is still, as I currently understand it, one of opposition to it. As I said in my opening remarks, your influence, your Government's influence, and particularly your experience in South Australia with native title would be extremely important, and that would assist no end, I believe, in having the Native Title Act properly amended, if it is necessary, with the support and cooperation of the Federal Opposition. Does the Government support the $1.4 billion Land Acquisition Fund announced by the Federal Government earlier this year, and will the Minister seek the support of his Federal colleagues for this fund?

The Hon. M.H. Armitage: Can the member for Ross Smith indicate which line of the budget my reaction to the Federal Liberal Party's policy position falls under?

Mr CLARKE: It is 'Recurrent Payments' on page 108 of the Estimates of Receipts and Payments—general expenditure on Aboriginal affairs.

The CHAIRMAN: I am afraid that the Chair will have to rule the question out of order. The question is hypothetical. It is a policy question, rather than a question about the direct allocation of funding. There is no allocation of funding specifically for this Federal policy. The Minister may comment if he chooses but, following the Chair's ruling, he does not have to do so.

The Hon. M.H. Armitage: The comment I make is that I fully support the Chair's ruling, which is why I asked the question in the first instance. However, I am more than delighted that the member for Ross Smith believes that a humble State Minister is able to influence Federal Party policy at all. I am more than happy to indicate to the Committee that the views of the State Liberal Party in relation to native title are certainly known to the Federal Liberal Party. I can assure the Committee of that given discussions I have had. However, I cannot influence the policy any more than that.

Mr CLARKE: I appreciate the Minister's view on that.

The CHAIRMAN: The member for Ross Smith would appreciate that this is an extramural matter rather than a State policy issue for which funding is allocated.

Mr CLARKE: Yes, I appreciate that. As the Minister was so forthcoming on the review of the Liberal Party Opposition, would he like to make an observation with respect to the Land Acquisition Fund?

The Hon. M.H. Armitage: My observation is that we have also discussed that with the Federal Liberal Party.

Mr WADE: I refer to page 287 of the Program Estimates, 'Specific Targets and Objectives', particularly Aboriginal education. Will the Minister provide information on the work and the programs undertaken by the South Australian Aboriginal Education and Training Advisory Committee?

The Hon. M.H. Armitage: As I travel around South Australia and speak to members of differing Aboriginal communities, I recognise how importantly they view the role of education and training. To that end, I met with the Chair of the South Australian Aboriginal Education and Training Advisory Committee earlier this year to discuss the member-

ship and the work of the committee. I then appointed members to SAAETAC, and SAAETAC and its secretariat has, in its restructured form, met twice already this year. It held a meeting early last month to discuss the report from the Ministerial Council on Employment, Education, Training and Youth Affairs, Aboriginal Education Strategy Working Group. I know from reports that that committee is vitally interested in progressing Aboriginal education and training.

The new membership has Aboriginal and Torres Strait Islander Education Systems Management representation, as well as a very strong community involvement and participation. Again, that is a feature of the interest of Aboriginal communities and their desire to be involved in matters affecting them.

Five members of that committee are Education Systems personnel, and the other 11 reflect those community interests. So, the committee represents all interest groups wishing to be involved with future policy developments in Aboriginal and Torres Strait Islander education. ATSIC and the five systems personnel referred to have agreed to fund and resource their participation, and the others will be the responsibility of SAAETAC from the State and Commonwealth allocations to the committee.

The members and organisations include ATSIC regional counsellors, Aboriginal community college principals, CSO officers, the Education Department, Aboriginal Curriculum Unit coordinators, DETAFE representatives, Catholic and Lutheran education officers and so on, so it is a broadly based committee with a lot of expertise, and I know that people within the Aboriginal communities are very much looking for success from committees such as this in their attempt to address some of the dilemmas facing community members.

Mr WADE: What objectives have been set for the South Australian Aboriginal Education and Training Advisory Committee to achieve over the next 12 months in respect of the aims that the Minister indicated that it wished to achieve?

The Hon. M.H. Armitage: Amongst other things, the major goal of SAAETAC for 1994-95 is to continue implementing its operational plan, and the initiatives in 1994-95 are to formalise effective regional networks based on the ATSIC regions; to conduct community seminars in those ATSIC regions; to encourage providers to have management information systems to record educational access, participations and, importantly, outcomes; to assist in the development and vetting of documents related to curricula; and to promote Aboriginal studies to Aboriginal and non-Aboriginal Australians.

Mr WADE: What was the major task of the national Aboriginal educational policy planning monitoring group in 1993? What is planned for 1994?

Mr Rathman: The key points of the plan are to ask for a performance appraisal and this was completed in June 1994. It has been prepared and submitted to the Commonwealth Government along with a State strategic plan for 1993 to 1995. As a result of the 1993 performance appraisal report, the planning monitoring group has decided to develop a new framework for the next rewrite of the State strategic plan. What it wants to do is to take into account some factors which are important from an Aboriginal point of view, such as the recommendations and findings of the national body, and also to develop strategies to be adopted for low priority areas. It wants to be realistic about what can be achieved within the current constraints, because there are existing constraints in education and for Aboriginal people there are a number of those.

It should be noted that a large proportion of Aboriginal young people find themselves without education. In fact, about 47 per cent of Aboriginal people leave school before the age of 16 as opposed to 40 per cent for the rest of the community. In examining and determining the roles of all the key players, it is important to take into account past results and to ensure that those results are not repeated in the future. In fact, if we look at the Aboriginal population in the age group between 15 and 24 years of age, we see that only 12.1 per cent of Aboriginal people were attending post secondary education. We have a lot to do in the education field. The group wants to consolidate and validate the priorities in terms of the community and also the department and agency.

It wants to ensure that there is development of a broad strategic framework process for each of these sectors to work within and also to ensure that the strategies can be validated at the end of the process. That has been a difficulty with broad based strategies such as this one. Of course, it will be establishing a small planning group consisting of members of agencies. As far as the consultative process is concerned, there is an approach at the national and State level to ensure that we move from consultation in these fields to more of a dialogue and participation at community level to ensure real results are achieved. As you can see from the results I have mentioned, past initiatives which were based around consultation have failed to deliver results. It is important that a more substantial initiative be put in place over the next triennium.

Ms STEVENS: Unemployment continues to be a disproportionately greater problem for Aboriginal people. What is the department's role in coordinating State Government participation in the Commonwealth Government's Aboriginal employment development policy?

The Hon. M.H. Armitage: Aboriginal employment is the most important issue facing Aboriginal community members today. As I travelled around South Australia when I was shadow Minister prior to the election and certainly since, if I asked members of Aboriginal communities—and I have to say that it was a fairly traditional question for a politician to ask—'What could I do for you if we were elected?' I guess in a fairly traditional way I expected a number of fairly traditional answers. What was overpoweringly striking was the fact that mostly members of these communities looked me fairly and squarely in the eyes and, as quick as a flash, said, 'You get me a job.' The reason they want jobs is so that they can be financially independent. Once they are financially independent they can provide better housing and health care for their families, better education for their children, and so on. It is my view that employment is the key issue.

What I also have found quite enlightening—and I discussed this yesterday with Mr Rathman and Dr Paul Hughes, an eminent member of the Aboriginal community—is that we can talk frequently about reconciliation and all sorts of things but, if you ask a number of unemployed people—white people, migrants and Aboriginal people—about their needs, their needs will be the same: what they want will be exactly the same. I am conscious that it is a vitally important issue.

I have made it part of my specific interests to encourage Aboriginal enterprise via such means as business breakthrough programs, and so on, on the basis that, if an Aboriginal enterprise is successful, it will employ further Aboriginal people. To that end, on a recent Aboriginal Land Trust visit to Ceduna, I was delighted to hear that an Aboriginal oyster lease supplies 30 per cent of the oysters for South Australia. They are the sorts of success stories that do

not get a lot of publicity but are positive. So it is a concentration of the State Government policy in the whole Aboriginal affairs area.

In relation to the Aboriginal employment development policy, which the honourable member mentioned, the role of DOSAA is primarily that of a coordinating one and a linkage between Federal Government and employing organisations. I should also mention the role of DETAFE with the Aboriginal Employment and Development Branch (AEDB). However, it is certainly an important focus for the State Government in addressing some of the important issues facing members of the Aboriginal community.

Ms STEVENS: How much money has been directed to that part of the budget?

The Hon. M.H. Armitage: I reiterate that the policy is primarily a matter for the Minister for Training and Further Education and Training, involving DETAFE. But the commitment of DOSAA in its coordinating and linkage role within that area is $114 000.

Ms STEVENS: You mentioned the Aboriginal enterprise forum initiatives: has any money been allocated in that area from your department?

Mr Rathman: The area of the enterprise development is a very new initiative that we have put forward, with the Minister's support. The concept is to try to draw together a fairly disparate group of agencies into one clear initiative, which will allow for better coordination. At the moment the Department of State Aboriginal Affairs dedicates approximately one full FTE between two officers to address the matter. We have given a large amount of assistance to projects such as trying to get Wardang Island to a stage where it can be commercially operated in the future with the support of the Point Pearce community, and to look at a number of initiatives such as oyster and abalone farming. The abalone farming project, in which the officers have involved organisations such as the Economic Development Authority and others, will result in private sector support. It is important to recognise that in an agency such as ours, which is a small corporate body of only 40 or so officers, we have to share the responsibilities, and it is generally about one FTE plus support resources at this time.

Ms GREIG: My question relates to paragraph 4 of page 287, in particular the establishment of a statewide Aboriginal women's committee. I am drawing this to our attention because the Hindmarsh Island bridge decision highlighted the need to have consultative processes with Aboriginal women. What is the Government doing to ensure that Aboriginal women have access to decision making processes?

The Hon. M.H. Armitage: As the member for Reynell mentions, the Hindmarsh Island decision making process indicates that it is extremely important that Aboriginal women have meaningful participation in decision making processes. As a response to that dilemma which we found, I would indicate to the Committee that there are two key developments in this regard. First, a statewide Aboriginal women's conference was held on 2 and 3 May 1994 to elect a working party towards the establishment of a statewide Aboriginal women's advisory body. Follow-up meetings of the working party were held in Adelaide on 22 and 23 June and 19 July 1994. Aboriginal women are seeking Government departments' cooperation to consult the statewide Aboriginal women's forum for representation on a number of generic committees established to address women's and family issues, and women on the statewide forum will be involved with local women's committees from which they draw their information.

The other key development relates to the administration of the Aboriginal Heritage Act, and it has become evident that importantly great efforts are needed to establish family genealogies to facilitate Aboriginal heritage work. The Government will ensure that women's interests are taken into account in the development of the heritage process. Certainly, one of the lessons learnt from the Hindmarsh Island experience was that it is vitally important that Aboriginal women have an effective mechanism to participate meaningfully in those sorts of matters.

Ms GREIG: In view of the significant concerns about how Aboriginal heritage protection is managed, what steps is the Department of State Aboriginal Affairs taking to ensure that the provisions of the State Aboriginal Heritage Act are being administered effectively?

The Hon. M.H. Armitage: The department has identified a need to ensure that it has appropriate administrative procedures to fulfil its important responsibilities. It has instituted a review of the Aboriginal Heritage Act. That review was not implemented as a result of the Hindmarsh Island determination; the need had been identified by management through an ongoing review of the department's charter, goals and responsibilities. The review is to be conducted in-house, utilising a senior consultant within the Public Service, and the project will review the Aboriginal Heritage Act and its operational aspects.

The review of the Act will include the following matters, at least as part of the project: identify and interview a representative sample of the stakeholders, if you like, including the traditional owners of Aboriginal heritage sites or objects; the Minister for Aboriginal Affairs; the Attorney-General; any appropriate Aboriginal community where the traditional owners are not yet identified; the State Aboriginal Heritage Committee; private companies and their consultants; local Aboriginal heritage committees; landholding bodies; the Federal Government, and so on.

The review will also check all other Acts and regulations, including any regarding the transfer of delegation to the DOSAA and the level of detail in response to section 90 matters; existing documentation and files, including all previous decisions taken under the Act and Crown Law advice; existing publications, including guides and guidelines from the former Department of Environment and Planning; and approaches taken on the implementation of equivalent Acts by other Governments, State and Federal. It will also include checking the Aboriginal Heritage Register to ensure that the registration system is operating appropriately; any continuing impact of the Roxby Downs Indenture and the Aboriginal Heritage Act; and any relevant outcomes from the Hindmarsh Island bridge decision which, as I said before, were not instigational in the review, but clearly a number of dilemmas have been identified in relation to that. It will also ensure appropriate ownership and participation in the project by DOSAA staff and all stakeholders. We believe that is an important review to make sure that the Aboriginal Heritage Act is as appropriate as it can be.

Mr CLARKE: I think this is a fitting closing question to the Minister, as it deals with reconciliation. The process of reconciliation is one which the Minister knows has very strong support from the Opposition, and as the Opposition spokesperson it is something to which I am personally committed. We must all work together to ensure that Aboriginal people—our first nation—and other Australians

achieve, in the words of the Council for Aboriginal Reconciliation:

> . . . a united Australia which respects this land of ours; values the Aboriginal and Torres Strait Islander heritage and provides justice and equity for all.

If I can leave to one side for the moment the State Government's involvement in the Mabo High Court challenge, what is the involvement of the department in this vital process of reconciliation?

The Hon. M.H. Armitage: Recognising the time, I will be brief. The very existence of DOSAA is part of the reconciliation process. We have made a point of having community representation on committees at every opportunity. The State Government was delighted to move and be part of the motion in Parliament, and I recognise the contribution made by the shadow Minister in relation to that. There are reconciliation study groups within various Government departments, with which we are very pleased. The Government's commitment to reconciliation can probably best be identified by people looking at the speeches made by both the Premier and I in moving and speaking to the motion in Parliament last Thursday.

The CHAIRMAN: There being no further questions, I declare the examination of the vote completed.

ADJOURNMENT

At 10 p.m. the Committee adjourned until Friday 16 September at 9.30 a.m.