HOUSE OF ASSEMBLY

Monday 11 October 2010

ESTIMATES COMMITTEE A

Chair:

Ms C.C. Fox

Members:

Ms F.E. Bedford
Mr S.P. Griffiths
Mr S.S. Marshall
Dr D. McFetridge
Mr A.J. Sibbons
Mrs L.A. Vlahos

The committee met at 12:30

DEPARTMENT OF HEALTH, $3,420,865,000

Witness:

Hon. J.D. Hill, Minister for Health, Minister for Mental Health and Substance Abuse, Minister for Southern Suburbs, Minister Assisting the Premier in the Arts.

Departmental Advisers:

Mr J. O'Connor, Executive Director, Finance and Administration, Department of Health.

Dr T. Sherbon, Chief Executive, Department of Health.

Ms N. Dantalis, Executive Director, Department of Health.

Mr J. Woolcock, Director, Corporate Finance, Department of Health.

The CHAIR: Good afternoon. I advise that the commencement of this committee has been altered from 10.15am to 12.30pm today in accordance with standing order 268. The estimates committees are a relatively informal procedure and, as such, there is no need to stand to ask or answer questions. The committee will determine an approximate time for consideration of proposed payments to facilitate changeover of departmental advisers. I ask the minister and the lead speaker for the opposition if they could indicate whether they have agreed on a timetable for today's proceedings and, if so, provide the chair with a copy. You have agreed on a basic timetable? Good.

Changes to committee membership will be notified as they occur. Members should ensure the chair is provided with a completed request to be discharged form. If the minister undertakes to supply information at a later date, it must be submitted to the committee secretary by no later than Friday, 19 November 2010. This year the *Hansard* supplement, which contains all estimates committee responses, will be finalised on Friday 3 December 2010.

I propose to allow both the minister and the lead speaker for the opposition to make opening statements of up to 10 minutes each. There will be a flexible approach to giving the call for asking questions. Supplementary questions will be the exception rather than the rule. A member who is not part of the committee may, at the discretion of the chair, ask a question. Questions must be based on lines of expenditure in the budget papers and must be identifiable or referenced. I would like to underline that again: please make it very clear, not just for me but also for the advisers, precisely which line you are referring to.

Members unable to complete their questions during their proceedings may submit them as questions on notice for inclusion in the House of Assembly *Notice Paper*. There is no formal facility for the tabling of documents before the committee; however, documents can be supplied to the chair for distribution to the committee.

The incorporation of material in *Hansard* is permitted on the same basis as applies in the house, that is, that it is purely statistical and limited to one page in length. All questions are to be

directed to the minister, not the minister's advisers. The minister may refer questions to advisers for a response. I also advise that, for the purposes of the committee, television coverage will be allowed for filming from both the northern and the southern galleries.

I declare the proposed payments open for examination and refer members to the Portfolio Statements, Volume 3, Part 8. Minister, would you like to make a statement and then introduce your advisers?

The Hon. J.D. HILL: Thank you very much, Madam Chair. I will start by thanking the committee—particularly the opposition member for Morphett—for its indulgence in allowing this committee to start a bit later. I attended the funeral of John Chattaway, which finished a little while ago, at St Peter's Cathedral. So, I am really very thankful for your indulgence in relation to that.

I am pleased to advise that I am supported today by Dr Tony Sherbon, the Chief Executive of the Department of Health, to my left, and next to him is Mr John O'Connor, the Executive Director, Finance and Administration Division, Department of Health. Immediately behind me is Ms Nicki Dantalis, Executive Director, Office of the Chief Executive, and next to her is Mr Jamin Woolcock, Director, Corporate Finance and Administration Division, Department of Health.

I have a brief statement to make. The 2010-11 state budget strengthens the Rann Labor government's commitment to meeting the health care needs of all South Australians by continuing the growth in services and our reform agenda. South Australia, like the rest of Australia and, of course, most other western jurisdictions, is faced with an ageing population which is requiring greater levels of health care. The Generational Health Review was undertaken in response to these demand pressures, and South Australia's Health Care Plan was launched in 2007 in response to the findings of that review.

The aim of the health care plan is to continue to provide increasing and improving services across the state. We are achieving this by a number of steps. Firstly, we are increasing the financial and human resources available to the system and ensuring the most efficient use of those resources. Secondly, we are undertaking an unprecedented expansion of physical infrastructure of our system. Finally, we are putting in place measures to control the growth in demand for hospital services.

The 2010-11 budget provides for a total operating expenditure for the health portfolio of $4.46 billion, which is an increase of $424.5 million (or 10.5 per cent), compared to the 2009-10 budget. The increase on spending in country South Australia, I am pleased to say, in 2010-11 has gone up to an even greater level to 13 per cent, and is consistent with our aim of providing more services locally in country areas.

Overall, health spending across government will be 111 per cent higher this year compared to the last year of the former government in 2001-02. That is an increase of $2.4 billion. Much of this additional funding has been used for the provision of additional staff. Today, I can announce that since June 2002 the government has employed an additional 4,322 nurses and midwives (a full-time equivalent of 3,271 positions), an increase of 39 per cent. We have also employed an extra 1,035 allied health and scientific professionals (824 full-time equivalent growth), an increase of 54 per cent.

The allied health professional workforce plays a critical role in South Australian hospitals in primary care and prevention and in community and aged care services. Allied health workers include dieticians, physiotherapists, occupational therapists, podiatrists, pharmacists, psychologists, radiographers, social workers, sonographers and speech pathologists, as well as many others.

I can also announce today that we have employed an extra 1,063 doctors (810 full-time equivalents) since 2002, an increase of 49 per cent. This is a slight full-time equivalent increase of 44, as I suspect more doctors since last year have increased the hours that they undertake in the public sector.

In light of the substantial increase in spending on health, the government has an obligation to all South Australians to ensure that money is spent in the most efficient manner possible. As part of this budget, SA Health was allocated savings requirements of $316 million over four years. SA Health is also required to achieve specific budgeting improvement measures, primarily focusing on realising revenue opportunities of $33.8 million over four years.

These savings measures will not adversely affect frontline services. In many instances, I am confident the measures will improve services for patients. For example, moving about

10 per cent of outpatient appointments into specialist or private GP offices will ensure patients get more timely treatment.

The government is also generating savings by consolidating pharmacy, medical imaging, sterilisation and biomedical engineering services. Recent experience of consolidating services, such as the creation of SA Pathology and Medstar, have demonstrated that patient care can be improved while services are provided in a more efficient manner.

Efficient price reform will generate $118 million of savings and will ensure all metro hospitals work efficiently through measures such as improving leave management, use of agency staff and better management of operating theatres. These changes are also necessary to transition to the commonwealth government's funding local hospital services on the basis of a national efficient price.

The final area of savings to be generated by SA Health are to be obtained by moving out of services that are not directly connected to providing a health service, areas such as car parking arrangements at hospitals and the sale of commercial ventures, such as Medvet. In addition to increasing the budget for services and staff and ensuring that the money is used in the most efficient manner, the government is also in the process of redeveloping every single metropolitan hospital. This, of course, includes the new Royal Adelaide Hospital, which will care for more than 85,000 inpatients a year, have 800 overnight and same-day beds, and will be one of the largest teaching hospitals in Australia. The 2010-11 budget provides $12.4 million towards site preparations for that hospital.

Adjacent to the new RAH will be the flagship research facility, which will house the headquarters of the South Australian Health and Medical Research Institute (SAHMRI). This state-of-the-art facility will be integrated with the new hospital, co-locating practitioners, patients, students and researchers in an industry-leading health and medical hub.

The 2010-11 budget also makes provision for:

- $10 million towards the $46 million redevelopment of Modbury Hospital as promised during the most recent election campaign;
- $23 million as part of the $163 million redevelopment of Flinders Medical Centre including the expansion of the emergency department;
- $30.7 million towards the $339 million redevelopment of the Lyell McEwin Hospital which is virtually doubling the size of that hospital. The third phase of the redevelopment is the largest and will provide an additional 96 inpatient medical surgical beds, 15 more intensive care beds, expanded neonatal services, commissioning of three theatres (one is completed already), a new paediatric ward, modernisation of existing inpatient ward areas and enhanced allied and outpatient department areas;
- $24.6 million towards the $127 million stage 2 of The Queen Elizabeth Hospital. Upon completion of the current stage, a new emergency department and theatre complex in the new building will commence in 2012-13, promised as part of the most recent election campaign;
- $21.9 million towards the $64.4 million upgrade of the Women's and Children's Hospital, promised during the election campaign, and the $24 million children's cancer centre;
- $47.8 million towards the $128.2 million redevelopment of the Glenside campus;
- $3.2 million as part of the COAG agreement to commit $40.3 million to the Repat General Hospital for the construction of new state-of-the-art rehabilitation services and 20 new sub-acute beds; and
- planning is also underway for a $31 million redevelopment of the Noarlunga Hospital which is starting in 2011-12.

In the country, the 2010-11 budget provides for:

- $23.5 million towards the $36 million redevelopment of Ceduna Hospital;
- $12.7 million to start the $41 million redevelopment of the Berri Hospital;
- $14.7 million towards the $69.3 million Whyalla Regional Cancer Centre and hospital redevelopment which includes $54.3 million of commonwealth funding;

- $1.8 million to commence the construction of the Port Pirie GP Plus health care centre;
- $2.8 million to upgrade Hammill House nursing home at Port Pirie Hospital; and
- $900,000 to replace two BreastScreen SA country mobile units that incorporate digital mammography technology.

The substantial increase in the operational and capital investment into our health system by this government is ensuring that people can access high-end acute health care when they need it. The Health Care Plan is also ensuring that we are becoming smarter about how and where patients receive medical care. Providing services in hospitals is an expensive way to treat patients so we have focused on prevention and primary health-care measures to keep people fit and out of hospitals in the first place while helping those who are already sick to manage their condition in order to avoid acute episodes requiring hospitalisation.

In the immediate term, not every medical ailment needs to be treated in hospital. We are providing an increasing range of services outside of hospital settings. This is not only beneficial for patients, because it allows them to receive care in their own home or at least closer to home, but it is also far more cost-effective for taxpayers.

At the centre of our primary health-care packages are the GP Plus health care centres. an approach pioneered in South Australia, GP Plus health care centres are now being replicated across the country by the commonwealth. Smaller centres have already opened at Aldinga, Woodville and Morphett Vale. The major centres at Elizabeth and Marion will be operational later this year and next year, respectively. GP Plus super clinics built in collaboration with the commonwealth will also be opened in Noarlunga and at Smart Road in Modbury later this year.

The success of preventative health measures will only be known in the longer term. However, the early indications are that our primary health measures are slowing the growth in demand for hospital services. In 2006-07, the last year prior to the launch of the Health Care Plan, metropolitan hospital separations had grown by about 4.6 per cent. In the years since, the growth in separations has slowed, year-on-year, to 3.3, 2.1 and 1.9 per cent last year. We have also seen a reduction in how long people are staying in hospital. In 2005-06 the average length of stay was 7.41 days. This has reduced steadily each financial year and in 2009-10 was just 6.99 days.

The growth in metropolitan ED presentations is also trending downwards. In 2006-07, ED presentations grew by 5.9 per cent. In 2007-08, the year after the introduction of the Health Care Plan, that growth had slowed to 2.6 per cent. In 2008-09 ED presentations actually declined by 2 per cent. Last year with the onset of swine flu, growth jumped back up again to 4.6 per cent which is still lower, of course, than 2007-08. Relative to other states of Australia, South Australia has managed to contain growth in emergency department services, despite the fact that this state has a greater proportion of older people.

In the two years after the release of the Health Care Plan (that is, 2007-08 to 2008-09) South Australia was the only jurisdiction to actually record a decline in emergency department presentations, with a 1.96 per cent reduction compared to increases of 0.45 per cent in Victoria, up to 4.21 per cent in Tasmania and 14.98 per cent in Queensland. The comparative national data is not yet available for 2009-10.

The department estimates that its range of preventive and primary health care measures in the financial year 2009-10 have prevented 13,227 emergency department presentations, 14,969 admissions, saved 34,526 bed days and prevented 8,480 outpatient appointments. These figures should increase dramatically when our major GP Plus health care centres and GP Super clinics become operational.

It does take time, money and effort to change the focus of a health-care system; however, there is now strong evidence that implementation of our plan is resulting in the containment of growth in inpatient activity and a reduction in acute inpatient average length of stay. This has made more hospital beds available to more patients, improving the flow through our hospitals. This results in a more efficient health system, more health care options and better health outcomes.

I would like to conclude by thanking all those responsible for these improvements and the giving of services every day—the doctors, nurses, allied health care staff and the administration and managerial staff in our hospitals. Such substantial change over a relatively short period is not easy and could not be achieved without the support, hard work and dedication of all staff in our health system.

Dr McFETRIDGE: I will make a very brief introductory statement, because we have only a relatively short period to examine $4.6 billion of health spending. I want to go back to Wednesday 24 October 2007 and remind the minister what he told parliament on that date. Minister John Hill you told this chamber:

> There are clear and strong community expectations that the Minister for Health be accountable for the public health system.

The minister went on to say:

> As I have said many times, the buck stops with me.

With that, I would like to go on to the questions.

The CHAIR: Yes, please do.

Dr McFETRIDGE: Thank you. I refer to Budget Paper 6, page 100 and emergency departments four-hour targets. Minister, how many South Australians have died as a result of delays in the emergency departments of our public hospitals while you have been minister?

The Hon. J.D. HILL: Thank you very much for that question. I am glad that the member for Morphett has raised the issue of emergency departments. It is obviously an issue of some moment in the media; certainly, it is something that this government has taken very seriously. In fact, the stats that I have just given indicate that we are making some real improvements in our emergency departments.

We have formed a working party with the key doctors from all of the emergency hospitals in Adelaide, including representatives of the AMA, the SASMOA, the nurses' union and leading public servants to work through a strategy to make sure that patients can be treated in an appropriate time. There are two issues about the results of an emergency department: first, to get patients treated quickly within said categories of time; and, secondly, in terms of managing an emergency department, to have those patients transferred to a bed (if they need a bed), or transferred home once their treatment has been completed.

The performance of our emergency services is detailed on our website for all to see. Members can see a range of outcomes at various hospitals depending on a range of factors, but, generally, those who have the most urgent need—that is, those who have life-threatening conditions which require immediate attention—are seen within the appropriate time, which is immediately, and I think, generally, that is 100 per cent the case.

The less urgent cases often have to wait lengthy periods of time, and that can be a number of hours in the case of low level issues. Generally, though, our system performs pretty well in getting people treated. The next issue which is of serious concern and needs to be addressed and which we are addressing is the time that patients who have been treated have to wait before they find a bed. This is the area where the emergency doctors and their colleges have been most outspoken in terms of what they believe ought to happen.

The simplistic solution to this which is often cited is that we need more beds, and that is certainly part of the solution but not the only part of the solution. What we also need to do is to make sure we use the existing services as well as we can. Part of our reform process is to make sure that patients are able to be transferred home more speedily so they do not wait in the bed after they cease to need a bed, so that opens up beds more quickly; and also making sure that long-term patients, for example, particularly those who are disabled and whom the community finds difficult to house, are found houses so they do not end up staying in hospital beds. Equally, with aged care patients who have been treated, they need to be found permanent accommodation. All those factors need to be worked on and we are working through that with the committee that I have established.

During the election period, we undertook even greater reform of this service and we are investing $109 million, over the next four years, to develop a whole range of processes to make sure that our emergency departments work in the way that they should. It is not just investment in the emergency departments but investment in other services such as longer periods of time when diagnostic services are available and the like.

The advice I have in relation to the number of deaths: I am not aware of any coronial inquiry into any death in an emergency department or any deaths into a patient who has died as a result of any delays, but I will certainly get it checked for you. I am not aware of any deaths. That is not to say that people do not die in emergency departments. Let us be clear about that: people die

frequently in emergency departments, because when they are taken to the emergency department they are close to death.

Often, for example, in the middle of the night, nursing homes will send a patient who is dying and who ought, if things worked the way they ought, to be allowed to die in their own bed in the nursing home. Sadly, sometimes they are transferred to emergency departments, but the cause of death is not the emergency department: the cause of death is natural causes. Patients do, of course die, in emergency departments. Patients do die in hospitals. That is often where most patients die. Unfortunately, most people end up dying in hospital.

Dr McFETRIDGE: Budget Paper 6, page 100, emergency departments again. For our targets, we certainly would not want palliative care patients dying in storerooms at Flinders Medical Centre again, would we, minister?

The Hon. J.D. HILL: Sorry, what was that?

Dr McFETRIDGE: We wouldn't want palliative care patients dying in inappropriate circumstances.

The Hon. J.D. HILL: Is this a question or just a casual bleak and nasty comment?

Dr McFETRIDGE: Let us go back to what is happening here with people in the AMA.

The Hon. J.D. HILL: Madam Chair, there was a comment made there which puts on the table a set of claims which are not accurate. If he is not going to ask me a question, I am seeking an opportunity to at least correct the record.

The CHAIR: Indeed, was there a particular reason for bringing up that—

Dr McFETRIDGE: No, the minister raised the issue, so I was just responding to what he had said.

The CHAIR: Member for Morphett, you raised something particularly emotive which was something which the minister had not raised. You have thrown it out into the chamber. Is this something you wish to ask a question about or are you just making passing comment?

Dr McFETRIDGE: It was the minister who raised the issue of palliative care patients, but I will go to the next—

The CHAIR: Are you asking a question?

Dr McFETRIDGE: I will ask the next question.

The CHAIR: So, you were not asking a question.

Dr McFETRIDGE: I will ask the next question.

The CHAIR: So, you were raising a passing comment.

Dr McFETRIDGE: The AMA and the College of Emergency Medicine talk of 100 to 150 South Australians dying purely due to delays in EDs in our public hospitals. That is over 500 people in the last five years who are classified as avoidable deaths. I refer to Dr Tony Eliseo, who, in 2008, said:

> In this state alone in South Australia we estimate that there is an extra 100 to 150 extra deaths per year purely due to these overcrowded emergency departments.

Why is nothing of consequence being done to relieve bed block? I know Dr Sherbon had the same problem in ACT health in 2004, so he should be an expert on this. We should be doing more to relieve bed block and not reducing out-of-hospital services and cutting back community hospitals taking people into step down. Minister, how many people have died avoidable deaths and what are you doing about bed block?

The Hon. J.D. HILL: It is going to be a long night if that is the approach that the member for Morphett takes in relation to the budget estimates. Let me go through the claims that he has made. Last week, on one of the commercial television—

Dr McFETRIDGE: I haven't made claims, John. This is the AMA, it is the College of Emergency Medicine, it is the Australian College of Surgeons—

The CHAIR: Order, member for Morphett! First of all, it is informal in here to a certain extent—you will not refer to the minister as 'John', you can refer to him as 'minister'. Secondly, if you are going to ask a question, please give the minister some time to answer it. I am setting out

these parameters right now. You can choose to listen to them right now or I can repeat them every single time this happens. It is up to you. Minister.

The Hon. J.D. HILL: Let me go through the issues that were raised. Firstly, there was a program on commercial television during the week which highlighted a grieving family who has lost a loved one, and my sympathies are obviously with anybody who loses a loved one. The person was not in a storage room. The person who died was a palliative care patient who had been taken into the hospital. The person was in a treatment room. It may not have been the room that they ideally wanted, but the person was in a treatment room.

The second question is about some statistical information that was put into the media a year or so ago, I think, by representatives of the College of Emergency Medicine and it relates to a statistical analysis that has been done in various places. I do not know if it has been done in South Australia, particularly—it is across the board, I think even internationally as well, I am not sure, but certainly across Australia, which is an analysis that puts in certain assumptions and produces certain findings.

As I said at the time, when this was raised over a year ago in the media, I am not aware of any coronial evidence to support those claims. There are no particular individuals that the college was able to point to. It was a generalisation based on a national statistical model, and I said, 'If you have concerns about particular patients you are under a duty to refer them to the Coroner; that is how we deal with it.'

That is not to say that there is not a need for improvements in emergency departments. As I said in answer to the first question, we are going through a whole range of processes to try to improve emergency department methods, or ways of dealing with people, and I will go through some of those for you.

We have already implemented a range of strategies to address increasing demand on emergency departments, including: $14.4 million, which was allocated as part of the 2006-07 budget, over four years to recruit additional public hospital emergency department staff to strengthen system capacity in the face of continued demand pressures and maintain timely access to services—from memory, I think that was one of the requests that the AMA put to me at the time—and the recruitment of a further 20 emergency department physicians over the next three years as part of the commitment during the Medical Officer Enterprise Bargaining Agreement in 2008—once again, put to us by the doctors—10 physicians in 2008-09, five in 2009-10 and another five in 2010-11. So, all things that doctors asked for, which we are doing.

Also, as part of the joint initiative with the Australian government through the Council of Australian Governments (COAG), health has received $61.7 million over four years from 2008-09 to 2012-13 to implement reform strategies. Building on these strategies, the state government, through the Every Patient—Every Service election commitment, has committed a further $109 million in operating funding over four years from 2010-11 and $2 million in investing funding for 2010-11.

To achieve the target of 95 per cent of patients being seen, treated and either discharged or admitted within four hours by 2012-13, the targets are staged from 60 per cent for 2010-11 to 95 per cent by 2012-13. Strategies identified to meet the target include:

- development of acute medical units. We have a couple of those in operation already and we are going to expand the use of those medical units to allow patients to be admitted very quickly for short periods of time, up to, I think, 48 hours, from memory;
- recruitment of additional senior clinicians after hours and weekends to support timely patient decisions. This is one of the bugbears of our system: despite the fact that patients get ill 24 hours a day often the most senior people are on duty only during 9 to 5, or extended hours but certainly only during day time. Our intention is to have senior people on duty right around the clock who can make decisions;
- enhancing community services over the weekend to support timely discharge of patients;
- increasing resources to assist with discharge of patients with a disability;
- enhanced clinical resources to support people with mental health issues;
- improved access to diagnostic and support services, so that people can get x-rays or CAT scans or whatever they need when they need it;

- enhancement of the extended care paramedic service within the metropolitan area, which has worked really well to keep people looked after in their own homes; and
- employment of additional doctors, nurses, allied health and administrative staff to support new/revised models of care and an increased move towards provision of 24/7 hospital services.

So a lot of thinking and a lot of work—in collaboration with doctors, the AMA, SASMOA, the nurses' union and others—has gone into this set of plans, some of which has been implemented, and there is more to go.

Let me tell you about the particular outcomes for 2009-10. An additional five emergency department consultants were approved across SA Health, in line with the enterprise bargaining discussions I have referred to, and $10 million has been utilised for the implementation of COAG emergency department reform initiatives. As a result of the staged implementation the following initiatives progressed during 2009-10:

- discharge lounges, see and treat clinics, recruitment of patient flow coordinators and administrative support staff, and planning for the establishment of acute medical units at the Royal Adelaide Hospital and Flinders Medical Centre;
- improved access to diagnostic and support services through the procurement of radiology equipment, ultrasound and cardiac equipment;
- increased information technology system capacity through the development of an operational business intelligence tool to provide real-time reporting and the purchase of an emergency department capacity management tool (CapPlan); and
- improving community awareness through media campaigns aimed at reducing demand on emergency departments.

Targets in 2010-11 include the last five additional emergency department staff committed as part of the MO enterprise bargaining discussions to be employed and the following initiatives to be progressed through the COAG reform:

- continued staffing of the discharge lounges, 'see and treat' clinics, and acute medical units;
- improved patient movement between ED and radiology, and extending hours of radiology access including after-hours and seven-day access; and
- continued media awareness campaigns.

Initiatives under Every Patient—Every Service will commence implementation in 2010-11, with $17 million of operating expenditure approved for 2010-11 and $2 million in investing expenditure. Key areas of implementation will include:

- progression of planning and resources for acute medical units at the QEH and the Lyell McEwin Hospital;
- additional recruitment of senior clinicians to support after hours and weekend access;
- agreed model of transition for patients with disability back into the community; and
- enhancement of the extended care paramedic service within the metropolitan area.

I am pleased to say that, in June 2010, 57.5 per cent of patients seen in metropolitan public hospital emergency departments were treated and either discharged or admitted within four hours. This percentage reflects the combined percentage for the Adelaide Health Service and the Children's, Youth and Women's Health Service. Individually, the 2009-10 estimated results for the Adelaide Health Service was 53 per cent and for the Children's, Youth and Women's Health Service 84 per cent.

It is anticipated that with the additional resources there will be achievement of the agreed first phase target of 60 per cent of all patients being seen, treated and either discharged or admitted within four hours by 30 June 2011. We project that the Children's, Youth and Women's Health Service will exceed this target, based on 2009-10 performance.

In addition to all this we are undertaking huge capital works programs right across the system. The emergency department at Flinders Medical Centre is currently being upgraded. Of course there will be some delay problems over the course of that development work and no doubt there will be complaints about that, but the reality is that you cannot make an omelette without

breaking eggs. The emergency department at The Queen Elizabeth Hospital is part of this stage that we have committed to; Lyell McEwin has had its emergency department upgraded, but we are also increasing the size of the Lyell McEwin so there will be extra beds there; Modbury Hospital has plans for an emergency department renovation and reformation; and so on, across the system.

There are huge investments, and big changes have already occurred. I am advised that there was one coronial finding of concern regarding the emergency department at TQEH earlier this year.

Dr McFETRIDGE: I will go straight on. I refer to Budget Paper 4, Volume 3, page 8.19, Corporate Services. The most significant contribution to South Australia Health's estimated 2009-10 deficit of $179 million was a corporate service deficit of $121 million. Given that the minister and the CEO of South Australia Health, Dr Sherbon, previously indicated the health budget was under pressure due to demand, why and how is it that the corporate services division can achieve such a significant deficit?

The Hon. J.D. HILL: What was the figure you are saying?

Dr McFETRIDGE: There was an estimated deficit of $179 million for SA Health. Of that $179 million, $121 million was due to corporate services.

The CHAIR: I see; he is rounding up.

The Hon. J.D. HILL: We are unsure what you are actually referring to. We cannot see any line there that says 'deficit' on that page.

The CHAIR: Member for Morphett, are you rounding up?

The Hon. J.D. HILL: You referred to deficit. Where is the word 'deficit' on that page?

Dr McFETRIDGE: The 2009-10 budget for corporate services was $90.945 million. The estimated result was $211 million—nearly $212 million. The variances across corporate services—

The Hon. J.D. HILL: Sorry; I understand what you are saying now. The word 'deficit' is what threw us, because there is no reference to that there. I will ask Dr Sherbon to explain.

Dr SHERBON: We will just check with the office, but that is additional expenditure authority that has been authorised by Treasury; that is not deficit funded expenditure. I refer the committee to the second paragraph of that Reason for Variance explanation included in the budget papers. This is for the Department of Health corporate services. It is not a budget overrun: it is an increase in expenditure authority because the Department of Health absorbed, as is explained in the second paragraph, the supply chain and procurement process functions from the healthcare regions, including warehouse stock. It also absorbed the centralisation of ICT functions and the funding associated with the change to a single WorkCover levy registration. So, that is the explanation for that changing figure. It is not an overrun: it is an increase in expenditure associated with the transfer of functions.

The Hon. J.D. HILL: And I assume there would be a subsequent reduction in equivalent funds in other lines.

The CHAIR: Would you like to ask another question on that matter?

Dr McFETRIDGE: I will, thank you, Madam Chair. This refers across several pages of the budget. I refer to Budget Paper 4, Volume 3, pages 8.13-8.15 and 8.17-8.19. The non activity-based cost pressures there were $103 million. When you add up the non activity-based cost pressures across all of those areas, then you add in those of the health services—the Adelaide Health Service; Child, Youth and Women's Health Service; Country Health Service; other health services; and ambulance—that makes a total of $129,495,000 non activity-based cost pressures, which is about 28 per cent of the total $179 million of the deficit.

The CHAIR: Member for Morphett, I am really sorry to interrupt you. Just for my benefit, you have named a number of pages, but I am not sure exactly which page we are on at the moment.

Dr McFETRIDGE: It is adding up all the budgets, the actuals and the variances of all those pages, ma'am.

The CHAIR: Not including 8.16, because that is just comments; is that correct?

Dr McFETRIDGE: That is right; it is just comments.

Mr GRIFFITHS: But it is all about Program 1 costings.

Dr McFETRIDGE: It is all about those costings in Program 1, as the member for Goyder points out.

The Hon. J.D. HILL: I am happy to try to accommodate but perhaps, rather than do it in general, we could go through page by page so that we know what we are talking about—rather than make a general kind of claim.

Dr McFETRIDGE: I will sum it up for you.

The Hon. J.D. HILL: No; the summary I got. What was the first page?

Dr McFETRIDGE: 8.13.

The Hon. J.D. HILL: What is it on that page that you queried?

Dr McFETRIDGE: We are adding up the policy, clinical services as clinical coordination; we are adding up policy and intergovernmental relations; we are adding up right across Sub-program 1.3, 1.2, 1.1 and Program 1. It is a whole series of spendings there.

The Hon. J.D. HILL: Can I put to you what I think you are asking about and then we will try to answer it. If you look at page 8.13 under Program 1, there are four columns of figures. The first is the 2010-11 budget, then the 2009-10 estimated result, the 2009-10 budget and then the 2008-09 actual. I think what you are looking at are the middle two columns, comparing the budget with the estimated result; is that correct? You are then drawing the conclusion that the budget says $179 million and the estimated result was $282 million, therefore the budget was overrun by a hundred and whatever. Is that the essence of what you are saying?

Dr McFETRIDGE: That is the essence of it.

The Hon. J.D. HILL: There are a range of adjustments that are kind of part of what Dr Sherbon's answer to your previous question was really about. It is not an overrun as such; it is transferring the way various moneys which are held by the health portfolio are brought to book. It also includes various commonwealth funds that have come through for various purposes. Once again, I will ask Dr Sherbon if you can add further light on it.

Dr SHERBON: Not much more than you, minister. That increase from the 2009-10 budget to the estimated result is, as the minister said, due to the absorption of some functions that I outlined in the earlier answer. Also, the minister referred to some commonwealth funding that has been received. These are figures for the Department of Health. It does not include the health care regions which are dealt with elsewhere in the budget papers. As I said, the department took some functions from the regions and also the department receives commonwealth funding.

The Hon. J.D. HILL: The point is that, as part of our reform process trying to make the system work more efficiently, certain things which were spread across regions are now run centrally. So, the budget for those goes centrally and we do more with less money. It has not been an overrun at all.

Dr McFETRIDGE: I refer to Budget Paper 4, Volume 3, page 8.24, In Hospital Services. The minister insists that much of the deficit position in health relates to activity pressures. Budget papers indicate that health services were over their funded activity targets by 12,314 resource weighted hospital outputs. If we apply the 2009-10 in-patient case-mix price of $4,065 to each of those, the cost pressure due to activity is approximately $50 million. So, to say that the budget blowouts are activity-based, increased demand, I think is exaggerating the true situation. The main cause of the deficit is in corporate services.

The Hon. J.D. HILL: I know that would suit the narrative that the shadow minister would like to have people believe, but the reality is that more and more people keep coming through our doors, and the level of health need tends to be greater, the acuity level of patients is greater, and it costs extra money. For example, there has been a growth in inpatient activity above funded levels in 2009-10 of $44.1 million and a growth of 12.2 in outpatient activity over the same period.

There are enormous pressures in the health system to provide services to people. The other thing, of course, is that salaries go up at a greater rate in health than they do across the broader spectrum. That creates pressure, technology costs are greater than inflation generally, the range of services that can be provided to people expands virtually every year, and so people can live longer and be kept comfortable for longer. So, all of these things are pressures, and what we are trying to do to assist them is to minimise that growth. As I pointed out in some of my earlier

remarks, we have been pretty successful in starting to turn that around, but there is a lot more to be done.

Mr SIBBONS: I refer to Budget Paper 4, Volume 3, pages 8.11 and 8.12. Can the minister provide further information on the redevelopments at all metropolitan hospitals?

The Hon. J.D. HILL: I thank the member for the question; it follows on nicely from one of the questions that the member for Morphett asked me earlier. It is really an intrinsic part of our Health Care Plan to make sure we have capital development of hospital infrastructure which is contemporary and able to provide services to our population.

In June 2007, as you would know, we released our South Australian Health Care Plan, which is a 10-year plan from 2007-2016. The plan outlines the necessary development of the health system over 10 years to meet the needs of the population. That plan clearly identifies the need to invest in the major hospitals in Adelaide, including the construction of the new RAH and the upgrade and expansion of the Flinders and Lyell McEwin hospitals, which together form the backbone of the state's high-level critical and complex hospital services.

In addition, the network of general and specialist hospitals is undergoing substantial redevelopment. In fact, every single metro hospital is in the process of being redeveloped. At the centre of the process of hospital renewal is the new Royal Adelaide Hospital. The government has approved the procurement of the hospital via a public-private partnership delivery model for a contract term of 35 years from financial close.

The final bids to finance, build and maintain the RAH have been received, and the shortlisted bidders were given the full specifications of the hospital last year and have spent the past six months working with the state to develop their final proposals. Those proposals are now being evaluated by experts from Treasury, Crown Law and SA Health, including senior doctors, nurses and allied health staff, and outside expertise will also be utilised where necessary. The preferred bidder will be selected later this year, and we expect construction to start early next year.

Work at the Lyell McEwin Hospital is continuing on the $339 million transformation of what was essentially a large community hospital into one of Adelaide's three adult tertiary hospitals. So far the redevelopment has provided: establishment of an emergency extended care unit; significant upgrading of medical care beds, enhanced day surgery and oncology facilities; the extension of SA Pathology and hospital pharmacy facilities; 50 mental-health beds, including the existing 20 aged mental-health beds; and research space. I am particularly pleased that we have got research activity happening there.

A significant proportion of the site asset infrastructure has also been replaced. The current third and final stage will be the largest part of the redevelopment, and it will cost $202 million. The proposed scope of works comprises: the construction of a new 96-bed acute inpatient building, inclusive of a helipad on the upper level; 15 more intensive care beds; expanded neonatal services; commissioning of three theatres (one already completed); a new paediatric ward; modernisation of existing inpatient ward areas; enhanced allied and outpatient department areas; and a range of internal reconfigurations, relocations, refurbishments and upgrade works to suit existing and expanded functional requirements.

In southern Adelaide, the 2010-11 budget provides $23 million towards the $163 million redevelopment of the Flinders Medical Centre. The redevelopment has already delivered an expanded coronary care unit and the new south wing houses maternity services. The acute medical assessment unit expanded from 19 to 36 beds, and the intensive care unit expanded from 24 to 32 beds. Construction works associated with the emergency department expansion are nearing completion and, when commissioned, will enable commencement of the progressive refurbishment of the department.

Some $50 million in infrastructure works are almost complete. When completed the Flinders Medical Centre redevelopment will also deliver an operating theatre expansion from eight to 12 and provision of integrated day of surgery admission facilities and day surgery unit, and an emergency department expanded from 31 to 50 treatment cubicles.

Alongside the three tertiary hospitals, SA's health care plan makes provision for the three general hospitals, namely TQEH, Modbury and Noarlunga and two specialist hospitals, that is the Women's and Children's and the Repat General providing services for veterans as well as palliative care and mental health services for southern Adelaide. Major investments have been made in all of these hospitals to ensure that they have the equipment and facilities required to meet the needs of their patients.

The government is committed to the staged approach of the total redevelopment of TQEH to ensure that that ageing infrastructure is replaced with state-of-the-art facilities that will achieve national benchmark standards for clinical service provision and space planning. To date, a total of $172 million has been committed towards the first two stages of the redevelopment which has provided for new modern inpatient facilities, research facilities, a multi-storey carpark, a childcare facility and associated sustainment, engineering and landscaping requirements.

The final elements of TQEH Stage 2 redevelopment are currently being designed and comprise delivery of new older persons' mental health services acute units (20 beds), provision of a new allied health and rehabilitation facility comprising therapy areas, assessment and consultancy spaces, patient amenities, and staff and administration spaces.

A $125 million election commitment to commence the next stage of TQEH redevelopment upon completion of the current works will deliver a new clinical services block accommodating the emergency department, operating theatre complex, medical imaging department, outpatient department and pathology facilities.

At Modbury Hospital, $12 million in capital has been allocated over six years from 2007-08 to 2012-13 to address urgent infrastructure upgrade works and major building maintenance for the hospital to continue to deliver the required clinical services, including replacement of the roof and the sewer pipe infrastructure, upgrades of mechanical and electrical services and the removal of asbestos.

The commonwealth government has contributed $1.08 million for elective surgery facilities to enhance the capacity of Modbury to manage increased levels of low complex elective surgery and $275,000 for elective surgery equipment. A further $46 million election commitment has been made for the redevelopment of Modbury hospital. The redevelopment will deliver an upgraded and expanded emergency department, a 36-bed rehabilitation inpatient unit and associated therapy and support functions, and continuation of essential site infrastructure replacement and upgrade. The design team for Modbury is currently being engaged.

The 2010-11 budget also makes provision for $21.9 million towards the $64 million upgrade of the women's and kids' hospital and the $24 million Children's Cancer Centre. The cancer centre development will deliver three additional levels on the Gilbert Building to provide single point oncology services, single point pulmonary medicine clinics and gene therapy laboratories. The election commitment for a further $64 million will ensure that the Women's and Children's remains one of the finest paediatric hospitals in the country. The redevelopment will include:

- provision of additional neonatal intensive-care cots to support neonatal services;
- new operating theatres and a procedure room;
- a consolidated medical day unit and dialysis unit; and
- redevelopment of the medical wards on level 4 of the Good Friday building to provide 36 single rooms for young patients and four new two-bed rooms for siblings who are admitted together in the medical wards.

The design team and builders have been appointed in the following works commenced:

- upgrade of the Good Friday building lifts;
- design and documentation of the additional levels to the Gilbert Building; and
- enabling construction works.

Finally the 2010-11 budget makes provision for $3.2 million as part of the COAG agreement to commit $40.3 million to the Repat General Hospital for the construction of new state-of-the-art rehab services and 20 new sub-acute beds. Planning is also underway for a $31 million redevelopment of Noarlunga Hospital which will start in 2011-12 and will include an expansion of inpatient bed capacity, four high dependency beds and a redevelopment of operating theatres and increased renal dialysis.

Upon completion of this ambitious set of capital works, every single metropolitan hospital will have been substantially redeveloped. There will still be some works that will need to be done but, by and large, the infrastructure in our health system will have been brought up to a contemporary standard. A few years ago we had the oldest and most outdated buildings in our system; by 2016, we should have the most modern buildings in South Australia. It is something that

we need. Unfortunately, while that building work occurs there will be some frustrations and issues which inevitably follow renovation and rebuilding.

Dr McFETRIDGE: I refer to Budget Paper 4, Volume 3, page 8.19, 'Corporate Services', which really rolls through into page 8.13 as well, which is 'Policy and Administration'. Dr Sherbon told the upper house Budget and Finance Committee in August that the budget bailout was $75 million. Last week's Auditor-General's Report talks about a deficit of $173 million and a bailout—that is the Auditor-General's word—of $149 million. Minister, can you tell the committee what is going on with having to bailout the health system, and did you increase any of the targets with the increased funding?

The Hon. J.D. HILL: Let me just say that, in general terms (and I might ask Dr Sherbon to comment), every year the health budget grows by about 10 per cent. We allocate funds through a process which is worked out—from time immemorial—with Treasury about how much money we spend for particular things. Generally, every year we have greater costs than were provided to us through the budget process, and that is driven largely by growth in demand and growth in some of the other costs through the pressures that I have described.

In the course of finalisation of the year's budget, we have been receiving top-ups. That has been the case under this government and it was the case under the other government. The difference is that we have done it honestly, and that those top-ups do not become debts attributed to an individual hospital or a group of hospitals (as was the case under the former government): they become built into the base of the health-care system.

If you were to look at a graph of outcomes, there would be a growth every year of 10 per cent or so . If you look at a graph of the budgets you would see a similar growth. It does not matter how many ways you cut it up, dice it or slice it, the reality is that the growth for health-care services in South Australia is growing at an astronomical rate.

We are doing everything we possibly can to make sure that we continue to address that growth and demand while, at the same time (and this costs money), putting in mechanisms to try to slow that growth by providing greater access to primary health care, by providing greater in-home care for people who have got chronic illnesses, by providing in-home care for patients who have come out of hospitals after an acute episode and greater services for the community through GP Plus health-care services. All those things cost money.

I am very proud to be part of a government that has given health this enormous set of priorities. This growth in funding is not as a result of some bloating of the bureaucracy which fits a narrative that those who are opposed to the government would like to create; it is not as a result of incompetence or any of the other things that people might like to suggest: it is a growth; there is growth in demand. That is not to say that we cannot run our system more efficiently, and there are ways that we can reduce costs by doing things differently.

However, I have to say that, every time the government tries to do something differently to rein in costs, we get criticism from those who make the same criticisms that the system is too expensive. I do not listen terribly much to that kind of irrational kind of criticism. I am focused as a minister and the government is focused on making sure that we deliver world-class services to the people of our state and that we do that as cost effectively as we can. If that means putting in extra money at the end of a financial year because there has been a growth in demand, so be it. I will ask Dr Sherbon whether, perhaps, he can provide further light.

Dr SHERBON: Through the minister and you, Chair, the question was about the Auditor-General's Report and the so-called 'bailout'. We are just doing a search.

The CHAIR: I am sorry, I should have said this earlier on. Thank you minister for answering this, but there is no compunction to comment on the Auditor-General's Report. We are here to talk about the budget; we are here to talk about lines in the budget. There will be an opportunity, as you are well aware, to examine the Auditor-General's Report. Now Dr Sherbon, if you would like to continue with your answer, please do by all means.

Dr McFETRIDGE: Madam Chair, a point of clarification. If there is information in the Auditor-General's Report which relates directly to the budget documents and provides more up-to-date information, surely we should be allowed to use that information because that is what it is about. The half an hour we will get on the Auditor-General's Report is completely inadequate for the health portfolio.

The CHAIR: Can you bear with me for one moment because this is a direction that I took from something that occurred last week? You can ask the question but you cannot relate it directly

to the report. I understand your time constraints and I understand the time constraints that you have in terms of the Auditor-General's Report, but it is another report and another debate in time to come, but I am sure you can bring this back to a specific line in the budget without talking about the Auditor-General's Report.

Dr McFETRIDGE: I will, I can absolutely guarantee it.

Dr SHERBON: Moving back to the question, the question related to budget papers 8.13 to 8.19, which, as I said earlier, are the Department of Health budget papers, not the health care regions. The allocation that Dr McFetridge referred to of $75 million in the Mid-Year Budget Review was to the health portfolio but was expended in the health care regions, not by the Department of Health. The Department of Health is the central entity. The health care regions deliver health care services. The Department of Health itself was not bailed out by any particular matter and the Auditor-General's Report relates to the Department of Health, not the health care regions. They are audited as separate entities by the Auditor-General.

The minister has indicated that there is scope for me to assist the committee by providing the following information; that is, as the minister said, there were activity pressures in the health portfolio and, in fact, in 2009-10, in-patient activity above funded levels equated to $44.1 million and outpatient activity above funded levels equated to $12.2 million. So, there were significant activity pressures that accounted for a very significant portion of the over expenditure in the health care portfolio.

There were some other elements, including the fact that the health portfolio is behind on delivering on savings initiatives. As we have outlined to the Budget and Finance Committee through my previous evidence on the last two occasions that I have provided that committee with information, we are working hard to catch up on the savings schedule set to us by government and we will continue to do so. They are the key elements of the expenditure issue that the minister covered in his answer.

Dr McFETRIDGE: The same reference. The activity pressures still only add up to a bit over $50 million, according to my calculation. Adelaide health service, Children, Youth and Women's Health Service, Country Health, other health services and South Australian Ambulance Service adds up to $50,056,410, which is way short of the $149 million that was used to bailout the whole of the health department. Some is for activity, but the vast majority of that $140-odd million is for non-activity costs.

The question I would really like to get on to though is: where are we going with outpatient services? Budget Paper 6, page 105, outpatient service reforms are to realise an annual savings of $21.7 million by 2011-12. Using the 2009-10 casemix price outpatient waited occasions of service of $138.65, this means approximately 156,754 fewer waited attendances per year. Where will these patients go and has the department undertaken any form of analysis to determine whether the private sector has the capacity to take these patients? Do they know what the unmet demand is, that is probably the crux of it?

The Hon. J.D. HILL: I thank the member for the question. Before I go on I should explain to him that the health department is the central bureaucracy, if you like, and then there are health regions which have their own corporate entity. 'SA Health' is the term that we use to describe the whole lot, or the portfolio, if you like.

The advice I have is that there was a $75 million adjustment in our budget mid year, and most of that was taken up by growth in demand. In relation to outpatient services, the reform of outpatient services is aimed at providing a better service to patients, and whether or not we had savings to make I still earnestly believe that this is the right thing to do, and I am encouraged by the large number of doctors who have said similar things to me since we announced this—it encouraged me, in fact, to go on with it.

As the number of outpatient appointments continues to grow, patients would have to wait longer to access services via the public system. So, by reforming outpatient services we believe that patients will get more timely treatment. It will also allow SA Health to prioritise emergency and critical health services, which are the pressure points in our hospitals.

Outpatient services have traditionally provided support services to both hospital-based inpatients and to community-based non-admitted patients and are usually the entry point, other than through the emergency departments, to inpatient care. All major jurisdictions within Australia are reviewing how public-type outpatient services are being provided.

SA Health commenced an outpatient review project in 2009 in order to improve the internal business systems for outpatient services. The key areas of focus have included: developing an agreed model of care, developing patient-focused booking systems, developing standard referral processes, and ensuring sound governance over outpatient-type services.

The interesting thing about health, I have found, as somebody who does not have a health background, is that we have some of the smartest people in the world delivering the most extraordinary services to individual patients but in a system which is pre-feudal in terms of its organisation, sort of individual cottage industries that are operating around the system.

What we have tried to do, and I do not say this in any pejorative way about the people who used to run the system, is to modernise the system in which these brilliant people are providing brilliant services so that the whole system operates as sharply as it possibly can, and outpatient services is just one area. For example, I am asked occasionally: how many people are on the waiting list of an outpatient clinic? The answer is: we do not know, because those stats are not kept. They are kept by individual doctors and their services and individual hospitals. There is no centralised way of knowing, and that is the reality of it.

The next phase of outpatient services reform is identifying which outpatient clinics can be provided in a community specialist or general practitioner environment. That review is expected to take about three to six months and will undertake a comprehensive data review of all outpatient services by clinic type. So, we will get to know all of the answers to those questions that I am often asked. It will establish criteria that can determine types of outpatient services that can be transitioned from the public health system to a community specialist or general practitioner environment. So, that picks up the capacity question that the member asked about.

The review will also provide advice on a consistent approach to outpatient services, which transforms current outpatient services to focus on essential services that support inpatient therapy and procedural care. For example, at the moment, we have had online for some years now the waiting time at every hospital for particular surgical procedures on the elective surgical list. So, if you want a hip replacement you know that it is going to take so long at this hospital compared to the other hospital so that you and your doctor can shop around, if you choose to, but how long it takes to get to see a clinic to determine whether or not you need surgery is unknown, it varies, and the information is not kept in a consistent way which could be made available to the public, which is certainly what I support.

The review will be overseen by a steering committee and a reference group from all key stakeholders and will include clinicians, professional colleges, unions, universities, and consumer groups, so, everybody who has an interest in this. The reform will be introduced over the next 12 months and, when fully implemented, up to 10 per cent of outpatient appointments will be provided in private clinics, with 90 per cent or more of outpatient appointments still occurring in hospitals. From memory I think there are about 1.1 million outpatient clinic appointments each year, so we are talking about 10 per cent of that. The majority of the 10 per cent of outpatient appointments to be provided in private rooms will be first consultations, and just from common sense that has to be a good thing.

You go to see your GP, who says 'You might need surgery, I'm not sure; I'll have to send you to a specialist to check, or you might need some therapy. I'm not a specialist, so I'll send you to a specialist. Are you a public or private patient?' If you are a private patient you see the specialist whenever you can get in, which is usually pretty quickly, and you are told what the problem is. You can then get on whatever queue is necessary in the private system to have surgery or some other therapy. What happens too often in the public system is that patients—particularly if they do not have a very urgent case, one which is assessed as being of low urgency—can wait quite a long time before they actually see a doctor to determine whether or not they need some follow-up therapy. If they could get to see the doctor quickly they could get therapy quickly, and that might avoid unnecessary operations. So from a patient management point of view it has to be a lot smarter.

I make this philosophical point: why do we consider that the assessment provision should necessarily be done at a public hospital? The GP the person goes to in the first instance, when they have a problem, is a private consultation. Most GPs bulk bill—I understand 70 to 75 per cent of interactions in South Australia are bulk billed, particularly in the case of pensioners and people on Health Care Cards—so it does not cost the patient anything. They do it in their private rooms, and that is done.

The GP starts the diagnosis, and the completion of the diagnosis then takes place in the public hospital for public patients; why shouldn't that also happen in the private system, and be managed through the Medicare system, in the same way? If the patient needs an operation or therapy they can then choose to go through the private system if they want to pay, which is the case now, or they can do it through the public system, but they will be able to get into that public system more quickly with a more settled diagnosis. The other thing, of course, is that if you see a doctor in their private rooms you get to see the specialist and not one of the juniors. As I understand it, in the public system patients sometimes have to go through a series of referrals to get a final diagnosis by a senior doctor.

This is about better health care, as well as about taking some costs out of the system. We are confident that this can be done because we know it is done in other jurisdictions—and done well and without any problems that I am aware of.

Dr McFETRIDGE: Same reference, Budget Paper 6, page 105, Outpatient Services. I am surprised that the minister says there are no lists of people waiting to see specialists before they can then get onto elective surgery waiting lists because Dr Paddy Phillips, for whom I have a lot of respect, told a meeting I attended that, 'You don't know what you don't measure.' I am informed, for example, that at the Flinders Medical Centre there are over 200 on the bariatric waiting lists, and I think they do about 15 surgeries (lap band surgeries, I think they do there) a year. There is a huge waiting list for orthopaedics at Lyell McEwin, a huge waiting list for urology at the Repat, and a huge waiting list for ophthalmology at the RAH. These are all people who have been referred by their GPs but who have not yet seen specialists.

There must have been some process gone through to decide how you will organise this. Dr Sherbon said that it was 1.1 million outpatient services; in your 'Frequently asked questions' it says that more than 1.2 million outpatient appointments are made. The real issue is: how do you know what you do not measure? How do you know what you will save? How do you know that you will reduce the lists of people who have been referred and are actually waiting to see a specialist?

The Hon. J.D. HILL: Well, I am happy to go through it again. I thought I covered all of that pretty well. I thought it was a bit longwinded, but I was trying to be comprehensive. We are aware anecdotally, from time to time; I certainly am aware when people write to me that they are waiting for a period of time to get to see a doctor in outpatients, to be assessed. Every time I say we have got elective surgical lists down to zero, long waits down to zero, people say they have been waiting two years, or 18 months, or 12 months or whatever. So, we know that some people wait a long time. Particularly if they are assessed as being less urgent they wait lengthy periods of time.

Often, the GP who makes an appointment with a doctor in a particular hospital will typically go to the hospital which they have always dealt with. There might be a shorter wait somewhere else, but they would not know that. So, there are a range of things that we don't know, but there are also some things that we do know. We know that the system is not working as well as we would want it to work, which is why we are going through a process of reviewing it to work out where the system is not working as well as it ought to and addressing those parts of it.

I have just outlined the process that we will go through, but we have targeted about 10 per cent of first appointments, which would cover a fair number, I think. The ongoing clinics (therapeutic clinics and so on) by and large we would expect to continue in the hospital. Some might happen more appropriately in GP Plus health care centres. They do not necessarily have to be in a hospital setting. They can be in a clinical setting but outside of a hospital. If we do that, it creates extra capacity in hospitals.

So, there is a range of ways that we can work this through. As I say, a number of the doctors who have spoken to me have been very supportive of this. I understand that, pretty well, that is the way it is done at Modbury Hospital—I think I have said publicly before—and I think some of the clinics at Flinders are done this way as well. So, there is a pretty good precedent for doing it. Our goal always has to be to try to provide the best service to the patients, and I think this review leading to reform will do just that.

Dr McFETRIDGE: Just following on from that response: minister, you still really haven't answered the question. I understand that you can reduce the time that patients are on the elective surgery waiting list by doing more elective surgery—and I will ask more questions about that—but it is the unmet demand. How do you know, even by referring 156,000 patients to private specialists—and I am not sure how you can achieve that—but even if you do that, how do you know how many people in those drawers in the hospitals have been referred to the hospitals unless you have done some preliminary work?

My follow on from that is that, if you have not done that work, how do you know you are going to be able to achieve the reductions in waiting times for people to have elective surgery or to see a specialist? They may not all need surgery. The issue of unmet demand is one that keeps on and on and on and we just do not see an answer at the moment.

The Hon. J.D. HILL: Well, once again I am just going over ground that I think I have already covered. We are going through a review process to focus on those very questions.

Dr McFetridge interjecting:

The Hon. J.D. HILL: I'm sorry?

Dr McFETRIDGE: Are you going to start collating the referrals from the GPs?

The Hon. J.D. HILL: Well, the working group will do whatever it needs to do. The GPs refer patients to doctors, and individual doctors or clinics keep their own lists, so the information is somewhere. It is not centrally collated. There is no mechanism in the same way as we document patients who have been seen by a specialist and put on a waiting list for an operation—we have all of that well documented. There is a common system, a common method of recording information, so all of that information is available and updated every month, I think, on the website. So, we have all of that information.

I would like to have the rest of it put there. It is a fairly onerous job to do all that and it would come at a great expense to get the systems in place to do it, and train the staff and so on. What we are going to go through is having a look at how and what can be better placed in the private rooms of doctors, many of whom do the work in a public hospital as well. I mean, you know, doctors work in both fields, by and large. So, that is the process we are going through and the evidence in other states is that this works quite well.

Dr McFETRIDGE: Minister, I know what you are trying to achieve, but I just do not see how you are going to do it. Surely, before making the announcement, you would have done the consultation. In your own directive about privately referred non-inpatient initiatives from November 2007—and it was supposed to be reviewed in April 2010, so it will be interesting to see whether you did that—it mentions on page 2 of the business rules applying to privately referred non-admitted patient models their rights to a private practice. There is a comment there:

> In many regions in South Australia, specialist clinical staff may not have rooms to see patients as part of their private practice.

These patients are still going to have to go and see specialist clinical staff in hospitals. You cannot refer them out. It sounds like the waiting lists we hear about for specialists are real.

The Hon. J.D. HILL: These are practical issues. It is the Adelaide dilemma, of course. If you do not like something, you say that there has not been consultation. If you do like something, you say, as Simon Birmingham said, 'Consult, consult, consult. That's all they do. We want action.' You have to do both. You have to have clear policy directions based on a broad strategic approach. We have that broad strategic approach. It is called the South Australian Health Care Plan.

We can articulate exactly what we are trying to do, and we apply that general philosophy with that general strategic approach to different parts of our system. All parts of the system eventually come under the spotlight of that reform agenda and, as we go through them, we find ways to make them work better. Part of the process we go through, once we put a spotlight on something, is the consultation with those who are affected: the people who deliver the service and the people for whom the service is provided. That is precisely what we are doing in this area.

We have targeted up to 10 per cent of outpatient services outside the hospital. Some of that, as I say, would be in places like GP Plus healthcare centres—which we are building—which will have rooms, and some will be consultations. The clinics done by private practitioners potentially could be done in that way as well. So, capacity issues and process issues will be worked through. That is what we do. You have to do both. You have to have a plan and you also have to have a process to consult about the implementation of that plan, and that is exactly what we are doing.

Dr McFETRIDGE: Going on from that, if it works, the patients will be referred to private specialists and, assuming that they can afford to pay the gap charged by this private specialist, they are then going to end up on elective surgery waiting lists more quickly, so that you will get a tsunami of patients waiting for elective surgery, because you will get more and more. Some will be diverted off—those who should have been to a physio or someone else first—but you are going to get an increase. Have you had a look at what will be the increase on elective surgery waiting lists?

The Hon. J.D. HILL: I guess that is one of the things that can be sorted through. During the election campaign the government announced—and we have a budget for it now—quite a substantial increase in the amount of elective surgical procedures. The commonwealth is supporting all of that, so I am confident that we will rise to meet the growth that is there. There might be a short-term bump as we transition from one process to another, but that transition will happen over a period of a few years.

We now have an elective surgery system which is working very well. At the end of June, only a handful of people had been waiting longer than—47 as at June 2010, down from 1,441. I will just read this:

> ...a reduction in overdue patients from 1,441 at the end of June 2007 to 47 at June 2010. That is a 97 per cent reduction in overdue patients over the first four years.

We do it by focusing on the problem, having common lists, common strategies, lots of consultation but good policy goals, and then directing resources to it. So, I am very confident that we can do this.

Dr McFETRIDGE: I refer to the same reference. Patients, who are going to their GP, of whom you say 75 per cent are bulk billing (I am surprised at that, but I hope it is true), then have to go to a specialist. How many specialists bulk bill? These gap payments, as I understand it, are $60 to $120. I am seeing an oral surgeon next week, and I have been waiting four months to see him. I do not know what it is like with other specialists. I hear stories of people waiting months and months to see doctors in private practice, never mind in the public scheme. What have you done to make sure this is going to work?

The Hon. J.D. HILL: All I can say is that we are going through the proper planning process to determine what can be done over what period of time and what assistance might be provided. In relation to the percentage of specialists who bulk bill, it is true that the figure is 70 per cent to 75 per cent (from memory; I will have it checked) in terms of visits in South Australia. Most GPs bulk bill children, most would bulk bill age pensioners and people on Health Care Cards, and some will bulk bill everyone, but overall 70 per cent to 75 per cent (or thereabouts) are bulk billed, as I understand it. I will check it if it is slightly wrong. For specialists it is a much lower figure, but that is in the current construct. My understanding is that in other states, where more of these outpatient services are provided through private rooms, the percentage of bulk billing increases. We would certainly hope that that would be the case now.

I think it is interesting that the member referred to dentistry, because most people have their dental care through the private system, and some dentists do charge a lot, it is true; and that is an area that really does need quite a lot of reform. Through the Medicare system the federal government does pay a proportion, at least, of the cost of seeing a specialist.

I am not sure that the average gap is of the order that you suggested; I think it is possibly less than that. In most cases, for patients who have financial problems it is reasonable to expect that they would be able to find a specialist who would provide a concession. For those who are in jobs and have reasonable incomes I do not think a small gap payment is so onerous. Seeing a specialist once is perhaps one gap payment, yet patients often see GPs maybe several times a year and pay the gap every time, so I do not think it would create that much of a burden.

Dr McFETRIDGE: I again refer to the same budget reference. What impact will the reform have on funding received from the commonwealth under Medicare arrangements, especially considering we are moving towards activity-based funding for outpatient services?

The Hon. J.D. HILL: I will ask Dr Sherbon to address that.

Dr SHERBON: Our estimate is that there is unlikely to be any net effect. As the minister said, we will be reducing 10 per cent of outpatient clinics; but, on the other hand, the other 90 per cent of outpatient clinics will continue to grow, as they currently are, at a very rapid rate. These clinics tend to provide ongoing care for patients rather than episodic consultations. We expect them to continue growing, so we do not expect any significant effect on what will become commonwealth funded outpatient services from, I think, 1 July 2012. We do not expect any net effect.

Dr McFETRIDGE: It is interesting that Dr Sherbon referred to the 90 per cent of outpatients that will be seen within the hospital system. I understand that specialists in outpatient clinics have rights of private practice and, as part of that right of private practice, significant non-operating funds have been created. Whether they are the same as the special purpose funds that are referred to in Budget Paper 4, Volume 3, page 812, I am not sure, but these non-operating

funds can be utilised to assist in equipment purchases and have been used by hospitals to develop an equipment replacement program in the past.

However, at the moment Health seems to be not allowing them to draw down on these funds to purchase equipment and the reason is said to be a very low budget for capital purchases. What is the value of these non-operating funds? Is it, as I understand, many millions of dollars because these funds are from the rights of private practice and volunteer fundraising. In fact, last week, I was told by a volunteer at Flinders Medical Centre that, according to their annual general meeting report, half a million had been put into one of these non-operating funds at Flinders Medical Centre. How many millions are in these non-operating funds?

The Hon. J.D. HILL: I am just trying to understand how they are accounted for in the budget papers. These funds, as the member said, are funds that are derived from private work. There are certain formulas in place largely driven through enterprise bargaining arrangements about what individual doctors keep and what goes to the hospital and so on and so forth.

There are funds that accumulate in special-purpose grants which can be applied to particular outcomes that fit in with the individual hospital's priorities. They can be expended, but there is a process that we go through to make sure they are expended according to priorities and needs. They are not just slush funds that can be used to satisfy particular ambitions or whims; it has to be in accordance with the overall strategic plans for the hospital.

I relate that commentary to earlier comments about how things used to be done in Health. We are moving to having a modern system of management, both clinical and financial. This is just prudent, sensible accounting methods. There are funds there; if you want to spend them, it has to be according to a particular process. It is not something you can just walk in and do one day without any approval process having to be gone through.

Dr McFETRIDGE: That is a really interesting answer. You say that these funds have to be spent with approval; you cannot just walk in there and use these monies. How many millions are we talking about in these funds?

The Hon. J.D. HILL: I am not sure whether it is identified in a way that makes it readily available to us, but we will get it for you. I will just explain why we have this process in place. There was a case a number of years ago where an MRI machine, I think, was purchased at The Queen Elizabeth Hospital. That was before I was minister, but it was certainly done outside of the commonwealth approval process, so there has never been a Medicare licence (if that is what it is called) for that machine. So, that expensive machine was purchased but it cannot be used to the full extent that it might otherwise be used, because the commonwealth has certain rules in place about MRI machines. You could argue that that was not a very sensible use of that available fund.

Equally, if a particular group of doctors wanted to buy a piece of equipment to do a particular procedure with, it would be sensible if we knew that, so that, if there is a state procurement process in place, then we can get the piece of equipment through that process at a lower rate. There is a whole range of practical reasons. Certainly, we will give the honourable member greater information in due course, if we can.

I refer to page 8.12 in Budget Paper 4, Volume 3. Under 'Annual Programs', the second light print line states, 'Purchases from Special Purpose Funds' and indicates the amounts that are expected to be spent in each of the years and were spent in the relevant years. In the 2010-11 budget we expect $9,855,000 to be spent from those Special Purpose Funds. They are to be spent.

Dr McFETRIDGE: I refer to the same budget reference. Minister, you said before that you cannot just spend this money and that (I am not quite sure of your exact words) you cannot raid the funds. Is it appropriate and is it, in fact, legal to use non-operating fund money for operating purposes? I will give three examples.

In March 2010 the Lyell McEwin Hospital transferred $200,000 from the private practice account to the general operating account; in May 2010 the Lyell McEwin Hospital transferred $600,000 from the trust accounts to the Lyell McEwin Hospital's general operating account; and on 18 May (just bear with me on this explanation; it is a little longer) this year the Lyell McEwin transferred $4 million from the Lyell McEwin Hospital's SAFA management account to Statewide Services within the South Australian Dental Service.

Following the transfer, the balance of the Lyell McEwin Hospital's SAFA cash management account was $1.9 million. On 18 May 2010, an additional $3 million was paid from this account. This resulted in a $1.1 million cash deficit for Lyell McEwin's operating funds in the SAFA cash

management account. The cash deficit was funded in effect by private practice funds and non-operating funds. I understand that, in some cases, these transfers were not approved by the authorised officers.

If this money was used to manage cash flows funding the department, were the hospitals in fact trading insolvent and using these funds without proper authorisation? For the chief executive then to approve the use of these non-operating funds is seen as a gross breach of financial probity and completely outside the principles and responsibilities expected of a public sector agency head.

It sounds to me very similar to the Kate Lennon affair but, instead of stashing the cash, this one is a grab for cash. It appears that, minister, you were warned about the use of these non-operating funds in the 2008 Auditor-General's Report, the 2009 Auditor-General's Report and, again, in the 2010 Auditor-General's Report.

The Hon. J.D. HILL: Thanks for raising this issue. Of course, I just point out to the committee that that matter was raised in the Auditor-General's Report and not in the budget; but we are happy, now that all these—

Dr McFetridge interjecting:

The Hon. J.D. HILL: Yes, I understand the connection the honourable member is making, but the fact that he knows about it is because it was in the Auditor-General's Report, and the fact that I know about it is because it was in the Auditor-General's Report. The reality is that this should not have happened, and quite properly the Auditor-General has made comment on it. I point out that no funds were—

Dr McFETRIDGE: In Kate Lennon's case those funds were misappropriated—they were just moved from one account to the another. This is exactly the same and without authorisation.

The Hon. J.D. HILL: I will ask Mr O'Connor, but I am not commenting on Kate Lennon. She sued the government for unfair dismissal when she resigned, and she lost.

Dr McFETRIDGE: You cannot resign and sue for unfair dismissal.

The Hon. J.D. HILL: That is exactly what she did, member for Morphett. She resigned and then she said it was constructive dismissal and she took—

Dr McFETRIDGE: How hard was she pushed?

The CHAIR: Order! We are not here to discuss the terms of someone's departure from a job some time ago. Let us return to the member for Morphett's question.

The Hon. J.D. HILL: I make the point that this kind of attempt to impugn the good character both of me and my officers is rejected completely. This individual officer (I do not know whether it is one officer or others), my understanding is, moved the funds into an account in an attempt to maximise interest so that there was a net benefit to the department. There was no attempt to fund other priorities that were not in the budgetary papers, but the Auditor-General did comment. I will ask Mr O'Connor to comment further.

Mr O'CONNOR: Thank you, minister. The matter that the member referred to relates to audit observations that the Auditor-General made in relation to the former central northern Adelaide health service and the two particular hospitals that he referred to. What we had there was a breakdown in controls where people had gone outside the approval processes and the documented policies and procedures that had been put in place across that former organisation. It is important to note that there are a number of other accounting controls in place other than the monitoring of the cash which identified these issues and they have been addressed and they continue be to addressed as we move forward. Policies have been improved and procedure will continue to be improved so that these—

Mr MARSHALL: This was first raised in 2008.

Dr McFETRIDGE: The issue here is that this was done completely against auditors-general instructions in 2008, 2009 and again this year, and it specifically states in the Auditor-General's Report that non-operating funds must not be used for operating purposes. Whether this is against Treasury instructions, I am not sure, but I guarantee there would be questions about the way things are being handled here. As you said, minister, the buck stops with you.

The Hon. J.D. HILL: And your point is?

Dr McFETRIDGE: If it is not illegal, it is certainly completely inappropriate. I do not see any difference between moving these funds without authorisation from one account to another account and then saying, 'It's not the same as the stashed cash affair.' Of course it is; this is a cash grab. This has happened three years in a row—2008, 2009 and 2010. How long does it take? There are some slow learners out there.

The Hon. J.D. HILL: It is all very well for the member for Morphett to smugly make these kind of claims. It is unacceptable. The Auditor-General has brought it to our attention. It has been dealt with. The guy has been disciplined. The rules have been reinforced. No money was lost. There was no attempt to undermine, as I understand it, the budget process. There was no attempt to put money into a secret fund which could then be used to do things which were the priorities of the individual rather than the system.

In fact, in answer to the first question you asked in relation to how the funds were being used, I said, 'We have to have protocols in place so that approvals need to be given.' That just reinforces that general point. We are building a system—it is not a perfect system yet—that has very strong protocols. We are moving from a series of individually managed run hospitals with their own boards to an integrated health care system which has contemporary systems and, from time to time, there will be problems and, when they arise, we will address them, but Dr Sherbon might want to add further.

Dr SHERBON: Yes, as the minister said, we have progressively improved the controls around non-operating funds over the last two or three years. Clearly, as Mr O'Connor said, there are some residual practices that are not in accordance with our own policies. The officer concerned has been formally counselled and the matter fixed. As the minister said, there has been no loss of public funds and the funds have been returned to the non-operating fund and will be used in accordance with the requirements of that particular non-operating fund.

When we first set about improving the procedures for non-operating funds, there was a great deal of concern because people were using them as virtual individual slush funds and we have totally removed that practice. This was a different matter. It was sloppy work and the person who did it will be held to account for it, but across the system the non-operating funds are managed in a far more accountable manner than they ever had been in the past.

Dr McFETRIDGE: Sloppy; it is a bit more than sloppy, it is completely inappropriate, and two auditors-general, Ken MacPherson and Simon O'Neill, have said so three years in a row. I have spoken to another auditor-general, who, while he did not say it was stealing, he said that it was completely inappropriate. Did you know about this, minister? Did the chief executive know about this? It was in the Auditor-General's Report of 2008-09. Surely, to allow it to continue on would have been sloppy practice, I would have thought.

The Hon. J.D. HILL: The points that I made before I make again. The development of contemporary systems within the health portfolio is a work in progress. We have made huge progress over the last few years and there are still areas of reform, but we are moving from multiple systems with multiple policies, multiple cultures and multiple lines of command to an integrated modern system. It is regrettable that officers choose to behave in what, I guess, can be seen as renegade ways, probably with good intentions, but they have been discovered and they have been reported on and we are building systems to make sure that they do not recur. This is about making sure that we use the resources that we have in the wisest possible way.

Mr GRIFFITHS: If I may ask a supplementary question. I have listened intently to the answers provided by the minister and the officers, but I am a bit of a process-driven person, so it seems to me that, if the 2007-08 financial year Auditor-General's Report identified an issue—and you have talked about improvements that have been made since—when, in fact, was the officer who held responsibility for the management of these funds first counselled on the fact that he (I presume 'he') was doing the wrong thing, and was this officer counselled more than once before some formal level of disciplinary action was taken against the person?

The Hon. J.D. HILL: I point out again to the opposition, which wanted a lot of time to ask questions about the state budget and they have now spent the last 20 minutes or so asking questions about the Auditor-General's Report and the counselling of officers in relation to reports of the Auditor-General—

Mr MARSHALL: It is in the budget.

Mr GRIFFITHS: There is a budget line for this.

The CHAIR: While I did make it clear that we could not talk about this Auditor-General's Report because we are anticipating debate, the gentlemen on my left are entirely within their rights to discuss former Auditor-General's reports should they wish to do so.

The Hon. J.D. HILL: I am happy to answer the questions.

The CHAIR: And they can tie it to a budget line, obviously.

The Hon. J.D. HILL: I am not sure when the individual officer was disciplined, or counselled, or talked to, but I guess we can find that out for you. I will get some advice on that.

Dr McFETRIDGE: The same budget reference. The Auditor-General's Report 2008 (page 542) states:

> The chief executive of the department also advised that the department is monitoring health unit special purpose funds.

That was in 2008. In 2009, there were very similar comments:

> ...a number of matters regarding the need for improved accountability for special purpose funds were raised with the chief executive officer...That review highlighted an absence of regional policies and procedures relating to special purpose funds and inadequate controls...

It is okay for you, minister, or your advisers, to glibly say that it is sloppy and that no funds were misappropriated, but three years in a row—and how many millions of dollars are out there? Is that particular person still in the job? Kate Lennon is not in the job.

The CHAIR: Can I ask which budget line that pertains to, just to make it very clear for everyone.

Dr McFETRIDGE: Budget Paper 4, Volume 3, page 8.12.

The CHAIR: And which line in particular?

Dr McFETRIDGE: Special purpose funds.

The Hon. J.D. HILL: I will make a couple of observations. Firstly, Kate Lennon resigned. That is pretty well established now by law, so it is a furphy throwing that into the mix. The officer, as I understand it, has been formally counselled, which is the technical language used for discipline. I can also refer to the Auditor-General's Report of 2010, page 588, where he finds:

> The audit found that the region—

That is the Adelaide Health Service—

> had developed, approved and promulgated a comprehensive policy and procedure for the administration and management of non-operating funds.

Which is the language that is used for these special purpose funds: NOFs describes them. So, it is true, the Auditor-General, and he does it every year, highlights areas where improvements need to be made and he also acknowledges when those improvements have been made, and they have in relation to this particular fund. There are probably those in the system (and this may be why the member for Morphett asked the first question) who are complaining that they now have to seek approval in order to expend those funds, but approval they need before they can do that. We now have a tighter system in place.

Dr McFETRIDGE: Minister, you do not seem to accept the seriousness of the problem here. To me, this reflects on the whole probity of cash management or fund management in the health department. As the minister the buck stops with you, and your chief executive should know about it. I do not think it is just this poor person in the hospital who is under pressure, who will be counselled; I think you as minister need to take some responsibility for this as well.

The Hon. J.D. HILL: It is all very cute for the—

Dr McFETRIDGE: The buck stops with you; you said it, John, on 24 October 2007.

The Hon. J.D. HILL: Exactly, and I am pleased with the reforms we have made. If you had had your way and had won the election, you would have got rid of that responsibility, and if you were sitting in my place you would say, 'I'm not responsible for this.' I am responsible for the way the system works, and I have officers at a senior level who are entrusted to make sure that there are processes in place which are followed. We have improved—quite dramatically—the procedures that are in place in the health system. I am not aware of any issues of probity that the Auditor-General has brought to our attention. There was a process that was followed by an individual officer on a number of occasions—

Dr McFETRIDGE: I think the issue of probity was—

The Hon. J.D. HILL: Hang on a minute, before you make your commentary; I have not finished. The officer did not follow the protocols and has been counselled. The system we have in place is now a stronger system than the one we inherited, and we are working to make sure that it is even stronger. Part of that process is to have a command system where there is a minister who is responsible, with a CE who is responsible to the minister and who is able to carry out all the functions necessary to get the process to work. In the past we did not have that system and, as a consequence, a whole range of processes and cultures and systems were put in place which could not be described as world's best practice.

Dr McFETRIDGE: Let us move on to another area where there are certainly some differences in accounting that need to be explained, and that is the new Royal Adelaide Hospital. I refer to Budget Paper 5, page 30. Minister, when cabinet approved the revised indicative capital costs of the new Royal Adelaide Hospital of $1.8 billion, who did you tell? Did you tell your chief of staff? Did you tell your chief executive?

The Hon. J.D. HILL: Sorry?

Dr McFETRIDGE: When cabinet approved the revised indicative capital costs of the new Royal Adelaide Hospital of $1.8 billion, who did you tell? Did you tell your chief of staff and your chief executive?

The Hon. J.D. HILL: I am not too sure what point the member is trying to draw out of who I told what. This is not a court of law here: it is an examination of the budget papers; 'How much money is there? How was it spent?' are the kinds of questions I would expect to answer. If the member is referring to the question that the shadow treasurer asked the Treasurer in question time only a few weeks ago, then I refer him to the answer that the Treasurer gave on that occasion.

The CHAIR: I am sorry, but I am on page 30 of Budget Paper 5; am I in the wrong place? Can the member for Morphett just give me that line again, because I simply do not—

Dr McFETRIDGE: Budget Paper 5, page 30.

The CHAIR: That is where I was. I am on the new Royal Adelaide Hospital site works; is that correct?

Dr McFETRIDGE: Yes. That refers to site works, costs, total costs—

The CHAIR: Right. Site works, costs, financial project management costs, but not really who the minister was chatting to or what colour socks he was wearing.

Dr McFETRIDGE: It is about the increased costs in the hospital and, unlike the Treasurer, I do not think, 'What is $100 million here or there?' I think $100 million is a serious amount of money.

The CHAIR: No-one is saying it is not.

Dr McFETRIDGE: So, when the Treasurer came out with that glib remark, then I think there is need to ask the questions who knew what, when, and who did they tell?

The CHAIR: Are you asking a specific question about whether the Minister for Health spoke to the Treasurer?

Dr McFETRIDGE: I assume he didn't use the Attorney-General's excuse and say he was in the toilet when the decision was made in cabinet about—I forget what that was. I assume, you were in cabinet, minister, at the time. You approved the revised indicative capital cost of $1.8 billion, so did you just then not come back and tell your chief of staff?

The CHAIR: Sorry, how is that relevant to this?

Dr McFETRIDGE: Because of the site works, the finances—

The CHAIR: Just explain to me very, very carefully how that is relevant.

Dr McFETRIDGE: Certainly, because the costings for the new Royal Adelaide Hospital have been an area of great concern—the site works, the remediation, the association with the South Australian Medical Health and Research Institute—there are so many issues here. We want to know—even the outpatients clinics that we were talking about before—what we are going to actually get, what is the scope of this hospital? That all comes back to the site works.

The CHAIR: Indeed; the scope, the site works, etc.

Dr McFETRIDGE: Yes.

The Hon. J.D. HILL: I am happy to answer questions about the site works.

The CHAIR: Yes.

Dr McFETRIDGE: No; I want you to tell me who you told about the $1.8 billion, minister. Did you tell Dr Sherbon? Did you tell your chief of staff?

The CHAIR: Did you tell your wife? When did you last see your father?

Dr McFETRIDGE: Dr Sherbon could tell his wife, because I understand that is the minister's chief of staff, I think.

The CHAIR: People will get married—'The world must be peopled'.

Dr McFETRIDGE: It is a close relationship and perhaps, yes, it is a good one. I don't know.

The CHAIR: That is a quote by the way. That is a quote from Shakespeare, I would like to point out. I didn't make that up.

The Hon. J.D. HILL: Look, all I will say to the member is he is grasping at straws here. The Treasurer has addressed this. He addressed it the other day in estimates and I am not going to add to what he had to say, other than to quote him when he said:

> I am very confident—

he was, and I am—

> that the taxpayer, certainly as it relates to the capital cost bid into this project, will be very pleased with the outcome, but I am not going to comment further. Given that we are in the middle of evaluating both tenders and interaction is occurring between both tendering consortia, I am very limited in what I can say publicly.

I am in the same category.

The CHAIR: I don't really think we are here to talk about people's personal relationships because it is a little bit grubby.

Dr McFETRIDGE: No, not at all. I am just saying 'close relationships'.

The CHAIR: It is a little bit grubby and a little bit inflammatory.

Dr McFETRIDGE: Not at all.

The CHAIR: So let's talk about the budget.

Dr McFETRIDGE: And that is exactly what we are talking about—the cost of the Royal Adelaide Hospital.

Mr GRIFFITHS: Madam Chair, may I ask a supplementary?

The CHAIR: Please.

Mr GRIFFITHS: Minister, it relates to this questioning area of the RAH PPP, and indeed an answer you provided previously where you talked about a 35-year period for the PPP. My very clear recollection, when discussed previously, was that it was a 30-year period for a PPP.

The Hon. J.D. HILL: Five years for the construction—that is what I understand.

Dr McFETRIDGE: Five years for the construction?

Mr GRIFFITHS: Okay, so there is no change therefore to the time in which payments will be made to the consortia?

The Hon. J.D. HILL: Look, this is not part of the budget papers. The final term will be determined, but the time from, as I understand it, covers the construction site. My memory tells me, and I am just trying to kind of get my head around it, that the various time periods of 30 and 35 years that have been used are consistent because one refers to the 30 years after the thing has been completed, and the other refers to the construction stage and the time after. I will just get that corrected if that is not right.

Mr GRIFFITHS: That is what I am looking to ascertain: just in fact if it is a contractual arrangement for 30 years post delivery of the project?

The Hon. J.D. HILL: Look, I understand that is the case. I will get that corrected if it is not correct.

Mr GRIFFITHS: Thank you.

Dr McFETRIDGE: Minister, I am still puzzled. You knew in November it was $1.8 billion. You signed off on it the with cabinet, yet you told Leon Byner—twice, on 10 March and 19 March this year—on 19 March, the day before the election, you told Leon Byner the cost of the new hospital is $1.7 billion. Now, you said that twice. Why didn't you tell the truth?

The Hon. J.D. HILL: Look, I think there are certain rules about making claims along those lines.

Dr McFETRIDGE: I can read you the transcript from the day if you would like—not a problem at all.

The CHAIR: First of all, member for Morphett, we don't talk about the veracity of media reporting or not, as the case may be. We have already had this problem during these estimates committees last week. Secondly, to level or to imply that other members are lying is really not something you can do, and you know that far better than I.

Dr McFETRIDGE: Perhaps he miss-spoke, because, on 19 March, the minister said to Leon Byner:

> Let me explain, Leon. The $1.7 billion was estimates that had been done through a rigorous process. We are very confident they are correct.

That was on 19 March, the day before the election, when you knew, minister, that it was $1.8 billion way back in November. It is a disgrace that you just keep trying to fob it off. What is $100 million here or there, according to the Treasurer? $100 million is a lot of money.

The CHAIR: Do you have anything that you want to say to that, minister? It seems to me to be a rather vague series of accusations.

The Hon. J.D. HILL: It is a vague series of accusations. There are things I would like to say, but I am constrained because we are going through a tender process. I draw the committee's attention to comments made by the Treasurer in estimates last week—which I have repeated—which explains why we are constrained, and his confidence that there will be a good outcome for South Australia.

Dr McFETRIDGE: Did Dr David Panter know about the increase in the cost, because he told the ABC on 27 July this year, 'The budget remains $1.7 billion. That hasn't changed.' I understand that Dr Panter is in charge of the project, as far as the scope and that sort of thing, so why was he left in the dark?

The Hon. J.D. HILL: All I can do is refer to my previous comments. There are things that I would like to say and, after documents have been completed, I will say them. I cannot say them at this stage, but I am very confident that the public of South Australia will get a very good outcome in relation to the hospital. Dr Panter has done a superb job leading the process for the development of this hospital, which will provide South Australians with an absolutely world-class facility for many years to come.

Dr McFETRIDGE: I refer to the same budget reference. If the government has not seen the tenders—and I assume that is correct—what made cabinet approve the extra $100 million? Just out of the blue? What information did cabinet have for that extra $100 million?

The Hon. J.D. HILL: All I can say is that I am not commenting on cabinet processes. It would be improper for me to do so. I refer the member to other comments I have made in relation to the PPP arrangements. The member for Goyder asked me—and I can confirm I was right—it is five plus 30, as I have described.

Dr McFETRIDGE: I refer to the same budget reference, and this is a bit more specific. What is the latest cost estimate to fix the site contamination (soil and water), and is this coming out of the PPP or is it being paid for by the government?

The Hon. J.D. HILL: I have answered this before. I have said that there was an upper limit of $40 million for that work, and it is still being assessed. in fact, we anticipate that it will be a lot less than that. The majority of the contamination would be part of the development of the hospital through the private consortium. Just as a matter of logic, if you are going to clean up a site, it is best to do it when you are constructing a great big hole that is going to be used for car parking or

other services. So, the majority of material there which will need to be cleaned up will be removed. From memory—and I think I have reported on this before—there are some hydrocarbons that are in the watertable for which I think the transport department is responsible for cleaning up. I beg your pardon, the consortium will do that as well. So, the figures are as I mentioned before.

Dr McFETRIDGE: Explain this to me again. The five-year construction period is not part of the PPP?

The Hon. J.D. HILL: No. When we signed the deal with company X, let us say—

Dr McFETRIDGE: I am just a humble veterinarian, not an economist.

The Hon. J.D. HILL: Of course. I will not comment. Let's say we have signed an agreement with company X to deliver a hospital in 2016. So, the contract is signed at the end of this year or the beginning of next year; that is five years. At the end of that time there will be a 30-year period in which we are in contract with a consortium to deliver a certain range of services; so, that is five plus 30. In the first five years, of course, they are not delivering services: they are constructing the hospital. So, there is a different nature of the relationship during that construction period; but it is 30 or 35 years, depending on how you look at it.

Dr McFETRIDGE: I refer to the same budget line. That they are not delivering the services is a perfect segue into this question. What is the predicted cost of the non-clinical support contract component of the PPP? For example, the 600-bed Fiona Stanley Hospital in Western Australia has been a PPP for 20 years, and it is a much smaller hospital. It is $2.5 billion, according to their auditor-general. That makes the non-clinical support contract for our new hospital with 800 beds in 30 years about $5.5 billion dollars.

The Hon. J.D. HILL: These are hypothetical questions. There is obviously a tender process, and I am not going to pollute that process by starting to speculate on what one bid might be compared to others, not that I have detailed knowledge of that, I hasten to add. I am glad that the member raised this, because Jim Katsaros, during his ill-fated attempt to be elected to the other place—that esteemed body—on the Save the RAH campaign (for which I think it got less than 1 per cent of the popular vote, I point out), tried to spin the line that the cost of the hospital would be the operating cost and the contract cost, plus everything else over a period of 30 years.

You can value things on that basis, but you also have to value the RAH on that basis: how much it will cost to provide services, do the maintenance and everything else at the existing RAH over 30 years. It is just farcical, fanciful and dishonest in its heart to say that the cost of the hospital will be the price of operating it for 30 years plus whatever the capital costs are.

It is clear that we will know that, and that is one of the advantages of this kind of arrangement, because you know in advance and you can budget for it. For a provider of hospital services, it is fantastic, because you commit to those services upfront, and you know that the maintenance budget is going to be maintained over the course of the contract and that there is not going to be a reduction. Often, when governments are looking for savings they reduce things like maintenance, and jobs are not done. Those kinds of figures are interesting, but we have to compare like with like. You cannot compare the construction costs with the construction costs plus the operating costs.

Dr McFETRIDGE: To clarify that, there are two components to the PPP: the build and the operation. The state government will be providing the doctors, nurses and the allied health workers, but the PPP consortium that wins the contract will be supplying all the non-clinical support services sector, so that really does come back to the estimate of that cost. You may say that you not going to give it away but, judging from Fiona Stanley in Western Australia, you are looking at well over $5 billion for that. It is that on top of the build cost?

The Hon. J.D. HILL: I cannot comment on the Fiona Stanley project in terms of the operating cost contracts, but the question is: what is good value for money? The bidding process will determine the aspects of the operation and what will be run by company X and what will be run by government. We will certainly run all the clinical processes, but things like car parking, food, cleaning, maintenance and so on, typically in a PPP become the operating responsibility of the body with whom we have contracted to then contract out to other parties.

So, a catering company will do some of it, a company that specialises in maintenance will do in other parts, and so on. The arrangement is put in place because you get certainty, you get focus on core skills and, ultimately, you should get a cheaper and more effective way of doing it. Your government, for example, when it was in office—and I am not criticising you for doing it—

outsourced a range of services in hospitals, such as catering, I think, in many hospitals, and cleaning in a number of hospitals, for the same reason.

I guess I could go and calculate for any of our hospitals what a 30-year operating expense would be for car parks, cleaning, maintenance, food preparation, portering—all those things that might theoretically be done by an outside group—and that would give you the cost of doing it over a 30-year period, but what you have to do is compare that then to what it would cost government to do it and what the level of service would be if we did it in-house. Clearly those kinds of things are often done by companies that specialise in them because they can do them in a superior way at a better price.

Dr McFETRIDGE: In relation to the same budget reference, what did Under Treasurer Jim Wright mean when he told the Budget and Finance Committee:

> ...the hospital is being pursued as a PPP procurement, and that is clearly our preference, but if the process ends up with a result that is not value for money we will have to consider the alternatives...or how to proceed...If it does not meet the value for money test it is not going to happen.

Did Mr Wright mean that the government will abandon the project? At what price is the new hospital not value for money—five billion or 10 billion?

The Hon. J.D. HILL: I suppose to really understand what Mr Wright said you would probably have to ask him, given that he gave the evidence, but I am happy to tell you what I understand him to have meant.

The CHAIR: We should also realise that whatever you say is simply an interpretation of Mr Wright's words.

Dr McFETRIDGE: No, Madam Chair. The question is—

The Hon. J.D. HILL: What is the government's policy—is that what you want to know?

Dr McFETRIDGE: No; I suppose it was a rhetorical question about what Mr Wright meant but my question to you, minister, is—and you talked before about getting best value for money for non-clinical services—at what price is the new hospital not value for money? Is it five billion, 10 billion?

The Hon. J.D. HILL: Well, I am not going to comment on anything that might give any assistance to any of the tendering bodies in the process we are going through but we have made it plain from the very beginning that our preferred way of procuring the hospital (and it will go ahead regardless of the procurement method) is through a public-private partnership because we believe that will give us a very good outcome.

A strong design backed up by strong financial management over the construction period reduces risks to government, and that is why PPPs are embraced all around the world by governments of all persuasions. It is not the only way of procuring a building. There are a range of ways of doing it. One is called a DBOM—design, build, operate, maintain. There are DBOOs—design, build, operate and something else.

Mr GRIFFITHS: Own and transfer.

The Hon. J.D. HILL: There's DBOOTs—that's right. There is a range of mechanisms, all of which have their advantages and disadvantages, or the government could go and act as its own developer and do all of those things. We have to wait until the tender process is completed but we have made it clear to the tenderers that we want value for money and that there are other options for us to pursue.

This is largely a Treasury process. From a health department point of view, we are interested in the outcome, so I guess the Treasury and the Treasurer's office are more aware of the various financial models that could be pursued to procure it. We are very confident that a PPP is a good way of going.

Dr McFETRIDGE: Just following on from that, minister, Mr Wright said, 'If it does not meet the value for money test it is not going to happen.' Ultimately at some stage you must have had some figure in your mind somewhere that has to be the cut-off point where you will go and tell these people, 'Sorry, end of story.' So, will the government redevelop the Royal Adelaide Hospital at Frome Road if the rail yards hospital is not value for money?

The Hon. J.D. HILL: I am not going to give figures which are not in the budget papers and which are not within the scope of this year's budget in relation to the Royal Adelaide Hospital. We

are going through a process, which will be completed very soon. After that process is completed, all these questions are much more easily answered. It would be improper of me to start speculating about the kinds of things that the honourable member is asking me to speculate about.

When we have signed a deal for procurement, it will be up to the opposition and others to question that, and we can justify or they can make claims. We will have all the evidence out there and we can proceed on that basis. Until we do that it is very hypothetical and not very productive, in my view.

The CHAIR: Thank you, minister.

[Sitting suspended from 14:45 to 15:00]

The Hon. J.D. HILL: In relation to the PPP arrangements, I will just clarify. The total term is 35 years and the construction stage may be five or six years, just to be absolutely 100 per cent.

Mr Griffiths interjecting:

The Hon. J.D. HILL: No, 35 total and construction five, six years; probably five years, but it could be six. I would not want to have any doubt.

Mr GRIFFITHS: That is how I understood it.

The Hon. J.D. HILL: Yes.

Dr McFETRIDGE: Budget Paper 5, page 59, the South Australian Health and Medical Research Institute. Will there be shared external infrastructure between the health and medical research centre and the new Royal Adelaide Hospital and, if so, what project will the funding come from?

The Hon. J.D. HILL: I will try to give an overview, if I can, and I will ask Dr Sherbon who is involved in both projects obviously. The PPP arrangement is for a certain set of things. The SAHMRI project is for other things, but there will be certain facilities, for example, I think from memory, there will be a cyclotron in the SAHMRI which will be accessed by the hospital. I will ask Dr Sherbon to try to give you a more detailed answer, if I can.

Dr SHERBON: To add to the minister's answer, the SAHMRI project shares a very small amount of infrastructure with the new RAH. There is one access road that will service both facilities. The two projects will contribute in proportion to that small amount of shared infrastructure, otherwise the infrastructure needs of the SAHMRI project are met by the SAHMRI project budget and not the new RAH.

Dr McFETRIDGE: Thank you, but the question is really: is the SAHMRI project sharing utilities such as gas, water and electricity? There is no costing coming out of the SAHMRI project to pay for that to reduce the cost of the new Royal Adelaide Hospital?

The Hon. J.D. HILL: No; SAHMRI has its own budget and its own board. It will be an independent corporation and will be responsible for its own charges. As the CE said, there is a bit of infrastructure and from time to time I dare say they will share things in a normal cooperative way between a research facility and a hospital, but they will certainly not be subsidising the cost of basic services.

Dr McFETRIDGE: Under the same budget reference, is it proposed that the sale of Medvet Laboratories will help fund the start-up of SAHMRI?

The Hon. J.D. HILL: No, the sale of Medvet was a budget initiative. Medvet is a corporation wholly owned by Adelaide Health Service, associated with SA Pathology, which provides medical and veterinary services to the private sector. It was established, as I understand it, some years ago because under the arrangements in place IMVS could not provide those services, so it set up a corporation to do that. It is not an entity that delivers public health services, and there is a benefit to the taxpayer from its sale.

Dr McFETRIDGE: I refer to Budget Paper 6, page 108, the new Royal Adelaide Hospital. How will the $370,000 in 2010 be spent to fund further information for an engagement of the community and clinicians for the new Royal Adelaide Hospital? As a rider to that, where is the single room Royal Show stand now, how much did it cost, will it be reused and are other modules being built at the warehouse at Netley?

The Hon. J.D. HILL: The total cost for the Royal Show stand was $167,364, and $13,000-odd was spent on communications for the new RAH for 2009-10, which included the new RAH website, signage for the new RAH and communication with bidders. There is a notional $75,000 communication budget for 2010-11 through the Statewide Services Strategy Division. This is a major project, and obviously the public needs to know about it. There was $370,000 for information and engagement of the community and clinicians for the new Royal Adelaide Hospital project. We are now getting to the stage of discussing with both the public and the clinicians the detail of the hospital, what things will occur there and how they occur. This is not a publicity campaign as such.

There is a Netley site. My memory is that the built work in the showground has been incorporated into the work that is now happening in terms of the three-dimensional model that has been created at Netley to allow clinicians to think through how a hospital room should operate. I will just confirm whether the showground infrastructure has been included. That is my memory but it may be something different. I think it is a very smart thing to build a three-dimensional set.

My wife recently had some medical work done and was in a hospital room. Although it was a nice room, it was not very well designed for a patient, which was obvious when we used it at various times. What we are trying to do is to make sure that the room is really user-friendly for patients. We know that most of the patients who will use the hospital will be over the age of 75, they will be frail, and they will need to be able to support themselves in that room without causing further injury to themselves. That is one of the things that we are working through.

Mrs VLAHOS: I would like to ask the minister a question regarding portfolio item 8.1 and 8.12 in Budget Paper 4, Volume 3. Can the minister provide further information on the major redevelopments in country hospitals in South Australia, particularly with reference to Ceduna?

The Hon. J.D. HILL: I am sure I can. Thank you very much, member for Taylor. I also thank the member for Taylor for taking such a strong interest in health and representing me at various times in various places in a terrific way.

As part of the 2010-11 budget, $84.1 million, or 13 per cent more, will be spent on services in country South Australia this year compared to last year. This additional funding will help to meet the government's long-term strategic goal of increasing the range of health services available in country areas. An important part of increasing the supply of health services has been an ambitious program of renewal and modernisation of major country hospitals.

The 2010-11 budget provides $23.5 million towards the $36 million Ceduna Hospital redevelopment, which has entered the construction phase, and is due to be completed in March next year. The Ceduna Hospital redevelopment comprises completely new buildings for the acute inpatient unit. The new buildings will accommodate an acute inpatient unit, aged care unit, renal dialysis, operating theatre suite, day surgery, emergency department, medical imaging and the primary support facilities that include catering, engineering, mortuary and support services. A physical connection with the aged care accommodation unit to the south of the site will also be provided.

The redevelopment also comprises a GP Plus Health Care Centre. This is the second stage of the project and will involve the alteration and refurbishment of the most appropriate existing building stock for use by Allied Health, GP Plus, Primary Health Care, dental, community health and a day care centre. These services are predominantly consulting and community support spaces which can be successfully incorporated within the existing buildings with a low to medium degree of refurbishment.

The 2010-11 budget also provides $12.7 million to start the $41 million redevelopment of the Berri Hospital. The concept design phase for the Berri Hospital redevelopment is complete and it is estimated that the redevelopment will be completed in 2014. The Berri Hospital redevelopment will provide new theatres, recovery and central sterile supply department, as well as a refurbished inpatient facility. A new rehabilitation facility and a new mental health unit will also be included.

There is also provision for $1.8 million in 2010-11 towards the construction of the $12.5 million Port Pirie GP Plus Health Care Centre, to be completed in 2013. The budget also provides $14.7 million to complete the South Australian government's $15 million share of the $69.3 million Whyalla Regional Cancer Centre. The balance of funding will provided by the commonwealth government. Consultants have been engaged to undertake design and documentation of the new centre through both the construction of a new building and the refurbishment of some existing facilities.

The new multilevel building will house a ground floor Cancer Wellness Centre, accommodating ambulatory services, including six chemotherapy chairs, outpatient consulting, day therapy, counselling, patient education and a resources room and a 24-bed inpatient accommodation facility, including designated space for inpatient cancer care and six palliative care beds and space for research, training and education activities to support clinical trials, cancer registry and cross-discipline teaching. Consultants were also involved in renovation and refurbishment of existing areas, including upgrading of two operating theatres and recommissioning of a third theatre for endoscopy and colonoscopy procedures and the associated recovery areas.

The regional cancer centre at Whyalla will provide an important component of the state government's plan to increase cancer services in country South Australia. The 2010-11 budget provides $5.9 million over the next four years to meet the election commitment. An electronic oncology prescribing system will allow, in the first instance, Port Pirie, Mount Gambier, Port Lincoln, Berri and, of course, Whyalla hospitals to be established as regional chemotherapy hubs. Once these centres are established and operating safely the service will expand to Port Augusta, Clare, Gawler, Mount Barker, Murray Bridge, Naracoorte and the Northern York Peninsula Regional Health Service and South Coast District Hospital.

The spending outlined in the budget also honours Labor's other state election health promises for country South Australia, including: $22 million over four years for improved facilities and biomedical equipment; and $7.39 million for 3,444 extra elective surgery procedures in country hospitals over the next four years. This, I think, was a very good budget for health services in country South Australia.

Dr McFETRIDGE: If we can just whiz back to the Royal Show stand, Budget Paper 6, page 108. I do not think you answered the first part of the question, minister—I was listening. How will the $370,000 in 2010-11 be spent to fund further information for and engagement of the community and clinicians for the new Royal Adelaide? Is that the erection of the hospital room and the technical suites that Dr Panter talked about last year when he was justifying the Royal Show stand?

The Hon. J.D. HILL: In part it covers that, but it covers broader processes for consultation and discussion with community. It is not an advertising campaign. You will not see ads in the press, as I understand it, and it is not TV ads, it is about talking to members of the community, getting them involved, and getting the clinicians involved in the planning processes and the development and awareness of the systems that are being developed—that is the important part. In relation to the Royal Show display, I am advised that it has been moved to Kurralta Park to further refine the brief with both staff and patients. So, it is being used as a working model.

Dr McFETRIDGE: Can I go to see it? I have asked three times.

The Hon. J.D. HILL: I am sorry?

Dr McFETRIDGE: I have asked three times to go to see the facility to see whether we are getting—

The Hon. J.D. HILL: You have not asked me, I am sorry.

Dr McFETRIDGE: I have written to you, I assume it is. I will check the letters and give them to you.

The Hon. J.D. HILL: I will try to arrange it for you.

Dr McFETRIDGE: On the single rooms, are we still having 100 per cent single rooms in the new hospital?

The Hon. J.D. HILL: That is the proposal that is before us, yes. The reality is that, if you have a mix of single rooms and multi-bed rooms, then you do not get all the advantages of having a lot of single rooms. Single rooms mean that you do not have to have a lot of therapeutic spaces outside of the individual room where patients have to be taken. So, you either have all single rooms or you do not. There is not much point in having 80 per cent or 70 per cent, as I understand it.

You get big savings if you have bigger single rooms where a lot of the services can be provided to the patient in their own room: privacy and space is really what is required. If you have a six-bay room and somebody needs physiotherapy, it is a bit disconcerting for the patient and for the others, who might not be very well, to have it done in that public way.

The advice, from memory, was that at the Royal Adelaide Hospital now the average length of stay is six or seven days, or whatever it is, and an average patient gets moved about nine times

for some treatment or other. The plan is, at the new hospital, to reduce that to somewhere between two and three times and to move the services to the person in the other time, so that reduces all of the risks associated with moving a patient and, obviously, provides a more pleasant experience for them while they are in the hospital.

Dr McFETRIDGE: Budget Paper 5, page 30, The New Royal Adelaide Hospital. On the website, the masterplan is pretty dated. I think it still says the Marjorie Jackson-Nelson Hospital on there. Isn't the master plan intended to guide the successful development and implementation of the infrastructure project, so that people can see what is going on?

The Hon. J.D. HILL: I am glad you asked this question, because it allows me to draw your attention—everyone's attention—to the fact that the new SA Health website went live on Wednesday, rather than having the difficult to navigate, complex and hard to understand set of multiple sites we once had. Someone told me that at one stage we had something like 500 sites—sorry, I am exaggerating, 170 sites. We had a lot of individual sites, and we could no longer work out who had set up some of them, while others were not operational. We now have what will, over time, become one integrated professional website which I hope will have all the information that the public might want.

Dr McFETRIDGE: On that same budget reference, we have two time lines for the construction of the hospital. One, on the website saying the Marjorie Jackson-Nelson, says that construction will commence late 2010 and the one on the Health Department's website, I think, says that construction will commence 2011 and that the new hospital will open in 2016. I understand that construction of the new hospital will not actually start until the final design process is finished, and I read somewhere that that will be in 2013.

The Hon. J.D. HILL: The construction process has, in fact, already started. I am advised that the first access road has already been built and, once the procurement process has been decided, and assuming that it is one of the tender parties, they will get into the detail that needs to be done. However, I do not think that the end point of it being in operation has ever changed: it has always been 2016.

Dr McFETRIDGE: Where did the money for the access road come from?

The Hon. J.D. HILL: That is the road that Dr Sherbon referred to before, which is the road that is shared with SAHMRI—

Dr McFETRIDGE: So it is out of the SAHMRI budget, which is propping up the—

The Hon. J.D. HILL: No, if you are saying that then you were obviously not listening.

Dr McFETRIDGE: I was listening very carefully.

The Hon. J.D. HILL: This was a road that, I think, Dr Sherbon said was jointly funded by the two projects in proportion to their relative use of it. So that is the initial period, but you are correct that the real grunt will happen once the tender has been signed up and detailed design work done. The reality is that these companies get into it pretty quickly, because they do not start getting paid until they have completed the building. That is one of the advantages of a PPP; the risk is in the private sector and not the public sector. That is one of the strong reasons for doing it.

Dr McFETRIDGE: So you will be updating the master plan? It will be the New Royal Adelaide Hospital, not the Marjorie Jackson-Nelson? I assume that the master plan is intended to be a guide for what we are actually going to get, not just a cartoon of what it could possibly be.

The Hon. J.D. HILL: I am not sure what point the member is making. The document he is referring to was probably put on the site when it was called what it was called; that is what it was at that time. There have been subsequent processes, and I am very confident that if the member looks at the new, easy to negotiate and navigate SA Health website he should be able to find it.

Dr McFETRIDGE: I downloaded the Marjorie Jackson-Nelson plan yesterday afternoon in my office. You would think—

The Hon. J.D. HILL: Well, it does not disappear from the web. Historic documents do not get taken off. This is not the Soviet here.

Dr McFETRIDGE: You go to the new RAH website, and that is what you come up with. Perhaps I am being pedantic but I think that master plans should reflect what you will actually get. The master plan shown on that website does not have the tramlines on it, it does not have a number of pieces of traffic movement infrastructure. Has that changed any of the guidelines for the consortia on access to the hospital?

The Hon. J.D. HILL: The advice I have is that the DPA that is in effect remains and the winning consortium will need to go through a development application process, so all of that will occur. At various stages in the development of this process, which has been going on now for three or four years, various documents have been put out. They are what they are. As the project develops, more documents will come out which provide more detail.

Dr McFETRIDGE: I refer to the same budget reference. What was the $6.2 million of works that have been transferred to DTEI from SA Health, and what was the $6.3 million contribution to the tram project for?

The Hon. J.D. HILL: I will just get some advice on that. Could you give us the budget reference?

Dr McFETRIDGE: Budget Paper 5, page 59, the new Royal Adelaide Hospital, site works and planning.

The Hon. J.D. HILL: Page 59, was it?

Dr McFETRIDGE: 59, or you can go to page 30, if you like, either of those; it is the same sort of thing, site works.

The Hon. J.D. HILL: Are you referring to Appendix 1 on page 59, 'transfer of works for the new Royal Adelaide Hospital to the Department for Transport'?

Dr McFETRIDGE: Yes.

The Hon. J.D. HILL: We are not precisely sure, but we will get some advice. I am assuming it was work that was being done by them for us, but I will get some advice for you.

Dr McFETRIDGE: What about the tram project? Is that the same thing?

The Hon. J.D. HILL: The tram project is not a health department project.

Dr McFETRIDGE: But there was $6.3 million contributed for the tram project from Health.

The Hon. J.D. HILL: I am not trying to be difficult, but I am not aware of the detail. I will happily get some advice.

Dr McFETRIDGE: Dr Sherbon told the Budget and Finance Committee that a contribution was made to the tramway project because the new rail project impacts on the tramway, whatever that means. We have made a contribution—

The Hon. J.D. HILL: If you know the answer because they have said it elsewhere, why are you asking it again?

Dr McFETRIDGE: We used to have the horse trams go down to the racecourse, but I did not think we were going to have ambulance trams.

The Hon. J.D. HILL: I will try to get some more information for the member for Morphett.

Dr McFETRIDGE: The member for Goyder might want to change tack here because I know he has a very strong interest in his country hospitals.

Mr GRIFFITHS: I refer to Budget Paper 4, Volume 3, page 8.31. I note with some interest that, in the figures that relate to the percentage of patients who are charged for admissions, the actual figures seem to be in the 11 per cent range, but the target set for 2009-10, and indeed for 2010-11, is 16 per cent. Can you provide me with some commentary on this: if this figure is not achieved, and it seems historically that it is not, is there a revenue impact upon Country Health that impacts upon the provision of services in country hospitals?

The Hon. J.D. HILL: Country Health, like all the other health services, is responsible for trying to generate income and run services efficiently. We made those comments at the very beginning. I think, from memory I said there the department needs to make about $30 million worth of ongoing savings, primarily through revenue, and this would be an example of that. So, that is a target that we would expect Country to make.

Mr GRIFFITHS: I have a supplementary question arising from the answer. What in fact is actually done to encourage those people who live in country South Australia to use their private health insurance? I know that the percentages vary, and it could be up to 40 per cent in some cases and probably down to 15 per cent in other communities, but is there an active campaign for people who live in the regions to ensure that, when they are admitted to public hospitals, if they have private health they access that?

The Hon. J.D. HILL: Within the bounds of decency, yes. We do not want to create a system where the first thing that people are talked to about is the cost of the service. I know that in the private sector that is sometimes the case. Under the arrangements, we encourage those who have private insurance to access that when they are using a hospital, whether it is in the country or the city. Some staff probably have a stronger performance than others. Some hospitals probably have a stronger level of performance than others. Over time, we would want to see that increase.

It is a significant factor in other states, and South Australia has not given much attention to this in the past but, given the enormous pressures that health places on our state budget, we have to look at every revenue option, and this is one of them. So, the department is actively encouraging, through staff communication with patients, the use of private insurance. Some people are happy to do it; others choose not to for philosophical reasons or whatever.

Mr GRIFFITHS: On the same budget page 8.31, I am just reviewing the performance indicators, and I am interested that there is no figure that demonstrates the performance results for the emergency departments or elective surgery for Country Health SA. Does Country Health SA actually keep those figures but not publish them as part of the budget document? If you do keep those figures, indeed what are they?

The Hon. J.D. HILL: There are two points I would make there. In terms of elective surgery, we certainly publish all of that material for the country. We used not to, and one of the reforms over the last couple of years is to make sure that elective surgery waits and the procedures that are done are now available on our website. I think the average waiting time is updated every six months and performances, I think, are updated more frequently than that, and we have certainly set targets.

In terms of emergency, we tend not to publish that data because, for most cases, people do not wait at all. With the possible exception of some of the bigger ones, country hospitals tend not to have waits. It is not the same kind of issue that it might be in the country. If somebody in most country settings needs really urgent and emergency kind of care—brain surgery and the like—they end up in the city anyway.

I can tell you that Country Health SA became part of the elective surgery booking list system in 2008, with data collected from 17 hospitals. In June 2010 we had 64 overdue patients in the country, which was a decrease of 26 from the previous year, and so on.

Mr GRIFFITHS: From what period beyond a certain number of days is overdue measured?

The Hon. J.D. HILL: Whatever the clinical approved time should be for a patient to get elective surgery for a particular procedure at a particular level of urgency. So, the doctors will assess somebody as being urgent, semi-urgent or not very urgent, or whatever the categories are. If you are urgent, you are supposed to get attention within a certain period of time—whatever it is. So, it is whatever the colleges—that essentially is at the heart of it, I think—or the profession anyway, sets. We measure against that, and there was a relatively small number. I have just got advice for the member for Morphett in relation to the $6.2 million he referred to in Budget Paper 5, page 59. It was allocated to the tram project to build three entrances to the new RAH site.

Mr GRIFFITHS: I refer the minister to page 8.9 of Budget Paper 4, Volume 3, in the highlights for the 2009-10 period. About 40 per cent of the way down he refers to completed negotiations regarding on-call contractual arrangements for country GPs and being in the process of finalising the respective agreements. It would be negligent of me if I did not ask on behalf of the member for Finniss what is occurring on Kangaroo Island. I am advised there is an issue also at Naracoorte. Can the minister give us an update on how those arrangements are proceeding?

The Hon. J.D. HILL: Contract negotiations with the KI doctors and Country Health are ongoing. Services on the island include emergency, obstetrics and anaesthesia. KI general practitioners established Island Locums Trust to provide emergency on-call services to the Kangaroo Island Health Service on weekends. Country Health is contracting locums to provide emergency on-call services mid-week. The local doctors are now providing emergency services from 8am Friday to 8am Monday—so that is good—but they do not want to do the rest of the time.

A recent obstetric review was undertaken by Professor Jeffrey Robinson, who is the Chair of the Maternal and Neonatal Network, to determine the long-term sustainability of obstetric services to KI, and I released that report to the doctors and publicly on, I think, 6 September. The review found that the maternity services on Kangaroo Island are safe, efficient and should continue, and that is a good thing.

Country Health has reviewed the report's 13 recommendations and is exploring options for their implementation. In particular, the report identified the need to maintain a midwifery workforce and attract medical students to the island. Country Health will work with the state's universities, including Flinders University Rural Clinical School, to place medical and midwifery students on KI.

The Kangaroo Island GPs withdrew emergency on-call services in November 2009; hitherto, I understand they provided them. Country Health engaged locums to provide an emergency on-call service 24 hours per day/seven days per week from November 2009 to 30 June this year. KI Medical Clinic GPs continued to provide obstetric and anaesthetic on-call support services during this time.

The targets for 2010-11 are as follows. From 1 July, the KI doctors commenced providing emergency services from 8am Friday until 8am Monday. Ongoing negotiations continue. GPs have indicated that they are waiting on the outcome of the maternity services review before signing contracts, but that has now been received. A meeting with the KI Medical Clinic GPs and CHSA is being organised to attempt to finalise the contract negotiations now that the outcome of the maternity services review is known.

Essentially, it boils down to this: we have entered into an agreement with the rural doctors and their members about on-call allowances for GPs to provide services across a range of areas but particularly in emergency departments. As of 1 October (this month), 346 rural doctors (or 84 per cent) had signed up to their invitation to enter into a formal agreement. So, it is an early part of negotiations. Country Health anticipates that a near 100 per cent acceptance of the new agreement by rural GPs is possible. There are some GPs who have contracts that are outside of this area, for example, the doctors in Gawler provide not an on-call service but an in-hospital service, as is planned for Berri. There are different arrangements in Whyalla, Port Augusta and Port Pirie, where, because of arrangements put in place, doctors cannot charge a gap. So, there are different arrangements in a number of places, but the vast majority of doctors have now signed up to this.

The KI doctors and the Naracoorte doctors have not signed up. We hope that they will but, if they choose not to do so, that is their choice, and then we will be in a position of having to find alternatives. On KI, the decision, if they do not sign up, will be to explore the establishment of another GP clinic there. We are certain that other GPs can be found (that is what the Rural Doctors Workforce Agency tells me) who would be interested in establishing on the island and providing that service.

We are not going to undo the agreement we have entered into with all the other doctors and pay them locum rates to deliver a service in their own community, and they do not like that. Unfortunately, if we were to do what they would like, we would break the agreement we have generally and we would create a precedent across the rest of rural South Australia, which would cost many, many millions of dollars to achieve. So we are not going to do that. I have to tell you that the representatives of rural doctors individually have said to me, 'Don't give in. We cannot undermine this agreement. We want a constant set of arrangements.' They deplored what they call the 'paper bag' negotiations that were a hangover from the past where special deals were done in special circumstances. Well, that is their term; I do not think anything illegal was done, but they were private contractual arrangements which differed in one locality from another.

As a representative of rural communities, I am sure that the member for Goyder would understand that there has to be fairness and transparency here, and that is what we are doing. If they do not want to sign up, that is fine. We hope to be good friends and we hope they can continue to provide the services they do, but then the obligation is on us to do something else. There is a similar problem in Naracoorte, although I guess in some ways it is easier for us to cover it, largely from Mount Gambier, given that there is a road between the two towns. Was it Millicent, the town?

Mr GRIFFITHS: The closest one to it?

The Hon. J.D. HILL: I beg your pardon, I am confusing Millicent and Naracoorte. There are issues in Naracoorte as well. Once again, the offer is on the table but, if they choose not to sign, then there is not a lot we can do. We cannot force them.

Mr MARSHALL: A supplementary to that question: can the minister advise the committee of the approximate cost of providing a locum service to cover the shortfall of the emergency on-call service on KI for those hours outside of the weekend arrangement?

The Hon. J.D. HILL: Well, it is a lot more—a lot, lot more. Simplistically, if we gave that money or a smaller sum of that money to the local doctors, they would be very happy and everybody says that would fix the problem. The reality is that it would create a bigger problem because all of the other GPs who have now signed up to contracts to deliver that service to be on call for $135,000 a unit would then say, 'We want that money, too,' then we would go back to the bad old days where we would have special deals in place and there would be general unhappiness, so we are not going to do that.

The other aspect, of course—and I will get the precise figure for the member—is that locums are paid to be locums. If we started paying ordinary GPs in their own communities the same rate as locums, then God knows how much we would have to pay a locum to do the job. They are paid more to take into account the relative disadvantage of having to travel into a community where you do not live, where you do not have contacts and all the costs associated with that. You have to leave your practice and so on. I have here the cost of locums for the period November 2009 to June 2010 which was approximately $263,000 for KI.

Mr MARSHALL: Just again, a supplementary on this important issue of the KI emergency on-call service: my understanding is that the differential between what the government is offering and what the KI medical service requires is in the order of $46,000 per annum. So is the government cutting off its nose to spite its face, especially considering the minister previously advised the committee only a few moments ago that there were different contracts in place in other parts of South Australia? I think he mentioned Port Augusta and maybe some other places on the West Coast.

The Hon. J.D. HILL: The difference is that the contracts I was referring to earlier require the doctors to be in the hospital. These are on-call arrangements. Let's take a look at the KI doctors. There is a practice there. There are three on-call contracts—one for anaesthetics, one for obstetrics and one for emergency. Every time I mention the figure they argue, but say there are somewhere between 30 to 40 (maybe 25 to 35) babies born on the island a year. So we pay the obstetrics contract of $135,000 and we pay the anaesthetics contract of $135,000, because you need two doctors for the baby. That is $270,000 we put into that practice for being on call.

Theoretically, all of those babies could be born during office hours and they get the $270,000 without ever having to come in. Of course, in practice that is not going to happen. But the number of times they are going to have to come in for those 30 or 35 babies over the course of the year you could say is a relatively small number of times. They will be called in maybe a dozen times, maybe 20 times. It is certainly important, and we are happy to pay it, but relatively few times will they be called in. Of course, they are on call, and that means that there are certain things that they cannot do, and they do share that amongst themselves; that is money they get for being on call.

In relation to the emergency department, that is where the harder work is. There are people on the island—visitors (particularly over the summer months) and, of course, locals—who need emergency care. It is critical that we are able to provide that. The doctors used to provide that, and they chose not to. They initially said that it was because of lifestyle factors, or words to that effect, that they had wanted to have more balance in work-life issues. Well, I understand that; that is fine if that is the case. They are happy to continue doing the weekend work, which pays at a higher rate, but they do not want to do the week day work, which pays at a lower rate.

They are saying that we should pay them the weekend rate for the week day rate. Well, if you break down those kinds of differentials between week day and weekend in that locality, you have to do it everywhere else. In addition, people will say, 'Well, weekends? I don't want to work weekends. I am happy to work during the week; I want my weekends free.' Then you would end up having to pay somebody an even greater sum for being on duty on weekends. This has potential for huge escalation if we were to break the arrangement.

The Rural Doctors Association told us that they want to have one system in place in South Australia. That is what the doctors, who represent GPs, told us. They came to me and said that they want to have one system in place, that they do not want to have private deals and sub-deals. We told them that we agreed, and we went through the process. We put an extra $5.3 million into it—I think we almost doubled the call-out fee—and we think that that was a fair outcome. I think the Rural Doctors Association said at the time that it was the best deal on offer in Australia, or words to that effect.

So, we think we have done a fair thing. If individual doctors choose not to sign up to it, of course, that is their call, but my responsibility, the department's responsibility, is still to provide

cover. We will do that in the most cost-effective way without undermining our agreement with the rural doctors. There are some arrangements in place, which I mentioned before—Gawler and other places—where the doctors are not on call, but they are on duty, so there is a different contract, and that is to do with the scale, largely, of the enterprise.

Gawler is probably the second busiest, about to be the busiest, hospital in South Australia. Mount Gambier is currently, I think, the busiest, and that has paid staff. The bigger hospitals tend to have different arrangements, and the smaller hospitals, where you do not need doctors in the hospital all the time, have these kinds of arrangements, and mostly they work very well. There are one or two cases where the doctors do not want to participate, but that is their call.

There was a question about Naracoorte. I have just got some advice, if I can share it. An agreement was reached with Naracoorte Hospital in 2004, which is the precedent I guess that the KI doctors point to, which is probably the point of the question the member for Goyder was asking me, and that was for a 10-year agreement; so, that has some years to run. Our view is that, over time, we want to move all of these on-call arrangements to being on a common basis.

Dr McFETRIDGE: I refer to Budget Paper 6, page 105, private hospital subsidies. What consultation was undertaken before this announcement, or was it one of these 'announce and defend' policies? Some of these hospitals will close—Glenelg community will not, but Moonta certainly is in danger. Did you talk to them?

The Hon. J.D. HILL: I thank the member for the question, but it is precisely a question that was asked in question time, and I will give the same answer now that I gave then. This is a budget. We do not consult on budget measures—never have and no government ever has. Sometimes there are things in the budget that people like and sometimes there are things in budgets that people do not like. After the budget comes down, the news is delivered. These decisions were not taken lightly but they were taken in the face of quite significant pressures on the state budget, and we had to make some savings. It was our view that the money that we paid to a number of the private hospitals did not represent the best use of that money for the public health system. I will go through each of them.

Glenelg hospital was providing some rehabilitation services, and we are grateful for the provision of those services but our intention is to provide those services ourselves at the Repat hospital and also at McLaren Vale, which will continue to be given some subsidies. In relation to the Keith and District Hospital, I had a conversation with people from that hospital. The local member brought them to see me some time before the budget. I did not tell them precisely what was in the budget but they came and asked me for even more money.

They have a very expensive system. We were funding, from memory, three beds for inpatients and, on average, only one of those beds was being occupied. So there are about 300 in-patient days a year—we were paying for 900 and were getting 300. So, it was not value for money. There is a need for an emergency service, given its location, and we will continue to provide funding for that emergency service at the Keith hospital. I think they have a profitable nursing home there. So there are things that they can do to make sure that they do run in a way which is cost effective.

In relation to Ardrossan and Moonta hospitals, both are relatively close to public facilities. Ardrossan hospital, for example, is 23 kilometres from Maitland hospital, and Moonta hospital is 17 kilometres from Wallaroo. There are people living in the outer metropolitan area, including in my own electorate, who live further away from emergency departments than people in those two communities.

If there was lots of money around, I guess you would continue doing it; but, when it comes to hard decisions and tight budgets, we thought they were lower priorities than other initiatives that we could take to make some savings in health. I know it is difficult for those communities who suddenly find that this line of money is no longer coming to them, but I am sure they will be able to accommodate the changes. I think all of them have said that they will continue in some form.

Dr McFETRIDGE: Minister, let me understand your answer. You said Ardrossan and Moonta hospitals are close to public facilities. You are taking away Recovery at the Bay, a successful program of Glenelg Community Hospital. These are community hospitals; they are not private. They are private only inasmuch as the public sector does not own them. You are removing those patients to McLaren Vale memorial hospital—a community hospital and a very fine hospital—which is 15 minutes from Noarlunga Health Services and 20 minutes—25 minutes, maximum—from Flinders Medical Centre. Who does mothers and babies step-downs to private hospitals any

more? Why is day surgery being done at McLaren Vale hospital when they can go to Flinders Medical Centre or Noarlunga health centre?

What is so precious about McLaren Vale memorial hospital? Many of the people going to the Repat will be living in town; most of the people going to Flinders Medical Centre are living in town. It is much easier to catch a bus or tram down to Glenelg to visit their relatives in hospital. It was a very good system that was working there. What is so precious about McLaren Vale?

The Hon. J.D. HILL: That is an interesting kind of rant. It seems you are suggesting that we should take—

Dr McFETRIDGE: It was not a rant; it is all fact. It is your answer, minister.

The Hon. J.D. HILL: You seem to be suggesting that we should cut the funding from one hospital and give it to another.

Dr McFETRIDGE: No, be consistent. Just be consistent.

The Hon. J.D. HILL: We have assessed the needs for rehabilitation, which was essentially, as I understand, provided by the Glenelg Community Hospital—and it is a fine hospital: I have no criticism of the hospital—and we are putting extra capacity into our system. I have already announced some of the extra capacity at the Repat. If you put more capacity in, you take pressure off other bits of the system. It does not mean to say people have to go to McLaren Vale or the Repat. They can go to other hospitals which are closer to home and which will have less pressure on them because there is other capacity in the system. It is just an economy.

The facts are that we do not need the services any longer. That is not to say that at some stage in the future we will not need them again, and I reserve the right to negotiate with any private hospital for services in the future if we believe that we need them. Despite your calling them community hospitals, which is what they call themselves, they are not public hospitals. Keith actually calls itself a private hospital—Keith and District Private Hospital. They distinguish themselves. They are not public hospitals, and our responsibility is through the public hospital system and that is where our priority is.

Dr McFETRIDGE: Aren't you contracting private hospitals for step-down facilities?

The Hon. J.D. HILL: As I said, I am happy to continue where we need to, but it is our call. We will do it where we need to. It is not about subsidising the aspirations of private hospitals: it is about providing a service to the public. So, we are happy to continue doing that through the Keith hospital through the emergency department because the public needs that. It does not need two empty beds at Keith.

Mr GRIFFITHS: Relating to the same budget page, I pose a specific question to you about the Moonta community hospital. It would not be surprising to you that I have met with the board of Moonta hospital and its CEO. They expressed their disappointment to me vehemently about this. They provided to me, though, the scenario in which they actually receive the dollars from the government which is based, as I understand it, on $120.05 per day for each bed for up to eight beds per day in which public patients are admitted to that hospital. Therefore, the amount that they receive from the public purse each year varies depending, indeed, on the number of admittances that occur.

This is a very different scenario from the Keith hospital you have referred to, and I have heard you say on radio that you fund 900 beds per year but have only 300 occupied. Surely, a scenario where a funding agreement is in place that pays only for beds that are actually physically used represents a good opportunity for that community hospital to continue to operate and indeed the public system to take pressure off public sector beds in nearby hospitals.

The Hon. J.D. HILL: That's correct, and that is why we are continuing in McLaren Vale because it does take pressure off a public hospital. Flinders is one of our busiest hospitals, and Noarlunga is becoming very busy as well. However, that is not the case in rural South Australia where there is not that same pressure in our public hospitals in smaller communities.

Dr McFETRIDGE: Wasn't Wallaroo sending patients down to Maitland not long ago because it was full?

The Hon. J.D. HILL: They may well have been, but we are not talking about Wallaroo. I am talking about Maitland in the case of Ardrossan and Wallaroo in the case of Moonta. There is hospital capacity in that community, and that is the advice that I have.

Mr GRIFFITHS: The growth that is occurring in the Copper Coast community, projected to be 20,000 by the year 2020, demands either an increase in the number of beds that are based in Wallaroo Hospital or the better use of facilities that already exist. For such a low rate per day per bed of occupancy, surely the argument presents itself that this is a worthwhile contribution to still make.

The Hon. J.D. HILL: All I would say to the opposition is that, as a government, we are faced with using the expenditure. In the earlier part of the examination today, I was quizzed on overruns and I was asked, 'How come you have these big overruns? Surely you should be able to manage.' That is the kind of rhetoric, and then we get into ways that we are trying to manage maintaining consistent contracts for on-call arrangements for emergency, 'But surely you should give a bit extra for KI. Surely you should give a extra for Moonta and Keith and Ardrossan,' and all the rest of it. All of this adds up: all of this is expenditure of public money.

Mr Marshall interjecting:

The Hon. J.D. HILL: Please feel free to get in the queue to ask a question, but I am answering this particular question. All those things cost money. We have to make decisions about what is the best way that we can spend the money to get the best outcome. Subsidising smaller private hospitals, which we have done in the past, is no longer an attractive option.

Mr GRIFFITHS: Minister, I refer back to an answer you provided previously where there may in the future be a need to re-engage or re-contract these—

Dr McFETRIDGE: Not if they're not there

Mr GRIFFITHS: Exactly—and that is the question I pose to you in regard to Moonta. I am told by the CEO that he considers that it is necessary to make a decision by the end of the first quarter in 2011 because they do not believe that the hospital can continue to remain open. Now, that is a 14-bed hospital. It means the retrenchment, basically, of 20 staff. It means that that facility is no longer available for something in the vicinity of $280,000 in the last full financial year. That is an enormous loss to the provision of health services within the northern Yorke Peninsula area that it will never recover from.

The Hon. J.D. HILL: Well, I am sure he is telling you all sorts of things, but can I say that, if the viability of that hospital—20 staff and 20 beds—depends on the amount that we are putting in, I would think that hospital has more serious problems than the ones that I am presenting it with. That is what Keith said to me, too. They said, 'You need to give us even more money.' We gave them in 2009-10—this is Keith—$627,000, and they said that we needed to give them another $200,000 to keep the place viable. Well, for one bed, that is a lot of money. I cannot tell you the details precisely of the other community hospitals, but when I say generally, that is what we were getting: one bed.

Mr GRIFFITHS: My questions relate to Ardrossan and Moonta, basically.

The Hon. J.D. HILL: Yes, I understand that. I am sorry, I do not have the same statistical information in front of me.

Mr GRIFFITHS: I just want to really make you understand—

The Hon. J.D. HILL: I understand the point you are making but you are getting into policy argument. I am telling you, in the budget, we have stopped funding those hospitals because we believe that we can better spend the available resources in another way. I understand you do not like that, and you are perfectly free to argue the other point, but arguing with me over a decision that I have made, that the government made, is rhetoric; it is not examining the budget.

Mr GRIFFITHS: Minister, if I can just finish off with this then, to me they are linked because it is a budget line. It is a decision you made to withdraw $1.174 million from those four hospitals from 30 June 2011 that will in some way devastate those communities. I am very fearful that they won't recover. The effect it is going to have upon the Ardrossan hospital will be immense also. They are profitable but it is a very fine balance. They have had financial challenges for the last 60 years and the withdrawal of $140,000 that is provided to make some contribution towards the cost of A&E will affect their ability to actually provide clinical care services and affect the ongoing viability of the aged care they provide too.

The Hon. J.D. HILL: The reality is, as I have said it, we have assessed this. These are two hospitals close to public hospitals. Our priority is public hospitals. We have increased funding to Country Health by about 13 per cent this year. I know members always look for the negative. I do not hear any commentary about what benefits there might be for their communities for the other

budget lines in Country Health. You are focusing on these three non-government hospitals. We are no longer going to subsidise private hospitals when we do not need to.

Dr McFETRIDGE: I refer to the Sustainable Budget Commission, where you wanted to shut 17 low-volume and another 20—37 hospitals they were going to shut. On that question, the Sustainable Budget Commission issues are in Volume 6 there and they go for page after page—

The CHAIR: Volume 6 where about?

Dr McFETRIDGE: I think it starts on page 99.

The CHAIR: Just give me an actual budget line.

Dr McFETRIDGE: I will give you one because my next question is on this: Budget Paper 6, page 104, on medical imaging. As I read the Sustainable Budget Commission documents that were leaked out there, it has on there 'CE priorities'. The priority for closing the Repat was 'CE priority 7'. Now, I assume that is 'Chief Executive priority seven', so that the chief executive had a list of the hits that he was going to make. Did you sign off on those, minister, as well before it went off to the Sustainable Budget Commission? Did you rule things in and rule things out?

The CHAIR: That is not actually a budget line because I cannot see anything at all on this page about the Sustainable Budget Commission. I seem to have had to bring you back during the course of this afternoon time and time—

Dr McFETRIDGE: There are a number of things—

The CHAIR: Please do not interrupt me; it is really uncalled for. A number of times this afternoon I have had to bring you back to the very point that the minister has made, that the advisors have politely tried to make and that I shall make again: we are looking at the budget. We are not looking at the Sustainable Budget Commission's report, draft or not. We are not looking at the Auditor-General's Report. We are looking—

Dr McFETRIDGE: Point taken, Madam Chair.

The CHAIR: —at a budget and a budget line. Have I made that quite clear?

Dr McFETRIDGE: You bet. You would make a very good school teacher.

The CHAIR: I believe that you have an education qualification?

Dr McFETRIDGE: I do actually, yes.

The CHAIR: Yes, takes one to know one.

Mr Griffiths interjecting:

Dr McFETRIDGE: Absolutely right. We will start at page 99, and we will go right through. There are a whole lot of budget initiatives, they are called. Why were these budget initiatives ruled in and other budget initiatives ruled out, such as closing the Repat and closing 37 country hospitals? The CE priorities that are listed against these budget initiatives that were ruled in—just tell me, minister, was the CE the chief executive's priority?

The Hon. J.D. HILL: Before I get to that, can I inform the committee that the Country Health SA elective surgery waiting list (known as BLIS) is not currently reported on the web as I reported, and apologise for that. It is only internally reported. It soon will be. The figures that I gave, though, are accurate.

In relation to the Sustainable Budget Commission, I am happy to give information to the committee. As members would know, government sets targets for CEs, sets targets for departments and sets targets for the Sustainable Budget Commission far greater than they anticipated having to meet so that we did not have pet projects coming up that CEs might want to get rid of and ministers did not, and vice versa, and so that all options could be put before the Sustainable Budget Commission. They were set a target in financial terms. You have to make theoretical savings of whatever the amount is.

If you do that in health and, indeed, if you do it in any agency, you start getting into the bedrock after a period of time. If you are given a target to reach in a theoretical way, well, it is bedrock you have to crack open, and that is what occurred. However, there was never the slightest intention to make the savings that the honourable member alluded to. He sounds a bit disappointed that we did not, because, if we had, that would have given him some fertile ground to explore his passions.

Dr McFETRIDGE: It is a disgrace, minister, that you imply that I would like the Repat to close. I refer to Budget Paper 6, page 104—

The Hon. J.D. HILL: You were disappointed, I'll tell you. Anyway, go on.

Dr McFETRIDGE: I will not dignify that with an answer. With respect to consolidation of medical imaging services, pressure on current medical imaging departments already results in long wait times for patients needing to receive imaging services. How will the consolidation of medical imaging services work, what impact will it have on wait times and when will it be implemented?

The Hon. J.D. HILL: I might ask Dr Sherbon to talk about that in some detail. I think that this is a really good initiative. What we have seen from the coordination of a range of services in the health system has produced some good outcomes. MedSTAR is one that I am most proud of. That is the combination of the various trauma services that used to operate independently of each other.

We have brought them together, we have saved money and we have reduced the amount of time it takes to get a team in the air to retrieve a patient. It is a remarkable achievement on both fronts. SA Pathology, which brings together a range of formerly independent or individual pathology services, is producing good outcomes. It is growing as a business, and it is a very tight-run organisation. It has also made some savings.

The procurement strategy that the government has in place through health brought together a range of procurement areas. We now have one procurement process, which has made huge savings both for individual hospitals (because we can get things at a better price) and in terms of the overheads required to manage that service. These are all smart things to do, and the kinds of things that private enterprise would do all the time trying to make sure that they deliver services in a better and more effective and efficient way.

The initiatives in relation to imaging, pharmacology and some of the other areas are all with that same sort of goal in mind. I will ask Dr Sherbon to talk particularly about the medical imaging services.

Dr SHERBON: The main source of saving for this initiative will be 'improve utilisation of equipment'. Currently, each hospital varies greatly in the equipment it acquires and also the maintenance contracts associated with what is very expensive, high-technology equipment. The opportunity for the statewide medical imaging service will be to consolidate equipment maintenance contracts and to streamline the process of purchasing equipment. So, rather than buying one CT for one hospital, if you buy three CTs for three hospitals then you obviously get a much cheaper price. There is an opportunity also to share scarce resources in terms of staff who provide particular sub-specialty skills.

As the minister said, the example from SA Pathology has allowed us to understand that we can secure a lot of savings, not necessarily by reducing services in these clinical services, but we can also produce savings through smarter use of equipment, smarter use of our purchasing power and smarter use of our staff.

Dr McFETRIDGE: Following on from that, can the minister guarantee that the consolidation of services and the use of on-call radiographers to review medical images—and it is 24/7, 365 days a year, so how you are going to get the radiographers to do it, I am not sure—will not mean that we have Rajasthan radiographers from overseas reviewing these images? Dr Sherbon partly answered my question before about medical imaging consolidation but did not give a time line on it and did not give any protocols or methodology involved with it. You can buy three CT machines, but I bet it costs more than one, and if you are going to buy three, well, that is great.

The Hon. J.D. HILL: There are a number of issues there. First of all, radiographers do not read images, radiologists do; so the radiographers will be in the field taking the pictures, the radiologists will be centralised, and I think that is the way a number of private organisations currently do it. As I understand, there is a shortage of radiologists worldwide. In fact, I think some companies have people internationally reading images. I am not suggesting we are going to do that, but it does happen. In terms of the time line, the budget paper I think goes through that. In 2011-12 we are expecting savings of $6.145 million; 2012-13, $12.29 million; 2013-14, $12.29 million.

Dr McFETRIDGE: It does not say how you are actually going to achieve them. What are you going to put in place to do that? So, okay, I said 'radiographers' and I meant 'radiologists'; we

all know the difference. I just do not want to see Rajasthan radiographers reviewing our patients, because we see enough outsourcing overseas.

The Hon. J.D. HILL: I am not sure what point you are making about people from the Indian subcontinent, but we will work on this in the way that the CE has described.

Dr McFETRIDGE: It sounds pretty airy-fairy at the moment, minister. I have seen the draft medical imaging service plan here and it is an interesting read, and the final plan, I suppose, will be out soon—we live in hope. I refer now to hospital car parks, Budget Paper 6, page 103. I will read a quote from Dr Sherbon to the Budget and Finance Committee about the Lyell McEwin car park. I parked out there the other day and it is an excellent car park. Unlike the Lyell McEwin, which is overflowing, the car park was not. It cost me $3 and I was only there for half an hour. It is $5 a day at the moment and that is going up to $13 a day. Dr Sherbon said to the Budget and Finance Committee regarding the Lyell McEwin car park:

> We have already completed the first component of stage C, which is a multideck car park, which has greatly relieved the visiting experience at Lyell McEwin and the staff experience. It has greatly assisted in recruiting staff and no doubt has a very significant positive benefit for the local community.

This is imposing commercial rates in car parks and putting the cost of car parking right up. Lyell McEwin is going to go to $46.77; it is now $44. Most of the patients and visitors at the Lyell McEwin can park for free; at Repat they can park for free, but it is going up. The Women's and Children's car park building is actually paid off, as I understand it, and it is making $2 million a year. You are going to go and sell it off. Isn't that privatisation?

The Hon. J.D. HILL: Really, the point that the member is making is that, somehow or other, doctors and nurses cannot afford car parking at one hospital but they can at another. We are trying to create a consistent system. I think the theme of this budget, and of the Health Care Plan, is to have consistency rather than ad hocery right across our system.

Dr McFETRIDGE: Not in private hospitals.

The Hon. J.D. HILL: The theme is to have consistency. What we are doing is making sure that our assets, that cost money to maintain and run and all the rest of it, do not become a burden on the health budget. We think it is reasonable that staff should pay equivalent to less than $2 an hour for being able to park and that patients pay a bit more than that—I think a maximum of $13 a day. So, if they were there for 12 hours, it would be only $1 an hour. Rarely would patients or visitors spend that long in a hospital. If they have to come frequently, or over extended periods in relatively short bursts, special arrangements can be made for them. Volunteers, of course, will continue to have access to free car parking, as will gold card and white card vets in relation to services for them, and there is always discretion in cases of hardship.

This is about having a consistent set of arrangements in place. I am not aware of any particular problems about our implementing this. The Flinders Medical Centre, for example, currently pays $46.56, and it can go up to $46.77 to make it consistent, so that is about the benchmark. People at the RAH pay slightly more because of the location as do people at the Women's and Children's Hospital. However, it is still a relatively modest price for secure car parking. As I say, it happens at other sites; we are just going to have a consistent approach.

The CHAIR: I would like to draw the committee's attention to the time. The time set for the beginning of further questions in relation to mental health and substance abuse was 4.15.

Departmental Advisers:

Mr J. O'Connor, Executive Director, Department of Health.

Dr T. Sherbon, Chief Executive, Department of Health.

Ms N. Dantalis, Executive Director, Department of Health.

Mr J. Woolcock, Director, Corporate Finance, Department of Health.

Mr M. Leggett, Deputy Director, Mental Health Operation, Department of Health.

The CHAIR: Minister, would you like to make a statement?

The Hon. J.D. HILL: No, no statement.

Dr McFETRIDGE: Budget Paper 4, Volume 3, page 8.5. This is target 2.7 of the strategic plan. How does the government expect to equal or lower the Australian average for psychological distress? Minister, can you tell the committee what concrete steps has the state taken to equal or lower the average?

The Hon. J.D. HILL: That is a very good question. A range of things will be employed. Having a Labor government, of course, obviously adds to the net human happiness quotient, so that is a very important starting point. Dr Sherbon has a measurement device called the K10 which he will talk to you about.

Dr SHERBON: The K10 is a survey measurement tool that measures psychological distress. It is a well-recognised international measure. It is the best available globally for psychological wellbeing measurement. So, the methodology is a standard questionnaire, a standard survey format and, longitudinally, you can measure it over time. I cannot give you the technical details of all the questions. We can certainly get that on notice if that is required by the committee and the minister agrees, but essentially it allows us to measure the psychological wellbeing of the community and it provides a reliable longitudinal tracking. Recent results have shown some slight improvement, from memory. We will have to check that, but certainly, in recent years, there has been a slight improvement.

Mr Marshall interjecting:

Dr McFETRIDGE: As the member for Norwood says, it was not the question. I am glad you are measuring this, because as Dr Paddy Phillips said, 'You can't know what you don't measure.' How does the government expect to be able to do this? What steps are you putting in place?

The Hon. J.D. HILL: I am happy to answer that. Sorry, I got slightly the wrong angle, my apologies. The State Strategic Plan, which has a series of goals against which we measure ourselves, is an attempt to be a community-based plan. This is what we as South Australians want. We went through a big consultation process, involved the opposition and a whole range of parties. This is about what our community wants. We want our state to be a happier place. As the member said, you don't know unless you measure it. So, we are measuring, if you like, wellbeing or happiness, or whatever kind of descriptor you want to put on it.

How do you achieve that? One of the ways—and I think perhaps Ilona Kickbusch, who was one of our Thinkers in Residence, gave us a clue—is through what we now know as the Health in all Areas policy. The health department, historically, has been responsible for providing services to people who are not well in some way, whether it is physical health or mental health, and so it provides a service to try to correct whatever that illness is. It is a traditional notion of what a hospital or medical service is.

What we want to move to is creating a healthy society which is focused on wellness or wellbeing, and that runs out through all the parts of government activity. So, it is not just the health department. In fact, in many ways, the health department is the least responsible for that. We need to provide services to people in a timely way, and that obviously helps individuals' sense of wellbeing if they are getting a service and a general sense of security to know they can get a service in a particular time frame. We have responsibilities. We are also promoting, through programs like OPAL and other programs, healthy behaviours and that will feed into it. In addition, all government agencies have a role in trying to create healthy communities.

Through the planning process, we want to ensure that when we plan we have good open spaces and access to recreational facilities, to nature and to vegetation so that people can get access to services and feel confident in their community and do not feel afraid. It moves from planning into policing and transport infrastructure and involves housing, so that people are not rough sleeping but have their own accommodation. There is an investment across all those areas. This is one of the more abstract ways we can see whether all those kinds of policies are working.

There are other things outside the control of state governments. Economic circumstances are outside the control of national governments to a large degree and can impact. If there is a huge spike in unemployment, obviously that has an impact on wellbeing. As a government, we need to ensure we have strategies in place to maximise our potential to generate wealth through a whole range of the natural resources and natural advantages we have as an economy and as a community. I do not want to sound too abstract, but that is what it is about: how we go in all those areas.

Dr McFETRIDGE: The concrete steps you are going to take to do that puzzle me. I refer to page 8.8 in the highlights. With the state mental health plan, what guarantees can the minister give—and I think the state mental health plan runs out in 2010—that, with the uncertainties of recent years with so many plans cancelled or redrafted, plans for reducing psychological distress will be implemented? If we look at the lack of any increase in funding for organisations like Beyond Blue we find it has not gone up—$278,000.

The Hon. J.D. HILL: I am not sure what the member means by 'plans that have been cancelled'. Health has been pursuing our state plan since 2007 and we are running it out, and this budget has money committed to it. I am not particularly sure what he is referring to, but I am happy to be more specific if I can get a better clue from him on what he means.

Dr McFETRIDGE: We have seen so many times that the government raises expectations but fails to deliver. You cannot keep doing that.

The Hon. J.D. HILL: They are allegations you are making without substance. Give some substance to it—prove it and then I can comment on it.

Dr McFETRIDGE: We only have 16 minutes. The member for Norwood has a question, and I have a couple more.

Mr MARSHALL: Will the minister update us on the review of the South Australian drug strategy? It was for 2005 to 2010: is there a new drug strategy and, if so, can the minister outline when it will be released?

The Hon. J.D. HILL: It is yet to be finalised, but a good deal of work has been done in relation to it. I had a fascinating discussion with leading thinkers in the drug area in South Australia a few weeks ago. They were giving me advice in relation to the drug strategy, and some of the facts I can recall are that in some areas, particularly with cocaine and ecstasy, I was asking how it was going because I thought there was a fair bit of it around the place, and they told me that there is virtually none in South Australia at the moment.

We have seen a reduction in the use of multiple drugs, including tobacco and legal drugs, so there is some cause for optimism about how we are going as a state in terms of the drug strategy. Perhaps Dr Sherbon might like to give more detail about the next drugs strategy plan.

Dr SHERBON: It is under development, as the minister said. It should be with the minister, if not by the end of this year then early next year. Obviously, it will then be a matter for ministerial consideration.

Dr McFETRIDGE: In Budget Paper 4, Volume 3, page 8.9, in the highlight there it states, 'Develop a mental health plan for Anangu Pitjantjatjara Yankunytjatjara Lands'—the APY Lands. How does the minister plan to develop a mental health plan for the APY and what significant and particular roles are there for the APY communities to be central to this program, because without them it just will not happen?

The Hon. J.D. HILL: In relation to this I certainly agree with the member for Morphett, and I acknowledge his great interest in the people in the APY Lands. We have a very good health service delivering services in the APY Lands—Nganampa Health, an Aboriginal controlled health service—so I expect we would do nothing in the health area in that community without the full cooperation and involvement of Nganampa Health, because it has a track record of giving good outcomes.

Mr MARSHALL: Just on that issue of developing a mental health plan, are the DASA services which are provided on the lands independent of Nganampa Health?

The Hon. J.D. HILL: Yes. The state government does provide services to the lands which are not part of Nganampa. Nganampa provides a range of services, and that is not to say they provide the only services, but everything we do we try to do in close collaboration with Nganampa. I visit there and have done so for the past few years. I did not go this year, unfortunately, for weather reasons and the trip was washed out. I have visited every year for the past three or four years and sat down and talked to them about what they wanted and where to go.

Mr MARSHALL: Does the minister have a comment about the effectiveness of the new DASA site in Amata, and were there any plans to rejig that site in any way?

The Hon. J.D. HILL: The site I guess you are talking about is the Howard government's funded site for people with drug dependency—a substance abuse facility. Other things have happened over the course of time since that was—imposed would be too strong a word—

developed by the Howard government. Opal petrol has done a lot to reduce the incidence of sniffing in the lands, and there have been other strategies, as well. As I understand it, the model of care they use there tends to be more of an outreach than a long stay, but that is not to say that it should not happen. I might ask Doctor Sherbon if there is anything further he can add.

Dr SHERBON: No. There has been some residential use of the facility. As the minister said, the commonwealth funded facility that was initiated by the previous federal government remains underutilised. However, as the minister said, the staff are much more active in community outreach, particularly with the use of marijuana on the lands, which is generally counteracted with educational programs delivered through youth and high school aged children's programs. So, staff are actively pursuing those arrangements. The staff are not underutilised, but the facility remains underutilised, and we are exploring options with Nganampa and the APY communities to increase the utilisation of the facility.

The state, of course, did contribute family residential quarters so that whole families can stay there, to complement the federal facility, and that has assisted. However, there does need to be an increasing confidence of use by the community. We are seeing the signs of that, but we are yet to see full utilisation.

Mr MARSHALL: What is the timeframe for that review?

Dr SHERBON: There is no formal review at this stage. The facility has been operating, from memory, for only two years. I will have to check that. There is increasing utilisation, so it is not as if the facility is not providing some level of care. I would expect that at some point next year we will, if not formally review then certainly assess the utilisation of the facility.

Dr McFETRIDGE: I think you can count on one hand the number of residents who have received residential care in that misused facility. My understanding is that the federal government is currently undertaking a re-scoping study of the facility, and I am surprised that they have not spoken to you on that. If I can move on to my next question.

The Hon. J.D. HILL: Hang on; you cannot do that.

Dr McFETRIDGE: I can.

The Hon. J.D. HILL: You can do it but I will interrupt you.

Dr McFETRIDGE: I am just correcting the record.

The CHAIR: Of course you may move on to the next question, member for Morphett, but if you are going to throw these comments out there—

Dr McFETRIDGE: I was assisting the committee.

The CHAIR: It is nice that you want to help, but it is inevitable that the minister is going to wish to respond. Minister, would you like to—

Dr McFETRIDGE: He is going to thank me, is he?

The Hon. J.D. HILL: No, Madam Chair.

The CHAIR: You will let it go. We will move on.

Dr McFETRIDGE: That is right, because I am right. Page 8.32, Budget Paper 4, Volume 3, Country Health. There are no performance indicators for mental health in Country Health. Does this mean, once again, that the country programs have been forgotten?

The Hon. J.D. HILL: On the contrary, I made announcements just recently about a range of extra services in country South Australia and the establishment of new facilities, after the Mental Health Act was proclaimed, to allow the detention of mental health patients for short periods of time in country facilities so that they do not have to come to Adelaide, with all of the problems associated with that for them and their families. We are wanting to build up, to the extent that we can, mental health services in country South Australia, and I think that is pretty clear.

I can give you some information. In terms of intermediate care it is expected that 18 country, non-facility based places will be open in the country between late November and December and January 2011, and that is six in Whyalla/Port Augusta, six in the South-East, two on Kangaroo Island and four in Port Lincoln. So, we are resourcing mental health in the country quite well.

Dr McFETRIDGE: Budget Paper 4, Volume 3, page 8.11, the new Glenside Hospital. Have the 130 or so design issues raised by the South Australian Salaried Medical Officers Association and the Public Service Association been sorted out, or where are we going with the design of the new facility?

The Hon. J.D. HILL: My advice is that pretty well all of them have been sorted out to the extent that we are proceeding to tender later this week based on the refined design.

Dr McFETRIDGE: I have looked at the plans and there are a few areas on those plans that do not seem fit for purpose. The rooms seem fairly compact, the corridors seem very compact, the offices for medical staff seem tiny, and there are three rooms that stand out as being really quite small rooms; that is, the art room, the music room and the gym. The art room, I think, is six metres by three metres and designed for 25 people. I cannot see you doing music and art in there. As for the chapel, or the multi-faith centre I think you call it, you could never hold a wedding or a funeral in there as they used to in the old chapel. The design seems completely inadequate. Have you considered those sorts of concepts, because I know they were raised with you by SASMOA and the PSA?

The Hon. J.D. HILL: I repeat my advice that I understand that most of the design issues have been sorted out and we are proceeding to tender towards the end of this week, but in more detail I can tell you that the Glenside campus redevelopment does drive a series of reforms in both the delivery of health services and in the physical changes to the site. Since the launch of the concept plan in 2007, SA Health has undertaken a very comprehensive engagement process with clinicians, staff, key stakeholders, schools, people who use our services and their families, community groups, councils, local community members, neighbours and other government organisations. All have been involved in the design.

Since late 2008, the design team engaged to deliver the new health facilities has also undertaken extensive consultation regarding the development of the concept. This has included over 150 people consulted directly, nine ongoing internal stakeholder workshops, and over 16 external stakeholder workshops. There have been more than 90 user group sessions since January 2010 alone.

Concept plans were placed on public display at Glenside over two full days in November last year. These displays were staffed by design team members and SA Health staff, with feedback forms provided, and so on, as well as consumers, carers, clinicians and locals being involved. Other methods of engagement have included public forums, meetings with councils, local businesses and local residents, open days, a community reference group, a website, mail-outs, a dedicated phone number, a dedicated email address, and a post office box.

So I think it is fair to say that there has been extensive consultation, including and especially with the affected unions (ANF, SASMOA, PSA and the Liquor, Health and Miscellaneous Workers Union). In 2007 there was a special engagement process for unions so that they could be involved at the very beginning, and the unions were engaged ahead of, or as part of, the major redevelopment public announcements, such as the release of the final master plan in April 2008. They have also been provided with the following information:

- provision of draft and final Glenside model of care documentation in late 2007/early 2008;
- mid-2008 to late 2009: provision to unions of the meeting minutes of the 137 transition phase focus groups undertaken with clinical and nonclinical staff; and
- April 2008 to present: provision of over 120 staff bulletins to staff.

Further to the consultation above, the Glenside Transition Consultative Committee commenced in July 2008 and concluded in May 2010. I would say there has probably been no greater process of consultation than on this project.

As part of the intensive consultation process, the unions were requested to provide written input to SA Health on issues pertaining to the design of the new health facilities at Glenside. Approximately 250 questions/issues were received from across the four unions. Much of the feedback received was consistent across the unions and represented in the vicinity of 50 separate questions and issues. Feedback received was generally consistent with other feedback and related to the following key themes: staff amenities; facilities management; office accommodation; roads and traffic; acoustics and acoustic separation of activities; shared activity space; space utilisation; safety and security; therapeutic environment provided by the current design; and functional

adjacencies. A written response to each union was provided on each and every issue raised and the responses have been discussed in detail as part of the ongoing consultation sessions.

The design team has continued to develop designs in response to this, and an updated set of design drawings were presented to the union groups at a meeting on 24 September. A further meeting will occur later this month. User group sessions are also currently being scheduled to take place over the next two weeks to present the updated health facility designs. The next stage of the design process will involve consumers and care representatives, and it is anticipated that consultation with union groups will continue around aspects including internal fit-out and operational issues, such as car parking. The design team we have employed is highly regarded and has won awards. We believe it will produce a wonderful new facility.

Dr McFETRIDGE: I refer to Budget Paper 6, page 105: Transfer of Non-Government Organisations Sector. What consultation was there with mental health stakeholders before this decision was made, or is it another case of announce and defend? As I understand it, those being transferred through to the non-government sector are Elpida House, Wondakka and Trevor Parry.

The Hon. J.D. HILL: I think there is a view, particularly among those who are expert in mental health in these rehabilitation kinds of facilities, that they are often better delivered by the private sector through the not-for-profit organisations. I understand that was part of the original Stepping Up report based on the process of consultation. It was certainly canvassed in the original Stepping Up report. My understanding is that the representatives of the consumers generally are reasonably happy with this process—the Mental Health Coalition, for example.

The CHAIR: There being no further questions, I declare the examination of the proposed payments completed.

DEPARTMENT OF PLANNING AND LOCAL GOVERNMENT, $17,703,000

ADMINISTERED ITEMS FOR THE DEPARTMENT OF PLANNING AND LOCAL GOVERNMENT, $2,510,000

Membership:

Mr Treloar substituted for Dr McFetridge.

Witness:

Hon. J.D. Hill, Minister for Health, Minister for Mental Health and Substance Abuse, Minister for the Southern Suburbs, Minister Assisting the Premier in the Arts.

Departmental Advisers:

Mr J. Hanlon, Deputy Chief Executive, Department of Planning and Local Government.

Mr A. McKeegan, General Manager, Finance and Corporate, Department of Planning and Local Government.

Ms S. McCormick, Director, Office for the Southern Suburbs, Department of Planning and Local Government.

The CHAIR: I declare the proposed payments open for examination and refer members to the Portfolio Statements, Volume 1, Part 4. Minister, would you care to make an opening statement?

The Hon. J.D. HILL: No, thank you, Madam Chair.

The CHAIR: The member for Goyder.

Mr GRIFFITHS: I will not make an opening comment other than to recognise that it is a relatively small budget area within the scope of what is provided, but I do understand how important it is for the people of the south that they have an advocate who is supporting them in every way. As someone with a parent who lives in the south—

An honourable member interjecting:

Mr GRIFFITHS: No, the member for Fisher. I refer to Budget Paper 4, Volume 1, page 4.11. I note that the objective of the office is to assist in the realisation of the government's policy commitments. Obviously, one of those is the innovation hub at Tonsley Park, which was purchased in December 2009. Minister, I am very interested still in what has occurred to those good people who worked for Mitsubishi, and I hope that you will have some information on this. It is not an employment, training and further education question. Does the Office for the Southern Suburbs maintain figures on those displaced Mitsubishi workers who have not been able to find employment yet, and can you confirm how many people that would be?

The Hon. J.D. HILL: I will check that information. In general terms, when Mitsubishi closed, the government gave me a responsibility in relation to helping manage some of the programs. One of the things obviously was to look after the workers, another thing was to look after the site and so on. We established a group, which was a coordination group that brought together heads of government agencies relevant to all the issues. The Office for the Southern Suburbs, I guess, was the executive to that group.

They invited the commonwealth, which sent a key person along, the local councils, the head of the Southern Adelaide Economic Development Board and the Vice-Chancellor of the Flinders University. So, it was a very high-powered group that undertook that coordination role. We were not responsible for directly doing things, just making sure that all the things that should have been done were done. We kept a very close look, particularly in the early days, on the outcomes.

I can tell you the advice that I have: Mitsubishi Motors announced that Tonsley Park would close in 2008. The key initiatives undertaken by both the federal and state governments—the feds put in more money than we did, of course—were the following: the Mitsubishi labour adjustment package was established to support workers to transition to new employment, providing a range of assistance services—that was a $10 million package that included $7.5 million dollars from the commonwealth, and $2.5 million dollars from us;

There were small business development grants. This was a particular initiative that came as a result of our experience with the Lonsdale closure. It was a request by the Onkaparinga council, in particular. So, we put a $5 million scheme together to support new investment and job creation in very small to medium-size businesses. The results of the final round of funding under this initiative were announced in August this year.

The South Australian Innovation Investment Fund was launched in July 2008. This is a $30 million fund to operate over a three-year period from 2008-09 to 2010-11. Its purpose is to support new investment attraction, job creation and innovative and technology-intensive manufacturing in the south.

Then, of course, we facilitated the development of the Tonsley Park site, and as the member said, the government has purchased that site. The office attends all the meetings of the Tonsley Park steering group and the Tonsley Park reference group. We also gave a small amount of money, $12,500, to the university to produce an oral history film of former Mitsubishi workers which kind of went to the psychological issues, I suppose.

The advice I have is that the tracking of workforce figures stopped after the first year or year and a half, or so. I can get whatever the most recent figures were. I think I have made public comments before, but I think the figures were reasonably encouraging. A large percentage of people had transitioned into other activities.

Mr GRIFFITHS: Minister, again the same reference points: I suppose, in life, timing is everything. It seems to me, as I understand it, there was a 20-month delay between the closure of Mitsubishi and the decision by the government to purchase the site and to pursue the innovation hub. Were you concerned that the delay in access to that site, and indeed its development, therefore would have restricted job opportunities in that area?

The Hon. J.D. HILL: Well, it is interesting how you have formed the question. You said there was a delay between the decision of the government to purchase the site and the purchase of the site—was that how you put it?

Mr GRIFFITHS: No, I think the decision was in December 2009.

The Hon. J.D. HILL: Between the closure and the decision to purchase this.

Mr GRIFFITHS: And the three-month gap in between settlement, I think, was it? I suppose my question relates more to the 20-month gap in between the closure—

The Hon. J.D. HILL: I think we decided to purchase the site a lot earlier than we actually purchased it because we were negotiating with Mitsubishi about what they wanted to do. In fact, I went to Tokyo to talk to their headquarters people there about selling it to us. They were very equivocal about what they intended to do with the site—whether they were going to hold it, sell it themselves or break it up—and all the rest of it.

So, we went into some pretty tough negotiation and eventually got agreement with Mitsubishi for us to purchase it as a whole site. We were very concerned that it would be broken up and the economic opportunities that flow from having such a large site, strategically, would be lost. So, we worked pretty hard. I think Mitsubishi played hardball as well, and we did in return.

It would have been better if it had been done earlier but, given that the global financial crisis kind of happened in the middle of all of that, it is a bit moot whether or not we would have been able to attract very much in that period, anyway, because things were pretty quiet. In fact, ironically I suppose in one way, that crisis may have helped us purchase the site in the time that we could afford—shall we put it that way. So, in some ways it kind of worked in our favour.

If you look at the employment stats for the south particularly and for South Australia generally, employment rates are holding up pretty well in the south, as they have been in South Australia. So, there is not that sort of overly large burden of unemployment. There are certainly some suburban areas in parts of my electorate, and the member for Reynell's electorate and so on, where there are relatively high numbers of unemployed people in relatively small geographical areas but, overall, unemployment figures are pretty good. I hope that throws some light on the decision-making process.

Mr GRIFFITHS: Minister, you referred to the unemployment levels. Does the Office for the Southern Suburbs maintain figures on what the unemployment level was, say, 12 months ago and what it is now?

The Hon. J.D. HILL: In general terms, we keep a close watch on it. The coordination committee that I referred to gets reports on a reasonably regular basis on where employment is tracking.

Mr GRIFFITHS: Can you quote what the percentage is?

The Hon. J.D. HILL: No, I do not have those figures with me. They are certainly available through the ABS, so I can get them for you.

Mr GRIFFITHS: It breaks it down into the suburb, does it, the area that the office supports?

The Hon. J.D. HILL: Perhaps if you can be more specific about what it is you are after.

Mr GRIFFITHS: For the area the Office for the Southern Suburbs supports—

The Hon. J.D. HILL: Marion and Onkaparinga, and we have now broadened, so we now look after Holdfast Bay and Mitcham council areas, too. The CEs from all of those four councils—

Mr Griffiths interjecting:

The Hon. J.D. HILL: Yes. It is taking into account the Adelaide geographical boundaries the government implemented some years ago. The main focus would still be Onkaparinga and Marion, but the others come in because it spills into their areas, too. The ABS keeps figures, I think, on local government areas, and we track those, so we can find those for you.

Mr GRIFFITHS: Minister, given that business enterprise centres are going to be somewhat challenged in the future, given another budget decision to withdraw some support, do you envisage that the Office for the Southern Suburbs will provide some level of small business support to the area, too?

The Hon. J.D. HILL: In a broad sense. This is a very small office, which has a budget of less than $400,000 or thereabouts, and it employs one or two staff. I tried, from the very beginning of its role, for it not to be a problem-solving unit for individuals or individual organisations. It is really there to try to make sure that whole of government focus is brought to bear and that there is really good coordination, particularly with the local governments and the other big players, such as the university and so on.

We have been really focused on the bigger strategic things, such as the Mitsubishi site, the implications of the rail and road expansions for the local economy, and helping to develop an economic development plan with the Southern Adelaide Economic Development Board—all of

those kinds of things. It is not to say that we would not have an interest in small business, but that is not a particular focus. If the question is: will be substituting whatever the services the BECs do, the answer is no.

Mr GRIFFITHS: I certainly hope that the BECs manage to survive and continue to provide services, but it is important for the committee's purpose to find out what is the scope of the office and whether it is capable of providing that support, and I understand from your answer that it is not intended to be that level of support, and I accept that.

The Hon. J.D. HILL: One of the things we did a few years ago that I thought was really useful was to get the two councils (Onkaparinga and Marion) to work together and, in the past, they had not. They had separate economic development plans, and now they have a consistent economic development plan, which is run through the Southern Adelaide Economic Development Board, which is chaired by Tom Phillips, the former CE of Mitsubishi, and it consists of a range of local business people. That has developed an economic development strategy for the south, which is consistent with where we are going as government, and we work closely with them to try to achieve outcomes.

They said, for example, one of the priorities for them was to see the Southern Expressway duplicated, and we have delivered on that. They said that they wanted to see broadband access increased, and the federal government, with a bit of lobbying, has been able to deliver on that. We are going to be involved in the revision of that plan through its next iteration. I am advised that we also have a small business development grant scheme for southern Adelaide businesses, which I mentioned before, which has about $5 million in it.

The number of full-time jobs that have been created as a result of that is about 215; so $5 million has been rolled out, with a minimum of $200,000. The scheme is aimed at supporting economic growth, employment and business development in southern Adelaide. Criteria include capital expenditure of a minimum of $200,000 and new job creation in the southern Adelaide region, and there is a bias towards innovation and the introduction of new technology. That has created 215 jobs, with over $15.68 million of capital investment; so a 3:1 ratio is pretty good.

Mr GRIFFITHS: Is the small business development grant now fully expended?

The Hon. J.D. HILL: I believe so. It finished in August this year. The final round was in August 2010.

Mr GRIFFITHS: I understand it would be very difficult to justify, given that you are not still tracking the unemployment numbers from Mitsubishi workers, but has any consideration been given to the extension of that and additional funds going into it?

The Hon. J.D. HILL: I understand there is a new scheme, not through these budget lines but through the Southern Adelaide Investment Fund, which was committed to in the last budget, and we can give you access to that. These grant funds are not a lock-step sort of process to give money to companies who are going to employ former Mitsubishi workers. It just does not work in that way. It is really money to go into that economy in the short term to create more job opportunities and also to put resources into the individual workers for counselling, retraining and so on, so all of those kinds of projects have been pretty well run out. There is the $30 million South Australian Innovation Investment Fund, which has not yet all been expended. We have spent $21.1 million; so there is about another $9 million left. It has created about 725 new positions, and we do monitor that scheme.

Mr GRIFFITHS: It is just that, in isolation, the 215 jobs created as part of the $5 million grant sounds impressive, but I am aware that Mitsubishi employed at least five times that number of people when the decision to close was made; so the effect upon the southern economy would have been enormous. Obviously, you can consider that, but it is just that the south is an area that has been identified for a long time as needing support. Certainly, whenever mayor Lewis talks about the need to support industry growth there, she is quite passionate about it.

I am rather intrigued by this. As you say, the office has a budget of slightly less than $400,000. In last year's *Hansard* of the estimates process, $15,000 in grants was available, but you do have some flexibility to move some figures around. It seems to me that, with the finalisation of the small business development grant, that is a lot of money being spent for very little dollars going out to other groups.

The Hon. J.D. HILL: We are not a grants body. We have a few dollars to help the odd conference, seminar or the like. It is not a grants body for small businesses to employ people. I would not want to make that suggestion. It might be that if a small business or the Southern

Economic Development Board wanted to run a conference or something we could help them; that is the kind of stuff that we do.

You made the point about only 215 jobs, but if you put the two funds together that is almost 1,000 jobs created through the Innovation Investment Fund, which is a slightly bigger fund for bigger organisations, where capital projects between $500,000 and $10 million occur. The small business fund, which is really for the smaller end, got 215; in fact, if you get 215 jobs out of $5 million invested, that is a pretty good rate, and the larger fund still has money in it. So, I think we have done a reasonably good job in creating an equivalent number of jobs to the jobs that were lost. Bear in mind that the majority of the Mitsubishi workers had terrific skills and a vast majority of them found other work.

Mr GRIFFITHS: They were very attractive to other potential employers, I understand that, but, obviously, those people did not necessarily want to have to relocate to find an opportunity. That is why growth within the region is important. I refer to Budget Paper 4, Volume 1, page 4.7, which talks about development and assistance in the implementation of regional strategies. I am not sure whether you alluded to this in one of your earlier answers, but: can you list the specific strategies that have addressed the economic, social and environmental priorities of the people of the southern regions?

The Hon. J.D. HILL: I can tell you the things that our office has been involved in. There is a whole range of strategies, of course, that are important to the south. The office plays an important role in making sure that the southern voice is heard. That is really its prime role—to make sure the interests and needs of the southern suburbs are taken into account as the government goes about its business, and making sure there are good lines of communication to connect local councils, in particular. You probably appreciate this as a former employee of local government: local government often feels it is not listened to and is ignored, and all of rest of it. One of the things that we try to do, which Sue and her predecessors do very well, is to make sure there are very good links to local government, and I certainly make myself available to hear what councils have to say so that the government takes it into account.

There are a number of things. The key strategic issues, for example, and the strategies related to them are the Tonsley Park cleantech precinct that we talked about. We took the lead role in that. Now that the land is purchased, the master plan process has begun. I have transferred the chairing of that to minister Koutsantonis, quite properly, as the responsible minister. We were very much involved in the Darlington transport study. We had a strong role in the 30-year Plan for Greater Adelaide around the TODs and the employment land, as it is called these days (it used to be called industrial land).

In regard to education, tertiary participation and university access, we have done a lot of work trying to focus on educational outcomes. As a former teacher, all my life I have had a strong view that there is a high correlation between educational outcome and employment outcome and happiness outcomes, and the reality is that not enough young people from the southern suburbs are finishing their high school. We are very much focused on what we can do to support them. Flinders University, in particular, has been very good in trying to get greater involvement and providing opportunities for young people in the south to see pathways through to university. TAFE, equally, has been very good at that.

Also, in a particular economic activity, we have fostered a Medical Devices Partnering Program, which involves the university, Flinders Medical Centre and the private sector, to create a hub on the Tonsley site, hopefully, for medical devices. South Australia has extraordinary talent in this area and we produce a whole range of medical devices that are exported all over the world. We have got great skill and entrepreneurial capacity in that area. By bringing them together, we hope to optimise that work.

Mr GRIFFITHS: Again I refer to the same budget reference but, specifically, social priorities for the area. Is there any specific age profile that creates more of a need and puts pressure upon the Office for the Southern Suburbs? Indeed, what is the office and, therefore, the government doing to assist those people?

The Hon. J.D. HILL: It was interesting in the early days, I guess, when the office was established, which was over eight years ago now, that we were probably trying to do too many things. I think over the last few years we have really focused very much on economic activity—jobs, and the things that are antecedent to the creating of jobs that go along with that—and land use planning issues which fit into the kind of infrastructure you need to get the economic activity working. Those two things work together. I do not think we have necessarily had a particular age

obsession but if there has been one it has been for young people and the focus on educational opportunities leading into employment opportunities.

Mr MARSHALL: Minister, you have talked about the diminution of services offered through the Office for the Southern Suburbs since it was instituted some eight years ago and we know the costs associated with a ministry, an office, audit fees and so on. Are you confident that the benefits that are derived from having a separate Office for the Southern Suburbs outweigh these additional costs? Have you given consideration to moving those functions performed by the office back into the other departments, for example, Trade and Economic Development as you previously alluded to?

The Hon. J.D. HILL: The member must have misunderstood what I said. I did not say that we had a diminution of resources, although they have gone up and down a little bit over the years. What I was really talking about is that there were very broad ambitions and I had the poor director at the time running around doing about a hundred different things. What we worked out over time is that we should have a more strategic and focused approach to using the limited resources and the key issue which underpins it all is the economic issue and what is associated with that which I have already been through.

I am very confident that it has been effective. I could point to the fact that the employment rate now is higher in the south than when the office started. Could I say that it is because of the office? That would be drawing a long bow but if it had gone the other direction you no doubt would be pointing it out to me and saying it has been a total failure.

One of the things that I have really tried not to do is to politicise it. I think it is a really important strategic role to help get things working and that involves cooperation. We have always provided briefings to members of the opposition when there were some in that area and tried to keep the politics out of it.

It is really about working with councils who obviously have their own politics and ignoring the day-to-day noise that often goes on in local government and state government about things and trying to just be practical about making sure that the right parties are brought together at the right time to make good decisions and I think we can point to some good outcomes in that regard.

We have also done everything we can to maximise the outcomes and reduce overheads. When we set up, we had an office: we no longer have a physical office. The director hot-desks down there if she needs an office, and is based in an office in town. That is where her home base is but she is on the road most of the time. We had our own receptionist and our own this and our own that so we just got rid of all that to focus on a really tight unit which is working with key decision-makers within state government and in the broader community. I think it is a really good model; I think it works really well.

Mr MARSHALL: Minister, we do not have ministries for other geographical areas in South Australia. It is a very small budget. It is a micro-ministry if you like—$400,000 per year. My question was really about whether or not there are actually greater costs associated with running this office rather than just moving those services back into the other larger departments which would service these precise areas—the office of local government, the Ministry for Trade and Economic Development and so on and so forth.

The Hon. J.D. HILL: There is another office—there is an office of the north, so there is one. The director of the Office for the Southern Suburbs is nestled, if I can use that language, within the Department of Planning and Local Government so she is an employee of that agency and in many ways her role is an extension of the role that John Hanlon and others in that office have about consulting and managing across the state. The director has a particular role in relation to doing those things and a bit more, I think, within the south. In my view, it has had big benefits for the south.

Mr GRIFFITHS: In the remaining 15 seconds I wish to read onto the record the omnibus questions for budget estimates 2010-11. They are:

1. Will the minister provide a detailed breakdown of the baseline data that was provided to the Shared Services Reform Office by each department or agency reporting to the minister—including the current total cost of the provision of payroll, finance, human resources, procurement, records management and information technology services in each department or agency reporting to the minister, as well as the full-time equivalent staffing numbers involved?

2. Will the minister provide a detailed breakdown of expenditure on consultants and contractors above $10,000 in 2009-10 for all departments and agencies reporting to the minister—

listing the name of the consultant, the contractor or service supplier, cost, work undertaken and method of appointment?

3. For each department or agency reporting to the minister how many surplus employees will there be at 30 June 2010, and for each surplus employee what is the title or classification of the employee and the Total Employment Cost (TEC) of the employee?

4. In financial year 2009-10 for all departments and agencies reporting to the minister, what underspending on projects and programs was not approved by cabinet for carryover in 2010-11? How much was approved by cabinet?

5. Between 30 June 2009 and 30 June 2010, will the minister list job title and total employment cost of each position (with a total estimated cost of $100,000 or more)—

(a) which has been abolished; and

(b) which has been created?

6. For the year 2009-10, will the minister provide a breakdown of expenditure on all grants administered by all departments and agencies reporting to the minister—listing the name of the grant recipient, the amount of the grant and the purpose of the grant, and whether the grant was subject to a grant agreement as required by Treasurer's Instruction No. 15?

7. For all capital works projects listed in Budget Paper 5 that are the responsibility of the minister, will the minister list the total amounts spent to date on each project?

8. For each department or agency reporting to the minister, how many Targeted Voluntary Separation Packages (TVSPs) will be offered for the financial years 2010-11, 2011-12, 2012-13 and 2013-14?

The Hon. J.D. HILL: Madam Acting Chair, I need to make a correction. When I gave some information about the Glenside tender, I said that part of precinct 1 was going out this week when, in fact, it is going out next week. My apologies.

The ACTING CHAIR (Ms Bedford): There being no further questions relating to the Southern Suburbs, I declare the examination of this section of the proposed payments adjourned until tomorrow.

At 17:18 the committee adjourned until Tuesday 12 October 2010 at 9:00.