HOUSE OF ASSEMBLY

Wednesday 2 October 1985

ESTIMATES COMMITTEE B

Chairman:
Mr G.T. Whitten

Members:
Mr H. Becker
Mr T.R. Groom
Mr K.C. Hamilton
Mr G.A. Ingerson
Ms S.M. Lenehan
Mr J.K.G. Oswald

The Committee met at 11 a.m.

The CHAIRMAN: It is my intention to enable the lead speaker from the Opposition side to make an opening statement, if he wishes, and the Minister to do likewise. I will allow three questions to come from the Opposition side followed by three from the Government side, and will continue to alternate in that matter. All questions will be directed to the Minister. If he wishes his officers to respond, he can call on them by name to do so. During answers to questions the Minister may state that he will obtain the information requested at a later date, but I ask that information be in a form suitable for insertion in *Hansard* and that such replies are in the hands of the Clerk by 18 October. Does the member for Hanson wish to make a statement?

Mr BECKER: No. We see the Estimates Committee's role as a function for members to obtain from a Minister information concerning his budget lines, and that is what we propose to do.

The CHAIRMAN: Mr Minister, do you wish to make a statement?

The Hon. J.R. Cornwall: I have prepared a lengthy and comprehensive statement relating to the health budget. It will be very useful in assisting members to follow both the blue book and the yellow book. Rather than read it, I seek your guidance as to whether it can be incorporated in *Hansard*, as I have copies that can be circulated to members.

The CHAIRMAN: If the Minister will indicate the title and request leave for its insertion it will be granted.

The Hon. J.R. Cornwall: I seek leave to have the document titled 'South Australian Health Commission 1985-86 Estimates—Minister of Health's Opening Statement' inserted in *Hansard* without my reading it.

Leave granted.

S.A.H.C. ESTIMATES—1985-86

I am this year taking the step of circulating an overview statement relating to the South Australian Health Commission's 1985-86 estimates.

The purpose of this statement is to provide members of the Budget Estimates Committee with a broader view of the funding and operation of the State's health services so that specific questions about individual health services can perhaps be addressed more meaningfully than in previous years.

I also wish to briefly address a number of general issues that relate to the commission's estimates, which might not otherwise arise. These principally relate to matters of managerial efficiency.

Some Managerial Issues:

South Australia possesses, arguably, the best and most accessible health services in Australia. They are also, arguably, on a par with the best in the world. They are reasonably economic, and they are provided with a minimum of the industrial disputation that bedevils the provision of health services in other States.

The excellence of these services can very largely be attributed to the management system and philosophy that has been developed in South Australia over the past several years. This system is based very largely upon the general premise of 'let the managers manage'.

In the context of the South Australian health system, implementation of this basic management premise has led to the steady evolution of independently managed health services which possess their own boards of management, and the devolution to those boards of powers that were once vested in Government departments. Considerable resources have been put into developing adequate management structures and managers in health units during the past several years. Such health services are responsible for their own day to day management and budgeting, and for a wide range of decision-making in regard to the provision of health services.

In South Australia there are now more than 200 separate health services which are funded by the S.A. Health Commission, ranging from complex organisations such as the Royal Adelaide Hospital, which is larger than most government departments, to a variety of small rural services in outback areas.

Coordination and oversight of this vast system, which employs well in excess of 20 000 people and spends more than $3 million each working day, is vested in the South Australian Health Commission and its Central Office.

Budgeting:

The commission has for several years made 'global' allocations to health services each year and encouraged health services managements to manage their resources flexibly within such global allocations to meet the changing demands placed upon them, with a minimum of bureaucratic decision-making processes. There is much to suggest that this approach has worked well.

It should be stressed that 'global' allocations do not mean an absence of budgetary control. Health services prepare line budgets on the basis of their global allocations. These budgets are cash-flowed on a monthly basis, and are monitored very closely by Sector Offices whose staff investigate any significant variations.

Health units are also subject to strict Health Commission policies and guidelines which include detailed policies on reporting requirements and accounting and audit procedures.

From time to time, the South Australian Health Commission is criticized in regard to specific incidents such as recent accounting matters at the Lyell McEwin Hospital. I should stress that such incidents are abnormal and occur when managers at various levels do not follow the Commission's stated policies. Such occurrences are normally detected very quickly and corrective actions taken.

It would of course be possible to insist upon a far more detailed set of central controls and approvals, which would go some way towards preventing the occurrence of such incidents. But the disadvantage would be that such detailed controls would also remove the ability of managers to manage. The evidence suggests that the introduction of such controls, while preventing some incidents, would be to the detriment of the overall quality of South Australia's health services.

There are also from time to time suggestions made that it might be preferable for the Commission to be replaced by a government department. I would stress that there is

not a shred of evidence to support the supposition that a government department would operate more effectively, or that such a department might offer some magic panacea which will prevent the occasional incidents of inadequate management practice that occur in any large system. In fact, if anything, the evidence suggests the precise opposite, which was one of the major reasons for the creation of the commission in the first place.

I turn now to the commission's actual estimates.

THE 1984-85 YEAR

(1) The commission's 1984-85 Gross Payments Budget:

The commission's original 1984-85 gross payments budget of $634.4 million was augmented during the year by $20.4 million for award increases, by $2.7 million in State government supplementary allocations, and by $1.6 million in additional Commonwealth funds, to make a 1984-85 gross payments budget of $659.1 million.

In addition, an adjustment to include the gross payments for net-funded agencies within the Health Commission's total figures in order to make them comparable with 1985-86 figures, added an additional $35.1 million to the 1984-85 gross payments. This addition resulted in a total 1984-85 SAHC gross payments budget of $694.2 million.

(2) 1984-85—Outcome of the year:

As I have already reported, the South Australian Health Commission's gross payments in 1984-85 were $5.2 million under budget. This represented a significant achievement by all of the managers in the South Australian health system.

While some of the savings occurred in 'tied lines', such as lower than anticipated workers compensation payments and superannuation contributions, the commission and its associated health units also achieved significant planned savings that allowed it to absorb $1.7 million in the carry-forward costs of 1983-84 new initiatives, as well as contributing to the overall under-budget result.

In addition, the receipts achieved by health units were $7.1 million above budget, and Commonwealth contributions, mainly under the Medicare Agreement, were $5.7 million above budget.

The total impact of these three factors was that the net cost to the South Australian Government of the Health Commission's 1984-85 operations was $17.9 million under the budget estimates, which contributed very significantly to the State's excellent financial situation at the end of 1984-85.

(3) 1984-85—Major Achievements:

South Australia's health units continued to provide in 1984-85, as I mentioned earlier, what are probably the best and most accessible health services in Australia, at a reasonable level of cost.

In budget terms, within each health unit and each sector marginal reallocations of resources were achieved which enabled health units to address new and emerging needs while remaining within budget allocations.

At the macro-level, the South Australian Health Commission was able to achieve re-allocations of resources and new funding to enable significant government initiatives aimed at meeting significant areas of need in 1984-85. These were focussed on the Flinders Medical Centre, the Lyell McEwin Hospital, the intellectually disabled, Aboriginal health services, and pensioners.

These were:

(a) Commissioning of an 8th operating theatre at Flinders Medical Centre—Funding of $285 000 was provided to the Flinders Medical Centre to enable commissioning of the much-needed 8th operating theatre. (Full year cost $484 000).

(b) Commissioning Ward 5B at Flinders Medical Centre—Funding of $380 000 was provided to the Flinders Medical Centre to enable the commissioning of 16 new surgical beds in Ward 5B. (Full year cost $767 000).

(c) Commissioning the Anorexia Nervosa Unit at Flinders Medical Centre—$47 000 was provided to the Flinders Medical Centre to enable an Anorexia Nervosa Unit to be established. (Full year cost $104 000.)

(d) Development of the Pain Clinic at Flinders Medical Centre—$105 000 was provided to the Flinders Medical Centre to enable development of the pain clinic. (Full year cost $323 000).

(e) Upgrading of accident and emergency services at the Lyell McEwin Hospital. Additional funding of $225 000 was provided for increased staffing of the Lyell McEwin Hospital's accident and emergency services. (Full year cost $480 000).

(f) Lyell McEwin Hospital—Additional staffing. Additional funding of $277 000 was provided for additional non-nursing ward staff at the Lyell McEwin Hospital. (Full year cost $369 000).

(g) Community based accommodation for the intellectually disabled. New funds of $400 000 were provided to the Intellectually Disabled Services Council to assist in providing community housing, particularly for over 30 year olds. (Full year cost $400 000).

(h) Expansion of dental services for pensioners. Additional funding of $250 000 was provided to expand public dental services for adult pensioners and unemployed persons. (Full year cost $500 000).

(i) Aboriginal Health Services—Expansion—$234 000 in additional funds was provided to enable the establishment of the Pika Wiya Health Service in Port Augusta. (Full year cost $300 000).

Additional funds of $22 000 (full year cost $90 000) were also provided to employ staff to work with the Aboriginal Community in Port Augusta in tackling the alcohol problem, $22 000 (full year cost $132 000) was allocated to enable the appointment of appointing Aboriginal liaison officers to hospitals serving significant Aboriginal populations and a further $75 000 (full year cost $75 000) for dental services for Aboriginals in the extreme north west of South Australia.

(4) The Commission's 1984-85 Capital Works Program:

The principal projects in 1984-85 were—

	SAHC Approved Estimated Cost $'000	Payments 1984-85 $'000
Glenside Hospital Organic Dementia & Infirmary	5 100	3 164
Noarlunga Health Village	3 450	1 952
Lyell McEwin Hospital major redevelopment	13 720	1 536
Flinders Medical Centre CAT Scanner	1 300	991
Independent Living Centre Accommodation Facility	365	365
Queen Elizabeth Hospital Monitoring Equipment	397	307
Wallaroo Hospital Redevelopment	8 238	290
Renmark Hospital Kitchen Upgrade	465	277
Royal Adelaide Hospital Linear Accelerator	1 655	273
Western Regional Rehabilitation Service Hydro Therapy Pool	296	271
Port Augusta Hospital Brickwork Rectification	290	269

The 1984-85 capital works programme was $3 million underspent which mainly resulted from—

Noarlunga Health Village—$928 000

Slippages on this project resulted from: Mechanical engineering contractor going into liquidation; Delays in delivery of building materials; and strikes by builders and labourers employees.

Provision for Central Linen Service—$950 000

Approval for the commencment of work on this project had not been finalised by the end of the 1984-85 financial year. Funding has been carried over into 1985-86.

Provision for Asbestos Removal—$425 000

Progress on this project was slower than originally anticipated. Funding has been carried over into 1985-86.

THE 1985-86 YEAR

(1) 1985-86 Gross Payments Budget:

The Commission's initial gross payments budget for 1985-86 is $736.1 million which is an increase of $82.1 million or 12.6 per cent on last year's actual gross payments.

The increased funding includes provision for

1. the full-year effects of award increases ($15.5 million)
2. inflation ($10.4 million)
3. increased workers compensation, superannuation and insurance costs ($5.9 million)
4. transfer of Magill Home from D.C.W. ($1.8 million)
5. Spastic Centre Grant ($0.7 million)
6. Carryover cost of 1984-85 new intiatives ($1.7 million)
7. Under expenditure on items in 1984-85 for which carryover funds were provided in 1985-86 ($1.7 million)
8. Reporting deficit funded health services in gross terms rather than net ($36.6 million)
9. 1985-86 New Initiatives funding ($7 million).

(6) 1985-86—New Initiatives:

The funds provided by the government ($7 million) together with the reallocation of resources by the Commission will enable the government to expand some programs and to undertake a number of urgently needed initiatives to maintain the high quality of South Australia's health services.

Proposed developments in 1985-86 are:	$'000
The 'Second Story'	320
Drug Prevention Education Programs	2 400
Nurse Education—Re-Training	337
A.I.D.S.	955
Rehabilitation of Brain Injured Fast Stream Unit	200
Noarlunga Health Village	1 400
Prison Clinical Services	549
Yatala Infirmary	300
Child and Adolescent Mental Health Services	180
Queen Elizabeth—Sexual Assault Referral Centre	171
Implementation of Recommendations—Migrant Health Task Force	145
Q.E.H.—Second Satellite Dialysis Unit	112
Community Services—expansion of Domiciliary Care Services:	
Eastern	45
Southern	256
Western	270
Paramedical Aides	55
Creation of 3 new trainee Psychiatry Positions	60
Aboriginal Health:	
Establishment of a Health Service at Ceduna/Koonibba	233
Administrative Trainee and Scholarship Scheme	50
Health Co-ordinator—Ceduna/Yalata (6 month contract)	35
Equal Employment Opportunity and Affirmative Action Program	43
Anorexia Nervosa	60
Geriatric Assessment Unit	145
Establishment of Directorship of Cranio-Facial Research at A.C.H.	64
Commissioning of eight medical beds at F.M.C.	200
	8 585

(7) 1985-86 Capital Works Program:

Proposed capital expenditure for the 1985-86 financial year is $31.7 million, which represents an increase of 99.4 per cent on the 1984-85 actual expenditure of $15.9 million.

The new major capital works to be funded in 1985-86 relate to:

- Stage 1 of the redevelopment of the Mount Gambier Hospital including replacement of boilers;
- Redevelopment of the maternity wing at The Queen Elizabeth Hospital;
- 'The Second Story', an adolescent health centre in Rundle Mall;
- Construction of the Port Adelaide Community Health Centre;
- Redevelopment of Wallaroo Hospital;
- Replacement of equipment at the Central Linen Service;
- Child-care facilitites at the Queen Elizabeth Hospital and Flinders Medical Centre;
- Redevelopment of the outpatient and casualty facilities at Modbury Hospital; and
- Establishment of the Pain Management Unit at Flinders Medical Centre.

This list represents the Government's major funding commitments to capital works for the health system for 1985-86. However, this should not be seen as the limit to this Government's commitment to the redevelopment and refurbishing of major health facilities. Detailed planning on a number of major projects is either completed or in progress, and a number of projects are already before the Public Works Standing Committee. The next five years and beyond, will see major development at the Modbury Hospital, Mount Gambier Hospital, stage 4 of the Adelaide Childrens Hospital, Berri Hospital (to provide regional specialist services in the Riverland), Whyalla, Mount Barker and Lyell McEwin Hospitals, the refurbishment of the Queen Victoria Hospital, the provision of additional priority facilities at Flinders Medical Centre, and the construction of the twin hospital complex at Noarlunga. The development of strategy plans for the redevelopment of the Queen Elizabeth Hospital and the Royal Adelaide Hospital is also being undertaken.

These 11 projects alone will represent an estimated expenditure in the order of 100 million dollars at current prices, and it is clear that the Commission must maintain a substantial capital programme in the years to come. The Government recognises that planned development for the health system must be adequately funded. In this context, the Premier has authorised the development of a 5-year rolling forward capital works programme for the Health Commission and the consideration of strategic issues beyond the initial 5-year horizon.

Minister of Health Miscellaneous, $533 423 000

Witness:

The Hon. J.R. Cornwall, Minister of Health.

Departmental Advisers:

Dr D.R. Filby, Acting Director, Policy and Projects.

Professor G.R. Andrews, Chairman and Chief Executive Officer, South Australian Health Commission.

Dr M. Court, Secretary, South Australian Health Commission.

Mr D. Coombe, Executive Director, Western Sector.

Mr R.J. Sayers, Executive Director, Southern Sector.

Mr. D. McCullough, Acting Executive Director, Central Sector.

The CHAIRMAN: I declare the proposed expenditure open for examination.

Mr BECKER: How does the Minister see the future role of the Health Commission? Do you propose to make any changes to its role? I understand that in New South Wales the Health Commission has been abolished and replaced by a Health Department.

The Hon. J.R. Cornwall: We do not intend to follow New South Wales, I am pleased to say. The Commission has worked rather well. I think that it is fair to say that we have learned a good deal in the almost eight years that the Health Comission has been established.

We have learned, for example, as I have said from the outset since I have been Minister of Health, that the so-called autonomy of the individual health units is not something that should or can be taken literally and that there should be some fairly firm lines of accountability. I am also aware that that would be resisted to some extent within the health units, but we are talking about public funding and about a budget in 1985-86 in excess of $750 million.

So, I intend in my second term as Health Minister that the legislation, in particular, under which the commission is established will be completely reviewed by Mr Ian Bidmeade, in consultation with the appropriate people in the commission and, where appropriate, outside the commission. In general terms, the commission has worked well in South Australia. Individually, our hospitals and health units are in significantly better shape than are those anywhere else in this country.

Mr BECKER: I understand that you have made statements that the Health Commission budget came in about $5 million under estimate last financial year. How was this achieved, and where?

The Hon. J.R. Cornwall: I refer to the third page of the ministerial statement that I have circulated. Item (2), under '1984-85—Outcome of the Year', states:

> The SA Health Commission's gross payments in 1984-85 were $5.2 million under budget. This represented a significant achievement by all of the managers in the South Australian health system. While some of the savings occurred in 'tied lines', such as lower than anticipated workers compensation payments and superannuation contributions, the commission and its associated health units also achieved significant planned savings that allowed it to absorb $1.7 million in the carry-forward costs of 1983-84 new initiatives, as well as contributing to the overall under-budget result.
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> In addition, the receipts achieved by health units were $7.1 million above budget, and Commonwealth contributions, mainly under the Medicare agreement, were $5.7 million above budget. The total impact of these three factors was that the net costs to the SA Government of the Health Commission's 1984-85 operations was $17.9 million under the budget estimates, which contributed very significantly to the State's excellent financial situation at the end of 1984-85.

Mr BECKER: What has happended to the money from those savings? Was any money saved in cash terms and, if so, where is it now located?

The Hon. J.R. Cornwall: The Treasury takes a very keen interest in the affairs of the Health Commission; in fact, all of the central agencies do. There is no secret—we do not have it hidden in any hollow logs, I can assure you. In terms of the details of that money, the Secretary of the commission could probably respond better than I.

Dr Court: The bulk of the savings is in a carry forward item which is shown in the supporting statement within the blue book; some $3 million was retained in the commission's trust account at the end of the year. Of course, that is taken advantage of by Treasury in making their allocation to us this year.

Mr BECKER: You do not think you have got it for this budget?

Dr Court: No, we do not get any credit in terms of having the money given to us to spend; it is returned to Treasury.

Mr HAMILTON: Under 'Coordination and planning for health services' it is mentioned that a number of role and function studies were undertaken; could the Minister outline the outcome of the role and function study in the Queen Elizabeth Hospital? Indeed, what is the future of the Queen Elizabeth Hospital?

The Hon. J.R. Cornwall: I can probably do that without prompting but, if I forget anything, then I am sure the Committee will forgive me if I have to refer to copious notes. The Queen Elizabeth Hospital was a matter of considerable controversy and contention on this very day last year, the day of the Budget Estimates Committee. As Minister of Health, I was the witness before the Committee on the first Wednesday, which happened to be the day that Messenger papers appear on our lawns, and quite coincidentally there was a statement made by a group of people from the Queen Elizabeth Hospital complaining rather bitterly that they had been poorly treated in negotiations for the 1984-85 budget. The fact was that the financial management and the general administration at the Queen Elizabeth Hospital at that time left something to be desired.

There was also ongoing unrest, which had been created by the impending retirement of Prof. Lloyd Cox, Professor of Obstetrics and Gynaecology. There had been a very strong suggestion from the University of Adelaide Medical School, in particular, that it might be appropriate to relocate the chair of obstetrics and gynaecology at the Royal Adelaide Hospital. Of course, that would probably have led to a significant downgrading in the hospital's role as a major teaching hospital. There had also been the metropolitan Adelaide hospitals planning framework produced by the Health Commission in 1982, which talked about reducing the Queen Elizabeth Hospital to 500 beds. There was real fear at the Queen Elizabeth Hospital that, if all these things came together, they would lose their teaching hospital status and would ultimately finish up having a no more significant role than that of a large community hospital.

The Queen Elizabeth Hospital has always had a role as a large community hospital serving all of the people of the western suburbs, and it has in its catchment area a potential population of 300 000 people.

Therefore, we established a role and function study, which has only very recently been released. The study recommends that the hospital retain all of its current major activities and that there should be additions in areas including paediatrics, adolescent health and geratology. Without boring the Committee with all the fine details, they are available in an executive summary put out by the team that did the role and function study; that has been endorsed by the Joint Union Council, the Medical Staff Society, the hospital board and the Health Commission. It seems to me there has been

a very happy ending to what could have been an unhappy saga. We have appointed an industrial relations officer who, with the cooperation of everybody at the hospital, is implementing a major industrial democracy program.

We are also about to complete a study looking at nursing levels. There has been a great deal of activity, and it is one story that has a very happy ending indeed. As a result of that, I think that morale at the hospital has been restored to being as high as any in the State. The future role of the Queen Elizabeth Hospital, both in serving the very large community of the western suburbs and as a major teaching hospital affiliated with the University of Adelaide Medical School, is now assured.

I am also very happy to report that this year the hospital came in smack on budget (I think it may have been $300 over or under in a $70 million budget). The Queen Elizabeth Hospital has been turned around, for which I must say that I claim little credit. The professional officers of the Health Commission have done a superb job, as have all the other people involved.

Mr HAMILTON: I refer to the aged and disabled on page 24 of the yellow book. One objective of the South Australian Health Commission for 1984-85 was to bring into clear focus issues relating to the care of the aged and the disabled. What steps have been taken to meet this objective in relation to services mainly for the aged and disabled? Can the Minister elaborate on the orthopaedic exercise pool at the Western Regional Rehabilitation Centre?

The Hon. J.R. Cornwall: I am not surprised that the member for Albert Park did not take long to ask a question about 'his' orthopaedic exercise pool. I understand that the member for Albert Park claims some credit for the fact that we were able to allocate capital funds for that pool last year. I am happy to say that it has now been completed. There will be a simple but moving ceremony in the very near future involving the member for Albert Park and me. Whether we will do that in our swimming togs is yet to be determined. It is an excellent facility—a 25 metre indoor heated pool.

It is not just a hydrotherapy pool in the conventional sense, the type usually associated with hospitals and other health facilities: it is quite a major pool, and it is being very well utilised by many people and groups in the western suburbs. With regard to the other initiatives in aged care, I think it would be wise of me to ask Professor Andrews to give a pen portrait of the fairly large number of initiatives that have been undertaken during the past 12 months in particular and during the first term of the Government in general. Professor Andrews is a specialist geratologist, so I think that it would be far more appropriate for him to answer the other parts of the question.

Prof. Andrews: Perhaps the most significant event over the past 12 months was the establishment of a policy and planning unit under the auspices of the Health Commission, known as the Ageing Project. This became possible as a result of federal moneys made available particularly to improve assessment programs in relation to aged care—assessment being a key issue in ensuring that the aged are provided with services appropriate to their needs and that services are most effectively and efficiently utilised.

A number of other States took up the assessment money to increase resources in the field and employ additional nurses and social workers and the like; in general terms, South Australia is well ahead of the other States in the actual provision of those services on the ground. We took the line that it was more appropriate to look at the process of assessment, improve it and develop a model for assessment which would be used uniformly right across our aged care, geriatric and domiciliary care services.

Substantial progress has been made in the development of that model, and I believe that it will be adopted Australia wide in due course. A number of other key projects in relation to improvement of aged care services have been tackled by the Ageing Project, including looking at accommodation and staff needs for aged care services and policies in domiciliary care.

It has provided us with a mechanism for bringing together the bureaucrats, the professionals in the field, the main agencies, other Government departments and indeed representatives of the aged themselves, so we can work towards the achievement of a comprehensive set of programs in this State. Significant improvements have been made in domiciliary care services and the provision of those services, and we expect those improvements will continue particularly in this coming year as a result of the implementation of the HACC program, the Home and Community Care program, which has been funded initially by the Commonwealth Government and will continue on a cost share basis. That will allow greater emphasis to be given to the provision of services to the aged in their own homes rather than depending on an institutional approach.

At the same time we have given greater emphasis to the development of acute specialist geriatric units within the hospital system and the Minister's reference to the Queen Elizabeth Hospital is particularly pertinent because that is one of the things that the role and function study recognised as an important area of development in the QEH. Last year a geriatric assessment unit was established and we see that being further developed in the coming years. So, in general terms, I believe that the health system has come to grips with the fact that the aged represent an increasing area of need in health care delivery. Both in the hospital system and in community care services, there has been a very appropriate response to that need. That does not mean to say that there is not a great deal more to be done. We see the ageing project as having an increasingly important role in identifying future areas of need and in proposing strategies for the hospital system, domiciliary care services and community care services to respond to those needs.

The Hon. J.R. Cornwall: I might add to that (and this appears at the appropriate page in the document) that in 1985-86, apart from the home and community care contribution, which will be close to $4 million, the Government, via the Health Commission, has provided additional funding which on a full year cost basis will be about $750 000 for the metropolitan domiciliary care services. For example, the southern domiciliary care service is one of the best services in the State but it is clearly acknowledged (and has been on many occasions) to be under-resourced, so there will be a very significant addition of almost $300 000 to southern domiciliary care. This is in line, of course, with the whole thrust of trying to keep people in their own homes, their own environments and in their own communities for as long as it is reasonably appropriate to do so.

Mr HAMILTON: The Minister has beaten me to the gun a bit because I was going to ask a question on what new measures are planned to provide for the frail aged and disabled, under the provision for home and community care. However, perhaps the Minister could elaborate on the expansion of services to be provided by the Royal District Nursing Society and also the allocation of moneys and assistance to dementia persons in our community. A group at Acacia Court, within my electorate of Albert Park, has had meetings on this very important subject of dementia. As I understand it, it is no respecter of age: it can affect people from all walks of life. What assistance has and will be provided to these people in the forthcoming budget?

The Hon. J.R. Cornwall: One person in every 20 over the age of 65 years and one person in every five over the

age of 80 years can expect to be a victim of dementia. Therefore, there is a very substantial increase as the population ages. Dementia is also recorded in people in their forties and fifties, in which case it is even more distressing. I will ask Professor Andrews to elaborate on that in terms of what is actually happening with service and institutional provision, and so forth.

Specifically with regard to the Royal District Nursing Service, there has been a major expansion and there is a further major expansion planned. The best person to explain that to the Committee would be Mr Ray Sayers, who is the Executive Director of the southern sector, and who is the person in the Commission responsible for the funding and dealings with RDNS.

Mr Sayers: The Royal District Nursing Service has been expanded in the metropolitan area to provide a coverage from 9 p.m. to 11 p.m. We are currently investigating the implementation of a pilot program which takes a coverage of the service from 11 p.m. to 7 a.m.—that is, a 24-hour coverage. This is particularly in relation to the hospice and palliative care aspects of district nursing. Within six months I would hope that the service will, for the first time, be a 24-hour service in the metropolitan area.

In addition, we have undertaken a lot of work in relation to the interface between the Royal District Nursing Service and other domiciliary services in the State. In that regard we have upgraded the physical facilities of RDNS and have located them with the three main domiciliary care services in metropolitan Adelaide. We have instigated a project that is working towards a common patient data base referral system and information system to enable us to incorporate RDNS in the overall domiciliary care services, as part of the service as opposed to a separate body. It will still remain separate, of course, but be totally integrated with the domiciliary care services.

The Hon. J.R. Cornwall: I think that Professor Andrews should cover the dementia point briefly. I know that this matter is of particular concern and interest to the member for Albert Park. He has a very active Director of Nursing in his electorate, whom I have met. This person is a champion of the cause. I will ask Professor Andrews to, as concisely as he reasonably can, tell us the current situation with regard to dementia care in both institutional and non-institutional situations.

Prof. Andrews: A number of points made in relation to age care generally could be related to this area. As the Minister said, it is one of the biggest challenges that will face health care in the future, given the proportion of people who will suffer from this disorder and given the demographic changes we expect, particularly in South Australia. The ageing project I referred to earlier has brought together the geriatric assessment units and the psychogeriatric services of this State so that a more coordinated approach can be adopted in the assessment and care of these people. That is very important because dementia is not wholly a physical or a mental problem: it is often a combination. It is most important that professionals work together in assessment, management and care of these people.

We now have a paper produced by the working party set up by TAP that proposes a coordinated approach integrating the services that are presently being provided by our psychiatric hospitals with those being provided in the acute geriatric assessment units I referred to. In addition, these people will increasingly put demands on domiciliary services. We believe that some of the resources applied to the HACC program and to the community care programs should be directed to their needs. We specifically sought, with the Commonwealth, that services to that group be approved as one of the service areas that can be funded under the HACC programs, as that was originally unclear.

We have achieved that in the contract that was finally signed. The other important area with regard to dementia is the needs of families and relatives of these people. You may know of Alzheimers Disease and Related Disorders Society (ADARDS). We have worked closely with ADARDS, which has received some assistance from the Minister in its work in promoting greater community understanding and knowledge of this otherwise very distressing disease.

A publication was produced about 18 months ago by the commission on the topic for general community consumption and information, and it has now been translated into several languages. It has been a well received publication in terms of community information.

The Hon. J.R. Cornwall: I am the HACC Minister. That area extends across a number of portfolios, including community welfare and local government, and is coordinated at Cabinet level through the Human Services Sub-Committee of Cabinet. I have the responsibility to deal directly with Senator Don Grimes, federal Minister of Community Services.

Mr BECKER: In paragraph (2) of the Minister's opening statement under 'Outcome of the year' he states:

> While some of the savings occurred in 'tied lines', such as lower than anticipated workers compensation payments . . .

Can the Minister say how this was achieved? How much is the commission required to pay in regard to workers compensation, and how is that amount arrived at?

The Hon. J. R. Cornwall: As Dr Court is the key figure in our workers compensation arrangements, I ask him to inform the Committee about that.

Dr Court: As to how much the commission is required to pay for workers compensation, the specific figures are as follows: 1983—$1.1 million; 1984—$5.3 million; and 1985—$7.7million. In future we expect larger payments, reflecting the general experience of workers compensation arrangements both in the public and private sectors.

Mr BECKER: What is the budgeted amount for 1985, and what has been the reason for such a large increase from 1983 to 1984 and to 1985?

The Hon. J.R. Cornwall: There are two reasons for the large increase. Obviously, there have been more claims to be met, but we are running on an actual cost basis so that there is no putting off the evil day, so to speak. Dr Court can explain in far more depth than I can.

Dr Court: The workers compensation arrangement that the commission has with the SGIC, and the amounts paid into what is a self-funding pool each year, are agreed between Treasury, SGIC, and the commission, so it is virtually impossible for us to be overfunded or underfunded within the workers compensation funding arrangement. This is why it is referred to as a 'tied line'. If we do during the year contribute less to the self-funding arrangement, the money is returned to Treasury. Does that answer your question?

Mr BECKER: This is a difficult matter. I am not against workers compensation, but it seems to me that there could be savings in this area. I am trying to find out how you base your premiums to SGIC. I want, also, to know whether those premiums are being kept at a low rate this year because of future claims. As I understand, with workers compensation about 60 per cent of claims are met within the first 12 months: the larger claims are deferred from two to four years. I was wondering whether the system being adopted means that large amounts of money are being deferred, or whether you have picked that up because of the large jump between 1983 and 1984.

The Hon. J.R. Cornwall: We are not deferring anything. The scheme is referred to, among other things, as 'burning costs'. I am not sure that I have understood it fully, so I take this opportunity to have Dr Court explain it to the Minister as well as to the Committee.

Dr Court: It is complex. I will attempt to explain the financial arrangements. First, the Committee needs to understand that the commission picked up responsibility for workers compensation payments from the previous Government arrangements in 1981-82. The commission is still contributing money to meet claims stemming from prior to that period. In the period prior to 1981-82 there were no provisions made for the cost of claims being settled in subsequent years. The dollars we pay and to which the Minister referred as 'burning costs' are an assessed figure that we pay each year towards providing funding for those costs coming from years previous to 1981-82.

Since 1982-83 the commission's arrangements with SGIC and Treasury have been on the basis that we will make four payments for workers compensation for the claims occurring in any single financial year, so that, for instance, in 1982-83 we paid an amount of money to SGIC estimated to cover claims arising and settled in that year. As has been mentioned, a large number of small claims are settled during the year in which they occur, and a lot of larger ones are deferred.

In the second year, which would be 1983-84, the commission made a contribution to the workers compensation funding on the basis of an assessment provided by SGIC of what claims will be paid in the second year but which occurred in the first year. We do the same in year 3. In year 4 we make a final payment to SGIC, which is the only part of what we pay that has an insurance component in it. The agreement with SGIC at this point is that any further claims that arise from the policy year 1982-83 will be covered by insurance arrangements.

For three years we pay amounts of money estimated by SGIC as being necessary to meet workers compensation settlements. In the fourth year we make a final payment. That means that in any one year they actually include components of payments towards pre 1981-82 settlements, a proportion still being paid for 1982-83, a proportion still being paid for 1983-84, and an initial payment for 1984-85. So far we have little knowledge of what claims will arise out of 1984-85. I am sorry if that is rather long and complex: it is easier to explain on paper or a blackboard. However, that is the system.

Mr BECKER: There is part of the question not answered. What was the budgeted amount for the last financial year because a claim has been made that there was a saving? How did you work out that budget amount, and how much did you save?

Dr Court: The budget figure was about $9.3 million and the amount handed back to Treasury from that was $1.6 million, in round figures.

Ms LENEHAN: My first question relates to women's health. As the Committee is no doubt aware, for a long time women's health issues have been largely ignored. I know that the Minister has given women's health special attention and has redressed this imbalance in quite a remarkable fashion in the past three years. I think that it is important for the public record that I ask the Minister what measures have been taken to ensure that access to appropriate health services has been provided for the women of South Australia?

Additional Departmental Advisers:

Dr C.C. Baker, Acting Executive Director, Public Health Service, South Australian Health Commission.

Ms Elizabeth Furler, Women's Adviser, Health.

Mr R.J. Exelby, Acting Director, Finance and Accounting Services.

Mr R.H. Blight, Executive Director, Management Services

Dr B.J. Kearney, Part-time Commissioner.

Mrs M. Menadue, Chief Administrative Officer, Minister of Health's office.

The Hon. J.R. Cornwall: It is appropriate that at this time Ms Elizabeth Furler joins us at the table. She is the Women's Adviser, Health, the first such women's health adviser appointed in this country. I put on public record that I think she has performed her duties with great distinction. I am pleased to say I chose her personally, and take a bit of credit for that.

To be as brief as I can, because we have done a lot of things in women's health in the past three years, the first thing was to appoint Ms Furler. We then moved fairly rapidly to expand women's community health services. The Adelaide Women's Health Centre, which was supported by my predecessor the member for Coles, and supported quite appropriately, was already in place and there had been something of a learning process in the establishment of that first women's community health centre.

We were able to provide them with a permanent and rather more salubrious home in North Adelaide at an all-up cost of around $500 000. We then set out to establish women's health centres based on documented needs in the suburban areas of Adelaide. We have, as a matter of very deliberate policy, insisted basically on two things: first, that the women's health centres are available to provide services to all females who wish to use them, whether they be 12, 85, or whatever, and despite their origins, background, or anything else. There has been an absolute insistence, as a matter of policy, that they provide services right across the board in terms of age groups.

The other thing on which we have insisted is that they do not provide parallel services. We have been careful to document the needs in advance and then provide the services lacking in other mainstream health services. It is because of that that I think they have been extremely successful and extremely well received. We have established a consultative committee on women and health, and devised and adopted a very comprehensive policy on women and health that covers women not only as users of health services but also as a very significant component of the work force in the health area: women comprise about 75 per cent of the total health work force of around 20 000, so they are significant contributors to the provision of services.

We have also begun to implement an equal opportunity policy, which has been formally adopted by the commission. At this time, we are conducting a very comprehensive survey of the needs of women in the Iron Triangle—Port Pirie, Port Augusta and Whyalla. I hope that when that is completed we will be able to move reasonably quickly to establish whatever is the appropriate range of services in that area. It may not even be a women's health centre because there is difficulty in having concentrations of population in such a way that one can have a fixed women's health centre. I do not pretend to know what might be appropriate for that area, nor does anybody else at this stage, but we have an ambitious CEP funded project taking place there at the moment.

The Women's Health Adviser, in particular, and other women's advisers have assisted in establishing a women's network in the South-East so that the needs of the Lower South-East, in particular, are being documented at this time, and services will follow. We are also at this moment looking at the Riverland. They are some of the things that we are doing: for the first time, we are moving into country areas. We sponsored the national conference on women's health for the end of the Decade of Women, which was held last month: Liz Furler convened and chaired that. It was a very great success: in excess of 700 women attended, about 10

per cent of whom were Aboriginal women from all around the country.

We have a project officer in Aboriginal women's health who commenced work in June this year on a nine-month project in the Women's Health Adviser's office. We funded the rape crisis office initially, and subsequently established a task force on child sexual abuse, which reports on a quarterly basis to the human services subcommittee of Cabinet and is already well down the track with its work and will report finally at the end of next year. We want to be sure that we get that right. It is an enormously distressing and very vexed area. A balance has to be struck between the criminal law—it certainly is the opinion of the task force in the discussion paper recently circulated that child sexual abuse should remain within the criminal law—and being very careful (in having the potential to break up families) that we do not victimise the victims: the interests of the child must always be paramount.

Hospital based child-care services have been provided at the Royal Adelaide Hospital, and currently the capital works necessary for child-care are going on at the Queen Elizabeth Hospital, the Flinders Medical Centre and Glenside, among others. There is a very ambitious commitment to hospital based child-care. That is not completely altruistic: it certainly has advantages in terms of a political statement, but it is also very important from a practical point of view. If we are to attract enough nurses back into the work force to meet the current shortfall, child-care is a fact of life. Whatever philosophy one bases it on, at the end of the day pragmatism demands that we have it. We are very actively involved there. They are some of the things, but it is by no means an exhaustive catalogue.

Ms Furler: There is very little that I wish to add. The Minister has talked about a policy on women and health. There is a consultative committee on women and health, which is in the process of a series of major consultations with women in South Australia. In the past six months three seminars have been held in country areas as well as seminars in the metropolitan area of Adelaide. This will continue for the next eight months, at least, in South Australia, culminating in a report to the Minister and to the Chairman of the commission, on the opinion and perspectives of women in South Australia on health and service provision issues.

Ms LENEHAN: I thank the Minister for the reply. I am one of the local members who has been a recipient of a women's health centre, namely, the Southern Women's Community Health Centre, and I am also one of the users of that centre. I now pick up an issue that is of concern to me in my area. I am, as I said, aware of the tremendous services that are provided by the Southern Women's Community Health Centre. I am also aware of the fact that it is imminently about to move into the Health Village and provide a presence there, but at the same time maintain an independent presence within the southern community. I am also aware of the tremendous demand for its services and the fact that, as the Minister correctly pointed out, there is no overlap in terms of the services provided by the women's health centre in the south and the provision of other health services within the southern community.

Therefore, is consideration being given to bringing the funding level and the allocation of staffing up to the levels provided by other women's health centres in South Australia? I draw the attention of the Minister to some statistics. I understand that currently the Southern Women's Community Health Centre operates on an allocation of 4.8 full-time equivalent positions, of which about .2 is a domestic position. Other health centres are now operating with approximately eight full-time equivalents. As a local member I would like to see a successful resolution of that consideration for the provision of adequate staffing—that would be in the area of approximately eight full-time equivalents so that the excellent work of the women's southern health centre can continue and can meet the ever growing demands that are being placed on it for services in the southern community.

The Hon. J.R. Cornwall: I omitted to mention the three additional services and where they had been established, so anxious was I to keep my reply brief because I can hear people on my right talking filibuster even at this moment. I have bent over backwards to try to keep not only my answers but everybody else's as brief as possible.

Mr Becker interjecting:

The Hon. J.R. Cornwall: I cannot control the members on either side, but I am sure that the Chairman can, and he is doing an excellent job.

The CHAIRMAN: Order! Will the Minister answer the questions and ignore the interjections, which are totally out of order.

The Hon. J.R. Cornwall: I will be delighted to do that. I have no difficulty in treating the members on my right and ignoring them. The fact is that we established women's community health centres at Elizabeth, Dale Street in Port Adelaide, and, as the member for Mawson knows, at Christies Beach/Noarlunga. We have been very careful not to be profligate in any way with the funding of them. There is a conservative school of thought that believes that women's health centres are some sort of self-indulgence; that school of thought does not begin to understand the philosophy and policies underlying the provision of comprehensive health services.

We have certainly had correspondence from one or two misguided individuals who have very much inflated the amount of funding involved and claim that there was not real value for money. I assure everybody in this Committee that we have been very prudent and careful to ensure that there is good financial management and that we get for the consumers the very best value possible for that portion of the health dollar. I understand that there may be a specific problem in the budget allocation in 1985-86 for the Southern Women's Community Health Centre. I ask Mr Ray Sayers to respond specifically to that, since it comes under his immediate supervision.

Mr Sayers: In relation to the Southern Women's Community Health Centre, a recent review of the fund allocation resulted in one additional position being given to the centre in this financial year, taking the total staffing to 5.8 full-time equivalents. An additional $4 000 has also been allocated to the service. At the same time a commitment was given to bring the service in the Southern Women's Health Centre up to the staffing and funding levels of the other two services in metropolitan Adelaide. A review of the fund allocation will be made in February next year. Therefore, there has been some expansion of that service since the figures have been given to you.

Ms LENEHAN: I have another question on health centres, so I will be pursuing that matter with the Minister at a later date. My third question also relates to proposed women's health centres. I was delighted to hear the Minister say that a network of women has been established in country areas. My particular concern is with the South-East and, as the Minister said in answer to my earlier question, the needs of women in country areas are being addressed.

I would like to have on the public record the fact that I have been approached, and I know that there has been a lot of discussion with a range of women in the South-East, for the provision of a women's community health centre, possibly centred at Mount Gambier. How far down the track have those investigations proceeded? Could the Minister give the Committee his thoughts on this request made

from the South-East for a women's health centre to provide the services that are needed in that area?

The Hon. J.R. Cornwall: I do not know how relevant my personal thoughts are on these matters. I have made it very clear that we want to know, and we want documented, what the unmet needs of the women in the South-East are. A strong networking arrangement has been established enthusiastically by a very representative group of women in the South-East. It certainly was not a case of finding a particular age group or a particular minority group and having them try and whip up some enthusiasm. There was almost a spontaneous coming together of a very wide and representative range of women from the Mount Gambier, Millicent and Naracoorte communities. However, I do not believe we are yet at the point where we could say that there should or could be a women's community health centre. Again, you come back to the problem of the size of the population in terms of providing static or even sessional services. We will proceed with due caution in this particular area. However, there has been a lot of work done and I think that the needs are starting to be defined.

I met with the representatives of the women's network when I was in Mount Gambier last Thursday. I have asked them to at least prepare a preliminary submission, based on the work that has been done to date. I hope that that will be in hand in the very near future. I repeat that it is not my intention to get into any knee jerk reaction or pre-election political gimmick; that is something I never do. I would ask Ms Furler to comment on the women's network in the South-East, because she has been instrumental in assisting them to get going.

Ms Furler: The women's network approached the Office of the Women's Adviser in the Health Commission almost a year ago to discuss the possibility of a health centre for women living in the south-eastern part of this State. After discussions with the Minister and other people in the commission, the position of the office has always been that until we have a clear picture of what women's health needs are in the South-East, and a fairly clear understanding of how existing services and current arrangements meet those needs or fail to meet those needs, then we are not in a position to look at the establishment of a women's community health centre for that area.

Up until now activity has focused around organising women in the South-East, in discussion with providers of health services in that local area, into a group that can facilitate that process of an examination of need. In the Iron Triangle local women and health service providers have organised together to make application for CEP funds to examine the health needs of women living in the area and current services. I think we are looking at the same sort of model for the South-East.

Mr BECKER: I do not want to dwell on the workers compensation point but because o the impact it has had on the Minister's budget last year, could he provide the Committee with some statistical information in relation to the number of claims made last year for workers compensation and the estimated amount of those claims? Can the Minister provide us with any information relating to the previous three years, so that we can get some comparison? Also, what is the cost?

The Hon. J.R. Cornwall: There has been a detailed study done of the incidence and the statistics of injury by a firm of private consultants. I do not believe that we have that available at the moment. I ask Dr Court to take the parts of the question that he can answer immediately and, if necessary, we will refer it and bring back further detail.

Dr Court: The workers compensation issue has been a great concern to commission management for some years, and it has been escalating. Three years ago the commission approached Reed Stenhouse, our insurance brokers, and sought help in tackling the issue of reducing the incidence of workers compensation claims in all of our health units. For almost 2½ years we have had a risk management program, which is being carried out by Reed Risk Control, which is a subsidiary of Reed Stenhouse, with consultants coming in from Eastern States. Those consultants are halfway through a five year program and have already carried out analyses of risk factors in major metropolitan hospitals.

Those consultants have produced guidelines and suggestions for management, which are now being considered by management in our major health units; they have also been instrumental in helping Reed Stenhouse to have a very detailed look at all claims over the last several years—the incidence, where they occur, the type of problem, the location and the cause. That report is being considered by the commission's occupational health and safety committee, which was established within the last six months to look at occupational health matters in general in health units. Of course, the workers compensation issue links in very closely to occupational health. It is also a part of the implementation of the Government's code of principles for occupational health across the whole public sector.

Therefore, the commission has identified the problem; it has set up an occupational health and safety committee involving trade union representation; it hired private consultants 2½ years ago, who are now halfway through the program; and it has just started considering a very detailed statistical look at the whole problem. As the Minister said, that report is not with us, but I am sure we can get it. It is like a telephone book and I am not sure what the Minister would like to do with it.

The Hon. J.R. Cornwall: It is more pertinent to ask what the member for Hanson might like to do with it. He has a great mind for facts and figures and pursues these matters very vigorously. I would not have any difficulty in making the report available to the honourable member except to the extent that the consultants might have requested confidentiality.

With that one exemption—which I am sure the honourable member would not find objectionable—I am certainly prepared to provide at least a statistical summary of the report. We have an occupational health and safety branch within the Public Health Division that in many areas is probably the best in Australia. Particularly for repetition strain injury, for example, we have developed a level of staffing and a degree of expertise both in the field and in research programs such as electromyography that make us a leader in this country.

We are also putting individual occupational health and safety programs in individual hospitals so that, for example, Dr Leleu was recently recruited from our occupational health division to a position at the Royal Adelaide Hospital. Dr Baker, the Acting Director of the Public Health Division, will provide some succinct detail about the specific area of occupational health and safety in our hospitals in particular.

Dr Baker: The health system is no different from any other industry: it is a hazardous industry in certain areas and it has to be tackled. The Health Commission is implementing the code of general principles which was launched by the Premier last year. It has established an occupational health and safety advisory committee and is coordinating its policies through the health units. I refer to specific problems within the health industry: first, the nursing profession being the largest number of employees in the health industry they suffer a large number of problems with back injuries from lifting and handling patients; and other operators within the health industry also suffer from back injuries in the ancillary services. There is also a problem with infectious diseases, and there is concern about that.

There is a problem with caring for the sick patients (some of whom are incurably ill) and the stress related problems that that generates.

An unusual aspect of the health industry is the close contact with health professionals. A lot of corridor consultation occurs between an affected individual and a doctor or nurse who may have some knowledge of a particular problem. Therefore, there is poor reporting of injuries and illness acquired due to employment. We wish to establish more effective reporting of those injuries to allow assessment and development of codes and policies to and in prevention.

Dr Leleu's appointment at the Royal Adelaide is interesting. His position is being funded by the SGIC as a result of the large level of workers compensation claims within that hospital. He has support staff of nursing and safety staff to provide him with advice and to assist him in implementing policies within that hospital. One of the high priorities seen by all the health and safety professionals would be the ergonomic problems. Back injuries are predominant not only in the nursing profession but in other professions, and affect other employees within the hospital service.

Mr BECKER: My next question has been answered partly because I was going to ask about the action being taken to reduce the incidence of workers compensation by preventing situations which cause injury to hospital employees or anyone in the health unit. I wanted to know about the occupational health and safety code that has been adopted by the commission. I have been given certain information, which is why I am interested in the statistics—to see how this relates.

From July 1978 to 30 June 1985 I believe that there were about 771 claims totalling $30.4 million. The areas that seemed to cause most concern were as follows: back, 243 claims totalling $11.6 million; the neck, 46 claims totalling $1.4 million; the shoulder, 59 claims totalling $2.4 million; the wrist, 42 claims totalling $1.3 million; the knee, 51 claims totalling $1.6 million, repetitive strain injury, 22 claims totalling $996 000; and then two or more injuries, 69 claims totalling $2.6 million. That adds up to a total of 532 claims. Many other areas are not included in the mainstream of statistics. What really worries me is what we are doing to employees in the health industry when there is such a large number of injuries. Fair enough, we look at the cost—but what damages are we doing to individuals who work in the industry? That cannot really be measured in dollars and cents. That is my great concern in this area.

The Hon. J.R. Cornwall: Given the detailed information that the member for Hanson has, I hardly think he needs access to the Reed Risk Control Report. In fact, I think he may already have it.

Mr Becker interjecting:

The Hon. J.R. Cornwall: As far as I can gather, following the corridor consultation that I just had with Dr Court, that is probably reasonably accurate. It must be seen in the context of figures gathered over a seven-year period so that, on my arithmetic, the 771 claims become 110 per year in an industry which employs in excess of 20 000 people. As I pointed out at the outset, the department has a total budget for 1985-86 in excess of $750 000 000. We really should keep some perspective in this area. Nevertheless, it is a relatively high risk injury profession for the many reasons that have been pointed out by Dr Baker. We are certainly concerned. The incidence of back injury to nurses, for example, is quite unacceptably high. It is not something peculiar to South Australia, but nevertheless it is quite unacceptably high and programs are being actively instituted to try to deal with the problem.

It was specifically because there was a recognition of the problem that this major consultancy was undertaken by Reed Risk Control. It is specifically because we acknowledged there were problems that not only our own occupational health and safety division but also individual hospitals are now upgrading their occupational health and safety programs and procedures. As Dr Baker pointed out, one of the real problems in the past—and this is a practical problem—was that a hospital was full of very skilled personnel and any problems were discussed in the corridor literally in passing and there were very poor statistics in a number of areas. We are getting on top of that, but we still have a fairly long way to go. We are acutely aware of the problem. I would think that the figures are fairly accurate. It is a major problem, but, as I said, please keep it in the context of 771 claims over seven years for a total workforce of about 20 000.

Mr BECKER: On 7 August, the Minister announced that provision had been made for a $10.4 million loan from the State Government Financing Authority at commercial rates. When speaking to the stop work meeting at the Central Linen Service, the Minister said:

> All outstanding borrowings will be consolidated and repaid. Under a capital restructuring program the laundry will operate on fully commercial principles. Provision has been made for a $10.4 million loan from the South Australian Financing Authority to ensure the best utilisation of the laundry's resources. There will be no write off of previous loans to provide unfair commercial advantage or special treatment. $4.9 million will be repaid to Treasury. The remaining $5.5 million will be spent on new machines, conveyor systems and other equipment needed to keep the laundry at the forefront of modern technological development.

The Minister also said that the Central Linen Service management would be required to hold prices to minimum levels and service the Finance Authority loan at commercial rates. Could the Minister please advise the Committee what is the rate of that loan? By the commercial rate does he mean the SAFA borrowing amount, which I believe is 12.9 per cent, or is it the commercial rate that we know in day-to-day operations in the financial market?

The Hon. J.R. Cornwall: I introduce Mr David Coombe who is the Executive Director of the Western Sector, which is responsible for taking an overview of the operations of the Central Linen Service. I would ask Mr Coombe to respond to that question.

Mr Coombe: Could I ask that this question be taken on notice so that I have time to respond to the request adequately?

The ACTING CHAIRMAN (Ms Lenehan): The information is to be supplied by 18 October so that it can be incorporated in *Hansard.* Is the member for Hanson happy with that reply?

Mr BECKER: Yes.

The Hon. J.R. Cornwall: We should be able to obtain that within minutes. We will not hold up the Committee for 2½ weeks before we bring it back. I have an idea that it is around 13 per cent, but at this moment I would like to get it to the nearest decimal point.

Mr HAMILTON: As a follow-up to my previous question, I notice that on page 34 of the yellow book reference to a mobile day care centre being established for the dementing elderly. I was unaware that that was available. How does that system operate? What does 'mobile' mean in terms of service—is it by caravan or ambulance? I was delighted to hear about the child care facilities at the Queen Elizabeth Hospital. That is a very progressive move. What is the likely completion date of that project? It has gained a considerable amount of interest in the local community. Indeed, the Woodville Primary School council has expressed an interest in this facility. Hopefully the Government may be able to see its way clear to expand that so as to take into account the needs of the parents of some children who attend the Woodville Primary School and the younger children who are in need of child care facilities.

The Hon. J.R. Cornwall: The mobile day care was, I think, originally the brainchild of Dr Peter Last and is now up and running. I will ask the Chairman, both in his capacity as Chairman of the Health Commission and gerontologist, to respond to that specifically. In relation to the child care centre at the Queen Elizabeth Hospital, I have been to inspect the site and have a good working knowledge of it, but I think it would be appropriate if Mr Coombe were to respond to that question.

Prof. Andrews: The mobile day care centre established for the many elderly was a pilot project funded through funds available for community health under the Medicare arrangements. The concept is that a small group of personnel are available on a rotating basis to provide activities and day care in a number of locations. At the moment I am not certain of the extent of the service that is being provided on this pilot basis and how many locations it currently operates from, but we will provide that detailed information. It is a very interesting concept and if it is shown to be an effective way of providing these kinds of service, we would explore its extension elsewhere.

Mr Coombe: With respect to child care at the Queen Elizabeth Hospital, as was previously indicated by the Minister in his opening address, this is in the stage of development. The specific concerns of the Woodville Primary School will be addressed by the composite committee based at the Queen Elizabeth Hospital that will be looking at how this centre will be run and where the clients will come from. I understand that the completion date is early next year.

The Hon. J.R. Cornwall: Mr Ray Blight, who has been co-ordinating child care centres, has a little more specific detail on this matter.

Mr Blight: Tenders for the centre have been called and evaluated and we expect an announcement to be made on the successful tenderer in a week or so. The construction period is likely to be about 10 to 12 weeks, so we can expect a completion very early next year. It may run over the Christmas break, which may cause some delays, but it will certainly be ready early next year.

Mr HAMILTON: I thank the Minister and his officers for that information. The Minister's opening statement refers to the Queen Elizabeth Hospital monitoring equipment, with $307 000 payments in 1984-85. What is to be allocated in 1985-86? Is it the approved estimated cost of $397 000? I also noticed reference to the redevelopment strategy plans for the Queen Elizabeth Hospital. What is basically planned in regard to that redevelopment? Could the Minister also elaborate on the sexual assault referral centre and the satellite dialysis unit?

The Hon. J.R. Cornwall: I ask Mr Coombe to respond specifically to that in a moment, but I will take those other matters. With regard to the future development of the hospital, now that the future role and functions have been recommended in very significant detail and we know where we are going, it will be logical for us to develop a master plan that will not only be over the next five years, but possibly over the decade.

I have already announced that we will be upgrading the ground floor of maternity. Based on my visits there as Minister, one would be led to believe that it needs money spent on it rather urgently. It is very heavily utilised: up to 70 or 80 people are there during the clinic and antenatal classes and so that is the number one priority.

Number two priority is the complete refurbishment of the maternity block, which has an estimated price tag of about $5 million. It is not in the capital works program for 1985-86, but it will have to be given a high priority. There are between 1 600 and 1 700 births per year at the Queen Elizabeth Hospital. The role and function study recommends, in an ideal situation, that it should handle up to 2 000 births per year from its catchment area, so that the general upgrading of the maternity block is a high priority.

With regard to the rest of the buildings, radiology is being upgraded. In terms of other priorities, I think it would be better to wait until a master plan is developed that shows sequentially what needs to be done and the relative urgency. The sexual assault referral clinic has recently been given significant additional funding. It does a magnificent job. It is a multidisciplinary approach, working with the rape inquiry unit of the CIB, which is staffed completely with female police women. Their liaison is from the time of a reported rape and any forensic examinations that may have to be conducted (and they have a panel of female doctors rostered for that purpose), right through to post-rape counselling over very often an extended period—and not only counselling of the victim, but the very necessary counselling of the victim's family.

The sexual assault referral clinic at the Queen Elizabeth Hospital is outstanding. I learned of its understaffing and difficulties in coping during a visit to the hospital. It was as a result of my personal request that Liz Furler and Mr Alan Bansemer went down and reviewed the operations. Again, as a direct result of that, the clinic has had additional full year funding of $176 000, and has recently been relocated into far better premises. This referral clinic is something in the health system of which we can all be proud.

Funding has been made available to establish an additional satellite dialysis unit in the financial year 1985-86. The North Adelaide satellite dialysis unit is now fully utilised: it is certainly cost effective and significantly cheaper than having the patient attend at the hospital, but finding a suitable site is proving to be a little difficult at the present. In an ideal world I would like to see it established in or about the Marion shopping centre, but it will certainly be established somewhere south of Anzac Highway. I ask Mr Coombe to revert to the specific question.

Mr Coombe: I assure members of the Committee, particularly the member for Albert Park, that the budget for the Queen Elizabeth Hospital contains a substantial amount for initiatives, including over $400 000 for the purchase of equipment requirements during this year. To that is to be added the Queen Elizabeth Hospital's bids in respect to the $4.2 million that is being made available to this State from the Federal Government in connection with the Medicare resolutions earlier this year.

I reassure the Committee, and the member for Albert Park, that the Queen Elizabeth Hospital is very well placed in those negotiations with the other teaching hospitals and the Commission. It seems that a great deal of its share of that $4.2 million will be directed towards radiological equipment to complement what the Minister has already referred to in respect to the upgrading of the radiological physical facilities. The Minister referred to major funding initiatives at the hospital in terms of the development of the sexual assault referral clinic, the expansion of the geriatric assessment unit, the expansion of the western domiciliary care service, and the establishment of the second satellite dialysis unit.

It is also worth noting that in the 1985-86 budget specific funding has been provided, in addition to its normal standstill funds, for the industrial democracy unit, nurse education refresher program, patient care information system bureau costs, maternity work, social work aid, commencement of a hospice service, autologous blood service, specific funding for the continuation of the care of Kylie Pocock, and funding for the upgrading of an EDP management system. They are some of the initiatives, not forgetting funding that will be made available later during the year for the upgrading of staff of the neonatology service. The

hospital is well placed this year in terms of funding provisions.

The Hon. J.R. Cornwall: Reverting to the loan to Central Linen Service from SAFA, those figures were not immediately available because as yet we have not taken the money. The equipment will be available, as I understand it, in about February next year. Interest from the time of borrowing will be payable quarterly at the present public sector interest rate as determined by the Treasurer from time to time. We will not know the rate with certainty until the funds are made available to the CLS and the first quarterly payment has to be faced up to. However, I can inform the Committee that the rate is now about 13 per cent to 13.5 per cent.

Mr HAMILTON: I was pleased to see that the Minister's opening statement contained the following:

> *(g)* Community based accommodation for the intellectually disabled: new funds of $400 000 were provided to the Intellectually Disabled Services Council to assist in providing community housing, particularly for over 30 year olds. (Full year cost $400 000.)

What community based accommodation is being provided and in what locations? What accommodation is provided for persons under 30 years of age? Equally important is the need for young children to be accommodated. I have communicated with the Minister about a problem with one of my constituents who wishes to have his child placed in Rua Rua Nursing Home. Despite attempts to convince the parents (I understand there has been a traumatic experience in making a decision) the family has encountered difficulty in having the child placed in community based housing. Therefore, will the Minister elaborate on this question, which involves a traumatic decision for the family (if and when it makes that decision)? Also, I place on record my appreciation for the assistance given by Dr Bruggemann when I took my constituent to see him in an effort to advise fully on what we were doing in this area.

The Hon. J.R. Cornwall: Generally, there is a clear policy with regard to the intellectually disabled that we support normalisation, the deinstitutionalisation, and the least restrictive alternative. In other words, all Intellectually Disabled Services are coordinated in such a way that clients are given the optimum amount of training to enable them to cope in a community situation to the greatest extent possible. That policy has been actively pursued for three years since the Intellectually Disabled Services Council and the Parents Consultative Council were formed as a result of an extensive consultation process that went on in the early 80s.

With regard to the location of these community houses, the answer is that they are in the community. As to where they are exactly, I suppose it is anywhere from Rostrevor to the western, southern, and northern suburbs. The deliberate policy, wherever it is possible to do so, is to buy an ordinary suburban house in an ordinary suburban street. We have found over a period that initially there may be some reaction from residents in the immediate neighbourhood. However, IDSC has become quite expert in explaining to local residents how the policy works and what good neighbours the intellectually disabled can and do make. That process is proceeding at a reasonable pace.

The other thing that we had to take into account was that in the first instance there was some resistance from parents, both those parents who had a child of whatever age in an institution, and those who were ageing or who were already aged and who had looked forward to being able to get a secure placement, as they saw it, in an institution for their child when they were no longer able to cope or were coming to the end of their lives. That all had to be handled with sensitivity and common sense. I am pleased to say that there is no question on balance that that has been done, and it has been a successful program.

As to Rua Rua Nursing Home, which is accommodated in Escourt House (I keep a very close eye on it; I jog past it almost every morning with my new life style), it has been mooted for some time that residents of Escourt House would be more appropriately accommodated in a number of various ways in the community. Altogether there are 100 beds at Rua Rua, and it is funded by the Commonwealth as a nursing home. First, we have to take into account that, whatever we do, we must not lose that funding. Recently, I have begun negotiations with Senator Grimes to ensure that under his policy—our's fits very well with it—the $1.4 million in present funding can be made available by more appropriate means so that, when we do start to deinstitutionalise, we will not put any of that funding in jeopardy. That is the first point.

The second is that residents of Rua Rua Nursing Home at Escourt House are multiply disabled and totally dependent, so it is quite unlike training and placing less disabled people or people who are not intellectually or physically disabled to the same extent. One cannot envisage a situation where any of the present residents of Rua Rua would be able to be semi-independent or substantially independent in a suburban situation. We can certainly envisage a situation where they could be accommodated in group homes, possibly ranging from four in the group home to 25 in a hostel. That is a quality of life issue.

An institution with 100 multiply disabled people being treated on a nursing model is certainly not ideal from a quality of life point of view. We will have to make haste slowly. In the first instance it would be most wise to find accommodation in the western suburbs, preferably comparable with the sort of environment that is available around Escourt House. It is a very pleasant place to live—West Lakes Shore—I can assure the Committee—so that there would not be a perceived downgrading of accommodation, but rather the other way. We will have to move reasonably slowly. I would hope that the first clients can be reaccommodated before Christmas.

I know that with some country families, for example, they have specifically moved to places like Grange, West Lakes, or surrounding suburbs so that when their child is placed in Rua Rua they will have ready access to visit the child. They will not be at all impressed or happy if they believe that there is some sort of threat that a client—their child—might be placed in the Adelaide Hills, the southern suburbs, or Smithfield Plains.

Clearly, all of those things will be taken into account. It will not be possible to deinstitutionalise or to completely vacate Rua Rua under a minimum timeframe of two or three years. It is a very valuable piece of real estate that forms part of my mansions program, and in the fullness of time I believe it will be surplus to our requirements.

Mr OSWALD: I am advised that the ISIS system, which was funded by the Commonwealth Government to the extent of more than $300 000 and to which must be added considerable State salaries and expenses, has foundered. On examining the history of its acquisition I was advised that a decision was taken to purchase software from the American CPHA group. Two officers whom I will not name toured for several weeks on an itinerary developed by CPHA viewing the system and operation.

I am advised that although both were users of computer systems neither officer had a strong systems background, nor any expertise or experience in evaluating systems as large as this. One officer returned to Australia first on the understanding that he would undertake the work necessary in preparing the contract. This was not done and no contract exists.

The other officer returned to find that no progress had been made towards furthering the agreement. Two computing systems division officers then went to the United States for a training course in the system. They found that little documentation existed. They reported on their return that the system was an outmoded batch system written in machine language and therefore completely inflexible and that CPHA was having enormous difficulty in meeting Health Commission requirements for changes to the programs.

Eventually, and after many hours of work had been put in by the commission, hospitals and CPHA their senior officials visited Australia to discuss future arrangements. The Health Commission wanted to break the contract but CPHA insisted on $400 000. The commission has decided to cut its CPHA ties and to write its own system. I am advised that the two officers responsible for the evaluation did not uncover any of the subsequent faults. They both retain their positions and one talks of his permanent promotion. He sees no responsibility attaching to him in relation to this matter. Apart from the initial $300 000, many man hours have been lost by the commission and hospitals. My questions to the Minister are as follows:

1. Can he justify the alleged gross incompetence surrounding the acquisition of the ISIS system?
2. Is it to be replaced?
3. By what is it to be replaced?
4. What has been the total net loss to both Federal and State Governments over this apparent debacle?

The Hon. J.R. Cornwall: Mr Chairman, that is why the Committee system does not work. That was extraordinary rhetoric, it is abrasive; it denigrates senior officers; it is trial by Parliament and is the sort of desperate tactic that we have been seeing in recent weeks in this Parliament, particularly in this Chamber. I find it offensive. The project has not foundered. The allegations of incompetence are allegations made by the member for Morphett and not by anybody else—there must be a horror story.

As long as this sort of behaviour persists at these Committees, they will never work. That is a great shame. They have been going now for five years. They have the potential to be as effective as similar Estimates Committees conducted by our federal colleagues, but this Opposition cannot restrain itself and cannot behave itself in these Committees. I find that most regrettable. Having said that, I ask Mr Ray Blight to respond specifically to both the rhetoric and the questions.

Mr Blight: I will give a bit of background to the ISIS system. ISIS is an acronym for Inpatient Separations Information System. It is pertinent to point out that the Hospitals Department and the Health Commission have been engaged in the operation of this type of system since 1968. In the early days it was known as the Morbidity Statistics System and resulted from a joint initiative undertaken between the then Hospitals Department and the Australian Bureau of Statistics.

The Health Commission assumed responsibility for the system early in 1984 as a response to the Australian Bureau of Statistics withdrawing from the operation and from support of that system. At that stage it was decided to enhance the system, to improve its information content and to improve the operational efficiency of the actual computer system supporting the information. Commonwealth funding was received for enhancement of that system under the Medicare arrangements. Specific funding was provided so that the system would produce the information required by the Commonwealth under the Medicare agreement. The Health Commission embarked upon a project to redevelop the total ISIS system in 1984 using both Commonwealth funding and funds that had previously been committed to the Morbidity Statistics System.

Early in the project it was decided that rather than develop internally the software required to support this system it would be more prudent to attempt to find appropriate software already developed and available. A survey throughout Australia revealed that no such suitable software was available nationally and it was decided to call tenders on an international footing.

We were aware from our investigations that two candidate systems developed and operational in America were available. Tenders were called and, after an extensive evaluation period, a recommendation was put to the Supply and Tender Board for the successful tender. That was the system known as the PAS system, which was offered by CPHA. Officials from CPHA visited Australia shortly after that and a contract for the supply of software and associated services such as staff training and various pieces of documentation to support the system was negotiated between CPHA officials and the South Australian Health Commission.

Following that negotiation the contract was forwarded to the Supply and Tender Board for its comment and also to the Crown Law Department for its opinion. After the appropriate processing through those bodies the contract was forwarded to CPHA at its headquarters in Ann Arbor in Michigan in the United States. The visit of senior Health Commission staff was deemed to be essential if we were to successfully transfer that software system from the host company in Michigan to South Australia.

Another fundamental part of the project was for the software to reside in South Australia and to be processed in the Government Computing Centre. At the time the request was made for the overseas visit, the Health Commission proposed to the overseas travel committee that three officers should visit: the head of the commission's information services division at that time, the product manager responsible for the ISIS project, and a technocrat from the Government Computing Centre.

In the event, it was decided that only two officers should participate in this visit and that in the first instance the two Health Commission officers would undertake the initial evaluation. Their role was to vet the user functionality of the system as opposed to the technical software issues. In making that decision, it was also part of the project plan that technical staff would in due course also visit CPHA to look at specific software questions. That second visit would be contingent on the first visit being successful in terms of functionality.

In the event, the second visit by the computer staff, which occurred late in December 1984, indicated serious deficiencies in the technical quality of the software. In following those difficulties through over a period of months we have found them to be a major problem. It is true that CPHA visitors came to South Australia again (in June of this year) to discuss specifically the software questions. During those discussions, CPHA indicated that it could correct the technical deficiencies that we had identified. It agreed that the problems we raised were serious, but its figure to correct those deficiencies was well over $1 million, which represented an escalation over the tender prices of many times: it was in excess of a three-fold increase in the costs and clearly could not be supported.

As a result of receiving that information, the Health Commission has reconsidered its options for the software component of the project. A decision has been made to proceed with the development of software here in South Australia. That has meant that substantial amounts of Commonwealth funds that we expected to spend on the purchase of the software last year have remained unspent, and they have been carried over into this financial year.

It is pertinent to point out that the CPHA component of the project related only to the software system. The overall

project is far more extensive, involving a very extensive network of data collection throughout our hospitals, the receipt and preparation of that data within the commission, the storage of that information within an interim software system, and the preparation of a wide range of reports from the system. The ISIS system is very important to the commission's role of rationalising and coordinating the health services of this State, and is viewed as a key health management system.

Our involvement with CPHA has not been all bad. As part of the arrangements, CPHA staff have undertaken a number of training courses for our coding staff within the hospitals. With the aid of that training we have converted from the ICD9 international disease coding system to the ICD9 CM system, which greatly improves the utility of the information that we are getting.

On the question of money being lost, a great deal of effort has been put into this project by the Health Commission and by CPHA. As I indicated, we believe that we have achieved many significant benefits from that involvement. Those benefits have been documented and conveyed to Health Commission management, but also to other outside agencies: the Supply and Tender Board, the Data Processing Board and the Auditor-General. There has been some loss of staff time, which has gone into assessing the CPHA software, etc., but that should be viewed as a reasonable investment to have been made to find out the facts about the CPHA software system before it was brought here and we attempted to run it in South Australia.

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

Mr Blight: A contract was negotiated with CPHA after the tender evaluation process; that contract was not signed because of the difficulties that had emerged. The two Health Commission officers, non-computing, who visited CPHA after the tender award, were highly competent to perform the functions for which they were sent to CPHA, and they both have very good records of performance within the Commission. No payments by the Health Commission have been made to CPHA, and a Crown Law opinion has been sought on the appropriate winding-up of the arrangements with CPHA.

Mr OSWALD: At page 13 of his report, the Auditor General says, 'I am concerned by four matters arising out of an examination.' The second dot point refers to the expenditure of $430 000 on two systems which have not proceeded to implementation. Will the Minister give details of these two systems, their individual losses to the State, in dollar terms, and what they have been replaced with?

Mr Blight: As far as I can ascertain from the Auditor-General's department, the two systems were a medium hospital patient management system, for which a figure of $340 000 was quoted, and a common fixed assets system, for which a figure $94 000 was quoted. The medium hospital patient management system was developed for the Hillcrest Hospital; it is a system providing the patient master index and admissions transfer separation functions. The development of this work was commenced by the Health Commission under the auspices of the Systems Review Board, which at that time was a board comprising senior hospital and Health Commission staff and was responsible for the allocation of computing resources.

The patient master index software developed by the commission was conditionally accepted by the hospital in September 1983, and the commission's computer division continued work on the system until April 1984. This work had been undertaken in conjunction with Burroughs Limited, as the system was targeted for the commission's Burroughs computer. In April 1984, the hospital entered into a cooperative arrangement with Burroughs at Frankston Hospital in Victoria to complete the admissions component.

The patient master index has been in production at Hillcrest Hospital since April 1985 and the admissions component was due to go into production at the end of September. When I last inquired about the system two weeks ago, staff training was progressing well and the implementation was on target.

With respect to the common assets system, the Health Commission, in conjunction with Royal Adelaide Hospital, Flinders Medical Centre, Queen Elizabeth Hospital and Modbury, prepared a specification for a computerised asset register system. At about that time each hospital had indicated an interest in the asset system, and as a result the four requests were merged into one.

A specification was prepared and, following a registration of interest in June 1981, tenders were actually called in December 1981. The successful tenderer was a local firm, John Nellor and Associates, and their package, the COFAS asset register system, was selected. Implementation of that system commenced at Flinders Medical Centre with the software being processed on equipment operated by John Nellor and Associates.

In approximately mid-1983, Flinders Medical Centre requested that its processing be undertaken on the commission's B5900 machine as opposed to proceeding with a bureau implementation, and resources were assigned to that late in 1983. In July 1984, after various management changes at FMC, it was decided that COFAS no longer met the hospital's requirements and the implementation was halted. At this stage, no other users have proceeded with implementation of the COFAS system, although the software is still available on the commission's machine. The COFAS system has recently been selected by the Victorian Health Commission as its preferred asset register software.

Mr OSWALD: Has that $430 000 just been written off?

Mr Blight: It has not been written off. The software for the asset system is resident on the commission's computer. As far as the funds expended on the Hillcrest system, that system has clearly proceeded to implementation and the expenditure made as part of that project has achieved its purpose.

The Hon. J.R. Cornwall: At my personal instigation, the Health Commission brought to South Australia early this year Dr Cliff Bellamy from Monash University, who is acknowledged to be pre-eminent in the field of health and hospital computing. In fact, I approached the Flinders University computing department, among others, to inquire who was the computing expert in this country, and they all agreed that Dr Cliff Bellamy was the person.

Dr Bellamy spent seven working days looking at our computing services in the major hospitals; he interviewed 31 individuals who were involved in hospital computing and he reviewed hospital computing, as it was in South Australia at the beginning of 1985. Dr Bellamy concluded quite firmly that health and hospital computing in South Australia was at least equal to the state of the art and competence anywhere in Australia and that in some areas we were leading the rest of the country. Sometimes I wonder how much more we have to do in the computing area to get over the sort of mentality that developed in the late 70s, when there was the computer fiasco at Flinders Medical Centre, where a $2 million computer never got up.

There has been nothing but steady progress since then. However, hospital computing is a complex and difficult area. It is a situation where literally one has to say nothing ventured, nothing gained. To stay up with the state of the art around the world, quite clearly there must be ongoing development. I would think that the South Australian tax-

payers in the course of the past three years have had good value for money. The development of computer systems has now been very substantially decentralised. It is up to individual hospital administrations and boards in most cases to develop their own programs, provided they comply with the checks and balances in the system.

By and large, when one looks at the amount being spent on computing and the results that are being obtained, I believe that we do pretty well overall. I think the admissions, transfers and separations system and the patient master index system, among others at the Royal Adelaide Hospital, for example, are systems of which we can all be proud. It is not an area that is entirely foolproof, because we are always at the leading edge and trailblazing to some extent. I believe it is time that we got away from the very negative mentality of the late 1970s and the very early 1980s and acknowledge, as did Dr Bellamy, that health computing in this State is equal to or better than any in the rest of the country.

Mr OSWALD: I think the Minister might acknowledge though that it is a proper line of questioning for an Opposition to give the commission an opportunity to answer some of the direct criticisms from the Auditor-General. I point out that, when he did his audit, the Auditor-General was familiar with Dr Bellamy and his work. In his report, the Auditor-General states:

> There was a clear difference in the objectives and depth of reviews undertaken by Dr Bellamy in his audit. In particular, Dr Bellamy did not undertake post implementation reviews of computer operating within health units.

Anyone who knows anything about post implementation reviews knows that it is all very well to do the work to put a computer in, but post implementation review is an extremely important area and, if Dr Bellamy did not do it, I think we should have a look in depth at the comments of the Auditor-General and ask the Minister these questions in the light of the fact that Dr Bellamy did not undertake any post implementation reviews.

Will the Minister reply to the other three points that the Auditor-General made in his criticism of computing in the Health Commission, when the Auditor-General said:

> I am concerned by four matters arising out of that examination—
> - the development over three years, of a stores and inventory control system (operating for one hospital only) at a cost in excess of $1 million;

The Auditor-General's second point, relating to $430 000 expenditure on two systems which have not proceeded to implementation, has been dealt with. The Auditor-General then went on to say:

> - an approval process which is slow and time consuming; which on occasions can take in excess of 12 months to authorise proposals submitted by health units—without any significant variation to the original proposal;
> - the lack of accountability with respect to the development of some projects.
>
> While the Commission's revised computing policy may overcome some of those deficiencies, it does not address the present time consuming approval process. That process, which can be wasteful of resources, seems to have been accepted as an inevitable part of the overall management process.

When the Public Accounts Committee conducted its inquiry into post implementation reviews of computer systems it also came to that conclusion.

The Hon. J.R. Cornwall: It is an entirely legitimate area for the member for Morphett to take an interest in, but when any member of this Committee cynically reads a prepared statement or a statement that has been prepared for him directly into *Hansard* and simultaneously circulates it to the media, I believe the forms of this Committee are being abused.

Mr GROOM: On a point of order, Mr Chairman, how many questions is the member for Morphett able to ask?

The CHAIRMAN: Order! There is no point of order.

The Hon. J.R. Cornwall: I will ask the Chairman of the commission to respond to that.

Professor Andrews: The Auditor-General did indeed make quite a number of points about computing in the health system. As the Minister pointed out, the system is being developed. As recognised by Dr Bellamy, on a national basis we are quite advanced in our achievements. The specific matters raised by the Auditor-General are quite legitimate in terms of the way that the Auditor-General looks at these types of issues in terms of costs and outcomes. However, the Bellamy review was more concerned with what had been achieved for the health system generally. I will deal with the Auditor-General's comments generally and, if the Minister wishes, Mr Blight can deal with them in detail.

The Auditor-General's first point related to the development over three years of a stores and inventory control system operating at one hospital and costing in excess of $1 million. The Auditor-General did not take into account the fact that that system also encompasses a very significant pharmacy function—it was not just stores and inventory control in the ordinary sense; it was indeed a stores and pharmacy inventory control system specifically tailored for hospital application. The system is a comprehensive on-line stores and pharmacy inventory control system which is relevant to the management of goods and pharmaceuticals worth many millions of dollars within major hospitals. The cost in excess of $1 million was not just for the development of the system, which is what the Auditor-General's Report regrettably seemed to imply. It also covered the cost of implementing the system, including very significant expenditure in preparing hospital staff for the system's proper implementation.

The introduction of computers into hospitals is not merely a matter of buying a piece of computing equipment and a piece of software and plonking it down in the complex environment of a hospital organisation. Obviously, there is a need for very significant training of the staff involved. All of the key stages during the project mentioned by the Auditor-General were looked at, and the then Systems Review Board (comprising senior commission and hospital staff) was kept thoroughly informed regularly of the progress and the approved changes in the project plan. In effect, we suggest that in this case the Auditor-General's review was rather superficial, not taking full account of the extent of the system nor of the matters covered by the cost of $1 million that he mentioned.

The second point made by the Auditor-General referred to two systems which did not proceed to implementation. I think that has already been answered. I refer to the slow approval process which was time consuming and, as the Auditor-General pointed out, 'on occasions can take in excess of 12 months to authorise proposals submitted by health units'. The problem of obtaining approvals for computer development was recognised at the same time as a review of the commission was undertaken and reported in the Alexander Report.

It was recognised then that the approval processes were slow and time consuming, and it was recommended by the Alexander Report, which was presented some two years ago, that the Health Commission had indeed made significant improvements. The executive panel of the commission became primarily responsible for computing matters, and the Systems Review Board, which had previously been established for this purpose as a key step in that process, was disbanded. The Systems Review Board was made up of senior officers within the commission and the hospital system. It met relatively infrequently and represented an

element that stretched out the approvals process but action had indeed been taken to remove that.

As Bellamy pointed out in his report, the approvals process still includes a data processing board and a supply and tender board, elements outside the control and responsibility of the commission. These are consistent with present Government policy. Nevertheless, the Auditor-General was notified of a commission project to compile a computing investment plan to be used to ease the approval process and gain a long-term funding commitment from Treasury for computing initiatives. This project forms part of the Health Commission's management improvement program for 1985-86. In essence we are saying that there have been significant changes that were not able to be taken account of in the Auditor-General's review. Some of the elements are outside our control, but we have moved to improve significantly the rate at which decisions are made within the Health Commission's management improvement program for this financial year.

The fourth point was the lack of accountability with respect to the development of some projects. Here we found some difficulty in responding directly to the Auditor-General because it was a rather broad and ill-defined statement. For the two systems that were reviewed by the Auditor-General, there was in our view a clear line of accountability. A project sponsor group chaired by the administrator of the pilot hospital was responsible for the time and cost performance of the project and was accountable to the chairman of the then Systems Review Board and also to the Chairman of the Health Commission for the same in both cases.

Our view is that, while the Auditor-General quite properly reported on matters that concerned him, taking account of the costs and achievements in the computing area, when one looks at those issues in a broader light, that is indeed what Bellamy did. One has to argue that, in a developing area like computer applications, certain risks are to be taken and investment has to be made to achieve any positive result. In the light of those acceptable risks and the achievements that have been made in computing, we believe that any imputation made, if you like, in the Auditor-General's Report that in some way we are deficient in the provision of computing services in this State in the health area is indeed quite false. As the Minister said, we are quite proud of what has been achieved in that area.

Mr GROOM: I am dealing with the line under 'Miscellaneous, South Australian Health Commission, $526 183 000' on page 110. I understand that the Health Commission both runs and also contributes to the finance of the Central Linen Service by way of payments for services undertaken by it. As I understand from the Auditor-General's Report that the Health Commission contributes about $375 000 of the funds received by the Central Linen Service, what would be the financial consequences to the Health Commission if the Central Linen Service was privatised?

The Hon. J.R. Cornwall: First of all there are more than financial considerations. It is essential that we have a reliable laundry service that can give a level of quality assurance that is so essential in a number of areas of hospital linen. We are not just talking about sheets, pillow slips, and bedcovers and the like. We are talking about sterile drapes, instrument packs, and so forth. It is important that that be done at a guaranteed level of performance. From that point of view, a reliable Central Linen Service with high standards is imperative. It is literally possible to close down a hospital system if you run out of laundry. It is as serious as that.

The financial consequences would be very considerable. The Central Linen Service has not raised its prices since 1983: that means that if one discounts at the CPI rate, there has been a net fall in the real cost of linen amounting to more than 20 per cent. If you set that against actual costs in the meantime, the savings to the health system are significant and would be several millions of dollars. Undoubtedly, if the Central Linen Service was to go to private enterprise, there would be a rise and potentially a reasonably substantial if not spectacular rise in the actual costs of supplying that linen.

That would be an immediate charge against the health budget, and in cutting up that cake—it is a large cake but it is not a very flexible one—if you start taking out additional moneys to pay for your linen service, then that is money that does not get spent in women's health or community health centres, preventative health, public health, or environmental health—somebody has to suffer along the way. It certainly saves the health service a substantial amount.

However, let me make clear, if I could just for a moment become a trifle political albeit objectively, I make no secret of the fact that I look for efficiency in the operation of the health services. For example, I think everybody knows that an approach was made to the Government many months ago to buy back the frozen food factory. That food factory was a mistake of the 70s for a whole lot of reasons that I do not need to canvass now. It was grossly overcapitalised. The private purchasers found, as did the government before them, that they were unable to operate it profitably.

Therefore, they approached the Government, the Health Commission in turn, and I as Minister of Health, to consider buying it back so that we could have an assured source of frozen food, particularly for Flinders and places like Flinders that were built without kitchens and relied on frozen food to keep the meals going. We looked around at alternative sources of frozen food, including the Queensland frozen food factory, so it was certainly not a case of wanting to do a deal with our comrades in the Queensland Government. We found that they could supply it more cheaply. We therefore resisted very vigorously any and all moves for the Health Commission to buy back the frozen food factory.

That was a commercial decision for which I make no apology. Quite the reverse, in fact: I am very proud that we were able to resist that, and negotiations ultimately have not only assured the retention of jobs but one would hope that when they are ultimately concluded, it will possibly mean the expansion of jobs. That is well outside this Health Commission. We are not interested in doing business in areas that are going to cause us to lose money.

For the same reason I recently announced that we were to conduct a major property rationalisation. There are many mansions (very large old properties) and quite large areas of residential land that are in the overall property folio of the health services. It is unlikely that they will ever be used in most cases, and in others services are often inappropriately located in grand old mansions, which is very nice for people occupying them, but is not cost-effective in the sense that one can deliver the same service in purpose built accommodation, which costs a great deal less money.

Over the course of the next three to five years we will be looking to rationalise our property folio and invest that money in areas of greatest need, whether it be refurbishing hospitals, building new ones, or whatever; things are on the priority list for the capital works program but could not be done in normal circumstances in the normal allocation. We make no apologies for trying to operate in the most effective and efficient way possible. If the group laundry and the Central Linen Service was an incubus about the neck of the Health Commission and health services, then I believe I would have a duty, as Minister of Health, to see whether we could not get rid of that incubus.

However, the fact is that since we began to adopt the recommendations of the Touche Ross report with regard to the Central Linen Service, productivity, simply through increased management and improved worker morale, has

increased by 30 per cent over the past 2½ years. That is quite a remarkable performance, remembering that it is still working with very old equipment which is well past its useful life and which, in some cases, is almost literally being held together with number 8 fencing wire, and running repairs are being done on the spot.

If we do that without renewing the equipment, one can imagine the sort of productivity that we can expect when that major re-equipment takes place from 1986. The simple reality is that the Central Linen Service is saving health services in South Australia millions of dollars a year. As to quantifying that in commercial terms, the way in which the accounting was previously done—and I am going back into the 1960s and 1970s—would make that rather difficult. The way we are now moving our accounting at the Central Linen Service to put it on a commercial-type operation means that it will be possible in the ensuing years to quantify that quite accurately. In the meantime I believe that it would certainly be possible to comment on the estimated amounts that it would have saved the health service quite specifically during the past two years.

Mr Coombe: I reiterate that it may well be difficult to put precise figures on the effect of the Central Linen Service leaving the Government arena, because it is known that the Central Linen Service is regarded by all its competitors as the price setter in the market place and, therefore, it is only reasonable to assume—as has been said before—that there would be substantial increases. The Central Linen Service cannot be selective of the linen it processes, and it provides, as we know, a comprehensive service for all institutions, including patient clothing from psychiatric institutions. It is that latter workload that would be decidedly unattractive to the competitors of the Central Linen Service under any proposal that would have the service leaving the ambit of Government.

As the Minister has said, the single most important measure of the Central Linen Service for comparison with any other large scale laundry of its type is its direct labour productivity level. The industrial standard for productivity for large scale laundries is 64 lbs (29 kilograms) per operator hour. A major free enterprise laundry in Victoria is achieving 32 kilograms per operator hour. The Central Linen Service is achieving 35 kilograms per operator hour, despite inadequate and obsolete equipment.

That level of production (35 kilograms per operator hour) is certainly testament to the ability of the Central Linen Service to be favourably compared to any large scale laundry in Australia. With regard to the precise financial savings, I will provide that information later.

Ms LENEHAN: Page 6 of the yellow book indicates that provision has been made for drug prevention, education, and rehabilitation programs. I am aware of increasing community awareness of this problem. This was more pointedly brought home to me because I received a letter today from the Morphett Vale Youth Club, stating:

> The committee of the Morphett Vale Youth Club wish to present an informative session or sessions on drug awareness, usage and effects to members of the club, particularly the senior youth group. We have researched several sources but are finding difficulty in securing qualified people to conduct these sessions. It would be appreciated if you could assist us with contacts or information on this very important social problem.

The reason I brought the contents of this letter to the attention of the Committee is to highlight the fact that there is awareness in the community of drug problems and that the community is taking initiatives to inform young people (such as young people in youth clubs). I will be replying to this letter and suggesting that we can organise some speakers, probably from the Drug and Alcohol Services Council. What action has been taken to deal with the distressing problem of drug abuse, and what support services are available in South Australia for drug victims?

The Hon. J.R. Cornwall: Somewhere in the documents honourable members will see that the budget for drug and alcohol services in 1985-86 is $4.159 million. In addition, the State and Federal Governments are permanently providing an additional $1.2 million each, an increase of $2.4 million in overall funding. In fact, funding for drug and alcohol services in this State will be increased by more than 50 per cent—a huge expansion in anyone's language.

The whole question of drug and alcohol services has been one that has exercised my mind ever since I became Minister and, in fact, for a long time before that. So, I had a good idea of where I wanted us to go. The old Alcohol and Drug Addicts Treatment Board and the legislation under which it operated were far more relevant to the 60s than to the 80s and, regrettably, there has been a dramatic change in the incidence and patterns of substance abuse in the last 20 years.

So, we repealed the alcohol and drug addicts treatment legislation and we reformed drug and alcohol services as the Drug and Alcohol Services Council as an incorporated body under the Health Commission Act. That had the effect of having those services join the family of the Health Commission. In that sense we are trying to draw the commission and drug and alcohol services closer together and via the commission to get the general health services involved in drug and alcohol services as well as the specific agencies—both voluntary and those provided by DASC.

One of the effects of that will be that we will hopefully get much earlier intervention. One of the things that have been very noticeable over the years has been that the medical profession and other health professions and health professionals have tended to eschew practice in the area of both alcohol abuse and other substance abuse. The illicit drug area, for example, is an area with which many general practitioners do not feel comfortable. That has not always been the fault of the practitioners.

One of the difficulties is that if one becomes known around the drug subculture as a doctor who is sympathetic to the victims of this vile drug trade one tends to build up a large clientel quickly of people who are drug dependent for one reason or another, and that in itself can present real problems for that medical practitioner or medical practice.

Of course, we have a computer prescription surveillance mechanism these days so that, if a particular pharmacy or medical practitioner appears to be writing a large number of prescriptions for restricted drugs or drugs that potentially can be abused *vis-a-vis* the normal patterns around that area of suburban Adelaide or that area of the State, then they tend to come under surveillance. There are difficulties in that sense.

In the other sense, I believe that undergraduate and postgraduate training in the areas of alcohol and drug abuse are quite clearly deficient. The ordinary GP and many other people in the health professions do not feel comfortable being involved with alcohol problems or with problems of drug dependency. For that reason we have begun active programs of educating the professionals. I sponsored a major seminar earlier this year conducted by the South Australian Post Graduate Medical Association. That was very successful and there will be more of that sort of activity.

Also, by getting drug and alcohol services into the teaching hospitals (and, in the first instance, we would hope to establish that sort of facility at Royal Adelaide Hospital) we will inevitably have undergraduate and postgraduate teaching upgraded in how to get into early intervention in the case of alcohol, in particular, and how to handle the other sorts of substance abuse problems that present. That is one area in which things are happening.

Of course, we are also completely reorganising and upgrading our services. I will be going to Cabinet shortly (within the next two weeks) with a blueprint for the reorganisation and the substantial upgrading of drug and alcohol services in this State. For example, under this proposal the Osmond Terrace property will become a centre dedicated to the treatment and rehabilitation of drug dependent persons. The role of Family Living at Joslin will be substantially changed. It is hoped that we may well acquire a country property which will become involved in the rehabilitation of the victims. A whole range of upgraded services will be in place before the 1985-86 financial year is out.

It is also a fact that South Australia was the first State to introduce—not only introduce but to proclaim—the Controlled Substances Act, which is a comprehensive piece of legislation. People would like to think that we can have a simple legislative solution to what is a complex set of problems, and the reasons underlying those problems are even more complex. One cannot do it simply by legislation; one cannot do it simply by policing the legislation, but that certainly can be a useful tool.

In the Controlled Substances Act there are severe penalties for the scum who are into trafficking and trading—those penalties are the most stringent in Australia: 25 years, $250 000 and confiscation of assets, not only of those people involved in trafficking but of those who may be involved in the financing of that trafficking. There is no question that the law in this area is adequate.

In addition to pursuing the sort of people who would peddle death through heroin and other narcotics, we have made clear arrangements for victims under the legislation. We have established drug assessment and aid panels. True, they have been going only since about June and so we have only three or four months experience on which to base our assessment of the operation, The early assessment is that after some teething problems (people having to feel their way, whether it is the police prosecutors, magistrates or appointees to the panels and everyone else involved in the new system) they are starting to work well.

They are seeing almost five referred people every week (the victims) and in turn they are being offered programs over six months which direct them absolutely along a rehabilitation path. I hope we have got the best of both worlds through that legislation.

In summary (I could go on for three days, although I do not intend to do so) we have put together a comprehensive package that involves prevention (taking programs at this very moment into secondary schools—the Free to Choose program) and we are involving the service clubs in the Teach a Teacher programs so that more and more the ordinary teacher in contact with those secondary school students on a daily basis is getting a level of expertise in drug prevention and education programs.

We will be launching a major program for primary school children in association with the Life Education program in New South Wales in the near future, and our rehabilitation and treatment services are being upgraded by a massive injection of additional funding. Many things are happening. Regrettably, I have to say that the evidence is that substance abuse tends to be very much associated with other underlying social problems.

Ultimately, the only way we will eradicate it is to adopt a broad, multi-disciplinary approach so that all of the professions and all of the relevant human services areas in which Government agencies are involved, and all of the voluntary organisations involved in delivery of human and community services, make a united effort to change the present system. While youth unemployment persists at the sorts of levels it is currently at I think that this problem will stay with us. We are certainly doing everything, based on experience from around the world, to prevent young people from getting into substance abuse. We are attempting to make sure that the best rehabilitation and treatment services are available to get them out of their problems if they go beyond experimentation to dependency, and to make sure that there will be an ongoing education program for the public at large.

Membership:

Mr M.K. Mayes substituted for Mr T.R. Groom.

Ms LENEHAN: My last question relates to the nursing profession. As members of the Committee are only too well aware, there is an Australia-wide shortage of trained nursing staff for our hospitals. The issue is extremely topical. I notice in today's *News* the headline 'Exodus threat on nurses pay'. I think this belies the actual article when one reads it. In earlier questions one of the points raised in terms of attracting trained nurses back into the profession was the provision of child-care facilities. I believe that that matter was very thoroughly canvassed this morning.

This is a fundamental facility that is required if we are to have trained nurses participating in the work force in an employment area which has shift hours. However, I do not believe that that issue alone is sufficient to attract nurses back into our hospitals. Will the Minister outline what efforts are being and have been taken to entice nurses back into the profession?

The Hon. J.R. Cornwall: I will tax my memory on this matter and go through as briefly as possible the range of measures that have been undertaken. If I should miss anything, I hope that the Chairman and Mr Ray Blight, who has been specifically involved in this matter, will come to my assistance. The first and I suppose the most topical matter is the Victorian Government's decision to grant substantial rises to certain classes of nurses. I do not have that detail before me: I have been unable to get it. As I understand, it is based on an equal pay submission and has some genesis, really, in the equal pay arguments of the late 1960s and early 1970s.

The position is that the vast majority of nurses are female. The contention is that their salary rates have been kept low *vis-a-vis* other health professions because of this hangover, if you like, from the days when we did not consider females to be of quite the same worth as their male counterparts. The Royal Australian Nurses Federation has lodged a log of claims with the South Australian Health Commission which envisages across the board pay rises of the order of 30 per cent. My advice is that that would clearly be well outside the guidelines of the Prices and Incomes Accord. We would most certainly not entertain anything that went outside those guidelines because we believe (indeed, I think that it is manifestly obvious to anybody who thinks about it) that the Prices and Incomes Accord has been one of the major reasons why the economy, both South Australian and national, has done so well in the past two or three years.

That claim would, in any case, ultimately have to be considered by more than just the Health Commission negotiating with the Royal Australian Nurses Federation or with the Minister of Health. It would have to be considered by the Public Service Board, the United Trades and Labor Council and, ultimately, if any agreement was negotiated it would have to go before the Industrial Commission. If it did not then meet the guidelines it would be thrown out, anyway, so there is little point in becoming involved in what is *de facto* an ambit claim.

On the other hand, I want to make very clear that I have been a staunch advocate for the nursing profession in the three years that I have been Minister of Health. They have been assisted by me and by the State Government through

the Health Commission to make the transition from the old hospital based apprenticeship, which goes back literally to the days of Florence Nightingale, to tertiary based nurse education, for example. Next year there will be a new campus opened at the Salisbury SACAE, which will be very substantially funded by the State Government.

I have consistently said to the Royal Australian Nurses Federation that I believe that the career structure is inadequate and in some ways grossly inadequate. The fact that the Director of Nursing at the Royal Adelaide Hospital, for example, is on a salary of around $40 000 a year while an administrator in a hospital of that size and complexity is on a salary closer to $60 000 (and that is a non-medical administrator because, if he or she is a doctor, he or she gets substantially more) shows that there are clearly anomalies in the area from Charge Sister upwards.

I have a ministerial Nursing Liaison Committee looking specifically at those matters—I am very sympathetic. I think that if we make the profession of nursing more attractive, both in terms of professional status and career structure, then we will attract more people to it; that means, in practice, more women back into the nursing work force. If we could get even a relatively small percentage of registered and enrolled nurses back into the profession who have currently, for one reason or another (whether because of marriage, child bearing or other occupations), left the work force we could solve all of our problems reasonably rapidly.

I revert for a moment to other areas where we are actively involved in trying to recruit, retrain or simply train adequate numbers of nurses to begin to meet the current shortfall. Hospital based child-care was discussed earlier today. We are actively involved in rapidly expanding the provision of hospital based child-care. We have negotiated an agreement with the Royal Australian Nurses Federation whereby migrant nurses will be recruited in the United Kingdom on both a permanent basis (where they have specific skills such as theatre sister or nurse educator) and on a 12 month basis where they are simply to join the general nursing work force.

On a recent trip to Canberra I was able to obtain $900 000 from the Minister of Employment and Industrial Relations to match our $600 000 to mount a $1.5 million series of retraining programs over the course of this and the next financial year.

The promotion of the profession to school leavers is currently going on so that we can attract adequate numbers of student nurses. The maintenance of the present level of hospital based nurse trainees, while progressively moving into the tertiary system, so that we are double training at the moment, with the other things, will see us in a far more favourable position within three to five years, but there are unquestionably a number of significant problems at the moment.

We have not at this stage been placed in a situation at any of our hospitals where we have had to close wards because of the nursing shortage, but it is an ongoing problem and a good deal of juggling is going on to maintain rosters. It is imperative that we attract as many nurses back into the profession as possible.

Mr BECKER: I will not go into the hypothetical question of whether the Central Linen Service will be privatised or not, but is the Minister aware of a survey taken from certain private enterprise laundries, and are further economies expected in the Central Linen Service after considering higher debt service fees that will occur when the new $5.5 million capital works program is implemented?

I am advised that the survey shows that the ratio of tonnes of linen per employee was 37.65 compared with the Central Linen Service 34.46. The labour cost per tonne was 41 cents for the private sector and 52 cents for the Central Linen Service. The operations per tonne cost exactly the same, at 38 cents each. That gave a total cost per tonne of 79 cents for private enterprise and 90 cents for the Central Linen Service.

The CHAIRMAN: How do you relate this to the lines that we are on at present?

Mr BECKER: A question was asked about the Central Linen Service.

The CHAIRMAN: That was a little different: the honourable member was asking about the effect on the Health Commission of the payment to the Central Linen Service. Your question is directly on the Central Linen Service, which comes under the works and services lines. You need to relate it back. If I allow it now I cannot allow it later: it is up to you.

Mr BECKER: All that I am asking is whether the economies mentioned by the Minister can be assured. I am getting a comparison at the moment. The statement was made that the Central Linen Service is an efficient operation, and on the surface it appears that way. I am wondering whether the economies can still be achieved after a rationalisation of the present borrowings, plus further developments. I want to know whether it can be maintained.

The CHAIRMAN: I will allow the question, but it means that questions on the Central Linen Service will not come up under the other lines.

The Hon. J.R. Cornwall: The simple answer is 'Yes', but a number of issues are raised by the member for Hanson, based presumably on material that has been made available to the Opposition by at least one, if not more, of the private laundry operators. First, the consolidated debt will be $10.4 million, so no special privileges are being handed out to the Central Linen Service. Its accumulated debt was $4.9 million. Provision had not been made for that in all the years that the laundry has operated, which is bad management. It is rather a stark public sector approach that is certainly not acceptable to me or the Health Commission at this moment in our evolution. The consolidated debt comprised that amount that had accumulated, plus the $5.5 million that is needed to re-equip. That $4.9 million will be repaid to Treasury so that we square the ledger after it has been borrowed from South Australian Financing Authority. The $5.5 million will be for the new equipment.

We anticipate on the projections that have been done that we will get a very substantial further increase in productivity. The debt will be serviced principally from a further increase in productivity. There is also the inevitability that at some time the charges will have to be adjusted. We cannot expect, and it would be foolish of me to suggest, that we can go on for the next decade and beyond charging 1983 prices, so at some state there will be price adjustments. Between the increased productivity and the competitive market rates, we anticipate to being able to service that debt and conduct the Central Linen Service on as near as possible to a commercial basis. Quite obviously, some advantages are enjoyed by the Central Linen Service—it does not pay tax, for example. However, that saving is ultimately represented as a saving to the health services generally.

As to the actual costs, the member for Hanson may have fallen into the trap of comparing apples and oranges. There is a very big difference between a linen service and a laundry service. Those figures to that extent probably misrepresent the true situation. A linen service—and the Central Linen Service provides many of our major hospitals and institutions with a linen service—provides the linen as well as laundering it. In fact, it has an arrangement with the State Clothing Corporation. It would be fair to say that the Central Linen Service is by far the State Clothing Corporation's biggest client. In that way, we also create employment where it is badly needed in Whyalla. The difference between a

linen and a laundry service is pretty obvious: in a laundry service the institution provides the laundry, and it is simply washed and processed. A linen service provides the linen and launders it as well. Any examination of those figures will show that the honourable member is comparing apples and oranges. The contention that it is the most cost efficient service in the State can easily be sustained on all the figures that have been provided to me.

Mr BECKER: In relation to the nurses issue and the publicity that is in the media, have the Minister's officers had the opportunity to estimate the cost and impact on the Health Commission budget of the Victorian Government offer of pay rises of about 40 per cent or $150 per week, and what will that impact be on all areas of the health services employing nurses?

The Hon. J.R. Cornwall: As I said earlier, I do not have enough detail to be able to quantify that. However, if the original log of claims had been met in Victoria I understand that the cost to its health service would have been in the order of $70 million.

Therefore, it has negotiated the claims down to $20 million. If the current log of claims that has been lodged with the South Australian Health Commission were to be met in full, without any offsets or other negotiated arrangements, the total cost to the South Australian health service would approach the budget of the Adelaide Children's Hospital. That might be a slight overstatement of the facts, as the Children's Hospital budget is around $40 million.

However, if we were to meet the log of claims, as presented, then it would be in excess of $30 million. On the advice that has been given to me, it is well outside the guidelines and it is not something that we are contemplating. The Health Commission would not have a bar of it; the Minister would not have a bar of it; members of the Public Service Board would probably have difficulty with their coronary circulation if they were to be seriously asked to have a look at it; but it is a basis for negotiation.

If we are ultimately to negotiate something similar to what the Victorian Health Department and Victorian Government appear to have negotiated, then the ball park figure would be about $5 million, which is still a lot of money, and it is a lot of services that we cannot provide if we have to find an additional $5 million for salaries. However, I am sympathetic to improving the career prospects of nurses. If we do not do that, we will continue to lose nurses rather than re-recruit them, and you cannot run a health service without nurses and doctors.

Mr BECKER: I agree with the sentiments as far as the nursing profession is concerned. We all owe a lot more to them than we give them. What is the nurse shortage in South Australia?

The Hon. J.R. Cornwall: The current shortage is estimated to be about 440 in the public and private sectors; potentially, that could stretch out to 800. We are certainly not comfortable at the moment and things may get worse before they get better. In the short term it will depend largely on the success of our re-recruitment and retraining programs.

The situation is that if nurses have not been out of the profession for more than five years, they can be directly re-recruited. By the provision of child-care facilities, flexible working hours, job-sharing and so forth (the Royal Adelaide, in particular, is doing a lot of this work), we may well be able to recruit a significant number in the short term. If we then have to go to retraining, that takes a little longer. If we actually have to wait for the system to catch up by double training, both in the hospital schools and the college-based schools, we will be looking at a lag time of about five years.

The other important point is that we have to get our sums right in the meantime because, if all of these efforts come good simultaneously, we could finish up with an excess of nurses. However, we have a lot of good people working on that very vigorously and I believe we can get through; however, things will be pretty tight for the next couple of years.

The other point that has to be considered is nurse ratios—both the ratios of registered nurses to enrolled nurses on the one hand, and what are reasonable staffing levels on the other. As student nurses are replaced by trained nurses, the question then arises—because of the additional competence of an experienced registered nurse versus a first or second year student nurse—how many registered nurses do we need to replace a specific number of student nurses? Those calculations are being made now.

Ms LENEHAN: The Minister mentioned a figure of $1.5 million that would be used in the retraining of nurses and then suggested that there was a shortfall of about 440 nurses. How many nurses is it planned to retrain with that $1.5 million? I think that is probably a more meaningful figure for people in the community who are interested in this retraining program than is a monetary figure, whilst I appreciate that it is an enormous amount.

The Hon. J.R. Cornwall: Two programs will be financed from that $1.5 million. I might point out that that federal money is provided under the Skills in Demand (SID) program of the Department of Employment and Industrial Relations. One program will retrain 350 registered and enrolled nurses and midwives over the currency of the program; the other program will retrain 50 migrant nurses currently living in South Australia, for whom English is not a first language. That is also very significant because it will fit in well with our migrant health program. The official policy is that nobody, regardless of ethnic origin, language and so forth, should be denied access to the health services, which should be available, on the same basis as they are available to any other South Australian. This will boost that program substantially.

Hopefully, we will produce 400 nurses who can return to the work force. However, the 438 nurses, which was the estimated current shortfall, has to be viewed in the overall context of a shortage of 800. Whilst that retraining will be enormously useful, we would still like to get back, as soon as possible, nurses who do not have to be retrained. That is where child-care becomes so important. The hours at the child-care centre at the Royal Adelaide Hospital are currently 7 a.m. to 5 p.m. There has been some criticism—on the grounds that they do not cater for people who wish to work afternoon shifts, they are not quite convenient for people who start a little earlier, and so on. I have always made clear that there is something of a learning curve there, too, and, if it is cost-effective and practical to open that child-care centre so that it does cater for the afternoon shift, we will certainly do it.

Mr OSWALD: What about the morning shift that comes on at a quarter to seven? That is a problem down there.

The Hon. J.R. Cornwall: I repeat that we would be quite happy to look at anything that is practical and cost-effective. It may be that as a first step the child-care centre should open at 6.30 a.m. It is important enough to ask Dr Kearney, the Acting Administrator at the Royal Adelaide Hospital and Director of the IMVS, to comment.

Dr Kearney: The hours of the centre at the Royal Adelaide Hospital are from 7.30 a.m. to 6 p.m. The management committee of the child-care centre has an application before the Children's Services Office for funds to extend the hours, but, we have not received a response to that request. However, we have surveyed the staff of the hospital seeking responses from those who would use the child-care centre if it opened before 7 a.m.—that is, at 6 a.m.—to cater for the early morning shift. Of the total nursing staff only six

people said that they would use the centre. We have a limited demand at present for the very early start, but there is a substantial demand during the day. We still have an application in for further funding to allow us to attempt to open earlier.

The Hon. J.R. Cornwall: I seek a point of clarification from Dr Kearney. It has been claimed fairly consistently and persistently around Parliament House over the past three weeks or so that the morning shift starts at 6.45 a.m. and, therefore, the 7.30 a.m. opening is not meeting any of the needs. I ask Dr Kearney to respond to that.

Dr Kearney: That has been our concern, and that is why we undertook the staff survey. We do not really believe that the present hours are inconveniencing the staff who use the child-care centre. I guess what we cannot answer is whether, if we provide additional hours, that will attract more staff to the hospital. That is what we want to try and answer. The present hours do not appear to be causing any major difficulties to staff who work at the hospital.

Mr MAYES: Page 6 of the yellow book states that the objectives being pursued by the Health Commission include provision for the introduction of the Home and Community Care program, jointly funded by the Commonwealth and State Governments. What is the present status of the establishment of the HAAC program; how far advanced is the administrative establishment of the program; and who will administer it within the community?

The Hon. J.R. Cornwall: The HAAC program has promised much since the Federal Government first announced it in the 1984-85 budget. Administratively in South Australia I have been designated as the Minister responsible for the HAAC program, liaising particularly with the Minister of Community Welfare and my other colleagues in the Human Services Committee of Cabinet. A task force has looked at the whole question of who, where, how, and what priority areas are involved in the provision of home and community care in the first instance. We have also reached agreement with the Federal Government; we were the first State to sign the HAAC agreement, about 10 days ago. The member for Unley may have noticed an advertisement on page 7 of last Saturday's *Advertiser* in which Don Grimes and I announced that the agreement had been formalised, and we called for interested individuals and organisations who had not already done so to submit their tentative programs to the office of the HAAC coordinator.

We have designated a specific senior officer who has come across from Community Welfare to head up the unit in the Health Commission building. Administratively, that is in place. At the top, I liaise directly with the Federal Minister for Community Services (Don Grimes), so we are cutting out as much red tape as possible. A committee has already been established, and the interim chairman will be Mr Ray Sayers of the South Australian Health Commission. Representation on that committee is made up of officers from the Department of Community Welfare, local government, and the Federal Department of Community Services (South Australian division), as well as the Disability Adviser to the Premier, and the Commissioner for the Ageing (Dr Adam Graycar). Ultimately, two appointees from the voluntary and consumer sector will be included, and I am negotiating in that area now. That committee is now up and running, and we have looked at every reasonable proposition in terms of the administration of the program.

Local government and voluntary agencies have an important role to play; and it was important that we did not throw out the baby with the bathwater, so the existing domiciliary care services clearly had a most important role to play. We did not want it to be fragmented, so we looked at existing services—the home handyman scheme, the home assistance scheme, the domiciliary care services, and other services being provided by local government on a somewhat patchy basis. It was decided that we already had in place a good organisation and a good network through the existing domiciliary care services around this State. We will amend their constitutions to the extent necessary to ensure that there is local government representation and voluntary sector representation in addition to the existing situation. They will also have to extend their horizons.

They are principally involved in two areas: first, the short-term support of the acute patient on discharge from hospital; and, secondly, the provision of what are sometimes called the high tariff services to the aged and disabled—services that range from physiotherapy to podiatry and, importantly, paramedical aid services, which can include the important domestic services. That area will have to be broadened to take on the so-called low tariff end, which may be support amounting to only two hours a week for a single parent with two or three dependent children. This financial year we will have available $3.78 million, so it is a substantial program. Next year the amount will rise to $3.93 million, as the State's contribution increases.

Thereafter, we will provide proportionate shares. If we provide $1.91 million, the Commonwealth will provide $2.69 million, so that will be a $4.6 million program with inbuilt expansion for the triennium. The six areas in which we intend to concentrate in the first instance are personal care, respite care, transport, housework, information and training, and coordination and integration. Proportionately, that will be divided between the disabled and the aged.

The only other point that I ought to make, because it is an important one, is that domicilary care services will not only have to extend their charter and their boards of management or management committees to take on board local government and the voluntary agencies, but they will also be obliged, where it is practicable and cost effective to do so, to subcontract to local government and volunary agencies. We wish to mobilise the whole community, and we will certainly use volunteers where it is practicable to do so, at the same time ensuring that under no circumstances will we allow professional standards to slip. Professor Andrews has a keen interest in this matter.

Prof. Andrews: The important home and community care program will extend a wide range of services to the aged and disabled in their homes. It is important to remember that it only supplements extensive services that are already provided in South Australia, and that is one of the reasons that the delivery of these services will be coordinated through our already well established domiciliary care network.

The agreement, as the Minister has already indicated, was signed two weeks ago, and an ad has already appeared seeking submissions in addition to those already made. The coordinating office has been established for the HACC program, and will be fully staffed over the next four weeks. We expect that it will include two officers seconded from the Commonwealth Department of Community Services in addition to officers employed by the Health Commission. Hopefully—and we are making submissions to this end—it will be funded entirely from Commonwealth sources through the HACC funds.

The policy committee the Minister referred to should be in place soon, and letters of invitation are going out now to members of that committee. The domiciliary care services have been advised of their role and are gearing up to respond, and the so-called program committees to be established at a local level will include local government representation, voluntary organisations, and others concerned with the delivery of these services. These will be put in place over the next few months.

The decisions about the new programs to be immediately funded will be made on the advice of the interim committee

in the next few weeks. Those programs that are sufficiently well developed at this stage should be able to commence soon after that. In order to allow programs that are still being worked up and that may come in in response to the ads, a second round of allocations and reviews will occur in two to three months time and will result in additional programs that will then take up the whole of the funds that have been provided, both as a carry over from last year and the new funds provided this year from the Commonwealth and State contributions.

Mr MAYES: What initiatives that have been mentioned in this document of the overview—for example, The Second Story, on adolescent health—have been taken by the department, and can the Minister outline the Health Commission's response to International Youth Year? I again refer to The Second Story and the Salisbury Shop Front program as well.

The Hon. J.R. Cornwall: It is now clearly recognised that adolescence is a period between childhood and adulthood that has special problems. It was traditionally regarded as being a period of robust good health. You were young and fit and raring to go. You might develop a pimple or two or three during adolescence, but apart from that, there were no real problems. We now know, of course, that that is far from the case. There is a complex set of circumstances that can give rise to a number of both physical and mental health problems during that rather difficult phase.

It is also increasingly acknowledged by the medical profession that it is an area that requires specific expertise. It is also an area in which we believe, and as a matter of policy are practising, that you need a multi-disciplinary approach. The underlying problems are the things that need to be defined often rather than the symptoms. For that reason, we have established The Second Story where a full range of services will be available from legal services through remedial teaching, active and passive recreation, restoration of self-esteem by finding something in every case for which the individual has a particular talent—and we all have talents at one level or another or in some area or another—so that is part of that multi-faceted approach.

In addition, ultimately there will be a full range of health services right across the community health spectrum, ranging from nutrition advice through sexually transmitted diseases and a whole range of other areas. The centre has been located, on purpose, in downtown Adelaide; it is central. We need a critical mass, I believe, to make sure that it is seen to be vibrant and alive, and if there are less than 40 or 50 people attending at any given time or during any given session, then it would tend to lose that critical mass and vibrancy.

There is a very clear policy and philosophy underlying the approach to adolescent health through The Second Story. It is quite a structured approach. In the past people tended to run adolescent drop-in centres—and the youth workers in this State and elsewhere have done a good job—which, in many cases, amounted to little more than tea and sympathy. The place was available; one could certainly get a sympathetic hearing, a cup of coffee, and so on. However, there was no structured goal.

The philosophy of The Second Story is that each person is treated very much as an individual and, while it is a very informal sort of approach and a 'user friendly' sort of atmosphere, nevertheless anyone who comes in will be required to go through a simple form of registration in the sense of providing some basic details such as name and address, and a few other relevant matters. That will be put into a subtly structured program which will see these young people emerge at the other end, one would hope, into the second story of their lives. People who come with problems may need one or two visits, or one or two years, on any program before one could say that they were happy and healthy young people again.

The Second Story is there also because we can put together a great deal of expertise by gathering them into a central position. That does not mean that other services will suffer. What we are about is establishing a network, both in the suburbs and around the State, with The Second Story as the hub, so that those other services can draw upon the expertise that will be developed at The Second Story.

We already have The Shopfront at Salisbury, which is a joint venture with the Salisbury council; The Galley drop-in centre at Tea Tree Gully, which is a joint venture with the Tea Tree Gully council; we will have a significant service in the Noarlunga Health Village, which will be opened on 20 October or thereabouts; and we are presently looking at a major multifaceted project at Elizabeth as part of the Federal Government's Project One program. I have recently been to both Whyalla and Mount Gambier to open and participate in seminars involving the young people of both those areas, to consult with them as to what sorts of services they see are needed, and to consult, naturally, with the health professionals. That is really just getting going and has a most exciting future.

It is interesting to note, incidentally, that there was initially some criticism of The Second Story in that we guarantee confidentiality. We think it is most important that young people are in a position where they can approach a health professional, confident in the knowledge that if they share some of their difficulties with that person then that will be treated in confidence. I think that that is something to which young people are entitled.

There was some suggestion, extraordinary though it might have been, that we were somehow trying to undermine the nuclear family, which is the basis of civilisation. Nothing could be further from the truth. Obviously, where there is a happy two parent family, there is a good relationship between the parents and children. One would hope that not too many of them will require the sorts of services we offer at The Second Story. On the other hand, there is very clear evidence that, where there are good home supports, any adolescent who experiences problems, whether mental health problems or other sorts of problems (maybe experimenting with drugs), can be rehabilitated much more rapidly.

That is quite the reverse of interfering with the role of parents. What we are doing is supporting that role. It is interesting that already at The Door we are getting 70 to 80 young people on a Friday night. It is only open, at this stage (the development phase), two afternoons and evenings a week. We are already overwhelmed—almost victims of our success, in a way. More importantly, parents are starting to arrive at The Second Story to thank the Director for the services that are being developed. We already have a good working relationship with the parents, I am pleased to say.

The other thing we have done, which is a major initiative and was announced earlier this week, is to reorganise and very significantly begin to expand the child and adolescent mental health services. That will be done in three phases. Dr Court can briefly outline them.

Dr Court: Phase one is the reallocation of staff in existing child/adolescent pschiatric services associated with CAHFS to the Children's Hospital and the Flinders Medical Centre; the establishment of services at those two hospitals; and the strengthening of support services for them. Phase two, commencing next financial year, will be the development of multidisciplinary community based teams in the Tea Tree Gully and Noarlunga areas; the strengthening of existing metropolitan teams; and the development of some country services. Phase three is the development of acute inpatient services both at the Children's Hospital and the Flinders

Medical Centre, the exact timing of which has not yet been determined.

The Hon. J.R. Cornwall: The exact timing of that will depend on the accommodation being available. Accommodation for both child and adolescent psychiatric inpatient services will become available as part of the stage 4 redevelopment of the Children's Hospital, which has already been approved by Cabinet and which, I think, Mr Chairman, is currently before the Public Works Standing Committee. I will say no more, except to express my hope that this proposal stays on the fast track.

Mr OSWALD: On the ABC news today there was a report that two employees of the Health Commission environmental health unit at Port Pirie had been suspended pending an investigation that they had used public moneys to finance work on their homes. Will the Minister advise the Committee of the known circumstances surrounding the alleged offences? What amount is alleged to have been misappropriated by those employees?

The Hon. J.R. Cornwall: If the ABC said that two employees of the Health Commission had been suspended, it got it wrong. One employee of the Health Commission has been suspended pending further deliberation by the Chairman and the commission. I find myself in a slightly awkward position, Mr Chairman, in that I would have to re-express the view that I have never believed in trial by Parliament or trial by the media. However, I can say that two people were involved: one was from the Department of Housing and Construction and one was employed by the Health Commission in the Environmental Health Centre. Both were involved in the decontamination program.

It appears that these persons used Government supplied material and resources to do some dedusting and renovation to their houses. On information provided to me, in one case the amount involved was $1 400; in the other case the amount involved was $320. We were made aware that there were potential problems at about the end of August, from my recollection. I was certainly told about it when I was on a trip looking at Aboriginal health problems during show week, so it was early in September. As soon as the Department of Housing and Construction and the Health Commission were alerted to the possibility of problems, they each sent their internal auditors to Port Pirie. The Crown Law investigator was also asked to look at the situation.

I was advised as recently as yesterday that there is no evidence of misappropriation at this time; that there is certainly no evidence to suggest criminality or any sort of criminal activity at this time. The simple fact of the matter is that the two people were involved in what was potentially at least an abuse of Government supplied goods and services to the extent in one case of $1 400 and $320 in the other case. Both those amounts were repaid by the officers subsequently.

I have nothing to add other than to repeat two things: there is no evidence of any criminal activity and there is certainly some emerging evidence of a degree of irresponsibility and stupidity. That irresponsibility and stupidity and the use of several hundred dollards worth of resources must be seen in the context of a program which this year has a budget of $2.8 million. Nevertheless, whether the amount is large or small, we would certainly never condone any action by any employee that involved in any way the abuse or misuse of taxpayers' resources.

Membership:

The Hon. P.B. Arnold substituted for Mr G.A. Ingerson.

Mr OSWALD: The Queen Elizabeth role and study function was in many ways a study of the whole State to see where the hospital fitted in to the provision of health care. One of the conclusions of that study is that the southern region is about 150 beds light. In view of this conclusion, if the Labor Party is re-elected to office after the next election, will the new Government expand Flinders Medical Centre or will it choose to expand Noarlunga Hospital to pick up that 150 beds?

The Hon. J.R. Cornwall: The timing would have to be spelt out. There is a firm proposal currently being developed which has been approved in principle by Cabinet for a twin hospital complex at Noarlunga involving a public hospital of 100 beds and a private hospital conducted by Mutual Community of 60 beds.

They will share many facilities, and that will provide a saving both in terms of capital costs and recurrent budget costs. Certainly, it is my intention and that of the commission that the public facility will have a close working relationship with Flinders Medical Centre, although it will not be directly an annexe of Flinders Medical Centre.

In other words, we want the best of both worlds and we believe we can obtain it. The clinical privileges of doctors and the quality assurance programs will be substantially an outreach function of Flinders Medical Centre. We would hope that there will be common admitting privileges to both the private and public hospital so that there will be quality assurance at a level that will be consistent with a first-class teaching hospital. That will provide 160 beds.

Clearly, there is a burgeoning population in areas like Morphett Vale East and, if one looks at the bed to population ratio, whether one works on 4.5 or 4, there will still be—that facility notwithstanding—a need for additional beds at Flinders, particularly in the areas of psychiatry, including child and adolescent psychiatry as part of the CAMS program to which Dr Court referred a moment ago, and purpose built geriatric accommodation that will in turn free up some of the beds currently occupied by the Geriatric Assessment and Rehabilitation Unit.

Altogether, at least in an ideal world, I know that Flinders has developed a major plan and program that it intends to present to the Minister and the commission in the near future which would look for, I think, 132 beds. If one looks at our capital works program, which has been expanded already very significantly for 1985-86 (and one would hope beyond), realistically I do not believe that we would see the provision of those beds at Flinders until at least the end of the decade, but we will certainly see the supply of the additional 160 beds within the term of the next Government.

Mr OSWALD: I am aware that the Federal Government determines the funding of the CAE faculty that trains speech pathologists. I understand that the CAE has only 22 places for trainee speech pathologists in South Australia at a time when there are 400 matriculants applying for positions as an option in their studies. Whilst their study is a federal responsibility in South Australia, the majority of speech therapists practise in public hospitals and carry a major role in the treatment of stroke victims and other forms of speech difficulties. The services of speech pathologists are stretched to the limit to the extent that a child from a disadvantaged background will have great difficulty in receiving public speech therapy treatment. The shortage has reached an alarming level at a time when I notice in the paper that Tasmania is advertising here for speech therapists.

In the case of speech therapists the Minister of Health has to administer health services while he has no control over the level of training and the throughput of students. I acknowledge that fact. Therefore, apart from our all expressing regret at the situation, what can the Minister do to increase the number of speech pathology graduates in South Australia?

The Hon. J.R. Cornwall: First, let me make it clear that to describe it as an alarming level is to get into hyperbole. One could not describe it as an alarming level but certainly

we are short of speech pathologists. I am constantly reminded of this by the member for Unley and I wondered whether he provided the member for Morphett with that question because he persistently and consistently asks me about speech therapists. He does declare his vested interest in the area, as I understand his wife is intimately involved in speech pathology.

This has been a worry to us. There was a move to reduce the annual intake of undergraduates even further last year. I resisted that vigorously and made representations directly to the Director of the South Australian CAE. As a result or despite it (I am not sure which) they kept the intake at the previous level at the expense of a post-graduate course that was planned to be conducted. I cannot influence it directly, nor can we be involved in funding in a cash situation. However, I have asked that they should investigate the possibility, since we cannot provide cash, that we might be able to provide kind. They run clinical services at Sturt, as I understand it, and that is a pretty expensive business and it may be that if we were to run them at Flinders or other of our major metropolitan hospitals and provide facilities and back-up support, that would ease the strain on Sturt to a considerable extent. There have been preliminary discussions along those lines. I do not know whether or not the Chairman can enlighten us further.

Prof. Andrews: I have nothing to add.

The Hon. J.R. Cornwall: That is the positive line currently being investigated. I accept the point, which is well taken, that we need more speech pathologists. I would be delighted to do anything practical that I possibly could (and would have the full support of the Health Commission in so doing) that would enable us to increase the number of speech therapists.

Mr HAMILTON: Page 43 of the yellow book mentions specialist neonatal services at the Queen Elizabeth hospital. Can the Minister say how often this service has been utilised and to what extent it is utilised by the migrant population? I ask this question for obvious reasons. More specifically, I would like to know the number of Vietnamese and Asian people using the service, as I have noticed such people entering the clinic. This morning I noticed a number of women who were very pregnant attending that hospital. While I was there I was involved in a promotion for Heartbeat organisation whose members are to push some beds down Woodville Road to Arndale on 26 October. This is one of those community groups that provides assistance and money for specific needs in hospitals. I believe the Minister would commend that. What is the use of this service by the ethnic population in the western suburbs, and specifically what is its use by Vietnamese and Asian people? I do not know what publicity is given to this hospital in the area, and I would like more detail about this matter.

The Hon. J.R. Cornwall: Nobody could every accuse the member for Albert Park of asking me Dorothy Dix questions. That is a pretty specific question, if one looks at the statistics required. I do not think that anybody present today could provide those figures accurately. I should be pleased to bring those figures back before 18 October to be published in *Hansard.* I will also write to the honourable member directly to make sure that he has those figures. This hospital is in his electorate and like yourself, Mr Chairman, and other members from the western suburbs, he has a special interest in and affection for the Queen Elizabeth Hopsital. I believe that that also apples to the member for Hanson.

Mr BECKER: It is our hospital.

The Hon. J.R. Cornwall: Indeed. A large Vietnamese population uses the services of the hospital, particularly the maternity pre and post natal services. We have done a number of things to support the Indo Chinese community in general and neonatal services in particular at the hospital. I am sure Mr Coombe can give more detail about this matter.

Mr Coombe: In the budgetry advice to the Queen Elizabeth hospital for this current year specific mention has been made of a supplementary allocation to be made later during the year for development of the hospital's neonatology service in terms of staffing. I understand that the hospital is on the brink of recruiting a neonatologist. Most certainly, the sector is acutely aware of the needs of the hospital, particularly in terms of the Vietnamese people in the maternity area and specific funding was made available late last year and will be continued this year for employment of a Vietnamese social worker in the maternity area. As an aside, down the road from the Queen Elizabeth Hospital funds have been provided to the Beaufort Clinic to employ a Vietnamese doctor this year.

Mr HAMILTON: Another area of concern to me over the years has been the Adelaide Dental Clinic, which I had an opportunity to visit recently with some of my parliamentary colleagues. I was most impressed by that clinic and I thank the officers responsible for showing us around. On page 48 of the yellow book there is reference to dental services provided by private dental practitioners through a scheme administered by the South Australia Dental Service. I would like to know, because of the number of inquiries I receive from time to time, how this service has progressed over the past three years and what sort of waiting list applies at this clinic. What facilities are provided after hours for people who have broken dentures or are in need of emergency dental services?

I would also like more detail in relation to money spent on Aboriginal dental care. I understand that money will be spent in the northern part of the State in and around Port Augusta. What are the results of dental treatment and how has it contributed to better dental care for Aborigines in South Australia? What measures have been taken to improve health services to Aboriginal communities, particularly in non-metropolitan areas?

The Hon. J.R. Cornwall: It is difficult to know where to start and finish with the South Australian Dental Service on the range of topics that the member for Albert Park has covered. However, I think that there are a few specifics that I should mention. The South Australian Dental Service is perhaps the best, or certainly one of the best examples one can find of how effectively a service can work within a global budget. The budget allocation to the South Australian Dental Service is of the order of a little over 17 million.

Within that budget it provides the school dental service, at a cost last year of $8.3 million and a proposed cost this year of $7.9 million, plus whatever amount may be necessary from the round sum allowance for any wage or salary increases; it conducts the Adelaide Dental Hospital and community clinics around the suburbs, increasingly in non-metropolitan areas; and, of course, it conducts the pensioner denture scheme, which is one of the real success stories and one of the best examples of cooperation between the public and private sectors that one can find. In 1984-85, there were 8 990, or very close to 9 000, authorisations under the pensioner dental scheme.

That means that almost 9 000 pensioners out there are chewing better today as a direct result of what the South Australian Dental Service has been able to do for them in cooperation with dentists in private practice, because those dentures are in addition to any dentures that may have been provided at the Dental Hospital or through any of the community clinics. The amount of money spent on that last year was $2.17 million.

Because of the flexibility within that global budget to which I referred, the actual funding to catch up completely on any backlog in the pensioner denture scheme was up from $1.3 million the previous year to $2.2 million in 1984-85. We anticipate that in 1985-86 there will probably be a little easing back because so many dentures have been provided under the pensioner denture scheme in the past two years that the waiting list is now down to about three months in non-urgent cases, and in urgent cases they are provided immediately. In terms of broken dentures, repairs, relines and so forth, where it is considered on clinical grounds to be urgent we can issue an authority at once. It is arguably one of the best schemes of its kind in the world—very good indeed!

The School Dental Service has been expanded within existing resources. Members will remember that it was frozen in primary schools as a result of actions taken by the Liberal Government between 1979 and November 1982. The first thing that we did on coming back into government was to extend that service to all Government assisted students in secondary schools in the calendar year 1983: that was done at once, in other words. Through 1984 the service was extended to year 8 children; through 1985 it is being extended to all year 9 students, and so it will go on until our bicentenary year, when the proud boast will be that every student up to and including the year in which they turn 16 in this State will have access to the School Dental Service at no direct cost to their parents. I need hardly say that it is a reasonably popular scheme amongst the parents; the costs of private dentistry can be very considerable.

We have still not been able to run a comprehensive orthodontic service. There is in general a shortage of orthodontists, even in private practice. In an ideal world, significantly more children, based on the observations of Dr Balmes in the Balmes Report, would receive orthodontic services. That is something that we still have to turn to. However, last year we made a start by beginning a pilot orthodontic program on a visiting basis in Whyalla, so it has not escaped our attention altogether, and that must be very much developed in the future.

In addition, we are expanding, as we promised before the last election, community dental services, in other words, general dentistry as opposed to dentures, to low income adults. Last year, there was an injection of $250 000 into that area, which will be $500 000 this year. The full year funding for that is an additional $500 000. As a result, the number of patients treated in community clinics in 1984-85 rose by 35 per cent, and will rise further this year. It has risen from 11 865 patients in 1983-84 to 15 278 patients in 1984-85. Those community clinics are increasingly going in around the State, particularly in the first instance in the areas of greatest need, but that is a very significant program, which will be continued and expanded through 1985-86.

The member for Albert Park also asked me, as part of that rather all embracing question, about dental services for Aborigines. They are being provided through the Aboriginal community controlled health services in Nganampa in the North-West, Ceduna/Koonibba, which is about to be formally established, Yalata/Maralinga, Pika Wiya, Port Augusta/Davenport, and in Adelaide they are provided through existing dental services. As to the amounts of money, I ask Mr Coombe to briefly refer to 1984-85, 1985-86 or both.

Mr Coombe: As the Minister has said, in essence the provision of dental services for Aborigines in the Far North and far western part of our State is carried out through the community based Aboriginal health services such as Pika Wiya at Port Augusta, Ceduna, Koonibba and Nganampa. I have not got specific costs for those first two services, but they can be obtained.

In regard to the provision of dental services for the Nganampa health service, which encompases four of the homelands in the Pitjantjatjara area—Amata, Ernabella, Indulkana and Fregon—the Health Commission has continued to provide in 1985-86 a $80 000 allocation for dental services. Indeed, the last time that I was in that area I met the dentist, and that was very recently.

To augment dental services, not only for Aboriginal people in the Far North and far west of our State but in the more remote areas—Oodnadatta, Marree and so on—private dentists travel with the Royal Flying Doctor Service. Indeed, last year my sector allocated something like $20 000 for upgraded equipment, specifically at Oodnadatta and Marree.

The Hon. J.R. Cornwall: It is a great pleasure to travel the North-West these days and to find in the Pitjantjatjara homelands four resident doctors, whereas two years ago there were none. There is now a resident dentist; six months ago there was nothing but visiting dental services. So, things are really starting to happen in Aboriginal health. However, that is only the beginning in a way. We are getting curative services on the ground, controlled by the local Aboriginal communities, who know best what their needs are. We still have a very long way to go in environmental and preventative health, however, but a very good start has been made.

Mr HAMILTON: As the Minister would recall, in February 1981 I raised a question in the Parliament in relation to cystic fibrosis. I was subject to some ridicule by a member of the Opposition for asking about this disease. I have maintained an interest in that area since then. I wrote to the Minister in the past day or so on behalf of a constituent whose daughter unfortunately has this disease. As I understand it—I am talking from memory—the daughter is resident in the Adelaide Children's Hospital.

I understand she is 24 years of age and undergoing treatment there. From memory, my constituent has asked: what other facilities are to be provided, apart from the Adelaide Children's Hospital, for such a person needing constant attention? I will certainly await the Minister's considered response to my correspondence: however, I believe that it may be able to assist my constituent in the interim if I could get some further information as to the sort of problems existing in this area.

The Hon. J.R. Cornwall: I have not personally seen that letter, so I am not briefed. I remember when this matter was raised by the member for Albert Park some years ago. I believe it was during an active period in Opposition, when he used to put many questions on the Notice Paper. I have Professor Andrews on my right and Dr Kearney on my left, and I would ask Professor Andrews to comment first.

Prof. Andrews: As has been implied, this is reference to a particularly distressing and complex disease and one that requires highly specialised treatment. The dilemma is that you have to centralise such services. It is simply not possible to spread the expertise widely, so the Children's Hospital is the main centre, since this disease usually becomes apparent in children.

However, with increasing improvements in the medical care of these people, they are living longer, and Dr Kearney informs me there is now a good relationship between the Children's Hospital and the Royal Adelaide Hospital, where the Royal Adelaide Hospital has facilities to accept these people once they reach a certain age—usually 18. There may be good clinical reasons from time to time why even at that age a transfer may not be made directly from the Children's Hospital to the Royal Adelaide Hospital, but in general terms there are services for adults at the Royal Adelaide Hospital. Perhaps Dr Kearney would like to elaborate on those.

Dr Kearney: During the last two years the Royal Adelaide Hospital has accepted about 10 patients, who would be adult patients with cystic fibrosis, from the Children's Hospital. Before then the Children's Hospital was able to manage all of the cystic fibrosis patients for the State. The management of these patients is complex and extremely expensive and, with increasing survival, there is a significant demand being placed on the hospital system.

The Royal Adelaide Hospital has been able to accept that number so far, but the implications for the future will be that if there are to be larger numbers accepted for treatment, an adult centre will be required. I am aware that the Cystic Fibrosis Association has recently sought a meeting with the Minister to discuss their requirements, and we will be meeting with them in the near future.

Mr BECKER: What is the estimated cost of repairs and maintenance now outstanding? What is the budget estimate for this financial year? The figure for the maintenance of the Adelaide Children's Hospital for last year was $566 000; Flinders Medical Centre $1.2 million; Queen Elizabeth Hospital $1.3 million; Queen Victoria Hospital $187 000; and Royal Adelaide Hospital $2.2 million, a total of $5.5 million, and that is just for those major hospitals. What is the situation for this financial year?

The Hon. J.R. Cornwall: I will refer this to the Secretary of the Health Commission and any other senior officer he may consider appropriate.

Dr Court: The amounts provided in budgets for this year 1985-86 are not yet known. Because of the budgeting system that we use, we make global allocations to health units that come back to us with a line budget. We will not know the exact amounts provided until we assemble all that information. I can say that for minor works and services and repairs and maintenance—the two lines you are referring to—over the past two years 1983-84, the total for all hospitals was $8.6 million, and in 1984-85 the total was $9.8 million. Therefore, in the past 12 months we spent 14 per cent more on repairs and maintenance and minor works in our hospitals.

We are well aware that we have a large stock of buildings and equipment in the system. Because of the Government's cash accounting practices, going back over 50 years, we do not know the exact value of that stock. You are probably aware that it is the subject of an inquiry by the PAC at present. As Mr Blight is coordinating that matter, he might be able to comment further.

Mr Blight: In recent months the Health Commission has committed considerable analytical resources to this issue, and that has been partly in response to the PAC asset replacement question. As a result of that work, analytical cost models have been produced for all of our medium and major hospitals. These models show the age, economic life and present value of each major asset component within our hospitals. Typical components are the building structure itself, mechanical and electrical services, medical equipment, and so on.

We have also completed similar models for all other health care units, but with a slightly smaller level of detail. At present we are analysing those models to produce an annual figure that we could plan to use in future to ensure that our assets remain intact. The work is close to being complete, and it will enable us to have a good planning base for asset maintenance in the future.

Mr BECKER: What is the age and value of your stock and how does the provision relate to the capital, if that is a fair assessment? What worries me is whether the repairs and maintenance are being kept up to date or whether any works are being deferred.

The Hon. J.R. Cornwall: That has been worrying me for three years, too. The conventional wisdom has been that we had stock, plant, and buildings to a total estimated value of around $2 billion. When I became Minister of Health the capital works allocation in the entire health area for that year was $11.7 million. If that had continued at that level, it would have taken an estimated 230 years to service or replace all of our stock at the end of its useful life. That was obviously untenable. That would have to be reduced by a factor of at least three.

I think that, if we had an accurate value and it was turned over on the basis of a 75 year roll-over, that would be somewhere near the mark. That is the conventional wisdom that I have lived with. In so doing, I have managed to get the capital works program this year up to about $30 million, which is a 99 per cent increase even on last year. It has been a battle to get it up and going again, but it is certainly a matter that causes me concern—not just in relation to some of the priorities being met in the next triennium, but it is more a question of what we might be doing to our children and our children's children if we do not accurately assess in this very complex and increasingly complex and expensive area just what sort of money we should be allocating in the long term.

I think a former Minister of Water Resources no doubt discovered that we had lived off artificial depreciation in relation to sewage mains and water reticulation for a very long time. In many ways it is like not painting one's house or a farmer not renewing his fences: you can certainly live off of artificial depreciation for a very brief period, but the day of reckoning must come. I hope Mr Blight does not now say that all my figures and estimates are wrong.

Mr Blight: It is not a question of saying that at all. The study indicates that the economic life for the building structure is about 75 years, as indicated by the Minister. It also shows that the other category of assets (such as medical equipment) has a very high rate of technological obsolescence: they turn over on a much shorter life cycle. Once the analysis has been completed for the first time, it will give us a base upon which we can plan appropriate maintenance and asset replacement expenditures.

Mr BECKER: What repairs and maintenance occurred at the five major hospitals that I mentioned earlier and which cost some $5.5 million?

The Hon. J.R. Cornwall: I will take that question on notice.

Mr BECKER: Is there any correlation between the expenditure for fuel, light, and power and the amounts spent on repairs and maintenance? The expenditure on fuel, light, and power at the Adelaide Children's Hospital was $760 000; at the Flinders Medical Centre it was $1 050 000; at the Queen Elizabeth Hospital it was $907 000; at the Queen Victoria Hospital it was $226 000; and at the Royal Adelaide Hospital it was $1.4 million. The total expenditure on fuel, light, and power at those five hospitals was $4.3 million. It has been suggested to me that there could be a correlation between that expenditure and the amount spent on maintenance. In the non-teaching metropolitan hospitals the expenditure on fuel, light, and power was $899 000, and the expenditure on maintenance was $740 000. It has been suggested that there could be some correlation between those figures and the break-down of the costs.

The Hon. J.R. Cornwall: The honourable member has raised a splendid issue. I have been reminded that the Health Commission pioneered energy studies, and I think they were begun during the period of the previous Government. We have an Executive Director from the Southern Sector who says that he can answer the honourable member's question.

Mr Sayers: It is not a direct answer to say that there is no correlation between the fuel, light, and power and the repairs and maintenance section of a hospital. The fuel,

light, and power costs most definitely vary according to the type of building, the type of services provided, whether or not there is a laboratory, and the general level of the services provided. The repairs and maintenance expenditure relies on something totally different—the age and type of the buildings, and so on. All of those factors are completely different for both classifications of expenditure and really have no correlation whatsoever.

Mr BECKER: Did the Minister say that some studies had been done and that that was the finding?

Mr Sayers: A number of energy studies have been undertaken in the major hospitals, and huge savings have been identified over the past three or four years and are reflected in the figures recorded in last year's actual expenditure. In fact, the figures would have been very much higher in all of those hospitals if the studies had not been undertaken.

Mr HAMILTON: As a person born and bred in Mount Gambier I have a degree of interest in that city. On page 6 of the yellow book I note with a great deal of interest under new major capital works to be funded in 1985-86 reference to stage 1 of the redevelopment of the Mount Gambier hospital and the replacement of the boilers. Can the Minister provide further information and more specific details with regard to that redevelopment?

The Hon. J.R. Cornwall: I was in Mount Gambier only last Thursday to announce the details with the Executive Director of the Southern Sector. There is a three-stage redevelopment, the first stage of which will be done in two phases, so it is very much a staged program which can proceed at a pace governed to some extent by the funding that is allocated in any particular year. However, it will be important that the first phase be started by the middle of next year. This, of course, has to proceed through the various approvals, but again I hope on the fast track. I said in Mount Gambier last Thursday that we could anticipate having workers on site by the middle of 1986 and that phase one of stage one would be completed as soon as it was practical after that. It is quite an interesting and rather exciting development which ultimately will change the facade of the hospital as well, because it is proposed to put in a series of ensuite bathrooms which will project as pods on the front facade of the hospital so that at the end of the day, they will virtually have a new hospital.

Included in that will be some additional purpose-built accommodation. I think it might be best if Mr Sayers were to go very briefly through the major facets of each phase. I do not think we need to know specifically what floor covering will be used on the third floor or things of that detail, but it would be useful, because it is a $12 million redevelopment. It is probably the biggest redevelopment of its kind that has been undertaken in our generation, in fact, using the existing building. Most of it will be within the existing walls. Perhaps Mr Sayers could give us more detail.

Mr Sayers: The Mount Gambier Hospital is to be substantially upgraded and that will occur in three phases. Phase one will cost $6.4 million. Stage one of phase one will be rectifying problems associated with the medical and pharmaceutical stores, providing a new central sterile supply department, new rehabilitation accommodation including a psychogeriatric unit, new medical accommodation including a new psychiatric unit and a medical isolation unit, upgrading of other building facilities associated with those and the upgrading of existing recovery area and sterile stock storage in the surgical suite.

Stage two addresses the new admission area, the new medical records department, new radiology department, new casualty department, new therapies department and a new pharmacy department along with stores facilities. That is phase one. They are all referred to as new facilities because it is a total change to the existing departments. They are in different locations on different floors and it is a complete change. Phase two costs $4.5 million providing basically an upgraded ward accommodation—paediatric ward, surgical ward, operating theatres, highdependency ward, obstetrics ward and delivery suite. A final phase costing $850 000 reflects the upgrading of the hospital administration and some work on the exterior of the facade of the hospital. Also in the total upgrade this year we are proceeding with the replacement of the boilers at a cost of $1.4 million and replacing the lifts in the main building at a cost of $400 000.

Mr HAMILTON: From page 26, could the Minister elaborate on the longstay nursing home type services in ward 1A at the Mount Gambier Hospital? How many does that accommodate in that ward? Is that a recent innovation or is it to be implemented? Next, on page 24 of the yellow document, it states the expansion of services provided by the Royal District Nursing Society as 1985-86 specific targets and objectives. Is the Minister able to provide some more information in relation to that expansion?

The Hon. J.R. Cornwall: I believe that that was covered at considerable length and depth this morning. The member for Albert Park may not have been present. He might have been talking and not paying attention, but he will find it all in *Hansard*. It is a good story and I would be very happy to tell it again, because we have very much extended the hours to 11 p.m. and this year we are hoping to increase that to around the clock service in the metropolitan area, 24 hours a day, seven days a week. The long-stay or nursing home type patients in Mount Gambier and district are catered for in the 30-bed nursing home at Boandik Lodge, and the 40-bed nursing home called The Oaks.

The Oaks is a rather more recent arrival on the scene. It is a private for profit nursing home in which the Director of Nursing and her husband are the owners. I must say that I visited it only last Thursday and I was very impressed. Where there is a direct involvement by the Director of Nursing in the ownership of nursing homes, one tends to get a better quality of care than when they are simply used as an investment by people who have no direct knowledge of or interest in the quality of care. The accommodation for chronic longstay patients at the Mount Gambier Hospital of necessity does not need to be very large at all. There would be a maximum of six longstay patients there at any time and there would only be six because they were awaiting placement or accommodation in one of the nursing homes or in some alternative appropriate accommodation.

I would have to say overall that on the Commonwealth formula of the number of beds per thousand of population over 70 years of age, that Mount Gambier and district—and by that I mean the lower South-East in general—is to some extent undersupplied with nursing home accommodation at this time, unlike most other areas in the State. In fact, I think there is probably an application for an additional number of beds at one of the current nursing homes. In terms of the hospital, unlike many smaller country hospitals in South Australia, it is not used for nursing home type patients.

Mr HAMILTON: Referring to the Alfreda Rehabilitation Centre, I have noticed over a period of years, and indeed I am led to believe, that there may be a problem in relation to car parking facilities, not only for staff but indeed for persons attending that centre in the future. I am informed that the centre strip of Port Road that goes past the Alfreda Rehabilitation Centre is to be upgraded. It is part of the 150 Jubilee Celebration funding. I am further advised that the Woodville council has rejected an application for cars to be parked on what is the current median strip. In bringing this to the attention of the Minister, has any consideration been given to the usage of the block of land adjacent to the centre for parking? This land is currently a place where

materials are dumped and it looks a little unsightly. Will the Minister obtain a report as to what facilities will be provided for staff and patients and the feasibility of using the adjacent land for those purposes?

The Hon. J.R. Cornwall: That is a very detailed question on a specific establishment, requiring further advice. I will provide that detail. However, there is a proposed review of the western region rehabilitation service. I have before me a letter dated 27 September from Mr David Coombe to Mr Bill Layther, the Administrator of the Queen Elizabeth Hospital, which canvasses the desirability of conducting a review, particularly with regard to issues which include the impact of the proposals for workers compensation reform (especially the emphasis to be placed on effective and early rehabilitation under the new legislation); space limitations within the existing facilities compounded by the commissioning of the orthopaedic exercise pool; proposed relocation of the service's day centre; and misalignment of Commonwealth and State fees policy for rehabilitation services.

That will be quite a comprehensive review and it may be appropriate, when we look at the question of accommodation, to see whether we accommodate the cars as well as the patients and staff.

The Hon. P.B. ARNOLD: I was interested in the response that the Minister gave to the member for Hanson about the need to meet the replacement costs of facilities in as much as while there has been a significant increase in the area—and there certainly needs to be—it is a problem that has been with us for a long time. The Minister referred to the Engineering and Water Supply Department and the cost of replacement of assets. I think there is a like situation in relation to capital involved. In that situation we are talking about the provision of approximately $5.7 million, which means that one is probably looking at a 300 year turnaround. I do not know the situation that we are leaving future generations. I was not here this morning and know that the shortage of trained staff has been canvassed at length.

However, it has been put to me that one of the difficulties of retaining trained professional personnel at the Royal Adelaide Hospital is the shortage of car parks. I also understand that not all members of Cabinet, particularly the Premier, share the same view in relation to the land that would be necessary to provide the additional parking space. I appreciate the problem of nurses working varied hours and having to travel home at odd hours during the night other than in private cars, which can be regarded in this day and age as somewhat risky. Is this area being addressed?

The Hon. J.R. Cornwall: A number of issues can be addressed to that question; one is replacement costs. I do not believe, on all the evidence currently available, that we are in the same position as the E&WS. I think that we are probably keeping up quite well, but only because we have increased the capital works program from $11.7 million in 1982-83 to a little in excess of $30 million this year. In allowing public services and utilities to run down, whether the E&WS, health (particularly hospitals), school buildings, or roads, one ultimately pays a very high price for small government. We should all take that message on board.

People cannot have it both ways. If there is an acceptance that the community has a responsibility, through its elected representatives and the Executive arm of Government to provide adequate human services (health, education and welfare) then there is a cost that must be borne. We have a duty, as legislators, never to lose sight of that. If we do and if we live off our artificial depreciation through so-called small government, then ultimately we do not pay the price, but our children and their children most certainly will.

I do not think that I have any great problems with Cabinet. I am a very persuasive fellow and I get my way in Cabinet most of the time. I have certainly told my colleagues on many occasions about the difficulties with car parking and the problems that that creates in holding specialist categories of staff, in particular, theatre sisters. It would be delightful to have a secure car park with direct access to one or more of the main buildings in the Royal Adelaide Hospital complex. The body we have more difficulty with than my colleagues is probably the Adelaide City Council. There has been a proposal for some time to build a 1 050 space car park at an estimated cost of $4 million. That project could be self funding if the staff were to pay $15 a fortnight ($1.50 per day worked) which is pretty reasonable, and we could proceed with that quite rapidly.

However, things are not always as simple as they seem. A number of interests on North Terrace have put forward a case that they have parking problems, and they include the Institute of Technology and the IMVS, to name just two. The medical profession in this State has a proposal which it put forward for a $5 million medical library, which would incorporate a car park.

At the end of the day it comes down to deciding what is and what is not parklands. There is a view that the RAH and the IMVS (all their buildings) are situated on parklands. There is a counterview that any plan drawn up subsequent to 1840 did not refer to the present Royal Adelaide Hospital site as parklands. There are competing interests. My view has been very simple and direct: I need nurses to run the hospital; I need car parking in order to attract those nurses and to retain them at the hospital.

I have made it clear to all interested parties that I am very single minded in that dedication to obtain car parking, which is well ahead of all the other priorities. Commissioner Ken Tomkinson, who has done all the work for the Government on relocating the bus depot and the rededication of the parklands at what is currently the Hackney Bus Depot (finding alternative sites and so forth) is currently going through an exercise with interested parties on North Terrace, which has only just begun.

It is being handled at the ministerial level by the Deputy Premier as Minister for Environment and Planning. It has been deliberately taken from my direct purview because the correct opinion was that I was a party with a vested interest and could not be seen to be impartial in the matter. My position remains exactly as it has always been: I want a minimum of 1 000 car parking spaces. I am happy for that to fit in in the most environmentally acceptable way that can be devised within the bounds of economic reason. I would not like to see some pie-in-the-sky proposition at the end of the day that would cost so much money that it would never be built.

The Hon. P.B. ARNOLD: Having said that and taking into account the competing interests, does the Minister see any light at the end of the tunnel in resolving the problem?

The Hon. J.R. Cornwall: I do. In fact, what is going to happen is that the architect who has previously been involved has been given a clear planning brief to produce a number of options. They will include RAH's proposal for a self-funding environmentally acceptable car park, but they range right through to looking after everyone's interest, both on the campuses that are enclosed in that area and across the road on the other side of North Terrace. As I understand it, that will be ready in about late November or thereabouts.

The Hon. P.B. ARNOLD: Will the Minister and the Government defer until after the next State election the proposed $5.5 million expansion of the Central Linen Service, taking into account the information that was provided by the member for Hanson earlier today as to comparable costs that were put before the Committee?

The Hon. J.R. Cornwall: I do not know how often I have to explain this to the Opposition—it keeps getting it wrong.

The Hon. Mr Burdett in the Council three weeks ago raised the question of comparable costs and I pointed out then, having taken the best advice I could find in the State, that he was comparing the costs of a linen service with those of a laundry service. There is no comparison. One is comparing oranges and lemons. I will go through it again—reasonably slowly.

The CHAIRMAN: I remind the Committee that, unless questionning on the Central Linen Service is related directly to the money spent by the Health Commission, it is out of order and is to be dealt with on the next line. I advised the member for Hanson that if he wished to pursue the matter now he could do so but that I would not allow questions on the other line, if we get that far.

The Hon. P.B. ARNOLD: That is fair enough.

The Hon. J.R. Cornwall: For the benefit of the member for Chaffey a linen service involves an operation where the linen is provided and laundered. In other words, what happens in practice is that the linen is mostly manufactured by the Clothing Corporation and provided to institutions by the Central Linen Service, and it is returned and laundered by the Central Linen Service. When that linen wears out, as it inevitably does, it is replaced in the contract price. That is quite different from a laundry service which for obvious reasons is easier to provide. The Central Linen Service through the Group Laundry provides both linen and laundry services, and it is erroneous to compare a linen service with a laundry service.

The answer to the question of whether the Government or I would defer the $5.5 million expenditure is 'No'. I am anxious that the good work at the Group Laundry continues. The present plant and equipment is long since past its useful life. We cannot afford to delay one moment longer.

Ms LENEHAN: In regard to young brain injured, I remind the Minister that when he was shadow Minister of Health both he and I attended a facility in Sydney for young brain injured and, I think, it was part of the Westmead complex. We were most impressed by the kinds of facilities and support services that were being provided for the young brain injured. While that experience was one that made us both search our souls and made us grateful that we were neither brain injured nor had people with whom we were personally involved who were brain injured, it was a sad situation. I recall that we discussed the need for a facility in South Australia that would be in some way comparable to the facilities provided in New South Wales. What steps has the commission taken to ensure that adequate services are provided for young brain injured in South Australia?

The Hon. J.R. Cornwall: The facility we visited was Lidcombe. At that time it was one of the few of its kind in Australia. They were doing excellent work there. Professor Andrews worked there at one stage of his distinguished career quite some years ago, and he knows the Lidcombe work well. I got very interested and concerned for the young brain injured during that period in Opposition and, as a result, a clear undertaking was given in the fighting platform that the Labor Party circulated before the last election to allocate $200 000 a year as a catalyst to developing services for the young brain injured in this State. In fact, when we got into Government I found that what we really needed was a major review of all the rehabilitation services on a Statewide basis as a first step towards, in an orderly way, upgrading those services on a priority sort of basis.

We have subsequently, as part of that major review—it took rather longer than anticipated—produced a blueprint for a comprehensive service for young brain injured in South Australia. Provided we are able to follow that blueprint, in a reasonably short time we should get to a point of providing the most comprehensive and the best service in this country for the young brain injured.

Estimates vary as to how many young brain injured people there are out in the community, particularly those who are brain injured as a result of road trauma, but there seems to be general agreement that they are probably increasing at a rate of a little more than 100 a year and that there may be in total as many as 2 000 people in the community who are brain injured. That can result in some quite bizarre behaviour patterns and that class of patient is often very difficult, behaviourly disturbed, and with a borderline IQ.

They are one of the classes of people who were considered by Dame Roma Mitchell in her report on the behaviourly disturbed. Again, we had to wait for that review to finish and the rehabilitation services review to finish before we could start putting them together. We have now produced a comprehensive blueprint, and I ask Professor Andrews to briefly summarise the details.

Prof. Andrews: As the Minister says, this is an increasing problem which in the past has tended to be dealt with in a relatively uncoordinated manner so that neurosurgical services were provided, some rehabilitation services were provided and some inappropriate ones (given the special needs of brain injured, particularly the young brain injured and the behaviour problems associated with their disability).

Then, often inappropriate long-term care was provided in nursing home type situations among older patients. The approach in this State now is to build on the New South Wales concept, where a much more integrated and comprehensive approach to assessment and active management of these patients is undertaken, often over an extended period and with quite impressive results in terms of their return to functionality and to the community.

That means that we had to get quite a number of services together. The centre chosen to be the focal point for this project has been the Julia Farr Centre. The plan envisages the transfer of staff and facilities from the Hampstead Centre to the Julia Farr Centre to provide a comprehensive base for the rehabilitation of these patients and their immediate neurosurgical management. A director, a project officer, and a paramedical person have been advertised for and will be appointed within the next couple of weeks to begin the planning and development of this service.

It is proposed that the Rotary Ward at the Julia Farr Centre be refurbished to provide proper facilities to care for those patients, that a plan for the development of day centres and consultative services in the non-metropolitan area be provided and the needs for long-term care and hostel-type accommodation in the community also be explored and planned for. A case registry is to be established, again at the Julia Farr Centre.

As the Minister has said, there is some debate about the numbers and monitoring this problem and also keeping track of the people who have suffered head injuries; that is a very important aspect of providing a comprehensive program. We believe that as this program develops over the coming year and in the succeeding few years we will be moving towards the most comprehensive quality service for this type of patient that will be found anywhere in this country and potentially in the world. We have, I think, as the Minister said, the blueprint to provide services and we are now in a position, I think, to implement the proposals that were originally put in concept a couple of years ago.

Ms LENEHAN: I am delighted with that answer. My second question relates to a major problem in our community, that of weight disorders. How have the services of the Flinders Medical Centre been improved for those people suffering from weight disorders? The Flinders Medical Centre currently services my electorate. I have been approached by people about this matter. Can the Minister tell the Committee what sorts of services are currently being provided for people with weight disorders?

The Hon. J.R. Cornwall: The principal weight disorders generally referred to in this context are anorexia nervosa and the more common bulimia. This is a disease of western civilisation. All my advice is that it is a result of the multimedia promotion of the 'Slim is Beautiful' picture. This is one of the very few periods in human history where slim has been regarded as beautiful. If one goes back not so many years members might recall from some of the paintings of the great masters that beautiful women were very round indeed. It now seems that they have to show many ribs.

That is, from a medical standpoint at least, regrettable. Anorexia nervosa and bulimia occur predominantly, although not exclusively, in females: about 90 per cent of cases appear in young women. The services in South Australia in terms of personnel and expertise are very good. There are a number of key players who are in world class. Professor Ross Kalucy, his co-workers and his unit at the Flinders Medical Centre are well known. There is a very active trans-hospital arrangement.

Dr Ben-Tovim who, strangely enough, works at the Repatriation Hospital at Daws Road, is very well qualified as a specialist in weight disorders. In fact, at this very moment we are negotiating with him to do a State-wide survey. I believe that he talked with the Chairman of the Health Commission only a few days ago and is in the process of designing a survey that I will be funding out of the Minister of Health's special grants line so that we can find out more accurately just what the incidence of these disorders is in the South Australian community. We know that that incidence is increasing. However, we do not know the exact incidence.

We also know, on the brighter side (I am happy to say), that whereas a decade ago about 10 per cent of those who were unfortunate enough to be afflicted with anorexia nervosa died, the figure in 1985, because of much better management and control, is more of the order of 1 per cent. In terms of the trans-hospital services, all of the major acute psychiatric wards can admit these patients if that becomes necessary. There is certainly pressure on the facilities at Flinders which will not, I must say quite frankly, be overcome until there is a purpose built psychiatric facility at Flinders Medical Centre and that is not in view until around the end of the decade. However, nobody should get the idea that patients are being disadvantaged. It is certainly true that arrangements are not always ideal, but the system is coping, albeit with difficulty.

The other thing is that very often one can imagine the distress of parents when they learn that their 13 or 16 year-old daughter has anorexia nervosa. They have at that time somebody who is excessively thin. They have heard all of the terrible stories and know as a matter of fact that the minimum time for resolution of the problem is 12 months. In many cases it can continue for as long as seven years, on the advice of Professor Kalucy, and in some cases well beyond that. Therefore, one can understand the anguish of parents when they first learn of the disease. That does not always lead to the most rational behaviour, and I say that in the most sympathetic and charitable sense.

It is the experience at the Flinders Medical Centre in particular that very often the assessment, general work-up and support can occur without the necessity for a patient ever to be hospitalised. However, there is great frustration in the meantime and a natural sort of feeling that people want the best for their daughter and that, if only they have her admitted as an in-patient for a month, all will be well. That is not the case. In summary, we are coping. There is an increased incidence of this disease, but I do not think that we will be able to say that we have completely adequate facilities in physical terms until such time as the child and adolescent psychiatric in-patient services are established at both the Children's Hospital and Flinders Medical Centre.

The Childrens Hospital stage 4 redevelopment allows for adolescent and child psychiatric in-patient facilities. That has already been approved by Cabinet and, as I said, is currently before the Public Works Standing Committee. So, one hopes that that will stay on the fast track.

We will have special purpose built facilities—I am doing the commercial again—available of 10 adolescent beds and 10 children's beds in designated psychiatric accommodation at the Childrens Hospital as soon as that is completed and commissioned. We would then look to providing further purpose built psychiatric in-patient facilities at Flinders for this purpose, but, in the meantime, because of some very good cooperation and because from time to time I communicate with the various experts who are providing the services, we have a fairly satisfactory trans-hospital arrangement.

It is fair to say that nobody who genuinely needs on all the valid medical grounds in-patient treatment in South Australia at this stage would be denied it. It is also fair to say that we really do not know accurately how many patients there are, how many are being handled by private psychiatrists and in the private hospital system and who would never come to our attention in the teaching hospital system, and so forth. For that reason, we are having a major survey done to assess the incidence and what services out there in the whole medical and hospital spectrum are handling those patients.

Mr MAYES: I refer to the Minister's document at page 6 and the agency overview. One item highlighted on that page is the development of a comprehensive strategy for the management of the health and medical problems associated with AIDS. As the Minister knows, I have taken up this matter because I had an inquiry from my local government authority regarding the liaison with the Unley council. What steps has the Minister taken to ensure that AIDS is properly handled as a public health issue, and does the Minister agree with some of the predictions in the daily press of doom and gloom in regard to AIDS as an illness within the community?

The Hon. J.R. Cornwall: I will be delighted to provide some background information, and then I will get Dr Baker, wearing his other hat as Chairman of the Central Board of Health, to tell the Committee what role, if any, local government and local boards of health have to play. I was rather amazed, to put it mildly, to hear that health surveyors thought that we had not been doing enough. The program that has been put in place in South Australia for AIDS is a very great credit to all of those who have been involved. I can certainly say that with no fear of being political about it because I have been scrupulously careful not to be involved in the arrangements other than in the sense of having to liaise with my federal counterpart when we were looking for money or to facilitate our participation in a national strategy. AIDS is far too important for politics to come into it at all, and I am sure that everybody would agree with me.

The situation in South Australia currently is that about 120 individuals are known to be infected with AIDS. There have been no local cases of full blown AIDS: there have been two deaths in South Australia, but they have both been in former South Australians who contracted the disease interstate and who literally came home to die. There are 120 known positives: in that 120, intravenous drug abusers comprise the majority, unlike the patterns in many other parts of the country and of the world.

It seems, among other things, that the level of promiscuous homosexuality that would be in Sydney, for example, is not practised in South Australia. We have some very good

evidence of that from the excellent work that has been done by Dr Michael Ross. We were perspicacious enough to fund research work by Dr Ross very early in the piece, long before the virus had ever been isolated, so we had prospective studies in place, which have been most useful.

Of that 120, over 100, are intravenous drug abusers. Based on our population as a percentage of the rest of the country, we could have expected 11 reported cases to date of full blown AIDS. As I said, we have not had any. The reasons suggested for the lack of cases by my advisers are early preventative education and research. We certainly were in an advantageous position *vis a vis* the United States, for example, because we had a time lag and, by the time we had to start actively instituting a program, a great deal more was known about the disease, its cause, its modes of transmission, and so forth. In that sense there was also an element of luck.

We established very early an excellent liaison with the male homosexual community because homosexuality was not a crime in this State. We were able to actively enlist the support of the male homosexual community, and they cooperated with us very well. Dr Scott Cameron and his team in the communicable diseases unit and in his role as Chairman of the AIDS Advisory Committee in South Australia have done a first class job in disseminating information. We have had excellent cooperation from the media: both newspapers, in particular, have been extremely responsible in their treatment of the education programs. There inevitably were the hype and the paranoia. It has been said, and it may well be documented, that phobias about AIDS—fear reaching the pathological stage of phobia—are probably 10 times greater in the community than the disease itself is.

I also have to say, and we say this consistently whenever the question of AIDS is raised in South Australia, that several cases of AIDS are expected to occur by the end of 1985. We should be aware that since there are at least 120 people in the community who we know are infected by the virus, albeit that they are asymptomatic—not showing any symptoms at this moment—a percentage of those will ultimately develop full blown AIDS. It has an incubation period of many years, as everybody would know. We ought to be aware that the first cases are very likely to occur in South Australia before the end of this year. Once that starts to occur, there will be a doubling of cases every six to nine months. It is estimated on the best figures that the epidemiologists can provide me with that 300 cases of lymphadenopathy syndrome and about 110 cases of AIDS or AIDS-related complex will occur in South Australia in the next few years. Probably within five to seven years we will have an estimated 300 cases of lymphadenopathy syndrome and something in excess of 100 cases of AIDS or AIDS-related complex.

They are just facts. I would reiterate that I believe that the education programs, the organisation of preventive programs, the implementation of AIDS testing, with the IMVS as the central laboratory, the service through the Sexually Transmitted Diseases Clinic at Flinders Medical Centre—and everything else that needs to be done have been done in a model way.

Whilst I concede an element of luck since we were in a lag period compared with the rest of Australia and other parts of the world, I would repeat that I think our public health people have done a superb job. As to the specific initiatives, funding of $1 million is involved. I think it would be better if Dr Baker were to summarise what will come into place during the financial year 1985-86.

Dr Baker: As the Minister said, South Australia was well placed; it was the first State within Australia to get a strategy for AIDS approved by Cabinet. Dr Michael Ross, an eminent psychologist, has undertaken a longitudinal study of homosexual men to see why certain groups of those homosexuals are at risk and to assess their risk in South Australia as opposed to other States.

We have had an AIDS unit staffed since 15 May and the IMVS is the State reference laboratory for virology. The IMVS is doing some very innovative work and is leading the field in certain areas of viral studies, looking for the HTLVIII virus. Obviously, training and education programs are very important, as is the training of health professionals and allied workers. We do not want to have the problems of health professionals refusing to treat AIDS affected patients. Also, information to the community in general has been provided and we are working closely with other States and the Commonwealth on this.

AIDS is transmitted by sexual intercourse, and one of the problems within Australia is the deficiency in STD services. The South Australian Government is upgrading the STD service on North Terrace and coordinating a program for STD services throughout the State, as well as improving AIDS education. The Flinders Medical Centre and the Royal Adelaide Hospital have specialised in-patient units for care of AIDS patients and have established outpatient units to look after AIDS or high risk groups attending for advise.

An AIDS Advisory Committee is established within the State, which has board representation from health professionals, the gay community and other groups within South Australia. That board is under the chairmanship of Dr Scott Cameron. We also have an input into the national AIDS task force at Commonwealth level.

Members should be aware that AIDS is still with us and will actually be in South Australia with some cases of full blown AIDS and increasing cases of the other lower grades of AIDS. Therefore, there will be a need for continued staffing of STD and AIDS units, and there will be a need for more resources to be applied to those sections, as well as to the IMVS for further research into the viral studies and possible development of vaccines. One of the problems of AIDS is that at present there is no cure; therefore, those people who are at high risk and those people who do have positive blood results suffer mental trauma and that trauma needs to be further investigated and support facilities provided, through the appropriate agencies.

If we address the issue of local government involvement in health, I would see that local government has a very important role in public health and education of the community in this area on health issues. I think the Minister would agree that he would like to see the health surveyor's role change from health inspection and regulation to providing support and advice to that local community. The question of local government's role in AIDS arrived in my office and I referred it to Dr Scott Cameron, Chairman of the AIDS Advisory Committee, to consider and report back. If it is desired, I can report back to Parliament on that matter.

The Hon. J.R. Cornwall: I know the member for Unley has a special interest in local government and its positive involvement in any preventive programs. I would give an undertaking to respond specifically to the Committee before 18 October and to personally write to the member for Unley as well.

Mr OSWALD: The Minister of Correctional Services suggested to the Estimates Committee that the question which arose during his session should be addressed to the Minister of Health, because the care of inmates of gaols is under that Minister's jurisdiction. The question that was asked of the Minister of Correctional Services was: how many cases of AIDS have been identified amongst inmates of South Australian gaols?

The Hon. J.R. Cornwall: Let us be clear about what we mean by 'cases of AIDS'. I take it that the member for

Morphett means how many positive tests have been reported from the prison population.

Mr OSWALD: The terminology at the last hearing was 'AIDS carriers'.

The Hon. J.R. Cornwall: If we are talking about HTLVIII positive blood results, I suppose they could be described as carriers in the colloquial sense. The lymphadenopathy syndrome and AIDS and AIDS related complex are notifiable diseases in South Australia and have been since quite early in the piece; they were certainly made notifiable diseases before we knew what caused AIDS. A specific decision was taken on all the best advice that was available from Professor Pennington and others, that positive AIDS, in the absence of clinical disease, should not be notifiable. The very good reason for doing that was that we believed that, if it were made notifiable, it would drive the at risk population underground, that we would lose their cooperation and that that would make it much more difficult to be involved in tracing and preventive measures. For that reason the question of AIDS positives has remained, not only outside the notifiable disease area, but it is also regarded as being very important that it remains a matter that is embraced by confidentiality.

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

The Hon. J.R. Cornwall: During the dinner adjournment I consulted with my senior advisers, and particularly with Dr Kearney in his role as Director of the IMVS. I believe it is quite ethical and in order for me to inform the Committee that of the prison population who had blood tests for AIDS there were in fact only two positive results.

Membership:

Mr Groom substituted for Mr Hamilton.

Mr OSWALD: I understand that the board of the Royal Adelaide Hospital decided to invest hospital funds in fixed term deposits in banks with a view to raising revenue on the short-term money market and then investing that money back into the hospital to help its deficit. Is that the case and, if so, did it occur for a period of time before being discontinued? If it was discontinued, why? If this has been done at the Royal Adelaide Hospital, has it also been done at other teaching hospitals?

Mr McCullough: The answer to this question is partly contained in the Health Commission's policy guidelines on accounting matters. Most of the large teaching hospitals, including the Royal Adelaide, invest funds. These funds take different forms. One form is the funds available from private practice, and another form is the funds available from operating funds. The Health Commission's accounting policy states that any interest earned from the investment of public funds—and that is all forms of operating funds or any funds provided to a hospital or collected by the hospital on behalf of the commission—must be paid to the commission and subsequently to Treasury.

The hospitals are free to and do invest other forms of funds from their capital accounts and from private practice funds. Generally, the form of investment is through the short-term money market, which is the way to gain the greatest amount of flexibility at the best possible rate of return. It is quite a proper and normal procedure, and it is in accordance with Treasury guidelines and the Health Commission's accounting policies.

Mr OSWALD: Did Mr McCullough say that the interest earned by the money invested by a hospital is remitted back to State Treasury and is not available to the hospital?

Mr McCullough: That is correct. That is a stipulation by Treasury.

Mr OSWALD: Is that a disincentive to invest money?

The Hon. J.R. Cornwall: In that area we have vigorously investigated incentive budgeting. There would be no point in having a commission as distinct from a department if there was not the potential flexibility contained within a commission structure to provide incentives that can be built into budgets. I point out that we are the only Health Commission left in the country. We are not only the best—we are the only one, and we are determined to optimise the benefits of being a commission. In fact, the Central Sector, of which Mr McCullough is the Acting Executive Director of Administration and Finance, pioneered incentive budgeting.

It might be of interest to the Committee to know that as a result of that policy, which has been ratified by the Finance Committee of the commission, hospitals may now carry over any savings without penalty. That has been practised in the Central Sector on a major pilot basis through the financial years 1983-84 and 1984-85. In relation to the matters raised by the member for Morphett, in most circumstances Treasury remains as inflexible with the commission as it would with any Government department. Our relationships with the central agency—notably Treasury and the Public Service Board—are matters which I think need to be even further investigated. The matter of optimising and making best use of the flexibility that should accrue from being a commission are things that will certainly need to be further pursued. As I said earlier today, the whole question of the legislation and its operation will be overhauled next year.

Mr OSWALD: I will certainly read *Hansard* and study both of those replies. I support incentive budgeting. I may have misunderstood the replies, but it seems to me that, if the Health Commission invests, as I see here, $2.7 million and it does not get the benefit of the interest earned and it goes straight through to State Treasury, I cannot see any incentive for the Health Commission. I believe the Health Commission should receive that money.

The Hon. J.R. Cornwall: It must be remembered that we are one Government.

Mr OSWALD: I refer to 'Source of funds—Intellectually Disabled Services', on page 1 of the blue book. Of the $12.106 million estimated for 1985-86, how much will go to the intellectually disabled services council budget, and how much will go in gross expenditure for salaries, wages and price increases at Minda?

The Hon. J.R. Cornwall: That is a very detailed question. It does include Minda, but the details sought may not be immediately available.

Mr OSWALD: I am looking for the budget figure for the IDSC last year and its budget for this year. If you have those two figures, it will save looking at the total budget and subtracting the Minda component and the component for salaries and wages, because this year's has had that figure included in it and last year's did not. Could you give me the figures of last year's and this year's IDSC budget?

Mr McCullough: I will give them to you separately. The salaries and wages component for IDSC, actual expenditure for the previous year was $20 098 000 in rounded figures in total, including Minda. Goods and services was $9 148 000 in rounded figures. The goods and services contains the grant to Minda for which I do not have the actual figure, but it is approximately $5 million. Those two figures added together will give you a figure of about $29 230 000. The base allocation for the Intellectually Disabled Services Council for this year is $28 787 000 but that amount will be supplemented by items that are specifically funded. For instance, superanauation and workers compensation premiums will flow through automatically and will increase the amount.

The council in fact received increases for inflation on goods and services of $498 000 and other approved adjustments including an add back of saving under the incentive scheme of $121 000. The saving that was added back was $120 000. So, they did not spend money unnecessarily the previous year and did not feel threatened that they had to, so they were able to pick it up this year. It was put back into the base. The amount in setting the allocation for this year included amounts for award carryovers and for the 38-hour week carryover. It had certain other subtractions which related to the items to be specifically funded. I can give the actual figures if they are required.

The CHAIRMAN: The honourable member for Unley.

Mr OSWALD: Mr Chairman, I have only had two questions.

The CHAIRMAN: I am sorry; I do not like the argument that I get from some people that I cannot count.

Mr OSWALD: I sought clarification from the Minister and he only explained some figures.

The CHAIRMAN: You are lucky that I am a very tolerant Chairman.

Mr OSWALD: You are very tolerant.

The CHAIRMAN: I won't always be tolerant.

Mr OSWALD: I acknowledge your generosity this evening. I thank you for that. Some children have varying degrees of intellectual disability and some children are not always as intellectually handicapped as they appear. In fact, in many cases, if recognised and assessed early, they can be treated and can live at an independent level. I understand that the IDSC recently wanted to run a pilot program to work in, I think, the Marion district—I could be corrected on that—but felt severely restrained because they could only afford to advertise the position at the base rate for a junior salaried speech pathologist when in fact the task would have required someone with a wide range of professional speech pathology experience and additional skills which could relate to other health professionals in the area.

Has the Minister received representations from the IDSC for additional financial support to provide an attractive salary for a senior speech pathologist to work in this study, and if so, did the Minister give additional assistance for that purpose and is that additional assistance reflected in the budget lines? If it is not, will the Minister consult the IDSC to assess the worth of this program and the justification for extra assistance for speech pathology amongst the intellectually disabled?

The Hon. J.R. Cornwall: The brief answer to that is, not to the best of my recollection. It would be unusual for an organisation like the IDSC, an incorporated health unit with a budget in excess of $28 million, to make representations to me about a specific salary for a specific employee. It would be most unusual indeed. That is the sort of representative on which may well be made by a group of parents or even by a parent consultative committee with whom I meet on a regular basis. It would be unusual, to say the least, to have the Director of the IDSC or even the council make direct representation to the Minister concerning a salary. That is just not the way the system works. I might say that the IDSC has been the major growth area in the entire spectrum of my portfolio responsibilities in the past three years. It has had additional funding in real terms of the order of between 13 and 14 per cent to the best of my recollection, so it has been very generously treated.

This year it will not be receiving much extra funding, although it is fed quite well in what is by anybody's standard a very generous health budget. It will not be given increases of the magnitude it has received in the previous two years. The principal reason for that is I believe that it needs a year to consolidate. The levels of funding—something of the order of an additional $2.5 million in real terms—for an organisation of that size takes a little bit of digesting. I think that a year of consolidation will do no harm at all.

Mr BECKER: Returning to the Health Commission, I understand that the Deputy Chairman of the Health Commission resigned in April this year. Are you able to inform the Committee when this position will be filled and what is the reason for the delay?

The Hon. J.R. Cornwall: I do not think it is an abnormal delay. The former Deputy Chairman of the Health Commission, Mr John Cooper, resigned to take a very senior post back in the United Kingdom. He was from the United Kingdom originally. He returned home for a number of reasons, including the fact that he has frail aged parents. It was also a very senior post that he went back to. I think we advertised the position some time during May. The reason why there has been some delay is that we selected a Deputy Chairman, who was an outstanding candidate for the position. He was a wellknown figure nationally in health administration and he even came and spent about 10 days with us to familiarise himself with the workings of the commission. He then returned interstate when his wife decided that it was a little late in the day to be moving to Adelaide. She did not appreciate the joys of living in Adelaide as do we lucky people, and regrettably he had to decline the position.

That is the reason in a nutshell why the position has not been filled sooner. Once that happened, we had to reconsider our position. We had to look at the previous field of applicants and within a fortnight I will be recommending to Cabinet the appointee who the commission and I believe should be the next Deputy Chairman. It has not been because of any conspiracy or difficulty. I must say that the Deputy Chairman elect was as disappointed as we were when, at the end of the day, for what were purely family reasons, it became impractical and impossible for him to take up the position.

Mr BECKER: Some months ago there was a hiccup in the administration of the Health Promotion Unit. How is that unit progressing? What programs are currently being promoted? I have always been interested in inoculation programs, particularly for measles, and believe that the community is not aware of the damage that measles can cause to children. I understand that four or five years ago about 30 per cent of children were being immunised. I understand that an intense program to increase awareness of this disease increased that figure to about 50 per cent. Is that program still continuing? Has there been any improvement on the percentage of children being immunised against measles? Is there a general education program about other transmittable diseases in young people?

The Hon. J.R. Cornwall: Mr Ron Hicks, a New South Wales senior journalist, and Professor Kerr-White from the United States, reviewed the operations of the Health Promotion Unit late last year; that was appropriate for a number of reasons, not the least of which was that that unit had, by that time, been established for about four years. It was part of my policy that all of our operations at some stage have what I refer to in the broad sense as an external audit. This was not in the financial sense so much as simply to see how they were operating and to have someone come from outside with a wider vision who could compare our situation in a whole range of areas relative to the rest of the country or what was happening on the world scene. We did this through the Sax committee, the Smith committee, and so on.

The Hicks/White review was completed just before Christmas last year and made a number of important recommendations, some of which concerned the administration of the unit, the policy matters, and the practical way to go in what is very much a new area, relatively, and is a

little hard to quantify in terms of dollars and cents. As a result of the policy recommendations, a Health Promotion Policy Committee was appointed in December 1984, chaired by the Secretary of the Commission (Dr Court); it has broad representation from persons with an interest in health promotion matters.

It is my intention that that will be confirmed as a formal section 16 committee under the South Australian Health Commission Act in the near future. However, it has operated quite well as a committee in the interim and has already made a number of very important recommendations particularly in regard to the commission's health promotion policy and where we should go in the next five to ten years; specifically, the commission's general health promotion strategy and its 1985-86 projects.

I have quite a lengthy and comprehensive list of those projects in front of me, one referring to immunisation phases one, two and three, with amounts of $36 000, $25 000, and $15 000. There are a number of other things: the breast self-examination campaign; the stop smoking campaign; and so forth. I ask Professor Andrews to give more details about immunisation.

Prof. Andrews: In spite of the difficulties that were referred to (or the hiccup, as it was expressed) I now feel very excited about the prospects for health promotion for two reasons. First, as the Minister pointed out, we had a comprehensive review of the directions and priorities in that area. The Health Promotion Services are now administered directly by the public health service under Dr Chris Baker. I believe that that has really had a very compelling effect in terms of bringing that unit into line. I believe it will be administered far more effectively and efficiently in the future.

I am also encouraged by the fact that there are a number of directions in which the program is now heading. The Minister mentioned immunisation. A number of programs carried out in the past will be continued because of their effectiveness, such as the breast self-examination program, the stop smoking programs, and programs concerned with amoebic menigitis, and other specific areas. Considerable resources will be applied to community networking and the use of the very widespread facilities and services in the health system to get more people involved in the activity of health promotion. This was the specific recommendation of the Kerr-White/Hicks report, which was referred to. I believe that that will be a most effective way to go in the future.

In addition, we have been successful in securing a new director—and unfortunately I cannot tell honourable members his name because we have not yet told him—who is a leader in that field. South Australia has once again been able to attract a first-class person to work in this State. No doubt he was attracted by the prospects that are now presented by health promotion following the difficulties we certainly admit occurred during the past year or two. The budget applied $66 000 to immunisation. Dr Baker can speak specifically to immunisation, as that is his area of responsibility.

Dr Baker: Immunisation is a traditional public health problem. We aim to ensure that every child who enters school is immunised prior to entry. We hope to achieve that in five years. Also, the elderly suffer an increased incidence of tetanus due to lack of immunisation and one of the phases is to improve immunisation of the elderly.

Mr BECKER: Are any statistics available on the number of children currently participating in immunisation programs? Are any goals or targets aimed for, particularly in relation to measles? I have an opinion about how dangerous measles can be. Do the Minister's advisers feel that measles is a particularly dangerous disease for children? Where does measles immunisation stand on the priority list in health promotion, particularly in the ethnic community?

The Hon. J.R. Cornwall: Apropos the importance and severity or otherwise of measles, clearly I will ask Dr Baker to comment on that. With regard to the specific numbers that the member for Hanson seeks, they are available. No-one has them on a piece of paper at this moment, but I will certainly undertake to provide accurate figures to the Committee before the expiry of the 18 October deadline.

Dr Baker: Measles can be an insignificant disease for some children but for others it can be life threatening in causing neurological and respiratory long-term impairment. The member asked for goals and, as I said earlier, our goal is to ensure that every child who enters school will be immunised from measles and from the triple antigen, from the other illnesses. Our goal at present is five years but, if our programs are enthusiastic (and immunisation is one of the four main programs that we are entering into for health promotions in the next financial year), we may be able to attain that goal at an earlier date.

Mr OSWALD: At page 1 of the yellow book I see under 'Ministerial Responsibilities' an entry for St John Council of South Australia. I recall that some time ago we passed the ambulance legislation that contained unanimous recommendations of a select committee of the Upper House which, amongst other things, were designed to preserve the rights of volunteers. I have been advised that there is some concern and, in fact, urgency has been expressed that unrest is starting to evolve among the volunteers and paid staff over delays in proclaiming this Bill. Will the Minister be good enough to tell the Committee why the Bill has not been proclaimed and when it is likely to be proclaimed?

The Hon. J.R. Cornwall: Very soon. I am taking a submission to Cabinet on Monday. Of course, we have to appoint a board. There have to be elections held under the control of the State Electoral Commissioner to have a volunteer representative on the board and an employee representative. Those elections are now being conducted. The elections are due to be concluded or declared within a matter of days, I think, and I am taking a recommendation to Cabinet as part of that submission, not only to proclaim the Act but putting forward my three nominees: a lawyer, a doctor and a consumer (as required under the legislation), and I would not have thought that there has been any undue delay. We have expedited that fairly well.

I would hope that, if there is any paranoia abroad, all responsible people will do whatever they can to hose that down. It has been a long saga—more by scuttlebutt than fact—and I think we are close to a situation of having in place mechanisms which will improve industrial relations and relations between the volunteers—the rank and file volunteers—and the paid staff of St John. It was interesting to note that the three Parties in the Upper House—the Labor Party, the Liberal Party and the Democrats—went into that select committee with very different views as to who was the villain of the piece, and they came out unanimously knowing who the villain was. I will not comment on that any further. I believe that we have a very good piece of legislation. Certainly, we have a formula for harmonious working relations between the commission and St John on the one hand and between the employer and the employees on the other hand, as well as between the rank and file volunteers and the paid officers.

Mr OSWALD: In regard to bed occupancies, it has been my understanding that in teaching hospitals, for example, a bed occupancy rate of about 80 to 82 per cent is the optimum that one would want to go to and that anything over that causes difficulties. It has been put to me that at Flinders Medical Centre the occupancy rate now is running in excess of 90 per cent, which is considered a precarious

position to be in for any hospital administration. In fact, it has also been put to me that it is a dangerous position. I am not willing to say that, because I have faith in the Flinders administration. What is the plan in the immediate short term to do something about this occupancy rate over 90 per cent at Flinders when QEH and RAH are running at the low and mid 80s?

The Hon. J.R. Cornwall: I would have thought that any of our major teaching hospitals that were running significantly below 85 per cent would not be well managed. If we were running significantly under 85 per cent for any consistent period then we would certainly look at closing beds. In fact, RAH runs consistently at about 85 per cent with the natural variations that one gets according to respiratory diseases in the winter and so forth. That is good management.

Flinders Medical Centre consistently runs above 90 per cent. I have said that publicly on many occasions and I repeat it for the benefit of the Committee. In fact, our statistics show it running in 1984-85 at 90.1 per cent. Again, allowing for the peaks and troughs every now and again it slips to over 100 per cent, which is not acceptable. It means that we have relative to the number of commissioned beds at Flinders—and there are only now eight beds at Flinders that have not been commissioned (I intend that they will be commissioned within a matter of weeks)—the busiest teaching hospital relative to its bed numbers in the nation.

Stage 4 was never completed; it was aborted by the previous Administration and has never been reinstated. As originally proposed, I do not believe stage 4 will ever be built. What we are proposing is 160 beds at Noarlunga, which is one of the principal catchment areas for Flinders. I cannot provide them overnight but they most certainly will be provided within the term of the next Government and we propose, as I outlined earlier today, an associate relationship at least with Flinders Medical Centre for the 100 bed public hospital at Noarlunga. That will ease the position substantially.

It will still leave us significantly below 4.5 beds per thousand of population, so I anticipate that a modified stage 4 at Flinders will undoubtedly be constructed. In the short term the hospital tends to be a victim of its own success. The only other recognised hospital to which people south of Tapleys Hill have ready access is McLaren Vale which is of course only a 46 bed hospital.

We have looked at a number of options, not the least of which at one stage was the thought of contracting out, that is, buying beds in the community hospitals. I do not believe that, currently, my advisers consider that to be a practical proposition. The Executive Director of the Southern Sector, Mr Sayers, should comment further on the position with regard to pressures on Flinders and on whether any action is appropriate or practical in the short-term.

Mr Sayers: Flinders Medical Centre is reasonably full during the week dropping to a bed occupancy rate of 80 to 85 per cent on weekends. It is a very active and sought after hospital. Plans to build a 160 bed hospital at Noarlunga will greatly ease the burden on Flinders. However, as the Minister has said, that will not occur for about three years. In the intervening period we have addressed the waiting list problem to ensure that patients are not disadvantaged and that the waiting list at Flinders does not blow out to longer than the lists at other hospitals.

We are trying to address elective admissions across all of metropolitan Adelaide. We are managing at present. The situation will slowly deterioriate for the next three years, but that is only natural with a population growth. Then the Noarlunga beds will come on stream. The long-term situation will then be that current plans for building a specialised psychiatric unit and a geriatric unit, mentioned here today, will free up more beds and will address the situation south for the longer term. At present our options is to make sure that the metropolitan teaching hospitals are treated as one in relation to elective admissions procedures, waiting lists, etc. in order that we can overcome any problems that we might otherwise have had in the next three years.

The Hon. J.R. Cornwall: I add, because it is directly relevant, that about 80 per cent of admissions to Flinders are through accidents and emergencies, so that automatically places great stress on the hospital. As I have already said, to a significant extent it is a victim of its own success and enormously good name. The other admissions over and above the 80 per cent are principally for elective procedures, particularly elective surgery.

One way to overcome that problem in a rational and well-managed system is to make sure that there are adequate trans hospital arrangements, so that if the orthopaedic waiting list at Flinders, for example, gets beyond what is reasonable and the waiting list is at the same time being adequately catered for at the Queen Elizabeth Hospital then it is my firm belief that those patients should also be offered the option. They do not have to accept that option in a free and democratic society, but they should certainly be told, to quote hypothetical figures off the top of my head, that a person can have a hip replacement done at the Queen Elizabeth Hospital in four months but that it will take 18 months if they stay on the waiting list at Flinders. In such cases people will be given the opportunity to elect to use the other hospital if they wish.

The main problem within the elective surgery area is the deferrals. It is a new phenomenon in South Australia, although it is regarded in many countries as being normal to have deferrals because queuing has been part of a cost control type of approach. In any queuing system one always finds patients who elect not to go on with surgery, anyway. That is not our policy; we do not find that acceptable. The biggest problem there is when someone is psychologically prepared to go to hospital on Sunday night to have a major procedure on Monday morning for which baby sitting or general domestic arrangements have been made to discover within two or three hours of being about to be admitted that there has been a busy weekend in the accident and emergency department and they must be deferred. When that happens for the second time the electorate offices here about it. When it happens a third time the cards and letters come into the Minister's office. That is undoubtedly our biggest problem at Flinders in practical terms at this stage.

Mr OSWALD: I have been taught, perhaps incorrectly, that once a hospital reaches around the 90 per cent occupancy rate it is a dangerous situation to be in in the short-term and that something should be done about it. The Minister suggested in his reply that, Flinders being a specific case, a 90 per cent occupancy was not a dangerous situation at that hospital. He went on a few minutes later to say that 80 per cent of Flinders' admissions came from accidents and emergencies. I would have thought that with 80 per cent of its patients coming in as accident and emergency patients a 90 per cent bed occupancy rate would create a dangerous situation.

I heard the Minister's reply, but if he could get a second opinion from a doctor who is familiar with big hospital administration and who can put my fears to rest over this 90 per cent figure I would be grateful. It seems to me that, if there is a 90 per cent occupancy rate and 80 per cent of the patients come from accidents and emergencies, we have a problem at the Flinders Medical Centre. Can I have a second opinion.

The Hon. J.R. Cornwall: First, it is not dangerous. We must not err on the side of creating fear and alarm where it should not exist.

Mr OSWALD: I am not trying to be a sensationalist; I am trying to clarify the situation.

The Hon. J.R. Cornwall: I can respond simply by assuring the member for Morphett, other members of the Committee and, far more importantly, the people of South Australia and the residents of the catchment area of Flinders that nobody, and I repeat, nobody, in any life threatening situation will be refused admission or not be seen at Flinders under any circumstances. They would always, as a minimum position, no matter how busy or crowded the hospital was at any time, be at least stabilised: they would be seen, assessed and stabilised. They would certainly be admitted.

Mr OSWALD: That is not my question.

The Hon. J.R. Cornwall: With great deferential respect, that is the honourable member's question. I tell the honourable member the Committee, and anybody else who is interested in listening, that there is no situation in which a patient in a life threatening situation would not be seen at once at Flinders Medical Centre, and admitted if that were necessary.

As to providing a second opinion from a specialised medical practitioner, I am pleased to do that at once. I have sitting on my right a Fellow of the Royal Asutralian College of Physicians, Professor Gary Andrews, who is very *au fait* with the conduct of busy teaching hospitals. In fact, he was at Westmead from the laying of the foundation stone through to the full commissioning of that hospital. Therefore, he is no stranger to busy teaching hospitals. He was also a very senior member of the staff at Westmead, so he is no stranger to clinical or life threatening situations. He is no stranger to medical politics. Therefore, he is very well qualified in all respects to respond at once.

Prof. Andrews: The question is interesting and pertinent. There is no doubt that hospitals that operate at that level, as the Minister has clearly stated, do not represent by any stretch of the imagination a situation of danger of peril, but they are clearly under pressure. It happens that the hospital that the Minister referred to in New South Wales from which I come—I correct the Minister at my peril, but I was there even before the foundation stones were laid or before the first pen was put to paper—is very similar to Flinders in a number of respects. It is a brand new hospital, built in an area of rapid growth and development, where there was a great scarcity of hospital services previously. The vast majority of its patients come through the accident emergency department, and it operates at about 90 per cent occupancy. So, it is a very parallel situation.

It reflects the effect of putting down a facility in an area where health services have in the past been very scarce, and where population growth, development, and demand for services inevitably outstrips the capacity to provide them immediately, with the consequence that the demand for and the pressure on services, particularly in-patient services, is very high indeed.

The people working at Flinders recognise this. They have responded very appropriately to that pressure and the services they provide there are second to none anywhere in the country. They cannot be under all that extraordinary a pressure when, at the same time as providing those expert services on an accident emergency basis, they attract the highest proportion of research funds of any hospital in this country. So, very clearly, the hospital is not in danger in that sense, nor are its patients in danger. They receive the highest quality of care that is available. If that situation is allowed to continue over succeeding decades, and the population grows even more and the demands grow even greater, we will be in a situation where the quality of care will be at risk of suffering. I do not believe that that is the case at present, although we recognise the level of pressure that is placed on the institution.

Mr BECKER: Following the line of questioning from the member for Morphett, two things worry me about Flinders Medical Centre: there is no medical superintendent at the hospital—I do not know whether that is good or bad; it would be interesting to know why we do not have a medical superintendent—and what is the system there from that point of view? If there is not a medical superintendent, what management is there in that area?

The Hon. J.R. Cornwall: Since that is a question that has been exercising my mind ever since I became Minister of Health, that is arguably the best question that has been asked all day: I wish I knew the answer. Flinders moves in mysterious ways its miracles to perform. Part of that was because it was a recent arrival on the scene, and the integration of the medical school and the research functions and their overlap with the clinical functions of a normal busy hospital are very blurred. It is much easier for us to know the real cost at the Royal Adelaide Hospital to the Health Commission in the areas that we are charged with the responsibility of meeting as distinct from that of the teaching and research functions. They can be put in separate boxes much more readily than they can be at Flinders, by the very nature of the way in which that was organised from day one.

I know that Mr Sayers, whose great strengths lie in accountancy and who has experience on the hospital staff both at Queen Elizabeth and Flinders, has tried to unravel these mysteries over a number of years. Objectively, one would have to say that he has had moderate success, but I do not know that anybody has unravelled that fully. I wonder how people like Professor Chalmers, the entrepreneurial and excellent Professor of Medicine at Flinders, would react to having a medical superintendent: there might be some real practical difficulties. But I have people on both my left and right who would be in a better position to comment on that, one from the medical perspective and the other from the accountant's perspective. I would be very interested to hear what both Professor Andrews and Mr Sayers have to say about that.

Prof. Andrews: What the Minister says covers it. There is a view at Flinders that a medical superintendent, if one organises the medical services in an appropriate way, becomes superfluous. With the very greatest respect to my medical superintendent colleagues—and I was one myself once—in many major hospitals the quality of person and the ability and capacity of individuals in the position of medical superintendent to actually superintend all things medical in the hospital is very limited. I wonder sometimes in those situations whether that is the appropriate way to oversight medical services in a major hospital setting.

What happens at Flinders is in effect an alternative, where there is a very defined departmental and divisional structure, and decisions in matters of medical policy and care are made in that system rather than being oversighted by someone whose task it is to do that on a full-time basis. They argue reasonably effectively that it works.

It is certainly different from other hospitals in this State, and there would be a contrary argument that it would be improved if they had a person in that type of position. I accept that they have not lost anything by not having such a post. It may be true that if Professor Chalmers at some stage moves on or retires, in the absence of someone with that degree of energy, enthusiasm, and experience and the background that he has, they would be forced to create such a post and fill it, but I see no problem in their not having such a person at present.

Mr Sayers: Perhaps it is time for personal views as opposed to taking formal Health Commission views. If there is a standard model of medical superintendent, it is based on a medical superintendent who is responsible mainly for the

junior medical staff of the hospital in relation to rostering, organising, selection, etc., and in relation to the administrative and medico-legal matters in the hospital. In the standard teaching hospital there is a medical staff society, which is usually responsible for the professional standards—the standards of a clinical practice that are set. Quite often the chairman of that Medical Staff Society reports and, in fact, has a seat on the board of directors and, therefore, takes the quality of care aspects directly through to the board.

I refer to that as a standard system because usually the full-time medical staff of the hospital in those cases head up most departments and the university contingent is usually separate from the normal administrative arrangements of the hospital. Flinders Medical Centre is totally different, and I would support the Flinders model because their medical staffing is organised differently from other hospitals. The staffing is organised on a divisional line with the university professor being the head of that particular division. As a consequence, the heads of division then outnumber the full time hospital or State paid heads of units.

Therefore, the Medical Staff Society at Flinders Medical Centre is very much a lesser society than that which represents the Queen Elizabeth Hospital or the Royal Adelaide Hospital. As a consequence, the heads of units, which are the professors of Flinders Medical Centre (I think about 23 at the last count) come together on a medical advisory committee, who then have a medical executive committee, and they elect a chairman. From a clinical standards viewpoint, that chairman is effectively the medical superintendent. Other matters of selection, rostering and administrative medico/legal matters are handled by the administrator. Therefore, it is a different model, but it is one that I think works, and works very well.

The Hon. J.R. Cornwall: Despite the vagaries of democracy, Professor Chalmers always seems to have the numbers at election time, which is a tribute to his entrepreneurial brilliance.

Mr BECKER: Have there been any difficulties between the Health Commission and the boards of hospitals? If so, what can be done to improve the working relationships between the commission and boards of hospitals? It has been alleged to me that staff in some hospitals feel they have two bosses—the Health Commission and their board. Should a senior officer of the Health Commission be appointed to a hospital board? This would make it difficult in some sectors; they would probably have to limit a person to no more than two or more boards, if that is feasible. Would anything be gained by having senior Health Commission personnel from the sectors, or wherever, as members of boards?

The Hon. J.R. Cornwall: To answer the second part of the question first: I do not think it would be practical to have relatively senior officers of the commission on hospital boards, for a variety of reasons. I will relate that back to the first part of the question in a moment. I think it would be seen as undue interference and rampant centralism and 'big brother'; it would engender a good deal of resentment and would certainly create more friction than currently exists. If we are into personal views, that is my personal view, but it is also a practical view.

Going back to the first part of the question, I am not aware of any real animosity between hospitals, whether it is the administration of hospitals or their boards, and Health Commission officers. On balance, I believe that sectorisation has worked well. People in the hospitals—whether it is our major metropolitan hospitals or our small country hospitals—now relate to individuals rather than amorphous departments or commissions, which they did not feel they related to previously. People know if they are in the southern sector and there is a problem, that they should contact Ray Sayers or Michael Jelly or Marie Jonson—they know the pecking order and the seniority. By and large, the country hospitals, particularly are vigorous supporters of sectorisation.

On the other hand, to some extent it reflects the sort of sentiment which you are expressing and which has obviously come to you from some persons in the hospitals. I think it reflects the problem to which I referred earlier today where we have gone from a position where the sectors were given global budget allocation and, in turn, went their own way and made global allocations to each of the hospitals who, in turn, spent that money largely in the way was seen fit, provided it was within pretty general guidelines in administrative circulars that go out from time to time from the commission. It was called autonomy.

Shortly after I became Minister I said that I thought 'autonomy' was a dirty word because while you have the Westminster notion of ministerial responsibility, with that goes the question of accountability in just the same degree. We had to have a system within which the hospitals and the health units, whether they were community health centres or the dental service or the intellectually disabled services or whatever, where through the sectors they had to be accountable back to central office and, through the chairman, to the Minister, because at the end of the day there is no question of where the buck stops; the buck stops right on my desk. If something goes wrong in an individual hospital, you do not have members of the Parliament, the press or anyone else wanting to know who is the 3IC in the western sector or fourth in the chain of command in the central sector, they seem to come to my office fairly directly.

You must have a chain and line of accountability and that means that, as a matter of quite deliberate policy, the chairman, myself and the commission, as represented by the commissioners, have tended to tighten the reins. As I said much earlier today, I think we have reached a point in our evolution where we will have to review the Act and look at how we can enshrine in the legislation the sort of accountability that I am talking about.

In going from a department in which the administrator in a hospital was little more in many instances than a cipher clerk and you would put a CO5 in charge of a 150 bed hospital, because all he had to do was shuffle pieces of paper and send them into head office—we went from there right across the other way to saying, 'The board is autonomous. We will give you $10 million or $12 million. Here are the general guidelines, so get on with the business.' I think that was going too far in the other direction. The truth clearly lies somewhere in between. I would be very interested to have the chairman comment on that question as well.

Prof. Andrews: Yes, I would agree with everything the Minister said in that respect. Where there is some tension between hospitals and the Commission, it is perhaps over doubt or confusion as to what degree of autonomy applies to the individual hospital and what should apply. One of the measures we use at present to remind hospitals of their responsibilities are the terms and conditions of funding. These have been applied on a number of occasions, when necessary. Regrettably, in a way, the ultimate weapon of withdrawing funds is a rather heavy axe and would very rarely fall, in fact. However, in a symbolic sense it certainly is a healthy reminder that hospitals do have responsibilities and obligations with respect to the funds they receive to provide services within the Government and the commission's policy.

I think the climate has become more and more healthy in our dialogue with the hospital system and there is growing respect there. I agree with the Minister that it is time after

some eight years that the Health Commission Act could very well be looked at and perhaps revised with respect to matters of accountability and relationships between the commission and its incorporated bodies and bodies that it funds directly.

Mr BECKER: Returning to the blue book, the information supporting the estimates, under the heading 'Statement No. 3, Construction of the 84-85 Gross Payments Budget', the initial estimate was $634 million in round figures. Then the additional funds were provided—$24.7 million; extra GTHA units, receipts, adjustments—$35 million. The final gross payments, budget 84-85, were $694.2 million; less actual payments for year ending 30 June 1985, $689 million. Variants was $5.1 million, less funds not requested from Treasury, $1.8 million. Net cost to SA closing balance, $3.3 million. What is meant by the funds not requested from Treasury of $1.8 million?

The Hon. J.R. Cornwall: I will ask Dr Court to respond directly to that.

Dr Court: The commission calls up moneys each month from Treasury according to the amounts of money we expect to spend in any particular month. By the end of the year 1984-85, we were well aware that we were going to underspend our budget. We therefore called up money to cover what we expected to spend in the month of June. We left $1.8 million with Treasury. We actually finished the year with $3.3 million in our trust account with Treasury—that is in total $5.2 million that we underspent, that we mentioned earlier today. We did not draw the money; it was in the bank.

Mr BECKER: That leads me to one matter which surprised me, and I think that we will get somewhere at some stage. How does the commission get its funds from Treasury? Do you just call for it every month? You do not get a cheque every month from Treasury, because I am amazed that you are not being given the credit for investing your money or whatever as it is disbursed.

The Hon. J.R. Cornwall: Treasury does the investment of any funds, essentially. As I said, we are one Government, and we have been very good to Treasury and we have been very good for Treasury in the financial year 1984-85. One of the reasons was we were pretty generously treated by our federal colleagues. We did forgo the hospital cost sharing agreement and that gave us an advantage in negotiations. We got a good deal for South Australia—there is no question about that—and that is one of the reasons that the total favourable balance to South Australia in the health budget was $18 million. We are just looking at a net there, but the total favourable balance overall was $18 million. There is an element of good management in that also, of course. I think that relates back to some extent to the member for Hanson's previous question.

If one looks at how things operated for the previous 20 years, prior to and for some short period after the formation of the commission, the fact is that the health services simply used to spend their way out of trouble. It was really quite amazing. If we could return to those freewheeling days of that period from the late 60s through to the 70s, it would really be a dream run. We really have to have managers managing in the mid 80s. That is why this accountability thing is far more relevant than it was in, say, 1977-78 when the commission was formed. What happened in the 70s was we had a wages explosion. We had the equal pay issue which of course caused costs to explode throughout the 70s. We had at the same time an explosion in technology as the computer arrived in medicine. That was happening all over the world, of course, but the total expenditure in health in this country went from 4 per cent of the GDP to 8 per cent of the GDP within six or seven years. That was an enormous impact.

People suddenly realised that this burgeoning could not go on. In the late 70s, the last Dunstan budget and the first Tonkin budget really put the screws into the health area, inevitably. The screws came on federally from the Fraser Government and one can take all sorts of political perspectives on it, but from this distance it was obvious that no matter who had been in government or whatever the health insurance system had been at the time, somebody had to put the screws on the burgeoning costs. I think it was done in a brutal and pretty blunt sort of way at the time, because we did not at that stage have the sort of management information that we have available to us in the middle 80s, so people decided that they would take 5 per cent or 8 per cent or 10 per cent off the top, or whatever seemed to be a reasonable amount, and went to individual hospitals and said: 'I'm sorry, that is your budget cut this year: live within it.' That, of course, was worse than the old system where you simply picked up the tab and paid without question.

We have come a long way. We have a good deal more sophistication. We have not yet arrived at a stage in our relations with the central agencies where I think they trust us enough. That is part of the problem. There is a big complex system which they see as gobbling up huge dollars inevitably because the health system is a very big and complex system. They therefore look at this commission that sits out there spending $750 million worth of public funds each year and they are disinclined to let go. I can understand that, but I think we really do have to explore, as I said several times today, moving to a situation where we can use the best elements of the private sector approach to management and combine them with the best elements or the more benign elements of public administration and try to arrive at the best of both worlds. We are still very much in the process of working that out.

Mr OSWALD: In relation to approvals given to hospitals to invest money on the short-term money market, during the month of September the RAH invested $2.7 million with the State Bank on the short-term money market. How would the RAH have had $2.7 million available to put on the short-term money market?

Mr McCullough: That money would be made up from a variety of sources available to the hospital. The hospital would pool various sources to get one large manageable package. The way one invests is generally through bills of exchange in amounts of $100 000, as a rule. These bills of exchange are due some time in the future. One buys them at a discount. When they are due they are cashed in and one makes the discount that way. It is the normal way that dealings are conducted on the official short-term money market.

Of course, they are fully secured securities and the State Bank acts as the agency. The sources of funds would be funds available from unpresented cheques, that is, cheques that have been drawn for payment; until the creditor receives the cheque and deposits it the funds are available. This is normal. All commercial businesses use this as a source of funds for investment. There are always a number of cheques outstanding at any one time, and that money has been passed on to the hospital. That is one source.

Another source is through the payroll. Again, public funds are passed on to the hospital: that is, money received by the hospital for the payroll and, before actually being received by the employees, there is a short delay. During that time funds are available. Rather than lying idle, the funds are used; it is sensible financial management to make good use of them. Another source of funds would be funds available from the hospital's capital account and from private practice. Public funds, that is, moneys advanced or collected by the RAH (patient receipts), are to be forwarded to the

Health Commission in accordance with Treasury instructions.

The Health Commission's accounting policy documents state that the interest earned on these funds must be paid to the commission and, consequently, through to Treasury. Interest earned from investment of private practice funds or any source of capital funds that have come from sources other than the Government are available to the hospital and may be spent in any way at the discretion of the hospital. There are usually rules and so forth, and committees that decide how this is done.

Mr OSWALD: I thought the money was actually invested wth the State Bank and that there was that security. With whom is the actual money invested?

Mr McCullough: I am making the assumption that they are using the short-term money market; that would be done through the State Bank. If one just invested with the State Bank it would give 12 per cent but, if one invests it through the State Bank on the short-term money market, one probably gets 14 per cent. If one gives the State Bank, say, $1 million surplus to invest it will merely invest it on the short-term market itself, so it is wise to actually invest on the short-term money market. It happens every day in all commercial enterprises and, of course, State Treasury is heavily involved in this sort of thing, too.

Mr OSWALD: There is not much security where the money is invested?

Mr McCullough: It is fully secured.

The CHAIRMAN: I remind the member for Morphett that he should direct his questions to the Minister and not to the officer. The Minister can then direct them to the officer if he so wishes.

Mr OSWALD: Yes. Will the Minister talk about his concept of area health boards? The concept of area health boards in New Zealand is well known to us and I understand from the yellow book that the Government is looking at area health boards in the Copper Triangle to integrate and co-ordinate hospital services in the Kadina, Wallaroo and Moonta area. I have some sympathy with co-ordinating three hospitals in that close proximity with common areas of interest, especially as there may be some value in doing that. However, there are other areas such as that in the Mid North in the Blyth/Clare area. Can the Minister indicate whether the area health board concept will be restricted just to the Wallaroo, Moonta and Kadina area, or is he planning to expand the philosophy to other areas and to set up health boards? Taking the Mid North, the Blyth and Clare area in particular, is the Minister willing to guarantee that he will not allow the area medical boards to take over the management of hospitals from local boards?

The Hon. J.R. Cornwall: They will not be area medical boards—they will be area health boards. They will grow by evolution. I have not a 5-year plan, a blueprint or a template that I am imposing on the various lumps of the South Australian map. The nearest thing we have to an area health board in practice is the arrangement that exists on the South Coast where, *de facto* at least, we have an arrangement based on Victor Harbor that is responsible in that area for the general coordination of health and hospital services.

That has grown naturally in a way that suits that area best. I would have thought that in the medium term there would be an ideal opportunity for a very much larger area health board, co-ordinating a much larger population in the western suburbs. The Queen Elizabeth Hospital is about to embark on its renaissance. As the Chairman would know, we are well advanced towards the opening of a quite exciting new community health centre in the old Motor Traders building. We already have a community health centre operating out of the Parks Community Centre. We have the Beaufort Clinic providing mental health services and the Family Planning Association providing clinics.

If one looks at the integration of hospital services through the QEH, rehabilitiation services through Alfreda, community health services, the community dental services and all of the other expanding services in what was previously an area that was relatively neglected one sees that there is a pretty exciting series of things happening in the western suburbs, including Dale Street Womens Health Centre. Where previously the criticism that we tended (and by 'we' I mean both major politicial Parties) to neglect seats that were in so-called 'safe regions', I am pleased to be able to say that during the period I have been Health Minister we have quite specifically discriminated in favour of the areas that needed their health facilities upgraded the most.

It is no coincidence that that has been in the Port Adelaide area, the western suburbs and northern suburbs in particular, and in the major reconstruction of the Lyell McEwin Hospital as the Lyell McEwin Health Village at an estimated 1985 cost of $50 million. There are the exciting prospects at Noarlunga, where the hospital is being built without fear, favor or political prejudice because its facilities are badly needed in the south. The region south of Tapleys Hill may well be an area where an area health board will grow by evolution because there will be confluence of all the health interests in the area.

Again, of course, we will witness as a matter of deliberate policy in our second term the growth of community health councils around the suburbs and the State. It is my intention in my second term as Health Minister to appoint a Director of Community Health Services. There will be a reorganisation within the commission to that extent. A greater emphasis will be placed on social health in the best sense so that everything will grow in an orderly way, but certainly by evolution. In Berri a regional hospital board has not yet got a regional hospital, to be fair.

The Hon. P.B. ARNOLD: When will they get it?

The Hon. J.R. Cornwall: In 1986-87, from memory. Also, there is the Riverland Community Health Service. The RCHS is, *de facto* at least, if not by name, virtually an area health board which does a splendid job in the Riverland; it was even able to gain a consensus as to where the regional hospital ought to be located. I am sad that, despite the vastly expanded capital works program this year, I was not able to fit in the regional hospital at Berri.

However, it is certainly accorded a high priority by the Commission and by me. While that consensus exists I am very anxious that we should start pouring the concrete. In general terms, the area health boards are not part of a centralist socialist plot, but will go with a very big dose of commonsense where they are appropriate.

They may embrace a population as large as 150 000 or 200 000, or they may on the other hand comprise an area that serves a population as low as 10 000 or 12 000. The area health board concept in the Copper Triangle appears to have bogged down rather badly since the Kadina Hospital found that it was not going broke; it seems to be a little less anxious to join the family at this stage, which is a pity. A rationalisation of the hospital and health services in the Copper Triangle would be a very useful model.

The CHAIRMAN: I am thankful that the Minister has reminded me by mention of the capital works program that two lines are to be passed: Minister of Health, Miscellaneous, which we are now dealing with, and the South Australian Health Commission, Capital Purposes. I remind the Committee of that.

Mr BECKER: We are mindful of it. Capital works might not be ready until 9.50 or 9.55 p.m. I must admit that so far this has been an excellent opportunity of obtaining a wealth of information and explanation to certain areas that

we are pursuing. The Estimates Committee has proceeded as I would like to see it proceed as an exercise of providing information and explanation. It is a very important area as far as we are all concerned.

The Hon. Robert Lucas asked a question on 8 August regarding AIDS screening tests and referred to a question that he asked on 14 May this year, when the Minister undertook to mail some information to him. For some reason, that did not happen. On 8 August the Minister said that he would undertake it as a matter of urgency because it is very important to the ongoing educational campaign in regard to every citizen. It related to the AIDS screening tests used by blood banks. The Hon. Mr Lucas asked about research information on the percentage of false positives and false negatives arising from the screening tests. What happened to that information? Is the Minister able to provide it?

The Hon. J.R. Cornwall: I wonder what happened to that information, too. My initial reaction is that it has been such a busy area that somebody may have mislaid or misplaced it. There certainly has been no plot of any description to see that it was not passed on. We have been very actively involved. I said in my answer at that time that I would be delighted to have it disseminated to every member of Parliament and to anyone else who was interested. Those things are normally picked up automatically by staff assiduously reading *Hansard* with a highlighter pen and then dispatching them to appropriate areas. I ask Dr Baker to respond briefly to the question of false positives and false negatives and also ask whether it has been drawn to his attention that there was an undertaking to provide certain information and see that it was widely disseminated.

Dr Baker: I remember a 'ministerial' coming through and our handling it, but I am not sure where it went in the system: I will certainly check on that. False negatives and false positives are of concern. What is important is that the test done by a blood transfusion is an initial screening test. Any person found positive is then counselled and a repeat test is done and that is a specific test by IMVS for HTLV III antibody. The negative is a very low risk—99.9 per cent, but I would like to seek clarification from scientific papers on that matter.

Mr BECKER: In paragraph (2) of the Minister's opening statement under the heading, 'Outcome of the year', we are advised that the Health Commission was $5.2 million under budget. We have been able to identify that $1.7 million was savings under lower than anticipated workers' compensation payments and the lower superannuation contribution was about $.5 million, which means that we can now identify $2.2 million. What are the amounts and the areas of other significant savings, bearing in mind that the significant planned savings were carried forward from the 1983-84 new initiatives? Can we have a further breakdown so we can balance the figures?

On the receipts side, receipts achieved by health units were $7.1 million above the budget. What are those receipts and how did that happen? The Commonwealth contribution, which was mainly under the Medicare agreement, was $5.7 million above budget; is it possible to know how that occurred?

The Hon. J.R. Cornwall: The planned savings achieved to fund the carryover cost of the 1984-85 new initiatives were $1.7 million. I think the member for Hanson said he had already identified that. There were savings resulting from deferred workers' compensation premiums amounting to $1.595 million offset by the increased cost of terminal leave payments of $1.024 million, giving a net plus of $571 000. There was a lower than expected employer superannuation contribution cost of $427 000 and there was a series of items on which there was significant under expenditure—health promotion services, ISIS (and we know that not one penny has changed hands on ISIS), insurance provision, a small amount from the old drug education program (not the new national campaign against drug abuse), and an amount of $133 000 that was under-spent on upgrading St Anthony's. Other sundry items amounted to $166 000 and other savings achieved, which is principally an amount that was under-spent in aggregate by the hospital system, amounted to $745 000.

Therefore, those sundries—from health promotion services to other items—amounted to $1.728 million. If you put your $1.7 million with your $1.728 and your $745 000 and your $427 000 from the lower than expected employer superannuation contribution costs, you should come close to the variant figure of a little over $5 million.

Mr BECKER: What about the receipts side?

The Hon. J. R. Cornwall: The amount was $7.079 million, which was due to increased revenue collections by recognised hospitals. I do not have a breakdown of that figure, but since it was for 1984-85 the amount overall would have been substantially lower than the previous year because it was the first full year effect of Medicare. I suppose I could claim great diligence on the part of the hospitals in chasing up this money, or I could claim quite accurately that the percentage of bad debts decreased significantly because all of the private patients are insured these days; whereas, under the fifth Fraser scheme there was always a percentage of people who did not qualify under the means test for free public hospital treatment and because they were just above it they tended to chance their arm. They were a pretty nasty cost to the system in economic terms, and it was not too pleasant for them, either. The Commonwealth contribution mainly under the Medicare agreement was $5.7 million above budget. Therefore, in the short term at least, Medicare has been a financial plus for the South Australian system

Mr BECKER: I refer to the Review of Services for Behaviourally Disordered Persons, published in May 1985. The review was chaired by the Hon. Dame Roma Mitchell. I refer to page 69 chapter 7—Further needs associated with behaviour disorders: emergency accommodation, as follows:

> There should be established as a matter of urgency a small facility to provide beds for voluntary short-term stay for severely behaviourally disordered persons who find themselves in need of emergency accommodation. It would be likely that some would remain for one night only with others staying for several nights. Some would make frequent use of the shelter.

I think this is a very important area and one of the important recommendations of the report (although all the findings are worthy of consideration). What consideration has been given to this recommendation, has a facility been established and, if so, where and when?

The Hon. J.R. Cornwall: The short answer to the honourable member's last question is, 'No'. I think it is probably quite fair to say that Dame Roma Mitchell's report has brought out the psychiatrists. They have not yet raised their placards or banners, but they do fear a return to the old days of asylums. I think that Dame Roma makes the point very well indeed (and I think it is a splendid report) that to a significant extent when we began to go through the revolution in the late 1960s and early 1970s some people were abandoned by the system. There will always be a group—albeit a relatively small group—for whom safe asylum is the humane and sensible approach both in their own interests and in the interests of the public at large, and for their own safety in some cases as well as for the safety of the public at large. That is a matter with which we will have to grapple.

Whether that safe asylum ought to be provided within the existing psychiatric hospitals or whether it should be provided in other settings is a matter that will have to be

determined. The Dame Roma Mitchell report has to be seen together with the report of the working party on the young brain injured which was referred to earlier today, because clearly there is some degree of overlap and one to some extent had to wait on the other. That is one reason for being a little longwinded in getting our total act together. What we now have is the Mental Health Advisory Committee, which is a relatively new committee that has been established under the South Australian Health Commission Act. An interdepartmental working party is to determine the issues arising from the Dame Roma Mitchell report. They will be specifically charged with developing and reporting on an implementation strategy. We have asked Commissioner Ian Cox to chair that working party because we see that as another example of the cooperative concern policies which the Government has been trying to develop across the range of human services, so that it most certainly will not be exclusively a health problem. We would like a degree a coordination between the caring agencies.

I am never above taking advice from professionals. My father told me when I was a very little boy that a professional would always beat an enthusiastic amateur, and I realise my status as an enthusiastic amateur in these matters. I am firmly of the opinion that the Mitchell report points us in the right direction. As to the crossing of the Ts and dotting of the Is, I believe that an interdepartmental working party at a very senior level, hopefully chaired by Ian Cox, is the appropriate way to go. It will be very much a working party, not a standing committee. I will be looking for some action and recommendations fairly quickly. As a minimum position, they will form part of the pre-budget considerations from February next year.

Mr BECKER: You could not get a better person to chair it than Commissioner Cox with his experience, and I hope that it will follow through Dame Roma's recommendations, because it is an area that concerns a lot of us here. I notice the Flinders Medical Centre now has a CAT scanner. What worries me is that there is a piece of technology that I have been led to believe makes a CAT scanner obsolete. It is called positron emission tomography (PET for short). However, there is a problem, in that you need a cyclotron to drive it and of course the only place where we could get a cylcotron manufactured is Lucas Heights. By the time you could fly a cyclotron to Adelaide safely, half of its life would be gone.

This piece of equipment can penetrate about an eighth of an inch of the brain and I was told in 1981 in Vancouver that this machine can pick up a tumour the size of a pin head and ultimately, with further development, it will be of tremendous benefit in diagnostic medicine and management of neurological disorders, particularly epilepsy. Whilst I realise that it should be a Commonwealth Government responsibility to purchase one of these machines, which I believe is worth about $3 million, I cannot see how we in South Australian could have one. Whilst I would like to see Adelaide as the centre of excellence in medicine in lots of areas, including neurology, I think that we will miss out on this one in the short term. What monitoring is being done to ensure that we can participate in the use of this type of medical technology? What chance do we have of obtaining this type of equipment in the future?

The Hon. J.R. Cornwall: We are well advanced at this stage towards acquiring magnetic resonance imaging. I realise that the honourable member is not talking about NMRI, but that is an improved technique on CAT scanning. There will be one facility in the first instance located at the RAH. We will ensure that the major radiology practices have access to it. They agree at this stage that it is appropriate to have one unit, to be used on a trans hospital basis. The other technology to which the honourable member referred is indeed very high technology. This problem of the short half life and creating a medical cyclotron and so forth are all difficulties that make it very expensive.

It is one thing to detect a brain tumour when it is still the size of a pin head; it is another to be able to take advantage of that diagnosis. In some senses the technology is well ahead of the neurosurgeon's ability to stay up with it, technically. These high tech things are now all assessed by a federal committee. The honourable member is quite right: if there is to be any real chance of this being made available in Australia then logically it would be located in one of the larger population cities in the first instance—Sydney or Melbourne would have to be the front runners. I will ask the Chairman to briefly explain how the very expensive high tech aids to diagnosis and technical advances are monitored and coordinated, and how decisions are taken.

Prof. Andrews: The question raises some very interesting points because these latest types of technology are just today's examples. We can confidently expect that newer methods of diagnosis and treatment will come on line tomorrow or the day after. We really are into the high tech business. It is not only high tech; it is also high cost and very often very high cost because one is talking multi million dollar expenditure for single pieces of equipment. It has been recognised that there should be a national approach to this, rather than each individual hospital or State going its own way.

The Commonwealth established a National Health Technology Advisory Panel, which is the first point of reference, to review available new technology that is developed overseas, and sometimes in this country (because in some areas we are leaders). Those issues are also considered at forums, such as the Australian Health Services Council and, when appropriate, referred to the Australian Health Ministers Conference, which is an annual event.

The usual approach, as in the case of NMRI, is to determine a strategy involving a limited introduction, with evaluation of the technology, so that its further development in the country is on a rational basis. Then one does not face a situation where fancy new pieces, but untried methods and equipment, crop up all over the place in both the public and private sector in a willy-nilly fashion and one virtually has to generate a demand in order to justify the investment, whether public or private. The question of a medical cyclotron for Australia is one that is actively being considered at the moment.

I believe some decision will be taken soon on that question. As the Minister implied, there will probably be one in the country as a whole rather than a number. We will all be party to that decision and the subsequent evaluation of that technology. There is little more one can say about it, except that it is a matter of increasing concern and requires our continuing attention because, at the same time as wanting to control the costs and demands for these pieces of equipment, one also wants to ensure that we are providing the best and latest facilities that are available. It is doing that in a rational way that is the critical question.

The Hon. J.R. Cornwall: Briefly, to give the Committee some idea of the sort of costs that we are talking about in ball park figures, we have recently done an exercise on fee for service for providing NMRI and the utilisation rates that we would have to achieve and the cost per procedure. The simple reckoning was that we would need to do 10 procedures a day— each procedure takes an hour—and that is 50 procedures a week. By the time we provided the appropriate staff and depreciation on the equipment and all of the other associated and on costs, we would be looking at about $500 a procedure, on a 50 weeks a year basis. That is big money in anyone's language.

On the other hand, it may well be cost effective by replacing a number of other procedures such as myelograms,

which it does rather better and, therefore, there is some cost saving as an offset. We have to be very careful, if we are going to keep the lid on those costs that we talked about earlier and regard hi tech not simply as a pleasant plaything but as an integral and essential part of good medicine.

Mr OSWALD: Earlier Prof. Andrews replied to my question about the 90 per cent bed occupancy rate at Flinders. Well after I was given that answer I remembered a case that was brought to my attention in my electorate office of a patient who had gone to Flinders for a hip replacement and who had been told that he had to wait two or three months, I think, for that elective surgery. I did not see the man involved but his family was in the office and they said that he was in a fair degree of pain. We have talked about the 90 per cent rate and I suggested that it was a dangerous level or a level of great concern. I was told by the Minister and others that I should not think that way.

If we did not have a 90 per cent occupancy rate and if we did not have 80 per cent admissions coming in through accidents and emergencies, we could get the occupancy rate down to the low or mid-80s and perhaps start admitting patients who are in pain and who are sitting at home waiting for admission. Although Professor Andrews suggested that 90 per cent was acceptable in view of the type of operations undertaken at Flinders, I say that 90 per cent is not acceptable, bearing in mind that amongst the elective surgery lists there are people who are in genuine pain and who want admission.

The Hon. J.R. Cornwall: I would like to make two points. First, in defence of Professor Andrews, he did not say it was acceptable: he said one could operate at that level without placing anyone in life threatening situations.

I do not know whether that agrees with Professor Andrews' recollection, but it is mine. We had a major study done of waiting lists at metropolitan public hospitals by Mr John Cooper who had great expertise in the health planning area. This was done shortly before his departure to the United Kingdom. It was almost his going away present to his colleagues in the commission. In that report, among other things, we were able to show that waiting lists had not changed markedly, although patterns might have changed around the edges. They had not changed markedly during the period pre and post Medicare.

The very sensible suggestion was made that waiting lists should be periodically circulated to practising GP's who would then have a much better idea about which hospitals were more likely to be able to do hip replacements, for example, in the minimum time so that they might adjust their referral patterns accordingly, because whichever hospital one goes to one will be seen by an orthopaedic specialist, anyway, as a public patient. As yet, to the best of my knowledge, that has not started to happen. It is my intention that it most certainly should happen soon. I ask Professor Andrews to answer the rest of the question.

Prof. Andrews: I think that the question has largely been answered by the Minister. I have little to add. My point was that 90 per cent bed occupancy did put the hospital under significant pressure but not to a level that I would believe could in any way be described as dangerous. It is quite clear that if you do not have to deal with accidents or emergencies at all you can simply run an elective system which would make it simpler for everybody, of course, and which would reduce waiting lists to zero. But, of course, that is not the real world.

The real world requires hospitals to cope first and foremost with accident and emergency situations and with a need for immediate admissions where that is required for clinical purposes. We do not have any choice in that. I think that it needs to be recognised that waiting lists for elective surgery do not just depend on questions of occupancy or accident and emergency demands. There are many factors including the availability of operating theatres (particularly currently with pressures on nursing staff numbers), the availability of nurses and especially the availability of skilled operating theatre trained nursing staff. Therefore, many other factors were taken into account in that review of waiting lists to which the Minister referred. I believe, in looking at waiting times for major areas of surgery, including orthopaedics, generally in the system and at Flinders specifically it will be possible to reduce some of the unacceptable waiting times that have applied in the past and recently.

The Hon. J.R. Cornwall: I point out on the plus side a matter which is very germane to the consideration of this Committee. If one allows the system to take off in an unregulated fashion and to get into gross oversupply of beds one gets to the situation that exists in the United States at this time. The one thing that struck me above all others when I visited the States for the second time last year was the fact that no Government of any political persuasion appears to have had the political courage (or been politically foolish enough, if you like) to try to reduce the bed numbers. The result is that the day bed cost in the United States is about double what it is in this country. I do not think that anybody would like to see a situation arise where through profligacy we got to a bed occupancy rate of 60 per cent. You could certainly have your hip replacement on demand the next day, if that were the case, but you would be paying $900 to $1 000 per bed per day for the privilege.

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

Works and Services—South Australian Health Commission, $28 814 000

Chairman:
Mr G.T. Whitten

Members:
Mr H. Becker
Mr K.C. Hamilton
Mr G.A. Ingerson
Ms S.M. Lenehan
Mr M.K. Mayes
Mr J.K.G. Oswald

Witness:
The Hon. J.R. Cornwall, Minister of Health.

Departmental Advisers:
Prof. G.R. Andrews, Chairman and Chief Executive Officer, South Australian Health Commission.
Dr M. Court, Secretary.
Mr R.J. Sayers, Executive Director, Southern Sector.

The CHAIRMAN: I declare the proposed expenditure open for examination.

Mr OSWALD: Page 6 of the yellow book refers to the establishment of a pain management unit at the Flinders Medical Centre. There is already a pain clinic there. Can the Minister tell the Committee what he has in mind for a pain management unit compared with the unit that is already there?

The Hon. J.R. Cornwall: It is not a question so much of what I have in mind, but of what Prof. Cousins and Dr David Cherry have in mind. They have put together what I consider to be, and on all the advice that I have received is, an excellent pain management package or regimen at

Flinders. It has literally been developed sometimes using corridors and makeshift arrangements over some eight years. If I am seen as almost a patron of the new pain control unit I will be very pleased. Indeed, they may see fit to call it the John Cornwall Memorial Pain Unit when I inevitably shuffle off the coil.

They have been operating in very makeshift conditions. From memory, almost $500 000 has been designated for a specific purpose built pain unit. It will still be the pain clinic, but there will be a designated unit. Of that amount, $100 000 will be contributed by the Flinders volunteers, to whom I have paid tribute publicly on numerous occasions: they do a splendid job.

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

ADJOURNMENT

At 10 p.m. the Committee adjourned until Thursday 3 October at 11 a.m.