HOUSE OF ASSEMBLY

Wednesday 26 September 1984

ESTIMATES COMMITTEE A

Chairman:
Mr Max Brown

Members:
The Hon. Jennifer Adamson
Mrs J.E. Appleby
Ms S.M. Lenehan
Mr I.P. Lewis
Mr K.M. Mayes
Mr J.K.G. Oswald

The Committee met at 11 a.m.

Minister of Health, Miscellaneous, $487 980 000

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

Departmental Advisers:
Professor G. Andrews, Chairman and Chief Executive Officer, South Australian Health Commission.
Mr A.J. Bansemer, Director, Policy and Projects, South Australian Health Commission.
Mr D. Coombe, Executive Director, Western Sector, South Australian Health Commission.
Mr R.J. Sayers, Executive Director, Southern Sector, South Australian Health Commission.
Dr C. Baker, Director, Public Health Division, South Australian Health Commission.
Dr D. Filby, Chief Policy Analyst, Policy and Projects Division, South Australian Health Commission.
Ms L. Furler, Women's Adviser, South Australian Health Commission.
Dr W.T. McCoy, Executive Director, Central Sector, South Australian Health Commission.
Mrs M. Menadue, Chief Administrative Officer, Minister of Health, South Australian Health Commission.
Mr R. Blight, Senior Director, Special Services, South Australian Health Commission.

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

The Hon. JENNIFER ADAMSON: My first question is on a procedural matter. Why is it that the blue book which contains the information supporting the 1984-85 Estimates was not made available to the Opposition until yesterday when, under the previous Administration, it was always tabled with the Auditor-General's Report before the House rose for the break before the Budget Estimates Committees? I have not received a copy and I am having to operate this morning with a photocopy provided to me by my colleagues because no copy has been provided to me as the lead questioner for the Opposition. I think that is an indictment of the Minister's office. It makes it extremely difficult for the Opposition to fulfil its function when a document as complex and complicated as this one is was not given to us until less than 24 hours before the Estimates Committee commenced.

The CHAIRMAN: Of course as a Committee we are dealing strictly with the vote before us. The question of the printing of the blue book is simply a question for the Minister's consideration. Perhaps the Minister would care to answer the question on the unavailability of the blue book, but I point out that the only thing before the Chair is the vote.

The Hon. J.R. Cornwall: The blue book is an adjunct, it is additional information which has been made available since the introduction of programme performance budgeting. The simple answer to the question is that it was not available until last Friday and my instruction to my staff was that it was to be posted to all members of Parliament immediately.

The CHAIRMAN: The blue book may be referred to but the Chair points out that we are not dealing with it as such. I stress that. As far as the Chair is concerned, it is simply a book that is produced for information and nothing more.

The Hon. JENNIFER ADAMSON: I am well aware of that and that was why, when in office, I made sure that about 30 pages of highly detailed information supporting what is a simple two-line statement in the Estimates of Payments was made available to all members. I believe that the Minister's office and the Commission have failed Parliament in not providing that report.

Having said that, I wish to ask the Minister of Health to outline the impact of Medicare on the State health budget in terms of cost to the South Australian taxpayer, in terms of waiting times, and in terms of the metropolitan hospitals and country hospitals in two sectors. Will he also indicate the impact on the Commission itself in terms of the Commission's budget for the past financial year?

The Hon. J.R. CORNWALL: The best thing that I could do would be to get a completely factual statement of the position from the Chairman of the Health Commission (Professor Andrews), who will, I am sure, in turn refer it to another senior member of the Commission who may help in giving a detailed factual and non-political assessment of the situation.

Professor Andrews: Generally speaking, Medicare was the subject of a detailed agreement between the Commonwealth and the State Governments. Part of that agreement included provision for compensation to the State for additional costs resulting from the introduction of Medicare, according to precise formulae set out in the agreement. In addition, provision was made for compensation for loss of revenue that resulted from the introduction of Medicare where free services were provided and other forms of revenue were no longer applicable. We believe that the formulae negotiated between the State and the Commonwealth in drawing up that agreement were fair (I hesitate to say 'favourable', because we will in future be negotiating that agreement again and we would not like to suggest that the Commonwealth has been over-generous with us).

We believe (and the estimates to date support this notion) that the State will not suffer any penalty in terms of costs associated with the introduction of Medicare. Indeed, we rather hope that the application of the formulae, together with effective management of the system, will benefit the State in financial terms in the introduction of Medicare. If more detail is required on the nature of the formulae and their application, I shall pass the question to other officers for comment.

Waiting time is part of the general issue of the overall impact of Medicare on the public hospital system. We did not expect massive changes in terms of utilisation. There has been an undoubted shift, as one would naturally expect, in terms of the health insurance status of patients both in the metropolitan and in the country areas. This has been more marked in country areas because the individual patient in country areas does not see great benefit in maintaining private health insurance in order to receive private care

from local doctors in the local hospital when, indeed, that patient receives virtually the same benefit as a Medicare patient.

There are certain effects of that on the doctors and their position and, indeed, their income which we are looking at with the AMA. There is anecdotal evidence that waiting times have been increasing: that evidence predates Medicare, I might mention. So, it cannot be said necessarily to be directly related to the Medicare issue.

However, with a greater number of people seeking attention and treatment in the public hospital system as Medicare patients, there is obviously a possibility that that will result in increased pressures on the hospitals, including waiting times for operations and attendances at out-patient clinics. Indeed, there has been some reduction in the occupancy of private hospitals, which suggests a shift in to the public sector.

Waiting times are extremely complex. Hospitals do maintain some waiting lists for some procedures on a formal basis. Many 'waiting lists' (notional waiting lists) are not in fact recorded by the hospital but in a sense are recorded by the attending doctor, in that the patients whom the doctor sees in surgery are recorded as requiring hospital treatment. There will be greatly varying degrees of urgency involved, depending on the procedure that is being considered and the condition of the patient. For example, a doctor may see a cataract patient and consider that that cataract needs treatment but it may be that the surgical treatment is not necessary for that condition for up to 12 months in the future having regard to the fact that a cataract virtually matures to the point where it is appropriate that that procedure needs to be carried out. That may well be in the future and that patient may be placed on a waiting list in anticipation. So, if one strictly looks at the figures and sees that there is a waiting list for cataracts of many months, for a significant proportion of the patients on that waiting list it would not be appropriate to operate immediately and that waiting list is then no disadvantage to them.

To get a closer understanding of the present situation and to monitor it, a committee has been set up, chaired by the Deputy Chairman of the Health Commission (Mr John Cooper), and some senior health administrators—John Blandford from the Flinders Medical Centre, Brendan Kearney from the RAH, and Bill Layther from the Queen Elizabeth Hospital—to review waiting times and waiting lists, particularly in metropolitan hospitals since the indication is that it is not a problem in country hospitals at present, and to devise and propose a system to monitor waiting times which may well include a survey approach to get a close fix on waiting times for particular procedures. It may be necessary to survey people as they come into hospital and literally ask them how long they have waited having regard, as I said earlier, to the complexity of waiting times for procedures. Also, that committee will be asked to look at the development of common waiting lists, both within a hospital and between hospitals, with a view to maximising the availability of the resources where they are needed. That again is a complex issue and needs to take account of clinical as well as administrative factors.

The last aspect of the question I would comment on was the impact on the Commission itself. I was not sure how that queston was different from the first: it had regard to the question of costs to the taxpayer since, of course, the Commission's funds are taxpayers' funds. The agreement with the Commonwealth included compensation for any additional major administrative costs to the Commission and left the way open for special representation in regard to specific areas that could be identified, and included such things as the funding of a total of $300 000 for the Inpatient Separations Information System (ISIS)—a computerised system to monitor very closely the hospitals operations and financial management and to provide to the Commonwealth information required in a timely way for Medicare statistics. We have had no indication that responding to these requirements of the Commonwealth has entered us into any additional burden or costs at this point.

The Hon. JENNIFER ADAMSON: The length of that reply prompts me to go back to the commencement of it and ask the Minister, in view of the Chairman's statements about very fair compensation, whether he can advise the Committee what was the amount of compensation, how it has been applied, and over what period it will be paid?

The Hon. J.R. Cornwall: The compensation was relatively very generous, because with the signing of the Medicare agreement we saw an end to the cost sharing agreement which had been in place since 1975. In regard to the precise figures, I think it would be far better for me to ask Mr Alan Bansemer to respond to that matter.

Mr Bansemer: The Medicare compensation, so called, has two broad components. The first is intended to compensate the State for loss of revenue from hospital income as a consequence of the changes in charges, and the second component concerns the cost increases. Specifically, the cost increases this year amounted to $6.9 million, of which $300 000 relates to the ISIS information system that the Chairman mentioned previously. The total compensation expected this year is $96.445 million, as shown in appendix I in the Estimates of Expenditure.

The Hon. JENNIFER ADAMSON: Pursuing that reply, what has been the loss of revenue to the State based on revenue that would have been expected had the cost sharing agreement been applied throughout this financial year? Further, in terms of that loss of revenue, has the Commission been able to estimate how many people have dropped insurance and gone from the private hospital system into the public hospital system? What is the cost to the State of that transfer to which the Chairman referred in his answer about the shifting insurance status?

The Hon. J.R. Cornwall: First, I think we should be very careful not to get into extravagant rhetoric. The fact is that there has been no net loss to the State at all. In fact, there has been a gain, and we have done quite nicely. With regard to how many people have dropped insurance, the figures that have been made available to date indicate that probably about 12 per cent of people and families have dropped insurance. The overwhelming evidence is that the people who have dropped their insurance cover previously had the minimum hospital cover, which they were forced to have, of course, under the fifth Fraser scheme if they did not qualify for a health card.

Also, of those who tend to be insured for the maximum possible amount (including extras) the figure is closer to 1 per cent. So that what we believed all the time has now been validated by the figures: in other words, many people who are just above the margins—the working poor—and who did not qualify for a health card under the former scheme were having great difficulty paying health insurance. These people, on whom private health insurance was imposed at a flat rate (and under which a person on a little more than $200 a week paid the same as a person on $2 000 a week) found that the necessity to insure from September 1981 was a very real hardship—particularly for those people with single income families on relatively low incomes.

So, the great drop has been in those families. There has been a very small drop of people clearly in the upper middle income brackets who are able to afford full insurance (including extras) significantly more comfortably. The effect that that has had on patterns within the public and the private hospitals would concern the Committee. The fact

again is that the activities statistics within the public hospitals show that there has been a significant, and in some cases a very significant, shift towards public patient status; in other words, more people are classifying themselves under Medicare, which entitles them to both hospital and medical care free of direct cost.

They are classifying themselves as public patients, and fewer and fewer people—in other words, one estimates 12 per cent of people who were having great difficulty because they were low income families—have tended to drop health insurance and have moved from being private patients in public hospitals to being public patients in public hospitals. Of course, the overall shift has occurred inside the hospital so that the utilisation rates overall have not changed significantly.

At Flinders, for example, the early indications were that there is very little change in the numbers of inpatients and outpatients being seen. At some of the other hospitals it varies around 1 per cent to 2 per cent. At the Queen Elizabeth Hospital there are some indications on the initial statistics that the overall activity may have increased by up to 4 per cent. However, the extravagant 12 per cent and 15 per cent figures that are touted about relate to the change of status within the hospitals and not to an overall increase in activity at all.

As to the impact of the genuine private hospitals—that is both the community non-profit hospitals in metropolitan Adelaide and the private for profit hospitals—the early figures suggest that there may have been a marginal drop; again, it is marginal. There has been a greater impact on some hospitals than others, of course. It would be fair to say, I believe, that categorisation (I refer to the category 1, 2 and 3 hospitals which have been created as part of a package ancilliary to Medicare) has probably had a greater effect on the finances of some of those hospitals than has the insurance status of their patients.

With regard to the question of compensation that I touched on peripherally, if the honourable member wants some more details, again I would ask the Chairman or one of the senior officers to respond. I stress again, of course, that there was no penalty: in fact, we are financially a little better off than we were under the old cost sharing agreement.

Professor Andrews: We have got some of our papers together to provide precise figures which may help in clarifying these issues. I did mention a shift in terms of the public and private sectors. If one looks at the total activity in the State through the occupied bed days, which gives one an indication of the total level of activity in the hospital system, one sees that the change pre and post Medicare in the recognised hospitals and the private hospitals has been very small indeed. The reduction in occupancy to which I referred in relation to the private hospitals shows up in the case of individual hospitals, but overall the total occupied bed days for the State, if anything, has shown a slight increase in the private hospital sector post Medicare. It should be clear that the compensation for loss of revenue to which reference was made is not just a loss in patient fees. Of course, it relates to other sources of revenue, for instance, the professional services fee that was previously paid by the Commonwealth with respect to private patients treated by hospital staff specialists.

The abolition of the out-patients fees and a reduction of the fees applying to private rates in the hospitals went from $125 per day to $80 per day. I refer to the recognised hospitals within, if one likes, the public hospital system in South Australia, and to the shift between those admitted as private and those admitted as public or now Medicare patients. For the period from February to July 1983, 25.7 per cent of the patients admitted to hospitals in South Australia were private patients. That figure is now 17.7 per cent, and it seems to be stabilising at about that level, although it may continue to decrease somewhat yet. The change began prior to the introduction of Medicare, and I think that reflected the community's anticipation of the introduction of Medicare and dropping its health insurance status.

Ms LENEHAN: Can the Minister outline for the Committee what supplementary funds have been made available in the past year for metropolitan public hospitals, and can he also provide a breakdown of how these funds were allocated?

The Hon. J.R. Cornwall: I think it is very important that we get these figures on the record at the outset. Since this Government came to office it has provided funds to supplement the budgets of metropolitan public hospitals to the extent of $7.4 million. I would like to give the Committee the details of that budget supplementation for the years 1982-83 and 1983-84. I flag to the Committee now that I will be seeking permission to have those figures incorporated in *Hansard*, and I have copies for all members of the Committee if they so desire. For the Royal Adelaide Hospital in 1982-83, in fact very early after we came back into Government in November 1982, the amount of $1.7 million was provided.

That is new money as a supplement to its budget in 1982-83. The QEH received $1.3 million as a budget supplement for the financial year 1983-84. In the financial year 1982-83 the Flinders Medical Centre received $1 million as a supplement to its budget. I repeat, that that was new money: it was money found by this Administration over and above its budget allocation. In the 1983-84 financial year Flinders Medical Centre received a further $700 000, so that in total it has received by way of budget supplementation $1.7 million under this Administration.

The Lyell McEwin Hospital is perhaps one of the unsung success stories of the health industry during the past 22 months. In 1982-83 an additional $300 000 was made available as a budget supplement and in 1983-84 a further $600 000 was made available. In the past two financial years the Lyell McEwin Hospital has received new money by way of budget supplementation to the extent of $900 000. In the 1982-83 Budget it was originally agreed after the Tonkin interregnum that the Adelaide Children's Hospital would receive an additional $250 000. In 1983-84 it was further negotiated and agreed that the Adelaide Children's Hospital would receive an extra $1 million.

I am happy to inform the Committee that in total the Adelaide Children's Hospital has had its budgets supplemented by successive Governments by $1.25 million. Those figures are written into and absorbed in subsequent budgets. The Modbury Hospital in 1982-83 received a supplement of $400 000, and in 1983-84 it received an extra $100 000. The Modbury Hospital has received over the past two financial years budget supplementation amounting to $500 000. Finally, the Queen Victoria Hospital received an agreed budget supplementation in 1983-84 of $50 000.

When all those figures are added together they show that in 1982-83 the amounts of supplementation totalled $3.65 million, and for the 1983-84 year $3.75 million was given by way of supplementation. In total, since 6 November 1982, in order to meet the commitments which we gave in a pre-election statement to restore a measure of reassurance and adequacy to our major public hospitals in metropolitan Adelaide, we have supplemented their budgets by a total of $7.4 million.

Mr LEWIS: Do you have copies of all those figures?

The Hon. J.C. Cornwall: Yes, I have. I seek leave to have those figures which are available in tabular form and are purely statistical inserted in *Hansard*.

Leave granted.

Hospital budget supplements	1982-83 $m	1983-84 $m	Total $m
RAH	1.7	—	1.7
TQEH	—	1.3	1.3
FMC	1.0	0.7	1.7
Lyell McEwin	0.3	0.6	0.9
ACH	0.25	1.0	1.25
Modbury	0.4	0.1	0.5
QVH	—	0.05	0.05
Total	$3.65	$3.75	$7.4

Ms LENEHAN: My second question relates to broad initiatives. Will the Minister provide an overview of the new initiatives which have been introduced and which will impact on both the provision and administration of health services in this State?

The Hon. J.R. Cornwall: I am sure it will be of great interest to the Committee to know that in the 1983-84 financial year the Government has been able to introduce a number of new initiatives which naturally will impact on the provision and administration of health services in this State. They are numerous, and I do not intend to try to take up the Committee's time by outlining all of them. I believe we have only eight hours, and that might not be long enough to go through all the initiatives taken in the past two financial years. I will list some of the major initiatives.

First, in the area of Aboriginal health many things were established. During 1983-84 we established the Nganampa Health Service, an Aboriginal community controlled health service. In line with the policy of this Government and now the Hawke Government I established a Committee of Inquiry into Aboriginal Health Services in South Australia under the Chairmanship of Gary Foley, a former Secretary of the National Aboriginal and Islanders Health Organisation. That report has subsequently been released as a public document and provides a significant blueprint for the future direction of Aboriginal health services in this State. Also, during the period we have established and continued a Statewide renal screening survey. This is conducted under the aegis of the QEH and, of course, while it is called a renal screening survey it does in fact look at many other health parameters, including diabetes and hypertension. We are developing a much more accurate profile of the health problems of Aboriginal people throughout the State. I must say that the more the data becomes available the more depressing is the picture, and it is for that reason that in 1984-85 we will be looking to further significant expansion of community controlled Aboriginal health services around the State.

Secondly, and importantly, we established the Office of the Women's Adviser within the Health Commission to advise the Minister and the Commission on new and existing policies and practices affecting the health of women both in the community and as workers in the health system. That was the first time in this country that a Women's Adviser on Health has been appointed. All the information and the feedback that I get from the activities of the Commission and the initiatives of the Commission and particularly our Women's Health Adviser indicate that it has been a remarkably successful initiative and a remarkably successful appointment in terms of Liz Furler who was given the job. Thirdly, quite recently we established a patient's information and advice office to provide information on health services and to receive and investigate complaints regarding services. Fourthly, at last, following criticism in successive Auditor-General's reports over a number of years, we have established the Commission's own internal audit unit.

Fifthly, the Intellectually Disabled Services Council has received additional moneys in 1982-83 and 1983-84 totalling $2 million. It has been an area of major growth and expansion under this Government. Among other things, three community houses enabling 13 clients to be relocated from institutional care were established, and funds were provided to non-government agencies to assist in the provision of services including community houses. The IDSC budget in terms of its support from voluntary and Government agencies is tremendously important. Also, their own direct activities have moved significantly down a path of implementing a policy of normalisation and deinstitutionalisation.

In August 1983 (that is, in the early part of the 1983-84 financial year), we established the South Australian spectacle scheme, which was based on the original spectacle scheme that was introduced in the dying days of the Tonkin Government. It was reviewed, expanded and made available not only to holders of pensioner health benefit cards, both invalid and age, in South Australia, but also to the long-term unemployed. In the spirit of bipartisanship that often moves me on these occasions, I would have to say that it is a very good scheme, and I think that all Parties agree on that. I congratulate the former Minister for her initiative on establishing the original pensioner spectacle scheme, and I am happy that we have been able to expand it and make it somewhat more comprehensive. The scheme has provided 62 000 pairs of spectacles for pensioners and low-income earners in the 12-month period from 1 August 1983 to 31 July 1984, at an average cost to the patient of about $17. So, the scheme has indeed been successful.

Funds were provided for the Independent Living Centre in the latter part of the 1983-84 financial year. Those centres have been plagued by a history of living from hand to mouth with some funding from Red Cross, some from the Health Commission, and some from wherever else it could be obtained. We ultimately took over financial responsibility for the centre with a budget of $180 000, and it has been incorporated as a unit under the Health Commission Act.

We have established women's community health centres at Elizabeth, Port Adelaide and Noarlunga, and I shall be happy to expand on that subject at length if the honourable member requires more information. During the latter part of the financial year 1983-84, we presided over the introduction by the Federal Government of Medicare, which has enabled services to be provided at no direct cost to a significant number of South Australians who previously were not insured and, indeed, unable to afford health insurance. I refer especially to the low-income and single-income families for whom prior to 1 February 1984 an unexpected serious illness was an absolute disaster.

Ms LENEHAN: Regarding Aboriginal health, I refer specifically to the Minister's remarks about the introduction of a renal screening survey, which the Minister said also included the identification of diabetes and hypertension. I am especially interested in this subject as it applies to Aboriginal health, because of the emphasis on prevention. Will the Minister say how much progress has been made in respect to the survey, and can he comment on the preliminary results from that survey? He said that the results up to the present did not present a successful picture in terms of what is happening in the community.

The Hon. J.R. Cornwall: Preliminary results are available, but I cannot provide the Committee with finite detail. The person who I believe could help us most in this matter (Dr Collings) is not with us at present. We will eventually survey the entire Aboriginal population of the State, but up to the present the survey has shown that 69 per cent of all adult female Aborigines and, I think, 52 per cent of all adult male Aborigines have a significant degree of obesity. Indeed, their level of overweight is significantly more than 20 per cent

of the normal weight of people of the same age and height. That condition is caused primarily by poor diet and poor eating habits, and a look at the bush tucker of people in settlements such as those in the north-west and at Yalata would verify this statement. That condition in turn directly increases the incidence of diabetes remarkably and also the level of hypertension.

Regarding renal disease, the incidence shown up to the present from a large number of the population surveyed is that Aborigines have 1 300 per cent more renal disease than the white population, and the incidence of end state renal failure (that is, kidney failure so serious as to ultimately result in death) is 3 000 per cent higher in the Aboriginal population than in the white population. They are just some of the figures. In every significant category, based on hospital admissions and separations in areas such as Port Augusta, we can say that the incidence of every nominated disease is at least twice the incidence that one would expect, based on surveys and epidemiological data, in respect of the white population of this State.

Mr OSWALD: My questions relate to the subject of waiting times. I was interested to hear Professor Andrews say that waiting times cannot be directly related to the Medicare issues. However, I question that remark. The Minister said that there had been an undoubted shift in health insurance. That is correct: there has been a 12 per cent shift from the private sector to the public sector.

The Minister said that about 4 per cent was taken up in the hospitals, and it would appear that hospitals, through their staffing arrangements and funding, are not capable of taking up any more at present. That leaves 8 per cent of the public who have come out of the private sector into the public sector becoming potential patients. In other words, we have a potential of 8 per cent knocking at the doors, so it would not be unreasonable to assume that that 8 per cent is being buried in the ever-increasing waiting lists.

My line of argument will follow that logic and the Minister may dispute it, but it would be a logical reason for the sudden swelling of waiting lists with the advent of Medicare and would suggest that the waiting lists are taking up those who are coming out of the private sector into the public sector and expecting treatment. Will the Minister give details of the composite lists and the length of waiting lists, by the types of surgery to be performed in the following hospitals: Royal Adelaide, Queen Elizabeth, Flinders, Modbury and Lyell McEwin?

The Hon. J.R. Cornwall: First, I have to say that regrettably the member for Morphett has been recklessly irresponsible in the way he has used figures. I made clear that the 12 per cent shift was occurring within our public hospitals; in other words, it was a change of status from private to public, but that in fact the overall activity levels were virtually static. For example, at Flinders Medical Centre—and I have to go over this again slowly for the member's benefit and I hope that he will absorb it—there has been virtually no change in overall activity, a significant shift from private to public status notwithstanding. I will do that by very simple sums so that I hope it will be clear then even to the honourable member who asked the question.

For example, if we started with 100 patients under the fifth Fraser scheme, 100 in-patients for the sake of the exercise, and 50 were public and 50 were private patients and they were in hospital as in-patients for whatever procedure, at the end of the day we would still have 100 patients. If under the Medicare arrangements, as has tended to happen, some 12 per cent of those patients changed their insurance status from the minimum hospital cover—which was being forced upon them under the old scheme—and became public patients, we would then have 56 public patients and 44 private patients but we would still have 100 patients; not one more and not one less.

If there was an increase—and I hope I do not sound patronising in this because I have to do it slowly and carefully so that everyone understands—of 1 per cent or 2 per cent in the overall activity at a particular hospital, then instead of 100 patients we would have 101 or 102, and they were the sorts of figures that I explained previously to the Committee.

With regard to the 4 per cent, to which the honourable member referred very loosely, that was a specific figure which I used with regard to the Queen Elizabeth Hospital. I did not say, I am not saying and I will not say that there has been a 4 per cent increase overall because that is simply not true. The increase overall has varied from virtually nothing at Flinders to 4 per cent at the Queen Elizabeth Hospital with an average of about 1 to 2 per cent. So, we have not been flooded by hoards of patients at our hospitals. The position has gone along, I guess, very much along the lines I predicted before the advent of Medicare. Indeed, the figure I was using at that time was something of the order of 3 or 4 per cent—that has been not met; the overall activity at our hospitals has been more in the area of 1 to 2 per cent.

The member, again playing with figures to produce the very hyperbolic statement about 'ever increasing waiting lists', having used false figures to present or to try to shore up the premise that there was a 4 per cent increase in activity overall, then got back to the 12 per cent shift in status, which is a vastly different thing indeed. He used his 12 per cent as he did in a grievance debate in this Chamber only a week ago. He took the figure of change of status and tried to use it in a way which either shows that he does not understand it or that he has some vested interest in distorting it. He used a change of patient status within the hospitals to represent a situation where an imaginary or imagined 12 per cent of private patients were beating on the door. Again, that is simply not the case: that 12 per cent has been the average change of status. The overall increase in patient numbers and patient activity has not remotely begun to approach that. I repeat again, and I will continue to repeat it as often as I have to, that the overall change in activity status within the public hospital system in metropolitan Adelaide in particular is of the order of 1 to 2 per cent.

Mr OSWALD: The Minister can prove my figures wrong. I do not recoil from them because I have also read in the press a statement put out by the private funds, the NHSA-Mutual organisation, that there has been a 15 per cent drift across from the private to the public sector. The argument is very strong that, while the public hospitals are using figures which I could also say are phony to justify the under-utilisation of their resources and say that they are not pushing people away, the reality is that the waiting lists are expanding. My question to the Minister was: would he give the Committee a detailed list of waiting lists in those five hospitals I mentioned? I am sure that, if he could supply the waiting lists as at the date that Medicare was introduced and the list as at today for those five hospitals, listed by operations waiting to be performed, we could then all decide whether the waiting lists are absorbing the public that are drifting out of the private sector to the public sector. As a secondary question to that, if the Minister's staff is unavailable to provide that list, would he have any objection if I or my staff contacted the five hospitals and asked to be supplied with a composite list of all the operations that are listed for waiting?

The Hon. J.R. Cornwall: I do hope that the honourable member is not being maliciously mischievous because that is not what these Budget Estimate Committees are supposed to be all about. The 15 per cent drift, as he calls it (we have

been through that before; however, he is not particularly bright or he does not wish to understand), or the 12 per cent drift—I contest the 15 per cent—whichever figure one accepts, is in those people who have relinquished their basic hospital cover—those people who, under the fifth Fraser health scheme, were obliged to take basic hospital insurance which they could not afford and for which they paid at the same rate as do members of Parliament, including the member for Morphett, who, I would suggest with great deferential respect, could afford it much more readily than could a single income family in the western suburbs with two or three children and a take home pay of $220. The people of South Australia and the people of Australia rejected that scheme as being iniquitous and unjust.

Let us return to the 12 per cent or 15 per cent and put it to rest for ever so that if anyone on the Committee raises it again today, we will know that they have difficulty in comprehending even the most basic statistics and facts or, alternatively, we will know that regrettably they are using this Committee for political gain. That 12 per cent to 15 per cent I repeat is with regard to the patient status; public *versus* private, within the public hospitals.

Mr LEWIS: Give us a figure.

The Hon. J.R. Cornwall: I have given the figures at least 12 times but I will give them again. The shift of private to public status within the public hospitals has been of the order of 12 per cent and that corresponds almost exactly with the shift that has occurred within the health insurance funds; in other words, about 12 per cent of people have dropped their basic hospital insurance which they could not afford and now, when they go to the Queen Elizabeth Hospital, the Royal Adelaide Hospital, the Flinders Medical Centre, or any one of a number of our great public hospitals, they classify themselves or admit themselves as public patients, whereas between September 1981 and 31 January 1984 they were forced to take insurance and, of course, were admitted as private patients.

But to talk about a 12 or 15 per cent drift to somehow try to conjure up a completely false picture of 12 or 15 per cent of patients suddenly deserting Calvary, St Andrews or Ashford Community Hospital, for example, and flocking in their droves to, say, the Royal Adelaide Hospital is mischievous nonsense. I assure all members of the Committee, and, to the extent that it is necessary, the people of South Australia at large who, I would suggest, are well known for their good common sense and who by and large are not expressing alarm at all, that overall the public hospital system is coping very well with the changes that have occurred. With the exception of the change of status in regard to patients who now admit themselves as public *vis-a-vis* private, there has been no revolution within the hospitals at all.

With regard to the supply of composite lists of waiting times at major hospitals, neither I nor my officers have that information at our fingertips, but I will take that matter on notice. Indeed a very similar, if not identical, question is already on notice from my Parliamentary colleague Hon. Dr Bob Ritson, in the Upper House. The reply to that question will be available when the Legislative Council resumes on 16 October.

It is worth spending perhaps just a little more time on the matter of the fabled waiting lists. There seems to be an Australia wide push from the conservative forces of politics to paint a picture of a British National Health style waiting list arising around this country. The fact is (as the Chairman of the Health Commission explained in some detail earlier) that waiting lists in this State have varied between hospitals and indeed within hospitals. It is a matter that the Commission has been addressing on its own initiative and at my request for some months. As the Chairman pointed out, we established a committee fairly recently to be chaired by the Deputy Chairman of the Commission and comprising the three most senior administrators of the State's three most senior hospitals. That committee will produce a lot of very valuable information and will certainly give us the opportunity to rationalise surgical services within hospitals and, just as importantly, between hospitals. It will also give us the opportunity to rationalise the public and private patients, on waiting lists.

What happens in the private hospitals outside of our system is very much a matter for the private hospitals and the doctors who attend those hospitals, provided always of course that they meet the standards of care and quality assurance mechanisms that the Government and the Commission insist on. What happens with the private *versus* public patients within our public hospitals is very much a matter of concern to me and to the Commission. Therefore, I believe it is important that we move towards a system of common waiting lists.

None of these matters have ever been addressed by Governments of either political complexion in the history of this State. It is very important, I believe, that there is a commonality between patients within particular classifications. It may well be that (I do not know, and I would not pre-empt the findings of the committee at this stage) that it could be quite inappropriate in future for individual surgeons to keep individual waiting lists. But I would suggest that in regard to the whole matter of waiting lists, yes, I will provide composite lists both to the member who has requested that information and to Dr Ritson, who thought of it first. On top of that I would say that I believe that members of this Parliament and the South Australian public will be given a great deal more information about waiting lists and that there will be a far more rational approach to them generally when we have available the report of the committee to which I referred. I would ask Professor Andrews to add to that anything that he may wish in view of the fact that originally the question was directed not only to me but also to Professor Andrews through me.

Professor Andrews: When one talks about the shift from the private to the public sector, if one is talking about the overall level of activity in those two sectors the figures demonstrate that very little change has occurred. Indeed, overall, the activities as reflected in total occupied bed days in recognised hospitals in South Australia show a slight decrease in the six month post-Medicare period compared with the six month pre-Medicare period. I think the confusion arises in regard to consideration of the shift in the level of people maintaining private health insurance in the community generally and the shift within the public hospitals in terms of the proportion of people who enter hospitals as private patients *versus* public hospital patients.

The 15 per cent figure referred to in regard to private health insurance funds clearly refers to the level of the community maintenance of private health insurance. The 12 per cent figure relates to the shift in the public hospital system between those people entering hospital and electing to be private patients and the reduction in that figure. It should be made clear that while that has some implications for the cost of running the system, those costs are wholly compensated for in the Medicare agreement: so, there is no cost to the State in that move.

On the matter of waiting lists, as a health administrator I would have to say that it is a complex question. Waiting list figures for a day immediately prior to the introduction of Medicare and a post-Medicare day (if such information is readily available) may be difficult to get out. These are details that can be kept at a point in time but not kept as historical data in great detail, and will not tell the whole truth. Even if there was a significant change, logically, one

could not necessarily ascribe that to the introduction of Medicare because one would not know what the trend was prior to that or what the effect that changes in the availability of certain procedures might have had in terms of impact upon that, and I refer particularly to the developing areas in surgery.

So, it is with those problems in mind that this committee (with very specific terms of reference that I will be pleased to provide, although I will not read them out now in case I bore you) has been set up to monitor that situation very closely in co-operation with hospitals. We recognise that there are pressures (and there is anecdotal evidence that there are some pressures on some hospitals), so we have moved very quickly to take account of that, to monitor it and to take whatever necessary action will be required.

The CHAIRMAN: I think the Chair should point out to the member for Morphett that it has allowed the current line of questioning simply because, although it deals, to some extent, with Medicare, it could have some effect on public and private hospitals. However, the Chair has no intention of allowing a debate to be entered into regarding Medicare and what it means.

Mr OSWALD: We are not.

The CHAIRMAN: Order! I am simply pointing out that the Chair will not allow members to enter into a debate on Medicare.

Mr OSWALD: I do not know that we will get very much further on this line at the moment, but I find it quite incredible to believe that the Minister of Health does not know the length of his waiting list for various types of surgery in his hospitals. I realise that he would not know down to the last operation, because it could vary from day to day, but this Committee cannot accept that the Minister is unable to pull out of a brief case now the waiting list for public hospitals in South Australia.

Mr LEWIS: He is obviously covering up.

Mr OSWALD: He could possibly be. Finally, has the Minister any objection to any members of the staff of the Opposition contacting any of the public hospitals and endeavouring to put together a list of their own?

The Hon. J.R. Cornwall: I do not think that there is much point in my persevering with the member for Morphett in these matters. He either cannot or does not wish to understand, but I will go through it once again, slowly.

Mr OSWALD: 'Yes' or 'no'; that is what I want.

The CHAIRMAN: Order!

Mr OSWALD: I am trying to help the Minister to get through in the time available.

The CHAIRMAN: I assure the honourable member that he is not helping the Chair at present. The Chair has made clear why it is allowing the line of questioning at this point: because it was to some degree dealing with the effect that Medicare may have on the status of public hospitals, but only on that basis. It could be said that the honourable member has asked, literally, the same question. However, I will allow the Minister once again to answer the question.

The Hon. J.R. Cornwall: The member for Morphett did say, in my recollection, that as part of what most charitably could be described as a preamble to his last question he found it absolutely amazing that I could not produce the instant and definitive waiting list from my brief case. Again, that shows that he does not begin to understand the complexities of the health and hospital system. A list that would give a number of 4 500 (or any other number) in splendid isolation would mean absolutely nothing if it did not give the various categories ranging from opthalmology to pregnancy, for example.

Mr OSWALD: I hope it would.

The Hon. J.R. Cornwall: Also, if it did not give categories of cold surgery, as it is known around the hospitals, *vis a vis* urgent surgery—the elective versus the non-elective—the relative urgency of all the various categories in a complex system, then of course it would not mean a thing. Simplistic approaches may suffice for the simple minded, but they do not suffice for me nor for the Health Commission.

I repeat again that those lists can and will be made available. Perhaps the member is simply waiting for some fabled list which has upon it someone who may be on it, for example, for three days, if he or she attended on Friday and was booked in for relatively urgent surgery on Monday; such a person would no doubt be on the hospital's list. On the other hand, it could involve someone who attended with a cataract that was diagnosed as requiring surgery at some time in the future, as part of the prognosis. If neither of those people needed surgery nor were ready for surgery at the time of the initial examination, but were jumbled up together, of course, the figures would mean absolutely nothing at all.

So, I repeat that this committee will define any contentious problem areas. It will assist in an integration and rationalisation of surgical services. I repeat that when all the work that is currently being done is available, I will make available to this Parliament—both to members of this Committee and to the Hon. Dr Ritson in the Legislative Council—a summary which will mean something. In the meantime, I refuse to be stampeded into giving raw figures which mean nothing to anyone. I also say that there is no question (and I make this point for those who would attempt to stir up Clayton's crises within our great hospital system) that there is little question that the South Australian hospital system is the best in this country.

The Hon. JENNIFER ADAMSON: Has it changed in the past two years since you criticised it?

The Hon. J.R. Cornwall: It would be inappropriate and out of order for me to respond to rude interjections, would it not, Mr Chairman? However, I would be very happy to respond to that if the member had the manners to ask it as a formal question later. I repeat that following the Budget supplementation of almost $8 million to hospitals that have had their hearts cut out by the previous Administration, we now, I am pleased to be able to say, have the best hospital system again in this country. That means, of course, that, given the general levels of medical expertise and hospital quality in this country, South Australia is the best in this country; it means that we rank highly on the world scale.

With regard to the other part of the question which referred to allowing the member for Morphett to approach the hospitals directly for a waiting list, I can only say that, in view of the total lack of understanding that he has displayed in the first 100 minutes of this Committee, that may be a very perilous course indeed. However, I will be more than pleased to allow him direct access at any time to the Chairman of the Health Commission and to the executive directors of the sectors and, through them and in consultation with them, to the administrators of the major hospitals that he mentioned. I think to let the honourable member loose without a minder, however, would be very dangerous and might not—

Mr LEWIS: He might get to the truth of the matter.

The Hon. J.R. Cornwall: He might not. Are interjections in order from those who do not even participate in the Committee?

The CHAIRMAN: Order! Interjections are out of order. I hope that the Minister does not refer to interjections.

The Hon. J.R. Cornwall: Mr Lewis is also very rude.

Mr LEWIS: And so are you.

The CHAIRMAN: Order!

The Hon. J.R. Cornwall: That would be very dangerous because the honourable member might simply use that position to continue to mislead the people of South Australia,

as he attempted to do in a grievance debate in this Chamber last week.

Mr LEWIS: Good speech!

The Hon. J.R. Cornwall: It was one of the worst speeches that has ever been delivered in the history of the colony and, subsequently, the State of South Australia, in which he was maliciously mendacious. I do not intend to expedite or in any way assist a member who chooses to use false figures to denigrate an excellent service, but I am prepared, as I said, to make the Chairman of the Health Commission and the executive directors of the sectors, available to the member for Morphett for that exercise. Indeed, it may do him the world of good.

The CHAIRMAN: Before proceeding, the Minister has inferred on two occasions that information could be made available to the Committee at a later date. I point out, as I pointed out yesterday, that any information which becomes available and which has some direct meaning in regard to the questions should be in a form that is suitable for insertion in *Hansard* and should be made available as soon as possible, but certainly no later than Friday 19 October. That would be much appreciated.

Mr MAYES: I refer to the overall review of the alcohol and drug treatment programmes offered by the Health Commission in this State. This is specifically cited on page 37 of the Estimates programme. What initiatives has the Health Commission planned for the overall review of alcohol and drug treatment programmes in South Australia?

The Hon. J.R. Cornwall: As I am sure all honourable members are aware, the Alcohol and Drug Addicts (Treatment) Act was recently repealed by this Parliament, and that was proclaimed on 3 September. At the same time, we replaced the old Alcohol and Drug Addicts Treatment Board with the Drug and Alcohol Services Council. At the same time as we did that, we also, at last, decriminalised public drunkenness. I think that that had been the intention of this Parliament as long ago as 1976, but the amendments that were put through at that time and I think subsequently again in 1979 did not take account of the practicalities of actually implementing that on the ground. Therefore, we introduced further legislation that has now been proclaimed, and we have made available (I am sure that that is one of the things that no doubt the honourable member in his diligent search of the documents has discovered) $200 000 for the operation of that programme for the financial year 1984-85.

The preliminary results are very encouraging. Of course, there are a number of options in metropolitan Adelaide. The person taken into what I guess we would call protective custody because he or she is obviously intoxicated in a public place is taken in the first instance to a police station, and from there to the sobering up centre or the Osmond Terrace clinic, which is now declared a sobering up centre, and such a person can be held for a period of up to 18 hours. Of course, one of the other alternatives is that the person simply be taken home if he has had too much to drink and has been something of a nuisance without breaking the law. Such persons can be held at a sobering up centre for up to 18 hours. They can be held at a police station—and this applies in the country areas of the State, of course—for up to 10 hours.

If they are not at that time fit to be released, then in the country areas at least it is normal practice for such persons to be conveyed to the local hospital. Without going on at great length about this, I am sure that the Committee would find it a matter of great interest that I was in Coober Pedy on Sunday where I talked to the local Sergeant of police who assured me that in Coober Pedy the new system is working extremely well, and I am happy to say that the police in Coober Pedy are very impressed with it. It means in practice that people are apprehended rather earlier than they were under the old scheme, where they had to be processed through the courts, as a result of which there was a little more reticence and reluctance on the part of the police to actually arrest these people and take them into custody. So, there is earlier intervention. That, in turn, means that there is much less law breaking (the other sorts of offences associated with public drunkenness), and I am pleased to be able to say that the early indications are that that significant reform is working well.

With regard to the new Drug and Alcohol Services Council itself, I have already talked with its members, and it has been formed in the first instance as a task force. The council is developing and will be given very specific terms of reference to look at a whole range of issues that need to be addressed. I will expect a report from it early next year in time for that to be considered in the pre-Budget discussions. There is an acknowledged need for earlier intervention with alcohol problems. I do not think anyone denies that we need to involve the medical profession and some of the allied health professions earlier in the recognition of alcohol problems, and it is my intention that we will do that by constructively moving programmes into the major public hospitals.

With regard to drugs and poly drug abuse, and particularly narcotic abuse, a number of options are offered to narcotic addicts and people with poly drug abuse problems. Again, Osmond Terrace is the centre in metropolitan Adelaide for treatment. We have a methadone maintenance programme also, a methadone programme generally, the Drug Dependence Clinic adjacent to Osmond Terrace, and the Family Living Centre at St Peters. However, I think that it is fair to say that in general we do not offer at this time the range of services that I would like to see in place. Let me say that included in that range of services is the question of education. I think that it is enormously important that we run constructive and sensible programmes in our schools.

I have already held talks with the Minister of Education and programmes are already in an advanced stage of development, and I trust and hope that we will see them in place in the very near future. I am also particularly interested in the provision of support groups for families and friends of drug abusers. Indeed, one of my staff spoke to Mr Ray Whitrod only this morning to get further advice on how that might best be instituted. It has been suggested (and I think that it is an excellent idea) that parent support groups in particular could be developed through the Victims of Crime Service in this State. We are pursuing that. I think that any parent who has had a son or daughter involved in this very ugly and distressing scene would know just how lonely they can feel, and they have all sorts of emotional feelings— quite unreasonably in some cases— about how they may have failed as a parent, for example.

I think it is enormously important that they be given mutual help and understanding during those difficult times. They are just some of the things that are being looked at but I can assure all members of the Committee that there will be a major revamp of all the alcohol and drug treatment rehabilitation and prevention services in this State during the calendar year 1985.

Membership:

The Hon. Peter Duncan substituted for Ms Lenehan.

Mr MAYES: My question relates to the Community Health Information Services. I note on page 5 of the yellow book that reference is made in 'Agency overview', under 'Strategies', to the development of new hospital and health care facilities. What initiatives are his Ministry and the Health Commission taking with regard to the development

of community health information services particularly in the southern regions?

The Hon. J.R. Cornwall: It is our belief that in many instances community health information services are best developed in partnership with local government. To address the generality of that question, currently there are ongoing and constructive discussions with the new President of the Local Government Association, Mr Des Ross. These discussions are ranging right across the area of public health and environmental health in the broader sense. To date I am happy to say they have been most constructive, and I would hope that during 1985 many good things will come out of the discussions.

It is also my intention to recommend that we establish soon a major working party comprising representatives of the Health Commission, the Local Government Association and the Local Government Department as core representatives, and also the Health Surveyors Institute and the Municipal Officers Association, with power to co-opt from areas such as education and community welfare, which again will address this whole area. We have also entered into joint ventures with local government. For example, I will refer to the northern suburbs, as I note that the member for Elizabeth has now joined us, and he has a particular interest in this area. The Munno Para council and the Health Commission have established through a joint venture a community health centre at Munno Para which I believe I will be officially opening soon.

Salisbury council, which has a progressive attitude to a range of community health and service areas, has recently opened a shop-front adolescent drop-in type of centre at Salisbury which I think is an exciting and certainly a most effective development. It is my recollection that its total funding will be around $50 000, which will mean about $25 000 each from the Health Commission and the local council. I think they are all sorts of things we ought to foster; they are not only community health initiatives: they are community development and information initiatives in the best sense.

Specifically, I believe that the Community Health Information Services can be and should be in most cases developed with a view to the human services available in an area generally—the community services available in an area generally—and, therefore, I think it is highly desirable that they be developed with agencies such as and including local government, community welfare and the Housing Trust. One such project was initiated by the member for Unley and me, so it is not surprising that he has some knowledge of it. The proposal was that it be a joint community development—a community health information services type of project—in Unley, having, it was hoped, the Community Welfare Department as a partner.

Mr LEWIS: How much did that cost?

The Hon. J.R. Cornwall: It would have cost, on the initial figures that were being talked about, $50 000; so, again, it would have been highly cost effective. It was my desire that we vigorously investigate the idea of it being conducted from the proposed community welfare office. It would have been a good example for a metropolitan council of how these things can work. I understand at this time that regrettably the Unley council itself, meeting as a full council, has decided by a relatively narrow margin that it does not wish to participate further in this project. If that is so, I find that most regrettable just at that time when the Local Government Association and many progressive local councils such as Woodville are very anxious to be involved in joint operations at the local and regional levels. It is a great pity if this project has any setbacks.

We have had quite a different experience with the Woodville council, which the Deputy Chairman of the Health Commission and I recently visited with other officers and spent an afternoon with the Mayor of Woodville, the Chairman and Deputy Chairman of his health committee and also the Executive Director of the Western Sector and council officers. They have started with the neighbourhood schemes in a quite modest but impressive way, and they envisage that ultimately there will be about 12 or 13 of the neighbourhood centres throughout the City of Woodville. We are vigorously investigating ways in which we can join in partnership with councils like that.

I would say, finally, and I think this is important, that concern has been expressed in the past, whether we are taking community health information services or Government information services generally, that we would go into some sort of partnership arrangement and once the service had been established and was shown to be indispensible the Government of the day would pull out and leave the local council inevitably to carry the 100 per cent funding. That is not, and it has never been, my intention. I have made it clear in any discussions I have had with local councils that I would be more than happy to enter into a five-year agreement which was signed and ratified by all parties. While it might be said that those agreements would only be as good as the life of the particular Government that signed them, I would think that any subsequent Government would try to change them at its peril. I believe that we can build in a level of guarantee to local councils, and in those circumstances I am looking forward to the development of many more of these initiatives at the neighbourhood, through local to regional level in the foreseeable future. There are already formal moves afoot in the Commission to develop specific policies in this regard.

These will be presented to local councils, I hope in the latter half of 1985. In general terms, therefore, there is a bright future, and I am anxious to get community health information services generally, as well as community health and community services, up and running in the foreseeable future in co-operation with local government. Significantly, only last Monday Cabinet approved the appointment of Mr Ian Cox as a Public Service Commissioner and, in consultation specifically with the Premier and the Health, Education and Community Welfare Ministers, as well as the heads of their departments and the Chairman of the Health Commission, Mr Cox has been given a specific brief to look at the co-ordination and integration of many of these human services areas.

Membership:

Mr Meier substituted for Hon. Jennifer Adamson.

Mr MAYES: Initially, in reply to a question from the member for Coles the Minister referred to the internal audit procedures which the Commission is initiating. I am aware, as are other members, of comments and criticisms in the daily press in respect of the overall financial management of the Commission. Will the Minister elaborate on his reference to the internal audit procedures which the Health Commission is currently considering introducing or expanding?

The Hon. J.R. Cornwall: Two important points are pertinent in this regard: first, the internal audit itself; and, secondly, the full review of financial and management information systems that has taken place within the Commission since I have been Minister. Both these matters are directly relevant to this Committee and should be pursued. The Alexander Review was commissioned virtually within weeks of the most recent change of Government specifically to investigate and report on the role of the Commission. In this regard, I refer to the approximately 290 people who drive the train out of Westpac building at 52 Pirie Street,

as well as the Chairman, the Deputy Chairman and the three part-time Commissioners who are in effect the board of directors of the Commission itself.

The Alexander Committee, chaired by Don Alexander, was asked to report on the Commission's role, its structure and its central office processes. The financial management processes of the Commission were embodied in a specific term of reference for the review. Rather than my giving the Committee what might be considered to be a political version of that event (because the last thing I would want to do would be to politicise this Committee and stop its functioning in the way in which Parliament intended it to function), it would be preferable to ask Professor Andrews to respond to the specific question on the internal audit. However, the whole subject of financial management information may well be an area that the Estimates Committee could pursue with profit.

Professor Andrews: This is a very important issue, and to underline that one might refer to the recent report of the Auditor-General, who pointed to the large budget subject to the control and supervision of the Health Commission under the direction of the Minister and the Government of the day, and to the heavy responsibility that that inevitably brought for ensuring that the system was operating effectively and efficiently. When one considers the fact that that direction is exercised through the overall supervision of more than 170 health units in South Australia, one realises that it is a complex task to ensure that the proper management of funds is pursued both within the Commission itself and within the health units. As the Minister said, the Alexander Report contains specific statements about that matter and about the creation of an internal audit team designed specifically to oversee the accounting arrangements and to decide on their appropriateness within the Commission itself. The value of that recommendation has already been proved in many areas that for years have been considered problem areas.

In addition, the internal audit unit is being seen as developing a wider responsibility as regards the financial management system generally, not only within the Commission itself but also ultimately in relation to the health units. Associated with that question is the establishment of a proper financial management and reporting system, and this was achieved, again following the submission of the Alexander Report, by engaging a consultant to undertake a complete review of existing procedures and to make recommendations for their improvement and for the creation of arrangements whereby timely and accurate information on all the operations of the health units, the sectors and the Commission itself could be available to the Commission, to the Minister, to the Government and ultimately to Parliament.

I am happy to say that the recommendations of that consultancy and of the review group associated with it have now been implemented, and I believe that the Commission is better able than it has ever been before to operate and manage the system with accurate financial information. As the Minister has said, we should be happy to go into greater detail regarding these areas, but those are my general comments.

Mr LEWIS: My question relates to an aspect of health administration that does not concern the treatment of trauma or any other medical condition but rather preventive health, especially as it relates to the provision of public services to communities, reducing it is said, by the provision of such public services, endemic disease of one kind or another. Is it true that in a community that does not enjoy the provision of potable water reticulated to households in the way in which we normally expect it to be provided disease levels are higher in that community compared to those in a community that enjoys a reticulated water supply? Further, if the water is filtered, does such filtration further reduce the incidence of disease of one kind or another compared to water not filtered but taken from surface sources such as reservoirs or the Murray River instead of underground sources below the surface water table which are free of contamination (provided they are not contaminated by septic water)?

The Hon. J.R. Cornwall: Those questions are far too technical for me to answer, and I would not presume even to begin to answer them. Before I became a senior Minister in the Bannon Government I was for many years a veterinarian. I would not draw on my basic knowledge in those areas to presume to answer the question. I think it far better if I were to ask Dr Chris Baker, who is the Director of our Public Health Division, to respond.

Dr Baker: Water is certainly a method of spreading disease, and it is important that it is of a high quality to prevent the spread of infectious diseases. Within South Australia the Minister of Health established a standing committee to look at the health aspects of water. This committee consists of senior officers from the Health Commission and senior officers from the E & WS Department. The purpose of this committee is to review the standards of potable water throughout the State, identify priorities where there needs to be an improvement in services, then ensure that that department, the water department, allocates adequate resources. As members would know, some of the water in South Australia coming from the Murray River is dirty, with a sediment in it but from the health aspect, after filtration and chlorination, it is potable and safe to drink.

Mr LEWIS: I thank the Minister for allowing Dr Baker to answer the question and I continue along the same line. By what measure would public health be improved in each case, that is, by providing reticulated potable water and then filtering it where it was contaminated by organic matter or other colloidal material?

Dr Baker: Water within the State is taken from a variety of sources; some from the Murray River, some from underground aquifers and, in certain areas where water is extremely scarce, it is taken from bore holes or from rain water tanks. There is an organisation both through local government of the health surveyors of local government and then the health surveyors acting through the public health service, regional health surveyors, who provide advice to individuals or communities and who can test the bore water for its quality.

Mr LEWIS: I was really trying to find out what measure of improvement we obtain in levels of health. I do not know what other benefits we get. I guess, we get whiter shirt collars, and so on, with filtered water but I suppose the main reason—at least we have been told in this House many times since I have been a member—for filtering water was to improve public health and reduce risk of endemic disease. As I well recall in an Estimates Committee a few years ago, you, Mr Chairman, drew attention to what you considered to be quite properly the health risk in your own electorate and the town of Whyalla by seeking information about when a programme to filter the water supply to that town would be undertaken.

I want to establish what improvement in public health areas is effected by, first, providing a reticulated supply of potable water to households and industry and then, secondly, by what further measure health is improved by filtering that water where it comes from run off sources, especially the Murray River. Having been unable to get that measure I would like to go on and ask: some time ago, on an experimental basis, a chloramination plant in lieu of a chlorination plant was installed at Tailem Bend to service the Keith pipeline. Chloramine which is a term to describe a mixture

of chlorine and ammonia does not kill as quickly as chlorine but it is known to last for a much longer period and for a greater distance in the pipeline.

As I understand it, if that measure was to be successful, if it was successful, such a plant was to be installed at Morgan to improve the health quality of the water in the long pipeline from Morgan to Whyalla. Now, I wondered whether or not that might be a cheaper way of providing safe water to the residents of Whyalla so that people will not get amoebic meningitis when one little kid squirts another little kid up the nose with a hose, or something like that.

If that is the best way of doing it then it clearly leaves available the resources which might otherwise be expended on the more expensive alternative of filtration to provide potable reticulated water to those communities in South Australia which presently do not have that advantage. I represent an enormous number of people who do not have potable water reticulated to them and, where they do have it reticulated to them, it is of the worst kind because it comes from the bottom end of the Murray sewer. It is pumped out of the lakes or the river at Tailem Bend and it is not filtered, as is Adelaide's supply. I guess, however, that people who receive it are grateful for the fact that at least they have that much.

Can I ask then what has happened with that chloramination experiment at Tailem Bend on the Tailem Bend/Keith pipeline that also supplies Meningie, and is it a less expensive alternative than filtering water in the elimination of endemic pathogens that might otherwise be spread by the vector of water.

The Hon. J.R. Cornwall: Before this proceeds any further, I think that, first, these questions—rightly, as you pointed out, Mr Chairman—ought to be addressed through you and before referring—

Mr Lewis: With the greatest respect, it was.

The Hon. J.R. Cornwall: I think the honourable member was tending almost to address the questions directly to Dr Baker and I must protect my officers of course—not that Dr Baker needs very much protection based on my experience with him in the past 12 months, but I think that the niceties ought to be observed. Having said that, and pointing out also of course that there is very strong and on-going co-operation between the E & WS Department and the public health authorities, some of the matters to which the honourable member refers clearly would be in the portfolio area of my colleague Jack Slater. Nevertheless, I would ask Dr Baker to respond to those matters which relate to us and our concern in the public health area.

Dr Baker: Members of the Water Policy Committee from the E & WS Department have undertaken a survey of the State. They have tabled their report to that Water Policy Committee, which consists of members of the Health Commission and members of the E & WS Department, as I said previously. At the next meeting, which is in one month's time, that report will be thoroughly analysed and priorities for the next year decided. I cannot pre-empt that meeting and would be unaware of which priorities would be decided at that meeting.

The CHAIRMAN: I wonder whether it might be better, rather than entering into a further difficult and major question that may take some time, for the Committee to adjourn for lunch. If the Committee so desires, we will adjourn.

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

Mr MAYES: I refer to initiatives that may have been considered by the Minister's Department in regard to the health of workers. At page 53 of the yellow book reference is made to environmental, occupational and protective health services. In regard to the development of preventive health measures within occupational areas, what steps is the Health Commission considering in establishing workers health centres?

The Hon. J.R. Cornwall: The matter of a workers health centre must be looked at in the context of the full package that the Minister of Labour in particular, on behalf of the Government, is undertaking at present. The Minister and I jointly set up the Matthews committee of inquiry into many aspects of workers occupational health and safety. Arising from that, three major recommendations were made. The first was that we should establish in South Australia an Occupational Health and Safety Commission, which would be a body that would take a tripartite approach (that is, involving employers, employees and the Government) to the whole question of occupational health and safety. The second recommendation was that we should establish in South Australia an Institute for Environmental and Occupational Health, again, with a board of directors who would be drawn from a tripartite background. Of course at the moment that recommendation must be seen in the light of South Australia's bid to have the proposed national Institute for Occupational Health and Safety established in this State. I am sure that honourable members would be aware that we have made a bid to have that institute established here, using the very substantial expertise that has been built up in recent years in our own Occupational Health and Safety Branch within the Commission.

The third recommendation was that workers health centres should be established. It was recommended that in the first instance there should be what one might call a central workers health centre and that *ab initio* that should be fully established, staffed and funded, and that, subsequently, the idea of further workers health centres, based to some extent on the model that we have used to establish women's health centres, should be applied. Cabinet took two further decisions which are of great importance. One was that the overall carriage of occupational health and safety issues, as well as any legislative amendments or proposed new legislation, should be the responsibility of the Minister of Labour. I enthusiastically concurred with that. The other matter of very great significance to the Government at present is the question of workers compensation, which I am sure all members of the Committee would know about.

So, at the moment many important and related matters concerning occupational health and safety are on our plate. In view of the ongoing negotiations in which the Deputy Premier will have to be involved, together with the unions and the employers, with regard to such things as the occupational health and safety commission, workers compensation arrangements and legislation, it was agreed that for the moment my proposal for a workers health centre should be held in abeyance. However, I can tell the Committee that there is a general Cabinet endorsement of the idea of establishing a workers health centre. By national and indeed by international standards that would be a major initiative.

The proposal that I have developed envisages that a workers health centre would be worker controlled in the sense that the board of directors would comprise a majority of people nominated by the United Trades and Labor Council—in fact, five out of nine members—and that it would provide clinical services, and have an advocacy role; in other words, that there would be someone employed by the workers health centre who would be able to go to the work place and assist the workers in any negotiations on safety agreements that they wanted to negotiate with employers. Therefore, it would have an active advocacy role, and also it would have an active role in the education process, involving education across the board. Members of the work force would be given access to the library facilities of the workers health centre and courses would be conducted in

co-operation with the Trade Union Training Authority for union officials, shop stewards and other job delegates. This would extend right through, I would hope, to establishing formal links with a teaching hospital and, preferably through that, with a medical school.

For the first time in this country we would be able to provide through the workers health centre a vehicle both for undergraduate medical training in occupational health and for postgraduate training. Under my proposal we would also use the workers health centre to train those in nursing and other allied health professions. In fact, it would be the most comprehensive proposal ever undertaken in this country. The last time we did any sums on it the full year funding cost was estimated at about $600 000. It is my intention that we will negotiate for some form of cost sharing arrangement with the Hawke Government and I believe there should be some trade union contribution made. There would also of course be some income, one would hope, from treating patients under Medicare on a fee for service basis where they were not compensable patients; in other words, where they were patients seeking assistance as members of the general work force but not with conditions specifically relating to workers compensation.

So, those plans are well advanced; the costing has been done with a degree of accuracy. As I said, at the moment I am, with the agreement of Cabinet, waiting until negotiations with regard to workers compensation legislation and the Occupational Health and Safety Commission and resolution of the question of whether a South Australian Institute for Environmental and Occupational Health or a National Institute of Occupational Health and Safety, are ultimately resolved. It is certainly my intention that we should move to establish an implementation team, which would be the interim board of directors and which would ultimately hand over a completed constitution for incorporation under the Health Commission Act; that should proceed in the first half of the 1985-86 financial year.

Membership:

Ms Lenehan substituted for Mrs Appleby.

Mr MAYES: My next question relates to the statement on page 33 relating to recurrent expenditure by Mental Health Services, to which I briefly refer. The specific targets and objectives listed within that programme cite the recent Smith inquiry and the development of a process for implementing the inquiry's recommendations. What steps have been taken and what is the status of implementation of the Smith Report regarding mental health services?

The Hon. J.R. Cornwall: Members would be aware that a number of very important inquiries were commissioned by me and by the Health Commission very early in my days as Minister. Without ranking them in importance, I guess that nobody would argue that the Smith and Sax Reports are probably the most significant of something like 10 inquiries that have been conducted, completed and, to some extent, to this point, actioned.

Ever since the Sax and Smith Reports have been available, the Commission has, first, been conducting an exercise to implement those things which could be done quickly, readily, easily and administratively and, I suppose, without cost, and, secondly, in developing a formal series of responses with regard to implementation. I understand that those things are now very close to completion. I think it would be most useful if I asked the Chairman to respond specifically with regard to the Smith Report as to where the responses are at, what the proposals are and what we might do with them. I intend, incidentally, that the Commission's official responses should become public documents within the near future. However, I ask the Chairman to respond.

Professor Andrews: Both the Sax and Smith Reports are, as the Minister said, extensive documents. I am sure members would not appreciate my going through the specific recommendations in detail, since that would take some hours. However, the approach has been to take on board all the recommendations made in the two reports, to examine them in the context of the Commission and of the Government's current policy and, in addition, to take account of the very many submissions that they generate from health units and other interested parties when they were made public documents.

That process of reviewing the recommendations and their currency is now completed and breaks up into a series of recommendations, a significant proportion of which indeed have already been implemented during the process of the review, another series that is currently being implemented by the Government and the remainder which I think constitute the more difficult areas for us on which further action is required.

A variety of working parties has been set up to pursue those questions. The approach that the Commission has taken to the implementation of the Sax and Smith Reports has now been documented and, as the Minister said, will shortly be put out to the community and health services with the Minister's and the Government's *imprimatur,* as a discussion and information document. The groups already established to pursue the specific recommendations are an advisory group on aged care services (since this is an area of major priority identified in both reports), a medical rehabilitation services group, a hospital services review group (in respect of the Sax Report) and a mental health advisory committee structured on the previously existing committee, but significantly upgraded in relation to mental health, to pursue those specific recommendations made by Smith.

Perhaps rather than going on with the rhetoric about all this, and since it is an area that covers so many specifics, I might leave it at that except if there are any particular questions that relate to recommendations in either of the reports and, specifically, in the Smith Report which we could take up in some detail.

Mr MAYES: What about the time table that may be envisaged by the Commission regarding the Smith Report in particular?

Professor Andrews: As I mentioned, quite a number of the recommendations have already been implemented at this point. The review process and procedure for further implementation and review should be available for public consumption within the next few weeks. Getting it through the various procedures should take no more than three or four weeks. The rate at which the specific recommendations might be implemented depends entirely on the nature of those recommendations. Clearly, where there are significant resource implications, that will take somewhat longer than in some instances where it is merely a matter of reallocation of resources and rearrangements of existing programmes. So, it is in effect an ongoing exercise that is currently in action.

I believe that the impact of Smith and Sax on the Commission and the development of services in this State will continue for at least the next two or three years as the various broader recommendations and their implications take effect. So, it is hard to put an end point on the implementation of the report, because some things clearly are already in place and some will continue to have influence on our directions over the succeeding years.

The Hon. J.R. Cornwall: I might add that there has been, as discussed in the Smith Report, a complete review of the Mental Health Act; drafting instructions for that significant overhaul have been recently approved by Cabinet and are currently with the Parliamentary Draftsman. So, I anticipate

that we will introduce that Bill into Parliament before the end of the Budget session.

Mr MEIER: I preface my question by referring to page 356 of the Auditor-General's Report and to the paragraph entitled 'The Corporate Office', which goes into various details and states, among other things:

> ... an impression gained by the review team that there was scope for reductions in the staffing levels of the office.

It is then pointed out that this could involve transfers to sectors, and so on. The Auditor-General's Report further stated:

> Additional statistical information requirements have also arisen with the introduction of Medicare. The review, completed in June 1984, resulted in a recommendation to increase the sector offices staff by five.

In the first instance, it seems a little interesting because, from the way I read it, the first impression was that hopefully there could be a reduction in the staffing level. However, the review suggested an increase in staffing, and I would be interested in the Minister's comments in that regard. Incorporated in that same question and idea is what percentage of the health budget is being spent in the Health Commission—in other words, in the running of the Health Commission as such against the amount being spent on patient care compared with, say, the situation during the past three or five years. So, there are two parts to the question: first, the specific staffing as mentioned in the Auditor-General's Report and, secondly, the sort of increase that has occurred in the percentage of the health budget going to the Health Commission as an administrative unit compared with the amount going to the patient care area.

The Hon. J.R. Cornwall: I am very pleased that the honourable member has raised that matter. In fact, at this point I can give only round figures. I will call on the Chairman in a moment and any other senior officer whom he may wish to assist to give the honourable member more accurate details. However, the central office of the Health Commission, that is, the people who are accommodated mostly at 52 Pirie Street in the Westpac building, number a little under 300. They account for little more than 1 per cent of the total health budget, which in administrative terms, of course, is an outstanding effort.

I refer to the second part of the question, which related to the recommendation that the numbers in the corporate office, according to the Alexander Report, could and should be reduced. There are two responses to that. One, of course, is that in the wake of the Alexander Report, which I initiated and which the Government commissioned, we appointed a steering committee that was headed by Mr Peter Agars of Touche Ross to assess in finer detail what actions could or should be taken with respect to financial management and a range of other issues. Again, I will ask the Chairman to comment on that in a moment. In fact, there has been a marginal increase in the numbers, I understand, in the central office but one has to remember that those numbers have mostly or almost exclusively come from any specific election promises or undertakings.

For example, the office of the Women's Adviser is responsible for the employment of 2.6 full-time equivalents. The Patient Advice and Information Office that has recently been established will account in 1984 for two full-time equivalents, and there are a number of other areas in which a relatively small number of people have been appointed to meet specific undertakings. In regard to the finer detail, however, I think that it would be sensible of me at this stage to ask the Chairman to respond more specifically.

Professor Andrews: The figure to which reference was made, that is, the percentage of the budget that goes to the operations of the central office compared with the rest of the health services, was 2 per cent in 1982-83. In 1983-84 it was 1.9 per cent, and in 1984-85 it is 1.8 per cent; so, there has been a small reduction, but a consistent reduction over the past three financial years, including the current one.

The Minister referred to the fact that the Alexander Report referred to the bureaucratic structure of the Commission, if one likes, and suggested that there might be room for an overall reduction, particularly in the corporate office, and that is indeed currently being examined closely by the Commission both generally and in response to a directive from the Government relating to the reduction of executive officer and administrative officer positions in the Public Service generally. However, there have been a number of areas where staff have been appointed to undertake specific functions, and I think that that is outside the reference made by Alexander. The Minister mentioned women's health and the patient advice office as obvious examples.

Another area where there has been a small increase in staff in the central office is that of internal audit, to which reference was made in relation to an earlier question. We believe that these increases have all reflected an improvement in the effectiveness of the Commission in women's health and patient advice, in relation to the provision of services to particular groups in the community, in addressing particular concerns in terms of the quality and accessibility of services and, of course, in the internal audit in terms of efficiency and effective financial management.

The Agars Report, to which the Minister referred, also resulted in a very small increase in the staff in the accounting division of the Commission, and that reflected that Agars made some very specific recommendations about the provision of detailed financial information on the operations of the individual hospitals, sectors, and the Commission generally, to which reference was made earlier. All in all, I would have to say that compared with other States (and here I speak as someone who has been associated with the South Australian Health Commission for only a little more than 12 months), I believe that it is a very lean administration and could not be described as excessive in terms of its bureaucratic component *versus* the delivery of services. That is in spite of the fact that it is in administrative terms a somewhat decentralised organisation through the operation of the sector offices.

Mr MEIER: I refer to page 185 of the Estimates of Payments and the line 'Noarlunga Health Village', the proposed expenditure for which in 1984-85 is $2.9 million and the estimated total cost $3.45 million. Using that as the start, it has come to my attention from visiting some country hospitals that they feel they are not receiving the amount of money that they could be receiving to operate because of the Noarlunga Health Village undertaking. I wonder what comment either the Minister or one of his advisers could make in relation to whether compensation is in hand so that country hospitals (or one could just as well be referring to city hospitals, I suppose) are not being placed at any serious disadvantage because of a major building programme in one area of the State.

The Hon. J.R. Cornwall: First, let me say that it would be a very sad and sorry state if the capital works programme of the South Australian Health Commission was so small relatively that $3.45 million spent over two financial years would distort it. I am sure that all members of the Committee would be aware that only last Friday I announced that the Government would be funding the major part (more than $12 million) of an $18.5 million redevelopment, for the final stage 4 redevelopment of the Adelaide Children's Hospital, among many other exciting things that are happening at that wonderful hospital. Members of the Committee would also be aware, as practising politicians sensitively in touch with what goes on, that the Government announced

some months before that the $31 million Lyell McEwin Health Village in the Elizabeth Central-Northern Region. The Health Commission's capital budget was reduced quite disastrously to $11.2 million in the last year of the Tonkin interregnum, but we have been actively restoring that to a far more realistic position.

I can assure the honourable member that the $3.45 million to be spent on the first stage of the Noarlunga Health Village (which incidentally I expect will be commissioned and open for business in August 1985) will not prejudice in any way the ongoing capital works programme in the country. For example, we have an exciting redevelopment going on in the district of the Leader of the Opposition at Wallaroo and we are currently involved in discussions with the other two hospitals in the Copper Triangle with regard to the potential and possibility of operating a three campus consolidated integrated hospital arrangement in that area which I find exciting, albeit a little expensive on the information I have been given to date.

I would also make the point (and I thank the honourable member for giving me the chance to raise it) that beyond a shadow of a doubt we have the best country hospital system, in terms of bricks and mortar, facilities and equipment, in Australia. I do not think anyone could seriously contend otherwise. There are just so many examples that I could go on and on. I am sure one that would come readily to mind to the former Minister is the Kapunda Hospital. My only real regret in life is that there is a plaque on it with Mrs Adamson's name on it instead of mine and I do not say that in any spirit of pique. I just think that the job that was done there in preserving the magnificent old bluestone building while at the same time completely upgrading the interior to the standards of a modern hospital was superb. I think that on any examination by any objective person it would have to be conceded that our country hospitals, on a bricks and mortar basis and on an equipment—

Mr LEWIS: How far is Kadina from Wallaroo?

The Hon. J.R. Cornwall: Sometimes I am very grateful that I am in the Upper House when I hear performances like that.

Mr LEWIS: We are, too.

The CHAIRMAN: Order! I am not too sure what the honourable member is getting at or what on earth this has to do with the line under discussion, but I ask the honourable member not to interject in that way and the Minister not to take any notice of him, either.

The Hon. J.R. Cornwall: I try not to, Mr Chairman, but I am only human and I have all the frailty of an ordinary human being, despite rumours to the contrary. I do not think I have very much to add.

Mr MEIER: I am heartened to hear that reply, and I know that two hospitals in particular will be also pleased to learn that the capital works programme going on at present will not necessarily unduly effect any programmes that are certainly at a planning stage in country districts. Likewise, it was pleasing to hear that discussions are taking place with respect to a three campus hospital based in the Copper Triangle towns. I am certainly aware of the redevelopment in the Wallaroo area.

Is the same formula basis used in ascertaining bed occupancy ratings in the major hospitals? For example, is the same formula used to ascertain the bed occupancy rate at Flinders Medical Centre, Royal Adelaide Hospital and Queen Elizabeth Hospital, or are any special factors taken into account when calculating such figures?

The Hon. J.R. Cornwall: To the best of my recollection the method of calculation is now uniform. I think there used to be some difference but this is a matter which I think I shall pass to the Commission in the person of the Chairman for a response, because he would be far more knowledgeable than I am on the subject.

Professor Andrews: Bed occupancy figures are collected on a uniform basis currently, and the bed occupancy figures quoted for Flinders and the Royal Adelaide would be completely comparable. There might have been differences in the past, but that is certainly not so in the present arrangements.

Mr MEIER: I believe there was reference to bed occupancy at midnight which could distort the figures considerably in some hospitals which might have a day care facility rather than a total 24-hour bed occupancy.

Professor Andrews: As I understand it, there were variations between hospitals in the way that those figures were collected in the past but the Commission's Information Services Division has, in consultation with the hospitals, established a uniform approach, and if there are differences now it would only be because the hospitals are not abiding by the rules; and if there is any suggestion of that (and I do not think there is) we would correct it.

Ms LENEHAN: In respect to some of the matters raised this morning in a general discussion about initiatives that have been taken by the present Minister and the Government, I would like to ask the Minister whether he could outline for the Committee any initiatives which have already been taken in respect of the role and function of the new Women's Adviser and also whether he is aware of any previous initiatives which he believes will have an impact on women and health in this State?

The Hon. J.R. Cornwall: Some important things have been happening in the area of women and health in South Australia during the past year. The office of Women's Adviser was established on 3 June and the appointee (Liz Furler) took up her duties on 3 January. In that office she now has a full-time secretary and a project officer employed on .6 of a full-time equivalent basis. Up to November of this year a student on placement from the social administration course at FUSA is working as a temporary project officer. I draw to the attention of members of the Committee the fact that Ms Furler has joined us at the table, and in a moment I shall ask her to respond in detail.

The exciting things that have been achieved this year or are being actively pursued include, first, the establishment of the office itself and the definition of its role and functions within the health system of South Australia. Secondly, there has been the development and public release of a policy on women and health, not simply women's health, and that policy was tabled recently in Parliament. Thirdly, at my instigation the Health Ministers conference earlier this year agreed that we in South Australia should host a National Conference on Women's Health in a changing society in Adelaide, in September 1985, exactly 10 years after the last major conference on women in the health field was held.

Many activities relating to women as users of the health services are proceeding. There are also significant activities relating to women as health services employees, remembering that more than three-quarters of the health work force are females. That does not mean, of course, that they are equally represented at the executive officer and managerial levels: they tend to be in traditional areas of employment such as nursing and housekeeping. However, we are working actively on that, and I am sure that Ms Furler can give the Committee more details.

So many things are happening in the areas of women in health and of women and health that I suppose we could go on for a long time, but I will leave it to the discretion of the Committee and of Liz Furler to decide how much detail should be given. However, I consider that it is worth while taking a reasonable amount of the Committee's time

on behalf of the women of South Australia, bearing in mind that they represent more than 50 per cent of the population.

Ms Furler: The period of nine months since I took up my appointment in the Health Commission has been spent busily making contact largely with service providers and with women in the community who are eager to use my position and office to start clarifying some of the more important bureaucratic and decision-making procedures used in connection with the allocation of resources in helping shape health services that may or may not be appropriate to their needs. Much of my time has been spent out in the community and the health services talking to various people and introducing them to the recently released policy on women and health. I expect that that policy, which addresses the needs of women both as users and as providers of health services, will provide very much the framework within which my office will operate over the next 2½ years.

The Minister has referred to a national conference to be held in September next year. That conference has the support of the Australian Health Ministers. Our office has planned a series of metropolitan and regional workshops on which we have already embarked and on which we will move more quickly early next year to make contact with women across the State, introduce them to the recently announced policy, initiate their discussion of it, and get them to raise issues which are important to them and which they think should be brought to my attention or to the attention of the Minister.

Regarding our activities as they relate to women employed in the health services, my office has, on behalf of the Commission, begun examining a possible strategy or approach to the implementation of equal employment opportunity objectives in the South Australian health sector, and we expect that the Commission will consider soon a proposal that will have a major impact on the policies and practices relating to the employment of women throughout the health sector over the next few years.

Membership:

The Hon. Jennifer Adamson substituted for Mr Meier.

Ms LENEHAN: I congratulate the Minister on the appointment of the Women's Adviser. This appointment has been welcomed by many sections of the community and, as a local member in the southern suburbs, I have received many favourable comments about the appointment. The Minister has said that women do not appear in the higher levels of management in the Department. Yesterday, I asked the Premier many probing questions about the implementation of equal opportunities in management positions, and I should be interested to know whether the office of the Minister of Health has any such plan for equal opportunities concerning promotion of women in his Department. Has the Minister such a plan and, if he has, at what level of implementation is it at present? If he has no such plan, are plans for such a programme to be implemented in the Health Department?

The Hon. J.R. Cornwall: First, let me remind the honourable member that we have a Health Commission and not a Health Department. Indeed, I am proud that we have a Commission that is the only Health Commission working well in this country. Increasingly, it is working extremely well, and we are deriving more and more advantages from its being a Commission and not a Department. True, we cop a few disadvantages from time to time when people start to take their autonomy literally but, by and large, it works extremely well as a Commission.

Regarding the Commission as an equal opportunity employer and its policy (or, until recently, its lack of policy) as an equal opportunity employer, I opened a seminar that was convened and organised by the Women's Adviser recently as a major step towards this end, and I know that this subject is near and dear to her heart. I shall therefore ask her to respond more specifically to the honourable member's question.

Ms Furler: The one day conference on equal employment opportunity held in mid June this year was an opportunity to bring senior managers in the Health Commission and the health system generally up to date with information about the position of women in the workforce and the limited information we have to hand about women in the health workforce in particular, and also to provide them with information about the current theory, practice and legislation that lies behind equal employment opportunity, both in South Australia and at the Federal level. This is because the Health Commission falls outside the ambit of the Public Service Act and the initiatives that the Public Service Board have taken over the past few years in the formulation of equal opportunity employment policies and management plans for various Government departments.

It is quite clear that the Public Service Board at the moment is beginning to review the progress it has made to date in this area, and certainly the activity that the Health Commission will be undertaking in this area over the next few years will be very much in collaboration and co-operation with the Public Service Board and other Government departments generally that have made significant in roads into this area.

Ms LENEHAN: I must apologise for my slip of use of language. It is a Health Commission and I agree with the Minister entirely on the success of the Commission. I move on to page 40 of the yellow document. In one of the sections under 1984-85 specific targets and objectives, it mentions in the beginning of that section that 1985 is International Youth Year. Will the Minister or his advisers outline for the Committee some of the specific initiatives which the Health Commission is planning to introduce for the youth of South Australia in International Youth Year?

Mr OSWALD: I rise on a point of order. The Opposition does not wish to deny Government members the opportunity of asking questions as they have a legitimate right to do, but this session of the Committee is now degenerating into a session where the Government and the Minister are using the time to spread out the Committee and deny the Opposition the opportunity to ask legitimate questions. We come here to question the Minister. It is our right as an Opposition to question the Minister on how he is running his Department. The Government members and the Minister are skilfully using this Committee to ask long questions and give long drawn out answers, thereby denying us time. It is now almost three o'clock. We have been here since 11 a.m. and the Opposition has asked four questions. It is not good enough, when this Committee is created for the sole purpose of giving the Opposition an opportunity to question the Minister on the lines. We enjoy hearing what the advisers say, but it is not the way to run the Committee.

The CHAIRMAN: Order! First, the honourable member has gone far beyond the point of order and, secondly, the Chair does not uphold the point of order. There is nothing in Standing Orders or the Estimates Committee guidelines referring to the Chair having the right somehow to stop Government members asking questions of the Minister. I also point out to the honourable member that the Minister is here on the invitation of the House of Assembly. We should recognise that situation. Nothing under Standing Orders says that the Minister has to be here. He is simply here on invitation. How the Minister replies to questions is beyond the control of the Chair—I assure the Committee of that.

Mr OSWALD: As long as I have made my point.

The CHAIRMAN: Order! I am not sure where we were.

Mr OSWALD: We were up to a filibuster.

The CHAIRMAN: Order!

Mr LEWIS: Mr Chairman, I draw to your attention the fact that, as I understand it, the conduct of Committees is to seek information from Ministers. Quite clearly the member for Mawson has indicated by her response to the answers that she has been given that she has been aware of the information given by the Minister even before she asked the question. That is in contravention of the intended Standing Orders for the Committee.

The CHAIRMAN: Order! First, if there is another outburst by the member for Mallee along that sort of line, the Chair will certainly deal with him. There is no point of order. As pointed out by the Chair previously, the Committee is formulated of three Government members and three Opposition members. The six members have the right to question—and the Chair has always recognised that right—under a system of one question from Opposition benches and one question from the Government benches in turn. Each side has the right to question the Minister. I repeat: the Minister is here on invitation—nothing else—of the House of Assembly. There is no point of order. In fact, I point out to the member for Mallee that he did not even take a point of order. He seemed to want to ramble on about something that had nothing to do with any point of order or any Standing Order of which I am aware. I am still confused. Has the Minister finished replying to the member for Mawson?

Mr LEWIS: With respect, Mr Chairman, may I seek from you some direction as to the nature of questions that can be asked? Are we seeking information from the Minister in these Committees or are we not?

The CHAIRMAN: I find the seeking of information from the Chair on this occasion absolutely astounding. I would have thought by now that all members of the Committee know perfectly well what is required of them. I have said, and I repeat, that each member of the Committee, whether a Government or an Opposition member, has the right on call to seek information from the Minister on the appropriate line. In this case the line is very broad.

Mr OSWALD: They are trying to cover up for the Minister, that is what they are doing.

The CHAIRMAN: Order!

Ms LENEHAN: We are seeing legitimate information, and you well know it.

Members interjecting:

The CHAIRMAN: Order! I remind both the member for Morphett and the member for Mallee that the Chair will deal with another outburst of that kind. I have been trying to explain for the last few minutes exactly what are the procedures as far as the Committee is concerned. Candidly, I would have thought that all members would know by now what are the procedures. I find these points of order rather strange, to say the least. I am not going to repeat the position. I believe I have explained the situation as fully as I possibly can, and I will not take any points of order on that basis.

The Hon. PETER DUNCAN: On another matter, Mr Chairman, has it been decided to take the afternoon tea break at 3 p.m. or 3.30 p.m.?

Members interjecting:

The CHAIRMAN: Order! There is no point of order. The Chair, out of the kindness of its heart, may decide to have a cup of coffee at 3.30 p.m., but we will not get in another question before then at the rate we are going. Has the Minister finished replying to the question?

The Hon. J.R. Cornwall: With respect, Sir, I have not started. I find at least the Opposition members in this House, to which I have been invited, most discourteous. I am somewhat upset by their behaviour. It is not the sort of behaviour to which I am accustomed.

The CHAIRMAN: Order! I hope that the Minister will not start to get into the act.

The Hon. J.R. Cornwall: No, but I point out that Opposition members have wasted 10 minutes of their own time. Based on the performance of the member for Morphett this morning, I hardly sit here in fear and trembling. Indeed, if his questions are not going to be more pertinent and more intelligent than they were before lunch, it is probably a waste of everyone's time being here at all.

Members interjecting:

The CHAIRMAN: Order!

The Hon. J.R. Cornwall: Specifically, in regard to the question to which the member objected—it related to adolescent health—I could think of no subject more important to this Committee than that. That, of course, will be the major thrust of the Health Commission and the Government in this State in International Youth Year—1985. There will be three major projects, if I can put it that way, one of which will be to very significantly upgrade the delivery of adolescent health generally. In a moment I will ask the Chairman to comment on the role and function study and review currently being conducted into the Child Adolescent and Family Health Service in this State. It is certainly our intention that adolescent health—which I might say is a neglected area around the world and not an area in which we have achieved as significantly as perhaps others—will be given the No. 1 priority in the calendar year 1985. So, that review is under way and the Chairman will comment in more detail on that in a moment.

Secondly, the specific question of adolescent mental health is currently being addressed principally in two areas. One, headed by Dr Bill McCoy, of the Central Sector, is looking at, among other things, the future of Willis House and the desirability of conducting tertiary level adolescent mental health services at the Adelaide Children's Hospital as part of the ongoing upgrading that is occurring at that magnificent hospital. It is also looking at utilising all of the resources; the field resources and personnel already in place through CAFHS, and the substantial talent that is available at the Adelaide Children's Hospital.

The other project currently under way is a review of adolescent mental health services by the western and southern sectors of the Health Commission and again, although they are not specifically looking at, from my recollection, tertiary services, they are looking at ways in which we can integrate and very substantially upgrade mental health services for adolescents. It goes without saying, to anyone in the community at least and certainly to those members of this Parliament who are sensitive to the needs of their electorate, that there is no area that I can think of to which we need to devote a higher priority. It is because of this that specifically, when I was recently in the United States I went, at the recommendation of people whom I met throughout the States and Canada, to The Door, in New York. That was not on my original itinerary. However, wherever I went to talk to people about adolescent mental health in general and about drug related issues in particular, they all said to me, 'When you go to New York you must go and look at the programme that is currently being conducted and has been for some years at what is called 'The Door'.' I certainly do not want to take up the Committee's time by going into great detail about the magnificent and comprehensive services provided at The Door; suffice to say that, at the time I visited The Door, Mr Bansemer was with me and I subsequently asked that he should go back and get more detail. Judy Black, of Mental Health Services, was also recently in New York and at my request she spent a substantial amount of time at The Door.

So already, at Ministerial level and senior Health Commission personnel level, we have established first name relationships with the senior people at The Door. We have a good idea of how it works. I said when I returned to Adelaide that it would have to be adapted and substantially modified. One cannot anticipate running a programme here that would be comparable in many ways to uptown New York, the Bronx. This is not a city, thank God, of 9 million people which is almost ungovernable: it is a magnificent little city of a million people which is arguably one of the most civilised places on earth.

Nevertheless, we have many problems and we intend to address them. If one looks at a specific programme and how we can get together the best elements of voluntary and Government agencies and the community, then I believe it will be a very significant and magnificent programme, if we do it properly. I am very enthusiastic, as the Chairman of the Health Commission knows, as well as anyone else who has been in contact with me in the past three months. I thank the honourable member for the question about adolescent health which is probably the most important one we will address all day.

The Hon. JENNIFER ADAMSON: When I last questioned the Minister immediately before lunch, in his reply he was praising the South Australian health system as being one of the best in the world whilst simultaneously stating that that health system had run down in the space of the three years of the previous Administration. It should go on the record that not only is that demonstrably wrong but it is specious rubbish to suggest that a health system can deteriorate in that space of time or that it can be instantaneously resuscitated by the ascendancy to office of the Minister.

However, having said that, I refer to the budget of the Queen Elizabeth Hospital and in particular to a report in the stop press in today's *News*, headed 'Specialists act on funds cut', which states:

> Queen Elizabeth Hospital's senior medical staff members said today they had refused to guarantee high standards of medical care for patients. They said this was because of the Bannon Government's decision to cut the hospital's funding. A meeting of thirty-five specialists condemned the South Australian Health Commission for its decision to 'fine' the hospital $620 000. The hospital's 1984-85 budget has been cut by this amount . . .

I have with me a copy of the memo circulated by the medical staff of the Queen Elizabeth Hospital. I stress that the details of that memo have been published in the weekly press that circulates in the area serviced by the hospital, that the board of the hospital has dissociated itself from the document in an article in the *Weekly Times*, the Messenger paper, and that the Western Sector Executive Director for the South Australian Health Commission has refuted the document.

However, in order that the Minister may respond directly to the document I wish to read it to the Committee. Headed, 'The present position at the Queen Elizabeth Hospital', it states:

> The Queen Elizabeth Hospital is undoubtedly very severely underfunded, leading to concern about the future ability of the hospital to provide patient services. The Queen Elizabeth Hospital is the only major hospital to keep within its budget limits over the past few years.

Certainly, that is endorsed and is on the record in terms—

The Hon. J.R. Cornwall: Mr Chairman, a point of order! Frankly, I query with you, Sir, the appropriateness of reading formally into the proceedings of this Committee a document which is not a memo, which is unsigned, and which is unsourced. In fact, it has no official standing with the medical staff committee or the board of the hospital, the administration or anyone else: it is a recklessly irresponsible document.

The Hon. JENNIFER ADAMSON: That is precisely why I want the Minister to respond to it.

The CHAIRMAN: On this occasion I will not uphold the Minister's point of order.

The Hon. J.R. Cornwall: I just wanted guidance.

The CHAIRMAN: Order! I understand that the honourable member is reading something into *Hansard*.

The Hon. JENNIFER ADAMSON: Yes.

The CHAIRMAN: At this point in time I am prepared to allow the honourable member to do that. I point out to the Minister that he has the right correctly to respond to anything.

The Hon. JENNIFER ADAMSON: It is for the very reason that I want the Minister's response that I seek to put the document on the record. I would certainly like in due course the Minister to acknowledge or refute the statement that the Queen Elizabeth Hospital is the only major hospital to keep regularly within its budget limits over the past few years. The memo continues:

> The 1983-84 budget was $65.7 million: the 1984-85 budget was $69.6 million; a decline of 2.3 per cent in real terms.

I would like the Minister in due course to identify what he and the Commission regard as the anticipated inflation rate for hospital services as distinct from ordinary cost of living over the next 12 months so that that figure can be seen in the context of the Commission's assessment of inflation. The document continues:

> The Budget for 1983-84 with an inflation only increase compared with the previous year—

in other words, a standstill Budget—

> was provided to the hospital, which was required to meet an increase in services of 5 per cent. This means that the Budget for the last year should have been increased by 5 per cent or $3.3 million. 'Over-spending' last year was 1.3 per cent—

minimal by anyone's standards in the health services—

> Therefore the hospital actually came in $2 million better than the actual Budget when increases in patient workload are considered. This year's Budget has a penalty against the patients of the hospital of $600 000—

the 35 specialists allege that it is $620 000—somewhat in excess of the figure referred to in this unsourced document—

> and overall represents a fall of 2.3 per cent in the Budget and 5 per cent when an increase in workload is considered. Further, there has been a projected increase for the next year of 5 per cent.

The Minister in his calculation (or possibly it was the Chairman of the Commission) acknowledged a 4 per cent increase, so there is a difference of 1 per cent on that figure. The document continues:

> Therefore, the Budget should be increased by $7.9 million over and above the current figure, making a total for next year of $77.3 million.

So that is a truly standstill Budget. The document goes on to say:

> The result of the above under funding means that the Queen Elizabeth Hospital is much more efficient than other hospitals in terms of service provision, given the same amount of funding. There has been no increase in hospital funding for many years and the situation now is one of severe under funding compared with other hospitals.

Under the heading 'Other facts', the document further states:

> The Queen Elizabeth Hospital has had an increase in services of 4 per cent but mostly in the high cost areas; that is an actual increase in expenditure of 5 per cent for the last financial year.

The document identified the costs per bed day as follows: Queen Elizabeth Hospital $251; Royal Adelaide Hospital, $278; and Flinders Medical Centre, unknown but thought to be in excess of $280. According to this document, costs per outpatient services are as follows: Queen Elizabeth Hospital, $45; Royal Adelaide Hospital, $48; and Flinders Medical Centre, possibly greater than $50. I would like the Minister's response to those allegations. The document

identifies 'necessary services not able to be provided' because of cost cutting as:

1. Triage in casualty—that is screening of patients to see who needs immediate treatment.

The Minister's statements made when he was in Opposition suggest that he regarded that as an area of high priority. The next service identified is:

2. High intensity nursing care for seriously ill patients.

That is obviously an essential service for any hospital. The document then goes on to identify waiting times for surgery as follows:

Prostate (10 months)—

which is an increase of eight months in one year. I would like the Minister's denial of that or, alternatively (and I do not want further details of what his committee is proposing), an assessment of it in the light of his knowledge—

blood vessel surgery (12 months); cataract (12 months); ear, nose and throat (eight months); plastic surgery (two to three years); obesity operations (more than six months); termination of pregnancy (two weeks and rising).

That is a very serious delay. The document identified outpatient waiting times as follows:

Eye patients (two months); ear, nose and throat (two months); three months for podiatry (this is a very dangerous waiting time because some people will lose their feet); psychiatry (two months); obesity (six months); diabetes (one month); and physical medicine (3½ weeks).

The document then identifies areas that are dangerously short staffed as being respiratory medicine, cardiac, diabetes, haematology/oncology and nursing. In regard to nursing staff, the document states:

The agreed minimal staffing level in 1981 by the Health Commission for safety of patient care was 1 146 nurses; the absolute minimum to provide a national standard of 4.4 nursing hours per patient per day was 1 109; the current nursing staff of the hospital is 1 059 and frozen. This means that the current nursing establishment is 10 per cent less than necessary to provide minimum standards and is a figure much lower than comparable in the Royal Adelaide Hospital and Flinders Medical Centre.

The document concludes:

The result is a dangerous overloading of nurses and lack of intensive care for seriously ill patients.

That is a lengthy document containing many figures. In the light of the Board's dissociation from the document and the Health Commission's rejection of it I think it is important that the Minister put on the record details of where and in what specific instances the document is inaccurate.

The CHAIRMAN: Before the Minister replies, the Chair points out to the Minister that the member for Coles has obviously been supplied with certain information, rightly or wrongly, and she has read into *Hansard* that information. I presume that she believes that it is correct.

The Hon. JENNIFER ADAMSON: I do not know; I am asking for the information.

The CHAIRMAN: The Chair has no power to stop the member for Coles reading such information into *Hansard,* and she was allowed to do so. Whether or not the information is correct is up to the Minister to reply to it.

The Hon. J.R. Cornwall: First, I am sure that anyone who has done his homework would have read the very lengthy reply that I gave to a question that was asked in the Legislative Council last Thursday in which I gave the background to this scurrilous campaign that is being conducted by a small number of recklessly irresponsible, faceless men at the Queen Elizabeth Hospital.

Mr OSWALD: That is only your opinion.

The CHAIRMAN: Order! For the rest of this session, I will not tolerate interjections like that. I ask the member for Morphett to cease that type of interjection; otherwise the Chair will certainly deal with him.

The Hon. J.R. Cornwall: The background to all this is that in 1981 a document called 'Metropolitan Adelaide Hospital Planning Framework' was produced by a senior officer in the Commission, Mr John Cooper, who, arguably is (as I am sure the member for Coles would agree) the best health planner in this country. The document recommended a significant redistribution of beds within the public hospital system in metropolitan Adelaide and an overall reduction in the number of beds in our public hospitals. Perhaps one of the most significant recommendations was a reduction of 200 beds—from 700 to 500—at the Queen Elizabeth Hospital. The former Government never acted on that recommendation. Again, it was only—

The Hon. JENNIFER ADAMSON: It was produced after we left office. It would have been very difficult to act on it.

The Hon. J.R. Cornwall: I am sure that I would be able to respond better without the very rude interjections of the little Aussie battleaxe.

Mr OSWALD: That was offensive. I do not care if I do get named: that was a most offensive remark. You, Sir, should keep him under control. That is the sort of thing the Minister does in another place, but he should not do it in this Chamber. It was an offensive remark from an offensive man to an honourable lady.

The CHAIRMAN: Order! I must confess I did not hear what the Minister said.

Mr OSWALD: Well, do not ask him to repeat it, Sir.

The CHAIRMAN: Order! I point out that, if the remark by the Minister was offensive to the member for Coles, as has been suggested, she has the right to take a point of order, and I would act on it.

The Hon. JENNIFER ADAMSON: I certainly would appreciate the Minister's withdrawing what I consider to be a most offensive remark.

The Hon. J.R. Cornwall: I have no difficulty: I am happy to withdraw, but I do wish that the member for Coles would restrain herself when I am trying to deal with this extremely important matter. Her interjections are not contributing anything to this Committee.

The CHAIRMAN: Order! Before the Minister goes on, perhaps I should say that we are dealing with certain lines of a Minister, and we can either deal with them in an orderly or reasonable way or we can get into the kindergarten stage. I suggest that we stop right now and come back to some sort of an orderly situation rather than continuing in the vein in which we have acted in the last quarter of an hour; otherwise we will be in the kindergarten stage.

The Hon. J.R. Cornwall: As I was saying when I was so rudely and inappropriately interrupted by the member for Coles, the fact is that that document was produced during the time of the previous Government but, as she says, quite rightly, they did not have time to act on it. Maybe that is just as well for the hospital system, because it made some pretty radical recommendations, and it was at the time when the Minister used to boast about cutting the heart and soul out of the public hospitals system which, at one stage, she described as in many ways being a residual service.

If we want to get into rhetoric about that at another time and on another more appropriate occasion, I will be happy to accommodate her. However, that was not accepted by me as Minister of Health without question. Such was my concern to act in the most appropriate way possible and in the interests of all South Australians and their health service for the next two decades and beyond that when I appointed the Sax Committee of Inquiry into South Australian hospitals—the most comprehensive inquiry into the hospital system ever conducted in this country—I referred the Cooper Document, the Metropolitan Adelaide Hospital Planning Framework to them for specific assessment.

Again, the Sax Committee, chaired by Dr Sid Sax (who is without peer in this country as a health administrator and planner), endorsed the recommendations contained in the original document; that is, amongst other things, that there should be a reorganisation and a reduction in bed numbers at the Queen Elizabeth Hospital. Again, because I had no desire to take precipitate action, I encouraged and fostered the Commission to talk to the board of management of the Queen Elizabeth Hospital and the senior administration to seek their co-operation for a major role and function study.

This was to be the definitive document, taking into account the recommendations of the Sax Committee and of the Metropolitan Adelaide Hospital Planning Framework, among other things. A small but significant number of senior staff at the hospital (acting I think in quite a crude way, and certainly in a most unsophisticated response), decided that the best way to pre-empt anything that might be recommended by the role and function study was virtually to go to war with the South Australian Health Commission.

That document, which Mrs Adamson has read into the record, is a recklessly irresponsible document produced by a group of faceless men at the hospital; it is unsigned and, to this time at least, unsourced. It has been repudiated by the board of management and the Administrator. Let me say at once, before we proceed any further down this track, that I have recently had a conversation with the Chairman of the Board of the Queen Elizabeth Hospital. In that discussion, I made clear to him that his probity and his propriety were completely beyond doubt in my view and in the view of the many people who know him as a man of outstanding propriety.

So, there has never been at any time any reflection on the Chairman of the Board. However, let me return to this recklessly irresponsible document, the unsourced and unsigned document, which Mrs Adamson (the member for Coles) referred to as a memo, thereby, despite her protestations to the contrary, making a shabby attempt to give it some sort of official status. It is completely unofficial, unsourced, and unsigned. As I said, it is recklessly irresponsible and is produced by a small group of faceless men at the hospital.

Among other things, of course, it will tend to have the effect, if we are not all very careful, of discrediting the hospital and causing distress to many residents of the western suburbs. The Queen Elizabeth Hospital received a significant amount of bad press last year, as I am sure even the member for Coles will recall. There were some quite significant complaints about the accident and emergency services at the hospital. As a result of the recommendations of the Sax Committee of Inquiry and of specific actions taken by me and by senior Health Commission officers, the A and E Department at the Queen Elizabeth Hospital was very substantially upgraded.

People should now know that they can go to the Queen Elizabeth hospital with great confidence. The clinical services provided in the Accident and Emergency Department and in the Outpatients Department are as good as those anywhere else in the metropolitan area. Quite frankly, the timing of this scurrilous document, when public confidence had been substantially restored in the Queen Elizabeth Hospital, is absolutely disgraceful; and it is absolutely disgraceful that the Opposition should try to give it the status of an official memo. I repeat that it is a scandalously inaccurate document and that its circulation by a small group of faceless men is recklessly irresponsible.

Frankly, if I knew who were its authors (and I have no proof of that) I would refer the matter to the South Australian Medical Board, because I believe that there have been, potentially at least, some serious breaches of the South Australian Medical Practitioners Act. The very best face one could put upon it is that the behaviour of these people is grossly unethical.

The only other point I want to make relates to an interpolation made by the member for Coles when she was reading that scurrilous document and referred to the fact that the Budget had been exceeded by 1.3 per cent. In fact, as we will show in a minute, it was substantially more than that. However, referring to the 1.3 per cent, she interpolated 'which is minimal by anybody's standards in the health services'. I cannot let that pass without comment.

First, of course, if we were to accept 1.3 per cent over expenditure from every one of our health units in a Budget which totals $634 million (as proposed in 1984-85), then of course the system would lurch out of control. My second point with regard to that, apart from its being an irresponsible statement, is that I find that it sits very ill with an Opposition which persistently and consistently, through its leading disciple (Mr Olsen), talks about privatisation and small government.

Frankly, you cannot have your cake and eat it too. If the Opposition believes in small government then so be it, although that may well be at the expense of the majority of South Australians. However, the Opposition cannot preach small government and at the same time advocate a position that in reality states and indeed demands that the Health Commission, the Minister of Health and the Government should allow the system, on demand, to lurch out of financial control. What is being attempted by a small group of recklessly irresponsible individuals at the Queen Elizabeth Hospital by the circulation of this document is to blackmail the Government, and I want to make clear that as Minister of Health I will not cop it. The Administrator of the Hospital has already made clear that he will not cop it. I believe firmly that the board of management of the hospital will not cop it.

Let me make very clear also (although I do not have to speak on their behalf: they can do that themselves) that I am just as confident that professional officers of the Health Commission will not cop it, and the Health Commissioners themselves—we include among those Health Commissioners one of Adelaide's most distinguished accountants from the private sector—will not cop it, either. Having said all that, I very much regret that this matter has even been made a political one by a small irresponsible group of staff of the Queen Elizabeth Hospital, aided and abetted by an ignorant Opposition. I think that it is a very sad day indeed that this has been allowed to happen.

Initially, when the significant budget overrun at the hospital and the actions proposed by the Commission were drawn to my attention, it was done virtually as a courtesy. It was not a political matter, nor should it ever have been viewed as such. It is an administrative matter: it is about sound management, and that is what the Health Commission is about, among other things. It was my decision at that time that I would accept the recommendations of the Health Commissioners and that I would most certainly not intervene. It would have been political and indeed political interference—which I think would have been totally unacceptable—for me not to have accepted all the advice of all the senior officers in the Commission and the Commissioners themselves.

I repeat: it should not be—and I regret that it has become through the reprehensible actions of the Opposition—a political matter at all. It is an administrative matter and, therefore, I ask both the Chairman of the Health Commission and the Executive Director of the Western Sector who have been directly involved in these important administrative matters to respond to the Committee. I point out that there is a matter of such fundamental principle involved here

that I trust that the Committee will hear both these officers at whatever length may be necessary to put to rest for all time the furfies, scuttlebutt and the gross inaccuracies contained in that unsourced and unsigned document.

Mr OSWALD: You haven't given the facts and figures.

The Hon. J.R. Cornwall: I do not normally respond to interjections. Quite deliberately I have not seen fit to get specifically into those areas, because this is clearly an administrative matter, and the Chairman and the Executive Director, Western Sector of the Health Commission, both extremely competent people, can do that from an administrative point of view—not from a political point of view: I do not play to politics of the gutter like some members of the Opposition do—and they will rebut it at the length that may be necessary.

The Hon. J.R. Cornwall: First, I ask the Chairman of the Commission, Professor Andrews, to outline for the benefit of the Committee the background to the budget overrun at the Queen Elizabeth Hospital, the negotiations that have occurred, the decisions that have been taken and the current state of play. I will then ask the Executive Director of the Western Sector, Mr David Coombe, who has been most intimately involved in the direct discussions with the hospital administration and board of management, to discuss the particular matters raised in substantially more detail.

Professor Andrews: I would reiterate the Minister's point that this is primarily an administrative issue and is about good financial management of the hospital system in South Australia. The problems in financial management at the Queen Elizabeth Hospital first came to light in December 1983 in the course of the 1983-84 budget. At that time the Queen Elizabeth Hospital, along with a number of other major hospitals in South Australia, was clearly overrunning its budget. In the case of the Queen Elizabeth Hospital the overrun was of such an extent and was such a cause for concern that a number of meetings were held with the hospital, not only at the level of the Executive Director and the Secretary, his staff and the hospital staff but at the level of the Health Commission's finance committee and the finance committee of the hospital. As a result of those discussions, a detailed budget review was undertaken to identify the cause of those overruns and what action might be necessary to correct them.

As a result of that review, it became apparent that the main reason for the hospital overrunning its budget (which had been agreed earlier in the year) was the increased level of spending on maintenance and minor works during that 1982-83 period, and that had been funded from its base budget on the basis that there had been savings on staff lines in the previous financial year. The 1983-84 level of spending on that budget reflected both that increased spending on maintenance and minor works and restoration of staff levels. In the detailed discussions it was apparent that there were a number of areas where the hospital could demonstrate that it had been under significant pressures and some budget variation was justified, and that was provided at the level of $532 000.

As a result of the budget review and that budget variation, the hospital then gave the Commission assurances that it would be able to live within its now newly agreed budget and that it would come in at the end of the financial year on target. Those undertakings were given in writing by the Chairman of the hospital board to the Commission. In spite of the fact that as the year went on it was clear that the hospital was still in an overrun situation, it believed it could bring it back by the end of the year through effective management. It simply failed to do that, to the extent of $1.3 million, representing a 2 per cent overrun against its agreed budget, even taking into account the $500 000 supplementation. I believe that for the Commission to have merely accepted that without further investigation, discussion and consideration would have been grossly incompetent financial management. We did in fact examine all the arguments put forward by the hospital executive and were prepared to accept that, again, given pressures on the hospital, some amount of that $1.3 million could be accepted as being reasonable to build into the hospital's base for calculating a budget for 1984-85.

Following that analysis, it was agreed that the sum of $620 000 should be excluded from the base for 1984-85 in respect of expenditure in the previous financial year. There was no penalty: it was merely a matter of determining with the hospital what the appropriate budget for 1984-85 should be. There is no sense of taking money away from the hospital. In fact, through the previous $500 000 supplementation and through accepting all but the $620 000 of the overrun there was a substantial increase in the allocation to the QEH.

The hospital was naturally enough concerned about this and about its problems of management to the extent that a special meeting of the hospital board was called and I was asked to attend. I did indeed attend that meeting and spent three hours with the board discussing its financial position as it was reflected in its previous year's performance and in the framing of its budget. Although the meeting was not without its tensions, I believe that it was conducted most properly in management terms, with the hospital and its executive acting most responsibly. A degree of accord was reached between the Commission and the hospital so that, when I left that meeting, I believed (and events that followed immediately supported my belief) that the hospital was prepared to find ways of living within that agreed budget without interfering with the quality, the range, or the extent of the services that it provided.

The matter of activity figures, which has been mentioned, is a complex issue and the 4 per cent increase that was referred to disappears somewhat when one takes into account all the figures. The best indicator of overall activity is the number of occupied bed-days and there has been only a slight change. Comparing the first six months of 1982, 1983 and 1984, the change has been only minimal. There was a period when an increase of about 4 per cent was recorded in admissions, which immediately afterwards was reduced. So, there is no obvious evidence of a substantial increase in activity in the hospital that would justify a substantial increase in its allocation over and above that which was agreed to in those discussions with the Commission.

I believe that it is very important for this Committee, concerned as it is with the questions of the Budget, the management of that Budget, and the Minister's lines, to understand that the Commission, charged as it is with ensuring that there is effective financial management in the system as a whole, must be allowed to do that.

I believe that we were following that course in discussions with the hospital. For there now to be an argument, coming from an anonymous source and full of largely misleading statistics with quite erroneous arguments in terms of budgetary implications, and for that to have any credence at all seriously weakens the Commission's ability to manage its hospitals. There is no question that the situation that the QEH has got itself into means that it will need to tightly control and manage the hospital to live within its budget, but it should be able to do that without any reduction in services to the community, and certainly without any reduction in the quality of care to patients.

Indeed, if we were to allow it to be simply topped up, the overall impact of that kind of financial management on the State's health services would be devastating, and we would have a situation where we could in no way guarantee, within the budgets provided by the Government as a whole

to run the hospital services, that we could maintain an effective, high quality and efficient service. I have dealt with the overall figures, and perhaps it might be useful for the Committee to hear from David Coombe in terms of some of the details that relate to those figures.

The Hon. J.R. Cornwall: Before we do that, to further illustrate the point I made before about a very small number of faceless men at the hospital acting in a manner that was recklessly irresponsible, I now have before me the two star edition of the *News*, in which some senior unnamed medical staff members are quoted. They have issued a statement which I have not seen—I am only the Minister of Health. That is the reprehensible way in which they seem to be carrying on, and I stress that they are a minority group. In the statement they say:

In view of the fines imposed by Cabinet through the Health Commission . . .

I make clear yet again that that is a total distortion of the facts. There has been no fine nor was any penalty imposed by Cabinet. There has certainly been no fine or penalty imposed by me.

As the Chairman of the Health Commission has made absolutely clear, there has in fact been a further supplementation of the hospital's budget by $1.2 million, but there has been an additional amount of $600 000 which has been classified as a first charge against a very generous budget of $69.6 million which the hospital has received for 1984-85. To further illustrate the point I made earlier, the article states:

A senior hospital source, who would not be named, said medical staff were absolutely furious with the Government.

The fact is that these anonymous, faceless, irresponsible people, who are not even representative and who have no support from the board or the administration, are completely distorting the facts to their own cheap political ends. They remain anonymous, presumably on some spurious grounds of ethics. That would be one of the great perversions of our time if that is the story. Alternatively, they remain anonymous because they do not have the courage to be named publicly. Either way, they look poorly.

I stress again that it was not a fine, it was not imposed by Cabinet or by me. I make the point again that it is an administrative matter, that there was supplementation of $1.3 million in total—very substantial by anyone's standards—and that there was an amount of $600 000 over and above that which the Commission, in a responsible administrative decision, said it could not and would not meet as part of this very substantial budget overrun. That is a first charge against the $69.6 million. When I was told about it, I repeat, the only political action would have been to interfere with the Commission and say, 'No, you should not do that. Let the hospitals overrun their budgets by as much as they like.' That apparently is the line that is supported by the members for Coles and Morphett.

These members would say, 'Do not be financially responsible,' and that is such a preposterous position that no reasonable professional officer could possibly adopt it. It would perhaps be even more outrageous if it were adopted by the Minister of the day. It would mean that the Health Commission, one way or another, would become a sick joke without any power at all to exercise financial responsibility in the administration of the health services.

So, that again should be clear. There has been no fine; there has been no penalty, in the sense of something imposed; and there has been no Cabinet decision to impose anything. I simply took the matter to Cabinet so that it could note the very responsible position that had been taken by a very effective and efficient Health Commission. I would now ask Mr Coombe to give some details in rebuttal of the scurrilous and completely inaccurate—

Members interjecting:

The Hon. J.R. Cornwall: Is he on this Committee, too? You have got the dregs today! The enforcer has arrived! I ask Mr Coombe to respond to some of the details of that document.

Mr Coombe: I welcome the opportunity to talk about the financial performance in 1983-84 and the Budget allocation for 1984-85 for the Queen Elizabeth Hospital. However, before I get into that detail I could say that, as Executive Director of the Western Sector, I have certain specific responsibilities to the Chairman of the Health Commission and, amongst other things, they include the provision within the macro allocation of resources and the policy guidelines as determined by the Commission of services within my sector and also, most importantly, the responsibility to ensure that incorporated hospitals, incorporated health units and any health service established, maintained or operated by or with the assistance of the Commission are operated in an efficient and economical manner.

I am also required to ensure the efficient management of financial and other resources allocated to a sector for health care programmes. I believe that the role of the board of management of our health units can be likened to that of trustees: they are trustees of a sum of allocated public moneys. I also believe that at our health units we have many very capable managers, and one of their prime functions is to manage within the allocation of those public funds. Statement 8 of the blue book clearly shows that the actual payments incurred by the Queen Elizabeth Hospital in 1983-84 was $67.081 million against an approved budget of $65.737 million. That represents an over-expenditure without authority of public funds of $1.344 million and, as we have been reminded before, that is after there had been, during the course of the year, substantial top-ups in excess of $1.3 million.

The provision of funds to the Queen Elizabeth Hospital—indeed, to any of our incorporated health units—is on the basis of a global allocation; that is, the health unit determines internally how the allocated funds should be distributed between the major divisions of salaries, wages, goods and services.

The Health Commission is charged with overseeing the efficient operation of our health units and, in respect of the Queen Elizabeth Hospital, the Health Commission has been in constant dialogue with the board in the administration of that hospital over budget matters since late 1983. The Commission's concerns about the management of the hospital and the likely overrun in the 1983-84 budget were expressed frequently, both verbally and in writing. Now, this is terribly important: the hospital was also informed that over-expenditure in 1983-84 would have an impact on its revenue base in 1984-85. Despite written assurances given to the Health Commission that savings would be made and that the hospital would stay within its budget, the final overrun was in excess of $1.3 million.

What caused the over-expenditure? The hospital submitted that the following areas were the cause of over-expenditure: increased patient activity; price increases over the allocated 6.5 per cent inflationary factor that applied in 1983-84; costs due to changes in patient mix; increased costs due to non recurrent offsets; increased nursing staff costs; terminal leave payments; and additional costs due to improved EDP information systems.

As a consequence of those causes which were submitted by the hospital, along with the supporting data which was provided, an amount in excess of $700 000 was accepted by the Commission on my recommendation as being justified in respect of the following: increased patient activity. Whilst I do not have the precise figures here, I assure the Committee that within that $707 000 every cent that the Queen Elizabeth

Hospital provided to me as representing increased costs due to increased patient activity was accepted. I accepted some of the causes associated with increased costs in patient mix. I also accepted some of the hospital's reasoning in terms of increased nursing staff costs.

Also, during 1983-84, supplementation had been separately provided to the hospitals in addition to the $1.3 million about which we are talking, in respect of terminal leave payments. With regard to additional costs due to improved computer information systems, the hospital had previously stated as a justification for the systems that there would be substantial savings.

Was the over-expenditure caused by undertaking new programmes? Any new or expanded programmes formerly presented by the hospital to the Commission and approved by it were specifically funded to the extent requested by the hospital. In particular, I refer to the Geriatric Assessment Unit and the expansion of the Satellite Renal Dialysis Unit.

In July 1984, as Executive Director, I advised the Commission that I was able to accept an amount of only $700 000 as being justified within the overrun of $1.3 million. Subsequently, I recommended to the Commission that an amount of $620 000 should be excluded from the actual expenditure of the Queen Elizabeth Hospital in 1983-84 for the purposes of calculating the budget base of the hospital for this current fiscal year. I repeat that the $620 000 is not a fine nor a penalty.

I repeat: the Queen Elizabeth Hospital has had its budget base increased by $1.2 million—that is far from having its budget base reduced. Furthermore, on my recommendation the Commission further resolved to adopt the policies of the Commission and to require the hospital to give effect to those policies pursuant to the hospital's constitution, and that the hospital advise in quantifiable terms what specific steps would be taken to reduce its general level of activity in order to accommodate a reduction in the 1984-85 budget base of $620 000. Secondly, the Queen Elizabeth Hospital had to provide evidence of a forward expenditure plan against which its actual expenditure could be monitored; a study was to be undertaken to determine the appropriate levels and mix of nursing staff at the hospital; and I was to attend all future finance meetings of the hospital. Further, a study was to be undertaken by independent consultants into the financial management of the Queen Elizabeth Hospital, and no additional or replacement staff were to be engaged by the hospital without the specific approval of the Hospital Staffing Review Committee. I have heard it said that that has been interpreted as being a freeze on staff. That is not so at all: it is just that there should be proper manpower planning procedures.

My sector allocation this year in round figures is about $120 million. The initial gross payments allocation to the QEH in 1984-85 does not represent a reduction in terms of the initial allocation, in percentage terms, made in 1983-84. In 1983-84, 58.5 per cent of my total sector allocation was given to the QEH initially. In 1984-85 that figure is 58.7 per cent. The extent of over-expenditure last year by the QEH is entirely out of line with the experience of other metropolitan hospitals. I admit that the budget will contain any overspending substantially to the level of understanding reached with the Commission at mid-year and that further an overspending of the order of 2 per cent against the budget which had already been revised is very large.

I am concerned, and the Commission is concerned, that if it appears to hospital managers and boards that expenditure overruns of this order will be accommodated there is a real danger of a serious loss of financial control in hospital services generally. In the circumstances, the Commission's decision (made irrespective of the hospital's performance) to require that restrictions be observed in 1984-85 was I believe entirely justified.

What about the future? Last night at 6 o'clock I received a letter from the Administrator of the QEH. Headed, '1984-85 Financial Allocation', the letter states:

> The allocation of $69 640 500 as advised in your letter of 5 September 1984 has been accepted by the board of management as a budget base. In accepting the allocation as detailed above, the board recognises that this involves a reduction in the 1984-85 budget base of $620 000.

Mr OSWALD: How much option did they have?

The Hon. J.R. Cornwall: I do not mind the member for Morphett being rude and interjecting persistently when I am speaking, but I think that it is grossly out of order when an officer of the Commission is speaking.

The CHAIRMAN: I uphold the point. Again, I point out to honourable members that the Minister's officers are here to assist the Committee in seeking information or material relevant to the lines. It certainly is rude to interrupt. I suppose that Ministers, for example, are used to being interrupted, but I certainly do not think that officers should be interrupted. I ask Mr Coombe to continue and to ignore the interruptions.

Mr LEWIS: Where in the Sessional Orders of these Committees does it enable a Minister appearing before the Committee to take a point of order?

The CHAIRMAN: I find the honourable member's interruption at this time not only rude but also grossly out of order. I did not take the Minister's point as a point of order. I simply clarified the matter of interjections occurring while one of the Minister's officers was addressing the Committee. I consider those interruptions to be grossly out of order, so there was no point of order. I do not know whether the honourable member is taking a point of order, but, if he is, I do not uphold it. I ask Mr Coombe to continue.

Mr Coombe: Members of the Committee would recollect that earlier I indicated that there were six steps, which were regarded as being policy matters, that the Queen Elizabeth Hospital was to undertake. They are as follows: that the hospital was to advise in quantifiable terms what specific steps it would take to live within its budget and that it provide evidence of a forward expenditure plan against which actual expenditure could be monitored. In regard to those two points, I quote from the Administrator's letter to me, which stated:

> I await your response to this letter, in particular your confirmation about funding for equipment purchases, and seek a further meeting with you at your earliest convenience to discuss further the planned reduction in expenditure and forward expenditure base.

The third matter of policy had to do with a study to be undertaken to determine the appropriate levels and mix of nursing staff at the QEH. The Administrator was very quick off the mark with my support, and he has had extensive discussions and received a submission from a recognised organisation to undertake such a study. The fourth point was that I should attend finance committee meetings of the board of management. Again, in his letter the Administrator stated:

> He has been provided with dates of forthcoming finance committee meetings for October, November and December.

I took that as being an invitation. The fifth point was that a study be undertaken by independent consultants into the financial management of the QEH, with particular regard to the planning, control and monitoring of activities and systems and the level and competence of existing staff. The Administrator stated in his letter:

> The Board endorses the study into financial management and requests that the hospital be involved in determining the terms of reference for such a study.

The final point was that no additional or replacement staff be engaged by the QEH until further notice without the specific approval of a hospital staffing review committee comprising the Administrator, Director of Nursing and Medical Director. In response to that, the Administrator has advised me as follows:

Finally, I confirm my previous advice that a staffing review committee comprising not only the members you proposed but also expanded to include senior management personnel has been in place.

The Hon. J.R. Cornwall: I would like to add one thing to that—possibly it is the only matter that has not been covered. I refer to allegations made about nursing levels. All sorts of wild allegations were made by these faceless people. I point out to the Committee, because I think it is most important, that in March this year, at the invitation of the board of management, I attended to present to the hospital its certificate of reaccreditation. Accreditation is something given by the Australian Council on Hospital Standards; it is not given lightly. Reaccreditation for a maximum period of three years, of course, as far as the Australian hospital system is concerned is, I guess, close to the acme of perfection in terms of a well conducted hospital.

Among the many stringent parameters used in assessing a hospital's performance for accreditation and reaccreditation naturally are the levels of staffing. So, clearly, the Australian Council on Hospital Standards (the peak body in this country on hospital standards) when it reaccredited the hospital took into account, among many other things, the levels of nursing. So, this assessment by independent experts from around Australia clearly did not agree with the faceless men; they obviously believed that the levels were adequate. One other thing that I should say again for the fifteenth time—and I will go on saying it forever if I have to, but I notice that the member for Henley Beach has joined us in the Chamber and he has a particular and a vital interest in this matter—is that the future of the Queen Elizabeth Hospital is absolutely ensured. It has a major role—indeed, major roles—to play in serving the 200 000 people, or thereabouts, who live in the western suburbs and who depend very heavily on the QEH for its services. It is a first-class hospital. After the role and function study has been completed, I give an assurance today that it will be even better.

The Hon. JENNIFER ADAMSON: I must protest at what I regard as an absolutely intolerable abuse of this Committee by the Minister. More than an hour ago I asked three or four simple straightforward questions, only one of which has been answered. We had a diatribe by the Minister which contained nothing but rhetoric. He was alleging that the Opposition was irresponsible in raising this matter; he was making allegations about faceless men at the Queen Elizabeth Hospital.

I suggest that the reason that no doctor so far—and I stress 'so far'—at the Queen Elizabeth Hospital is willing to identify himself or herself is that no doctor would wish to submit himself or herself voluntarily or willingly to the treatment meted out to Dr Dutton at the Adelaide Children's Hospital by the Minister—treatment that is well known in the health services around South Australia as coming from this Minister. It is absolutely futile for the Minister to suggest that it is reprehensible of the Opposition to raise these issues.

The very reason this document was raised in this Committee was to enable the Minister to refute it if he could. The principal question that I asked, because it is so relevant to the Budget and the sums that are being argued about, was the question of inflation and the amount that is estimated by the Commission to be the rate of inflation for the forthcoming year. No-one addressed that question; no-one addressed the question of the waiting times, the cost per outpatient services by comparison with other hospitals. No-one, least of all the Minister, refuted the statements in this document about the waiting time for surgery—10 months for prostate; 12 months for blood vessel; 12 months for cataract; eight months for ear, nose and throat; two to three years for plastic surgery; and more than six months for obesity. No-one even addressed the question of outpatient waiting times in this document: two months for eye outpatients and two months for ear, nose and throat.

The nursing staff levels were addressed very belatedly by the Minister by way of interruption at the end of the questions, but no-one has addressed the statements in this document that the nursing establishments are lower than comparable patient ratios at the Royal Adelaide and Flinders Medical Centre. We have had nothing more than a diatribe from the Minister—a load of rhetoric. His pomposity is matched only by his verbosity, and that is saying a great deal. As to his assertions when he started to answer my question about the metropolitan hospitals planning framework, I point out to the Minister that this document was first published in 1983. I submit that it would have been very difficult for a Government to act upon a document that had not even been completed when it left office. None of the questions I posed have been answered.

We have been subjected to a treatise on the role of the Commission and on the role of hospital boards, all of which I am well familiar with, and so are members of the Committee. We did not have our specific questions answered, nor was the question of the 35 specialists at the Queen Elizabeth Hospital and their statements that they cannot guarantee to maintain high standards of medical care addressed. Whether those 35 specialists are regarded by the Minister as scurrilous faceless men is something that he will no doubt want to take up with them, but I doubt that the community being served by those 35 specialists would regard them as scurrilous faceless men.

The questions which were not answered will be put on notice, because my colleagues and I have virtually given up hoping that the questions we put will be answered, as so few of them have been. For simple questions like the ones I have put to take more than an hour of the Committee's time with no substantive answers is, in my opinion, a complete waste of Parliamentary time.

I refer the Minister specifically to the metropolitan hospitals planning framework and also specifically to his statement that the document called for the reduction by 200 of the number of beds at the Queen Elizabeth Hospital. In view of his criticism of the previous Government for failing to take action on a document that had not even been published when it left office, what action has the Minister taken in respect of this document, published more than a year ago, to reduce the numbers of beds in metropolitan Adelaide hospitals by any degree whatsoever since the document was published?

The Hon. J.R. Cornwall: There is one old truism, there is no question about that: they do not come back. We have just had a real example of the fact that the member for Coles is a light of other days. Unfortunately, she again tried to give credence to this unsourced unsigned document. She started off by saying that she was simply reading it into the *Hansard* record so that I would be given the opportunity in the most responsible way possible to refute it and (far more importantly, as I pointed out) so that the senior officers of the Health Commission—particularly the Chairman and the Executive Director—would be given the chance to refute it.

I regard this whole matter as going to the heart of administration of the health system in this State. For that reason, I make absolutely no apology for taking up an hour of the Committee's time. Of course, most of that time was taken

up by two of the most senior professional officers in the system. I repeat that I find it extraordinary, to say the least, and reprehensible that the member for Coles and the Opposition should be trying to give credibility and currency to an unsigned, unsourced, unidentified document allegedly from one or a small number of senior medical staff at the hospital—those who are so responsible, a so-called senior hospital source, who would not be named. The member for Coles tries to give that credibility and credence. She tries to undermine the very foundation of financial responsibility within the public sector and does it proudly.

The CHAIRMAN: Order! I think we should stop at that juncture. The Chair is placed in the situation where it allowed the member for Coles to read at some length a document making, in the Chair's opinion, rather grave allegations. The Chair has allowed the Minister and his advisers to reply at some length, simply because the allegations were of a grave nature. I point out to the Minister that, as the Chair understands the position, the member for Coles has now asked a further question about the waiting time for out-patients at the Queen Elizabeth Hospital. It may be desirable in the interests of the Committee getting back to some sort of reasonable position for the Minister to reply to the actual question.

The Hon. JENNIFER ADAMSON: I pointed out that that question would be put on notice. The question I asked was what action had been taken to close beds in response to the recommendations of the metropolitan hospitals planning study.

The CHAIRMAN: The Chair apologises to the member for Coles for that. The point that I am trying to make is that I think that we should come back to the actual question that has been raised, rather than rehashing the whole hour or so of discussion.

The Hon. J.R. Cornwall: Unfortunately, I cannot remember what the question is.

The Hon. JENNIFER ADAMSON: I am happy to repeat the question. The Minister made reference, as did I, to the metropolitan hospitals planning study proposals and made the observation that the previous Government had not acted upon those proposals. I pointed out that it would have been very difficult for us to do so as the document was not published until 1983; it was released by the Minister himself and was not in my possession when I left office. He stated in his reply (and I can understand how he may have forgotten because it is well over an hour ago that he commenced to make it) that this document recommended a reduction in the number of beds in metropolitan hospitals, notably the Queen Elizabeth Hospital, from 700 beds to 500. I ask him to be specific in indicating to the Committee what action the Commission has taken to implement the recommendations outlined in the metropolitan hospitals planning study proposals specifically in respect to the Queen Elizabeth Hospital.

The Hon. J.R. Cornwall: I went into that at great length and detail this morning, as I did on the question of waiting times. I do not know what your position is here, Mr Chairman, but we have a Standing Order where I come from which forbids undue prolixity or tedious repetition, so I do not think that I will take up any further time of the Committee repeating what I have already said at great length.

The CHAIRMAN: The Chair can only take it that that is the Minister's reply.

The Hon. J.R. Cornwall: It is just as a matter of courtesy to your House, Sir.

The CHAIRMAN: Has the member for Coles any further questions?

The Hon. JENNIFER ADAMSON: Yes. One can only wonder how the Minister of Health has managed to survive in a Chamber that cannot tolerate prolixity or repetition. I refer to the Queen Elizabeth Hospital in respect of beds, and this is not a repetition of the question I asked earlier.

The Hon. J.R. Cornwall: It's pretty boring, though.

The Hon. JENNIFER ADAMSON: The Minister may think that it is boring, but there are others who may find some interest. Will the Minister advise the Committee whether the role and function study to which he referred has as its prime goal the achieving of a smaller number of beds at the Queen Elizabeth Hospital than the number that presently applies? The implications of this are extremely important because, quite clearly, if bed numbers are reduced at the hospital in accordance with the recommendation of the proposals it would be unlikely to be able to maintain its status as a teaching hospital for the University of Adelaide. It is extraordinarily important, both for the future of the hospital and its ability to live within its budget, that the Committee knows whether or not the Minister in the forthcoming financial year intends to close a bed in that hospital.

The Hon. J.R. Cornwall: The member for Coles is a very unpleasant lady sometimes. The short answer to that is 'No'. There is no point in setting up a role and function study and having the Minister of Health in particular preempt what its findings might be. That may have been the way that the member for Coles operated when she used to pontificate from heights of great ignorance during her brief interregnum as Minister of Health. However, I intend to be around for a long time in my portfolio, and I take my duties very seriously, so I do not act in that way. However, as I said, the short answer is 'No'. I will ask the Chairman of the Commission to give a more detailed response to that rather loaded question.

Professor Andrews: The role and function study is being carried out independently of the direct question addressed in the metropolitan hospitals planning study. Clearly, the role and function study must take general account of the distribution of beds in Adelaide, and any decision that is made to redistribute beds or reduce beds at the Queen Elizabeth Hospital will be taken on board in the course of that. On the other hand, the role and function study may itself argue for an increase or decrease in the number of beds based on the needs of the community that the Queen Elizabeth Hospital serves and the various regional and superregional functions of that hospital.

Therefore, there is an interaction, but the role and function study is concerned with meeting the needs of the community served by the hospital rather than with the question of the distribution of beds in the State as a whole. The Sax Report reviewed the recommendations in the metropolitan hospitals planning study and endorsed in general terms the argument for a reduction in the number of beds at the Queen Elizabeth Hospital. The Commission has appointed a committee, headed by John Cooper, who I think was the principal author of the metropolitan hospitals planning study. The function of that committee is to consider the distribution and range of hospital services across Adelaide and the rest of the State with a view to advising the Minister and the Government on any future reductions or increases needed in the number of beds in and between hospitals.

Ms LENEHAN: The member for Coles has referred to some specific aspects in this document, which seems to be the focus of some discussion and indeed debate in the Committee. I wonder whether the Minister would like to comment on some of the specific allegations contained in the document under the headings of finance, other facts, cost per bed, cost per outpatient services, waiting times, nursing staff, etc.

The Hon. JENNIFER ADAMSON: I rise on a point of order. The member for Mawson is repeating almost verbatim the question I asked which was the subject of more than an hour's delayed reply by the Minister and his advisers. I

suggest that the time of the Committee would be very much wasted if that question were again put to the Minister.

The CHAIRMAN: I uphold the point of order to some degree. It is not desirable (and I think common sense ought to prevail) that we repeat and repeat questions. I believe that the member for Mawson is broadly repeating what has taken place. However, having said that, if there is any specific point that the member for Mawson believes she ought to ask the Minister with regard to that document, then the Chair is quite prepared to allow her to do that. I ask that we do not keep repeating questions. As the member for Coles has pointed out, one and a half hours has transpired since she asked the original question about this matter. Has the member for Mawson a specific question?

Ms LENEHAN: I did specifically want some clarification of the statement that the QEH is the only major hospital to keep within its budget limits over the past few years, and the document then goes on to argue that point. I restrict my question to that area.

The Hon. J.R. Cornwall: The member for Coles seems to want everything to run her way: she goes to bat for a minority group at one of our major hospitals, the only hospital, I might add, to blow its budget and not only blow its budget but to do it by more than 2 per cent, which goes to the heart of the whole matter of the financial arrangements in the big health industry within this State with a proposed annual budget for 1984-85 of $634 million.

In view of the huge amount of misrepresentation which has been undertaken by a minority with the enthusiastic support of the Opposition, I was determined that every possible aspect be covered and that it should all be on the record. I cannot think of anything more significant or more important that any of the Budget Estimates Committees will be considering. For that reason, Sir, and with your indulgence (and certainly I seek your guidance), I believe it is important that the Executive Director of the Western Sector, who is one of the numerous officers who has come here today to provide detailed information to the Committee, should be given the opportunity to comment—whether he sees fit to rebut or agree with or whatever, I would not seek to control. I think it is appropriate that he should comment on some of the more extravagant claims at least of that very strange document to which the Opposition seems to be trying desperately to give some credence.

Mr Coombe: In the document which has been described as being unsourced, unsigned and also undated, reference is made under the heading 'Finance' to overspending last year being 1.3 per cent. That perhaps is a typographical error and perhaps it should be $1.3 million which is what it was, which is 2 per cent. Under another major heading 'Other Facts' it is stated that the QEH has had an increase in services of 4 per cent but mostly in high cost areas. I am sure that members recollect my saying earlier that, in response to detailed submissions from the QEH, I allowed as justifiable expenditure an allowance for its increased patient activity and increased cost due to changes in patient mix. On page 2 of the document reference is made to costs per bed day. It quotes the figures as being for the QEH $251; for the Royal Adelaide $278; and for the Flinders Medical Centre unknown but believed to be more than $280. I assume that that statement is referring to cost per occupied bed day. I do not have the figures of cost per occupied bed day but I draw members' attention to statement 12 of the blue book, which shows that costs in 1983-84 for those three major hospitals, on an adjusted occupied cost per bed day, work out at $258 for the Royal Adelaide, $268 for the QEH and $283 for the FMC. Therefore, the statement in the unsigned, undated and unsourced document that the QEH is 10 per cent more efficient than the Royal Adelaide and Flinders Medical Centre is quite untrue.

In relation to the statement on waiting times, I heard one of my colleagues earlier today refer to that perhaps more appropriately as 'booking times'. I understand that the Minister has given an undertaking to the House about booking times. There is a statement at the bottom of the document in relation to the number of nurses based on a national standard of 4.4 nursing hours per patient. That standard might have been relevant a few decades ago or in the late 1960s but I can assure the Committee that much more sophisticated measuring techniques are now in force. I also draw the Committee's attention to the fact that the QEH has agreed to my recommendation, endorsed by the Commission, that a nursing staff study be undertaken by independent consultants.

I also draw the Committee's attention to the fact that, on the information provided by the QEH itself in terms of staffing levels, between August 1983 and August 1984 there has been an increase of 40 nursing staff at that hospital, 30 of whom are registered nurses—and that is on information provided by the hospital itself.

Finally, I wish to quote a letter from the Administrator of the hospital, dated yesterday, which he sent to the Editor of the Messenger Press in response to the article to which Mrs Adamson referred and which had been incorporated in the Messenger Press. The letter states:

> The Board of Management of the Queen Elizabeth Hospital have considerable concern regarding the publication of a document prepared for internal consideration by a small group within the Queen Elizabeth Hospital staff. Some of the information is inaccurate. Much of the language used is emotive and, certainly, unprofessional.
>
> I wish to assure your readers that the Board of Management are in consultation with the Health Commission regarding the funding arrangements. Some of the waiting times, as stated, are misleading. Urgent surgery and appointments for outpatients can be arranged immediately. Nursing staff numbers have to do with the number of beds available, and also due recognition must be given to the mix of trained staff compared with trainees.
>
> I wish to reassure the public that this accredited hospital will continue to provide the appropriate level and quality of service demanded.
>
> Yours faithfully,
> W. I. Layther, Administrator

That is all I am able to comment on at this stage in terms of the document.

The Hon. J.R. Cornwall: There is one other detail which is pertinent to that question and I ask the Chairman of the Health Commission to comment upon it.

Professor Andrews: The question related to budget performance in previous years. The QEH in 1981-82 came in $240 000 over the approved budget; in 1982-83 it came in $83 000 over the approved budget and, of course, we are all aware of the result in 1983-84, and I will not repeat that.

When the relationship of that performance to the performance of other hospitals was examined closely by the Commission in the budget review to which I referred earlier, we concluded that the Queen Elizabeth Hospital had been treated extremely fairly compared to other teaching hospitals in South Australia in the past.

Ms LENEHAN: Mr Chairman, I have not asked questions on this Committee to protect the Minister, as suggested by the member for Morphett earlier today: I have asked my questions because I am genuinely seeking information that I believe is of value to members of my community.

Members interjecting:

The CHAIRMAN: Order! For the information of the member for Morphett, I warn him and tell him that I do not do so lightly. I remind the honourable member of the consequences of any further action by the Chair: if I go further, the whole session will be immediately stopped and the Parliament would reassemble tomorrow. If the honourable member wants that, he can have it. However, I do not want it and I do not think that the rest of the Committee

wants it. For the benefit of the member for Morphett, who has indicated that the next question is coming from the member for Goyder, I point out that the member for Goyder is not a member of the Committee.

Ms LENEHAN: At page 40 of the yellow book, the following statement appears:

> There are increasing numbers of notifications of child maltreatment under the Community Welfare Act which require medical assessment and management in consultation with health professionals and other agencies. Such assessments are mainly conducted at the Adelaide Children's Hospital and the Sexual Assault Referral Centre, Queen Elizabeth Hospital.

My question relates to the provision of medical and counselling facilities at the Sexual Assault Referral Centre referred to in the yellow book. As I visited the Centre only recently, I am familiar with the kind of service provided there. The Centre has only three staff members. During this financial year would it be possible to consider directly funding the Centre? The Centre provides a service that is unique in South Australia. It is the only Centre in this State that provides the type of medical assessment and provides the forensic evidence that is later used in rape trials. It seems that there is a good case for a direct funding line for the continuing activities at the Centre, which is under great stress because of a great increase in patient activity. This area is of great concern to me and to many other members of the community. Could a commitment be given as a result of the increase in activity at the Centre?

The Hon. J.R. Cornwall: I am substantially concerned about the behaviour of the member for Mallee, among other things.

Members interjecting:

The CHAIRMAN: Order! I ask the Minister not to take notice of the member for Mallee.

Mr LEWIS: The Minister's big mouth—

The CHAIRMAN: Order! I hope that the member for Mallee is not flouting the Chair. The Minister should reply to the member for Mawson, and stop worrying about interjections.

The Hon. J.R. Cornwall: I do not worry, Mr Chairman, but he puts me off my train of thought. As I was saying when I was interrupted by the member for Mallee, sexual assault generally is a matter of deep concern to me. Indeed, child sexual abuse and the rape services are both matters of deep concern. Since we came into Government, I have almost trebled the funding available to the Rape Crisis Centre, far and away above my Party's pre-election undertaking. I have also authorised the production of a major document on incest and child sexual abuse, the original material for which came as a result of a phone-in survey conducted by the Rape Crisis Centre last year. That document has since been assessed by the Institute for Family Studies, again at my instigation. At present, we are preparing a submission for a major document on both incest and child sexual abuse and the response and recommendations from the Institute on that document are to go to Cabinet.

I expect to release that document as a public document within a month. It will be a significant and disturbing document. These are all areas that either have been or will be upgraded. As to whether the Sexual Assault Referral Centre at QEH could or should be separately funded, that is another matter. The defined or perceived goals of the Government and the Commission are nearly always synonymous, but sometimes they are not synonymous perhaps with what the hospital politicians see as the areas of priority. A classic case in point over the years, until clear directions were issued some time ago, concerned the accident and emergency areas in our major hospitals which tended to be Cinderella areas for decades, but that situation has now been reversed. Whether it is desirable in special cases such as these to direct the boards and administrations regarding funding or whether it is desirable, maybe even necessary, to specifically earmark sums when we need a specific upgrade is a matter on which I have an open mind.

If, however, a well documented need is demonstrated for significant additional funding for the Sexual Assault Referral Centre, which does excellent work, I should be willing to take whatever reasonable action was necessary to see that such upgrading occurred. However, I understand that Ms Furler has visited the Centre in the recent past and discussed certain issues with senior staff there, so it might be appropriate if she could briefly explain to the Committee the current state of play.

Ms Furler: The member for Mawson is correct in suggesting that the role and function of the Sexual Assault Referral Centre are unique in South Australia. It is providing a model service, at least metropolitan-wide, but it seems to be experiencing difficulties in meeting the current demands made on it, especially in the area of child sexual abuse.

I have been meeting with it for some time now, and I understand that it has made a series of submissions to the Queen Elizabeth Hospital on the difficulties it is experiencing both in terms of its staff establishment and its accommodation requirements. At the moment, I am being furnished with a history and summary of those funding submissions and the negotiations that it has had to date. The Minister has alluded to the fact that he is about to release the report on child sexual abuse, which was commissioned by him, from the Adelaide Rape Crisis Centre. I imagine that the Government will want to consider the possibility of any mechanisms or strategies that it might put in place to consider the recommendations of that report. It will consider those mechanisms and strategies as picking up the difficulties experienced by the Sexual Assault Referral Clinic at the Queen Elizabeth Hospital.

It seems that the difficulties it is experiencing will have to be taken into account within the total context of the services that are provided to victims of sexual abuse in this State, in order to develop services, policies and programmes in a co-ordinated fashion across the State.

The CHAIRMAN: Before proceeding, I have been approached off the record by a previous member of the Committee regarding my upholding an alleged point of order that was taken by the Minister. I want to go on record as saying that, in this instance, I upheld a point of order, which was quite wrong in the circumstances, as the Minister has no right to take a point of order. I clarify the position by quoting what I said not much later. I stated, 'I find the honourable member's interruption at this time not only rude but also grossly out of order. I did not take the Minister's point as a point of order.' I point out to the Committee that, although I have been quoted in *Hansard* as upholding a point of order, I say now as I said then that I did not take the point that the Minister was making as a point of order. I simply upheld a situation where I believed at that time that the Committee was interrupting and interjecting, which was quite out of order in any circumstances. I can only explain it in that way. I hope that the member does not afford me the unfortunate situation of writing me an eight page letter in seven months time saying that I did or did not uphold a point of order.

Membership:

Mr Meier substituted for Mr Lewis.

Mr MEIER: I found some of the Ministers comments very disturbing when he was answering questions from the member for Coles earlier. He used such words as, 'the ignorant Opposition', 'reprehensible actions of the Opposition', 'absolutely disgraceful', and 'faceless men'. I wonder

what the Minister thinks this Committee is on about, for a start, and whether we are supposed to turn a blind eye to the facts put before us and ignore them as being possibly incorrect statements. I wonder whether the Minister believes that the Committee's role is to take up points both from the documents that have been presented to us in connection with the Budget and also from other documents that have come to our attention, such as the articles that have been presented to this Committee today. It seems strange to me that, in a State where we are supposed to have freedom of expression and freedom of the press, the Minister seems to indicate that such should not be the case when it affects his portfolio, if I read his statements correctly.

The Hon. J.R. Cornwall: Mr Chairman, can I address that question?

Mr MEIER: I have not got to the question yet, Mr Chairman.

The Hon. J.R. Cornwall: The honourable member did ask at least one question, with respect.

The CHAIRMAN: The Chair has been extremely tolerant this afternoon. I asked the member for Mawson to refrain from repetitious arguments, and I find now that the member for Goyder wants to repeat something. I suggest that we get back to seeking information from the Minister, with the Minister replying with the information. Does the member for Goyder have a question?

Mr MEIER: I believe that the relevant title is 'Chairman of the Western Sector'. A statement has been made in relation to the Queen Elizabeth Hospital. On the front page of the Messenger newspaper, Mr David Coombe is reported as saying:

> I totally reject any claim that the Queen Elizabeth Hospital is under funded.

We have heard a considerable amount of explanation on that very fact. How can that statement be made when it would appear that, as an example, the radiology section of the Queen Elizabeth Hospital seems to be operating under somewhat difficult circumstances—circumstances which I believe are such that the medical specialists do not have an office between them. They have to pool secretaries, not that that is necessarily unfair or cannot work. My information is that something like an average of 250 radiology examinations or reports are conducted per day, and there are only two audio typists to attend to those radiology reports. In this connection, they alternate between weeks as it is. It would appear that there is invariably a 36-hour delay on reports being available, and, apparently some time ago, when one of the audio typists was away for some weeks, there were delays of two to three weeks before those reports were made available. I would be interested to hear from the Minister what facilities are available at other hospitals, such as the Flinders Medical Centre, in relation to the radiology section, and whether he believes that the radiology section at the Queen Elizabeth Hospital, as one example, is sufficiently funded and does not need upgrading.

The Hon. J.R. Cornwall: I must respond to the remarks which apparently contained a question and referred to the general conduct of this Committee. I am increasingly disenchanted by the conduct of the Budget Estimates Committees. I must say that that is no reflection whatsoever on the Chair. I believe that you, Sir, are an excellent Chairman and have kept order very well to the extent possible in difficult circumstances. However, I make the point that I came today, supported by something like 15 officers from the South Australian Health Commission, to discuss an estimated Budget allocation for 1984-85 of $634 million. I believe that, had Opposition members of this Committee conducted themselves in a way that I was optimistic and perhaps foolish enough to hope they would conduct themselves, a great deal of information could have been made available during the course of the almost eight hours that we have been allocated.

If members and anyone else care to examine the *Hansard* record, they will see that initially, at least, I responded very briefly to questions and immediately asked for professional and non political comment from senior members of the Commission who have accompanied me. Unfortunately, not at my instigation, the Committee deteriorated very quickly into simply a political exercise. Frankly, if that is the way in which these Committees are to proceed in future, I see very little merit in them.

However, at last we have a specific question about a specific unit in a specific hospital, and that is quite useful. I know the radiology department to which the honourable member refers. I have personally visited and seen the facilities or, should I say more accurately, the lack of them. I have promised specifically that they will be upgraded to the sort of standard that one would expect to find in a modern teaching hospital.

The major problem is one of physical crowding. The staff are senior and competent and the standard of work is first class—as good as one would encounter in any other major hospital. However, I concede at once that the physical facilities are not up to the standard which one would anticipate in 1984. I believe that the upgrading of that area is in the minor capital works programme for 1984-85. I cannot say that with any certainty, and I will ask Mr Coombe to comment on that in a moment. If it was not previously in the minor capital works programme for 1984-85, by Ministerial direction it most certainly will be as at now. I ask Mr Coombe to give us any further technical detail that he might have.

Mr Coombe: I, too, after my three month appointment with the Commission, visited the radiological facilities at the Queen Elizabeth Hospital, and I agree that the facilities, as the Minister has said, are inadequate: there is no question about that. I have suggested in writing to the Administrator of the hospital that he join that project together with a minor project involving the relocation of the ultrasound department at the hospital and submit it to me, and I will do my utmost to see that they enjoy some sort of priority. It would make better sense, rather than to tackle the two projects separately, to join them together. I have not yet had a response.

Concerning the Department of Diagnostic Radiology at the Queen Elizabeth Hospital, on 27 August I advised the Administrator that the Minister had given approval to proceed with the purchase of a replacement X-ray generator for room 8 at an estimated cost of $300 000.

The Hon. J.R. Cornwall: By way of further explanation, the Committee should be very careful not to confuse the recurrent Budget with a so-called minor capital works programme. Although in the health area we are fairly big spenders, 'minor' tends to be a word that is applied to amounts usually under $500 000, none of which indicates that we are other than scrupulously careful with every last dollar and cent that we spend, as the Committee has seen during the course of this long afternoon. What we have been discussing at great length this afternoon is the recurrent Budget allocation to the Queen Elizabeth Hospital for 1984-85 of $69.6 million.

Mr MEIER: Often the minds of the people who work in an establishment do not differentiate between one line of a Budget *versus* another. At least that point has been clearly made to the Committee, and I thank the Minister and the Director of the Western Sector.

Page 141 of the Sax Committee Report of Inquiry into Hospital Services in South Australia (although a similar comment was made earlier), under the section relating to the Queen Elizabeth Hospital, states:

The metropolitan hospital planning framework proposals recommended that the in-patient accommodation at the Queen Elizabeth Hospital be reduced from 702 to 500 beds. We support this proposal.

Is it either the Minister's or the Health Commission's intention to see this recommendation implemented at the Queen Elizabeth Hospital? To implement such a recommendation one needs to have a pretty good excuse. If a hospital is being forced to meet its budget and apparently has endeavoured to cut the fat in every possible area, it is not difficult for a Minister or the Commission to say, 'Well, we are going to cut some beds from your hospital.' On the surface that may, in the long run, be a possible motive for the headlines that we have seen today.

The hospital wants a clear assurance that it will be a major teaching hospital for the Adelaide University. I know that the Minister made a passing reference to it. However, we find that a role and function study is being undertaken at present, and I wonder what the aim of that study is. Is it another excuse to say, 'We are not quite certain where things are going and, if we have a role and function study, we may be able to make some more decisions.'? It seems that, if in doubt, a committee is set up so that the results of that committee can be used in the desired manner.

The Hon. J.R. Cornwall: I have two quick responses: the first is that I sit here and reflect on politics and sometimes I am not impressed by the practitioners of the art. Secondly, I hope that the member for Goyder was absent when that question was answered at great length some time ago, but I shall answer it again if the Committee wishes. Let us start at the beginning—the background to this.

Mr MEIER: I hope that the Minister is not going to go on and on. I felt it was such a general answer that no specific commitment was given at all.

The Hon. J.R. Cornwall: That is absolute nonsense! The honourable member is better than that normally. He should leave that sort of activity to the members for Coles and Morphett. We are in this situation at present, where people are recklessly distributing irresponsible documents because a small number of people have decided to guard their patch, to guard positions of what one would see, I suppose, as privilege at the Queen Elizabeth Hospital. Indeed, two weeks ago, I was told that a prominent member of the medical staff at the Queen Elizabeth Hospital—the leader of this minority group—had said quite openly that they intended to declare war on the Commission and the Minister.

That is a most regrettable state of affairs, to say the least. The matters before this Committee concerning the Queen Elizabeth Hospital, its budget, role and function study, and all the other matters that have been canvassed today are not political matters at all. They are administrative matters and are not matters on which decisions should be made on a political basis. Decisions should not be made on those matters by the Minister of Health or the Government in the first instance. With the Commission acting with its full responsibility, as charged under the Act, the matters require, and are certainly receiving, the full support of the Government. As I said earlier today, two documents have been produced previously: one is the metropolitan Adelaide hospital planning framework, which was produced by Mr John Cooper, now Deputy Chairman of the South Australian Health Commission and arguably the best health planner in Australia. That document was commissioned during the time when the previous Government was in office.

As the member for Coles pointed out (and perhaps it is fortunate for the hospital system that she did not have the opportunity to act on it), I received that document shortly after the Labor Government came to office. I referred it to the Sax Committee of Inquiry into South Australian hospitals for independent assessment. That committee, in broad terms at least, endorsed the recommendations made and the particular recommendations concerning the Queen Elizabeth Hospital. I realised that it would be a controversial matter, and I had no wish to confront the Queen Elizabeth Hospital or anyone else. In consultation with the hospital the Commission decided to undertake a role and function study, and that decision received my blessing. Let us be clear about the way the system works: I have no wish to be a third rate health commissioner of the Commission, but a first rate Minister. The role and function study is currently under way and should be bringing down a report by the end of February. I would further point out that senior members of the hospital administration and members of the hospital's board of management are members of the team undertaking that role and function study, together with members of the Commission and other appropriate people.

Therefore, the hospital has a direct input into the operation of that major role and function study. With this situation I could not have been more sensitive, responsible or responsive to the needs of the hospital and, even more importantly, to the well documented needs of the 200 000 who, like me, live in the western suburbs of Adelaide. We have had the Metropolitan Adelaide Hospital Planning Framework assessed by the Sax Committee, and the recommendations from that are in turn being assessed as part of a major role and function study. I have said many times that the future of the Queen Elizabeth Hospital is assured. Its role and functions may change in the next 30 years from what they were in the first 30 years of its operation, but notwithstanding that, there is no question that the hospital will continue as a major community resource, a major community hospital in the best sense, serving all of the needs of the people of the western suburbs, and also its purpose as a teaching hospital.

Mr MEIER: I take heart at some of those reassurances given. The Minister's statements about certain aspects of the Committee's proceedings deteriorating into a political exercise are interesting, because the Minister himself readily engages in that sort of activity whenever the opportunity arises. However, that is not a matter for us to discuss. Earlier the Director of the Western Sector referred to a claim made by the Queen Elizabeth Hospital that it is 10 per cent more efficient than the Royal Adelaide Hospital or the Flinders Medical Centre. A discrepancy with the figures on costs per occupied bed day over the past 12 months is apparent. As reported in *Hansard* of 11 September this year in reply to a question from the Hon. J.C. Burdett about cost per occupied bed day over the past 12 months ended 30 June 1984, the Minister replied that the cost for the Royal Adelaide Hospital was $257.71, for the Queen Elizabeth Hospital $268.83, and for the Flinders Medical Centre $252.57.

However, some people at the Queen Elizabeth Hospital have produced their own figures on the cost per bed day and have arrived at the figure of $251.00 for the Queen Elizabeth Hospital, and $278.00 for the Royal Adelaide Hospital. They tended to agree that for the Flinders Medical Centre the cost was in excess of $280. On the basis of those figures they have claimed therefore that they are 10 per cent more efficient than the Royal Adelaide Hospital. Can the Minister indicate whether it is possible to get different results by including or excluding certain factors? It would seem to me that figures produced by the Queen Elizabeth Hospital would probably stand up as well as the figures that the Minister has obtained from the source that he used.

The Hon. J.R. Cornwall: If that is the honourable member's view, I hope that he is never the Minister of Health. However, I am sure that he would lose that opinion fairly quickly if he were faced with that daunting task. I learnt very quickly (although I guess that in the health area there

are lies, damn lies and statistics) that one can place great credence on the figures that are produced by the people within the Commission, who, of course, have no axe to grind. In the quite early days a major exercise was conducted by Mr Cooper, with the blessing, I might add, of Mr John Blandford, a well qualified and respected Administrator of the Flinders Medical Centre when it was making precisely the same sort of claim with regard to its funding: that it was a very efficient hospital that was being under-funded *vis-a-vis* the Royal Adelaide Hospital and the Queen Elizabeth Hospital. As a result of that investigation and other initiatives, we have produced the very best and most accurate figures available. There is no question that the figures produced by the Commission are the best and most objective figures available. One tends to get competition between the hospitals. One of the problems at the Queen Elizabeth Hospital is that it sometimes looks with envy, I guess, at the Flinders Medical Centre.

Flinders was built as the third wave of the teaching hospitals: the Queen Elizabeth Hospital was built as the second wave. It is interesting to go back. Historically, one sees that the Royal Adelaide Hospital was initially our first teaching hospital, and a magnificent teaching hospital it is. However, it was built originally for public patients, full stop.

A very different approach was taken at the time that the Queen Elizabeth Hospital was completed in 1954. Special allowances were made, albeit in a rather different way, for some private patients. The whole pattern was changed. Of course, it was almost two decades later that the Flinders Medical Centre was built and started literally *de novo,* given all the advantages of an era when there were virtually burgeoning funds available both for bricks and mortar and recurrent funding, and all the advantages of being almost a generation later.

From the start the Flinders Medical Centre had a much higher percentage of salaried medical specialists; it had a much higher degree of integration between the teaching, research and clinical functions than one expects from a major hospital. It had a great number of advantages. I think that the problem developed, given that for the population of the State of South Australia it could be argued that we have one medical school too many, and given that if we had the wisdom in 1970 that we have in 1984 a second medical school may never have been established in this State, that a level of paranoia, I suppose, emerged at the Queen Elizabeth with the view that in any rationalisation and integration perhaps it would no longer be a teaching hospital. That is certainly not the intent of this Government. We have certainly not been given that advice.

I must say at once, too, of course, in case anybody should want to read too much into my frankness, that there is absolutely no intention that we should not continue with two medical schools. I simply say that in the enthusiasm, particularly of the early 1970s, I think some planning mistakes were made. The QEH suffers from a degree of paranoia, I think, and sees itself under some sort of seige, unreasonably and quite unnecessarily.

I have urged them several times, and urge them again today, to concentrate on co-operating with the role and function study and to stop trying to fight very negative battles which do the hospital's public image and reputation potentially quite severe harm. Those concerned should co-operate with the major role and function study so that there can be a renaissance at the Queen Elizabeth Hospital, so that it can find its way with those roles and functions as a major South Australian hospital which can be absolutely assured for the next three decades without any necessity for people there to be continually looking over their shoulder, as they see it. It is very important that that be on the record. I now ask the Chairman of the Commission to respond specifically to the question of cost per occupied bed day.

Professor Andrews: The formula used by the Health Commission is a national formula—the formula used by the Commonwealth. In taking account of cost per bed day and comparing hospitals, one needs to take account of both inpatients and outpatients. So, it is cost per adjusted bed day since many of the costs relate to both inpatients and outpatients, and in a formula it is difficult to dissect those two. A more accurate comparison between the hospitals takes account of both categories of patient.

The formula, to be precise, is derived as follows: gross payments minus recoveries, which gives one the total cost. That is divided by the number of occupied bed days plus the number of non-inpatient attendances divided by 4.25. Arriving at that formula has been an accepted approach for many years. On that basis the figures as shown in statement No. 12 demonstrate a cost for the Queen Elizabeth Hospital, as has been pointed out, which is rather higher than the Royal Adelaide Hospital but lower than the Flinders Medical Centre.

Mr MEIER: I rise on a point of order. Does the document being referred to have the full formula set out in it and does it calculate the figure for the various hospitals?

Professor Andrews: Statement No. 12 is from the blue book. It shows, for instance, that in 1983-84 the adjusted daily average cost per bed day was $268.83 for the Queen Elizabeth Hospital, compared with $257.71 for the Royal Adelaide Hospital and $282.57 for the Flinders Medical Centre.

Mr MEIER: That was not the point. I wanted to ensure that the method of working it out was fully incorporated in *Hansard,* and the formula is comprehensive.

The CHAIRMAN: I point out to the member for Goyder (and the member for Coles took up the point) that the blue book was handed to the Committee only this morning but that we are not really dealing with that blue book: we are allowing members to refer to it. The Chairman of the Health Commission has simply referred to that book. There is no need to incorporate it in *Hansard,* as I understand it. That is not required, nor is it desirable.

Mr MEIER: I thank Professor Andrews for his answer and the Minister for giving me a lot of details about teaching hospitals for which I did not even ask in my question.

Mr MAYES: I am delighted to see the member for Goyder's interest in the Queen Elizabeth Hospital: I am sure that the Minister is as well. I ask the Minister a question about therapeutic substances—vitamins, and so on—in relation to the discussion that is occurring within the community of which I am sure he is aware. With the introduction of the Controlled Substances Act, what steps and initiatives is the Health Commission, under the guidance of the Minister, taking in regard to future developments, including vitamins, or what might commonly be called therapeutic substances such as herbs, in the light of the debate occurring in the community?

The Hon. J.R. Cornwall: First, the Controlled Substances Bill, as it then was, was introduced in this Parliament in November last year by me. Quite deliberately, we allowed it to lie on the table for several months. I think that it was April when we resumed, so it lay on the table for at least four months. It was then the subject of a very substantial debate in both Houses before it eventually passed. During the course of the consultation that went on, some initial concerns were expressed by such diverse groups as the Natural Nutritional Foods Association through to the homeopaths, all of whom were worried that we may, by regulation, put them out of what they regarded as legitimate business. Of course, had the Government intended to put any of those people out of business or to markedly restrict

their business, we could have done it by regulation under the old legislation, anyway.

So, there was hardly a conspiracy to put the fringe medicine people out of business. As a result of those representations, however, I agreed to form, and we have subsequently formed, a subcommittee which is to report to the Controlled Substances Advisory Council and which comprises people from the herbs and 'natural remedies' section of the alternative medicine area. I might say that the people in that industry, that is, those who represent legitimate and responsible associations, have expressed to me the view that the proprietors of natural food shops, for example, who sell herbal remedies and other like medicaments should at least have some basic training so that they are able to give a modicum of reasonable advice to prospective customers.

Of course, it is a vexed area. The whole question of vitamins is an example. There is very well documented evidence (and there has been for a very long time) that megadosing with vitamins A and D can cause very serious damage, and it is highly desirable that the maximum dose of those vitamins or the maximum quantities in any particular multi vitamin preparation be limited. On the other hand, there is no move afoot of which I am aware in this State to restrict the sale of B group vitamins, that by and large, when given in large doses enrich the urine and subsequently the Engineering and Water Supply Department. In other words, they are excreted when taken in large doses. The body uses what it needs, if any, and they are excreted. The thing that concerns me a little at present is that some members of the pharmaceutical industry (and I am talking about the multinational industry), according to a recent *Four Corners* programme and other sources of reliable information, may have actually moved in and subverted to some extent the nutritional foods and nature shops.

If that is occurring to any extent, in other words, if they are trying to protect themselves against what they see as the ravages of the Health Commission or our public health authorities (as though the public health authorities were going to bat for the multinationals, whereas in fact the multinationals are tending to infiltrate the natural food shops), then that would be a matter for concern. However, in terms of restricting the sale of B group vitamins, for example, I will ask Dr Baker to comment. However, I certainly have not seen any specific proposal and, as I said, we have specifically formed a subcommittee to report to the proposed Controlled Substances Advisory Council under the Act so that that council knows precisely what is in the minds of people in that part of the industry at any time. However, I ask Dr Baker to respond with any more specific detail that he thinks appropriate.

Dr Baker: The Controlled Substances Act is designed to control therapeutic substances and the use of health foods and other health substances that are consumed. Health foods are consumed because the individual considers that they will have an effect on his health, and we have found in our research (and it has been well documented in literature throughout the world) that some of these remedies contain extremely toxic substances. It is important for us to be able to identify these toxic substances and control them, and under the provisions of the Controlled Substances Act we can do this. As the Minister has said, we are setting up a subcommittee to the Advisory Council to look at how we will tackle this problem.

There is a need for quality control. Therapeutic substances produced by pharmaceutical companies have to undergo strict quality control and toxicological testing. However, health foods at present do not have to do that, and the standard of quality can vary greatly from batch to batch. Also, the standard of labelling varies. There is false advertising suggesting cures where there is little evidence that the substance will produce that cure or have that effect. The terms of reference of the working party that we established are as follows:

a. To examine ways and means of classifying herbal medicines and nutritional supplements, including vitamins, into groups for the purpose of applying controls as therapeutic substances under a South Australian Controlled Substances Act;
b. To examine ways and means of applying the code of good manufacturing practice and the voluntary advertising code on therapeutic goods to these products;
c. To examine and recommend an appropriate system of licensing the manufacture, wholesale dealing and retailing of herbal medicines—including the desirability of limiting the retail sale/supply/dispensing of some preparations to suppliers who have undergone appropriate training;
d. To examine methods of developing standards for safety (and, later, efficacy) and advertising on a co-ordinated national basis;
e. any other matters referred by the Minister.

A need has been identified by the population at large for herbal remedies. Many people are turning to alternative medicine, but we in the public health service feel that it is important to ensure that they are taking substances that will not have an extremely toxic effect on them, that they are taking them in the full light of the effect they will have on them, and that the labelling is true and is not encouraging them to take the substances for a cure that that remedy will not give them.

The CHAIRMAN: I wonder whether it might be advisable to adjourn now, rather than go into another lengthy question and interrupt it. If the Committee is prepared to agree we will adjourn.

Mr OSWALD: Has the Government finished that line of questioning, or is there another question?

Mr MAYES: We have one more question to go, but we do not mind.

The CHAIRMAN: That is the point I am making.

Mr OSWALD: I merely want to ascertain whether we have the call after dinner.

The CHAIRMAN: The member for Unley still has two questions if he wishes to ask them. We have now wasted another minute, so I suggest that we adjourn for dinner.

[*Sitting suspended from 5.59 to 7.30 p.m.*]

Membership:

Mrs Appleby substituted for Mr Mayes.
Mr Groom substituted for the Hon. Peter Duncan.
Mr Plunkett substituted for Ms Lenehan.

Mr OSWALD: I turn our attention now to the Modbury Hospital and the 'Mod bods', the patient recording system, and the diagnostic accounting system. When the system was first put in at the Modbury Hospital, the original costs were envisaged to be a capital outlay of $84 851 and an annual running cost of $24 003. A couple of systems were looked at, as I recall from the Public Account Committee's review on the subject, but the actual development cost for the total of the 'Mod bods', the PRS (patient recording system) and the DAS (diagnostic accounting system) on a B1726 computer was $258 820, made up of a capital outlay of $171 820 and staff resources of $87 000. The actual running costs were $111 580. What has been the total cost for each of the last three years for the 'Mod bods', PRS, and DAS systems at Modbury Hospital?

The Hon. J.R. Cornwall: Clearly the matters are not directly within my knowledge. Unlike the previous Minister, I have never made any claims, extravagant or otherwise, about hospital computers. It is a very difficult area, fraught with pitfalls for the unwary. There has been a large investment of time and effort in hospital computing for the last five years or more within the South Australian health serv-

ices. I believe we are now reaching a position generally where the fruits of the labour of a number of people are starting to show up in a quite positive way. They are my general remarks, but with regard to the quite specific questions asked by the member for Morphett, it would be far more productive if I were to refer them to Mr Ray Blight directly and immediately.

Mr Blight: I can give actual expenditure at Modbury Hospital for all computing for the 1983-84 year. The sum total of computer equipment related charges (and that would be maintenance, software, consumables and so on) was $272 000 in that year. The computer staff expenditure totalled $92 000 and included not only computer professional staff but data preparation staff, and so on. However, it is probably worth mentioning that that expenditure covers not only the 'Mod bods' application, which was really limited to an out-patient booking function, but the computer installation at Modbury, where they have upgraded their machine to a more modern computer. It supports ATS (admissions transfer separations) functions, the patient master index, and the out-patient booking application. In addition to that, it supports financial functions such as general ledger and accounts payable. It supports an on-line connection to the Commissions pay-roll computer and, in addition, quite extensive manpower reporting applications are also included in the Modbury suite of programmes. It is quite a comprehensive installation. As to the projected figures for 1984-85, computer equipment related charges we estimate to be $289 000 and staff costs to be $105 000, giving a total of $394 000. The figures for years prior to 1983-84 can be provided.

Mr OSWALD: One of the medical staff at the Queen Elizabeth Hospital a few weeks ago related to me a situation whereby that doctor had to do a tour of the wards one evening to find empty beds around the hospital because they were admitting patients and the computer resource was unable to tell them where there were beds in the hospital. This alerted us to the problem that obviously exists at the Queen Elizabeth, that there is a computer problem down there. Without going through the whole of the PAC Report in 1980, we were told then, as the Minister would be aware, that a computer was about to be implemented that would cover the problem of admission and transfers at the Queen Elizabeth Hospital. We are all aware of the history leading up to the present day. What is the present state of the computer at the Queen Elizabeth Hospital? This question is asked in the light of difficulties being experienced on admission, in light of reported difficulties in the admission of patients, and also in light of rumours floating around the community and through the health service that there are big problems in the Queen Elizabeth Hospital with which nobody seems to be able to come to grips.

The Hon. J.R. Cornwall: I picked up the word 'rumours'. That is a bit like unsourced and unsigned documents. Nevertheless, the questions as to how the computing systems are going in the hospitals generally are good ones and I thank the honourable member for them.

Let me very briefly make a couple of general remarks. I am not computer literate, and there are times when I think that those who are do not write good English, or at least not English that I can easily comprehend. So, although I have tackled with great vigour the whole question of health and hospital computing, I have found it necessary ultimately to depute via the Chairman to various key personnel in the system. Also, of course, the 'big is beautiful' thing which led to those extravagant claims about an ATS system serving 2 000 beds in three major teaching hospitals, and so forth, has long since gone out the window.

We are now, as a Commission and as a health system generally, back to what I think is a far more responsible, and certainly a more practical, position where individual hospitals are developing their own systems, provided, of course, that it is done within the general areas and limits of responsibility that are assigned to their boards of management. I think that that was probably started, from recollection, towards the latter stages of the period in office of the Liberal State Government, and certainly it has been, to a significant degree, enhanced under this Administration. It is a complex and difficult area in which cost benefits are not always the easiest things in the world to quantify. Sometimes in fact it is easier to quantify patient benefits rather than actually putting dollars and cents on it, particularly in view of the fact that, unlike the American system, where a lot of this computer technology was initially developed, we are not conducting for profit hospitals. Having made those comments in general terms, I again immediately ask Mr Blight to respond to the specifics of the question.

Mr Blight: The Queen Elizabeth Hospital has been operating a patient master index system basically as a batch system on the Government Computing Centre for some four or five years. It was, in fact, the first of the three major hospitals to implement an automative patient master index. Of course, that falls far short of the comprehensive admissions transfers system. Approximately 3½ years ago, it acquired a small mini computer, which was used as an add on, if one likes, to its pathology machine. Since then that mini computer has maintained a file of inpatients, so the hospital has had recourse to a very small modest system which gives it details on its actual inpatients. As soon as a patient is discharged, his record is removed from the computer.

Approximately 15 months ago the issue of a comprehensive admission system for the Queen Elizabeth Hospital was referred to the Computing Policy Committee, and at that meeting a clear indication was given to the hospital that it should proceed with the development of a proposal to the Commission for such a system. I can recall that, whilst no commitment was given to the funding of that proposal, whatever it might eventually be, there was a clear indication that funding would be likely for a modest proposal. In that time both the technical and management staff of the hospital have been involved in the definition of their requirements for a patient care information system, and in the past few months a document summarising their views has been presented to the Commission.

That document was recently the subject of a meeting between the Administrator and his senior staff and the Deputy Chairman of the Commission. As a result of that meeting, it was agreed between the Commission and the Queen Elizabeth Hospital that it needed to do further work to refine its strategy for developing and acquiring a patient care system, and they have gone away to do that further refinement. I might add that there is input from the staff of the computing system of the Health Commission in helping the hospital to finalise that work.

Mr OSWALD: I have only three questions, so I must change the subject. I would like to expand on that. Perhaps I can come back later in the evening and do so. Would the Minister identify at the Royal Adelaide Hospital, Queen Elizabeth Hospital, Modbury Hospital, Flinders Medical Centre, Hillcrest Hospital, Glenside Hospital and Lyell McEwin Hospital all the computers which have a minimum capital cost of $20 000 by type, cost and usage and which have been purchased in the past four years and, in particular, specifically identify those computers which have been, first, replaced during the past four years, giving the reason for their replacements, including the cost and the identification of the replacement unit; secondly, advise on any computers known to be earmarked for future replacement and the reasons for their replacements; thirdly, the estimated costs of those replacements? In asking that question, I concede

that that information may not be readily available this evening, and I would be very happy if it was placed on notice and a detailed considered reply presented at some later time.

The CHAIRMAN: I point out again that if the Minister has not all the relevant material that the honourable member is seeking, I would appreciate very much if he would make it available, if he so desires, in a form in which it can be incorporated in *Hansard* as soon as possible.

The Hon. J.R. Cornwall: Yes; obviously I have not got all that detail. I may well have most of it at my fingertips, but there are a couple of minor details that I cannot easily recall. It would be far better if it could be placed on notice and we could get all the details together and make sure that they are forwarded in response to the Committee well before 19 October, which I believe is the deadline you gave earlier today, so that they can all be incorporated in *Hansard* and placed on the public record. I would be very pleased to do that.

The Hon. JENNIFER ADAMSON: I refer to page 185 of the Estimates of Payments, the South Australian Health Commission's capital works programme and the sum allocated to the Royal Adelaide Hospital linear accelerator. I cannot see anywhere else in that programme any funds allocated to the Royal Adelaide Hospital in terms of capital works. I think that many South Australians, having read the news that $18.5 million is to be spent on redevelopment of the Adelaide Children's Hospital, would be asking themselves when funds are to be made available for the redevelopment and upgrading of some of the older and less acceptable parts of the accommodation at the Royal Adelaide Hospital. I therefore ask the Minister what plans the Government has, if any, for upgrading the Royal Adelaide Hospital, because I know that the board of the hospital was most anxious for upgrading during the years that we were in office. Also, can the Minister or his officers advise the Committee what funds are being allocated by the board of the hospital this financial year from the global budget for what might be described as minor works in order to improve some of the accommodation which is not acceptable?

The Hon. J.R. Cornwall: I have no proposal before me for any major redevelopment at the Royal Adelaide Hospital. The only one that I can recall seeing since I became Minister is a possible proposal or series of proposals for a new entrance to the hospital.

The original one was a rather grand thing and, from memory, the estimated cost in 1982 money was about $3 million. Subsequently, a much scaled down proposal was prepared by one of Adelaide's leading developers, who had a very good reputation, that would have cost more in the order of $1 million. They are the only capital works proposals involving bricks and mortar for the Royal Adelaide Hospital that I have seen in the time that I have been Minister. Concerning oncology and linear accelerators, and the expensive equipment involved, I am sure that the member for Coles will recall that she was Minister at the time when proposals were forthcoming for a significant upgrade of the facilities in that area. That initiative, I am happy to say, has been carried on under this Administration. Dr McCoy could give us more details, but the new bunkers have been, or are in the process of being, installed, and significant new capital equipment has been made available.

Also, there is currently a firm proposal to develop private facilities at St Andrews Hospital which, I must say, I view with mixed feelings to the extent that it will share its reporting and quality assurance mechanisms with the State facilities at the Royal Adelaide Hospital. I guess that that is a good and positive thing. To the extent however that the hospital will be treating all patients, including pensioner patients, on a fee for service basis, it will impose some financial strains on the Commonwealth Health Budget via Medicare and from several points of view will be a move backwards rather than forwards. However, given that due to circumstances and events which occurred prior to either the member for Coles or myself being Minister of Health and which resulted in what one would have to call an unfortunate dip in the oncology services at the Royal Adelaide Hospital, and given the real problems that were encountered in recruiting senior qualified medical staff and the training of medical staff to become senior qualified staff, I will not cavil if those facilities will mean any significant reduction in the modest waiting time for radiotherapy that currently exists at the Royal Adelaide Hospital.

Frankly, I think that about covers the generality of the question, but it may be that Dr McCoy has at his fingertips at least more detail about what one might call the major items of any proposed developments at the Royal Adelaide Hospital under the so-called minor capital works programme.

Dr McCoy: I will list briefly the items on the Royal Adelaide Hospital capital programme. They are, the 20 million volt linear accelerator for $1.673 million which will be completed and in use early in 1985; a sum of $230 000 is included in the 1984-85 programme for a radiotherapy after loading system for use in gynaecological radiotherapy; and a formal submission from the hospital is awaited on that. The hospital has been given approval for a stage 1 consultancy into a reorganisation of its Catering Department in the East Wing which is expected to cost $276 000. The sum of $200 000 has been allocated to the hospital from the central sector capital fund in 1984-85 for upgrading of the Renal Unit at that hospital, and $200 000 is included on programme for replacement of the PABX unit at Hampstead Centre.

Previously, the major proposal from the Royal Adelaide Hospital was for a new front entrance. This has now essentially been withdrawn by the hospital and replaced by another major proposal for the consolidation of the operating theatre complex into the McEwin and the new operating theatre building at the Royal Adelaide. There are 21 operating theatres at the Royal Adelaide Hospital, widely scattered throughout the East Wing, the McEwin building, and the present casualty building, and there is a proposal to consolidate them so that they are mainly in one block, and this will improve utilisation greatly. That proposal is being worked out by the hospital and will be supported by the Commission for inclusion in the capital programme. I think it unlikely that it can be this year.

The Hon. JENNIFER ADAMSON: It is pleasing to hear that the Minister is able to state with authority that there are minimal waiting times for oncology treatment at the Royal Adelaide when earlier in the day he indicated that he was not able to make any definitive statement about waiting times; that is something interesting to have on the record.

I refer to page 17 of the blue document, the deficit funded health services, actuals and estimates, in respect of the Royal District Nursing Society whose net payments last year were $2.172 million and the proposed payments this year are $2.6 million. I ask the Minister what is the increase in real terms that the society will be able to use, and to what use will those funds be put?

The question is particularly important in the light of the acknowledgment in the yellow papers that both Medicare and the ageing of the population will impose costs and strains on the health service, and that one way in which those costs and strains can be relieved is by providing domiciliary care following early discharge of patients from hospital or, possibly, even the ability to keep people at home rather than admit them to hospital.

The previous Government provided substantial additional funds to enable an extension of hours for the Society, which in turn would have enabled some people to receive evening care and thus remain in their own homes. What is the increase in real terms, if any, and to what use will those funds be put to expand the Society's services?

The Hon. J.R. Cornwall: The logical person to answer that question is Mr Sayers, as administratively the Royal District Nursing Society falls directly under the umbrella of the southern sector of the Health Commission. I call on Mr Sayers to do so.

Mr Sayers: I have a list of the additional items that have been funded this year for the Royal District Nursing Service. I do not have with me the specific costs of each item, but I can give an estimate. The first item requiring funding additional to that required in the previous financial year was the extended afternoon shift service, the extended hours service, from 9 p.m. to 11 p.m. A special small allocation was made to research the need for the hospice care to continue after 11 p.m. until 7 a.m. in the morning. No funding has been made available for the period from 11 p.m. to 7 a.m., but that matter is being investigated, and possibly some funding will be required this year.

Additional funds have been made available for two additional staff for an in-service education programme to develop domiciliary nursing standards and to train nurses by means of in-service education. In relation to the quality of care provided, four additional staff have been placed in the day shift component of the RDNS to enable pressure points in the existing services to be alleviated. About $40 000 has been provided for the improvement of accommodation of nurses in the field. I do not have details of the specific amounts of money involved, but I can provide more details about that later.

The Hon. JENNIFER ADAMSON: I would appreciate receiving such details that are not necessarily available at the time when questions are asked. Further down on page 17 of the blue document reference is made to the St John Council of South Australia being provided in 1983-84 with net payments of $3.674 million. The estimated net payment for 1984-85 is $3.2 million. That is a substantial reduction. Acknowledging that there has been an estimated increase in receipts of $8.1 million to $8.5 million, can the Minister explain the reason for this apparent reduction in net payments?

The Hon. J.R. Cornwall: First, I point out immediately that of course I am the Chairman of a Select Committee of the Upper House which is looking into many aspects of St John, and I must be extremely careful not to discuss matters currently before that committee before it reports to Parliament. Accordingly, I call on Mr Sayers to comment directly on the matter and, of course, geographically its location comes under the umbrella of the southern sector of the Health Commission.

Mr Sayers: First, I point out that there has been no funding cut to the St. John organisation. An increase in funding has occurred for a number of reasons. The apparent reduction in the figures appearing in the blue book can be explained in relation to a major item, namely, a variation in its motor vehicle replacement programme and a large amount of money provided in the last financial year. A slight reduction has occurred this year because last year we had the tooling up costs for the new twin life ambulance. Included in last year's expenditure was an amount of $130 000 for a replacement aircraft, and that is not in this year's allocation.

Also included in the current allocation are five additional positions for St John. It has expanded by including positions for an area training officer, a radio communications technical officer, two other training officers for the country and a clerical officer. Therefore, funds for five additional staff have been included in the St John allocation for this year. Another item that has affected the allocation is that taken into consideration was a $70 000 cash surplus from the previous year which has been taken off this year's allocation. The final major reason affecting the budget was that the last of the fairly major replacement of communications equipment occurred last year. That has now been completed. There is still a small amount there for finalising that, but substantially it has been completed. Those items, coupled with the anticipated increased income from patient transport carries, all add up to a standstill-plus budget for St John this year.

The Hon. JENNIFER ADAMSON: A budget that is standstill plus what?

Mr Sayers: The plus would cover the five additional positions, costing about $80 000 or $90 000. The communications equipment to be provided this year costing about $50 000 is added in. Therefore, it is about $150 000 to $180 000-plus over a standstill allocation.

Mr OSWALD: In 1984-85 what will be the cost of extending the School Dental Service to some secondary school students?

The Hon. J.R. Cornwall: I will seek some assistance from the Director of the Central Sector in a moment in regard to the provision of an accurate figure. I understand that the cost will be minimal. In fact, the initiatives taken during a period of the present Government's term of office include extending the School Dental Service from all primary school children to initially those secondary school students who are Government assisted (who qualify for the book allowance under the stringent means testing that is applied and administered under the Education Department) and more recently the extention to more secondary school students in year 8, which is occurring now and which will be in place for all of them by the beginning of the 1985 school year.

I understand that almost all of that additional activity has been put in place as a result of savings accrued within the current primary school dental programme. Those savings have resulted, first, because of the significant efficiency of the system which is unique in this country in that it uses a mix of school dentists and therapists.

Secondly, of course, because of the general reduction in the incidence of caries due to fluoridation, among other things, it is now feasible and indeed desirable, from a cost effective and clinical point of view, that the re-examination period be extended. The short answer is that it is being introduced at virtually no additional cost to the system. I cannot put an accurate figure on that, but that is my recollection of the general thrust. However, I ask Dr McCoy to expand on that.

Dr McCoy: I am also unable to put a precise figure on the question. However, I am able to give some indication of the way in which the South Australian Dental Service is handling the problem. With a standstill budget, the South Australian Dental Service has been able to absorb the cost of extending treatment to Government assisted secondary students in 1984.

In 1983 the number treated was 6 296; in 1984 it will be a greater number than that. Because of the lower primary school enrolments, very substantial funds have been freed in the School Dental Service and made available for two major initiatives: first, a transfer to the Adelaide Dental Hospital for improvement in public dental services for adults and now, with the extension of the School Dental Service, for Government-assisted school students in 1983-84. For example, in 1983 it is estimated that $250 000 was transferred from the School Dental Service to the Adelaide Dental Hospital for use in public dentistry for adults. Again, I am

not able at this stage to give a precise figure, although that could be obtained from Dr Blaikie.

Mr OSWALD: I find it rather extraordinary that a Government should undertake a new initiative and not have any idea of its cost. Will the Minister explain how the course for dental technicians is funded?

The Hon. J.R. Cornwall: User pays.

Mr OSWALD: What criteria were used in assessing those who were and were not admitted in the first intake of dental technicians?

The Hon. J.R. Cornwall: I have no idea; that is a matter within the purview, albeit indirect, of the Minister of Education. It has nothing whatsoever to do with me. I am the Minister of Health, not the Minister of Education.

Mr MEIER: Regarding the criteria used in assessing dental technicians who did the first course, I remember writing to the Minister some time ago because of a constituent who was a little upset because he felt he might be missed out. It is interesting to hear that it is under the Minister of Education's portfolio.

My first question relates to the Estimate of Payments, at page 168, dealing with the Red Cross Blood Transfusion Service. The amount shown indicates that the estimated expenditure for the coming year is $1.3 million as compared to actual expenditure last year of $1.338 million. I am interested to see that this amount appears to have decreased. Has sufficient money been made available for research and development in the Red Cross Blood Transfusion Service, and does the Minister feel that this area will be able to be promoted and developed as it should be? This service is very important to our community.

The Hon. J.R. Cornwall: In response to the second part of the question, I give an absolute assurance that it will be at least maintained and promoted to the extent that it needs to be. With regard to the first part of the question—has there in fact been a reduction in actual funding of the Red Cross Blood Transfusion Service—I defer immediately to my Director of the Central Sector, Dr McCoy.

Dr McCoy: I can give an assurance that funds to the Red Cross Blood Transfusion Service are not being cut. Indeed, there has been an enhancement of funds to that centre. There are two specific items, one being for $19 000 (and I recall providing a budget variation for that sum, I think last week, to enable the service to gather blood for cytomegalo virus screenings so that newborn babies can be transfused with blood that is negative for this virus). A reserve is also held by the Commissioner of $37 500, because there is some suggestion that the parent Red Cross Society may be forced or may wish to reduce its contribution during 1984-85 to the Red Cross Blood Transfusion Service. I suspect that the reason for variation in the figures is technical. If my finance manager was here I could answer that question, but I am happy to provide a full written answer later.

Mr MEIER: So, it possibly could read, rather than $1.3 million, $1.356 million, with the extra $56 000 coming from $19 000 and $37 500?

The Hon. J.R. Cornwall: I think it would be desirable to take Dr McCoy's offer up. As Minister, I reaffirm that commitment that we will provide a comprehensive answer for incorporation in the eventual final report of the Estimate Committee on health.

Mr MEIER: I ask a further question relating to that page and the item headed 'South Australian Health Commission Central Office'. The amounts shown in the Estimates of Payments (appendix 1) at page 168 are $340 166 for the last year as against $220 000 for the estimated budget this year, which is obviously a very significant drop in funds. There is no asterisk or alternative symbol to explain why that drop has occurred.

Professor Andrews: The figures referred to might be a little confusing since they relate to source of funds and reflect receipts of certain items taken into the Central Office in the last financial year and related, for instance, to sale of motor vehicles and other miscellaneous sums accredited to the Central Office accounts.

The change between years merely reflects fluctuations like the number of vehicles sold in that particular year. As the Government has moved to creating a central car pool, the Central Office of the Health Commission is no longer in the position of selling cars and receiving receipts for those amounts, so that accounts for the significant reduction in the receipts in this current financial year.

Mr MEIER: It is a real reduction: it is not something that is transferred somewhere else to another document.

Professor Andrews: That is right.

Mr MEIER: I have another question on that matter.

The Hon. J.R. Cornwall: Before we get to that, we have since located additional Red Cross figures as revealed in the blue book and I think that it might be useful at this stage if we respond immediately.

The ACTING CHAIRMAN (Mr Plunkett): It would be appreciated if the Minister could supply that information.

The Hon. J.R. Cornwall: To help members of the Committee or indeed the South Australian public in any particular situation where they might be concerned, Dr McCoy can explain that very succinctly and briefly.

Dr McCoy: I was not able to follow the numbers that were being quoted previously, but I refer to page 17 of the blue book, headed, 'Deficit funded health services' in regard to 1983-84 actuals and 1984-85 estimates. In regard to the Red Cross blood transfusion service the actual gross payments in 1983-84 were $3.4137 million and the estimated gross payments for 1984-85 were $3.5605 million. Those are the allocations that have actually been made to the Red Cross. The amount of $3.5605 million will escalate during the year with salary and wage increases, is increased by $19 000 for the cytomegalo virus screening, as mentioned earlier, and is also potentially increased by the reserve to which I previously referred.

Mr MEIER: There is certainly some confusion between the Estimates *versus* the blue book figures, but it seems to be all right. While I am referring to the Estimates, and still on appendix 1, under 'Community health services', there is a figure for the 1983-84 period of about $36 million, whereas the estimate for this year is almost $45 million. I wonder where the large increase in expenditure is envisaged.

The Hon. J.R. Cornwall: I believe that the Dental Services has some $8 million allocated; it was previously in the health category of recognised hospitals. Dentistry was part of the recognised hospitals categorisation and it was there, of course, among other practical reasons because some cost sharing used to occur under the old Commonwealth-State Hospital Agreement. For budgetary purposes it has now been transferred more properly to the community health programme and, therefore, one has $36 million plus inflation plus the additional $5.3 million (I think) for the Adelaide Dental Hospital. When one puts that all together, there appears to be a burgeoning, but while there has been a reasonable increase in funding it is unfortunately not of the order of $7 million. I ask the Chairman to add anything that he may wish to that.

Professor Andrews: There are some other amounts that I think the Committee might like to know about. I refer to $720 000, which represents the full year effect of community health initiatives commenced in 1983-84 which were funded as a result of contributions from the Commonwealth under the Medicare arrangements to restore community health services to the 1975 levels. A sum is set aside, about which I think the Minister spoke earlier in response to another

question, for the purpose of community health initiatives to be implemented in conjunction with local government authorities, and I refer to the sum of $220 000.

There is the full year effect of establishing the Elizabeth Women's Community Health Centre, to which reference was also made earlier. The full year effect of expanding services to the disabled through the Independent Living Centre of $146 000 was referred to earlier. All in all, those initiatives, in addition to the shift of the Adelaide Dental Hospital expenditure into this line, result in a 24.6 per cent increase in community health services expenditure overall.

The ACTING CHAIRMAN: So that I am not accused of playing favourites, I would like to say that the member for Morphett had indicated that he wanted to ask a question, but I take it that the lead speaker is the member for Coles. Therefore, I now call on the member for Coles.

The Hon. JENNIFER ADAMSON: My question relates to public health, which appears on page 168 in the Estimates of Payments. The actual payments in regard to public health services were $4.6 million last year and $5.3 million is estimated for this year. Can the Minister indicate the way in which those additional funds will be spent, and specifically what staffing arrangements he has in mind to assist the Commission to prepare the regulations to enable the proclamation of the Controlled Substances Act? When the Bill was being debated in the House of Assembly the Minister representing the Minister of Health gave an absolute assurance that resources would be made available to ensure that the regulations for the Controlled Substances Act would be drawn up in the shortest possible time.

I would be pleased if the Minister could indicate what additional staff resources, if any, have been made available to the Commission in that area and when the Act will be able to be proclaimed, notwithstanding our recognition that it cannot be proclaimed until the food legislation has gone through Parliament. Not all of it can be proclaimed, but we want to know at least when the regulations for the Controlled Substances Act will be ready and what assistance is being given to the Commission to enable that to be at the earliest opportunity.

The Hon. J.R. Cornwall: First, the major increase in expenditure other than the normal allowance for inflation in public health spending relates, of course, to the environmental health office in Port Pirie and the environmental health programme specifically with regard to lead pollution in that city.

With regard to the Controlled Substances Bill, the member for Coles has virtually answered her own question. She realises that there will have to be a phasing in, the regulations will have to be prepared and parts of the legislation proclaimed as possible. For example, we will be ready to go in the reasonably near future with the setting up of assessment and aid panels for the victims of drug addiction. The last phase clearly will have to wait until we have finished our extensive consultation with all interested parties, particularly the Local Government Association, with regard to the food legislation. Quite clearly, the Food and Drugs Act cannot be repealed *in toto* and replaced with the Controlled Substances Act and the new proposed Food Act until the proposed Food Bill actually becomes an Act. It will be done in phases.

As I understand the situation at the moment, it is fairly much on course. Dr Baker has a detailed breakdown of the sort of thing that the budget will be spent on. He has a far more detailed knowledge, understandably, of the progress of the regulations proposed under the Controlled Substances Act than I do and I ask him to respond in a little more detail to the question.

The ACTING CHAIRMAN: Will the Minister introduce his officer?

The Hon. J.R. Cornwall: I am sorry, Sir. I overlooked the fact, your being so familiar to members of this Committee, that you were not here earlier in the day. Dr Baker was introduced to the Committee earlier in the day. Dr Chris Baker is the Acting Head of the Public Health Division of the South Australian Health Commission and recently was appointed as Acting Head in that position following the retirement of Dr Keith Wilson, who I know members will recall gave public health services in this State distinguished and outstanding service over a very long time.

Dr Baker: The Controlled Substances Act is seen by the Health Commission and the Minister as having a high priority because of the need to control the abuse of narcotics and drugs of abuse. A legal officer has been seconded to the Health Commission and that officer is engaged full-time in drafting regulations. Officers from pharmaceutical services are assisting him, and regular meetings are held on a monthly basis to assess the development of the drafts. Shortly the Minister will be appointing the Advisory Council and, hopefully, one or two months after that the first regulations can be phased in. As the Minister said, it is a matter of phasing in certain parts of the Act to replace the drugs part of the Food and Drugs Act. There will also be a Food Bill introduced into Parliament.

The Hon. JENNIFER ADAMSON: Whilst on the subject of drugs, I refer to page 17 of the blue document, in particular to the Alcohol Board's budget of $3.4 million. What plans does the Commission have for establishing prevention and rehabilitation programmes for women in the drug and alcohol abuse area? None exist at the moment. In light of evidence of increasing drug and alcohol abuse by women, it is clearly an urgent need. What funds will be allocated to those programmes if any are envisaged?

The Hon. J.R. Cornwall: With respect, it is not true to say that we have no programmes for alcohol and drug abuse amongst women at the moment.

The Hon. JENNIFER ADAMSON: That was my information from the Board.

The Hon. J.R. Cornwall: The member for Coles interjects. Fortunately, to this point she has restrained herself this evening, having distinguished herself not too well earlier in the day. She interjects and says that that was her information from the Board. There is no Board. There has not been a Board since 3 September and the sooner we get used to that the better. There is a reformed and much expanded Drug and Alcohol Services Council and, as I explained to this Committee much earlier today, that seven person council has been constituted in the first instance as a task force specifically to look at a whole range of ways and a number of areas of concern where our existing services to drug and alcohol abusers need to be upgraded. The old policy under the old Act placed stress not only on treatment but also on discipline and will be revamped. Again, I said earlier today that we will be looking at the whole range of reforms that are necessary from much earlier and more effective intervention through to the range of residential programmes.

I guess it is reasonable to ask what specific programmes we might provide for women in view of the fact that it is acknowledged clearly by me, and by anyone who thinks about it, that polydrug abuse is said to be an increasing problem with women. The use of things like valium and serapax is acknowledged to be an existing and relatively serious problem. It is also true that the whole thrust of providing more services through our women's health centres (and we have quadrupled those services in less than two years) and the philosophy behind many of these services which plug the gaps in the traditional services, amongst other things, is to remove the necessity for very dangerous props like valium and serapax drugs. We have already moved in that sense.

In terms of more specific responses it is a matter that we could properly refer to the task force which is going to report in time for pre-Budget discussions for 1985-86. I am sure that the member for Coles will not be disappointed with the recommendations that are forthcoming from that task force. I make it clear—and have done so to the Alcohol and Drug Addicts Treatment Board, to my personal staff, to the Chairman of the Health Commission, to the Director of the Public Health Division of the Commission, and to anyone else who cares to listen at any time—that I have a particular passion and concern for seeing our services for drug and alcohol abusers significantly upgraded.

Just as importantly, I believe passionately that the philosophy underlying those policies and goals needs to be based, in the case of the victims at least, on a caring and compassionate approach. I am prepared not only to discuss that with anyone who will listen at any time, but also to make it clear to people that we will never get anywhere by victimising the victims and that, in the matter of drug and alcohol abuse, the individuals who are the victims must be treated with great compassion and our efforts must be directed towards rehabilitation.

With respect to the scum who traffic in illegal drugs, particularly narcotics, I have said on scores of occasions that I reserve my special contempt for them. The general thrust of philosophy of this Government is embodied in the Controlled Substances Act, which very substantially increased the penalties for the vermin who trade or traffic in narcotics in particular, whilst there was a general very positive thrust to set up aid and assistance panels and to help in every way possible the victims of what I regard a vile trade.

The ACTING CHAIRMAN: Before calling on the honourable member for Coles for the third question, I suggest that perhaps the Committee and the Minister could agree to a coffee break for a period after this next question. I am in the hands of the Committee.

The Hon. JENNIFER ADAMSON: Speaking for the Opposition, we would be very keen to press on, because so much time was lost this afternoon that we would be loath to lose any more time. However, that is in the hands of the whole Committee rather than just the Opposition. I just make the observation to the Minister in response—

The ACTING CHAIRMAN: If I could just have the attention of the member for Coles before she continues, I have not been on the Committee all day, but, given the length of time that the Committee has sat (and it has been a fairly heavy Committee; I have listened to it from outside in the Library as I have been playing the loose person in the two Committees), I would suggest that, even though the lead speaker, the member for Coles, may not see that there is a necessity for a short break, it may be the position of the rest of the Committee and the Minister that there is a need for a break. I would suggest that perhaps the member for Coles would reconsider. When I say a 'break', I am not suggesting quarter of an hour, but rather about 10 minutes. I would ask that the Committee and the Minister be back here promptly on time. I would therefore ask the member for Coles whether she could reconsider the matter. It has been put to me as Acting Chairman that there be a small break.

The Hon. JENNIFER ADAMSON: I have the assurance of the member for Brighton that, if a break is held, no questions will be forthcoming from the Government side, and on that basis I am happy to take the break, as long as the time is adhered to.

At page 17 of the blue document, the IMVS figures, the 1984-85 estimates, compared with the 1983-84 actuals, are extremely difficult for the lay person to comprehend. Obviously, the quite dramatic changes in payments between the two years are the result of the introduction of Medicare. Would the Minister or one of his officers outline to the Committee the arrangements that have led to net payments in 1984 being $22.7 million compared with $6.5 million in 1983-84, and can he also apply a similar explanation for the huge disparity between receipts and payments for the IMVS? In other words, all figures right across the board are significantly different for the two years, and it is difficult for anyone to comprehend the difference unless there is an understanding of the impact of Medicare. I am particularly interested to know the cost to the State of South Australia, the State taxpayer, of these changes.

The Hon. J.R. Cornwall: I would ask the Chairman of the Health Commission to explain that very shortly. There is a very simple and adequate explanation, I can assure you. I might say they are very good questions concerning the funding of the IMVS for 1984-85.

Professor Andrews: Perhaps I will answer the general issue that relates to the change in arrangements with the IMVS. The detailed funding, if the Committee wishes to follow it up, can best be dealt with by Dr McCoy, who is directly responsible for this area. The basic difference in IMVS funding this financial year compared with previous financial years is that previously pathology costs were charged by IMVS to individual hospitals and, of course, those charges were cost shared under the cost sharing arrangements. That indeed was the main purpose, if one likes, of that approach.

With the introduction of Medicare, those direct charges to hospitals have been removed and replaced by a direct grant from the Commonwealth to compensate for that loss of revenue. So, the makeup of the IMVS budget is quite different in this current financial year consequent upon that change. I might also mention that that has also had an effect on the budgets of hospitals, and some of the variations that Committee members might see in hospital budgets reflect the fact that they are no longer being charged by IMVS for pathology services provided to hospital patients, as those costs are met throught the Commonwealth grant. Perhaps I could ask the Minister whether he might like to get Dr McCoy to comment on any of the issues relating to changes in the level of funding of the IMVS.

Dr McCoy: The funds made available to the IMVS from hospitals amount to $12.95 million in 1984-85 (that is the current estimate of cost), and the estimated Commonwealth contribution for private practice foregone, because no fees have been raised for private patients, is $6.691 million.

These are both estimates and are based on a formula that has to do with the number and the mix of tests. These will be reviewed periodically during the year and they will be varied as the mix changes and as our understanding of the system improves during the year.

The IMVS budget is now controlled by a gross payments budget in the same way as any other health unit is controlled. The gross payments budget is basically at a standstill level. However, it is presently at a very much higher level than it was at the end of 1982-83 because in 1983-84 the IMVS increased its expenditure considerably.

Mr OSWALD: What changes to the composition of the Dental Board does the Minister propose to make in his amending legislation, and will it have identical powers to those which it has at present?

The Hon. J.R. Cornwall: I am not clear what point the honourable member is trying to make. I suppose that the best thing I can do is to read into *Hansard* the provision relating to the composition of the board. The legislation provides:

> The Board shall consist of eight members appointed by the Governor of whom—
>
> *(a)* four shall be nominated by the Minister;

(b) three shall be dentists who have been nominated in the prescribed manner by a majority of dentists who vote on the question; and

(c) one shall be a dentist who has been nominated by the Council of the University of Adelaide.

(2) Of the members appointed on the nomination of the Minister—

(a) two shall be dentists at least one of whom is employed by the South Australian Dental Service Incorporated;

(b) one shall be a legal practitioner; and

(c) one shall be a person who is neither a registered person nor a legal practitioner who has been selected by the Minister to represent the interests of persons receiving dental treatment.

In fact, we have not yet appointed anyone.

Mr OSWALD: Is it intended to set up an advisory committee or similar body and, if so, what will be its functions and powers?

The Hon. J.R. Cornwall: The honourable member is talking about the Dental Policy and Implementation Committee, which was an undertaking in the platform of the Labor Party before the election and which was recommended in a similar sort of fashion by Dr Barmes in the Barmes Report. I understand that it is about to happen as a section 18 committee under the Health Commission Act. I would stand to be corrected, but I believe that it will be the first section 18 committee appointed, although I can assure the Committee that, if I remain Health Minister (and I intend that I should), it most certainly will not be the last. From my recollection that matter has already gone to the Health Commission or is in the process of going to it. Indeed, I am now told *sotto voce* that it is with the Commission to come back to me to go to Cabinet for ratification. Certainly it is my intention, unless there is some extraordinary reason that Cabinet finds not to proceed, that there will be a representative implementation and review committee.

I do not think it would be out of order if I were to ask the Chairman, at least in general terms, to talk about the proposed composition of that committee, what dentists would be represented, how they would be represented, and so forth.

Professor Andrews: The committee will comprise myself as Chairman of the Health Commission, four representatives of the South Australian Dental Service Incorporated and four representatives of the Australian Dental Association, as well as the Executive Director of the Central Sector.

A question was asked about what function that group would have. It will have a broad oversighting function in terms of the development and implementation of the Government's and the Commission's dental health policies.

That will provide a forum for communication between the Commission, the South Australian Dental Service and the dental profession. We hope that that committee is set up as a matter of priority. As has been mentioned, the matter has been dealt with by the Commission and has been referred back to the Minister for Cabinet approval.

Mr OSWALD: I have been advised that recently a number of staff have resigned from the Drug Dependence Clinic at Norwood. What are the problems at the clinic, and what is the future of it?

The Hon. J.R. Cornwall: I am not personally aware of the resignations or of the reasons for them. With regard to the future, I hope that it expands into a rather better one. I regard it as being quite unsatisfactory that people with alcohol problems and people with drug problems should be treated at the same facility. There is no empathy between middle aged alcoholics and young drug users—for a whole variety of social reasons. Young drug users treat middle aged alcoholics with the contempt that they believe they deserve, while 40-year-old alcoholics treat drug abusers with even more contempt. So, there is just no commonality. That is one of the reasons why there were real problems at the old St Anthonys. Very sensibly, during the time of the previous Minister the family living programme was formed at St Peters, based at the premises which were formerly used by St Anthonys, which is for drug abusers and for the victims of drug abuse only. People with alcohol problems are handled at the new St Anthonys, if one can call it that, as well as in other facilities. The mixing of the two problems simply does not work. Therefore, we need upgraded facilities.

I think it is fair to say (and I believe it is fairly common knowledge) that some personality problems have occurred in relation to the staff at the Drug Dependence Clinic or between staff of that unit and other personnel. In short, I think the whole matter needs a shakeup, and that will be one of the things that the Drug and Alcohol Services Council, formed as a task force, will look at.

Mr OSWALD: In regard to the Physiotherapy Board, when will amendments be introduced to enable any person not presently registered to become registered?

The Hon. J.R. Cornwall: Currently the Government is involved in discussions with the board and with the Physiotherapy Association, and it has been for quite some time. Amendments are proposed, but I am not aware of any proposal that would enable people who are not at present registered to become registered. Perhaps I have not interpreted the question in the way in which it was intended. By way of a supplementary question could the member for Morphett provide me with more detail?

Mr OSWALD: I am not able to do that in the depth that I would like, other than perhaps to ask when will these amendments be introduced.

The Hon. J.R. Cornwall: I would have hoped originally before the end of this Budget session, but I think to be on the safe side, in view of the many other proposed pieces of legislation that are being developed at the moment, I would have to say in the autumn session of Parliament. If the honourable member is suggesting (or has perhaps been told) that there are proposals to give some form of limited registration to people who are not qualified, he can immediately set at rest his mind and the minds of constituents who may be physiotherapists.

There was a particular problem with regard to a practitioner in the sports medicine area—almost an inherited problem—but I am happy to say that I believe it was resolved to the satisfaction of all parties after lengthy and somewhat difficult discussions. There is always the ongoing and vexed question, I suppose, about sports trainers and, in particular, football trainers and masseurs of what constitutes a football trainer and a masseur, how much laying on of hands there may or may not be, and so forth.

We certainly would not propose to tighten the law so that those people who provide *bona fide* and valued services for football clubs and other sporting organisations would be prejudiced in any way. However, by the same token there is no proposal of which I am aware at the moment, and certainly none that I have initiated, which would contemplate even limited registration for persons other than those who are qualified physiotherapists in the normal sense of the term.

The Hon. JENNIFER ADAMSON: Earlier in the day the Minister was extremely scathing of what he and I acknowledged to be an unsourced document, the contents of which I read to the Committee. I am in a position to advise the Committee of a source for the following resolutions that were passed by members of the Queen Elizabeth Hospital's Medical Staff Society at a meeting of the Physicians Subcommittee on the 18th of this month. The resolutions are pertinent to questions on the Queen Elizabeth Hospital's budget, and I think that they should be read into the record. Resolutions to the following effect were carried:

1. The subcommittee believes that the responsibility of the hospital to provide an adequate standard of care for patients in need of it will be impossible to discharge if the threatened contraction of financial support is imposed.
2. That this subcommittee recognises that professional health care services at the Queen Elizabeth Hospital are over extended which is leading to a denial of those services to an increasing number of patients.
3. That this subcommittee wishes to support the board in its assertion that the so-called overspending is, in fact, due to proper treatment of patients according to clinical need rather than inappropriate spending in other areas.

The Minister earlier threatened that if he were to discover the names of the doctors—if they were indeed doctors—involved in the preparation and distribution of the unsourced document they would be referred to the Medical Board.

I doubt that the Minister would want to refer the Physicians Subcommittee or members of it to the Medical Board. It may even be possible that a member of the Physicians Subcommittee is also a member of the Medical Board. But I ask the Minister whether, in light of the belief of the Physicians Subcommittee of the Queen Elizabeth Hospital Medical Staff Society, it is impossible for the hospital to provide an adequate standard of care if the present budget is imposed in all its stringencies.

That being the case, if the physicians and Medical Staff Society stands by its belief that it is impossible to provide an adequate standard of care, will the Minister using his powers under the Health Commission Act, that is, to have general direction and control of the Commission, require the Commission to provide adequate funds for adequate standards of patient care?

The Hon. J.R. Cornwall: That question is as mischievous as it is silly.

The Hon. JENNIFER ADAMSON: Tell that to the doctors.

The Hon. J.R. Cornwall: I would be perfectly happy to tell it to those doctors who have been irresponsible enough to try to bring the Queen Elizabeth Hospital into disrepute by their actions. Notably, again the document is sourced but not signed and, of course, it is written in somewhat more restrained tones than is the completely unsigned unsourced document that the member for Coles read into the record much earlier today. I am able to tell the Committee that we have, of course, a much more recent document and I must say a much more restrained document.

I refer to the Chairman of the Medical Staff Society and this campaign that it has been orchestrating with the Opposition for the one day of the year that the Budget Estimates Committee dealing is with health. As part of that orchestrated campaign, a letter from the Chairman of the Medical Staff Society was delivered to the *Advertiser* this afternoon. That is signed and sourced, but significantly it is a very different and a much more restrained document than are the various anonymous ones that have been circulated earlier. I was asked to comment on that during the dinner adjournment, and consistent with the position that I have adopted continuously in this matter I said that it was appropriately an administrative matter and, therefore, for the Commission.

I will comment when people play politics on political matters: I think that I have a right and a duty to comment. However, I refuse absolutely to meddle in administrative matters. I refuse totally to undermine the legitimate rights and duties of the South Australian Health Commission as the member for Coles suggests. I refuse absolutely to undermine the basis of responsibility in public financial management as the member for Coles suggests. I wonder how she can possibly make such wild statements when the Leader of the Opposition—the champion of privatisation and small government—is in this very Chamber.

'Hear, hear', says the Leader of the Opposition. I am not sure whether he is allowed to interject. He is not a member of this Committee, but I welcome his support. I am very pleased that he has come on side with me and I am pleased that, as a putative although unlikely Premier, he is showing at least some measure of responsibility, albeit that that is very much overdue. He is a champion, as is his Party, of small government, of financial responsibility. Yet, the member for Coles, and I think the Leader of the Opposition (the putative but unlikely Premier), ought to take note of the antics that members of his Committee have been getting up to all day. They have been putting me under vicious, hostile and unrelenting attacks to write an open cheque. Now she asks herself indoors and insists that I ought to instruct the Commission to write an open cheque for the Queen Elizabeth Hospital because the physicians and the Medical Staff Society want to stand over them.

I say with great pleasure that all of the senior members of the Health Commission with whom I have ever had anything to do do not have hearts like walnuts. They not only have very considerable ability and considerable convictions in their chosen professions, but they also have the courage that ought to go with those convictions. Having said that, and having handled the outrageous political and practical implications of the preposterous proposition that the member for Coles has just put before us, I would ask the Chairman of the Health Commission—as a distinguished member of the medical profession and one who has more postgraduate qualifications than I can either remember or pronounce—to respond to the professional aspects and administrative implications of that most silly question that the member for Coles has just asked.

Professor Andrews: The substance of matters raised by the physicians subcommittee was detailed in earlier questions. I doubt that the Committee would appreciate my repeating those details. I would comment that, with the greatest of respect to my medical colleagues on the physicians subcommittee, in matters that have to do with the hospitals budget, the framing of that budget, and the financial management of the hospital, the dealings of the Commission have been with the responsible officers, the executive of the hospital and the hospital board. I believe when a physicians subcommittee comments in this manner on the nature of the budget and the consequences of the budget, it is venturing into areas well outside its expertise. I have said on other occasions that I and other members and officers of the Commission would be only too happy to meet with the Medical Staff Society or any subcommitee and discuss the questions that they have raised with respect to community and clinical services. I expect that they will take up that invitation.

However, when it comes to the question of framing the budget and the financial management of the hospital, we properly deal with the responsible officers at the hospital. I do not believe that the executive staff of the hospital or the hospital board or its financial officers would agree with the position being taken by the physicians subcommittee, which I suggest is inexpert in this area.

The Hon. JENNIFER ADAMSON: It seems extraordinary to members of the Opposition that the Minister should describe the budget of a teaching hospital as an administrative matter—in other words, something beyond his control—when in Opposition he regarded the budgets of teaching hospitals as virtually entirely the responsibility of the Minister and the Government of the day. He seems to be adept at reneging on his responsibilities. I would describe the latest outburst in describing the budget of the Queen Elizabeth Hospital as an administrative matter of which he can wash his hands like Pontius Pilate as one of his more remarkable exaggerations. In fact, listening to his replies is rather like wading between a mixture of treacle and mud. He pours treacle over himself and the officers whom in Opposition

he was pleased to vilify and he completely obfuscates the answers to the questions.

In relation to the Queen Elizabeth Hospital and the tragic situation of one of my constituents who is a brain injured patient in that hospital and who is apparently unable to be transferred to any other unit in South Australia on a respirator, even though I am aware the Minister has made inquiries about the possibility of having this young woman transferred to Julia Farr, I turn to the question of the Government's policy on brain injured victims. In the policy statement, the Labor Party said:

> A Bannon Labor Government will initiate a new deal in long-term rehabilitation services and facilities for young brain injured victims in South Australia.

The policy went on to say:

> A State Labor Government will make an annual grant of $200 000 for three years to act as a catalyst in initiating and co-ordinating these long-term rehabilitation projects.

On what was the $200 000 spent last year and where does it appear in the Budget? On what will the $200 000 be spent this year, and where does it appear in the Budget?

The Hon. J.R. Cornwall: I am not sure that the $200 000 was spent directly last year, as a matter of fact.

The Hon. JENNIFER ADAMSON: It was a promise.

The Hon. J.R. Cornwall: Of course it was a promise, good lady and, unlike most of yours, it will be kept. I should say that about 90 per cent of our promises are in place and we are not yet at the two-year mark.

An honourable member interjecting:

The Hon. J.R. Cornwall: Could I clarify, before we go any further, the status of this fellow who sits on the front bench? Is he a member of this Committee? Has it been formally noted that he is a pinch hitter? He is annoying me with his inane remarks; he is parking on the bench. Is he a member of the Committee?

The CHAIRMAN: Order! The member is now baiting the Chair.

The Hon. J. R. Cornwall: No.

The CHAIRMAN: I point out to the Minister that the Leader of the Opposition has every right to sit here, even though he is not a member of the Committee. However, I would suggest that he should not keep on interjecting in the vein that he is doing so; otherwise, we might go through the same procedure as we did earlier this afternoon.

The Hon. J.R. Cornwall: That clarifies the position. The plight of the young brain injured was brought to my attention and I became accutely aware of it during that very diligent and useful period that I spent as shadow Minister of Health in Opposition. Indeed, during that period, amongst other things, I visited the Lidcombe Hospital, which was the subject of a recent national television programme specifically on the young brain injured. I also had quite some contact with Professor Dennis Smith, who is the only occupant of a chair in rehabilitation in this country.

I developed, to the extent possible in Opposition without all the resources that go with being in Government, a general policy in relation to rehabilitation. The fact is that, at least on the evidence that is available (and I must say that in this State and country it is reasonably scant), after further extrapolating figures that are available from overseas, and given the rate of road trauma and the fact that about 50 per cent of all road trauma occurs in young males between the ages of 18 and 25 years, it is reasonable to assume that there are probably about 200 young brain injured or new young brain injured in this State very year. There are a whole lot of sequelae of brain injuries, not the least of which on occasions are quite bizarre behaviour patterns—diminished responsibility and a whole range of other things. Of course, it is an area in which I am not expert.

However, it is an area in which the Chairman of the Health Commission, Professor Andrews, has substantial expertise. On coming to Government, I immediately asked for an assessment of the existing rehabilitation facilities which in some areas, including this one, were clearly not adequate. Following that assessment, I then asked that a further assessment be done as to where we should reorganise and integrate, and what further facilities might be necessary.

There is currently a committee, which is chaired by Professor Andrews and which is finalising those matters so, logically, I will ask him to respond in a moment. Apropos the particular constituent to which the honourable member referred, I must say that I am of course very much aware of the case. It is a very sad case indeed. Recently, I met with the parents, and their child from recollection is in her late teens and has been a patient in the Intensive Care Unit of the Queen Elizabeth Hospital for about 12 months. She did suffer a cardiac arrest in November last year and, according to the clinical assessments, she is vegetative and has been so since November of last year. It is a very sad and very distressing case. She would die, of course, without the very substantial artificial means by which she is currently kept alive.

When I met with the parents, they expressed a desire that she should be transferred to the Julia Farr Centre. It was my understanding that Dr Last was co-operating and co-operative towards that initiative. However, I must say that I have not been able to follow the case day by day or week by week since I met with the parents about two months ago. I assured them at the time (and I reassured them via their local member) that if there was any way at all in which I can help I would be very pleased and very willing to do so.

With respect to the current state of play with the young brain injured and the implementation not only of that policy regarding what was seen as a seeding grant for a pilot project but also of what else might be proposed for next year and beyond, I would ask Professor Andrews to respond.

Professor Andrews: Perhaps I could make a few brief remarks. The issue is, as the Minister has said, a very important and a growing one, with some 200 new victims each year. There are four phases of management of the head injured person, and one is, of course, the acute phase. It is the very fact that our management in the acute phase has greatly improved in recent years that has resulted in other problems: people are now surviving who would not have survived in the past.

The Hon. JENNIFER ADAMSON: I rise on a point of order. I wonder if the Chairman of the Commission would like me to refresh his memory as to the actual question. I simply asked on what the $200 000 annual grant was spent last year and on what it will be spent this year.

The Hon. J.R. Cornwall: With respect to the member for Coles, I have already said that to the best of my recollection $200 000 was not spent last year directly on any project. A survey was carried out, of course, about which the Chairman would tell the honourable member if she were not so rude as to interrupt.

The other thing that the Chairman was trying to do (and I think he was doing it very well) was to outline to the Committee in just what directions we will be going during the second half of the 1984-85 financial year, and particularly beyond that. However, if the member for Coles does not want to hear that, then the simple answer to her question is that there was not a direct pilot project on which the money was spent. Some of the money was spent on a survey. A significant amount of work has been done on what quite obviously is a far bigger and more complicated area than I could define as a simple practising politician in Opposition. But I believe that we have come a long way. Perhaps we

can tell the member for Coles and her colleagues all about it next year.

The Hon. JENNIFER ADAMSON: We have established that the promise to make an annual grant of $200 000 a year for three years has not been kept. I would regard that as at least being an answer, albeit an unsatisfactory one, to the question. At page 32 of the yellow book reference is made to services to the intellectually disabled. The Minister would know that constituents of mine and of those other members who have been referred to me are extremely distressed that the much wanted promises of the Government in respect of upgrading community based services to the intellectually disabled do not appear to the parents of such children to have been honoured. I refer particularly to the intolerable burden that is placed on parents, particularly on mothers in coping at home with children who would be placed in institutional care if beds were available at institutions. The physical and emotional burden of caring for such children without a great deal of practical support from the home is more than they can bear. Marriages are cracking up under the strain and intense pressure is being felt by all concerned. Therefore can the Minister outline precisely what he has done in terms of providing practical, on the ground, in the home help to parents whose children have to be cared for at home simply because there is no place available for them either in community based care or institutional care facilities?

The Hon. J.R. Cornwall: I have not done anything to provide practical home help. I am not a service deliverer. That was a stupid way to frame a question, and the member for Coles should not allow herself to get carried away by her intense dislike for me personally. I have always regarded her as being a very amiable woman, but I must say a very foolish one, based on today's performances. The intellectually disabled area generally has been the major growth area, on a percentage basis, of the health portfolio under my administration as Minister.

In 1982-83, remembering that we came to Government on 6 November, we supplemented the budget of a then very new Intellectually Disabled Services Council by almost $1 million full year funding for that year. In 1983-84 we funded the IDSC with a further $1 million.

In this coming financial year, once we have validated the savings in some other areas, I intend that we fund the IDSC by a full year amount approaching $500 000. So, over the three financial years of this Government, total funding to the Intellectually Disabled Services Council will have been extended by $2.5 million, which is something in excess of 10 per cent of the base budget of the IDSC that we inherited, or around 8 or 9 per cent of the total budget when one improves the funding of places such as Minda.

The total funding this year for the IDSC will be something just in excess of $28 million. So, in money terms, we have done a great deal. In practical terms, after the initial difficulties with the then Chairman and Chief Executive Officer, I am very happy to be able to tell the Committee that we have come a significant way in implementing the policies of normalisation and deinstitutionalisation that we promised.

I am also happy to say that I am sponsoring a major inter-agency seminar this Friday to which we have invited many voluntary agencies and a large number of Government agencies (both State and Commonwealth) to talk about generic services and how they can, should and must be provided to the intellectually disabled, just the same as they are provided to many other groups. Specifically with regard to services in the community to those families with intellectually disabled children and to the intellectually disabled themselves, I ask Professor Andrews to comment briefly, and then ask Dr McCoy (who, as the Executive Director of the Central Sector, deals directly with the Chief Executive Officer of IDSC) to speak.

Professor Andrews: We have had recent discussions with the IDSC on the setting up of a pilot project in conjunction with the Southern Domiciliary Care Service with a view to looking at the provision of home care services on a pilot basis and the potential extension of that to other areas if that pilot exercise is successful. We believe that this approach may lead to eligibility for Commonwealth funding under the proposed Commonwealth community home care programme when funds are released for that purpose in the next few months.

I mention this matter, because it is only at this point in the stage of preliminary discussions between ISDC, the Commission, the relevant sectors and the Southern Domiciliary Care Service. However, it is an indication of the realisation that the provision of services to intellectually handicapped children in the home will be an increasingly important aspect of providing support and assistance to parents who are charged with the responsibility of care for those children.

Dr McCoy: I refer briefly to the $1.9 million in new funds provided for IDSC in the past two years. Four metropolitan regional centres have been established, with the appointment of 31 staff members in a number of professional groups. I conclude by saying that Mr Bruggemann, the recently appointed Chief Executive Officer of IDSC, and the council are aware that, in spite of considerable developments in the resources of that council, there are some criticisms from parents that services are not available to them in their homes. Professor Andrews has outlined one particular remedy. There are others that are being considered. The council is certainly aware of that criticism and is reacting vigorously to it.

The CHAIRMAN: Before calling the member for Goyder, I draw the attention, particularly of the Opposition, to the time. We have one more line to deal with, and the Chair will be placed in the position of rapidly going through that. The member for Goyder has a question.

Mr MEIER: Thank you, Mr Chairman. I believe that you have been very flexible this afternoon and this evening, and at least because of the many documents to which we have had to refer we have not had to be totally restricted in the sense that other Committees have. Page 12 of the yellow book states:

> It is South Australian Health Commission policy to promote the incorporation under the South Australian Health Commission Act, 1975, of recognised hospitals and other health units.

My question is: why is that the policy?

The Hon. J.R. Cornwall: First, there are some practical reasons and there are some industrial reasons. I will come back to those in a moment, but above all I believe that there are some extremely important symbolic reasons. The declaration through incorporation means that a hospital, whether it is in the metropolitan area, a provincial area or even in the remotest part of our far flung State, recognises that there is a true spirit of partnership and co-operation with the South Australian Health Commission and recognises itself as part of a very big and very co-operative family, which, through the Health Commission, participates in providing part of the integrated, co-ordinated and rational health service that I think is a very significant hallmark of the cohesive South Australian society.

Apart from that, as I said, there are practical and industrial reasons. Under the Health Commission Act the Health Commission is the employer for industrial purposes and it makes negotiation of awards, for example, and makes negotiations with the unions that have State-wide coverage far easier if we are dealing with single entities. I believe that the other very good reason is that it makes rights portable

between individual health units so that there is no loss of superannuation, for example, when a person transfers from employment in one incorporated health unit to another.

There are obvious advantages for that in country hospitals which may be looking at recruiting senior staff or a director of nursing. It means that the entire State is their oyster when they go looking for a competent and highly qualified trained nurse who may be a suitable director of nursing for their country hospital because that means that that person can go to the country, do whatever period may be appropriate (whether it is 12 months or 12 years) as a director of nursing of a country hospital, not lose any of the portability of leave rights, whether it be sick leave, long service leave or superannuation, and, at some appropriate time in the development of his or her career, return to the metropolitan area or go on in the fullness of time to one of the larger provincial hospitals. There are practical, industrial and, perhaps most important of all, symbolic reasons why I personally encourage incorporations, as Minister of Health, and why the Health Commission, as a matter of policy, actively supports incorporations.

Mr MEIER: That is a most interesting answer because I understand that the intention of the Health Commission Act to provide incorporation under that Act was not to make it virtually compulsory for all recognised hospitals or health units to become incorporated. The principal reason to provide for incorporation under the Act was to provide for hospitals such as the Royal Adelaide, Queen Elizabeth and the Flinders Medical Centre to be able to operate under boards instead of being run by the Department of Health, as previously. It would seem that the Health Commission wants to have constitutional as well as budgetary control.

The Hon. J.R. Cornwall: Let me say, first, that the Health Commission has total budgetary control, whether or not hospitals are incorporated. While ever this Government is in power and I am Minister of Health we will continue to have total budgetary control. We certainly would resist the monstrous proposition put to this Committee less than an hour ago, in the presence of no less a person than the Opposition Leader, by the member for Coles that I should exercise my powers under the Health Commission Act to direct the Commission to meet any demands that the Medical Staff Society at the Queen Elizabeth Hospital might make with regard to budgets. Maybe we will return to anarchy one day in the very distant future, long after the member for Coles and I have both been interred politically and probably physically, but there will continue to be financial accountability while this Government is in power.

Frankly, it has nothing to do with whether or not a hospital is incorporated. Conditions of subsidies can and do apply. There is nothing to fear from that viewpoint. Furthermore, I point out that the Sax Committee recommended that hospitals should accept their responsibilities and, as such, it was desirable that they should indicate their willingness to function by incorporation. We are extremely flexible in the matter of constitutions; provided that they come generally within the spirit and the intent of the Health Commission Act, we accept a very substantial degree of flexibility in the constitutions under which health units incorporate. I further add that it is not compulsory. The Government does not insist and the Health Commission does not insist, but we think that it is the decent, proper and right thing to do. The Commission and the Minister both encourage it on that basis more than anything else. I can assure the honourable member of two things. The first is that it does not hurt a bit. That has been the experience of all hospitals that are incorporated, whether country or metropolitan.

The other thing of which I would assure members of the Committee is that it is not part of a centralist socialist plot on the part of the Health Commission or the Minister.

The CHAIRMAN: Order! The Chair should wind up this particular line now, because I know that a member does want to ask at least one question on the other line. I think, because of that, that we should conclude. I therefore declare the examination of the line completed.

Works and Services—South Australian Health Commission, $18 450 000

Chairman:
Mr Max Brown

Members:
The Hon. Jennifer Adamson
Mrs J.E. Appleby
Mr T.R. Groom
Mr E.J. Meier
Mr J.K.G. Oswald
Mr K.H. Plunkett

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

Departmental Adviser:
Professor G. Andrews, Chairman and Chief Executive Officer, South Australian Health Commission.

Mr OSWALD: I refer to page 55 of the yellow book. The 1983-84 specific targets and objectives document reads:

> The first stage of the re-equipment programme at the Central Linen Service, as recommended by the Touche Ross Report, was completed.

The 1984-85 significant targets and objectives document states:

> The Central Linen Service will continue with implementation of recommendations as outlined in the Touche Ross Report.

I am advised that until now a watered-down version of option 1 has been implemented. I am also advised that the amount of capital recommended in option 1 has not been put into the Central Linen Service, nor have retrenchments been achieved to the level recommended in the Touche Ross Report. I ask the Minister, in view of the short time available, whether he could just briefly comment on that statement.

The Hon. J.R. Cornwall: First of all, let me say that retrenchments were never recommended nor adopted. The recommendations concerned the loss of something like 90 jobs through attrition. 'Retrenchment' is not, and will never become, a word in my vocabulary. The fact is that a modified version of option 1, from my recollection, was adopted. It proceeds to re-equip the Central Linen Service and expend the amount of capital envisaged at a somewhat slower rate, by a matter of about 12 months, from memory.

I am sure that members will recall that when I went out to the Central Linen Service and called an authorised stop work meeting to talk to the entire workforce of the Central Linen Service and to honour firm election commitments, I was given a standing ovation—well over 12 months ago. The morale at the Service is enormous. The place has been completely turned around and is operating profitably. It is operating so efficiently that prices have not risen and, as far as I can gather, it is not in prospect that they will rise for at least another 12 months.

One of the reasons why there has not been a loss of jobs through attrition is that we negotiated with the unions, in return for guaranteeing, long term, about 190 jobs at the

Central Linen Service, which incidentally was run down to a disastrous point when we came back into Government. Those jobs have not been shed by attrition at the rate recommended, because of the great success of the Central Linen Service. I am told there has been a reasonable queue waiting to get into the Premier's office from private operators in the laundry area, who are complaining very bitterly that the Central Linen Service is successfully tendering and competing not only to regain many of the clients whom it lost during the time of the Tonkin interregnum, but also for brand-new clients. We are competing on a commercial basis, paying Treasury rates of interest and competing in the market place. The Central Linen Service is a jewel in the Crown.

The CHAIRMAN: I think it is a little late to ask another question. I suggest that Committee members who still have questions should put them on notice.

Mr GUNN: I did want to raise a question, but the forum will not be open.

The Hon. J.R. Cornwall: Send me a letter in writing!

The CHAIRMAN: There is no question before the Chair. I simply declare the examination completed.

ADJOURNMENT

At 10 p.m. the Committee adjourned until Thursday 27 September at 11 a.m.