HOUSE OF ASSEMBLY

Wednesday 14 September 1988

ESTIMATES COMMITTEE A

Chairman:
Mr D.M. Ferguson

Members:
Mr H. Becker
Mr M.R. De Laine
Mr G.A. Ingerson
Mr M.D. Rann
Mr P.B. Tyler
The Hon. D.C. Wotton

The Committee met at 11 a.m.

Minister of Health and Minister Assisting the Treasurer, Miscellaneous, $844 917 000; Works and Services—South Australian Health Commission, $49 877 000

Witness:
The Hon. F.T. Blevins, Minister of Health.

Departmental Advisers:
Dr D. Filby, Executive Director, Planning and Policy Development.
Dr W.T. McCoy, Chairman, Health Commission.
Mr R. Sayers, Deputy Chairman, Health Commission.
Mr J. Dadds, Director, Resources and Planning, Public and Environmental Health.

The CHAIRMAN: The lead speaker for the Opposition has indicated that he does not wish to make an opening statement. Does the Minister have any opening remarks?

The Hon. F.T. BLEVINS: Yes, I will set the scene for the Committee by describing the overall position of the Health Commission, along with a few comments. The State Government has provided $1025.3 million to the Health Commission for 1988-89. This represents an increase of $46.6 million or 4.8 per cent on the $978.7 million in 1987-88 and, in addition, the Government will fund salary and wage increases as they occur during the year. This increase in funding has occurred despite the reduction in total Commonwealth funding to South Australia. In establishing the 1988-89 recurrent budget for the Health Commission, $7.2 million has been returned to Treasury, primarily as a contribution to the 4 per cent settlement and reduced workers compensation payments. However, an additional $8.2 million has been received under various initiative programs such as the social justice strategy, Medicare incentives grants and hospital enhancement.

This net increase in funds for 1988-89 follows a slight underspending of the commission's budget in 1987-88 of $3.7 million. However, as a result of changed Treasury arrangements this underspending was carried forward into 1988-89 so that the health system was not disadvantaged. On the capital side, the Government has provided $50.4 million in 1988-89, which is an increase of $12.7 million or 34 per cent on the 1987-88 expenditure of $37.7 million. The 1987-88 year has seen considerable achievement within the South Australian health system. The public hospital system increased its number of admissions by 2.1 per cent to 251 000 but, through increased productivity, was able to shorten the average length of stay from 6.24 days to 6.07 days. The efficiency of the health and hospital system in South Australia has improved substantially in the past five years. Independent analyses support this. For example, the Grants Commission, in its most recent report, stated that health expenditure per head of population in South Australia was the nearest (of all the States) to the recommended level.

Work on AIDS prevention has been strengthened through the appointment of additional staff and the upgrading of facilities. The commission has established additional palliative care services, including a hospice at the Daw Park Repatriation Hospital, and funded the appointment of a Professor in Palliative Care, the first in Australia. Major capital works in 1987-88 included the redevelopment of the Lyell McEwin Hospital and Wallaroo Hospital and major works at the Adelaide Children's and Modbury Hospitals. Funding was provided for medical equipment and the upgrading of computer services. Planning for future major works, particularly at Noarlunga, Royal Adelaide Hospital and the amalgamated Adelaide Children's Hospital/Queen Victoria Hospital was also undertaken.

In this bicentennial year there has been a focus of attention on Aboriginal issues and on the poor state of Aboriginal health. One of the most significant reports on the cause of poor health in the lands in the north-west of the State was the result of a joint effort by the Ngnampa Health Service and the commission's Public and Environmental Health Service. This UPK report is central to an integrated Government program to provide services and facilities to Aboriginal people which will improve their health status. In 1987-88 we saw a further reduction in the number of staff employed within the Central Office of the Health Commission. At 30 June 1988, 472 full-time equivalents were employed in the Central Office compared with 501 in 1987 and 543 in 1986. Further reductions are anticipated in 1988-89.

The 1988-89 year promises even more achievements. A sum of $2 million has been provided for the enhancement of clinical services within hospitals, and $3.2 million is provided for specific service developments aimed at increasing day surgery and post acute and palliative care so as to free up scarce acute hospital resources. An additional $500 000 is available for the treatment of AIDS sufferers. Within the social justice budget the commission will commence implementation of the UPK report, establish sobering-up centres at Port Augusta and Ceduna, and upgrade services for the disabled, including completing the devolution of residents of Ru Rua to community houses. Improved community, mental health and aged care services in country areas will also be implemented.

Funding will be provided to commence implementation of recommendations of the Steer Review of Services for the Intellectually Disabled, the Primary Health Care Local Government Program, and additional health and social welfare councils. The 1988-89 capital program will see the continuation of major works at the Adelaide Children's Hospital, Modbury, Lyell McEwin and the Royal Adelaide Hospitals, with work commencing at the Noarlunga Hospital site. In the country, the Riverland Regional Hospital, Mount Gambier and Port Pirie Hospitals will be redeveloped. In excess of $9 million has been provided for medical and computing equipment. In these difficult economic times the Government has shown its commitment to health services within this State by substantially increasing the level of capital resources, and increasing in real terms the level of recurrent resources available to health. The 1988-89 year will see health services build upon the achievements of the past few

years to create a better health system for all South Australians.

The CHAIRMAN: We are taking these lines together, as long as members bear in mind that the Chair has extraordinary powers and, if members disagree with my ruling, all discussion on this will cease.

Mr BECKER: An article on page 8 of today's *Advertiser* reports that regulations governing the manufacture of drugs and medical goods in South Australia are inadequate and that none of the State's 11 therapeutic goods manufacturers meet all the required Federal standards. Will the Minister explain why legislation to suspend or revoke drug manufacturers' licences has been in place since 1984 but regulations to enforce that legislation have not yet been drafted? Does the Minister agree with the Health Commission's therapeutic goods section manager (Mr Lloyd Davis) that, because of the defect in the legislation, the licensing system is an impediment to controlling the industry? Does he agree with Mr Davis's view that it is almost impossible to revoke the licences of South Australian manufacturers who produce substantive goods? What steps will the Government take to correct this situation?

The Hon. F.T. Blevins: I know as much about this issue as the honourable member because I only read it in the paper this morning, so I call on Mr Dadds for the information.

Mr Dadds: The licensing of therapeutic substances is currently carried out under regulation 100 of the Drugs Act. As a condition of licence, manufacturers are required to comply with a code of good manufacturing practice which is prepared at national level by the National Biological Standards Laboratory. One of the deficiencies in the current regulations is that the remedy for non-compliance with that code, whether they be major or minor, is the withdrawal of licence, which members would appreciate has important economic consequences for a business. For minor technical deficiencies, alternative approaches, such as the issuing of notices to make changes within a specific time, might be more appropriate.

Currently, a subcommittee of the Controlled Substances Advisory Council is preparing drafting instructions for new regulations relating to therapeutic goods, which will bring them under the Controlled Substances Act. These regulations were delayed to follow on the transfer of the poisons regulations currently under the Drugs Act when they were brought under the Controlled Substances Act. Unfortunately, the drafting of those regulations has taken much longer than expected. There have also been discussions at the national level about the introduction of Commonwealth legislation into the area of therapeutic goods and this would replace State legislation, as products are manufactured predominantly for the national market.

New South Wales has a fairly major commitment in this area at a State level, and it has important consequences that have not yet been resolved federally. In South Australia inspections of therapeutic goods manufacturers are carried out jointly by National Biological Standards Laboratory officers and the Health Commission, and reports of these inspections are followed up by State officers.

The Commonwealth Parliamentary Public Accounts Committee wrote in December 1987 encouraging the Health Commission to make a submission on the review that that committee was carrying out on the efficiency and effectiveness with which the Commonwealth carried out its therapeutic evaluation and testing function. That included a review of operations of the National Biological Standards Laboratory. The commisson put in a submission in February 1988. Subsequently in June 1988 the committee sought further comment on certain statements made by Commonwealth officers to the committee and a number of detailed questions were put to the commission.

A response was provided in August 1988 and Mr Lloyd Davis, the Health Commission's Manager of Therapeutic Goods, Public and Environmental Health Division, was invited to appear before the committee, which he did yesterday. The response of August 1988 by the commission indicated that the recommendations made from joint inspections were often numerous, making immediate implementation difficult for economic reasons which required priority to be established in requiring changes to be made.

An Australian owned pharmaceutical enterprise is not highly profitable, as shown by previous Commonwealth inquiries. Most South Australian manufacturers are small, with only one of international stature. All the inspections are unsatisfactory in the sense that there can always be recommendations for improvement and, if on exploring those unsatisfactory elements there is no avenue for the company to be made satisfactory, withdrawal of licence is considered. This can be a difficult process.

It has happened in the case of one sheltered workshop that packaged dressings locally. The commission's submission also indicated that local industry needs to be encouraged, consistent with adequate standards of manufacture. It should not be discriminated against in favour of international manufacturers.

The Hon. F.T. Blevins: I am sure the Committee will agree that that was a comprehensive response from Mr Dadds. I would make one other comment on this morning's *Advertiser* article. I am advised that some of the comments attributed to Mr Davis were not statements that he made: they were statements made by members of the committee. I just offer that caution in attributing some of the statements to Mr Davis, because I understand that they were not his.

Mr BECKER: I am waiting to hear the remainder of the response from the administrative officer who was interrupted by the Minister. It is important that we get the full story. We are now told that the *Advertiser* statement is incorrect. I do not care who said it. The article is there and it is important that we be advised fully as to the situation in South Australia. It has taken more than four years to get the regulations moving. The article does not read well for South Australia at all, let alone for South Australian manufacturers. It is most important that we satisfy the Commonwealth, and the people of Australia generally that South Australian therapeutic manufacturers meet the highest of standards. I would be interested to hear the rest of the report because what happens from here on is between the Minister and the paper.

The Hon. F.T. Blevins: The member for Hanson now has the full report. He can see that there are no secrets tacked on the end which I did not want him to have. I believe that I, and not a public servant, ought to have made the statement qualifying what was in the *Advertiser*. Then, if the *Advertiser* has any quarrel with what I said it can take it up with me and not with the public servant. I am sure that the member for Hanson will agree that that is a perfectly proper procedure.

The member for Hanson was selective in his quoting from the statement in the *Advertiser*—perhaps for brevity so as not to waste the time of the Committee—and he did not go on to quote the response from one of our leading drug companies to the reported statements that came from the committee. I think that that is unfortunate. I advise all members of the Committee to read the total article. I am not sure whether the member for Hanson was implying that the drug manufacturing industry in this State is somehow

below par or is in some way dangerous to the consumers of these products; but, if he was, I think that that is very unfortunate.

My understanding is that overwhelmingly the companies engaged in manufacturing goods of this type are reputable and ethical. Fauldings, in particular, has an international reputation, and I would not like the member for Hanson or other members of the Committee to in any way foster a view within the State or elsewhere that in some way it or other drug companies manufacturing in this State were not doing the right thing. There is no doubt that the legislation does not appear to be all it might be, and I will certainly have a look at that and have it tidied up where that is required. I think that what Mr Dadds told the committee confirms that. It is a complex area, but it is certainly not an area where I feel we ought to in any way denegrate the industry in this State. If there is any fault, it is in the legislation or the regulations and certainly not in the products—they have a well deserved international reputation.

Mr BECKER: That is pleasing to hear because that was what worried me: the article portrayed the message that none of the State's 11 therapeutic goods manufacturers meet all the required Federal standards. I am pleased that the Minister can reassure the Committee, South Australians and Australians that our manufacturers have the highest ethical standards; and I would have thought that that was the situation. I do not think that any company enjoys a higher reputation than Fauldings, and I am pleased that it remains a South Australian company because we nearly lost it at one stage. I think that Fauldings has a magnificent future with respect to what it is developing. Page 4 of today's *Advertiser* also states that public servants are banning the move to the new South Australian Health Commission/Department for Community Welfare offices on the corner of Rundle Mall and Pulteney Street. Apparently, they are dissatisfied with a range of issues, including inadequate space for staff, high and disruptive noise levels and the lack of security. The Chairman of the Commission, Dr McCoy, is quoted as follows:

> Delays [in shifting to the new premises] beyond the first week of October would cost the Government $200 000 a month in penalties to the building's developers.

The article also states that the commission borrowed $4.1 million to fit out the building for the move and that that had forced the commission to incur an extra payment of $720 000 a year in rental and debt servicing. Does the Minister believe that the $4 million loan to fit out the building is justified in view of the present dispute about staff accommodation and facilities, particularly as delays in shifting to the new premises might cost taxpayers an additional $200 000 a month; and were occupational health, safety and welfare requirements considered when the location and design of the offices was decided?

The Hon. F.T. Blevins: The newspaper article this morning accurately expressed some of the views that have been expressed to me by the PSA, that is, that it believes that the new building is inadequate for the number of people who will be using it. I have not done a detailed inspection of the building but there is no doubt that space will be tight. It may well be that some individual employees of the Health Commission and the Department of Community Welfare will have less space in which to operate in the new building than they do at the moment. In some areas the current space available in the Health Commission, and in DCW, is very generous indeed.

Mr INGERSON: Palatial!

The Hon. F.T. Blevins: The member for Bragg says 'palatial', but I have never yet seen working conditions for public servants that could, in any way, be described as palatial. However, it certainly has been indicated to me that some of the space is somewhat generous. Part of the rationale for moving to the new building was to have all the Health Commission people together instead of being dotted around the city in several different buildings and also to have DCW located with the Health Commission given their very close working relationship and the even closer relationship that is being fostered.

The Health Commission report—which I am happy to make available to the Committee—indicates that on all counts the new building does comply with all the various occupational health and safety regulations, etc. So, there is no technical breach by the Health Commission of any of the relevant Acts or regulations. However, that is not to say that people will not be working in smaller spaces than they work in at the moment. It would be a great pity if industrial action stopped the move. Of course, there is not a great deal that we can do about it. Fortunately, we do not have conscription of labour in Australia—certainly, not yet. All we can do is talk through the issues with the union.

I understand that the Health Commission building at 51 Pirie Street is not the biggest problem. The biggest problem is the Health Commission employees in the Savings Bank building and the DCW employees in the GRE building who are showing a reluctance to move. However, my experience over the years is that, if one keeps talking these things through with the union while making adjustments where that is possible, all disputes are eventually resolved. So, I am very confident that this dispute will be resolved.

The penalties mentioned by the Chairman of the Health Commission in the paper this morning are quite serious, and it would be a great pity if we had to curtail programs within the Health Commission purely because of this industrial dispute. That would be very much to the detriment of the people of this State and also to the employees concerned because, obviously, if we have to reduce programs, we have to reduce employees. That is highly undesirable and I hope that it does not happen. However, there will certainly be no additional allocations from Treasury or anywhere else. If we are faced with a $200 000 a month loss because of industrial action, it will be absorbed by the Health Commission and, as I said, that would be unfortunate.

The overwhelming benefits to the State of having all the Health Commission employees and the DCW located together speaks for itself and should not need elaboration. I regret the foreshadowed action, and I hope that we can talk our way through it so that it does not occur.

Mr RANN: Mention is made of the establishment of mental health teams in a number of country areas. Could you outline the progress in improving mental health services in our country areas?

The Hon. F.T. Blevins: That is an important question in which I think all members of the Committee would have an interest. There is no question that, as far as it is practicable, all South Australian citizens are entitled to the same level of health care and other Government services. Quite obviously, one cannot do everything in the country that one is able to do in the metropolitan area, but that certainly would not be a reason for saying that it is all too hard and that, therefore, the country ought to miss out. We certainly do not believe that that should be the case.

This Government is committed to fostering the best possible health care outside the metropolitan area as is the case within the metropolitan area. I have a personal and vested interest in this matter, because I am amongst the 300 000 people or so who live outside Adelaide. There has been considerable progress in this area. The Health Commission has been developing an operational policy to ensure that

mental health services are implemented throughout our country communities. It is proposed that city-based expertise will progressively devolve into clinically viable units, which will operate in many country areas. The plan includes a basic design of establishing local mental health teams in each region. It is planned that local community mental health nurses, social workers and psychologists will provide services in conjunction with regular, usually monthly, visits of city psychiatrists, psychologists and other experienced mental health professionals. As a result, a comprehensive specialist mental health service will be available for people within their own communities.

I will give just one practical example of a result which is very close to home. I refer to an example in Whyalla. A cooperative effort in planning between the management of Whyalla Hospital and the South Australian Health Commission has produced a specific plan for the establishment of a mental health team within the City of Whyalla. The team is part of an organised community health structure and will be based in Whyalla West, close to the residential population. The objectives of the team are to focus 50 per cent of the effort on the youth of Whyalla in an area which in the past has not received the attention which it perhaps has deserved.

Visiting services from Adelaide will continue at the same rate and will work with and complement the locally based service. An amount of $200 000 per annum has been assigned to this project from savings in budget made by the Whyalla administration so, in effect, all savings are being redeployed within the region. This team was projected to start in 1988. The team leader, a senior social worker experienced in mental health, has already been appointed to start in mid-October. Negotiations are continuing with several nurses to establish two or three community mental health nurse positions which are expected to be filled within the next few weeks. Advertisements have been placed for the position of clinical psychologist with the mental health team in Whyalla. A number of people, including an overseas psychologist with excellent qualifications and experience, have expressed an interest in the position. All in all, this past year has seen a breakthrough in this area for the people of Whyalla and, hopefully, before the end of the year we will have a functioning mental health service.

Mr RANN: The program relating to services mainly for adults with mental and behavioural disorders refers to a review of mental health services that was recently completed in South Australia. Could you outline the main recommendations of that inquiry and what steps are being taken by the commission to implement those recommendations?

The Hon. F.T. Blevins: This area is, and has been, a very difficult one for the whole community. A number of boarding houses are dotted around the metropolitan area and I am sure that most members of the Committee will have had some experience, in one form or another, of dealing with people in these boarding houses. I do not think that anybody could say that the present service, including the arrangements, the regulations or the control of these boarding houses, is totally satisfactory, but that is not to say that all of them are totally unsatisfactory. However, it is an area which does need attention and we have given it some consideration. I think that the area first came to prominence about 12 months ago, at which time the Human Services Committee of Cabinet acted promptly to establish the review. In an attempt to identify the main areas of concern, a survey of all boarding houses was undertaken and one of the most significant findings was that 55 per cent of respondents considered that the needs of disabled residents are not being adequately met. That is a very high figure.

The major forms of assistance sought are recreational work activities for residents, together with social work support. As a result of the review, during this financial year the South Australian Government will make available $239 000 of new initiatives funding under the social justice strategy. I think that this is an area of such importance that the Committee would welcome some further elaboration. I would like to invite Mrs Judy Hardy, who is the Principal Planning Officer, Mental Health, to give the Committee some further details as to what the Health Commission is doing in this particular area.

Additional Departmental Adviser:

Mrs J. Hardy, Principal Planning Officer, Mental Health.

Mrs Hardy: This review was established following allegations about a year ago of abuse, neglect and exploitation of psychiatrically and intellectually disabled persons in boarding houses. Little was actually known about the population of these boarding houses, so it was necessary to undertake a survey. With some difficulty, because no records are kept anywhere of these places, we were able to identify 31 boarding houses. We distinguish these from lodging houses, in that boarding houses provide personal care services over and above just board and accommodation.

In fact, 25 managers of boarding houses completed questionnaires and nine of those 25 boarding houses were owned by three proprietors. Of the six that did not complete the questionnaire, we are aware that three of the boarding houses are owned by one proprietor, and they are exclusively occupied by psychiatrically disabled people. The 25 in respect of which the questionnaire was completed, contained 387 beds, and a staggering 48 per cent, or 185 people, were actually receiving treatment for psychiatric or intellectual disability. A further 6 per cent, or another 23 people, had such a disability in the view of the manager.

We were surprised to learn that 73 per cent of the residents had been at the same place for greater than one year, because we had been told that these people moved around a lot and did not actually stay in one place. So, it is quite clear that this is the permanent home of many of these people.

Licensing is provided for in the Local Government Act 1934 and the Health Act 1935, but it is not mandatory, and only 11 of the 25 councils have chosen to enact by-laws or regulations relating to boarding houses. This in itself has caused some significant difficulties. The role of the boarding house has changed over the last 25 years and a new population has emerged. This has been possibly encouraged by the deinstitutionalisation practices that have occurred in this State and the fact that adequate community based services have not kept pace with these deinstitutionalisation practices.

Also, there has been a failure to recognise the changed role of boarding houses in the planning of supported accommodation services. This has led to a number of problems, particularly the fact that the residents of these places have no rights whatsoever; they can be evicted at any time with no notice, and they can be charged whatever the management decides for no services whatsoever or for very minimum standards of care. There is no support for staff and there is no support or financial assistance for people living there. The clientele is difficult: many of them are similar to those currently in mental hospitals in the accommodation program and in rest homes, but the majority of them are quite young and have multiple problems which have been compounded by alcohol and drug abuse. As a result they have quite significant behaviour disorder problems as well.

The majority have lost contact or no longer fit the admission criteria of the established mental health services. So these people have problems maintaining or even obtaining accommodation, managing their finances, and accessing services. Minimal public health standards exist in relation to physical conditions but none exist in relation to the care of residents.

There is currently widespread support for the development of physical and quality of care standards not only for boarding houses but for all places providing supported accommodation, and there are a range of these. The committee, comprising representatives from the Health Commission, Department of Community Welfare, local government, and the Commissioner for the Ageing, have developed proposals for generic legislation which we hope will move forward shortly. However, the most critical thing in the view of the committee of review was that an immediate safety net be established in the form of support services to disabled residents in boarding houses. The $239 000 that the Minister mentioned, which has been allocated in initiative funding for this year, will allow this to commence.

The model most appropriate for this is community based support services comprising workers who have skills and flexibility to provide a practical hands-on case management service to a wide range of disabled persons no matter what their diagnosis. Establishment of this service, facilitated by extension of existing mental health accommodation programming, will occur rather than the establishment of a totally new service. The service will be regionalised, and additional staff will be employed to enable community support services to be established, comprising social workers, occupational therapists, community mental health nurses, activity supervisors and direct care workers, and clinical services will be provided by visiting clinicians. Via this mechanism, direct care will be provided to psychiatric and borderline intellectually disabled residents where they choose to live because many of them are not capable of going to services and accessing them for themselves. They will be assisted to obtain and maintain accommodation, to participate in activities, to undertake training programs as appropriate and generally be assisted to access the services that they need.

We believe, as a result of doing this first study into boarding houses, that there are in fact just as many, if not more, such people requiring assistance living in lodging houses, and increasing numbers are also living under bridges. In addition, many families require assistance to relieve the burden of caring for disturbed relatives day after day. This program will require additional new funding over the next few years.

Mr RANN: Can the Minister briefly outline the contribution which the Health Commission has made to the Government's social justice strategy in this financial year?

The Hon. F.T. Blevins: The Government's social justice strategy is a cornerstone of this Administration. There is no question that the Government has put the economy of this State on a very sound footing, and we would not be content with that as a Government unless we were delivering social justice to the people of South Australia. I would be out of order if I went through the entire social justice program that the Government initiated in the last budget, but suffice to say that it is very extensive. It includes a great deal of reallocation within Government departments, including the Health Commission, but many millions of dollars has also been added to departmental budgets to enable the Government's program of social justice to be pushed forward even further.

Most of what the Health Commission does could come under the title of social justice. It is difficult to isolate any particular initiatives and assume that was all that the Health Commission did in social justice, because that is not the case. The vast bulk of the billion dollars that we will be spending in 1988-89 could very easily come under that heading but certainly, within the budget papers presented to Parliament, specific initiatives were outlined, and they include a total $1.122 million for 1988-89 through that separate social justice budget.

I am happy to outline how the Health Commission will use these funds. The UPK report on environmental and public health implementation will receive $56 000. Country Aboriginal health services, including drug and alcohol education, sobering-up centres at Ceduna and Kooniba and antenatal programs, will be allocated an amount of $310 000, which is very extensive. In the disability areas, which are long overdue for additional funding, the Government is pleased to be able to provide $318 000 to fund an ongoing program of devolution of patients from Ru Rua into the community, in line with the Government's and modern thinking.

Psychiatric and intellectually disabled residents at boarding houses will be provided with $239 000 in assistance. Mrs Hardy has just detailed the problems within the community in this respect, and it is certainly part of the Government's social justice package. The problem of child sexual abuse remains a high priority of this Government. Problems in this area are being brought increasingly to our attention, but I am not qualified to say whether that is because it is an increasing phenomenon or whether it is because there is better or more frequent reporting. Nevertheless, the Government has provided the Health Commission with another $119 000 in this area. Dental services have received $80 000.

In addition, through reallocation within the Health Commission, there will be an overall figure of $1.23 million in a full year, and I will break that down for the Committee. Of that amount, $425 000 will go to improved community health services in country areas, about which I am particularly proud. Aged care services in country areas will receive $185 000, and improved mental health services in country areas will receive an allocation of $390 000. The Government will also provide $230 000 to assist in dealing with the social and behavioural problems of schoolchildren, which is an unfortunate problem that the community must deal with. The Health Commission has played its role in the Government's social justice strategy both in reallocations and in coming up with very worthwhile projects for the new funds that the Government has been pleased to supply.

Additional Departmental Adviser:

Mr D. McCullough, Executive Director, Corporate Services.

Mr BECKER: What is the list of demands that have been made by the Public Service Association in relation to the office accommodation at the Citi Centre development? When will Health Commission officers meet with the PSA to resolve the impasse?

The Hon. F.T. Blevins: I am happy to supply the honourable member for Hanson with the letter that I received from the PSA and my response to the demands. Discussions with the PSA have been going on for some time. A steering committee has been dealing with the move and accommodation for 12 months, so it is not something that has suddenly come upon us. However, even with the steering committee, there appear to be a few problems in a couple of areas, but I am confident that we will be able to talk

them through in a spirit of give and take and come to an accommodation that is satisfactory to all.

Mr BECKER: Whilst on the subject of the Citi Centre development, over what period is the $4 million loan being repaid? At what rate of interest was the loan negotiated? What will be the full repayment figure of that $4 million?

Mr McCullough: The period of the loan is 10 years. It will be negotiated directly with the State Treasury Department and there is some flexibility in that because it has been indicated that it may be possible to flex the loan to 15 years if that is required. However, at this stage, it is envisaged to be a 10 year loan. The rate of interest will be set by SAFA in accordance with the normal borrowing requirements for the State, and that rate is not disclosed. However, it will be the normal SAFA rate. The total funds envisaged to be borrowed amount to $4.5 million, which will cover the fit-out costs and the cost of decommissioning existing accommodation. The total repayment will be met by the Health Commission over 10 years. The source of the funds will be savings generated from within central office costs. They will be exclusive to the central office and no funds will be withdrawn from health units or direct service delivery.

Mr BECKER: What justification does the Minister have for the commission's incurring a $720 000 a year additional payment to cover rental and debt repayments? How many staff positions will go to achieve the $752 000 a year savings which Dr McCoy says will be attained by moving to the new premises?

Mr McCullough: The savings over 10 years are documented in evidence given to the Public Works Standing Committee. The savings were identified at that stage as $4 159 000 over the 10 year period, to be derived from attrition of staff as result of economies achieved from the joint location of the different parts of the Health Commission central office and public and environmental health services. As to the situation this financial year, savings of $750 000 have already been achieved as against the increased cost of $720 000. So, as from the first year, we are on target. The target set for the first year was $597 000 in accordance with the evidence given to the Public Works Standing Committee, and we have achieved $750 000.

Mr De LAINE: I refer to page 332 of the Program Estimates and the aged and physically disabled program. Can the Minister report on the progress of the day centre for head injured people?

The Hon. F.T. Blevins: The day centre building has been completed in the grounds of the Payneham Rehabilitation Centre. The facility is already up and running and the coordinator was appointed in June this year. The centre is open for clients three days a week and it may be necessary to extend that later. There is the capacity to cater for up to 15 clients a day. I am pleased that another program, which at this time last year was still being planned, is now in place. The centre for head injuries is a good example of that. So the Estimates Committee is a good way to measure the progress or otherwise made over the previous 12 months. I have been pleased in all my portfolios to look at the line estimates and briefing notes at the end of 12 months and see how much progress has been made, and this project is a good example of that progress.

Mr De LAINE: I refer to the intellectually disabled services program at page 333 of the Program Estimates and the devolution of the Ru Rua Nursing Home. Can the Minister report on the program of establishing alternative accommodation for residents?

The Hon. F.T. Blevins: I hope that members understand the policy if they have not visited Ru Rua to see the conditions and the absolute need for change. It is Government policy, and therefore the commission's policy, that Ru Rua be closed down gradually (certainly for this purpose) and that residents be devolved into smaller living units in the community. We would all agree that that is a good policy with a highly desirable objective. As at 31 July 1988, 16 Ru Rua residents had been relocated to community based houses.

The remaining 80 residents will be relocated in April, May and June 1989, so by mid 1989 Ru Rua will be empty. Costs are associated with any program, but these are funds that we are happy to make available. This year we are allocating $447 000 to enable the complete devolution of patients from Ru Rua into the community. Ongoing resources will be required and we estimate that our expenditure will have to increase by over 100 per cent over this year for this program, and about $1 million will need to be made available in 1989-90.

This is necessary because we cannot tell people that they are to live in a different environment, that they are going back into the community and they are then on their own. That has been tried elsewhere with quite tragic results and South Australia is certainly not going down that track. I am not saying that, where this policy has been found wanting elsewhere, there has not been goodwill, but resources are needed to enable the community to take care of people who would otherwise be in an institution. It is possible that residents could be better maintained in Ru Rua rather than to be kicked out and told that they were on their own. I ask Ms Johnson to comment further.

Additional Departmental Advisor:

Ms C. Johnson, Executive Director, Statewide Health Services.

Ms Johnson: As the Minister has outlined, 16 people have moved out of Ru Rua at Estcourt House. There has been much planning to facilitate the relocation of the remaining 80 residents. Parents of residents have been heavily involved in that planning. Committees have been established and much consultation and thought has been given to the location of residences, the style of residences and the type of residents who will live together in any one house. Residents are involved in selecting furniture, working out where they will sleep, and so on.

The next nine months will involve much activity in enabling the remaining 80 residents to move. Funds from the sale of Estcourt House in a few months will be used to purchase the remaining residences, and to purchase motor vehicles to enable residents in houses to have access to community services. Also, day services for residents will be expanded when they have moved out of Ru Rua, and there has been considerable planning to enable day services to be available in sufficient range and size.

Mr INGERSON: Will the Minister provide answers to the following questions: how many cars permanently or regularly available to Health Commission employees for travel between work and home have been fitted or are about to be fitted with private registration plates? During the past financial year what was the total amount of sick leave taken by Health Commission employees? How many of those days were not covered by medical certificates? How many days not covered by medical certificates were taken on a Friday, Monday, or a day immediately before or after a public holiday?

How many land or building sales of assets owned, formerly owned or under the control of the Health Commission occurred last financial year? Can those sales be itemised,

giving the location of the property, the sale price, and the names of both the agent and the buyer, and stating whether the sale was conducted by auction, advertised sale or private negotiation? What Health Commission properties are planned for sale this year?

The Hon. F.T. Blevins: Yes, eventually.

The CHAIRMAN: I am not sure whether anyone can absorb questions like that.

The Hon. F.T. Blevins: I did very easily, Mr Chairman, and I will supply the answers eventually. Absorbing the questions was no problem: finding the answers may take a little longer. However, we will not stop the operations of the Health Commission while everybody searches for these answers.

Mr INGERSON interjecting:

The Hon. F.T. Blevins: In good faith we will try our best to supply answers to those questions at the earliest possible time. Whether or not those questions can be answered in 10 days, I have no idea; but we will certainly do our best.

Mr INGERSON: Mr Chairman, my understanding is that if a question is accepted by the Minister the requirement is that it be replied to within 10 days.

The CHAIRMAN: The Chair is not in a position to require an answer of any magnitude from the Minister; it is up to the Minister as to how he answers the questions. The honourable member has a multitude of ways in which to obtain the information he requires. As the day proceeds he can ask more questions. I understand that this line will go until 6.30 p.m., and the honourable member can come back and ask more questions of the Minister if he so desires. He may request that this information be tabled in *Hansard*, for which there is a time limit of 7 October. If it comes down to a determination, the Chair is not in a position to force information being given. The idea of this Committee is for members to continuously ask questions on the budget line, and that is the way in which we will proceed.

Mr INGERSON: There was no intent to ask the Minister to supply the answers today. I asked those questions together because they are statistical in fact, recognising that a lot of work was involved. I understood the Minister to say that he would supply answers, and I was only questioning whether that could be done by a fixed date.

The Hon. F.T. Blevins: I will supply the answers and I hope that they will be satisfactory to the member for Bragg. However, they may not be. Some of the information he requires is available through the Auditor-General and I have no control over whether he will supply the information to us so that it can be passed on to the honourable member. As for the work done in relation to sick leave, etc., by the Auditor-General, I will attempt to get those answers for the member for Bragg within 10 days. If that is not possible then with the best will in the world the member for Bragg will not be getting his answers.

It may be that the effort required to seek out some of that information is grossly in excess of its value to the Committee, in which case we will not, to satisfy the member for Bragg, put into it those huge resources and stop doing other things in the Health Commission. All Governments have followed that policy for the 13½ years that I have been in this Parliament, and I am sure that that policy has been followed for longer than that. When questions of this nature require an army of people to go through dockets and files for ever and a day for no perceived benefit, other than to satisfy the curiosity of the member who asked the questions or to tie up a Government department for a while, then obviously we do not do it. As I said, I always approach these Committees with respect and deal with the questions in good faith. Wherever it is possible for me to assist the Committee, either now or in the future, I will be pleased to do so.

Mr INGERSON: I hope that the Minister was not suggesting that on any line he would refuse to supply information to the Parliament, because I would have thought that that would be a different question.

The CHAIRMAN: Order! I point out to the honourable member—and I thought that I previously tried to do this rather gently—that there are ways and means available to him to obtain information. When Parliament resumes he may ask a question during Question Time, or at any other time he may move a substantive motion. He also has the opportunity to ask questions in this Committee. Neither the Chair nor the Committee has the powers of a Royal Commission. The Committee cannot force the Minister to give information he has no desire to give.

Mr INGERSON: A letter from a constituent, expressing concern about changes to the Hampstead Centre and about budget cutbacks and their effect on patient care, states:

> As you are aware, my father is a quadriplegic and has lived in the (Hampstead) centre for the past nine years. During my last visit, there has been unrest among staff and patients about a possible ward closure . . . I have been informed of an enormous cut made recently to the centre's budget, which confirms the closure of a ward. This cut has been an immediate shock to the centre with little warning or reasoning behind it. I am led to believe this is the third cut to be made to the centre in the same number of years. As you can imagine, these cuts and ward closures have a very traumatic effect on the patients and staff. What eventuates with the ward closures is that a social worker is employed to relocate the patients and staff to rest homes and other hospitals. This is very disturbing and disruptive to these disabled and aged people. For many of them, the Hampstead Centre is all they have and has been their home for many years. The other disturbing factor is that the relatives and friends of the patients are never directly told of these changes and are always the last people to know.
>
> In regard to my father, if he is required to move from the centre, the effect would be devastating to him. Even to move from his room is disruptive enough, with this being his fourth or fifth move in nine years.

The letter is signed by Mr Greg Reeks of Berri. Will the Minister confirm that the Hampstead Centre has had a cut of $380 000 in its budget this year—or $800 000 in real terms? What has been the reason for this 11 per cent cut in real terms funding, and what effect will it have on patient care and services? Will the Minister confirm that the number of available beds has been reduced from 96.3 beds in 1986-87 to 87 in the year ended 30 June 1988, and, I believe, further since? If so, was this cut a consequence of repeated budget reductions? What effect has this reduction had on patient care? Have patients been relocated to other institutions? If so, where? Are there plans to further reduce bed numbers at Hampstead Centre?

The Hon. F.T. Blevins: There is a whole series of questions there. Some can be answered immediately and some I will have to take on notice. However, again, I want to clarify the point for the benefit of the member for Bragg; that is, in relation to taking questions on notice and how I will be handling it. It is not a question of not giving information to Parliament: it is following the procedure of this Government, previous Governments and all Governments that I can remember—and probably many more before then—that if the amount of time and resources required to answer a question produces no apparent benefit, then the Government will state that quite clearly as the answer to the question. The Government makes it perfectly clear that it does not believe that the time, the resources and the disruption required to answer a particular question is warranted. So, there is no question of not giving information to Parliament. It may not be the information that the hon-

ourable member has requested, but it certainly is information, and that is why we have elections.

It is unfortunate that this question has been asked during the Estimates Committee. In my view, it is tantamount to abuse of the Committees to use them in this way: to bring up an individual case of someone who is apparently going through a difficult period and to name them.

Mr INGERSON: They asked to have it done.

The Hon. F.T. Blevins: So, they asked for it?

Members interjecting:

The CHAIRMAN: Order! I would not like to be in a position where I had to name somebody because, if I had to name somebody, this Committee would cease operating immediately and Parliament would have to be called together at 9 o'clock tomorrow morning. When I ask somebody to stop interjecting I expect them to do so. I want this Committee to be conducted in the way that all Estimates Committees have been conducted so far, and that is without interjections, allowing for questions and answers as we examine the operations of the department concerned. The honourable Minister.

The Hon. F.T. Blevins: I concur with that. I do not think we have touched on a single line yet. The Opposition appear to have absolutely no interest in the material provided in the blue book. It is disappointing to me because a tremendous amount of time has gone into preparing information to give to the Estimates Committees. It would be a great pity if all that we give them is responses to this morning's *Advertiser*—with due respect to the *Advertiser*. Had there not been those two stories in the *Advertiser* this morning, the Committee might have finished and adjourned at midday.

However, I believe that it is an abuse to name people who may be having problems at the moment. I do not think that is what Estimates Committees are for. The policies of the Health Commission and the Government in relation to the Hampstead Centre have been long announced and well explained to the community. They are explained to the people residing at Hampstead Centre. We do not hamfistedly deal with people in the way that the member for Bragg has stated.

I would appreciate the permission of the Committee to ask David Blaikie, who as Executive Director of the Metropolitan Health Services is directly responsible for the area in which the Hampstead Centre fits within our organisational structure, to outline the Government's general policy in that area and to outline to the Committee what has happened so far, including the extent of bed closures and the forward program.

Additional Departmental Adviser:

Dr D. Blaikie, Executive Director, Metropolitan Health Services.

Dr Blaikie: First, as background, I am sure the member for Bragg is aware that the Hampstead Centre is an annexe of the Royal Adelaide Hospital. It is an annexe that provides a range of medical rehabilitation services, surgical rehabilitation services, a spinal injury unit, as well as nursing home care.

In fact, some bed numbers were given which do not seem to agree with the information I have. Currently there are 162 beds at Hampstead Centre, of which 75 are nursing home beds. The remaining are rehabilitation beds. It is interesting that this year the Royal Adelaide Hospital has conducted a major strategy planning study and as part of that study the Royal Adelaide Hospital itself has defined the Hampstead Centre's primary role as rehabilitation. As a result of that, the provision of all permanent nursing home care will be progressively withdrawn from that centre. That was one of 171 recommendations in the Royal Adelaide Hospital's strategic plan which has been released.

There have been 50 nursing home beds closed at Hampstead in the past two years. Indeed, it is part of the Government's budget strategy and that of the Health Commission to close a further 25 beds in the current year. That will leave 50 nursing home beds at the centre.

There are many reasons behind the decision to close, one of which I have just mentioned: the Royal Adelaide Hospital's own strategy plan. However, in the first place, according to the Commonwealth Government's criteria South Australia has too many nursing home beds. In addition, the north-eastern area of Adelaide, where Hampstead is located, has a plentiful supply of private nursing home beds. Further, changes in the funding arrangements between the State and Commonwealth Governments would suggest that the State Government does not need to be as heavily involved in nursing home care as it has been in the past.

With respect to this particular closure, this year, as on previous occasions mentioned by the honourable member, a social worker will be employed to progressively relocate patients from the centre. Of course, the first strategy is not to put new patients into beds but to move them voluntarily, as has been the case in the past two financial years, to alternative locations.

I do not know the specific details of the case quoted to the Committee. I think it is important to say that the closure of these 25 beds will provide space in the main Hampstead Centre site for relocation of the spinal injuries unit, which is currently in very poor accommodation in that area and which has been part of the State Government's announced property rationalisation program. I am certain that the end result of that exercise will be to have a very efficient and well accommodated rehabilitation centre at the Hampstead site, but there will be some remaining nursing home beds which will be used more for short term and respite nursing home accommodation.

The Hon. F.T. Blevins: Now that the member for Bragg has named the patient concerned, I will have the queries raised by that patient investigated and I will get back to the member for Bragg, if not the whole Committee. It was made quite clear in Dr Blaikie's report that patients are only moved to alternative accommodation on a voluntary basis.

Mr INGERSON: My next question relates to the metropolitan hospital budgets. Will the Minister confirm that Adelaide's six metropolitan general hospitals, the Royal Adelaide, Flinders, the Children's, Queen Elizabeth, Modbury and Lyell McEwin are collectively being asked to take budget cuts of almost $13 million during this financial year? If so, will he explain how these hospitals will maintain current standards of patient treatment and facilities? If cuts of the order mentioned are not being sought, what new budget allocations have been negotiated for each of these hospitals and what were their actual allocations during the past year?

The Hon. F.T. Blevins: Obviously, the series of questions asked by the member for Bragg are in writing. If he could give us the written questions, it would make it easier to go through them one at a time to enable us to answer them with complete accuracy.

The CHAIRMAN: I think that is a perfectly sensible suggestion. It is up to the honourable member whether or not he wants to supply the questions but, if he could do so, it would certainly assist the Committee.

The Hon. F.T. Blevins: I have the exact figures for each metropolitan hospital. I am happy to read those figures into

the record and, if the member for Bragg wishes to ask questions, I think that would be a more productive way of going about it. Given the multi-faceted nature of the question, today I can outline our policies and finances for the metropolitan hospitals and point out, as I did in my opening statement, how the overall funding for our hospital system has been maintained in these difficult times. If the member for Bragg does not want those overall statements, it would really be helpful if he would give us the specific questions. I will relate the savings which have been requested by the metropolitan hospitals as a contribution to the 4 per cent second tier wage award. That award followed a decision handed down by the Industrial Commission. There was significant agitation in Parliament to ensure that the savings were real savings and that the 4 per cent was not paid as a wage increase without meeting the Industrial Commission's requirements of offseting productivity increases.

These are just some of the offsetting productivity increases which have been allocated to our metropolitan hospitals. They do not come anywhere near the 4 per cent. Of the total budget of the various hospitals, they represent only 0.45 per cent. In dollar terms, for the Royal Adelaide Hospital, it is $609 750; for the Queen Elizabeth Hospital, $394 900; for the Flinders Medical Centre, $384 950; for the Modbury Hospital, $129 650; for the Lyell McEwin, $95 100; for the Queen Victoria Hospital, $95 900; for Glenside Hospital, $118 100; and for the Hillcrest Hospital, $112 600. It may be of interest if I detail a few of our other major health units and the productivity savings as a contribution to the 4 per cent which we expect from those health units. For the Hutcheson Hospital, it is $14 400; for the Southern Districts War Memorial Hospital, $7 300; and for the Noarlunga Health Service, $14 700. That is a smaller contribution from those hospitals than from the group to which I referred earlier and it is only 0.4 per cent of the total allocation to those hospitals.

The community health centres will also be asked to make a contribution to productivity increases under the 4 per cent and that will be a gross contribution of $150 000, which is only 0.33 per cent of their total budget. We appreciate that, in some health units, it is easier than in others to make savings. One cannot expect the same degree of savings in very small health units as one can achieve in a much larger organisation and we have taken that into account. Whilst complying overall with the decision of the Industrial Commission, we have not asked for any savings from community health programs with gross allocations of less than $150 000 and certainly none from the domiciliary care services and grant funded agencies. We will compensate elsewhere within the Health Commission for those units not having to make savings.

I could provide much more detail on this issue, but it is important that the order of the Industrial Commission be complied with and that the 4 per cent productivity savings or some contribution towards them be made. Those agreements were made between the unions and me when I was Minister of Labour. I am pleased, as I am sure all members of the Committee are pleased, to be able to carry it out and to demonstrate that those agreements we made were not sham agreements or concocted for paying a wage increase but, rather, they were genuine agreements and the evidence of that is before us.

Mr INGERSON: As part of the question has not been answered and I understand what the Minister has said about its complication, may I request that the second part of that question be answered in writing to the Committee within the statutory requirement of the ten days? Basically, we are asking for the new allocations to those hospitals and I know that is a statistical thing.

The Hon. F.T. Blevins: I take issue with the member for Bragg's use of the term 'statutory requirements'. There are no statutory requirements at all, as has been explained, but I think the best way to assist the Opposition and to assist the entire South Australian community to understand, will be for me to obtain a breakdown for each hospital and a comparison with last year, showing the allocations. Following information from the Federal budget, some of the allocations have not even been notified to the hospitals as yet. If there is time after lunch I would be happy to go through all those figures for every hospital but if the member for Bragg chooses to have them tabled rather than given to the House, that is fine. If the honourable member turns to the blue book he will find virtually all that information on statement No. 8.

Mr TYLER: For some time now there has been talk of a merger between the Adelaide Children's Hospital and the Queen Victoria Hospital. Can the Minister give the Committee some details of the progress of this proposed amalgamation?

The Hon. F.T. Blevins: This is one of the most exciting issues that I have had to deal with for a long time. I am sure all members would be aware of the background to this issue: the fact that the Queen Victoria Hospital is showing its age and it either had to be redeveloped or relocated. The Government was not going to say to the board of the Queen Victoria Hospital, 'I am sorry, you will have to close down, it is far too expensive to renovate that building and we will build you a nice new building elsewhere'. We do not deal with our health units in that way. The Queen Victoria Hospital is dear to the hearts of a lot of people in South Australia and quite properly so, so we would not adopt that particular attitude. Neverthless, the board of the Queen Victoria itself realised that perhaps the refurbishing of the hospital was not the best way to go and that a relocation in a new building would serve the needs of mothers and babies in this State better than refurbishing the old building on that particular location.

The issue arose some three or four years ago and I do not want to go back over its history, but extensive discussions have taken place between the boards of the Queen Victoria Hospital and the Adelaide Children's Hospital over those years. I am absolutely delighted and so is the Government that, in October of last year, the boards of the Queen Victoria and the Adelaide Children's Hospitals gave approval in principle to the establishment of a new corporate body to discharge the roles and functions of the two hospitals from the Adelaide Children's Hospital site, provided the following conditions were met.

Those conditions were: the completion of construction by December 1992 and the transfer of the Queen Victoria Hospital services to the Adelaide Children's Hospital site by February 1993. So, they wanted a relatively quick building program and we agree that that is highly desirable. Another of the conditions that the two boards put on their approval in principle was the provision for adequate car parks to meet the needs of the new hospital and I believe we can only say 'hear hear' to that. The development of an agreed constitution is obviously a must. While I am happy to help them in developing this agreed constitution, I do not envy the task of those who are drawing it up. It will be a difficult exercise and one which I believe will be ultimately successful. Another condition covered the provision of sufficient funds in the interim to ensure the maintenance of proper levels of services and facilities at the Queen Victoria and Adelaide Children's Hospitals. I can only say that it

goes without saying that this Government will ensure that services and facilities at both those hospitals continue until the new premises are built, both boards noted that proposals for a pregnancy advisory centre and paediatric research institute predate the amalgamation proposals and are to be funded separately.

For the interest of the Committee I would like to outline some of the project details, for example, the physical facilities that will be provided. In December of 1987, Cabinet gave approval in principle (as all members would remember) to the construction of new capital facilities at the Adelaide Childrens Hospital site at an indicative maximum estimated cost of $30.85 million and agreed to the timetable that had been proposed by the two boards. Proceeds from the sale of the Queen Victoria Hospital at Rose Park obviously are to be used to offset the capital cost of the new project. The project provides for the sharing of numerous facilities and the construction of a new building containing Admissions/Outpatients Department, two 26-bed post natal wards; 34 bed anti-natal ward including 12 low dependency units; 18-bed high dependency delivery suite; neo natal intensive care and special care unit; ultra sound and laboratory facilities. They will be added to the Adelaide Childrens Hospital facility. Integrated university and staff specialist accommodation is also proposed.

The outcome of all this will be that obstetric bed numbers (at present 86) will remain the same as currently at the Queen Victoria Hospital. Level 2 neo-natal cots have been increased by 2, to 37 and level 3 neo-natal cots have been increased by 1, to 15 in accordance with the recommendations of the Neo-Natal Services report. Provision has been made to replace existing Adelaide Children's Hospital beds with 15 gynaecology beds—half of the present Queen Victoria Hospital establishment.

The amalgamation feasibility study estimated that the proposal has the potential to generate cost savings of approximately $2 million per annum once the hospital has been established. The draft constitution has been developed for formal ratification by the two boards, some time during this month. The target date for the dissolution of the two hospitals and the creation of a single corporate body has been set for 1 February 1989. Briefing work for the design of the new buildings has already commenced. Demolition of the Florence Knight building is to commence in April/May 1989 and an amount of $290 000 is available in this capital works program. Construction of the new buildings is due to commence in July 1990 and, as requested by the joint boards, it is expected to be completed by December 1992.

Planning approval for one of the most critical areas of the new complex, that is, the car park, has been sought for what will be a self-funding multistorey car park. That is currently before the Adelaide City Council and the City of Adelaide Planning Commission. The project is well under way and I cannot praise too highly the two boards concerned for the way they have worked at this very difficult and complex amalgamation. It is really a credit to both those boards that they are now so far down the track that there are commencement dates and finishing dates.

Mr TYLER: An issue of concern, particularly to nurses, that has been around for some time is that of staff parking facilities at the Royal Adelaide Hospital. The Minister made an announcement a few weeks ago about a proposed car park at the hospital. Can he supply the details?

The Hon. F.T. Blevins: The car park issue at the Royal Adelaide Hospital has been a matter of some controversy for a fair while. At the moment, there is provision for 782 car parking spaces at the hospital. For a number of years, shift workers, visiting medical officers and other staff have argued that the position is totally unsatisfactory. There has been an ongoing saga of potential remedies for the problems and numerous options have been put together over the years, but none have been satisfactory. However, after very extensive consultations with unions, the Adelaide City Council, conservation societies, the Health Commission, the Department of the Premier and Cabinet and many others, Cabinet was pleased to give an in-principle agreement in June of this year to the construction of two multistorey, five-level car parks providing a total of 1 305 spaces.

The program is as follows: construction of a 577 space five-level car park on Adelaide City Council owned land immediately south of the Royal Adelaide Hospital Chest Clinic bounded by Frome Street and Vaughan Place; and construction of a 728 space car park in the northern precincts of the hospital on land owned by the IMVS and RAH. Construction of the Frome Street car park is scheduled to commence in 1988-89 and, on the evidence available, should be paid for from staff and visitors' charges within 10 years. The construction of the northern precinct car park is due to commence in 1996 or 1997 or earlier if possible and, on completion, will allow the return to parklands of approximately 1.8 hectares of land north of the medical school.

The proposal that I have outlined, to which Cabinet has agreed, lines up with the Government's quite clearly stated position on this question of car parking. It has to be self-funding because the Government is not in a position to provide funds for the car park, so the staff have to fund the car park themselves, and that has been agreed to. The Government also determined that the proposal needs union support, and that has been achieved. It must also be acceptable to the City of Adelaide Planning Commission and allow the return to parkland of land currently used for car parking, in accordance with the City of Adelaide Plan. The proposal is before the Planning Commission and the City of Adelaide. Hopefully, the outcome will be favourable.

Staff charges are estimated to be $8 a week in the multistorey car park and $6 a week for all other spaces within the precinct. Those charges will be indexed in line with the CPI. I do not know what commercial costs are, but $8 a week appears to be very reasonable. The important part is that the car park is to be self-funding. It is not a profit-making concern of the Government. If it were a commercial operation, about $40 a week could be charged but that is not the idea. Staff have helped the Government enormously in this. In addition, 150 of the 1 305 car parking spaces are to be provided for staff of the South Australian Institute of Technology nearby. Given the complexities of the North Terrace precinct, I am sure that part of the proposal will be welcomed.

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

Mr TYLER: Earlier this year the Government announced that several Health Commission properties would be sold to provide funds for relocation of services to more appropriate accommodation. What progress has been made in that rationalisation program?

The Hon. F.T. Blevins: The program began in January this year when Cabinet gave its approval for the proceeds from the sale of a number of Health Commission properties to be used for capital works associated with the relocation of services to more appropriate accommodation. Many of the properties are 'mansions' originally built for residential purposes. They require constant maintenance and are not suitable for office accommodation and are not readily acces-

sible by public transport. The Government's program is in several stages and I will refer to progress in stage 1. Certainly, some of our properties are in the process of being sold under stage one. The sale of Marden Hill, which is located on O.G. Road and was previously used as a 'drop-in' centre for clients of the Intellectually Disabled Services Council, is in progress.

The sale of Moorcroft House on East Terrace is in progress. That building is currently used as offices for the Mental Health Accommodation Program. Also in progress is the sale of surplus land and buildings at Hampstead Centre, which is an annexe of Royal Adelaide Hospital, and at present it provides a broad range of nursing home, medical rehabilitation, community health and domicilliary care services.

Also in the process of sale is surplus land and buildings at Payneham Rehabilitation Centre, which is currently occupied by the Head Injury Service for outpatients, a service which was previously provided by the Commonwealth Government but which is now the responsibility of the Julia Farr Centre. The funds from the sale of those four properties will be used to relocate the Spinal Injuries Unit from the Morris site to the main Hampstead site; to purchase community housing for the intellectually disabled; to provide outpatient facilities and a day centre for head injury patients at the Payneham Rehabilitation Centre; and to relocate the Mental Health Accommodation Program to the Payneham Rehabilitation Centre.

Members will be aware that it is difficult in these times of financial constraint and essentially a contracting public sector to not only maintain programs but also add new programs and improve the existing services. The commission is fortunate in owning a number of properties that were acquired at much more reasonable prices than apply today; it is able to realise those assets and use funds in existing and new programs. That is a sensible way to go.

This has nothing to do with privatisation. There is no suggestion of selling assets to pay the rent, which is certainly not nor will it ever be the policy of this Government. We want to see assets used in a more sensible way. That is highly desirable and the program thus far has been successful. Over the next four to five years we will see much more of the utilisation of Health Commission assets in a far more appropriate way for the 1990s.

The Hon. D.C. WOTTON: My first question relates to grants to health agencies and community health generally, and I seek information about three organisations. I understand that Health Commission grants to the Royal Society for the Blind have been reduced by about $2 million this year, a 56 per cent cut from last year when the society received $3.58 million. This year it will receive $1.57 million. What is the reason for the drastic cut in funding and what effect does the Minister believe the reduction will have on operations?

Last year the Anti-Cancer Foundation received $209 000 in health grants but preliminary figures indicate that there is no allocation for 1988-89. The Centre of Personal Encounter (COPE) will receive about $288 000 in health grants, a cut of $262 000, or 48 per cent. What are the reasons for such cuts in funding and what effect will it have?

The Hon. F.T. Blevins: As to the Royal Society for the Blind, it is more a technical reduction than an actual reduction. I ask Ms Johnson, Executive Director, Statewide Health Services, to further explain.

Ms Johnson: The reduction in the 1988-89 allocation compared with the 1987-88 allocation is illusory more than real. In 1987-88 the Royal Society for the Blind and COPE were gross funded. In fact they were given an amount and the revenue they raised went back to Treasury. This year those two organisations have had their funding method changed to grant funding; they are given a grant and any revenue that they raise they then keep and use as expenditure. While the grant that they have been given may appear to have been reduced, the net effect is the same. The allocation has not been reduced in real terms.

The Hon. F.T. Blevins: Negotiations are still continuing with the Anti-Cancer Foundation. This year its grant will again be substantial, but it is yet to be determined whether it will be as high as last year.

Dr McCoy: Mr Powell, a senior officer of the Statewide Services Division, has been negotiating with the Anti-Cancer Foundation, which has major capital assets. A contribution of $100 000 by the Health Commission is currently being negotiated.

The Hon. D.C. WOTTON: I see a substantial reduction in funding provided to the Adelaide Rape Crisis Centre, the Adelaide Women's Community Health Centre, the pensioner denture scheme and the Centre for Continuing Education in Health and Application. Why has that come about and what effect will those reductions have on the workings of those organisations?

Ms Johnson: The Rape Crisis Centre provides a counselling and support service to women who have experienced rape or sexual abuse. For security reasons it operates from a confidential address, and from a very large, double storey bluestone residence in the near eastern suburbs. The residence is considerably larger than it requires for its operation, its small staff and the volunteers and interested people who on occasions conduct part-time activities. The collective was advised, in May 1988, that accommodation costs would have to be reduced either through sharing the present premises with another organisation or moving to smaller premises.

Quite a few discussions have been held about this and assistance was offered in relation to looking at more suitable premises. For this reason, the budget was reduced in its rental line. I am not aware of any other reduction.

In 1988-89 there is a slight reduction in the allocation for the pensioner denture scheme. Additional Health Commission funds, through the Statewide Services Division, were allocated part way through 1987-88, and this elevated the amount for that year above the usual. The allocation for 1988-89 is not a reduction over usual expenditure.

Dr Blaikie: The Adelaide Women's Community Health Centre is responsible to the Metropolitan Health Service Division. I remind the Committee of earlier comments that were made by the Minister in terms of the budget allocation. The centre, being a community health centre, was this year required to make a saving of $1 864 (under the 4 per cent second tier increase), or .33 per cent of its overall allocation of $563 000. That is the only contraction in its budget and it will not be reflected in the blue book.

Members need to be aware of two things. First, one-off things occur from year to year, and last year the pelvic inflammatory disease project was specifically run from the centre. That has now been completed and a once-off budget reduction of $27 000 occurred. Secondly, when making comparisons between last year and this year for any of the health units one needs to remember that the blue book figures for 1988-89 do not include expenditure for workers compensation which was included in 1987-88. That explains the apparent differences between the allocations.

Mr Sayers: The Centre for Continuing Education at the Elton Mayo School of Management was funded and operated by the Health Commission until 30 June. As from 1

July that function was transferred to a new joint staff development unit under the South Australian Health Commission and the Department for Community Welfare. There has been no reduction in that service. In fact, staff development during 1988-89 in South Australian health services has been expanded and the transfer of the function from the Elton Mayo School of Management to our unit was one of the areas which constituted substantial expansion in staff development functions of the Health Commission.

The Hon. D.C. WOTTON: I refer to the shortage of doctors available for medical practice in South Australia, in hospitals generally and, more particularly, in 24-hour clinics and after hours emergency locum services. What can be done to attract doctors to this type of work? What are the reasons for the shortage? What is the Health Commission's forecast in the long term for trying to solve this problem?

I understand that the Health Commission has some plans for solving the shortage. It appears to me that the solution would be to sponsor medical practitioners from overseas, for example, from the UK or New Zealand as the doctors coming from these countries have qualifications that are accepted by the South Australian Health Commission. What is the Health Commission doing to overcome the present shortage? What percentage of registered general practitioners are available for rostered medical work? Will the Minister give a commitment, recognising that there is a shortage of doctors (especially in the after hours locum service), that the Health Commission will not hinder the temporary sponsorship of overseas medical practitioners?

The Hon. F.T. Blevins: I certainly cannot give that commitment. When we use the term 'shortage of doctors' there are certainly areas with insufficient medical practitioners but, overall, South Australia has the highest ratio of medical practitioners to patients anywhere in Australia and, possibly, the world. The problem we have is shifting those doctors out of the metropolitan area, or, within the metropolitan area, getting them to work in the public hospital system. There are a whole range of reasons for that including, for example, the award provisions for the salaried medical service within State public hospitals. Ongoing negotiations are occurring with SASMOA—the union that represents them—to get a more appropriate award, because I believe that it contains some deficiencies which certainly require attention. That is happening and the union recognises that it is happening.

The Health Commission certainly is not sitting flat-footed and saying that no changes are required. It is just a question of negotiating those changes. When one looks at the award structure, at first sight it looks somewhat ort for those of us who are accustomed to more conventional award structures, working conditions and hours of work. However, when one understands a little more how the conditions evolved and the support that the union has given them, it is not quite as clear cut as it looks. For example, if one hears of doctors working in the public hospitals for 36 hours on the run, certainly on the surface those of us who have been brought up in the industrial movement are absolutely horrified. However, when one looks more carefully at the subject, one sees that it is not quite as simple as that—it is much more complex.

The main complaint from SASMOA relates to payment for standbys, and so on, within the hospitals. I believe that eventually we will come to some agreement with SASMOA because there is certainly some merit in its case. In relation to the number of trainee medical officers, again, there is a problem in certain hospitals because trainees can nominate which hospital they want to go to. There does not seem to be too much difficulty filling the Royal Adelaide Hospital, the Queen Victoria Hospital or the Children's Hospital. However, some of the smaller hospitals do have a problem filling their requirements. Unless we get into conscripting doctors, all we can do is negotiate with them and work it out. We cannot compel doctors to work in our public hospitals; we cannot compel them to work as locums for after hours services; and we cannot compel them to work in the non-metropolitan area. I am sure that if we attempted to do so the member for Heysen would be among the first to complain.

This State, on the surface at least, has an abundance of doctors, particularly GPs who on average are not on high incomes. In my view, many of them are on incomes that are totally inadequate for the skills that they have. So, I have some difficulty with the suggestion that even more doctors should be brought in to the system. Further, once those doctors are here, they cannot be compelled to stay in a country town forever; they cannot be compelled to work as locums in after hours clinics; and they cannot be compelled to work in the public hospital system. We can probably get doctors to come here from overseas very quickly indeed. The only outcome of that maybe that the average income of GPs will fall. We may not get any more doctors in the non-metropolitan area, the public hospital system, acting as locums or doing weekend work. There is no guarantee that bringing in overseas doctors will, in any way, assist with the problem.

I believe that we must try to make it more attractive for the doctors that we have here to go to non-metropolitan areas, to work in our public hospital system and to give an after hours service and locum services. I think that is the most desirable way to go about it. However, that is easier said than done. Some programs have been undertaken by the Health Commission, and I will ask Dr Blaikie to describe them. Yesterday the College of General Practitioners, the Health Commission and the AMA released a joint report on the problems of GPs in South Australia. It was mainly a survey of GPs and a compilation of answers to that survey. It threw up some very interesting figures, particularly on incomes. I do not think that anybody having read those figures would disagree that, overall, general practitioners are certainly not generously paid.

Therefore, I cannot give any guarantees on impeding overseas doctors or not impeding them. The one guarantee I can give is that we will be working as hard as we can to ensure that everybody in South Australia, whether in the metropolitan area or in the country, has access to high quality care which, in my view, includes reasonable proximity to a GP. I ask Dr Blaikie to provide further information in answer to the question.

Dr Blaikie: The Minister has pointed out that we cannot compel doctors to work in any location. The classic example is the Lyell McEwin Hospital which this year began with two less resident medical officers than it needed and, throughout the year, it lost another five resident medical officers. As a result of those losses, the Health Commission has advertised extensively for general practitioners, with some, but not total, success. We have been able to recruit 14 local general practitioners to staff the Accident and Emergency Department at the Lyell McEwin Hospital, and those officers will provide some 32 sessions; and we recently recruited an overseas trained doctor who has taken up a half-time position at the Lyell McEwin Hospital. The problem of the large number of doctors in South Australia must be taken seriously but, where there are definable shortages in areas such as orthopaedic surgery, the South Australian Health Commission has supported the Royal Adelaide Hos-

pital, Modbury Hospital, and the Lyell McEwin Hospital in advertising overseas for specialists in that discipline.

The number of doctors across Royal Adelaide, Flinders, Queen Elizabeth, Lyell McEwin and Modbury hospitals increased from 788 in 1985-86 to 873 in 1986-87. So, while there are some difficulties at present, particularly at Lyell McEwin, I do not think it is reasonable to say that the system itself is suffering a shortage of doctors. Locum services are not within my direct area of responsibility, but I am advised by staff of my division that there is a tendency amongst the young doctors these days not to want to work the sorts of hours which are involved in the locum services. I have no proof of that: it is anecdotal or comment. But certainly in the dispute with the trainee medical officers there is some desire to keep what most of us would consider more normal hours of duty rather than working the long hours and the night-time hours that are required.

Mr RANN: What is the situation with regard to the availability and supply of the drug AZT in the treatment of AIDS sufferers?

The Hon. F.T. Blevins: Whilst the AIDS problem is a relatively recent phenomenon in Australia and South Australia, it does create a fair bit of alarm not only in the community but also in the health professional area as to how best to cope with what could become an epidemic. Of course, we hope that that does not happen and hopefully the current education programs will prevent such an occurrence but, nevertheless, the problem is still there and we must deal with it.

Current estimates are that 36 per cent of persons infected with HIV or the AIDS virus will develop AIDS within five years. Most of those with AIDS will die within a year of diagnosis. A drug (AZT) has been shown to extend the life expectancy of persons with AIDS by about a year. This extension of life is often of good quality and allows infected persons to remain at work. AZT is an expensive drug and costs perhaps $10 000 per person per year. Last year the Commonwealth Government provided $10 000 for the drug towards the total bill of $112 000. This year, for the first time, the Commonwealth will fund AIDS in hospitals to a total of $508 000. Half of that will cover the cost of drugs used for these persons and the residue will go towards other costs of inpatient and outpatient treatment within our hospitals.

I understand that the price of AZT is now likely to decrease to $8 000, and this compares favourably with a number of other drugs widely used for the treatment of disseminated cancers in persons with even shorter life expectancies. From time to time one receives complaints about the high cost of drugs, and the cost benefit analysis. AIDS victims are not at the top of the popularity poll, but this particular drug which is now available costs about the same as some other drugs used in the treatment of cancer. I do not think that anyone would quibble with the cost of the drugs used in the treatment of cancer, so I hope that that situation will also apply to the cost of the drugs used in the treatment of AIDS, because they are the same drugs.

Currently 14 people are receiving treatment at the Royal Adelaide Hospital, four at the Flinders Medical Centre and one at the Queen Elizabeth Hospital. Trials are commencing with AZT treatment in less sick persons and in asymptomatic persons but, as yet, there is no hard data on benefits to be gained nor on dose schedules. South Australian and Australian authorities will continue to review the situation. Early and effective planning to cope with the epidemic of AIDS in South Australia has certainly cost money, but I am confident that, in the long run, we will incur less costs and will have fewer sick people. Prevention is everything. Once somebody is diagnosed as having AIDS, it is likely that, within 12 months, that person will be dead, so the AIDS education programs, whether they be in schools or bars, will save not only lives but also large amounts of money. Savings in both those areas are highly desirable.

Mr RANN: Is there any updated information as to the incidence of AIDS in South Australia and how we compare with other States? Further, is there any change in trends, particularly with regard to high risk groups?

The Hon. F.T. Blevins: I seek to incorporate in *Hansard* a brief statistical table which details that information.

	Episodes	
		Jan. June
Clinic—275	1987	1988
Genital Herpes	344	138
NSU	555	250
Genital Warts	1 103	482
Clinic Attendances	8 300	5 635

South Australia

HIV

1985	94
1986	61
1987	77

	1985-87		1988	
Risk Factor	No.	%	No.	%
Homosexual	164	70	24	63
IV Drug User	39	17	10	26
Homosexual/IV User	10	4	1	3
Blood Products	9	4	—	—
Other	10	4	3	8
Total	232		38	

AIDS	Cases	Deaths
Males	23	12
Females	2	1
Total	25	13

Gonorrhea

1987: 558

Males 330 (0.5/1000); Females 228 (0.3/1000)

Jan.-Aug. 1988: 194 cases

Syphilis

1987: 150

Aboriginal 137 (9.6/1000); Non-Aboriginal 13 (0.01/1000)

Jan.-Aug. 1988: 49 cases

Worldwide AIDS Cases (to 30 June 1988)

Africa	11 753
Americas	74 862
Asia	243
Europe	12 594
Oceania	958
Total	100 410

Australia (2 Aug.) ..... 943 (482 deaths)

Mr RANN: Are steps being taken to provide community health services in the city of Salisbury?

The Hon. F.T. Blevins: I know the deep interest, if not love and affection, that the member for Briggs has for the area, and quite properly so. It treats him very well and he, of course, reciprocates. I will give some background so that I can put our commitment to the area in some kind of context. The Local Government Association of Salisbury is a very significant one, and had a population of 99 044 in 1986, projected to grow to 119 035 by 2001. Relative to many other areas in suburban Adelaide, Salisbury has been poorly provided with community health services in the past. Ingle Farm community health service is located at Roopena Street in the south-east of the Salisbury local government area and has traditionally serviced a population of some 35 000 people. The Lyell McEwin health service has oper-

ated a small community health centre at Burton, a growth area in Salisbury West. The Shopfront Youth Health and Information Centre is a focus for services to young people and operates from the main shopping centre in Salisbury. It is funded by the South Australian Health Commission in conjunction with the Salisbury council. We congratulate them on being a far-sighted council which involves itself very much in these areas.

The Ingle Farm community health service was one of the original services established under the Whitlam community health program in the 1970s. The service is located in premises in association with a multi-partner, general medical practice. I think that is worthy of comment. My information is that that is unique and that this is the only place in Adelaide where it occurs. It is interesting that the tripartite review of general practice in South Australia, which was announced yesterday, made some suggestions in line with what is already happening at Ingle Farm. So the community out there, along with the Health Commission, has been very far sighted indeed, and that is something that we would encourage.

Because of the need to extend community health services to the entire Salisbury local government area, and because of the relative concentration of resources in the Ingle Farm catchment area, the Health Commission has supported the extension of the Ingle Farm community health service as a regional service for the City of Salisbury. Progress towards this objective has included the transfer of the Salisbury West community health centre at Burton from the Lyell McEwin health service to the Ingle Farm community health service; the relocation of Ingle Farm community health service headquarters from the Roopena Street site to Hollywood Plaza, the proposed district shopping centre for Salisbury West; and transfer of administrative responsibility for the Gilles Plains community health service from Ingle Farm to the Tea Tree Gully community health service.

We are not resting on our laurels as regards future developments, which include:

- a joint planning study comprising Salisbury council, the South Australian Health Commission, Department for Community Welfare and Ingle Farm community health service which has been established to recommend staffing and building requirements, management structures and service philosophies for a Salisbury community health service;
- development of a new constitution for a Salisbury community health service to replace the existing Ingle Farm community health service;
- sale of the existing Ingle Farm community health service premises at Roopena Street and construction of purpose built premises in Salisbury West;
- the allocation of additional funds for the expansion of community health services in Salisbury; and the renegotiation of the agreement between the South Australian Health Commission and Salisbury council with a view to transferring responsibility for 'shopfront' to the proposed Salisbury community health service.

I think that gives a very good indication of the way that the Health Commission is responding to the needs of the community and, again, I would like to congratulate the Salisbury council on the way it has cooperated with the Health Commission in identifying needs and also giving tangible expression of its support for the things we are doing, and in the way it has cooperated with us in the particular venture that I have mentioned. The Salisbury area, as everyone knows, is a growing area with many needs, and it is certainly an area that will be given a great deal of attention by Government agencies such as the Health Commission over the next few years while the population is still expanding.

Mr BECKER: Has the Health Commission cut funding to domiciliary care service centres in this State by more than $790 000, or by almost 5 per cent on last year's funding? What were the reasons for the overall cut and why were the Eastern, Lower North, Western and Port Lincoln domiciliary care service centres singled out for particularly large cuts in their budget? What effects will these cuts have on domiciliary care services in general throughout the State? I refer to an article in the *Westside* Messenger of 31 August 1988 where I drew attention to the work of the Western domiciliary care centre from the Queen Elizabeth Hospital which is under the direction of Dr Mykyta.

Following a complaint from a constituent, I visited that centre, and I wish to place on record my appreciation of the work of the staff in that area. It is a huge district with a very small staff, trying to provide services that we all demand and expect domiciliary care to give, with limited resources and with about 5 000 people on the books. I am absolutely amazed that they are able to provide the care they give. The 135 staff are, in my opinion, hard pressed and have to be extremely careful. We were assured, following an article in the local paper, that Western domiciliary care funding would not be cut. Referring to the Administrator of the Queen Elizabeth Hospital, David Coombe, the article states:

> The domiciliary care service, an external wing of the Woodville hospital, received about $3.4 million in State Government funding in 1987-88. Mr Coombe said he expected all current domiciliary care services to be maintained. He had assurances from Western Domiciliary Care Director Lu Mykyta that he would be able to manage. 'The level of funding is tight, as it is for all Government allocations but it is manageable.'

As I understand there has been a considerable amount of money cut from domiciliary care services, I would like to know how much has been cut from the Eastern, Lower North, Western and Port Lincoln budgets, as well as from the domiciliary care budget overall, and what impact that will have.

The Hon. F.T. Blevins: The short answer is 'Nil': there has been no reduction, none at all. Two things may have confused the member for Hanson: one is that there are not 27 pays this year—there are only 26 pays—so there is obviously a reduction there, with one pay less. Also, I am advised that the Geriatric Assessment Program is still awaiting Commonwealth funding to be allocated to various domiciliary care units, so there has been no cut at all to domiciliary care. The statement made by David Coombe, the Administrator of Queen Elizabeth Hospital, was perfectly accurate.

Mr BECKER: The Minister did not provide the amounts for the eastern, lower north, western and Port Lincoln sectors.

The Hon. F.T. Blevins: It is statement No. 8 in the blue book.

Mr BECKER: Can the Minister give a categorical assurance that no more country hospitals will be closed or have their status changed markedly either in the remaining term of the present Government or in the unlikely event that the Government is elected for another term? Will he give those assurances specifically for the following hospitals: Angaston, Booleroo Centre, Central Eyre Peninsula, Cleve, Cummins, Elliston, Karoonda, Kimba, Loxton, Meningie, Millicent, Onkaparinga, Snowtown and Southern Yorke Peninsula, all of which have occupancy levels of the order of or below those of Laura, Blyth and Tailem Bend Hospitals, which are now facing closure?

The Hon. F.T. Blevins: I am surprised at the argumentative way in which the member for Hanson framed his question. I can give part of the undertaking that the honourable member requires. If he paid attention in Question Time, two or three weeks ago, he would have heard me giving the member for Flinders the quite clear undertaking that the Government has no intention of closing down or altering substantially any further hospitals in the non-metropolitan area. I cannot speak for future Governments and I will certainly not get into a slanging match about the likely or unlikely result of the next election. Irrespective of which Party is elected at the next election, I cannot give any categorical assurances, and the member for Hanson knows that.

The Health Commission is going through an exercise that is designed to redistribute resources more equitably within country regions. In some communities that can be quite difficult. However, the Government does not go into these exercises because it likes a fight or likes to annoy people. It does it for what it sees to be very good reasons. Those reasons are explained to people in the community to be affected and are talked through with them. However, at the end of the day, some pretty tough decisions must be made. Without wanting to be parochial, I should point out that the number of reductions in acute beds in the towns mentioned by the member for Hanson is fairly small compared with the reductions taking place at the Whyalla Hospital in my electorate. Whilst I do not agree with them, I sympathise with the people in Laura, Blyth and Tailem Bend.

One cannot say forever and a day that a health system or an education system will remain set in concrete. When populations change or when the needs of the population change, some facilities may need to change. For example, as a population becomes older, the need for obstetric services in a particular locale may be reduced in place of more nursing home beds. One cannot say that, because a hospital was established in a particular area, it will stay that way forever. That would be flying in the face of reality and reason. I do not believe that, apart from those who make some political mileage out of these decisions, any member of this Committee would not agree with me.

Mr BECKER: I assure the Minister that I was not being provocative or humorous. This is a deadly serious matter. Having been raised in the country, I worked to build up the services and facilities of the local hospital by all sorts of fundraising. To have it taken over by the Government is a very serious issue and I can understand why country people want to know about the future of their hospitals. No matter what size the country town is, there is pride in making the hospital the best in the district because one never knows when one may need its services. A lot of pride, hard work and dedication on a voluntary basis have gone into establishing and maintaining country hospitals. It would be a damn shame if we are to lose them.

In January, the Central Linen Service contracted its dry-cleaning operations to a private drycleaner because of production inefficiencies associated with the service's equipment. What were these perceived inefficiencies? Has dry-cleaning from Glenside Hospital been going to a Hills cleaner for two years? Is it true that Central Linen Service picks up the Glenside dry-cleaning, takes it back to the Central Linen Service site, sends it off to the drycleaners, picks it up when finished, and takes it back to Central Linen Service before sending it back to Glenside? If so, why has this inept and expensive practice been maintained for two years? Are any Health Commission officers weighing linen to check the alleged throughput by Central Linen Service? What tenders were placed for this contract?

The Hon. F.T. Blevins: With respect to the honourable member's earlier statement, I do not doubt for one moment the seriousness with which he treats the issue of country hospitals. In my 23 years in Australia I have never lived anywhere else but the country so I am aware of the sensitivity of hospital services in country areas. However, I know the member for Hanson too well to be able to say that his view is not that the role of a hospital, which was established 30, 40 or 50 years ago in different circumstances, should not change.

The dry-cleaning operation at the Central Linen Service was a small part of the total operation and it was not viable for us to continue. We put it out to contract, which is the sensible thing to do. The contractor came from the Hills, but his name escapes me. He was the only dry-cleaner who tendered and he won the contract.

Additional Departmental Adviser:
Mr I. Dunn, Chairman, Central Linen Service Board.

Mr Dunn: Tenders were called. We contracted out the dry-cleaning function because the equipment was old and the space was needed for other production facilities. Looking at a cost benefit aspect it was more productive and effective to subcontract the work. It also gave us an opportunity to improve the quality of the service provided to clients. As to the transportation arrangements, I am not familiar with the movement of all linen for the 100-plus clients, but I understand linen is moved to the Hills subcontractor and returned to Adelaide by Central Linen Service trucks, which is an effective method. This was considered when the decision was taken to let out the dry-cleaning work. As to who weighs items, I cannot provide that information now.

Mr BECKER: Will you take the question on notice?

The Hon. F.T. Blevins: Yes.

Mr De LAINE: Much has been made of the impact of the need to make savings in hospital budgets on the range and quality of services. Can the Minister cite an example of an initiative taken by any health unit in country South Australia which has been successful in establishing savings without a reduction in the provision of services?

The Hon. F.T. Blevins: I could give many examples, because all our health units are aware of the requirement to operate more efficiently. They are bombarded with information from us to the effect that we have a contracting public sector and that our allocations from Canberra shrinks yearly. Everyone in both country and metropolitan hospitals is aware of this and works with us to ensure that the hospital is an efficient unit. They do not want to constantly be under attack for inefficiency and so on.

As I stated in my opening statement, our hospitals are the most efficient in Australia. That is not just my view: there is emperical evidence to back that up. One initiative undertaken by the board of directors and hospital management of Port Augusta Hospital resulted from the board and Chief Executive Officer recognising in November 1987 that they would be significantly over budget at the end of the 1987-88 financial year unless dramatic corrective action was taken. I am advised that a number of options were considered and evaluated by a range of personnel including the board of directors, senior hospital staff, medical practitioners and staff of the Country Health Services Division of the South Australian Health Commission. As a result of this consideration it was decided that the hospital's two separate male and female surgical wards could be realistically combined into a single ward with the closure of 26 beds. The 'raw' saving which could be expected from that

closure was 18 full-time equivalent staff members, but it was quickly realised that the net savings would be significantly less if the level and quality of services were to be maintained.

As the activity level in the medical and surgical wards of the hospital at the time was frequently up to 90 per cent, it was established that with 26 less beds new ways of providing service and maintaining quality of service needed to be established. With the surgical ward amalgamation a number of new services were introduced to Port Augusta Hospital which included day surgery, pre-admission anaesthetic checks, pre-admission documentation, and augmentation of home nursing services to support earlier discharges when doctors felt that to be appropriate and in the patient's best interest. As a result of this management initiative the net savings for the 1987-88 financial year was in the order of $100 000.

There has been a further interesting outcome since the ward restructuring. As a result of these new services and an increased awareness by doctors and staff of the need to conserve resources, the actual number of patients admitted to the hospital has increased. The day surgery unit has been a major contributor to this.

This is one fine example of a management improvement initiative in the hospital services in country South Australia which has provided an increase in the range of services available to people in that area without a decrease in the quality of service. I am pleased to say that Port Augusta Hospital received full accreditation by the Australian Council of Hospital Standards subsequent to this ward amalgamation.

With a great deal of pleasure and pride at some time in the not too distant future I will present that hospital with its accreditation. Over the years it has not always enjoyed the best press and for Port Augusta Hospital to be in such superb shape deserves recognition. I will be playing a small part in that.

Mr De LAINE: At page 337 the Program Estimates refers to capital works at Mount Gambier, Wallaroo and Murat Bay hospitals. Will the Minister report on the Murat Bay hospital project at Ceduna?

The Hon. F.T. Blevins: I am pleased to take this opportunity to advise that the Murat Bay District Hospital has been requested to call tenders for the upgrading of the hospital's paediatric ward. There are major physical deficiencies in the paediatric ward of the hospital which regularly accommodates a number of Aboriginal patients.

The problems with the existing six bed ward include: inadequate facilities for mothers of Aboriginal children who wish to stay at the hospital during the period of hospitalisation of the child; facilities for the isolation of patients with gastric conditions need improvement; facilities for high dependency patients also need improvement to allow direct observation from the nurses station; and the location of the present children's ward allows the noise level from these patients to disturb patients in other wards of the hospital.

The proposed work to overcome these problems involves the conversion of the hospital's north-east wing, which is currently under-utilised, into a number of separate areas including a new isolation ward, improved bathroom and toilet facilities and more flexible ward accommodation, and the nurses station will be relocated to a more appropriate location for patient supervision.

The design solution which has been proposed is very imaginative and when constructed will provide significantly improved paediatric ward facilities and will overcome all the present deficiencies that I have outlined. An amount of $180 000 has been allocated to the project which will be supplemented by $60 000 to be provided by the hospital board from the hospital's capital account to meet the cost of the project. It is anticipated that tenders will be received prior to December 1988 and that work will commence early in 1989.

Again, this is an indication of the Government's commitment to health in country areas and, where appropriate, to upgrading country hospitals. Mention was also made of Wallaroo, Port Pirie and Mount Gambier hospitals, and our capital works program. Quite extensive moneys are being provided—many millions of dollars—to upgrade our country hospitals, and this is particularly pleasing to me as I live in the country. It is a real example of the way in which this Government governs for all South Australians, whether or not they live in the metropolitan area.

Membership:

Mr Robertson substituted for Mr De Laine, who took the Chair in Mr Ferguson's absence.

Mr BLACKER: What is proposed in relation to minor and major works for the upgrading of hospitals in my electorate, given that Murat Bay and Whyalla hospitals have been covered?

Additional Departmental Adviser:

Mr R. Blight, Executive Director, Country Health Services.

Mr Blight: The most significant project in the electorate is the redevelopment that is scheduled for the Port Lincoln Hospital at an estimated cost (December 1987) of $7.4 million. The design work is due to commence in 1989-90, with substantial construction work commencing the following year. This project is aimed at generally upgrading the hospital. It is proposed that there will be a small increase in acute beds from the existing level of 45 to approximately 64.

Included in the redevelopment will be the removal of further asbestos contamination. Some $250 000 was recently expended through the Department of Sacon on asbestos removal, and that enabled the theatre and outpatients area to be cleaned up. Unfortunately, we have been advised that further contamination has occurred throughout the hospital, primarily as a result of degradation in the lagging of steam pipes, and it is clear that the asbestos problem in the hospital is substantial.

The upgrading will include new obstetric facilities, general ward upgrading, upgrading of casualty and outpatient facilities, a new main entrance and admissions area, improved administration facilities, an expanded IMVS laboratory, improved staff amenities, bulk stores, and the full upgrading of fire protection facilities. The member will be aware that during the past year we completed a minor redevelopment of the theatre at the Cleve Hospital. However, a further major redevelopment of that hospital, commencing in 1992-93, is proposed. With the minor works just completed we believe that the hospital will be able to fulfil its function satisfactorily in the intervening years.

The work at Murat Bay and Ceduna hospitals has been referred to. The upgrading of equipment and a number of minor projects will occur over the next five years, but that will be on a scale not of interest in the general context.

Mr BLACKER: What about the upgrading of fire services, particularly at Cowell?

Mr Blight: The commission maintains, in its capital works line, specific funding for fire upgrading. Cowell has been identified as being part of that, but I do not have the figures

in front of me. I understand that work will commence this year, and the member would be aware that last year there was a small improvement in the administration set-up at Cowell Hospital.

Mr INGERSON: Have country hospitals been allocated a total of $125.8 million this financial year by the commission—a 10 per cent cut in real terms funding compared to the 1987-88 financial year? What were the reasons for such a large cut in funding? What effects will it have on patient care and the delivery of services in country hospitals?

The Hon. F.T. Blevins: No, there has not been a cut in funding of that order. I have already outlined, in general terms, the amounts of cash that have been allocated to the hospital system. The aim this year was essentially a standstill budget. We have done a little bit better than that when all the various programs are added together.

I concede that the member for Bragg, indeed any member, when going through the blue book, will not pick up all the funds going to hospitals. There are other funds from other programs, including Federal Government programs. I can organise a briefing on this funding for honourable members. As Executive Director of our Planning and Policy Development division, David Blaikie would be the most appropriate person to give that briefing and outline where the funds go. Alternatively, I have had a pamphlet prepared which gives the broad picture in health and a broad comparison between this financial year, as a result of the State budget and the Federal budget and last year. It indicates very clearly the additions to funding that the health units have received or are in the process of receiving.

While the honourable member was wrong in the premise on which his question was based—he was quite incorrect—I can understand why that happened. It is not the honourable member's inability to count: it is the complex way in which the total health budget for this State is constructed.

Mr Blight: The health unit allocations to country hospitals, community health centres and domiciliary care centres have been maintained essentially at standstill funding. The operating allocations that have been made will enable all of those units to provide the same level of service this year as as provided last year.

As was mentioned earlier in this hearing, a small productivity target contribution has been set. As with the metropolitan area the level of that contribution in the country area is about .45 per cent. In applying that percentage any country health unit with a budget of less than $100 000 was not set a target for that contribution. All other units were treated the same and an equal contribution of .45 per cent was set except in two instances, both of which included larger units where it was felt that capacity existed for a slightly higher contribution.

The allocations that were advised to country hospitals at the beginning of this financial year did not include HACC funding. Those funds are yet to be advised to the country health units. That will certainly be done within the next two weeks. However, that means that, for some units such as the Port Lincoln Domiciliary Care Service, which last year had about $70 000 worth of HACC funding, a preliminary look at the allocation might suggest that it has been cut by $70 000. That is not the case. The HACC funding will be provided at about the same level as last year. Therefore, I hasten to reassure members that in service delivery terms there will be no reduction.

Mr INGERSON: What are the latest construction cost estimates for the community health centre at Clare? What is the estimated annual running cost of that proposed centre? What are the estimated annual costs for transporting patients from the Blyth district to Clare for either treatment at the health centre or acute care at Clare Hospital? What are the estimated annual costs for transporting patients from the Clare district to Blyth Hospital for nursing home care? How will patients be transported between the two centres? Who will be manning the transport?

The Hon. F.T. Blevins: Some of the finer detail of that question is not available immediately, such as the precise cost of transporting. I am sure the member for Bragg would not expect it to be available now. Therefore, it would be better to take the entire question on notice. We will certainly be able to get those figures back to the honourable member in time for inclusion in *Hansard.*

Mr INGERSON: In the last annual report of the Lyell McEwin Health Service statistics show that in 1986-87 health nursing made more than 41 000 contacts, a rise of almost 37 000 in just three years. What constitutes a client contact in the above figures? Is it a legitimate measure of the services provided by the health service? Is the dramatic rise in client contacts over that period an important consideration when staff numbers or budgetary allocations are being reviewed?

The Hon. F.T. Blevins: As I understand it, this is a relatively new service. That is why there has been this huge increase from one year to the next. It appears that it started operations only at the end of one year. Therefore, the figures would be very low and, of course, in a full year of operation it looks like an enormous increase. However, I do not have the annual report of the Lyell McEwin Hospital with me. I will get that report, have the question examined and bring back a reply.

Mr TYLER: The number of people on booking lists at public hospitals has often been used by the Opposition as an indication of alleged difficulties facing the health system. Can the Minister comment on the recently released Coster review of booking lists?

The Hon. F.T. Blevins: This certainly has been a political issue over the last 12 months or so, mainly because we have only just started producing booking lists and that allows that information to be used—or misused. I stress that the waiting list is not a single cue. If there are 6 000 people on the waiting list, there is not someone who is 5 427 and has to wait for the other 5 426 to be dealt with.

The Coster report, with which I agree totally, is excellent and the recommendations will be implemented in conjunction with the various parties, for example, the AMA and some of the colleges. The report found that about 50 per cent of people waiting for elective surgery (and I stress that it was elective surgery because, if anybody needs immediate surgery, it is immediately available for anybody in this State) were dealt with within three weeks, or certainly within less than a month. I think that is quite a remarkable achievement, when it takes a month to get one's act together to go into hospital, to arrange leave, to care for children, or whatever. I think that situation is a credit to the South Australian hospital system. I cannot conceive of any other State having such a short waiting period for half the people on its booking lists.

The report also found that around 600 or 700 people were on the waiting list for any significant period, and that was for over 12 months. Various reasons for that, including certain types of operations, shortage of surgeons in a particular specialty, and people waiting for individual surgeons who were extremely busy, were identified. Irrespective of how many additional theatres, hospitals or staff, that surgeon can do only a certain amount of work so, if you elect to have that particular surgeon, there will be a considerable waiting period. People also nominated particular hospitals where again there was a waiting list for theatre space. A

hospital across town may not have had that waiting period and, if the patient could be persuaded to use one hospital rather than another, or one surgeon rather than another, the number of people who are on the waiting list for a significant period would be reduced.

I suppose the trick is to attempt to get the maximum amount of information to patients and GPs (who refer patients to specialists) to see whether they can use the information to make a more informed choice. If they are told that the waiting period will be perhaps six months if they elect to have a procedure done, say, at the Royal Adelaide Hospital but, if they choose to have it done at another specified hospital, they will have to wait only three weeks, they can then make that choice. In the past, that kind of information has not been available in a usable form, but we are collating it and we will make it availabale to GPs, patients and hospitals, or wherever we feel it will be useful. It is expected that, when people have that information, they will make a more informed choice and, if they still elect to wait 12 months because they want a particular surgeon at a particular hospital, that is their choice. Other choices will be available to them that will involve much shorter waiting periods. I believe that many people will still elect to have a particular surgeon at a particular hospital, but these surgeons can work only for so many hours per day, so there will still be quite extensive waiting periods, but that will be voluntary because the people will have that information.

We can also do other things. I think that the explosion in day surgery is already making a significant contribution towards reducing the booking lists. More and more procedures are now capable of being performed on a same day basis. This has enabled us over the past 12 months to reduce considerably the numbers on the booking list and to reduce the median waiting time to about 10 weeks, so I think that that is quite a remarkable achievement. More can be done in the area of day surgery; and more theatres can be built, and we are doing that. The program has been outlined, for example, at the Royal Adelaide Hospital.

Another esoteric thing that we can do is to adopt performance agreements with the major metropolitan hospitals. In the short time that I have held this portfolio I have come to the conclusion that, by and large, the major metropolitan hospitals perform brilliantly, so I am not very optimistic about putting more on them in the way of performanace agreements when they are already performing very well. Nevertheless, every little bit helps and we will enter into those performance agreements with the metropolitan hospitals. Again, that will assist in relieving the pressure for those few people who are waiting for an unacceptable period to have surgery.

I think it is a great pity that the issue was made as political as it was, because it created a perception in the community that the metropolitan hospitals were grossly overcrowded and that people had to wait to get into hospitals to have procedures performed, but of course that is not the case. The difference between elective and necessary surgery was blurred and lost in the politics of the argument. I think that it engendered some fear in the community that, if they required a necessary operation, they would have to join some kind of queue, but that is certainly not the case.

I expect that, now that the Coster report has been presented and the facts quite clearly stated, the booking list issue will no longer be as political as it was. The Coster report and the statistics make one realise that, to try to get the median waiting time down to below 10 weeks, it would cost tens of millions of dollars, and then it would probably be reduced by only a couple of days. When 50 per cent of people electing to have surgery in this State are being dealt with within a month, it would cost a fortune to improve that situation and I believe with very little benefit. We have to target those 600 or 700 people out of the 6 000 on the booking list who are waiting perhaps for a significant or unreasonable period. We cannot do anything about that situation if they wait for a particular surgeon. Obviously, the surgeon cannot double his or her output. Perhaps with improved day surgery procedures, they may be able to make a significant dent in their own waiting lists.

I believe that about 50 per cent of people being dealt with in a month is probably about right. If we had a system with the capacity to take in everybody who wanted an elective procedure, we would have to increase the size and staff of our hospitals enormously. I do not believe that anybody in the Committee would want to do that. I believe that 50 per cent being dealt with within 30 days is an example of efficiency and that to cut that down would probably be undesirable. It would create inefficiencies in the system because it would be much larger than desirable. So, again, our strategy is to target those few people who we believe are waiting too long and to give them the option of going to another hospital and having possibly a different surgeon. That will shorten the time that they wait for their elective procedure.

Mr TYLER: My next question on admission and surgery rates is supplementary to my previous question. I recall that in March this year the Chairman of the Health Commission announced a working party, to review admission and surgery rates in South Australian hospitals. Does the Minister have the findings of the working party and can he make some of that detail available to the committee.

The Hon. F.T. Blevins: I can do that but, as the Chairman of the Health Commission announced the working party, I think it is only fair that he should detail its findings.

Dr McCoy: The high admission rates to hospitals in South Australia has been identified in the hospital utilisation and cost study conducted under the auspices of the Australian Institute of Health. It is a fact that the admission rate to hospitals in South Australia is high by Australian standards, and it is also a fact that the admission of people to hospital in Australia is high by international standards. We are the highest in Australia, and Australia is very high by international standards—in fact, much higher than the United Kingdom or the United States. As a result, a working party was created. The working party's convenor is Dr Blaikie, and it has representation from the College of Surgeons, the Royal Adelaide Hospital, the South Australian Salaried Medical Officers Association, the AMA, the Private Hospitals Association, Brendon Kearney from the Royal Adelaide Hospital, the Royal Australian Nurses Federation and the Royal Australian College of General Practitioners. So a large group of people are looking at a difficult problem.

The particular statistic that is of note is that in South Australia in 1987 there were 252 admissions per thousand population compared with the Australian average of 206. So, there is quite a differential. The working party has met on two occasions and has not yet come up with any finite answers. It has agreed to do a statistical analysis of the admission and surgery rates and also examine a more extensive range of procedures than those that were reviewed by the Sax committee. Some members may recall that the Sax committee of inquiry (instituted by the previous Minister in 1983) reported that in South Australia and in some parts of Adelaide there were very high rates of gall bladder surgery (cholecystectomy), removal of tonsils and adenoids, mastectomy (removal of the breast) and caesarean section (removal of the baby surgically).

A study conducted by the Professor of Surgery at the University of Adelaide (Professor Jamieson) following the Sax committee of inquiry was unable to identify any evidence of unnecessary surgery in hospitals north of Adelaide. However, the Blaikie working party has agreed to do a more extensive statistical analysis of other surgical procedures and also to do preliminary work to examine the United States data to see whether there are some terminology differences between the United States and Australia that may explain the difference.

It has also been decided that there will be a prospective review of admissions at the Royal Adelaide Hospital, again, to determine whether or not a committee of experts would deem any as unnecessary. That work will be ongoing and I would expect it to take some months yet, but hopefully before the end of this year there will be an interim report from the working party on practical ways of reducing the apparently high rate of patient admissions to hospitals in South Australia.

Mr TYLER: I turn to an area to which I know the Minister has a great commitment—workers compensation. I understand that during 1988-89 the South Australian Health Commission will implement changes to its present system of workers compensation claims management. Why are changes deemed necessary; what changes will occur; when will the changes be effected; and what progress has occurred with respect to the implementation of the changes?

The Hon. F.T. Blevins: As the member for Fisher said, this is an area in which I have a particular interest and a very strong commitment. Statistics over the past few years indicate that the incidence of industrial injury and disease within South Australia has been unacceptably high. It is not only the loss of human resources that concerns me but also the very real money loss both to some of the individuals concerned and certainly to employers in the State as a whole. I have never believed that the Health commission record was particularly outstanding in this area. There is certainly much room for improvement and I am very pleased to outline to the Committee the changes that are necessary within the Health Commission and just how we will bring them about.

The South Australian Health Commission is an exempt employer under the Workers Rehabilitation and Compensation Act 1986. As such, it has a responsibility to actively manage its employees' claims rather than rely on an external agency to make decisions in claim management. The Health Commission supports the view that, in an organisation of its size, self-insurance is potentially more cost effective than external insurance as it should facilitate greater management involvement, which is essential in containing costs.

The Health Commission will seek to implement system procedures involving clearly established risk management and preventive programs, clearly defined claims handling procedures, clearly defined rehabilitation policy and procedures, an effective management information system which provides reporting facilities for identification of injury trends, line management involvement in decision making and claims management, and budgetary incentives to help minimise the costs associated with workers compensation, including maximisation of the opportunities for rehabilitation. The Health Commission will establish a central unit to coordinate workers compensation and provide advice, support and training for health units in self-management claims. The framework for implementation will be in place by 1 January 1989. So far, a manager of insurance services has been appointed, proposals for external agencies for a claims processing and consultancy service subject to South Australian Health Commission management are presently being considered, and negotiations with Treasury to agreed budgetary and accounting frameworks have commenced.

As an employer, the South Australian Health Commission has an obligation to its employees to ensure a safe and healthy working environment. After negotiations with the Health Commission, Cabinet decided to reduce its allocation this year for workers compensation. That is happening in most Government departments and Government operations. In my previous portfolio, I thought that the cost of workers compensation was excessive and that the framework of the workers compensation legislation was inappropriate and contributed greatly to the high cost of workers compensation. The programs included in the legislation provide a framework in which all Government departments and statutory authorities are in a position to make real inroads into the costs, both human and financial, of industrial injury and disease, and the same thing is happening in the private sector. Over the past 12 to 18 months, there has been a huge change in attitude to occupational health and safety and workers compensation in the private sector and in the public sector. The South Australian Health Commission is part of that changing attitude and approach.

The Hon. D.C. WOTTON: How many times in the past financial year has the radiotherapy equipment at the Royal Adelaide Hospital been out of commission? What was the duration of those periods when it was out of use? What has been the effect on waiting periods for patients either already on radiotherapy treatment for cancer or beginning such treatment? What are the respective ages of the equipment? What moneys have been allocated in the 1988-89 budget for replacement of that equipment?

The Hon. F.T. Blevins: I do not have the details as to dates and number of people affected that the honourable member requested. However, I ask the Chairman of the Health Commission to go through very briefly some of the programs for updating the radiotherapy equipment at the Royal Adelaide Hospital.

Dr McCoy: The commission will obtain the answers to the detailed questions because neither I nor Dr Blaikie are aware of recent breakdowns in equipment, when they occurred and how long the machines were out of commission. Over the past few years there have been major developments in the radiotherapy branch of the Royal Adelaide Hospital. It is true that, in the early years of this decade, the radiotherapy department of the hospital was poorly equipped, it was understaffed and it had major problems. However, since that time, major improvements have been made. For example, at one time only one full-time radiotherapist worked in the department. The department now has four full-time radiotherapists plus two who are in private practice and give sessional time to the Royal Adelaide Hospital. Dr Kearney and Dr Wigg of the hospital are planning the recruitment of a fifth full-time staff member to the department, I hope within the 1988-89 financial year.

Since 1981, about $6 million has been spent on new equipment in the radiotherapy department. The department has two 4 million volt linear accelerators; one 20 million volt linear accelerator, which has high energy electrons used in radiotherapy; a whole body CAT scanner; a radiotherapy simulator; an after loader; a mould room; and a computer planner. Cancer registries have been established in all hospitals. Most recently, a superficial radiotherapy machine was purchased. Problems with cancer and the need for radiotherapy are increasing because of the ageing of the population, resulting in more people presenting with cancer. There is also a realisation by clinicians that radiotherapy is an important method of treatment both for the cure of some forms of cancer and for the amelioration or palliation

of many people who have disseminated cancer throughout their body.

The cure rates for a number of cancers by radiotherapy have been markedly improved in the past decade. In this financial year, an order has been placed for a second whole body scanner, costing $800 000, and a second radiotherapy planner has also been ordered. This three-dimensional planner will allow the radiotherapist to see a three-dimensional picture of the tumour within the patient's body.

In that way it will allow him or her to plan the radiotherapy accurately, because it is essential that only that part of the body that contains the tumour is treated. Radiotherapy emits X-rays which are dangerous radiations, and it is important to confine the radiation beam to the tumour. We do this through radiotherapy planning, and I am assured that the methods of radiotherapy planning used in the radiotherapy department at Royal Adelaide Hospital are much better than anywhere else in the country. From a position 10 years ago when we had major concerns about radiotherapy, we are now in a position to assure the Committee that the department provides a high standard of high technology care for people with cancer.

The ACTING CHAIRMAN (Mr De Laine): In accordance with the statement by the Chairman, now would be an appropriate time for an afternoon tea break.

Mr BECKER: There is no arrangement made about an afternoon tea break. The arrangement with officers of the Minister's department was that we would meet from 11 a.m. to 6.30 p.m., with the usual lunch break. There has been no discussion or representation about afternoon tea, which we oppose.

The ACTING CHAIRMAN: At the commencement of yesterday's committee the Chairman made it clear that there would be a break at mid-afternoon. The honourable member has had the luxury of moving around but, in deference to the Minister and his advisers, they have not had a break and have not been on their feet for some time.

The Hon. D.C. WOTTON: What is the total cost of any furnishings purchased or ordered for the new Health Commission central office? What specific items were purchased or ordered, and what is the cost of each? What is the cost of furniture purchased or ordered for the Minister of Health's office? What specific items were or are being obtained, and what is the cost of each item?

The Hon. F.T. Blevins: There will be little new furniture going into the building. Certainly, there will be some new furniture in the Minister's office. There will be new ergonomic work stations for some of our clerks where the present work stations are inadequate. The present Minister's office has built-in furniture and it would be inappropriate to rip it out and rebuild it in the new badly built office—which is in the shape of a triangle. Problems would arise in taking furniture from a rectangular room to be used in a triangular room. I am not sure about the reception area, but I will get those details.

The Hon. D.C. WOTTON: My question is supplementary to my question earlier this morning about the Royal Society for the Blind. We have been advised by the society that its fund raiser for 1987-88 raised about $1 million. The answer provided this morning was that any reduction in grant was of a technical nature. As preliminary funding for the society for 1988-89 is about $1.5 million, as there has been a fund raiser of $1 million, which gives a total of about $2.5 million for the year compared to a total allocation of $3.5 million last year, there is a reduction of about $1 million. Why is it necessary for that reduction and what effect will it have on the society's operations?

The Hon. F.T. Blevins: I will ask Ms Johnson, Executive Director, Statewide Health Services, to respond.

Ms Johnson: I am not clear on the answer to that question. The Royal Society for the Blind has not had its budget cut in real terms. If the fund raising, as the honourable member says, is $1 million, I am not sure what that includes. One of the variables with the Royal Society for the Blind's revenue comes from the sale of products. It also has varying needs in expenditure, depending on materials and so on that it requires to make products. It then sells them and gets revenue; whether this revenue from its workshop sales is included in that $1 million or whether the $1 million is purely from fund raising I do not know.

All of that aside, the budget has been worked out so that there is not any financial deterrent or cut in the budget for the Royal Society for the Blind. I would need to look at what that fund raising includes before I could give a detailed answer, so we need to take that question on notice.

The Hon. F.T. Blevins: As Ms Johnson stated, we will take the question on notice and examine the *Hansard* report of the member for Heysen's question, but we have had no queries at all from the Royal Society for the Blind. This is the first time that the question has been taken up with us. I infer from that that there is no significant reduction, if any: it is just that the accounting appears to be done in a different way.

Ms Johnson: The receipts for the Royal Society for the Blind in 1987-88 amounted to $2.097 million. That would include the amount that the honourable member mentioned for fund raising as well as revenue from the sale of products from the workshop and so on. The payments in that same year amounted to $3.577 million. The difference between gross payments and receipts is approximately $1.5 million, which is the grant proposed for 1988-89. I think those figures balance.

Mr RANN: There has been quite a bit in the media about street kids and related concerns. What action has been taken by the Bannon Government to assist children and adolescents who frequent the inner city?

The Hon. F.T. Blevins: Unfortunately, a greater incidence of young people either live on the streets or are at risk because of their lifestyle. A variety of agencies deal with this problem, including the Health Commission. There have been frequent calls for more cooperative action between the various youth services in the city. We have all seen the newspaper reports of the homelessness and organised vice involving young people. In 1987 the Government announced a $500 000 package, consisting of capital and recurrent funds, aimed at assisting at-risk children and adolescents who congregate in the inner city to enable them to cope with a range of psychological, social and emotional needs.

Elements of that package included a doubling of crisis accommodation for young people in the inner city area by increasing the number of emergency beds in the St Johns, Westcare and Joyce Schultz shelters to 38 beds; the appointment of a neighbourhood youth worker to develop alternative venues and activities for young people; the appointment of a youth worker to counsel and assist at-risk Aboriginal adolescents ($4 000 of that was provided by children from the Paradise Primary School from the proceeds of a charity film night premiere in aid of inner city kids, and I commend the children of the Paradise Primary School for that initiative); a joint Drug and Alcohol Services Council and Department for Community Welfare study on the use of drugs by street youth in the inner city to enable us to get some hard data on the use of drugs; a project to determine the characteristics and needs of the small but vulnerable group of intellectually disabled youth who fre-

quent inner city areas—a group that everyone would concede is particularly at risk; a joint Police Department and Department for Community Welfare staff development program to inform police officers of available education, health and welfare resources when dealing with street-wise adolescents; and a detailed study to determine the social, health, welfare and educational needs of Italian and Greek city kids.

So it was a comprehensive package. The total program for inner city kids recognises that the responsibility for dealing with the problem of these young people must be shared by the community at large and not left to Government alone. The range of measures adopted was aimed at ensuring maximum cooperation between the numerous agencies involved with the welfare of young people: the South Australian Housing Trust, the Department for Community Welfare, the Adelaide City Council, youth shelters, the Service to Youth Council, the Second Story in Rundle Mall, the Hindley Street Youth Project, and others. So a large number of players are involved. We can all only hope that not just the Health Commission but all those other agencies have a significant measure of success.

It appears to be a growing problem. It is certainly a problem with which we do not have a great deal of experience in dealing, so we are learning as we go along, but we believe that amongst this range of agencies there is now sufficient expertise so that, if they work in cooperation, significant impact can be made on the target group. Anyone who has occasion to be in the inner city area at night can on occasions only be appalled by what they see. These people known as 'inner city kids' are in fact children: they are South Australian children, who belong to the whole community, and the community has an obligation to look after them. The community is facing up to its responsibilities and is doing something significant about them.

Mr RANN: Referring back to the capital area, when talking about the provision of health services for Salisbury the Minister mentioned the Lyell McEwin health service. I notice in the book reference 'The commissioning of dental clinics in stage 2 of the Lyell McEwin redevelopment'. Will the Minister give an update on the Lyell McEwin redevelopment?

The Hon. F.T. Blevins: The total estimated cost of that stage 2 development is, at December 1988, $14.15 million. The total expenditure to 30 June this year has been $3.315 million. The proposed expenditure in 1988-89 is $7.687 million, with a planned completion date of November 1989. The construction will be of reinforced concrete framing, faced brick external walls and a steel frame roof structure. This redevelopment will impact on the capacity of the Lyell McEwin Hospital such that 166 replacement beds will be provided and 142 existing beds will be decommissioned.

On completion of stage 2, the Lyell McEwin Health Service will be operating 208 commissioned beds, an increase of 24 over its existing establishment but still three short of its final allocation of 211 beds. Inpatient accommodation comprises 50 maternity beds in two 25 bed wards, 84 surgical beds in three 28 bed wards, a 20 bed paediatric ward, a 12 bed high dependency ward, and an 18 cot neonatal nursery. In addition, accommodation has been provided for the South Australian Dental Service and patient education.

The member for Briggs will know that services in the Elizabeth region have been run down over a number of years. Continuing upgrading is essential to provide health services in this region which are comparable to facilities in other metropolitan regions. It is essential that stage 2 commences as soon as possible after the completion of stage 1, as the operation of the hospital would be greatly hampered by a significant delay. As an example, the new operating theatres are on a different level from the old wards and, therefore, all patients must use the lift going to and from the theatre. This is very inefficient.

The Public Accounts Committee indicated that the South Australian Health Commission would probably need in the region of $50 million in today's terms over the next five years to replenish its assets. Hospitals such as the Lyell McEwin are wearing out and are in need of remedial action. I am particularly pleased that we have been able to obtain something like $50 million this year for our capital works program, and I anticipate—although one is pretty brave in this world in making predictions about next and subsequent years—that we will be able to come close to the figures that were suggested by the Public Accounts Committee. It is not only a question of expanding the system of opening new units but also of maintaining and rejuvenating our existing assets. Of course, the Lyell McEwin is only a small, but very significant, part of the total capital works program. This area well deserves an upgraded hospital with additional facilities.

Mr BECKER: How many patients have been transferred from the Flinders Medical Centre to other hospitals in the past financial year? What were the reasons for those transfers?

The Hon. F.T. Blevins: In 1987-88, 422 patients (or an average of 35 a month) were transferred from the Flinders Medical Centre to other hospitals. The majority, 167 patients (or 14 a month) were transferred to the Repatriation General Hospital at Daw Park and were mainly medical patients; 138 patients (or 11.5 a month) were transferred to the Royal Adelaide Hospital, 58 being medical transfers and 79 being surgical transfers; and 18 patients were transferred to the Adelaide Children's Hospital. Statistical tables detailing the transfer of patients to other hospitals for 1987-88 and transfers on to the Royal Adelaide Hospital for 1987-88 are as follows:

Summary of Transfers of Patients to Other Hospitals—1987-88

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	Total
R.A.H.	7	19	17	16	10	17	11	17	7	5	9	3	138
Repatriation	19	23	18	13	16	8	7	10	3	4	18	28	167
Q.E.H.	3	2	0	2	1	1	1	0	0	1	2	0	13
A.C.H.	2	0	2	1	3	0	1	1	1	0	2	5	18
Other	4	8	7	7	5	9	6	5	5	14	7	9	86
	35	52	44	39	35	35	26	33	16	24	38	45	422

F.M.C. 'Transfer On' to R.A.H.—1987-88

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	Total
Medical	3	6	16	10	5	5	8	1	1	0	2	1	58
Surgery	4	12	1	6	5	12	3	16	6	5	7	2	79
Other		1											1
Total	7	19	17	16	10	17	11	17	7	5	9	3	138

Mr BECKER: How many beds were available for use at the Flinders Medical Centre as of 30 June 1988? How many beds were available for patients during the year? What was the total number of occupied bed days to 30 June 1988? What was the average percentage of occupied bed days for 1987-88?

The Hon. F.T. Blevins: I refer the honourable member to statement No. 13 in the blue book which contains all that statistical information.

Mr BECKER: What is the status of the $14 million theatre upgrading at the Royal Adelaide Hospital? What problems have occurred with this development and what delays have been caused? What effect will these problems and delays have on the final cost and completion date of the scheme? I understand that the ophthalmology surgery unit has been transferred to the new surgery unit. Why did that occur when the existing unit was satisfactory?

The Hon. F.T. Blevins: Part of the question is best answered by referring to our capital works in this area. As was indicated in the Premier's budget speech, a major project costing $18.6 million is due to commence in 1988-89. This will result in the provision of a centralised operating theatre suite, a dedicated day surgery facility, and an admissions centre on North Terrace. The new complex will have 14 theatres, including a two theatre day surgery suite, a new recovery room, a holding bay, and staff changing areas.

The current situation with respect to operating theatres at the Royal Adelaide Hospital is not very good. The attached support facilities do not provide maximum efficiency in theatre utilisation. We expect that, after the redevelopment of the theatres and the improvements that will result from the capital works program that I have already outlined, there will be: a reduction in duplication of staff; a reduction in duplication of equipment; a reduction in duplication of stores and supplies and possible overstocking; improvement in efficiency of the portering service, stores deliveries, CSSD deliveries and removal of dirty theatre linen; decreased intro-operative infection rates, particularly in relation to elective orthopaedic surgery; and improved staff change rooms and other facilities within the general theatre complex. In relation to the question from the member for Hanson on delays in ophthalmology, I will examine the *Hansard* report and investigate whether I can give him a more detailed answer.

Mr ROBERTSON: I refer the Minister to the proposal to provide another venue for the relocation of a number of services in the south-western suburbs. I refer specifically, to the Southern Domiciliary Care and Rehabilitation Service, the Royal District Nursing Society, the Southern Hospice Care Association, the Psychogeriatric Outreach Service and the Southern Community Health Research Unit. I understand that negotiations have been finalised on the relocation of these services. How cost-effective will that relocation be? Will the facilities provided be adequate to meet the needs of the agencies involved?

The Hon. F.T. Blevins: This is one issue of which the Government is particularly proud. I know of the strong interest of the honourable member and other members in this area. The member for Hayward constantly draws this and other issues in the region to my attention. The proposed development, in two stages, is on Department for Community Welfare land at Sturt Road, Marion, and it was presented to Cabinet in August 1985. Cabinet approved the development of sketch plans and estimates for Stage 1 of the village. During a review of the project, it became apparent that the Marion city council was interested in developing new administrative premises within the Marion area.

In October 1987, Cabinet approved the commencement of formal negotiations with the Marion City Council for the purpose of acquiring the existing Marion Council Administration Centre as the site for stage 1 of the Marion Community Services Development. This involved the Marion City Council acquiring one hectare of land on the Sturt Road site to enable the establishment of new administrative premises. Provision of $1.935 million has been made within the Health Commission's 1988-89 capital works program to enable purchase and refurbishment of the Marion Council Administration Centre to accommodate the five health units which originally comprised stage 1 of the Marion Health Village; that is, the Southern Domiciliary Care and Rehabilitation Service; the Royal District Nursing Society; the Southern Hospice Care Association; the Glenside Psychogeriatric Outreach Service; and, the Southern Community Health Research Unit.

Contracts between the Marion council, the Department for Community Welfare and the South Australian Health Commission have been signed and the council intends to commence construction of its new council chamber/administration centre in the near future. Detailed plans for stage 2 of the development have not yet been finalised. However, the proposal will certainly be very cost effective as the community of Marion will gain a more appropriately located and refurbished community health facility for less than $2 million. Therefore, the cost effectiveness is very high. The facility will certainly be adequate. Along with the Marion council, we have done a lot of research in the area to find out what the appropriate facility should be, and to ensure that it will be as adequate as we can make it. Therefore, we are very proud of the facility that will be provided. It is a credit to the Marion council, to the Health Commission, and to those local members who have agitated strongly for this facility.

Mr ROBERTSON: I refer the Minister to page 14 of the commission's blue book. There is a reference to a preliminary budget allocation of $637 000 to establish the Daw House Hospice at the Daws Road Repatriation Hospital. What services will be provided by that hospice?

The Hon. F.T. Blevins: Daw House Hospice, as from 8 August 1988, has provided inpatient hospice services which were transferred from Kalyra. The unit will hold 15 patients and it includes motel-type accommodation for relatives and has areas in which day care can later be provided. It will also participate in an outreach service provided by existing community organisations. The unit will be operated by the Department of Veteran's Affairs on behalf of the South Australian Health Commission, which will share operating costs. The establishment of Daw House was part of a broad development of community based hospice care which the Bannon Government has been undertaking in South Australia over the past five years.

Since 1983, almost $1.5 million has been directed into the development of hospice care services right across the metropolitan area; a system which enables the terminally ill to remain at home wherever possible, with domiciliary support and for as long as it is reasonable to do so. A recent initiative was the appointment of the world's first chair in palliative care, to provide a focus in South Australia for education and research in the care of the terminally ill. Professor Ian Maddocks of Flinders University was appointed to the Chair and will jointly become the Director of Daw House. Daw House will become the nucleus of the Southern Hospice Association and, together with the chair in palliative care, will form the major hospice service in the state. It will play an important role in the ongoing development of hospice services in South Australia, which are becoming the most comprehensive and effectively coordinated in the country. The unit will employ 23 staff, including a considerable number of experienced and dedicated staff previously employed at Kalyra Hospital.

It was with a great deal of pleasure that, a few weeks ago, I opened this facility in conjunction with the Federal Minister of Veterans Affairs, Ben Humphrys. I commend the facility to the Committee. If any member of the Committee wishes to inspect the facility at a convenient time, I know that the administration would be only too pleased to show it to them. It is a quite remarkable establishment, and I certainly consider Daw House a fine replacement for Kalyra or, indeed, any other establishment.

Mr ROBERTSON: I refer to page 336 of the Program Estimates and 1988-89 Specific Targets and Objectives. With respect to the development of appropriate sobering up services at both Port Augusta and Ceduna/Koonibba, what progress has been made to date in their establishment? What are the services intended to achieve? How long will it take to get the services in place?

The Hon. F.T. Blevins: As the honourable member would know, this service has been a long time coming. The necessity for sobering-up services in Port Augusta and Ceduna has been well known for a number of years. I am pleased that, as part of the Health Commission's social justice strategy in Aboriginal health, it is proposed that the facilities will become operational as soon as possible. In Port Augusta local support for the establishment of a centre of up to 12 beds remains very strong and the hospital is the favoured site at this stage. An advisory committee comprising representatives from the local hospital, the police, the Pika Wiya Aboriginal Health Service, the Salvation Army and Alcoholics Anonymous has been formed to assist the Drug and Alcohol Services Council and the South Australian Health Commission to develop operational policies, management arrangements and a revised architectural brief. Integration with existing facilities and services in Port Augusta is being emphasised.

As regards Ceduna, local organisations and community groups support the establishment of a centre in the Murat Bay Hospital grounds due to the availability of stable management, back-up staffing, a well equipped kitchen, linen and other equipment and, of course, general practitioner medical services. An advisory committee has been established to assist the Drug and Alcohol Services Council and the South Australian Health Commission with detailed planning. Membership comprises representatives of the council, the hospital, the Far West Aboriginal Progress Association, the Ceduna Koonibba Health Service, the police, the Department for Community Welfare and the Commonwealth Department of Aboriginal Affairs. I am sure that everybody will wish the two centres well. The centres have been needed for a long time and I am pleased that, during this current financial year, something which will fulfil what everybody agrees is a great need will be established.

Membership:

Mr De Laine resumed his membership: Mr Robertson withdrew.

Mr BECKER: Can the Minister provide a detailed breakdown by specialty of the number of people waiting for elective surgery at each of Adelaide's seven public hospitals and show how many have been waiting for surgery for up to three months, six months, one year, 15 months, 18 months, two years, 30 months, three years, 40 months and four years or longer? What is the total number of people who have died during the past 12 months while awaiting elective surgery at each of Adelaide's seven public hospitals?

The Hon. F.T. Blevins: That information is available, but I regret the implication in the question that people in this State are dying while waiting for surgery. We are talking about elective surgery. In very many cases, when you are dealing with a number of old people, the elective surgery will be postponed for a whole range of reasons. The doctors concerned in managing the patient will make judgments as to whether or not the elective surgery ought to go ahead, even though the person is on a booking list. I make it clear that people in this State who require non-elective surgery have no problems in obtaining immediate access to our public hospital system. However, we are talking about elective surgery. I regret that the issue has been used in an attempt to give the impression to the South Australian community that they could die while awaiting necessary surgery. That is not the case. Any necessary surgery is performed immediately. However, I will provide a great deal of statistics and information.

Dr Blaikie: In 1987-88 we were able to determine that, at the Royal Adelaide Hospital, the Queen Elizabeth Hospital, Flinders Medical Centre, the Modbury Hospital and the Lyell McEwin Hospital, there were 108 deaths of people whose names were on the list for elective surgery procedures. An examination of those deaths does not suggest any relationship between the deaths and the procedures for which those patients were waiting. Examples of the types of elective surgery procedures for which they were waiting included vaginal repair, cataract extraction, cystoscopy, abdominoplasty, fasciectomy and other plastic surgery procedures. I do not think that there is any association between the fact that some people have died while they have been on booking lists and the procedures for which they were waiting. We have a table of booking lists which defines the specialties at each of the hospitals in the periods nought to six months, six to 12 months and greater than 12 months. The table reads as follows:

NUMBERS ON BOOKING LISTS IN MAJOR METROPOLITAN RECOGNISED HOSPITALS
WAITING TIME BY SPECIALTY—JULY 1988 (time in months)

Specialty	FMC				RAH				TQEH				LMc				MOD				TOTAL				ACH			
	0-6	6-12	>12	Tot.	0-6	6-12	>12	Tot.	0-6	6-12	>12	Tot.	0-6	6-12	>12	Tot.	0-6	6-12	>12	Tot.	0-6	6-12	>12	Tot.	0-6	6-12	>12	Tot.
General Surgery	220	31	28	279	228	52	24	304	196	12	3	211	119	11	3	133	133	9	2	144	896	115	60	1 071	116	16	3	135
Ophthalmology	78	1	0	79	295	73	29	397	109	31	3	143	4	0	0	4	—	—	—	—	486	105	32	623	44	3	0	47
Neurosurgery	6	0	0	6	17	0	0	17	13	0	0	13	—	—	—	—	3	0	0	3	39	0	0	39	5	0	0	5
Orthopaedic	202	37	11	250	319	118	92	529	330	41	2	373	—	—	—	—	121	14	1	136	972	210	106	1 288	63	4	1	68
ENT	156	67	124	347	158	39	10	207	172	47	34	253	198	37	4	239	100	12	0	112	284	202	172	1 158	356	56	12	424
Urology	88	26	36	150	74	18	17	109	139	17	2	158	70	3	0	73	74	21	5	100	445	85	60	590	16	0	0	16
Gynaecology	154	7	5	166	51	1	1	53	120	18	1	139	141	30	10	181	107	3	0	110	573	59	17	649	—	—	—	—
Vascular	4	2	1	7	50	6	6	62	52	27	16	95	—	—	—	—	—	—	—	—	106	35	23	164	—	—	—	—
Plastic	121	33	131	285	121	32	26	179	73	17	32	122	4	4	0	8	22	2	1	25	341	88	190	619	32	0	3	35
Thoracic	4	0	0	4	92	3	7	102	2	0	0	2	—	—	—	—	1	0	0	1	99	3	7	109	—	—	—	—
Craniofacial	—	—	—	—	1	0	0	1	—	—	—	—	—	—	—	—	—	—	—	—	1	0	0	1	6	1	0	7
Other/Not known	1	0	0	1	1	0	0	1	—	—	—	—	—	—	—	—	—	—	—	—	2	0	0	2	—	—	—	—
TOTAL	1 034	204	336	1 574	1 206	210	93	1 509	1 407	342	212	1 961	536	85	17	638	561	61	9	631	4 744	902	667	6 313	638	83	16	737

Mr BECKER: Is it possible to have an extension of those figures taken out to cover 15 months, 18 months, two years, 30 months, three years, 40 months and four years or longer? I know that the term 'elective surgery' is not looked upon as being lifesaving surgery or emergency surgery, but a couple of situations have been referred to me in my own electorate and one relates to cataract operations. A cataract can grow very quickly and thus impair one's vision. It is alarming to be advised that people with cataracts who probably should not drive motor vehicles are doing so. I was advised by my ophthalmologist that, even though I could not have a transplant, my vision was better after my cataract was removed than was the case with other people who had cataracts and drove to consult this specialist. I helped to arrange for a man in his late 70s to have a much needed hip operation. If this man fell again, he could have damaged an artery and bled to death before he reached hospital. In some cases, under extreme circumstances, people are greatly relieved when these operations are performed much earlier.

So, it is comforting to note that efforts are being made to reduce the waiting lists even though we consider the waiting lists do cause some concern and representations are continually being made to us by our constituents or their relatives seeking these various types of operation. Can you tell the Committee how many people were on the Adelaide Children's Hospital waiting list as at 30 June 1988 and what are the statistics for the various specialties. What was the waiting time in months for surgery in each of these specialties and what were the above statistics for the financial years ending 1983 through to 1987?

The Hon. F.T. Blevins: The first part of the question gets back to the statements I made earlier in the Committee. When we have dealt with the issue of booking lists, the information that the member for Hanson's constituent requires is available, and will be available, but if the constituent went to Modbury the waiting list would be nil. It is known as instant attention. The throughput at Flinders Medical Centre is rapid and there are 78 on the booking list (it is not a waiting list, because nobody waits) for that kind of procedure. With 78 people dealt with between zero and six months, one can see that the throughput at Flinders is rapid. There is no reason why the honourable member's constituent should be waiting any more than a few days or a couple of weeks, provided that constituent does not want a particular doctor at a particular hospital, and that is the problem we have. Doctors can only work so many hours a day, and if you want a particular doctor, you have to wait.

That information will be made available in a more usable form, so that the member for Hanson can ring up and assist his constituent by saying, 'Cataracts—no problem—go to Modbury' or 'Go to Flinders Medical Centre' which would probably be closer than Modbury for the honourable member's constituent. The booking list problem is, I believe, in part, a problem of lack of information on the part of the patients. I do not know the details of the second case that was outlined about the 75-year-old person who was waiting for or had requested a hip replacement. Those types of operations are performed. I cannot remember if the member for Hanson said that the person concerned had died.

Mr BECKER: No, I made representations and he was given the operation, and he is a very happy person.

The Hon. F.T. Blevins: I hope the member for Hanson is not suggesting he used undue influence. If he is, we will have to tighten up the system. Certainly, we are very happy for the member for Hanson and his constituent but you can see the problem. We do procedures in 1988 that we would not have dreamed of doing even 10 years ago and the demand for elective surgery is insatiable. Certainly, it outstrips the ability of the community to pay for it in the sense of giving instant access. The demand for plastic surgery is very high indeed; I am certainly not making any comment on the requirement for some of those operations but they are very clearly elective procedures.

If people waiting for plastic surgery, for example, or if everybody over the age of 75 or 80 who wanted a hip replacement, wanted it that day, the community does not have the capacity to finance that kind of service. It is just not there. We would be paying tens of millions of dollars—even hundreds of millions of dollars—extra to have that capacity for people to walk in and have procedures done today which 10 years ago they could not have had. I repeat the point I made earlier, that 50 per cent of the people on booking lists have their operation within 30 days, and that is a remarkable achievement.

With regard to the third part of the question, relating to the Adelaide Children's Hospital, yes, I have that table, and I feel it is probably best tacked on to the table that I had incorporated in *Hansard* a couple of minutes ago. It is part of, and can form part of, that same set of statistics. So I would attach the number of booking lists regarding the Adelaide Children's Hospital to the table 'Number of Booking Lists in Major Metropolitan Recognised Hospitals'.

Mr BECKER: How many people waiting for elective surgery at near city country hospitals as at 30 June 1988 have received such operations since then, and can the Minister provide details as to which hospitals have treated such patients prior to, and since 30 June 1988?

The Hon. F.T. Blevins: The short answer is, 'Not enough'. It seems to me to be a great shame that we have the capacity, in some of our near country hospitals to perform these operations perfectly adequately, and yet the system is so cumbersome that it is extremely difficult to have a patient transferred from a booking list at one of the major metropolitan hospitals to virtually an instant admission into a near country hospital. I believe that is a great pity in both ways. The person obviously is waiting longer for the particular operation; and, secondly, I believe that 25 per cent of people who live in the country actually come to Adelaide for their medical procedures. When we are losing patients out of our country hospitals in the way we are, action has to be taken that requires a change in the role of those hospitals. Country people coming to Adelaide is a contradiction that we ought to do all we can to address.

I have the figures that the member for Hanson requests. I just comment that the program to effect those transfers is not totally satisfactory. I feel it is a great pity that more people do not take advantage of the opportunity; I know it is complex and involves referrals from general practitioners to specialists and that specialists work in particular hospitals but it ought not to be beyond the wit of everybody concerned—doctors, patients and the hospitals—to organise the thing a little better so that we can utilise our near country hospitals more and also have patients treated more quickly.

Attempts have been made to have patients on booking lists treated in private hospitals. It has been offered to the medical profession on a fee-for-service basis but it has refused to cooperate for its own reasons, which the profession sees as valid. It is a great pity, given spare capacity in the private hospital system and when the State is prepared to pay for public patients to be treated in those hospitals, that we cannot get our act together. I do not know all the arguments against it. Suffice to say, the profession has not cooperated. The private hospitals are hardly flourishing, for that and other reasons.

Transfers to the Mt Barker and Southern Districts War Memorial Hospitals were more successful. Of 234 patients

from the Royal Adelaide Hospital and the Queen Elizabeth Hospital who were contacted, 69 accepted the offer and had surgery. Another 43 people had already been operated on or no longer required an operation, and that highlights the inadequacy of the information available. A considerable number of people (about 20 per cent) on these booking lists, which the commission has started to establish, have already had their operation or changed their mind but, for some reason, they are still on the list. Of those 234 people, 86 chose to remain on the Royal Adelaide and Queen Elizabeth booking list or already had an appointment at those hospitals and decided to wait rather than transfer. Another 36 patients from that 234 were undecided about what to do and the matter was left.

The program was worthwhile and had some success. It is a challenge for the commission to make it more successful, to get the information out to patients. It is clear from the Costa report that a program similar to that undertaken at the Royal Adelaide Hospital is unlikely to be successful. In that case the hospital contacted the patient, attempting to effect a transfer. The Costa report made perfectly clear that doctors were unlikely to cooperate when that procedure was adopted. The commission will have to give information to the patient, hoping that the patient, armed with that information, will go to his or her GP and ask about the possibility of having elective surgery at another hospital after referral to a specialist working at that hospital. I have already announced that the commission will try that procedure, because it is a pity that our near country hospitals have spare capacity while some of our metropolitan hospitals have quite significant booking lists in some specialties.

Mr TYLER: I refer to page 307 of the Program Estimates, noting that two significant items are mentioned: the construction of a new 120 bed hospital complex at Noarlunga and the redevelopment of the Riverland Regional Hospital. What are the details of those proposals?

The Hon. F.T. Blevins: The Noarlunga facility will be a 120 bed hospital, comprising a public hospital of 90 beds and a private hospital of 30 beds. The estimated capital cost of $19.524 million (August 1988) has been included within the Health Commission's capital works program. The project has been referred to the Public Works Standing Committee. Construction is scheduled to commence in February 1989 with completion in August 1990. Services to be provided at the hospital will be consistent with those of a level 1 community district hospital and will include: minor casualty; primary care; consulting services; theatre and delivery suites; diagnostic laboratory; radiology; pharmacy; and allied health services.

The provision of the new hospital facility at Noarlunga will serve the local government areas of Noarlunga, Willunga and Happy Valley and will reduce pressure on the Flinders Medical Centre. Provision has been made for the hospital to expand to 180 beds in the future. As the member for Fisher often says, part of his electorate in Happy Valley is known as 'Nappy Valley', so provision has been made for expansion. There is a 60 per cent projected increase in the number of live births from 1 910 in 1985 to 3 046 in 1996 and the ageing of the population (a 144 per cent increase in persons aged over 65, from 4 166 in 1981 to 10 182 in 1996) will result in an increased demand for health services in that catchment area. The existing medical drop-in centre at the Noarlunga Health Village will be relocated to form part of the primary care/minor casualty service at the hospital. Operating costs of the hospital are estimated to be $7.6 million in a full year (August 1988).

With respect to the Riverland Regional Hospital, over the years each of the five hospitals in the Riverland have been developing their hospital facilities independently. A review in 1981 revealed that recent applications for capital funding contained duplications of specialist facilities. To alleviate this situation, ultimately it was recommended that Berri Hospital should be redeveloped to provide the specialist services for the Riverland. In addition to the specialist facilities for the region, the hospital will continue to provide basic level 1 hospital services to the township of Berri. The existing hospitals at Loxton, Renmark, Barmera and Waikerie will continue to provide basic level 1 services to their immediate townships. The proposal involves the building of new ward accommodation of 56 beds and a new clinical services block.

The existing Berri Hospital will be modified extensively to accommodate all support services. The regional rehabilitiation facility has already been completed at a cost of $490 000—that was in 1985. Again, that is another indication that the country hospitals program of this Government is an extensive and rational program. It means that, in those areas where it is sensible to redevelop or to centralise, particularly in specialist services, it is in the interests of the whole of that region that that be done.

Everyone in the Riverland would have to agree that we cannot have five independent operations with none of them capable of sustaining the range of services that that region demands, and the rationalisation that is occurring and the redevelopment of the Berri Hospital is an indication of the way in which country hospital services in general have to be dealt with. We can no longer afford the luxury of having many disparate unviable hospitals when, given the catchment area and the numbers in the region, we can have a decent regional hospital whilst these other hospitals remain but in a slightly different role. We can also attract the specialist services that everyone living in the country knows are desperately needed.

For people like me who live 400 kilometres from the city and who have to come to Adelaide for specialist services, a rational use of resources within the community will assist in providing those specialist services at home and be of tremendous advantage to country people. I commend the Government, my predecessor and the commission for the attention they have paid to country hospital services and country health in general.

Mr TYLER: For some time the Opposition has been claiming that medical equipment in our teaching hospitals is rundown, and the member for Heysen referred to the Royal Adelaide Hospital in that regard. What funds have been provided in recent times for the purchase of equipment in our hospitals?

The Hon. F.T. Blevins: It has been regrettable that the Opposition has from time to time made statements about our hospitals and their equipment that cannot be substantiated by the facts. We have an extensive program of upgrading hospital equipment and adding new equipment. Under the Commonwealth Teaching Hospitals Equipment Program a total of $12.6 million was provided over the last three years, comprising $4.2 million in each of the financial years 1985-86, 1986-87 and 1987-88—a substantial sum for the State.

As to the State Hospitals Equipment Program, in 1988-89 the State Government provided $4.8 million from the capital works program for equipment in major metropolitan and country hospitals. As the details of the proposed allocations will be of interest to the Committee, I will ask the Chairman of the commission to detail them shortly. As to operating budgets, in 1987-88 a total of $5.133 million was spent on equipment from the operating budgets of the seven major metropolitan hospitals and the IMVS. The 1987-88

expenditure compares with the total of $4.739 million in 1986-87, which represents an 8.3 per cent increase in funds for equipment. The details of equipment expenditure by unit are as follows:

	1987-88 $	1986-87 $
Adelaide Children's Hospital	291 000	388 000
Flinders Medical Centre	1 393 000	1 432 000
Queen Victoria Hospital	112 000	119 000
Royal Adelaide Hospital (including IMVS)	2 082 000	1 901 000
Queen Elizabeth Hospital	748 000	494 000
Lyell McEwin Hospital	236 000	197 000
Modbury Hospital	271 000	208 000
Total	5 133 000	4 739 000

That represents an 8.3 per cent increase. However, that is not the only source of funds that hospitals have for the purchase of equipment.

Other sources include private practice equipment funds, capital donation and bequest accounts and the Commissioners of Charitable Funds. I will not go into those details, but the amounts are significant. As I am sure that the committee would be interested in the breakdown of equipment purchased as recommended by the Medical Equipment Priorities Committee, I ask the Chairman of the commission to give those details for the individual hospitals.

Dr McCoy: It has been pleasing in the past four years to see a massive investment in high cost technology equipment in major teaching hospitals. As the Minister said concerning this program, for the last three years it was provided by the Commonwealth and I am pleased that this year the State Government has continued that program and increased the amount available. In all the major hospitals, including major country hospitals, there have been significant investments in capital equipment. Referring to the highlights, anaesthetic equipment in teaching hospitals has been a matter of concern to the commission because it tends not to be a high cost and individual item, but the package of equipment is a high cost indeed.

This year $138 000 is being spent at the Children's Hospital and $110 000 at the Queen Victoria Hospital to upgrade the anaesthetic equipment. That is a major advance. The Children's Hospital has a new operating microscope at a cost of $64 000 and the Flinders Medical Centre has a new X-ray image intensifier, which is to be used in the operating theatre, at a cost of $150 000. A new whole body nuclear medical scanner has been provided at Flinders at a cost of $460 000. At the Queen Victoria Hospital the Haematology Department has a blood cell analyser at a cost of $90 000. Earlier I referred to the whole body CAT scanner and the radiotherapy planner at the Royal Adelaide Hospital which together cost $1.1 million. At the Queen Elizabeth Hospital a new image intensifier in the cystoscopy theatre cost $90 000.

Another image intensifier in the Room 8 X-ray Department cost $70 000; the Neurology Evoked Response System cost $105 000; a digital angiography system at the Queen Elizabeth Hospital cost $500 000—this is a magic piece of high technology equipment that combines X-ray pictures with computer technology, allows for a great enhancement of the picture and has been enormously successful in examination of arteries in the body that are subject to degenerative change.

At the Institute of Medical and Veterinary Science a new ultra centrifuge for immunology cost $110 000; an autonephalometric system cost $65 000. At the Lyell McEwin Hospital a general obstetric ultrasound unit cost $185 000; another fluoroscopy and general X-ray unit cost $490 000; another mobile X-ray equipment cost $60 000. At Modbury Hospital, an image intensifier for the X-ray Department cost $150 000, and a replacement obstetric ultrasound unit cost $150 000.

Equipment was provided at two of our major country hospitals: at Mount Gambier, a new fluoroscopy and angiography unit, $600 000, and an ultrasound unit, $80 000; and at the Whyalla Hospital, radiology equipment upgrade, $180 000. That is a total list involving over $5 million. Allowing for slippage, which always occurs in the purchase of major equipment, we do not expect to exceed the allocation, which for this year is $4.86 million.

Mr INGERSON: In relation to the Foundation for South Australian Sport, as the Minister would be aware, there is a considerable amount of concern amongst member associations about when the guidelines will be set in relation to applications to the fund and about exemptions. I understand that some exemptions are controlled by the Minister of Recreation and Sport but others are controlled by the Minister of Health. Also, there is some concern about what the healthy lifestyle promotion is all about. Will the Minister advise the department where we are with this foundation and when the guidelines and any other information will be made public?

The Hon. F.T. Blevins: The guidelines are in the process of being prepared. When they have been prepared, announcements will be made. As soon as those guidelines are available the honourable member can have a copy of them. I am not sure that this is the appropriate forum for me to wax eloquent over what a healthy lifestyle is all about. I would have thought that the member for Bragg would know that. It seems to me to be pretty basic. I have found the concern that he expressed on behalf of sporting bodies—I have been here only a short time—to be very minor. Of more interest, the people associated with sports, to whom I have spoken or who have spoken to me, just want the cheques. They are not terribly concerned about the things that appear to concern the member for Bragg.

A great deal of concern has been expressed to me about the member for Bragg's attitude to the foundation: it is implacably hostile. That is a great pity because some of the spin-offs for health and sporting and arts bodies in this State, in the application of this money are considerable, so everyone is a winner. But, the member for Bragg is still pretty churlish about the whole exercise: that is a great pity. Jim Jarvis, who spoke on behalf of the foundation and who wrote to me a few weeks ago after the member for Bragg raised a matter in the House, put it very well. I can only refer the Committee back to his letter in *Hansard*: it certainly made one or two points very strongly indeed.

I was also a bit distressed (which is not too strong a word) at the attack by the member for Bragg on the foundation when it gave the Olympic Appeal $100 000. I would not have thought that anyone in this State would be anything other than overjoyed that the Olympic Appeal was able to benefit by $100 000 from the foundation. It was one of those things that pleased everyone; however, it appeared not to please the member for Bragg. That is very sad, but the guidelines will be available soon.

Mr INGERSON: As a supplementary question, now that we have been able to vilify the member for Bragg, perhaps we can answer the question. When will the program that will be available under this new foundation be made public? What sort of promotions will be put forward by the foundation as coming from the Minister of Health so that the public is aware of the good work that the foundation may

enter into? I know that the Minister has enjoyed himself: now, perhaps he can answer the question.

The Hon. F.T. Blevins: I certainly did not vilify the member for Bragg. It would be unnecessary for me to do so: the member for Bragg seems to be capable of doing that himself. I stated clearly that the guidelines will be available shortly. The member for Bragg will no doubt get them as early as anyone else.

As regards programs, that will essentially be something for the foundation to decide within the guidelines. I do not see any great problem with that. The foundation consists of highly intelligent people who are dedicated to sport, the arts, and health. I am absolutely certain that with a very small support staff they will be able to come up with imaginative and useful programs that everyone will welcome. I assume that everyone will welcome them: there is always that caveat that maybe some person around the place has sour grapes but, nevertheless, those people are very capable of coming up with imaginative programs. It is not for me, the Minister for the Arts, or the Minister of Recreation and Sport to dictate to them: it is not necessary. Whilst the guidelines will be clear, they will not in any way detract from the independence of the foundation. That was a basic tenet of the foundation. I have every confidence in its ability.

The Hon. D.C. WOTTON: I have been made personally aware in very recent times of the magnificent work that has been carried out by the Australian Kidney Foundation, and in particular the South Australian division of that foundation. I would like to be able to provide all the support I can to that organisation. The future objectives of the foundation revolve around the priority that will be given to research, prevention and treatment of kidney disease in children, education of both public and medical professions in the necessity of early detection and treatment of the disease, and an active role of the foundation as a catalyst between patients and associations or groups to fund projects or community service.

I have been made aware that its most important priority is to increase the public's awarness of organ donation as a successful and cost-effective way of restoring a high quality of life to people who have experienced renal failure. I am also aware that it wants to establish itself at an even more professional level and significantly increase its current meagre return on fundraising. Its capacity to continue its awarness drive with respect to the need of organ donations must result in an ultimate saving to all taxpayers. I understand that application has been made for a grant over the next three years to enable the organisation to employ full-time staff. What assistance is being provided to this organisation by the Government?

The Hon. F.T. Blevins: I share the honourable member's respect for the Australian Kidney foundation, and I think that the work it does is absolutely superb. My particular hobbyhorse is organ donation, and I have made no secret of that. When I see people who are leading miserable lives because of kidney failure, who have to spend hours on kidney machines every three days (twice a week or whatever) and who die becuase there is no suitable organ available, I am outraged that every day we burn and bury perfectly viable organs. While I respect the arguments of those who do not want to donate organs—a person's right to do that is not to be questioned—I think that society is failing when it allows, alongside this misery that people suffer because of kidney failure, the daily burning and burying of viable organs. This totally unnecessary misery and suffering is caused because society cannot get its act together. I wonder whether members of this Committee have looked at their driving licences and have bothered to sign the back—and I suspect that most have not—indicating that they are willing to donate organs—kidneys or whatever.

The foundation attempts to draw to the attention of the public the necessity for individuals to do something about kidney donation. At present I have no knowledge of any specific new request from the foundation to enable it to employ a fundraiser. This year we have allocated $6 000—a not insignificant amount—to the Kidney Foundation to assist it with what it does, but I am not sure whether that amount is in response to the request that was outlined by the honourable member. Recently a Statewide coordinator was employed at the Queen Elizabeth Hospital to facilitate the better matching of organ donors to the people who need them. I am sure that within the present inadequate system we can do better. While I am pleased to see the provision on the back of driving licences indicating that the holder is willing to be a donor, I do not think that sufficient publicity is given to this when licences are renewed. Many people who have carried driving licences for years I am sure have never looked at this microscopic declaration. I believe that the Minister of Transport could help us obtain more donated kidneys, in particular, and other organs.

Dr McCoy: The commission has received a request from the Australian Kidney Foundation, and this request was referred this month to the commission's Renal Services Advisory Committee, which will report and made a recommendation to the Minister.

Mr RANN: I move:

That the sittings of the Committee be extended beyond 6 p.m. and that at 6.30 p.m. the sittings be suspended until 8 p.m.

Motion carried.

The Hon. D.C. WOTTON: Last week in the House I raised with the Minister the possible closure of some CAFHS centres, and the Minister indicated that he would bring down a reply. Recognising that the House will not be sitting for a few weeks, is that information now available?

The Hon. F.T. Blevins: Yes. Not just the member for Heysen but the member for Coles and, I believe, the Leader's office have been constantly requesting this information. There will be no reduction in funding from CAFHS. CAFHS, like any organisation, constantly has its operations under review and makes adjustments. A large proportion of what CAFHS does relates to the now absorbed mothers and babies organisation. Obviously, where there is a mothers and babies clinic in an area where there are not too many mothers and fewer babies, one must look at the operation and see whether or not one is using the resources wisely; and if, after examing a particular area, one decides that it is not, then, in consultation with the local community, it may be that the operation (or parts of it) should be transferred to other locations where there is an expanding need for CAFHS services.

I can give the honourable member a list of the various relocations that are proposed. As I understand it, the service is never totally withdrawn: it is scaled down, altered, or expanded in some areas. Certainly, in general, the ongoing review of the operation shows that resources need to be shifted from places of declining demand to places of increasing demand. That is certainly something that everyone on the Committee would agree with. I will provide a list of locations that are under review.

The Hon. D.C. WOTTON: As far as the Government is concerned there is no reduction in funding.

The Hon. F.T. Blevins: None whatsoever. I stated quite clearly at the start of the examination of this vote that it

essentially represents a standstill budget with some modest increases in a number of areas. CAFHS is no different. The CAFHS budget is essentially a budget plus CPI, minus the contribution for the 4 per cent productivity increases, plus any wage increases that occur between now and the next budget. I can give that answer for virtually every sector.

Mr RANN: There has been a great deal of talk about patients' rights in recent years with patients perhaps finding difficulty with the new technology and in determining their rights in respect of surgery. What is the Health Commission doing in terms of promoting patient advocacy in hospitals?

The Hon. F.T. Blevins: The Health Commission has established a task force to report to the Government on the question of patients' rights. We all know that from time to time an issue will arise—generally in question time—where a patient feels that he or she has not been treated properly by an individual health unit, whether it be a hospital or whatever. Of course, from time to time they are correct. We wanted to establish what patients' rights were and how people can effectively realise, or assert, their rights in this area. Therefore, a task force on patients' rights was established by the previous Minister in February 1987 to examine patient/staff communication issues and complaint mechanisms.

The task force reported to the previous Minister early this year and since that time the Health Commission has developed a strategy for implementing the recommendations contained in the report. This task is being managed by the commission's Quality Assurance Office. In its first report, the task force noted that, while liability for patient compensation remains based on fault, the obligation of hospitals and the commission to insurers inhibits free disclosure of medical records to, and communication with, aggrieved patients, whatever mechanisms are adopted to provide complaint and information services to patients.

The Australian Health Ministers' Conference in March 1988 agreed that the task force would develop a proposal for a national or uniform no fault compensation scheme for medical misadventure. Since March the task force has written to a range of organisations which have interests or obligations in the area of medical misadventure, professional indemnity and no fault compensation, seeking submissions, comments or information that may assist the task force in its consideration. Responses were sought by 30 June 1988. However, major contributors such as the Law Council of Australia, the Insurance Council of Australia and the AMA have sought extensions.

The chairman and exeuctive officer of the task force have met with representatives of the Medical Defence Union, the Medical Protection Society and the AMP Fire and General Insurance Company, which is the insurer for the South Australian Health Commission. They have also visited New Zealand to examine that country's accident compensation scheme. Data collection is substantially completed and preparation of a draft report has commenced. The draft report will be distributed to the State/Territory advisory committee in late October for comment. The task force will meet with the advisory committee in mid November to consider the draft report. The recommendations of the patients' rights task force regarding patient advocates was endorsed by the previous Minister. Funding has been set aside as part of the new initiatives for 1988-89 to support quality assurance. At this time the details of what will be done and the funding involved are yet to be finalised.

That indicates that the Government does take the issues of patients' rights seriously. Recipients of professional services are more and more asserting their rights, and quite properly so. Happily, the submissive patient or client of a professional of the past is fading away. The fact that people have these rights and that they are entitled to assert them (and that we should assist them in that) is a very sound principle. I am not suggesting that doctors, lawyers or other professionals are in any way oblivious of their clients' rights, but assistance to those clients or patients to assert those rights is more than justified.

Mr RANN: Last week the Public Works Standing Committee visited the Mount Gambier Hospital to inspect some of the upgrading work that it processed through last year's budget. Can the Minister supply an update on ongoing works for the Mount Gambier Hospital?

Mr Blight: The work carried out last financial year to refurbish the central sterile supply department was meant to be done as part of the phase 1, stage 1 redevelopment. That development work was to commence in full last financial year but, due to capital constraints, that was not possible. The work that was carried out was done partly through the application of hospital funds and partly through additional funding provided by the country health services division. The 1988-89 capital works program will allow the phase 1, stage 1 work to commence in full. That will enable the finalisation of the central sterile supply department development to be completed. However, it is also proposed that it will include improvements to the rehabilitation and assessment ward, refurbishment of a medical ward, provision of new psychiatric and psychogeriatric beds, redevelopment of the theatre recovery area and a new medical records department.

The Mount Gambier Hospital, particularly in those areas mentioned, is in a run-down condition, and these development works will certainly improve the functional relationships within the hospital and its operational efficiency. Phase 1 stage 2 of the work is scheduled for 1991-92 at a cost of $4.25 million. That work will include upgrading the Casualty and Radiology Departments and will allow some further redevelopment of wards. It is unfortunate that there is a gap between the phase 1 stage 1 work and the phase 1 stage 2 work.

It is my view that the accident emergency services, which are in stage 2, are of a very high priority, and I will commence negotiations next week with the hospital board and the hospital planning committee to look at the possibility of swinging some of that work into the phase 1 stage 1 moneys. It should be possible to complete the theatre recovery redevelopment and the accident emergency development and to provide a day surgery facility within the funds allocated in the program.

In addition, $650 000 is scheduled for upgrading the laundry in 1989-90. That laundry is servicing not only the Mount Gambier Hospital but also a number of nearby hospitals. Not associated with the hospital but scheduled for the Mount Gambier township is the redevelopment of the health village. That has an estimated cost of $1.9 million, scheduled for 1991-92. However, I must state that we are currently looking at a leasing option which may enable us to move ahead with the health village concept in advance of the 1991-92 capital project.

Mr RANN: Are there any moves to upgrade palliative care in South Australia?

The Hon. F.T. Blevins: Earlier on I indicated some of the programs. I particularly mentioned Daw House and what a superb facility that was, but we are also involved in many other things. We have a very extensive program in this area. The philosophy behind hospice care is interesting because, whilst it is not a totally new area, I believe that only in recent years we have given it the attention that it obviously deserves. Hospice care is a multi-disciplinary program of

palliative and supportive care which provides physical, psychosocial and spiritual care for the dying person and their family. The primary objective of hospice care is to minimise pain and suffering for the terminally ill. Hospice services have expanded significantly in the metropolitan area in the 1980s.

When the Labor Government came to office, the Southern Hospice Association was the only hospice service funded by the Health Commission, and that involved a mere $20 000 annually, so we have certainly come a long way since November 1982. Between 1983-84 and 1986-87 more than $1 million was directed to the development of community based hospice care.

Developments in the past two years have included, in the north of the metropolitan area, the appointment of a coordinator based at the Lyell McEwin Health Service and the provision of visiting medical specialists in palliative care at the Lyell McEwin and Modbury Hospitals; in the western suburbs, the provision of $160 000 for the Phillip Kennedy Centre and a further $70 000 for a Medical Director and Palliative Care Nurse based at the Queen Elizabeth Hospital; and, in the south, the appointment of a half-time Medical Officer, with clerical support, to augment hospice care services in the region. In addition, over $600 000, capital and recurrent, has been provided for expanding the activities at the Flinders Medical Centre Pain Unit. A total of $340 000 additional funding was allocated in the 1987-88 budget for new initiatives in community based hospice care.

An additional $40 000 was provided to the Flinders Medical Centre Pain Unit, which provides valuable support for the Southern Community Hospice Program. An amount of $125 000 was provided to the Mary Potter Hospice and an additional $15 000 was provided to the Phillip Kennedy Centre in recognition of the significant costs that both organisations have borne in the past in caring for the many public patients who need hospice care. Further, $130 000 has been provided for the establishment of a Chair in Palliative Care at the Flinders University to provide a focus for education and research in the care of the terminally ill. Also, $30 000 has been provided for the appointment of a Social Worker/Coordinator of Volunteers at the Queen Elizabeth Hospital.

In 1988-89 provision has been made for the establishment of a Central Eastern Palliative Care Team, which will be developed and coordinated by a Director of Palliative Care working from both Calvary and the Royal Adelaide Hospitals. In the future, it is likely that additional funding will be provided in 1988-89 from the Medicare initiatives package to allow additional enhancement in the provision of hospice care.

Within the next year or so South Australia will have the best, most comprehensive and the most efficiently coordinated hospice service in Australia. The challenges for hospice care in the next decade will be to cater for the needs of an ageing population with a concomitant increase in crude mortality rates, a large proportion of which will be due to cancer and to cater for the needs of those suffering terminal illnesses following the effects of the AIDS virus. AIDS sufferers are just as much in need of hospice care as those with terminal cancer, and there is no logical reason to have separate programs for their care.

While the provision of substantial services has been a long time coming, I am pleased that, in South Australia, we are now doing it very well indeed. I think it would be appropriate if Ms Johnson from the State-wide Health Services Division added something to that, because some very interesting and important initiatives have occurred in this area within nursing also.

Ms Johnson: The Royal District Nursing Society provides skilled nursing care to the sick and disabled in their homes on the basis of need. The RDNS has supplied a limited service in the evenings to the metropolitan area and has submitted a proposal to extend this service to a 24-hour service and into the country areas. The new services are intended to cater for those people at home who need post-operative service and also for those people who are terminally ill. The Health Commission is negotiating with the Commonwealth Government to obtain funds under the Medicare agreement in order to provide for the expansion to a 24-hour nursing service and to cover country areas. The expansion would allow for the commencement of a night service from 11.30 p.m. until 8 a.m. at a cost of about $381 000 and the commencement of two additional evening shifts and the extension of the four current evening shifts from 9.30 p.m. until 12 midnight at a cost of about $328 000.

Mr BECKER: How many beds have been closed in Adelaide's seven major hospitals either permanently or temporarily in the 12 months to 30 June 1988? If they were closed temporarily, for how long were they closed and for what reason? What effect have these bed closures had on waiting lists at the hospitals involved?

The Hon. F.T. Blevins: I believe that, with the possible exception of the Lyell McEwin Hospital, the answer is possibly 'None'. We close beds down not just in the metropolitan area but also in the country area, including our largest provincial city, not because it has anything to do with the booking list question but simply for greater efficiencies within the hospital. Wards are amalgamated, etc. so that you get a higher usage rate of beds; hence the economies that obviously flow from that. But if there is anything further in your question that I have not answered, I will have the question examined and, if there is anything further that needs to be added, I will give it to *Hansard* before the appropriate date.

Mr BECKER: Are you able to provide the Committee with copies of all specific budget correspondence sent to all hospitals and health units under the control of the Health Commission which details the allocations for 1988-89, specific cuts and/or special grants and the breakdown of wages and salaries, goods and services funding; and are you also able to provide a copy of all directives to hospitals and health units from the commission during the 12 months ending 30 June 1988 relating to funding and financial reports?

The Hon. F.T. Blevins: I am not sure. I will have that matter examined and, if it means tearing the Health Commission apart for the next six months to find those documents, I will advise the honourable member. It may well be that they are readily available, but at this stage I do not know.

Mr BECKER: Can you tell the Committee where, in the budget lines, is the provision to pay the legal costs for your predecessor, the Hon. J. Cornwall, in relation to the Humble defamation case?

The Hon. F.T. Blevins: Did you see it in the budget lines? Well, there you are.

Mr BECKER: It is not a matter of not seeing it. Is it there: that is what I want to know? I want to know where it is.

The Hon. F.T. Blevins: Have a look. You have had a look, you have not seen it, so it is not there. It is certainly not in my lines, so what has it got to do with this Committee?

An honourable member interjecting:

The Hon. F.T. Blevins: Do not tell fibs; the Premier did not say it was.

The CHAIRMAN: Order! We will have one question at a time from the member whom I designate, and at the moment it is the member for Hanson.

Mr BECKER: The supplementary question is that on page 114 of *Hansard* of 10 August 1988, in answer to a question from the Leader of the Opposition, the Premier said:

> It is very simply done by adding the appropriate amount to the Health Commission lines.

He was answering this question from the Leader of the Opposition:

> Will the Premier advise the House from which part of the State budget the money will come to pay Dr Cornwall's bill of some $220 000 if it is not to come from the health budget? In a previous ruling the Auditor-General indicated to the Parliament that damages in the Chatterton case had to come from one of Mr Chatterton's departmental lines in the agriculture budget.

The Premier replied:

> If in fact what the Auditor-General was saying is that it had to be paid through that line, that is very simply done by adding the appropriate amount to the Health Commission lines.

Therefore I repeat the question: which line?

The Hon. F.T. Blevins: It is not here so it is not before the Committee today. If the Premier adds it to our lines, that is fine: he will add it to our lines and we will pay it out. It has nothing to do with the programs of the Health Commission. It is not here.

Mr BECKER: I therefore move:

> That this Committee condemns the Bannon Government for agreeing to pay all legal costs (about $150 000) involved in the defamation case of the former Minister of Health, the Hon. J. Cornwall, by appropriating funds from the 1988-89 health recurrent budget.

The Hon. F.T. Blevins: It has not been appropriated.

The CHAIRMAN: It is competent for the Committee to receive a motion. I have a motion before the Chair. Does the member for Hanson wish to speak to his motion?

Mr BECKER: Yes, Mr Chairman. I raise the issue, because the question was asked in the House of Assembly, and an undertaking was given by the Premier that it would be simply done to cover the cost of the previous Minister of Health by adding the appropriate amount to the Health Commission lines. We are here considering a budget and approving an amount of expenditure, be it a balanced budget or a budget that will run over the allocation; and when we are asked to consider a budget surely we should be considering a budget that covers and contains all costs for the current financial year, as far as reasonably can be expected.

We know that a sum of money will be paid at this stage. There are some costs incurred, and I cannot say exactly how much those costs are, or if they are simply the legal costs. There is also a directive that was given to Parliament—'Recommendations *re* the representation for Ministers in defamation proceedings', clause 7 of which states:

> Any Government expenditure incurred in respect of defamation proceedings in which a Minister is involved, will come from funds appropriated to a department administered by the Minister concerned.

So I reiterate that, if I am asked to consider a budget—and it is supposed to be a fair and reasonable budget—it is fair and reasonable to know exactly what is contained in that budget and what costs are expected to be met from it. If it is anticipated that there will be some expenditure, a provision should be made. That expenditure may not occur and, if it does not occur, of course, there is a surplus or a refund to Treasury, but provision should be made to cover those costs if that is the Government's intention, and I believe the Committee has every right to know.

What disturbs me more is that the amount that the Government has budgeted to pay the damages in the Humble defamation case has caused considerable discussion in the community, and the Government knows there is widespread community outrage at the Premier's decision to indemnify the former Minister.

Our move in Parliament is simply an attempt to reflect public opinion. We believe taxpayers must be protected against this Government's attempt to use some of their hard earned money to pay for Dr Cornwall's inability to hold his tongue. At the same time as the Government was agreeing to indemnify Dr Cornwall, it was also planning further reductions in funding to teaching hospitals, country hospitals and a wide range of health units, such as the Anti-Cancer Foundation, the pensioner denture scheme, and the Adelaide Rape Crisis Centre.

In fact, the cost of medical services to the community in this State is not being reduced. The cost to the average citizen is increasing for those who wish to make use of the services available, either through the Government hospital system or the private system. Some are forced into the private system because of the waiting lists. The public believe that they should not be asked to pay any of the Minister's costs.

The former Minister had plenty of opportunity before the case went to trial to apologise to Dr Humble. His refusal to apologise exasperated the eventual seriousness of the case when it was found against him. A public apology before the trial would have significantly reduced the cost to taxpayers by eliminating the need for an expensive court case and defamation award. The former Minister's arrogance continued in court where he initially refused to concede that he had made any of the statements about Dr Humble; yet, in later proceedings he conceded that some of the comments might have been made. It is still by no means clear whether the Government will indemnify the former Minister for any fringe benefit tax accruing from payment of the defamation and legal fees.

It is for those reasons that public concern has been expressed because it affects health services and the health of the people. People are concerned that moneys allocated to the health budget are earmarked for that purpose. The decision by the Government to pay the legal costs, by taking them out of the health budget, has caused real concern within the community. As a matter of principle the Opposition condemns the Government for its decision.

The Hon. F.T. Blevins: This is my fifth or sixth year before the Estimates Committees and this is the most miserable performance I have seen from the Opposition. Had it not been for two articles in today's *Advertiser*, with one or two exceptions, Opposition members would have had nothing to ask. They did not do any homework on the information that I provided last week, on which they could base sensible questions. Quite clearly, that has not been done. All that has happened today is that, in the remaining 10 minutes, the member for Hanson has read a prepared statement villifying all and sundry.

There is no allocation to pay any costs of the former Minister. It has nothing to do with our budget. The Premier made perfectly clear that, if any costs were incurred, they would be added to the health budget. It is irrelevant to the Health Commission or to any health unit in this State. If costs total $150 000, we will get a cheque for $150 000 and it will be paid wherever it has to be paid. We will merely be a vehicle for paying that. That is what the Premier said. Of course, it is easier to stand up and read something like this than do the hard slog.

We never present a budget to the Estimates Committees that is everything we expect to pay out in the following 12 months. For example, no provision is made for wage

increases. I have stated several times during this Committee that, if wage increases of 3 per cent or $10 are awarded, that will be in addition to the budget. I made perfectly clear that there will be additional expenditure and that that expenditure will be provided from Consolidated Revenue via Treasury. There is nothing new about that and I would have thought that the member for Hanson had been here long enough to know that. Whatever the costs, if any, from Dr Cornwall's case, it will have no effect on the health budget: it cannot have any effect. For those reasons, I urge the Committee to oppose this quite preposterous motion that has been moved by the member for Hanson.

Mr RANN: It is quite clear that this is a frivolous motion. It is a pity that the member for Hanson did not use the tea break to read the budget. He did not know when asking the question and moving the motion whether there was a line in the budget concerning the indemnity. All this argument has been thrashed out. The proprieties and precedents have been established and this matter is breaching all parliamentary traditions. The member for Hanson realises that this matter is before the courts and that there is an appeal. With the appeal, the matter has become *sub judice* and there may be no money to pay out whatsoever. This is a joke item. He calls himself a shadow Minister: he is just a shiver looking for a spine to run up.

[*Sitting suspended from 6.30 to 8 p.m.*]

Mr BECKER: We moved this motion as a matter of principle. We object strongly to the action taken by the Bannon Government. We are not prepared to cover those costs—whatever they may be. From our point of view the motion and the debate has nothing to do with the proceedings before the court. It is purely a matter of principle in reply to an answer given in the House of Assembly as to the provision of the amount under the budget. What worries me and what disturbed the Opposition is that the Minister said, in effect, that this is not a balanced budget.

I take on good faith from the Premier that when we consider a budget it covers everything that might occur and the amounts are correct. Otherwise, it is not on. We are asked to approve a budget involving the total expenditure of just over $1 billion. Certainly, we will not approve just a rough figure. It is about time that we got a little closer to the estimates in respect of the budget. That is what the principle is all about. I will not take any of the nonsense that has been stated in this debate. This is a matter of principle, and we stand behind it strongly. I commend the motion to the committee.

The Committee divided on the motion:

Ayes (3)—Messrs Becker (teller), Ingerson, and Wotton.

Noes (3)—Messrs De Laine, Rann (teller), and Tyler.

The CHAIRMAN: There are three Ayes and three Noes. There being an equality of votes, I cast my vote for the Noes.

Motion thus negatived.

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

Works and Services—South Australian Health Commission, $49 877 000—Examination declared completed.

Correctional Services, $47 815 000

Chairman:
Mr D.M. Ferguson

Members:
Mr H. Becker
Mr M.R. De Laine
Mr G.A. Ingerson
Mr M.D. Rann
Mr P.B. Tyler
The Hon. D.C. Wotton

Witness:
The Hon. F.T. Blevins, Minister of Correctional Services.

Departmental Advisers:
Mr M.J. Dawes, Executive Director, Department of Correctional Services.
Mr R.M. Durant, Director, Community Corrections.
Mr I.J. Winton, Director, Support Services.
Mr K.R. Goulter, Chief Finance Officer.
Mr R.G. Wright, Senior Finance Officer.

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

Mr BECKER: Is the department's annual report available? Last year I found the statistical information extremely valuable and it could save the Committee much time. I am mindful of the situation that has occurred in South Australia over the past six years or so. In 1981-82 the recurrent cost of the department was some $19 million and the capital expenditure was $4.4 million—a total of $23.8 million. During that year the average daily number of prisoners in gaol was 813, and this was backed up by 616 staff whose salaries were $12.4 million; and the average cost of keeping a prisoner in gaol was $19 900.

As at 30 June 1988 the recurrent cost of the department was some $59.6 million and the capital expenditure was $13.3 million—a total of $72.9 million. This total amount shows the tremendous commitment necessary to obtain a reasonable standard of accommodation in correctional services. Also, as at 30 June 1988, the average daily number of prisoners in gaol had dropped to 809; the number of staff employed had risen to 1 098 (an increase of 78.2 per cent), and their salaries were $34.6 million (an increase of 179 per cent); and the average cost of keeping a prisoner in gaol had leaped to $58 000 per annum (or a 191 per cent increase). Those statistics are an indication of the mammoth task that is required to provide security for those who offend.

We are concerned that about 62 per cent of prisoners—particularly those who have served 12 months or more—reoffend in the first five years after release. We seek programs and attitudes to help reduce that rate. The task of those who supervise prisoners is not easy, and we are aware of problems in relation to stress and difficulties in carrying out that job, such as allegations of assaults and abuse by staff. Of course, prisoners are always causing mischief by laying all sorts of allegations against the staff, and this must have some impact on management in trying to run a peaceful operation.

When the Adelaide Gaol was still operating it was alleged to the Opposition that some prisoners at the gaol were video filmed while being strip searched. Why and on how many occasions did this occur? Is it planned to video-film strip searches at other institutions and, if so, why?

The Hon. F.T. Blevins: I will give a broad outline of the department's work since the last Estimates Committee before responding to those questions. The 1987-88 financial year

has been eventful for the Correctional Services Department and one where the plans and efforts of past years have been fully realised. In particular, the year was marked by the completion of the capital works program designed to enable Adelaide Gaol to be closed. The gaol was the State's oldest public building and during its 140 years of existence more than 300 000 prisoners passed through its gates. The Government and the department were pleased to be able to leave the gaol as it was impossible to set reasonable contemporary standards of hygiene in an unsewered, mid-nineteenth century building or to provide appropriate protection and standards which could be described as the minimum necessary for humane containment.

This achievement was made possible by the completion of Mobilong Prison, a medium security institution, which was opened on 21 October 1987. Mobilong has accommodation for 160 prisoners in a campus-style prison within a secured perimeter and provides an environment and facilities which allow for relatively free movement appropriate for the medium security status of the inmates. A wide range of programs is available at the prison to encourage personal development in education, trade training, sport, recreation, and social skills.

The reception role of Adelaide Gaol has been taken over with the completion of E Division at the Yatala Labour Prison. The first prisoners were received in January 1988, and it was officially opened on 10 February 1988. The division marked the completion of the ambitious program to update the State's prisons system to enable the closure of Adelaide Gaol. E Division has accommodation for 54 medium security prisoners but has a temporary capacity of 85 until the completion of F Division at Yatala Labour Prison. The department was extremely successful in arranging the simultaneous openings of Mobilong and E Division with the closure of Adelaide Gaol. Prisoners were successfully transferred to other locations and a reallocation of staff was undertaken with minimum disruption.

The Community Corrections Division of the department was provided with a much needed facility at Noarlunga when a new facility was opened in May 1988. It is the first purpose-built community correctional centre in the State and it will deal with approximately 200 offenders. The centre, built at a cost of $1.1 million, will serve offenders who are on parole, probation or are involved in the community service order scheme.

During the year a royal commission into Aboriginal deaths in custody was established. The Commissioner commenced his investigations in South Australia and the department cooperated fully with the royal commission. It placed enormous demands on the department and, in doing so, diminished its capacity to operate across many areas, and particularly to respond to demands from other sources for new initiatives or for replies to inquiries. It is indeed a compliment to the staff of the department that their dedication and support was shown to the degree that they were able to contribute so much to the royal commission in response to the Commissioner's requests. The Government is currently dealing with the issues raised by the royal commission and is providing additional resources to enhance the development of programs to Aborigines, increase employment and training opportunities and to improve access to social work services.

The year saw a continuing emphasis on staff training and education and there was a significant increase in the total number and types of courses offered plus a marked increase in the average attendance time at courses. During the year over 650 officers attended 126 courses with an average attendance of 10.6 days each. During the year the department, in association with the Department of Recreation and Sport, implemented an innovative program to develop staff fitness and health programs. Programs have been developed at a number of departmental locations and a research program is in place to evaluate its success. It is hoped that this program will result in a reduction in workers compensation, absenteeism and staff turnover, along with an increase in staff morale.

This financial year the Government has provided an additional allocation of 5.8 positions for the Community Corrections Division. This is as a result of a staffing review undertaken in conjunction with the Department of Personnel and Industrial Relations. The review was completed in early 1988 and involved refining of the staffing formulae and providing additional staff to handle the workload identified. Further, the capital major works program has been provided with $13.375 million this year which will ensure the completion of existing works in progress and the commencement of additional works at the Adelaide Remand Centre, a new community corrections facility at Mount Gambier, low security female accommodation at Northfield Prison Complex and the provision of a new administration building at that institution, additional accommodation at the Port Lincoln Prison, and the provision of a new kitchen at the Yatala Labour Prison.

The year will see the completion of B Division and the commencement of F Division and G Division at the Yatala Labour Prison. The development of sentencing options has continued with increasing numbers of offenders being given community service orders and involved in an expanding fine default scheme. The staff of the department have responded to the demands of their work with a high level of dedication and cooperation in a most difficult year. Their skill and cooperation have enabled the department to meet its major objectives. The 1988-89 financial year promises to be one of continued development for the department and the beginning of a new era following the closure of the Adelaide Gaol. I can only agree with the member for Hanson's opening comments, that the amount of money that the State has invested in this area is a credit to the Government.

It is no credit to all previous Governments, irrespective of Party affiliation, that the prisons were in the condition that they were in when this Government came to office in late 1982. As everyone will be aware, that has meant a huge capital works program, a very large increase in staff and a huge investment in staff development.

Two royal commissions were held into prisons in the five years prior to this Government coming to office. The prison system within this State could only be described as abysmal. That is certainly not the case now. Of course, the debt servicing costs of the huge capital works program, have been allocated against individual prisoners. There is not much chance of cost recovery in that area. Therefore, obviously, all the new buildings and new accommodation, and so on that has had to be done over the past four or five years has added enormously to the costs in real terms of containing each prisoner.

I wish I could say that the State is at the end of its major capital works program in the correctional services area. Unfortunately, that is not the case, because I believe that the increasing length of sentences that courts are quite properly handing out for more serious crimes are absolutely guaranteeing that in the not too distant future a new maximum security prison will have to be built in South Australia. Such a prison will cost an enormous amount of money.

The community, quite properly, has demanded longer sentences for the more serious crimes and the courts have responded. However, there is a cost in dollar terms to the State for that action. I do not see the new prison being required over the next couple of years, but after that planning will certainly have to start. At that time the costs will be allocated against the number of prisoners, and that will send the per capita cost of imprisonments in this State even higher. It is the capital expenditure that is doing the financial damage.

The member for Hanson also raised the question of recidivism and quoted a figure of about 60 per cent. I am not sure that it is quite that high. Nevertheless, the rate of recidivism is too high. If one person comes back into prison then that is one too many. However, the solution to that problem has been beyond the wit of all societies since crime first commenced—and that was a long time ago.

I encourage the members of the Committee to go and have a look at our gaols. All our gaols have very meaningful programs to one degree or another. In some of our smaller gaols the programs are not as comprehensive as we would like, but we are working on it. However, certainly in the major institutions there is the ability for people to take part in meaningful programs; whether they are literacy programs or trade training programs, they are all there.

However, you cannot compel people to take those programs, show an interest and, hopefully, to learn while they are in gaol how to modify their behaviour so that it is acceptable in the general community. No-one has been able to come up with the answer. We believe that we have had some success, but I would not pretend that we can change the outlook on life of a significant number of our prisoners. We can only create the climate and they have to meet us half way on that. Of course, very many of them choose not to do so.

The member for Hanson raised the question of an incident where a strip search was allegedly videoed at the Adelaide Gaol. Unless I am given more detail I cannot respond to that. I would need preferably a name, but certainly a date of the videoing. Videoing of strip searching is something that would only occur in our prison system on very rare occasions, if at all. However, I can certainly see circumstances where a prisoner was being particularly difficult and where prison officers would have to take out of a cell a prisoner who refused to come out and was playing up for one reason or another. In that case we would video all those incidents so there could be no allegations of brutality against prison officers or, if there were allegations, so that they could not be sustained. Although I know of no instance, it is possible that in that kind of situation the videoing of the entire incident has occurred. If the honourable member gives me the details of the alleged incident I will have it investigated. However, I can assure the Committee that there is no routine video-taping of strip searches.

Mr BECKER: How many staff have been assaulted at each Correctional Services institution during the past financial year and how serious have such incidents been? In particular, what is the situation at Port Augusta and Yatala? I have been concerned that some time ago reports came through that there was a difficulty with staffing levels at Port Augusta. I understand that that may have caused some problems. Of course, we are reminded that there was an incident a few days ago at Yatala where an officer suffered injuries which required his being taken to Modbury Hospital. Is the incidence of assaults within institutions being contained or are we experiencing difficulties with certain types of offenders?

The Hon. F.T. Blevins: I do not have the details of those assaults. I will certainly get them for the honourable member. My impression from the various incident reports that I see is that the incidence of assaults on officers is not increasing. If I had to take a punt here, I would say that it was either stable or decreasing. However, I will get the actual figures for incorporation in *Hansard.*

The issue of staffing levels is always a bone of contention, as the member for Hanson mentioned in his opening address. We have doubled the number of staff over the past four years with a similar number of prisoners. Therefore, we can hardly be accused of not looking after our staffing and putting on more staff where we thought it appropriate.

I have not heard any complaints recently about shortages of staff at Yatala. There is an ongoing problem at Port Augusta Gaol, but I point out that a staffing review of all our institutions was undertaken and I think that another approximately 50 prison officers were employed as a result of that review, which was completed and negotiated within the past 12 months. Port Augusta did receive additional staff as a result of that review. At Port Augusta Gaol on occasions we have a significant rate of absenteeism through sickness or workers compensation and, in those circumstances, it is very difficult to maintain the normal programs at the prison. From time to time prisoners get things a little out of perspective and tend to fly off the handle, which makes it very difficult for those officers who are on duty. Under the auspices of the Industrial Commission an investigation is being conducted into the staffing levels at the Port Augusta Gaol. I am sure that, to one degree or another, as is the case with all industrial disputes, it will eventually be resolved to the satisfaction of all the various parties.

Mr BECKER: Why was the Aborigine who assaulted an officer at Yatala a few days ago not placed in detention pending an inquiry, which I understand is the normal procedure?

The Hon. F.T. Blevins: I think that it was more a misunderstanding than anything else. The manager of the institution was not available. It was the considered opinion of the person in charge of the institution at the time that it was sufficient for the moment to isolate that particular prisoner in his cell. The prison officers expressed their disquiet about that action, and I have some sympathy for their point of view. In my view, they acted very responsibly. They held a stopwork meeting and had discussions with the management. The standard practice within the prison is to be codified or written down so that, irrespective of whether or not the Manager is available, everybody will know precisely what procedures have to be followed.

In fairness to the staff who were on duty at Yatala at that time, it is very easy for people who do not work in the institution, who are not there at the time of the incident and who do not have to cope with the atmosphere of the institution at that time, to sit back and judge. Some very quick judgments have to be made by individuals who are in charge when such a situation arises in a prison like Yatala. Every Manager, Acting Manager or Chief Correctional Officer will concede that, on some occasions, they would have handled things a little differently, but all members of Parliament would say the same. It is very difficult to manage an institution like Yatala when such incidents are occurring. I am quite happy to show members videotapes of incidents which have occurred. These recordings are made to present in evidence if the matter goes to trial. The videotapes will give members some idea of the atmosphere at the time and the difficult judgments that people have to make.

Mr RANN: What has the department done in recent times and what is it continuing to do in terms of broadening the mix of staff in relation to recruitment and, in particular, I refer to women and Aborigines?

The Hon. F.T. Blevins: All members would be aware of the unacceptably high percentage of the prison population being of Aboriginal descent. It is an indictment on our society that this is the case. I do not have the total solution to the problem, but a number of things are in place across all Government agencies that it is hoped will alleviate the problem and, at worst, contain the problem so that it does not worsen. In relation to correctional services, over the past 12 or 18 months we have done a number of things. I suppose that one of the key things is to try to attract the right mix of staff for not only Aboriginal but all prisoners, and that involves attempting to recruit and, having recruited, to train people of Aboriginal descent into the role of prison officer. We have attempted to do this in a number of ways, but the most basic is to develop an advertising program which states quite clearly in our recruitment advertisements that the department is an equal opportunity employer and that applications are invited from persons, regardless of sex, sexuality, marital status, pregnancy, race or physical impairment.

In relation to Aboriginal recruitment, the department has used the services of Ms Lesley Wanganeen, Aboriginal Recruitment Officer, and Ms Ruby Hammond, Aboriginal Equal Opportunity Officer, both of whom are from the Department of Personnel and Industrial Relations, and Mr Doug Graham, an Aboriginal Vocational Officer from the CES at Port Augusta, in order to make the job of Correctional Officer more attractive to Aborigines. The recent result has been the acceptance of three new Aboriginal recruits, two of whom are female. They will begin their training on Monday 26 September 1988 and they will comprise about 12 per cent of the total trainees in the course.

Statistics show that the percentage of female Correctional Officers has increased from 9 per cent of total custodial employees in March 1987 to 11 per cent in April 1988. Over the same period the increase for Aboriginal employees has been .1 per cent, from .5 per cent to .6 per cent, which everybody would agree is totally inadequate and, if any members can assist in recruiting Aboriginal employees into our prison system, we would be very grateful. It is absurd to have a prison system which has a high percentage of Aboriginal prisoners and to have such a low percentage of Aboriginal prison officers.

The department maintains a gender mix on the selection panels which interview all new recruits. An appropriate Aborigine was part of the selection process when Aboriginal applicants were involved. A family information evening has recently been established and is conducted before each correctional officer induction course. Some objectives of these evenings are to provide factual information in order that the applicant may make an informed decision about the career choice and, further, to encourage the understanding and support of the applicant's family or friends in the new career.

On these occasions selected custodial and non-custodial staff share information with the applicants, thereby setting up a support network upon which they are encouraged to draw at any time. I believe that a support network is of benefit to all officers, but it is recognised that minority groups (and that includes women and Aborigines in this system) can draw more benefit from it as time progresses. Furthermore, in a move to ease the transition of the new Aboriginal recruits through training and into employment in prisons, assistance of an academic and social nature is also planned.

The departmental equal employment opportunity officer conducts training sessions for all officers not only to inform but also to break down the barriers against employees who are outside the former 'norm'. Policies which benefit women and Aborigines, for example, equal employment opportunity, sexual harassment, pregnancy within correctional officer employment, have been established. Staff development publicises and coordinates short courses, workshops and seminars of interest to, and attended by, a significant percentage of women. During 1987-88 18 per cent of course participants were female, and they comprise 11 per cent of the custodial numbers. A further 97 female staff attended courses organised through the department but conducted externally.

Currently, the Department of Correctional Services is in the process of creating eight new positions, which may be filled by women or Aborigines, for example Aboriginal liaison officers, educational liaison officer and part time activities officer. We certainly are aware of the deficiencies in the gender mix and the racial mix of our prison officers and, as I have outlined, we are doing everything that we can to correct those imbalances. I would welcome any assistance or suggestions from anybody that will assist us to do what we do even better.

Mr RANN: I understand that AIDS and hepatitis B are a problem in prisons all around the world. How does the Department of Correctional Services manage communicable diseases amongst prisoners here in South Australia?

The Hon. F.T. Blevins: The Member for Briggs is absolutely correct—communicable diseases are a real problem in prisons. They obviously require special management because prisons are a closed, confined society. What one could perhaps get away with outside the prison system, one will not get away with within the prison system. So, unless the prisoners who have communicable diseases are very well managed, one runs the risk of infecting not only other prisoners but also staff of the institutions. It is something we take particularly seriously.

For example, all prisoners taken into custody for more than seven days are required to have a blood test. It is mandatory. Those prisoners still in custody three months later are retested. This program of mandatory testing has operated since 10 August 1987. Counselling and confidentiality are integral parts of the testing program. It is not just done as if the people were cattle; it is done in a very humane way. People are treated as individuals. If any problems show up as a result of the blood test, people are treated exactly the same as if they were free individuals. They are given the same medical attention, both physical and psychological, where appropriate.

As I mentioned earlier in the previous Committee hearing, I believe that, in the area of communicable diseases, information and education are terribly important, and particularly so in institutions. One problem is the maintenance of individual prisoner confidentiality. It is the responsibility of the Director of the prison medical services to inform the delegate or the Executive Director of the condition and identity of any prisoner who is identified as having a communicable disease. This information is conveyed to the Manager of the institution accommodating the prisoner and the prisoner assessment committee.

The prison medical service generates a medical 'regime' which outlines how an infected prisoner should be managed within an institution in the way of accommodation, recreation, visits, employment, etc but does not state the nature of the infection. In other words, it is done on a 'needs to

know basis'. Only the amount of information that has to be relayed for the protection of other people within that prison community is divulged. The nature of the disease is not divulged, if it is not necessary. We are, of course, guided totally by the prison medical service in this; we do not assume an active role. We react to what the doctors tell us to do, and that is the way that we want it.

Of course, the special placement of communicable disease prisoners is necessary from time to time. As a rule, we attempt to manage prisoners with communicable diseases in the general prison system unless we are told otherwise, that is, unless the prisoner's regime, which I mentioned earlier, as prescribed by the prison medical service, requires special circumstances due to the prisoner's condition and the subsequent medical hygiene requirements necessary to prevent the spread of the disease.

In relation to any medical regime, prisoners with either a demonstrated assault record against staff or prisoners, or a history of sexual assault on prisoners, may also be placed under a special security regime so as to protect staff and other prisoners. Under all other circumstances, prisoners are placed by the prisoner assessment committee in any prison subject to the normal assessment criteria. Communicable disease prisoners, under these circumstances, may participate in the normal activities of the institution, including work, contact visits, recreation, education, etc. Wherever possible, prisoners with communicable diseases are housed in single cell accommodation.

As I mentioned earlier, we set a great deal of store by education and counselling. The prisoner health project officer is responsible for the education and dissemination of information to prisoners on a range of topics related to communicable diseases, including prevention techniques and the implications of living with a disease. The use of prisoner peer groups to interact with prisoners, particularly in the area of AIDS, is currently being developed in conjunction with the education unit of the sexually transmitted diseases clinic.

Members of the prison drug unit, the prison medical service and institutional social work staff have received training as AIDS counsellors. Prisoners will also have access to specialist counsellors from public health agencies as appropriate. Home detention and unaccompanied leave may present some problems. In circumstances where a prisoner with a communicable disease is granted home detention or unaccompanied leave, the occupants of the residence are initially informed that the prisoner has a communicable disease. So, as honourable members can see, we do take the matter very seriously. I believe that we handle it very sensibly with the minimum amount of disruption, either to the prisoner who has the disease, or to anyone else within the prison community.

Mr RANN: I refer to the fine default program. Can the Minister inform the Committee what progress has been achieved in the development of the fine option program?

The Hon. F.T. Blevins: Whilst I stated, in response to the opening statement by the member for Hanson, that we were looking a few years down the track at having to build another high security prison because of the lengthening sentences that are being handed out by the courts, we have attempted to maintain similar numbers within the prison system by diverting prisoners who come into our system for a short time, and the overwhelming majority have always been fine defaulters. I am not sure of current statistics, but over recent years two-thirds of our annual intake of 3 000 prisoners have been fine defaulters.

That is a staggering number. More than any other State, South Australia gaols its poor. The development of the fine option program was in response to that statistic, that people should not be gaoled because they are poor, that programs should be available for them to do something more useful than spend a few days in gaol at enormous expense to the taxpayer. Taxpayers pay twice. Not only do they not get the fine but in effect they are fined by having to pay out hundreds of dollars a day to keep fine defaulters in prison.

The Government was very pleased to commence the program at four locations in November 1987: Glenelg, Port Adelaide, Elizabeth and the Iron Triangle. From 1 July this year, the program became available at all community service centres across the State. A budget bid for additional resources to cover the program in 1988-89 was deferred pending an established pattern of expanded use of the provision by the court. The program utilises the existing community service order structure and it was expected that, initially, community service order program resources could absorb fine option offenders.

Any person who has been fined by a court may approach the appropriate officer of the court to seek approval to meet their obligation by way of community work. If the appropriate officer of the court agrees that the payment of a pecuniary sum would create undue hardship for that person and his or her dependents, the Department of Correctional Services can be requested to undertake an agreement with that person to work off the sum at $100 per eight-hour day of community work. The appropriate officer of the Court Services Department has the discretion to use the provision for fine option. The Department of Correctional Services has the discretion to accept them.

As at 30 May 1988, 160 persons had undertaken fine option. To date, the Department of Correctional Services has been able to meet all requests. Use of the program is growing slowly, and the Department of Correctional Services is working with the Court Services Department to publicise the availability of the program. It will not be possible for the department to absorb any significant increase in fine option numbers within existing resources. This is due to the general increase in the use of community service as a sentencing option and the consequential increase in resource utilisation. A review of both programs will be undertaken in November of this year.

It is a very exciting program, one that the department hopes will be used by an increasing number of fine defaulters. We do not want fine defaulters in our gaols. Gaols are for those people who quite properly should be there because of the crimes they have committed, not because they are poor and unable to pay a fine. I hope that the work that the Department of Correctional Services is doing with the Court Services Department will increase the use of this particular option, because it is seriously under-utilised at the moment to the cost of the defaulter, prison accommodation and the taxpayer.

Mr INGERSON: What penalties are imposed upon persons detected passing drugs to prisoners during contact visits? What penalties are imposed on prisoners?

The Hon. F.T. Blevins: It is a criminal offence and the penalties are imposed by the courts. The police investigate such cases and, if it is felt that a prosecution can be sustained, the police lay charges. The matter goes to court and is dealt with by the court in the usual manner. On occasions, the department suspects that people have the intention of passing illegal substances during a visit. Those people are refused permission to go into the institution unless they submit themselves to a strip search. A number refuse, but a number go through with it. It is not a pleasant procedure and it is not a course of action that the department wants to take. However, the incidence of drugs in gaols is far too

high. It is certainly not as bad here as in the Eastern States where the use of drugs is widespread. However, any incidence of drugs in gaol is one incident too many and, whenever the department has enough evidence to call the police, it does so.

Mr INGERSON: Has the department investigated the New South Wales Department of Correctional Services sliding scale of penalties for breaches of contact visit rules?

The Hon. F.T. Blevins: The Executive Director was in New South Wales last week and can give the Committee the benefit of his investigations to detail the position in New South Wales and any recommendations he is considering making to me.

Mr Dawes: In New South Wales, the department has a policy of withdrawing prisoners from contact visits for up to six months if the prisoner is found to be in possession of drugs immediately after a contact visit. The prisoner is strip searched and visitors to the institution are dealt with by reference to the police and are subsequently banned from contact visiting for a certain period. Prisoners continue to have the benefit of secure visits, commonly referred to as cubicle visits, where a partition exists between the prisoner and the visitor so it is not possible to transfer drugs or other illegal substances or implements between the two parties. The practice in our department is to remove prisoners from contact visits, but we will probably look at taking a firmer line against prisoners who traffic in drugs and are found to be doing so immediately after contact visits.

Mr INGERSON: Has provision been made at Mobilong and Yatala Prisons for conjugal visits and, if so, why? When will such rights be permitted? What arrangements are provided to enable prisoners to consummate marriages if marriages are permitted?

The Hon. F.T. Blevins: The Government does not have a policy for conjugal visits, and I am not sure whether the honourable member wants me to go into the arguments for and against that proposition. If the Government did have a policy, it would be very easy to convert space in both Yatala and Mobilong Prisons for such a purpose, but there is no intention to do so.

Mr BECKER: How many cars permanently or regularly available to Department of Correctional Services staff for travel between work and home have been fitted or are about to be fitted with private registration plates?

The Hon. F.T. Blevins: The answer is 'one'.

Mr BECKER: During the past financial year what was the total amount of sick leave taken by Department of Correctional Services staff? How many of those days of leave were not covered by a medical certificate? How many days of sick leave not covered by a medical certificate were taken on a Friday, a Monday or a day immediately before or after a public holiday?

The Hon. F.T. Blevins: I will take that question on notice although the paperwork involved will be enormous.

Mr BECKER: How many land or building sales were made in the last financial year of assets owned or formerly under the control of the department?

The Hon. F.T. Blevins: I am advised that the answer is 'nil'.

Mr BECKER: Have staff been awarded the 4 per cent so-called productivity wage and salary increases? If not, why not?

The Hon. F.T. Blevins: PSA members certainly have but general duty officers have not because they refused the 4 per cent; they disagree with the productivity offsets that the department requires under the terms of the Industrial Commission's decision. That is their decision.

Mr BECKER: What productivity offsets were sought in the negotiations with staff?

The Hon. F.T. Blevins: I will have to provide the log of claims: I cannot remember them. They were considerable.

Mr BECKER: Has the recent 3 per cent pay increase been awarded to departmental employees? If so, to whom? If not, why not, and when will such an increase be granted?

The Hon. F.T. Blevins: The 3 per cent productivity increase has not been awarded to anyone in the public sector as far as I know. I cannot say when that will occur; it will be a decision of the South Australian Industrial Commission.

Mr De LAINE: What allocation is included in the Department of Correctional Services budget for the Home Detention Scheme?

The Hon. F.T. Blevins: The 1988-89 budget provides for expenditure of $492 000 on the Home Detention Program, which compares with an actual outlay of $219 000 in the previous financial year. The main funding increase relates to the acquisition of electronic surveillance equipment which will be introduced into the system during the next few weeks. Initially, 15 units are being leased for assessment during a 12-month period in the context of the South Australian Home Detention Program. Additional units will be available on a lease basis if requested.

The method of surveillance involves random telephone dialling and is commonly described as the passive system of electronic surveillance. Upon a prerecorded telephone signal, the home detainee is required to connect his or her wristlet to a verifier box to confirm the present of the detainee. It is proposed to comprehensively review this system during the first 12 months of operation in the South Australian Home Detention Program.

The developmental nature of the technology dictates a cautious approach to the long-term acquisition of appropriate equipment at appropriate costs. Analysis of tenders received in response to our tender call indicates a need to support the development of electronic surveillance equipment in South Australia using local knowledge and resources in order that local competitive tenders can be made in the future. I understand that the Department of State Development has seen fit to deal with this question. The 1988-89 budget has been framed around an expected average of 40 detainees per day on the Home Detention Program. Under current circumstances, the number could increase to about 60 before further staffing resources would need to be considered. However, the full impact of electronic surveillance equipment would require this aspect to be reviewed. The current position is that an approximate average of 40 detainees per day is being achieved.

To some extent I find that disappointing. I had hoped when we introduced this program that the numbers would be doubled to about 10 per cent of our prison population. Because of the way the legislation is framed it has been difficult to achieve that figure. We deliberately started the scheme conservatively. That was necessary because we were learning when we were introducing the program and we needed to err on the side of caution. There are prisoners within the system who could be detained safely on the program at their cost rather than the State's cost, but the legislation prevents our doing that now.

The program is difficult for most individual prisoners. A number of people will not apply for the program as they believe that the temptation to go outside the home on unauthorised business—even if it is only for a walk in the park—is too great and that they could not comply with the stringent conditions. I would like to see another 40 prisoners involved in the program. Perhaps with the introduction of electronic surveillance it is possible—it is not something

that Cabinet has considered—that the Government will ask Parliament to change the legislation. I believe that 80 could be involved safely and economically for our community. However, at present 40 is the highest number that we can realistically achieve.

Mr De LAINE: The home detention program was extended to cover a broader category of prisoner. What is this broader coverage, and what is the success rate of the program?

The Hon. F.T. Blevins: The cost of home detention compared to keeping somebody in gaol is certainly very economical (and the figures are contained in the Auditor-General's Report). As I stated in response to the previous question, the program has been successful as far as it goes but, in my view, it does not go far enough. For example, I believe that the present legislation discriminates against women prisoners. It provides for two-ninths of the head sentence to be served in prison before a person is eligible to apply for home detention. A number of female prisoners have a high head sentence but a relatively low non-parole period. Under the legislation it is not possible to release them on home detention because they will probably be out anyway after serving two-ninths of the head sentence. So, I believe that women prisoners in particular can be assisted by a careful and modest change in the legislation.

We have also expanded the amount of time that people can go on home detention, and three or four months was the maximum that we would permit in the early stages of the program. Now, in certain carefully selected cases (and it is still very few), we allow people to go on home detention for as long as six months. As I stated earlier, the program is not by any means a soft option. In some cases it is easier for the person to serve their time in prison with no temptations from outside society. If someone breaches a home detention order by being other than where they are supposed to be, they can be charged with escaping lawful custody, and the penalties for that can be quite severe. It is by no means an easy program for a prisoner to complete.

I will obtain details of the cost for the honourable member, and I assure the Committee that it is considerably less than keeping that same individual in the prisons system. Another problem we have with the legislation is that prisoners serving life sentences cannot go on the home detention program because they are not considered to have a finite sentence; and it is impossible to calculate two-ninths of a life sentence. It is ridiculous that prisoners who have served 15 or 20 years in gaol cannot serve out the last three months at their expense rather than at ours. After serving a term of imprisonment for that many years prisoners are well and truly conditioned to our way of thinking and are pretty well incapable of fending for themselves in the outside world.

In my view there is no reason why prisoners, at the end of extremely long sentences, should not go on that program for the last three months at their expense rather than at taxpayer expense; but the legislation prevents that. When the legislation went through it was not our intention that that occur, but as in all legislation we learn by using it, and often we do not foresee all the possible circumstances in which it will be used. At some stage Cabinet will probably look at whether or not the additional numbers on home detention warrant changing the legislation, but certainly no decision has been taken on that.

Mr De LAINE: The Minister touched on the introduction of electronic surveillance equipment as part of the home detention program. How will this equipment work?

The Hon. F.T. Blevins: As I stated earlier, the prisoner will wear a wristband that will contain some kind of electronic wizardry which I am not competent to describe. The prisoner will never know when the phone will ring but, when it does, a message will say, 'Please place your wrist in the box provided.' That box, which is connected to the phone, will register a message on some kind of recording device or computer to the effect that the prisoner is in the correct location at that time, and that that has been verified by the electronic surveillance device.

Some questions have been raised about electronic surveillance. Certainly, some quite legitimate civil liberty arguments can be put. Some people feel that it is abhorrent to have somebody, in effect, electronically shackled to the Department of Correctional Services. As a strong libertarian I respect that argument, but I do not believe that it carries a great deal of weight. First, the program is totally voluntary. If somebody prefers to stay inside rather than go on home detention, obviously they do not have to comply with any of the requirements of a home detainee. Also, it seems to me that electronic surveillance restrictions on home detainees are considerably less than if they were in prison. So, it is a matter of degree. I think that people's civil liberties are greater on home detention, albeit with electronic surveillance, compared with being inside prison walls. Whilst I respect the argument, I do not believe that it is persuasive.

The Hon. D.C. WOTTON: A considerable amount of publicity has been given to problems associated with the City Watch House and the fact that so many prisoners are held overnight in appalling conditions. What arrangements are being made to ensure that remandees received from the courts at or about 4.30 p.m. can be accommodated at the Adelaide Remand Centre? I understand that, if a person is allowed to go free by the courts, they have difficulty in collecting their belongings from the Remand Centre after 4.30 p.m. Is it possible to look at a situation where permanent overtime can be arranged to overcome the 4.30 p.m. deadline for admission to the Remand Centre?

The Hon. F.T. Blevins: The biggest difficulty is not the closing time of the Adelaide Remand Centre; it is sheer numbers. It would not matter whether the Remand Centre was open 24 hours a day; if it is full, it cannot take more prisoners.

That problem has, on occasions, certainly been compounded by the fact that the Adelaide Remand Centre does not receive prisoners after 4.30 p.m. The reason for that is a purely monetary consideration. The Government believes that to constantly pay overtime, or to have another shift for the convenience of a convicted prisoner, rather than have them stay at the watch house overnight, is not justified. It would be very expensive to put on another shift, which is not always needed.

Obviously, there is a possibility of overtime, but I believe that society pays quite enough to look after its prisoners. I do not believe that there is a great deal more scope or tolerance in society to pay any more. Whilst I regret that some prisoners have to stay in the watch house overnight after they have been convicted, I believe that that is a much lesser evil than loading more costs on to the taxpayer. It is not an everyday occurrence—it is an occasional occurrence. We are having some difficulty even getting a general pattern of what it is. Perhaps we could make some provision, but I certainly do not believe in opening up the remand centre after 4.30 p.m. to receive the occasional prisoner, or occasional couple of prisoners. It is not cost-effective and society pays enough at the moment to manage its 850 or so prisoners.

The Hon. D.C. WOTTON: A research project has been conducted by the Management Assessment Panel into behaviourally disturbed prisoners. What are the findings of

that research project? Can the Minister also indicate how these persons are to be treated in future?

The Hon. F.T. Blevins: The investigation has not been completed, so the report has not been handed down.

The Hon. D.C. WOTTON: Who is carrying out the investigation?

The Hon. F.T. Blevins: The group conducting the investigation is from the Health Commission. That group is looking at the Dame Roma Mitchell inquiry to see how the recommendations can be implemented. However, that has not been completed. At the moment we manage people who are behaviourally disturbed in the best way we can. I certainly would not pretend that it is totally satisfactory. That was outlined very clearly by Dame Roma Mitchell. The ideal situation would be to have another institution where behaviourally disturbed people could be kept. The cost implication of that is horrendous. To build another separate prison would cost the State a fortune, even though it would be a relatively small project because we do not have a large number of behaviourally disturbed people.

However, it is something that society will have to deal with at some stage. We cannot go on forever trying to manage these people within our prison system. We have enough problems managing prisoners who do not come within the behaviourally disturbed category. Although, from time to time you would think that that was the case with all of them or certainly a significant proportion. I can only see it being a very expensive exercise. But, it is certainly a problem that has to be dealt with at some stage. There is no question about that.

Mr BECKER: The previous question in relation to behaviourally disturbed prisoners asked by the member for Heysen referred to an answer given to the Estimates Committees last year. I would have thought that the report would have been available by now.

The Hon. F.T. Blevins: I will find out when that report is due and let the member for Hanson know. I will be interested myself and I think that if we follow it through then we will all know.

Mr BECKER: Are prisoners at James Nash House under the control of the Department of Correctional Services or the South Australian Health Commission? What care and control does the Department of Correctional Services have over the welfare of prisoners at James Nash House? I refer to an unfortunate incident that occurred a few months ago where a person at James Nash House—

The Hon. F.T. Blevins: That is before the courts.

Mr BECKER: I was going to ask the Minister whether an inquiry had been conducted.

The Hon. F.T. Blevins: It is before the courts. A charge has been laid.

Mr BECKER: A person has been charged with murder?

The CHAIRMAN: If this matter is before the courts, I would rule it *sub judice* and we will leave it alone.

Mr BECKER: Are prisoners at James Nash House under the control of the Correctional Services Department or the South Australian Health Commission, and what care and control does the Correctional Services Department have over the welfare of prisoners at James Nash House?

The Hon. F.T. Blevins: The people at James Nash House are under the care and control of the Health Commission, and the Correctional Services Department has just one liaison person at James Nash House who liaises between the Correctional Services Department and the Health Commission and advises on some aspects of security. The prisoners are under the control of the Health Commission.

Mr TYLER: There has been recent publicity about a prisoner named Barry Moyse costing about $4 million to be imprisoned for 20 years. Of course, that assumes that he will stay in Yatala Prison for that entire period. The Auditor-General's Report claims that the cost of keeping a prisoner in Yatala Labour Prison is $114 000 per annum. That contrasts with a number of other prisons like Port Augusta Gaol, where it costs $31 000 per annum. I assume that those sums include the debt servicing of the restructuring which has occurred at Yatala Labour Prison. What is the actual cost minus the debt servicing?

The Hon. F.T. Blevins: I have here a table of those figures which I will incorporate in *Hansard.*

COMPARATIVE STATEMENT OF COSTS PER PRISONER AS EFFECTED BY DEBT SERVICING CHARGES 1987-88

Institution	Average Prison Nos	Net cost of operations		Net cost excluding debt servicing	
		Net cost of operations	Average annual cost per prisoner	Net cost of operations	Adjusted average annual cost per prisoner
		$000	$000	$000	$000
Adelaide Remand	151	8 773	58	6 816	45
Adelaide Gaol	133	4 437	33	4 169	31
Yatala	151	17 288	114	10 951	73
Northfield	63	2 650	42	2 541	40
Mobilong	70	5 777	83	3 641	52
Cadell	93	3 024	33	2 480	27
Mount Gambier	20	988	49	844	42
Port Augusta	89	2 726	31	2 400	27
Port Lincoln	39	1 251	32	1 063	27
	809	46 914	58	34 905	43

The Hon. F.T. Blevins: I will give a couple of examples. The debt servicing at the Adelaide Remand Centre is $13 000 per prisoner; at Yatala, $42 000 per prisoner; at Mobilong, $31 000 per prisoner and I will not read the rest.

Mr TYLER: What new initiatives have been provided for in the Correctional Services Department budget allocation for this financial year?

The Hon. F.T. Blevins: An allocation of 5.8 full-time equivalent positions has been made to the Community Corrections Division. This is as a result of a staffing review undertaken in 1987-88 in conjunction with the Department of Personnel and Industrial Relations. The review was conducted in consultation with staff at all levels and it specifically examined the staffing formula previously set by a similar review in 1984. The review was completed in early

1988 and the report was completed in May 1988. The staffing formula will refine and encompass the work of probation and parole officers, community service officers and clerical officers. On the basis of the staffing formula and the workload as at December 1987, the report recommended an additional 1.8 FTE probation and parole officers, one FTE clerical officer and three FTE community service officers. Funding for these positions is in the 1988-89 allocation.

Mr TYLER: As a supplementary question, could you provide some details of Aboriginal prisoners and programs which affect them? What new initiatives have been outlined in this current budget?

The Hon. F.T. Blevins: In the past financial year institutions were asked to prepare submissions for funding of projects for groups of prisoners such as women and Aborigines who had been identified as being disadvantaged. Specific projects that are worth noting include the establishment of an Aboriginal unit at Cadell Training Centre. Prisoners participating in this project undertook a silk screening project and have produced a poster for Aboriginal prisoners highlighting the risk of AIDS.

At Port Augusta Gaol funds were used to supplement education resources at that institution by providing additional adult literacy tuition. In addition, at Port Augusta Gaol, a special project involving the Aboriginal community has commenced, whereby responsible local Aborigines have undertaken to provide assistance on a paid basis to Aboriginal prisoners to ensure that, on release from prison, they can return to their traditional homelands with a minimal risk of reoffence.

The numbers involved are small, but we believe they are significant. In terms of other projects and initiatives, I would like to briefly highlight the following:

- A Commonwealth grant of $27 000 has been received to enable a staff member to develop programs for Aboriginal prisoners. This project will be evaluated carefully to enable further development in terms of programs for Aboriginal prisoners to occur.
- In May 1988, a report entitled 'Priorities for program initiatives 1988' was completed and implementation of this report is now under way after consideration by departmental executive.
- Institutional managers have undertaken a staff development/planning session focusing on Aboriginal offenders.
- An updated Aboriginal resource book which provides a comprehensive outline of resources and agencies that can assist Aboriginal offenders has been issued to all institutions. This book has prepared by the Aboriginal Liaison Officer located within the Community Corrections Division.

I believe that gives some indication. There are a number of new initiatives and some other programs have been developed, but I do not want to load the Committee with detail. The department has allocated $71 000 this year to recruit five additional Aboriginal correctional service officers. Again, the more Aboriginal people we have acting as officers within our gaols, dealing with all prisoners, not just Aboriginal, but certainly integrating better within the present system, the better.

I mentioned staff training earlier. We have quite extensive staff training now which is something of which, prior to the last four or five years, we did very little. The induction course which is undertaken by all of our officers has been developed with the assistance of the TAFE Aboriginal Unit. Part of this course involves a segment aimed at assisting staff to identify potential suicide risks. Two other advanced courses include sessions by a lecturer in Aboriginal affairs.

During the year, we will be employing an additional Aboriginal liaison officer and an additional Aboriginal programs officer and there will be an increase in social work services at gaols with a high intake of Aboriginal prisoners. So, we have accepted our responsibilities in this area. Additional programs will be implemented and additional staff will be engaged to deal with the problems that are particular to Aboriginal prisoners. I believe that we will have a reasonably comprehensive program to deal with the regrettably very high number of Aboriginal people within our system.

Mr BECKER: How many incidents were reported within the prisons during the last financial year, and how does the number of incidents compare with the situation in the previous financial year? It is always interesting to receive, with the department's annual report, a description of the incidents that occur in the prisons. I note that in 1986-87 as compared with the previous year there was an increase of 50 per cent in the number of incidents involving drugs and an increase of 95 per cent in the number of alcohol related incidents. The report details various types of what we would consider to be serious incidents such as attempted escape, self-inflicted injury, attempted suicide, offender—offender assault, hunger strike, refusal to obey an order, fire, and so on.

The Hon. F.T. Blevins: Those figures will be available in the annual report. I am proud of the report because everything is put in—warts and all—so the community is fully informed, as it is entitled to be. I will give the figure for escapes to the year ended 30 June. The escape rate is calculated as 100 times the number of prisoners escaping divided by the daily average prison population, so that it is a constant measure. I am pleased to say that the figure for 1988 of 1.32 is the second lowest on record. In 1983, the figure was 2.08; 1984, 2.71; 1985, 1.58; 1986, 1.16; and 1987, 1.92. The total number of prisoners escaping was 11 and, overwhelmingly, those prisoners would be better classified as having absconded because they worked outside on prison farms and tended to wander away.

What is particularly pleasing is that no prisoners escaped from Yatala Labour Prison. Because Adelaide Gaol was closed for the bulk of the year, there were no escapes from there. No escapes were recorded from the Remand Centre, Yatala, Mobilong, Northfield, James Nash House or the Mount Gambier Gaol. There was one escape from Cadell, nine from Port Augusta Gaol and one from Port Lincoln Prison. All prisoners were returned, and returned very quickly. The member for Hanson is very welcome to see the incident reports, although some of them are very sad. A number of Aboriginal prisoners who work outside at Port Augusta just wandered home. The police go to their homes and bring them back.

What is particularly pleasing about the figures is the security at Yatala. The prisoners complain about the high level of security but it is more than justified in the interests of the security of the community and it has cost a small fortune to make Yatala a secure institution. There has been only one escape incident in the past three or four years, which is an extraordinarily low figure compared with the previous average of approximately 20 escapes a year. That is a credit to the staff at Yatala and the Department of Housing and Construction, which designed the security at the prison.

Mr BECKER: How many casual employees does the department have? Where and in what capacity and classification are they employed?

The Hon. F.T. Blevins: I will obtain those figures for the honourable member to have them incorporated in *Hansard* prior to the date that has been nominated.

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

ADJOURNMENT

At 10 p.m. the Committee adjourned until Thursday 15 September at 11 a.m.