HOUSE OF ASSEMBLY

Thursday 29 June 1995

ESTIMATES COMMITTEE A

Chairman:
The Hon. H. Allison

Members:
Mr M.K. Brindal
Mr R.D. Clarke
Mr M.R. De Laine
Ms J. Greig
Mr J.P. Rossi

The Committee met at 11.6 a.m.

State Aboriginal Affairs, $7 789 000

Witness:
The Hon. M.H. Armitage, Minister for Aboriginal Affairs.

Departmental Advisers:

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

Mr Garnett I. Wilson, Chairman, State Aboriginal Heritage Committee.

Mr Rick Starkie, Project Officer, Department of State Aboriginal Affairs.

Ms Val Power, Women's Issues, Department of State Aboriginal Affairs.

Mr Peter Campaign, Project Officer, Department of State Aboriginal Affairs.

Ms Julianne Cirson, Accountant, Department of State Aboriginal Affairs.

Mr Peter Dewhurst, Project Officer, Department of State Aboriginal Affairs.

Mr Harry Vosnakis, Project Officer, Department of State Aboriginal Affairs.

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

The Hon. M.H. Armitage: Yes, Mr Chairman. I have a great deal of pleasure in presenting the Committee with the financial statement for the 1995-96 financial year for the Department of State Aboriginal Affairs (DOSAA). During the past year the department has developed and adopted a statement as a shared vision for the department. I quote from that vision statement as follows:

> The Department of State Aboriginal Affairs will plan, implement and monitor policies and programs within Government which contribute to Aboriginal people being able to function with a sense of dignity and equality with all Australians.

As Minister, I share that vision. The key elements in the statement I believe are dignity and equality. The Government is determined that Aboriginal South Australians will be accorded the dignity and respect that is due to them as the first South Australians. The Government is further determined that Aboriginal Australians will attain equality with other South Australians in all the various streams of our community life. Clearly this vision encompasses the breadth of Government policy and programs.

The department does not seek to meet all the needs of the Aboriginal community. To do so would be to duplicate mainstream services and deny the responsibility of those mainstream agencies to service all South Australians, including indigenous South Australians. Rather, we believe that a key role for the department is to foster a strategic Aboriginal input into policy and program development so that, whether by specialist or general program, the needs of the indigenous people are addressed and recognised. I would stress to the Committee therefore that, whilst DOSAA maintains an overview of Government services to Aboriginal people, the appropriations of other departments to Aboriginal programs are properly matters for other Committee sessions.

I believe DOSAA is very fortunate to have a group of highly respected members of the Aboriginal community on staff. They have committed themselves to address the needs of their community through State Government service. Of course, public service carries with it professional limitations and I recognise that often these officers are put under unfair pressure to undertake actions—even political actions—which would sometimes breach those obligations. I take this opportunity to urge those members of the Aboriginal community who put pressure on public servants to take a wider view of the needs of the community.

In many ways, DOSAA is a vital bridge between the Aboriginal community and the State Government. Officers of the department have a unique opportunity to access Government to ensure that Aboriginal perspectives are taken into account. As a Minister for the Crown I receive very frank—and sometimes brutally frank—briefings from Aboriginal officers on the views of the Aboriginal community in relation to various things that are happening. To politicise Aboriginal public servants, though, would be to silence a very strong and consistent voice for Aboriginal people within the Government. Today, I am accompanied by senior officers of the department and the chair of the State Aboriginal Heritage Committee. That completes my opening statement.

Mr CLARKE: I have a brief statement, and I made a similar statement at the commencement of the Aboriginal Affairs Estimates Committee last year. We have been fortunate in South Australia over the past 20 years where largely there has been bipartisan support with respect to Aboriginal matters in this State. That has marked us with some distinction compared with other States of the Commonwealth. While my following comments do not directly relate to the department *per se*, nonetheless they are important to the Aboriginal community.

One of the greatest pleasures I have had since being elected to Parliament, admittedly only 18 months ago, was as shadow Minister for Aboriginal Affairs dealing with the passage of the State Government's legislation that was complementary to the Commonwealth native title legislation. Ultimately, the State legislation, as it passed both Houses of Parliament, was an excellent piece of legislation, perhaps not as good as I would have liked in totality but, compared with the legislation as first introduced, any unbiased opinion would say it was substantially brought up to the mark and largely meets the aspirations of the Aboriginal community in South Australia.

At the end of the day, whilst there were hard negotiations with the Government about the final outcome of the legislation, it was done in an atmosphere without rancour or ill-will. There were certainly differences of opinion and philosophical

approaches to the legislation but, at the end of the day, I think it was good State legislation that ultimately came through. That could probably have happened only in South Australia as compared with other States of the Commonwealth where there are far less tolerant views. I would like to see that maintained for everyone's benefit in this State. With those opening comments, I would now like to frame my first question.

I refer to page 275 of the Program Estimates. Despite the recommendations of the Royal Commission into Aboriginal Deaths in Custody and action by the Government at Federal and State levels, tragically Aborigines are still dying in custody in South Australia. Has the Minister had discussions with the Minister for Correctional Services about recent deaths in the Port Augusta prison? In particular, did the Minister ensure that the Minister for Correctional Services had put in place and monitored effectively all the relevant recommendations of the Royal Commission?

The Minister might recall a question I put to the Minister for Correctional Services some weeks ago arising from a death in custody of an Aboriginal person at Port Augusta where there were allegations that a person with suicidal tendencies was left in a cell on his own with a belt and, ultimately, was found hanged. Of course, that is subject to specific recommendations of the royal commission.

The Hon. M.H. Armitage: First, in addressing what is obviously an important matter, and that is any death in custody, I am interested to observe that the shadow Minister has chosen this Committee to address the matter when no questions on this very important matter were addressed to the Minister for Correctional Services at all yesterday. I have to say that the Minister for Correctional Services is the Minister responsible for those programs. So, whilst I in no way underscore the importance of the question—and I look forward to answering it—I am amazed that in the Committee yesterday no question was asked of the Minister who puts in place the policies in relation to that matter. However, there are a number of points that I would like to make.

First, as I indicated, any death in custody is a tragedy. Since 1980, eight Aboriginal people have died in prison. During the 1994-95 financial year seven deaths occurred in South Australia's prison system; of these, two were Aboriginal. One died from natural causes and the other committed suicide. I am informed that details of both deaths are currently the subject of the Coroner's Court, so specific information relating to those deaths is not available. I understand that that is not the point of the shadow Minister's question but I merely inform the Committee that that is the case.

When I first heard of the matter that the shadow Minister addressed, I spoke with the Minister for Correctional Services and indicated the themes of what I am saying to the Committee now—that any death in custody is appalling. It is obviously undesirable, given the history of Aboriginal deaths in custody which led to the royal commission. I believe there are a number of strategies for the management within prisons and I indicated to the Minister that, from the perspective of DOSAA, we would seek full information on whether those strategies and so on had been upheld and, if there was, in any way, a problem with the implementation of it, how that could be altered. As I say, when the Coroner's Court brings down the verdict, I would expect to be completely briefed on those matters.

There are, however, some positive things in relation to these sorts of matters and, certainly, one of those is the Aboriginal Visitors' Scheme, which was developed and managed by DOSAA in response to royal commission recommendation No. 22. That has now been devolved to Aboriginal community management: the Aboriginal Legal Rights Movement now runs the scheme statewide. The department funds the operations and assists in the monitoring and evaluation but, as the shadow Minister would know, Aboriginal control of these things is a very important element.

DOSAA was instrumental in establishing the independent Aboriginal Justice Advocacy Council with statewide community representation to monitor royal commission issues. I have had a number of meetings in the past few months with the executive of AJAC. I had a meeting with what I understand was the full AJAC committee at Port Adelaide a couple of months ago and a most useful dialogue and understanding has been set up between the Chairman, Mr Tauto Sansbury, and me. That committee is doing an excellent job.

The Government has the Aboriginal Justice Inter-Departmental Committee, which has the overall role of all the departments and which has been convened by DOSAA. That continues to meet to monitor the various State Government responses. Whilst, as I said before, any death is a tragedy—and I certainly look forward to the end result of the Coroner's Court—certainly DOSAA and I, as Minister, have been definitive in saying to the correctional services area that we would expect that those recommendations of the royal commission would be upheld.

Mr CLARKE: Has the Minister spoken to his colleague the Minister for Employment, Training and Further Education about the cutting of Aboriginal project officer positions in DETAFE? In particular, I draw your attention to the recommendations of the royal commission Nos 236, 237 and 238. I will read part of a question I put to the Minister for Employment, Training and Further Education in the Estimates Committee on Tuesday 27 June, as follows:

> Recommendation 236 of the Royal Commission into Aboriginal Deaths in Custody deals with Aboriginal youth programs. Recommendation 237 specifically states that 'there is a need for the employment and training of Aboriginal people as youth workers'. Recommendation 238 states that 'once programs and strategies for youth have been devised and agreed. . . Governments should provide resources for employment and training of appropriate persons to ensure that the programs and strategies are successfully implemented at local level'.

Minister Such replied that that was a responsibility of Family and Community Services and not his own department. This seems to be a bit of hand-balling from one department to the other. Have you had discussions with Minister Such and also Minister Wotton about this issue of the cutting of Aboriginal project officer positions in DETAFE, and what alternatives will there be with respect to instituting those particular recommendations about setting up programs for Aboriginal youth?

The Hon. M.H. Armitage: That is a very important question because, as I have travelled around the State visiting almost every Aboriginal community in the past 18 months since becoming Minister, and certainly a couple of years before that as the shadow Minister, the issue of Aboriginal employment is high on the list of things which the communities wish to discuss. They say to me that if they are financially independent with a job they are then able to purchase better health care, better housing, and so on, for their families and for their children. Certainly, there is no question that employment is important.

However, as I indicated in my opening statement, DOSAA does not have a specific role in the provision of those services, so that each Minister must make up his or her own mind within their budget as to how they run that. As DOSAA's role, if you like, is to keep the other areas up to the mark, I continually speak about those matters with the various Ministers. I indicate to the Committee that as the Minister I elected recently to make specific efforts in relation to Aboriginal employment because it seemed to me, having been in the position as Minister since the election, that there is an incredible amount of goodwill towards Aboriginal employment but that it is perhaps dissipated within the Government.

For instance, we have the DETAFE exercise about which the shadow Minister talked, but also within DETAFE is the AEDB (Aboriginal Employment Development Branch), which does a fantastic job. That is a wonderful program, and the people running that program are highly skilled and motivated. The Business Advisory Panel is an excellent organisation within the Aboriginal Lands Trust—again, fabulous people, doing a wonderful job. Val Power has done a lot of work with Aboriginal employment in relation to the Inner Adelaide Youth Strategy, and again is doing a fantastic job. The Business Breakthrough Program assists Aboriginal people in developing small businesses. Obviously money and energy are put in through the EDA. We have our own development team for employment within DOSAA. In other words, a number of arms of Government are all doing their best, but I wondered whether there was not an opportunity along the lines of what we are doing, in both DOSAA and my other portfolio, of attempting to eliminate some of the administrative expenses that would be occurring with all those activities.

Indeed, I have indicated to all respective Ministers that we ought to have a meeting, which I am convening, of all relevant officers to see whether we can tie together all those strategies and have some defined outcomes at the end. Whilst we do not have a particular responsibility for it, I think that the calling of the employment summit, if you like, is the role that DOSAA ought to have in order continually to put the finger on people and say, 'We can do this better for Aboriginal people.' All those areas will produce Aboriginal employment on the ground, which is what the Aboriginal community wants.

Mr CLARKE: Are you aware of any Government agency which, as part of its budget, will carry out recommendations 236, 237 and 238? If it is not DETAFE or FACS, is there any other specific Government agency that will do that?

The Hon. M.H. Armitage: I will address the specifics in written form with the shadow Minister. As I understand the recommendations—I do not have a copy in front of me—they recognise the importance of efforts to increase Aboriginal employment. As I have indicated, DOSAA, being the over arching policy body, is looking to coordinate all those efforts to make sure that the Government's efforts to employ more Aboriginal people are even more successful than they are at the moment.

Mr CLARKE: Referring to the situation at Marree and Finniss Springs Station, will you bring the Committee up to date with what, if anything, your department is doing to try to resolve the conflict between the Arabanna and the Dieri people? As you are aware, that situation led to a tragic death earlier this year. In particular, there have been a number of allegations in the past that certain mining companies are inflaming the situation at Marree.

The Hon. M.H. Armitage: Do you wish to name them?

Mr CLARKE: The specific allegation that I have heard is that Western Mining Corporation is seeking to exploit the differences of opinion between those two groups of people. I realise it is an extremely complex area which cannot necessarily be resolved overnight, but what steps, if any, has your department taken to resolve this situation and, in particular, to ensure that no outside parties are necessarily stoking the fires of dispute and not allowing the matter to be resolved in an amicable way?

The Hon. M.H. Armitage: I reiterate that it is not DOSAA's role to ensure that outside parties are not stoking the fires of discontent. If the shadow Minister believes that is occurring, I point out that there are Government agencies which might be involved in it, but that is not our role.

A lot has happened since 12 January when the death occurred at Marree. Family well-being counsellors of the Aboriginal Employment Development Branch visited Marree between 23 and 27 January 1995 to assess the community's needs and the causes underlying the conflict. They highlighted that a coordinated State agency approach would be the best way of addressing the areas of need, such as housing, police aides, employment and training, post-trauma counselling, and so on. Based on that advice, an inter-agency meeting was held on 20 February 1995 and immediate commitments to support Marree were provided by the Housing Trust, the police, the Education Department's school support and liaison area, DETAFE, the Aboriginal Employment Development Branch and DOSAA. On 6 May there was a meeting between DOSAA, the police and the Aboriginal Legal Rights Movement to discuss action required arising from that conflict, and a follow-up inter-agency meeting was held seeking feedback on progress.

On 5 April a special meeting was held in Port Augusta between DOSSA, DETAFE, the Aboriginal Employment Development Branch, DECS and the South Australian Aboriginal Education, Training and Advisory Council to discuss and determine action and issues specifically related to Marree such as: addressing the literacy needs of the Marree community; addressing great concern about the children of Marree being traumatised by the incident; giving assistance and support to the school; a review of that inter-agency support; and continuing monitoring services, and so on.

Further, in May 1995 Val Power, the Women's Youth and Family Issues officer from DOSSA, visited Marree and spoke at length with the Aboriginal women within that community. That was obviously a very important counselling exercise, and Val has emphasised to me and to DOSSA the need for continuing Government support. The shadow Minister will see that a lot has been done, recognising the traumatising effect that the Marree incident may have had. I believe the shadow Minister is quite correct in saying that there is no overnight solution to the conflict problem, but certainly the long-term effects of those events can be ameliorated.

In relation to the allegations concerning mining companies and outside parties fuelling the fires, I guess, I am delighted to report that only this morning I heard that there was a most successful meeting yesterday between, in particular, Mr Reg Dodd and the mining company to whom the shadow Minister referred in relation to an easement across Finniss Springs which, in the latest briefing I have had from the Chief Executive of Western Mining, would answer all concerns. The mining company understood the potential for conflict and has moved the area in which it is seeking to place a water bore from Northfield B further north-east. It is now undertak-

ing an enlarged environmental impact study but believes that the end of its involvement in that area is nigh, with everyone benefiting.

Ms GREIG: I refer the Minister to page 275 of the Program Estimates and Information which identifies as a Government objective the protection of Aboriginal sites and objects. What action has the Minister taken to ensure that Aboriginal heritage services are appropriately resourced?

The Hon. M.H. Armitage: I thank the member for Reynell for a very important question, and I am pleased to address the matters contained in the question in relation to Aboriginal heritage. In the context of the proposal to construct a bridge to Hindmarsh Island, the development of a number of Aboriginal heritage issues were clearly highlighted, including a number of problems with the consultation processes. The problems related to the interaction between Federal and State processes, the relationship of Aboriginal heritage processes to other planning processes and, as everyone would acknowledge, the need to promote reliable outcomes from Aboriginal heritage consultation.

As part of the State's response to the Federal Minister's decision on 10 July, the Premier announced a consultation process with the Aboriginal community to seek to improve Aboriginal heritage consultation processes to promote more reliable outcomes. On 6 September 1994 the Premier convened a workshop of, I guess, 50 or 60 Aboriginal leaders from around South Australia. A delegation spoke with the Premier and me after that meeting and raised a number of issues which it believed were the most important and which included: the need for protection of Aboriginal sites; funding of local communities; the need for a full-time chairperson of the State Aboriginal Heritage Committee; and some concern in relation to matters involving other areas of Government.

Following that meeting, a Cabinet submission was proposed and, in December 1994, was approved. It enabled the Government to respond to those concerns. We increased funding for Aboriginal heritage by $700 000 over three years. It was a pleasure to take to Cabinet something which asked for an increase and have it agreed. It was an unusual event, and it demonstrates the commitment of the Premier and the Government to Aboriginal heritage.

The submission supported the key elements of the Aboriginal input from the meeting and a program of protection and preservation of Aboriginal sites which were deemed to be most in need of protection. In 1993 a report was prepared for the Department of State Aboriginal Affairs entitled 'A Strategy for the Conservation of Aboriginal Cultural Sites in South Australia'. It identified a number of Aboriginal sites requiring protection. Forty two of those sites were given very high priority, 221 sites were given high priority, and 250 were given moderate to high priority. We supported the allocation of $300 000 over three years to fund an emergency program for the protection and preservation of those Aboriginal sites. In the next 12 months, that program will fund 20 weeks of field work by officers of the department, and certainly resolution of the very high priority cases.

As I mentioned, the consultation also suggested that the Aboriginal community felt that there should be a full-time chairperson of the State Aboriginal Heritage Committee, and the Government certainly considered that such an appointment would significantly enhance the Government's interaction with the Aboriginal community and help with the resolution of heritage issues.

The consultation meeting raised the issue of core funding of local Aboriginal heritage committees. At that stage, committees received only project-related funding from land users and from DOSAA. The former Government had undertaken to provide $500 of core funding to each local committee, but those payments had not been made for some years. The Government, in its commitment to improve heritage processes, now provides $1 000 per annum to each local Aboriginal heritage organisation or committee. We believe that that will cost $17 000 per annum.

In summary, Cabinet endorsed a program of protection and preservation of Aboriginal sites. We endorsed a program of funding support for and development of local Aboriginal heritage committees, and we endorsed the appointment of a full-time chairperson on the State Aboriginal Heritage Committee.

Mr ROSSI: I refer to page 275 of the Program Estimates, which mentions an objective to 'Promote the economic and cultural development of Aboriginal people in SA.' The Community Development Employment Program is a key element in Aboriginal self-directed economic development. Does the State support the CDEP?

The Hon. M.H. Armitage: Certainly, the CDEP is very much supported by the Government. I ask the Chief Executive Officer, David Rathman, to provide further details.

Mr Rathman: In Ceduna, from 13 to 17 March 1995, there was a Community Development Employment Program conference. It was the first South Australian Community Development Employment Program conference of participating communities, and it was supported by ourselves and the Commonwealth. Of the 28 South Australian communities with CDEPs in place, 18 were represented at the conference. The conference focused on the concept of economic development and it was hosted by the Ceduna CDEP.

A wide range of speakers provided information to the delegates and, as the keynote speaker, I focussed on the concept of taking unemployed people to a point at which they can run their own enterprises. Other speakers included ATSIC from Canberra and people who could give some background in commerce. The South Australian Chamber of Commerce was represented, as was SA Tourism and a number of people from around the State. It seemed surprising that it was the first opportunity for the group to come together, even though it had been funded by the Commonwealth for 10 years. There had never been an opportunity for people to share information, develop networks and participate in workshops about common solutions to their problems.

The most significant initiative was the formation of an association of CDEPs, to be known as CDEP SA Inc. Members of the Committee may be pleased to know that that group would have strong buying power if they combined their resources. That is what it intends to do through this process. An interim steering committee of five delegates was formed, and it has met at Port Augusta and agreed to divide the State into four administrative areas for CDEP. The mission statement agreed at the conference for CDEP SA Inc. is:

> To work to the further interests of all CDEP member organisations in South Australia.

It plans to be fully established and operational by the end of this year. It is planned that the CDEP conference should be an annual event, and it will be held in Adelaide some time in March. The whole process of economic development is now being focused through CDEP, given the high unemployment rate among Aboriginal people. The Ceduna CDEP is a good example. Murat Bay has one of the largest oyster operations in South Australia. It is jointly owned by the CDEP com-

munity at Ceduna. Such initiatives are welcomed. We believe that they are a vehicle through which we can promote greater economic independence.

Mr BRINDAL: My question will vary slightly from what I was going to ask. It concerns page 275 of the Program Estimates, and specifically the goal to 'Provide policy advice in the coordination and delivery of services.' I wish to point out the problem that exists in the Anangu Pitjantjatjara traditional lands. State Governments arbitrarily divided State boundaries, but there is at least one Aboriginal group who straddle three State boundaries: the Northern Territory, South Australia and Western Australia. That group is closely related to other desert groups in the Northern Territory.

As the Minister will know, there is a problem associated with that, and it is exacerbated, as the Minister will also be aware, by the fact that the Anangu Pitjantjatjara dreaming comes down—Mr Wilson will probably correct me—through near the top of Port Augusta and extends as far as to the west of Zanthus. I understand that, in 1992, the Council of Australian Governments endorsed a multilateral national commitment which was aimed to improve outcomes for Aboriginal and Torres Strait Islander peoples. In the context of what I have just said, what steps have been taken to forward that important agenda for Aboriginal people?

The Hon. M.H. Armitage: That question demonstrates the dichotomy of views between the rather artificial barriers that we put between our States now, particularly with today's announcement about the railway line to Darwin. Everyone would love it if there was not that line across the top of South Australia between the Northern Territory and South Australia, as used to be the case, when it was actually the northern territory of South Australia. However, there are a number of artificial boundaries which indigenous Australians do not recognise.

The national commitment to improved outcomes in Aboriginal affairs arose, as the member for Unley said, from a recommendation of the Council of Australian Governments in 1990. The National Sub-committee on Monitoring, of which the Department of State Aboriginal Affairs is a member, is responsible for progressing that agenda. Key tasks are to establish a reliable and comprehensive data base on Aboriginal communities and, particularly important, to integrate planning processes across Governments in respect of programs for Aboriginal peoples. The department has commenced a project to develop a community profiles information system which will provide essential data to facilitate planning processes and decisions on resource allocations, and ATSIC is collaborating through funding support.

A small working group comprising DOSAA and representatives of ATSIC managers has commenced a process to enhance integrated planning across all levels of Government: for instance, local, State and Commonwealth, including ATSIC. So, advancements have been made. DOSAA is part of the national subcommittee in relation to that.

If I can put on my other portfolio hat, at a recent Health Ministers' forum I noted in particular the concern of what is a grouping of Ministers known as the 'top end Ministers for Health'—in other words, Western Australia, the Northern Territory and Queensland—and I felt that maybe there was a potential role for South Australia to be involved in that. The fluidity of the peoples in those areas presents a particular problem in disease control, public and environmental health, etc. It is things like national commitments, better planning processes and so on that will enable us, hopefully, to overcome those sorts of problems.

Mr BRINDAL: The Minister is undoubtedly aware of the Wiltja program, which takes Pitjantjatjara people from their traditional lands and brings them down to Woodville High School. The Minister, to the credit of this Government, has announced a capital improvement for an expansion of that program. I understand that one of the problems is where a Pitjantjatjara student comes from Western Australia: whilst the South Australian Government picks up all the costs for South Australian students, there is currently no way of recouping any costs for a Western Australian student. To the credit of this Government, I believe it is educating those students, but it is doing so at a cost burden. In conjunction with his health portfolio, are they the sorts of things the Minister would hope will be addressed?

The Hon. M.H. Armitage: They are exactly the sorts of issues we have to grapple with on a daily basis. Resource allocation is one of the key factors. For instance, if large numbers of people from the AP lands require evacuation for some health crisis, they are evacuated to Alice Springs. As the Minister for Health in South Australia, I am not at all inclined to spend money on the Alice Springs hospital, yet I recognise it will perhaps provide better health care for people who may live just this side of the border. They are the sorts of issues that, hopefully, the national program will address.

Mr CLARKE: I want to ascertain the Minister's position with respect to the building of the Hindmarsh Island bridge. Prior to the last State election, when he was the shadow Minister, the Minister said the bridge should not be built and cited matters of Aboriginal heritage as one of the reasons. As we are all aware, there was the Jacobs inquiry, and he gave a ministerial statement in May last year in which he gave—

Mr BRINDAL: I have a point of order, Mr Chairman. Is the Minister responsible to this Committee for what he said prior to becoming the Minister? I fully acknowledge the Deputy Leader's right to question his actions since becoming Minister. Can the Minister be held to answer before this Committee for what he said before he was elected?

The CHAIRMAN: The question is valid in relation to current Government policies.

Mr CLARKE: On 3 May last year, when the Minister made his ministerial statement which cleared the way at that time for the building of the bridge, he said:

> I recognise that Aboriginal sites will be damaged by the construction and that this fact causes great distress to the Aboriginal community. The Lower Murray Aboriginal Heritage Committee, representing the Ngarrindjeri people, remains implacably opposed to the construction of the bridge. I have met with representatives of the committee on at least four occasions and discussed their concerns. My staff and I have had numerous written and telephone communications with members of the committee and their legal representatives. All of these communications leave me in no doubt of the Aboriginal opposition to the construction of the bridge and that the community will be extremely disappointed.

Given the Minister's statement in May 1994, if he believed the Aboriginal people in May 1994 as to their sincerity and their opposition to the construction of the bridge, why has the Government now instituted a royal commission into the veracity of the claims made by these same people?

The Hon. M.H. Armitage: The matters specifically in relation to Hindmarsh Island can be divided into three areas. The matter of the declaration in relation to the bridge is clearly a responsibility for the Federal Minister for Aboriginal Affairs. The matters relating to the royal commission are clearly the responsibility of the Attorney-General. As

Minister for Aboriginal Affairs, I was particularly concerned in the past few months about what was clearly fracturing within the Aboriginal community. If the member for Ross Smith does not realise that in the Aboriginal community at the moment there is considerable turmoil, and within the Ngarrindjeri community there is, most unfortunately, family versus family member in relation to this, he must have had his head in the sand for the past three or four months.

In my role as Minister for Aboriginal Affairs, I was getting considerable input from members of the Ngarrindjeri community and other communities who were indicating they were perturbed at the turmoil within their own community, and a number of the other communities were concerned at the allegations which had been made, and the effect of those allegations on the credibility of Aboriginal heritage processes in other areas around Australia, not only South Australia. Accordingly, the South Australian Government's position was quite clear in that it was, we believed, a role for the Federal Minister to have an inquiry. We are on record for a number of days asking the Federal Minister to have that. The Premier wrote to the Prime Minister and almost immediately the Prime Minister turned down that request.

So, given the fracturing that was going on in the community, the dissent that was being caused, and the potential damage to other Aboriginal heritage processes, I think the exercise of an inquiry, which I stress will not detail the actual beliefs of people on either side of the dispute—it is quite clearly not addressing those matters—was an appropriate step to take. I should add that the recent allegations made by a variety of people from within the Aboriginal communities have been made by people who were not part of the original consultation process as they were not members of the Lower Murray Aboriginal Heritage Committee at that time.

Mr CLARKE: By way of supplementary question, in May last year you had gone through what I take it from your ministerial statement to be an exhaustive process of ascertaining the facts of the situation, and you were left, in your own words, in no doubt as to the opposition to the building of the bridge. The royal commission that your Government has called is bringing into question the veracity of those claims made by those same people when you said you had no doubt about their position in May last year.

The Hon. M.H. Armitage: I am surprised that the shadow Minister has not bothered to look at the time lines, given that he was so specific in talking about my ministerial statement made on 3 May 1994. That was the situation on 3 May 1994. The royal commission is not inquiring in any way into the information with which I had been provided until 3 May 1994. All the claims about the veracity or otherwise of the beliefs are related to allegations about events that have occurred since that time. That is patently clear and transparent, and I am surprised the shadow Minister does not realise that.

Mr CLARKE: Given the Minister's stated position prior to the election, are you for or against building the bridge?

The Hon. M.H. Armitage: As a Minister of Cabinet, that is clear: just look at my ministerial statement of 3 May 1994.

Mr CLARKE: Would you support the release of the Jacobs report in full to the public or do you consider it secret white fellas' business?

The Hon. M.H. Armitage: One of the most interesting things in this whole exercise is that, as Minister for Aboriginal Affairs, I have been studious in upholding the Aboriginal Heritage Act. There are a number of reports that contain information in relation to Aboriginal concerns and matters which, over the time since I have been the Minister and since the Hindmarsh Island bridge arose as an issue, I would have been delighted to release. But, upon asking the various informants to those reports whether that was an option, I have been routinely turned down. As the member for Ross Smith knows in relation to a question I was asked by either him or the Leader of the Opposition earlier this year, I was distressed and surprised to find that a number of those reports which, under our Aboriginal Heritage Act require my authorisation—and I get my authorisation from the Aboriginal communities, and they have said 'No'—have been released by people whom I would have expected to know better, for instance, the Federal Minister for Aboriginal Affairs and officers of the Aboriginal Legal Rights Movement. I have been meticulous in releasing nothing that the Aboriginal communities would not allow me to release.

Mr CLARKE: Late last year, in reply to a dorothy dixer, the Minister talked about how important access to education is to meet the needs of Aboriginal children. In fact, the Minister went on at great length about the importance of the issue and said that the Government was aware of the dilemmas. But you did not say what the Government is doing or going to do to overcome the dilemma. In July 1993, a report on the 'Early Childhood Service Needs of Aboriginal Communities in the Northern Country Areas of South Australia' was published by Anne Glover under the sponsorship of the Children's Services Office and with funding by the South Australian Aboriginal Education and Training Advisory Committee.

The study area covered the CSO northern areas region embracing the Anangu Pitjantjatjara lands, the Maralinga Tjurutja lands, Yalata and communities in the Far North, the Flinders Ranges, Whyalla, and the Pirie and Eyre regions. The report said that within communities early childhood services are seen as having three significant functions: first, supplementing family care; secondly, providing opportunities for children's socialisation; and, thirdly, preparing children for their future education. Is the Minister aware of the critical issues raised in the report dealing with Aboriginal environments, staff, early entry into services, transport and collocation of services, and can he say how these issues are being addressed?

The Hon. M.H. Armitage: Again, I reiterate what I said in my opening statement. The Department of State Aboriginal Affairs has a policy overview role, not the provision of services. I recognise that Aboriginal education is particularly important. However, I am surprised that no questions about this matter were addressed to the Minister for Education and Children's Services.

Members interjecting:

The CHAIRMAN: The member for Unley; thank you. The Chair is quite capable of looking after the debate.

The Hon. M.H. Armitage: That indicates exactly how important the Opposition believes this issue is. Opposition members were willing to ask question after question until they ran out of time. Obviously, they believe that the Minister for Education and Children's Services, who has the opportunity to address these issues on the ground, was not worthy of being questioned because there were so many other issues that were more important than this issue.

The CHAIRMAN: The Chair points out that in each of the Committees there has been the opportunity for questions to be placed on notice in the event of there being insufficient time for formal verbal questioning.

The Hon. M.H. Armitage: Recognising that I am not responsible for education, I do have here a number of commitments from the Department of Education and Children's Services related specifically to Aboriginal people. For instance, I indicate that for Aboriginal education workers in schools there is a total of $4.6 million; $180 000 for Aboriginal education teacher in-service training; $110 000 for the Aboriginal Islander Career Aspiration program, student support; $680 000 has been transferred to community control in the Aboriginal Education and Strategic Initiative program; and there is the Aboriginal Student Support and Parent Awareness Committees and the Anangu operational control in schooling, where a total of $680 000 is being spent.

Ms GREIG: I refer to page 275 of the Program Estimates, which states that State Aboriginal Affairs will 'coordinate a statewide Aboriginal Women's Advisory Committee and promote and implement initiatives that specifically address Aboriginal women's issues'. Can the Minister outline the initiatives that are being undertaken to allow Aboriginal women to be involved in decision making processes affecting them personally and their families?

The Hon. M.H. Armitage: I thank the member for Reynell for her question about the Aboriginal Women's Advisory Committee. I will ask Ms Val Power to answer the question and provide information.

Ms Power: On 2 and 3 May 1994, a statewide Aboriginal Women's Conference was held to elect a working party to facilitate the establishment of a statewide Aboriginal Women's Advisory Body. Consultations with Aboriginal women's groups across the State are almost complete, with the first meeting of the Aboriginal Women's Advisory Council planned to be held in the second half of 1995. The proposed role of the council is as follows:

- Provide prompt policy advice and research for the Minister on sensitive or strategic issues affecting Government initiatives relating to Aboriginal women, in particular, the protection of Aboriginal women's heritage and cultural business to be recognised by Government.
- Monitor national and international issues relating to indigenous women to advise on implications for Aboriginal women in South Australia.
- Ensure that the needs of the Aboriginal women and the aims of Government policy are recognised in Aboriginal advancement planning.
- Develop initiatives and strategies for Aboriginal women by ensuring that Government planning and policy processes result in verifiable improvements in the social and economic conditions for Aboriginal women.

The Department of State Aboriginal Affairs employs an Aboriginal Women's, Youth and Families Officer who specifically addresses the needs of Aboriginal women and families across the State to provide a support service as required. From a national viewpoint, this officer is the State representative on the National Working Group meeting facilitated by ATSIC on 2, 10 and 11 May 1995 to discuss and report on the importance of access and equity for indigenous women. The outcome of the meeting is that each State representative is to deliver a completed questionnaire paper by the end of 1995 for consolidation into a report to the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and to the Ministerial Conference on the Status of Women.

In the area of youth, I am pleased to announce that the Aboriginal Youth Service will be established and opened by 1 July 1995. The management has representatives from Aboriginal organisations in the metropolitan area of Adelaide and the Kaurna tribal name of the youth service will be Kumangka Aboriginal Youth Service, which will be dealing with problems currently being experienced involving Hindley Street's homeless children.

Mr CLARKE: I would like to, if I may, put these following questions on notice for the Minister. As I have explained to the Minister, unfortunately I am due in the other Committee.

The Hon. M.H. Armitage: I am more than happy with that. I understand that will be the end of the Aboriginal Affairs estimates.

Mr CLARKE: Yes, then health will proceed. It relates to the last question that I asked the Minister. We would have liked to question the Minister for Education but, as the Minister for Health will find out between now and 10 o'clock tonight, there is an endless number of questions—all very important across the board—and not all questions will be reached, particularly when the Minister for Education is even more voluble than the Minister himself, which is saying something.

My questions are as follows: what work is being done on the collaborative service delivery between health, welfare and education and care agencies? While some individuals see collaboration as a way of maximising service deliveries, others see it as a cost cutting measure: is the CSO making an effort to involve Aboriginal communities in this process? The report says that in the study area the systematic evaluation of services and programs is limited and that programs tend to be judged on attendance rather than researching the nature and effects on children: what is the CSO doing to correct this situation?

The Hon. M.H. Armitage: I am more than happy, as I indicated before, to answer the questions in written form, but I do not know that the Deputy Leader referred to the report from which the questions come.

Mr CLARKE: Yes, I said in my earlier statement that the report was that of the 'Early Childhood Service Needs of Aboriginal Communities in the Northern Country Areas of South Australia.' It was published by Anne Glover in July 1993, under the sponsorship of the Children's Services Office, with funding from the South Australian Aboriginal Education and Training Advisory Committee.

The Hon. M.H. Armitage: It is a report for another portfolio area.

Mr CLARKE: Yes.

The CHAIRMAN: It is a ministerial portfolio. If the Minister is happy to receive the question and delegate at least part of the answer to another Minister, that would suit the Committee. There being no further questions, I declare the examination of the vote completed.

South Australian Health Commission, $673 950 000

Membership:

Ms Stevens substituted for Mr Clarke.

Departmental Advisers:

Mr R. Blight, Chief Executive Officer, South Australian Health Commission.

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

Mr J. Blackwell, Executive Officer, Country Health Services.

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

Mr B. Dixon, Director, Aboriginal Health.

Mr D. Filby, Executive Director, Policy and Planning Division.

Mr M. Forward, Director, Private Development Unit.

Ms C. Gaston, Executive Director, Metropolitan Health Services Division.

Dr M. Jelly, Chief Medical Officer, Metropolitan Health Services Division.

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

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

Ms S. Page, Director, Quality Culture Unit.

Mr D. White, Chief Nursing Officer, Metropolitan Health Services Division.

Ms A. Pascoe, Senior Policy Officer.

Mr S. Conboy, Manager Finance, Finance and Information.

Mr P. Hoult, Senior Consultant, Private Development Unit.

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

The Hon. M.H. Armitage: Mr Chairman, I am pleased, once again, to present the budget estimates of the South Australian Health Commission for the forthcoming financial year. As you may recall, only nine months ago, when we were last here, I set out the budget strategy for the health system over the ensuing three years. The health sector had been asked to achieve savings of $63.5 million per annum by the end of that period as part of the Government's overall budget and debt reduction strategy. Following further close examination of the State's forward financial position, all agencies have been asked to achieve additional savings in 1995-96. For health, this has meant an additional $6.5 million savings requirement or a total of $70 million per annum by the end of 1996-97. The total savings requirement represents 5 per cent of the Health Commission's current payments budget or 1.7 per cent per annum over the three-year period.

Any savings target presents a challenge. However, in the context of what is possible and what is being achieved elsewhere in both the private and the public sectors as Australia restructures to compete within Australia and with the world, the target set for health is more than achievable. When the Treasurer presented the State budget four weeks ago he indicated that the Government's three-year budget strategy was 'on track'.

I am very pleased to confirm that the health system is as well. The Health Commission will achieve its budget for 1994-95. It will have achieved almost 50 per cent of its three-year savings target in the first year and, in addition to these significant financial achievements, the commission will have made great progress in structural and microeconomic reform; it will have increased hospital activity—admissions have increased by 4 per cent in metropolitan and country hospitals to the end of April 1995; and it will have reduced numbers on the waiting lists (in particular, those waiting more than 12 months) with a 50 per cent reduction to the end of March 1995.

The broad budget strategy for the Health Commission in 1995-96 is based on the following:

> The need to achieve a $26 million contribution to the overall savings target required by Government. This represents 1.8 per cent of the Health Commission's total payments budget.
>
> The continuation and refinement of casemix-based funding for hospital services under which hospitals are paid for the work they do at a standard and efficient price.
>
> The quarantining of disability services from making any contribution to the savings target in 1995-96. This is the second year in which disability has been quarantined, reflecting a priority towards meeting the unmet needs of members of our community with a disability. Disability services have been set an efficiency dividend, nevertheless, to enable further reallocation of funding from administrative and support services into direct client care.
>
> Continuation of strategic measures to ensure that the health system in this State is not only cost effective but is able to meet or to exceed world's best practice. A city state like South Australia with a highly integrated and a cooperative community has a unique opportunity to achieve this.

Contracting out, private management of public health services, private financing, amalgamation of health service providers, regionalisation, focus on population health and a clearer delineation of funding, purchasing, ownership and health service provision roles will all play their part in this. The new private management arrangements at Modbury Hospital are an excellent example of these reform processes in action. The transfer of hospital management to Healthscope has demonstrated to the health system that further hospital efficiencies are possible and that the Government is very serious about the involvement of the private sector in the provision of public health services—and I emphasise 'public health services'. The associated private hospital at Modbury will create a larger public private hospital site with greater drawing power for clinicians to the outer metropolitan area and the opportunity to share facilities, such as day surgery suites, which may not otherwise be provided as quickly from the State's capital works program.

The budget process, as members would be aware, has been brought forward this year and, as a result, this has had some implications for the manner in which the Health Commission presents its estimates to the Committee. Traditionally and, I emphasise, uniquely the Health Commission has provided additional supporting information to its budget by preparing a loosely-termed blue book. The blue book has included actual financial results for the financial year and comparisons against final budget figures. As this has not been possible within the time frame for Estimates Committees this year, a blue book is not available today but will be prepared within the normal time frame and be completed by the end of August.

Acknowledging this, I have provided the member for Elizabeth with additional information breaking down all Program Estimates to a health unit level. However, in considering this information the Committee needs to be aware of the following: 1994 budgets are those presented to Parliament over 12 months ago. Since that time decisions have been made with regard to health unit allocations, and health unit reported outcomes will reflect these budgetary variations. The 1994-95 outcomes are estimates based on information supplied by health units as at the end of March

1995. Actual results might well therefore vary significantly health unit by health unit.

The 1995-96 estimates are not based on actual results for 1994-95 and include projections of funds carried over from 1994-95 as estimated by health units. Anticipated refinements of the casemix funding model, policy changes associated with health unit revenue estimates, and other subsequent resource variations mean that the final budgets provided to health units will be different from those detailed in the additional information provided. I stress again that the figures are indicative and will not be the final budgets provided to health units.

The Health Commission budget for 1995-96 provides for a reduction of $17.5 million (2.5 per cent) to $674 million to the State's contribution from Consolidated Account; a $50.9 million increase (3.8 per cent) in recurrent payments to $1.406 billion; and a capital works budget of $70.4 million, an increase of $2.3 million after excluding the ever present motor vehicles. The primary health care pool has been increased from $1.5 million in 1994-95 to $2.5 million for projects to improve and extend links between hospitals and community-based services. A world's best practice pilot home visiting program to improve the health status of families through early intervention will be established at a cost of $1.2 million over two years.

Increased funding will be used to accelerate the development of community and mental health teams, the provision of psychiatric services in metropolitan general hospitals and access to psychiatric services by country residents. Additional funding will also be made available for mammography and cervical screenings, Factor VIII for haemophiliacs, improved control of hepatitis C, immunisation services and adult dental services. Despite the budgetary cuts, I am pleased to say that the capital works program has been maintained and, at $70.4 million, is well above the average of $56.5 million over the past five years.

Major projects to be funded include $16.7 million for Info2000 (the Health Commission's technology strategy), which focuses on clinically oriented systems and the replacement of existing systems with new, common and integrated systems over the next five years; $5.4 million to continue the South Australian mental health service devolution program; $2.9 million to complete major extensions to the Accident and Emergency Service at the Flinders Medical Centre; $3.6 million for the second stage of the Port Lincoln Hospital redevelopment; $2.7 million for upgrading cancer services at the Royal Adelaide Hospital; and $1.9 million for a second new aircraft for the Royal Flying Doctor Service.

In addition to these projects, private financing is being arranged for the building of a new hospital and community health centre—very importantly, Mr Chairman, at Mount Gambier. The 100-bed hospital will cost $26 million and it is proposed to spend $12 million in 1995-96. I commend the financial statements and budget to the Committee and look forward to responding to members' questions.

Ms STEVENS: I will forgo my opening statement; we are already 40 minutes into the time allocated and I will make other comments at other times in relation to what I was going to say. On page 254 of the Program Estimates it is reported that Modbury Hospital received almost $8 million more in 1994-95 than was allocated in the last budget. For 1995-96, the first full year of management under Healthscope, Modbury will be allocated $42.746 million, an increase of $70 000 over last year's estimate, while Flinders Medical Centre, the RAH and the Women's and Children's Hospital all will receive less than their 1994-95 allocation.

The Minister has claimed that the Modbury deal will save $6 million per year. By the end of 1995-96, nearly 18 months after Healthscope's takeover, almost $8.5 million should have been saved on this deal, according to the Minister. Instead, an extra $8 million will have been spent on Modbury Hospital. Where is the evidence of the $6 million per year savings which the Brown Government claims will come from the outsourcing of Modbury Hospital?

The Hon. M.H. Armitage: I am delighted to address this question, because the member for Elizabeth clearly does not understand these things and has not bothered to read media releases and look at copies of the contracts which were released on the signing of the agreement. I find that interesting, because there was a hullabaloo before about our being secret, yet the information that we have provided has not been read. In any material like this there are always some up front costs to allow for the transfer of staff from the public to the private sector employer. Those up front costs were included in the documentation that was made public. The summary of the contract which was released, and which included a comment on the agreement, reads:

> The transfer of operational management responsibilities to Healthscope entails substantial front end costs to Government which are mainly related to the costs of staff transfers, redeployment and separation packages. Taking all such costs into consideration, the financial analysis shows that all costs will be recovered and the Government will begin to receive a real return on the transaction in less than three years. The Health Commission, Department of Treasury and Finance and the independent financial analysts are fully confident that the costs of service provision are and will remain substantially beneath the costs of similar public sector provision throughout the life of the agreement.

That was made public. It is important to note that when there is a transfer from the public to the private sector there are a number of pay outs which constitute a large proportion of what are loosely termed the up front costs; but those pay outs include a large number of accruals which were accruing to the public sector anyway. For instance, we had to pay leave costs of $5.1 million up front, but they would have had to be met by the system when the leave was taken or the staff resigned. They were literally an up front cost. In other words, they were not a new cost; we had to pay them all in the one instant rather than as people took leave.

If the hospital had remained under public management, it would have had to shed staff to try to meet its casemix derived budget, and a number of those costs would have occurred anyway. Cross-over incentive payments were a Government decision to encourage staff to transfer and to reimburse them for other benefits, such as accrued sick leave. If they had stayed within the public sector, they would have called on part or all of that sick leave and we would have had to meet that cost anyway. In other words, it is not a new cost; it is a cost that the public sector was quietly accruing, but it fell due when the employees moved to the private sector employer.

All those up front costs were acknowledged publicly from the beginning. The central agencies, such as Treasury and Finance and, importantly, the independent financial analysts, knew all about that. All those costs were factored into the net present value carried out by the Health Commission, and they were validated by the Department of Treasury and Finance and by the independent financial consultants. The net savings were calculated as being between $5 million and $6 million. That was a conservative estimate in terms of Government

savings, because they do not include the payroll tax that the private company must pay to the State Government and which those employees were not accruing for the State Government when they were in the public sector. The calculations result from an analysis of the life of the 20-year contract, they are converted to an annual average, they are conservative, and they do nothing more or less than put together all the facts and figures which have been made available publicly and which have been checked by independent financial consultants.

Ms STEVENS: As a supplementary question, could you outline where the $16.4 million has gone? I get that figure from the extra $7.9 million that you spent on Modbury in 1994 together with the $8.5 million which supposedly would have been saved at $6 million per year from February 1995 to 30 June 1996.

The Hon. M.H. Armitage: I am more than happy to answer any question, but I need to be clear. Is the member for Elizabeth referring to page 254?

Ms STEVENS: Yes.

The Hon. M.H. Armitage: Under 'Modbury Hospital' there is a figure of $42.6 million as the 1994-95 estimate and $50.5 million as the 1994-95 revised figure. Is that the $7 million to which the honourable member is referring?

Ms STEVENS: It is $7.9 million.

The Hon. M.H. Armitage: I am informed that that represents the up-front costs that were generated as a one off, all of which were accruing anyway. I am trying to tie in with your question the $42 million in 1995-96.

Ms STEVENS: You have just answered with respect to the $7.9 million. You said, in relation to this contract, that $6 million would be saved every year, so over 18 months that would be about $8.5 million. That has not arrived either, so I am asking: where is it? Added together it makes $16.4 million.

The Hon. M.H. Armitage: As I understand it, the member for Elizabeth has not assimilated the information that I provided in answer to her first question, which was that the $6 million was a per annum saving averaged over the 20-year duration of the contract, and that is after you have taken all the up-front costs and everything else into consideration.

Ms STEVENS: You are still going to have to make up this $16.4 million over the entire contract.

The CHAIRMAN: I ask the member for Elizabeth to address her questions through the Chair rather than to enter into a conversation with the Minister. I am not sure whether that was a question or a statement.

The Hon. M.H. Armitage: I would like the member for Elizabeth to explain her reference to $16 million. I am not sure that I understand it.

Ms STEVENS: We have just established that an extra $7.9 million, which you get by taking away those two figures, has been spent on Modbury Hospital according to the 1994-95 figures. You have assured us that the contract will save $6 million per year. We are saying that by the end of June next year, which will be about 17 months of the contract, another $8.5 million should have accrued.

We are not seeing that because this year's forward estimate shows that no savings are coming back to the Government from Modbury Hospital—in fact, you are putting in $70 000. Did the up-front costs really amount to $16.4 million? Is that why we are not seeing any profits? There is no money coming back; there is no reduction.

The Hon. M.H. Armitage: At the risk of being tedious I will reiterate to the Committee that the $6 million per annum saving is an average saving across the life of the contract. If you take all of the benefits and divide the total by 20 months (the life of the contract), it is a saving of $6 million per annum. That was devised not by us but by the independent financial consultants. Having said that, I point out that, across the life of the contract, there are a number of up-front one-off costs. Instead of allowing those costs to accrue over a long period, as they were under the public sector, the public sector paid out those costs to encourage people to move to private sector employment.

Mr Brindal interjecting:

The Hon. M.H. Armitage: That is in one instance, as the member for Unley says. All of that contributed to the jump, if you like, in the 1994-95 revised amount. There are other additional matters, such as the further $2.9 million in savings in 1995-96 which will not be reflected as coming off the budget but as another 1 500 weighted separations that will occur. I remind the member for Elizabeth and members of the Committee that the Modbury contract was set during peak activity in 1992-93. There is considerable opportunity for us to gear up Modbury Hospital to that activity level.

Ms STEVENS: Who will pay the up-front costs?

The Hon. M.H. Armitage: As in all these contracting deals there is a commitment from both Treasury and the agency doing the outsourcing. The Health Commission and Treasury paid for it as one up-front cost to achieve the change.

Ms STEVENS: What was the total of those up-front costs paid for by the Health Commission and Treasury?

The Hon. M.H. Armitage: I will take that question on notice.

Ms GREIG: At page 259 of the Program Estimates and Information under 'Metropolitan hospitals' reference is made to the provision of effective and high quality services. Will the Minister indicate the role that information technology might play in this and whether there is the potential for any spin-offs which might see benefits extending beyond the health system?

The Hon. M.H. Armitage: I am pleased to inform the Committee that today I announced that the Government successfully concluded negotiations for an agreement with a leading international information technology firm, MacDonnell Douglas Information Systems (MDIS), to develop jointly the next generation of health industry software systems. It is highly likely that significant exports will be generated from the project, particularly focused on South-East Asia and China. South Australia won the contract after lengthy negotiations and despite being out bid by other States, which I think is significant in the present context.

The Managing Director of MacDonnell Douglas Information Systems in Australia literally reiterated today that South Australia won this contract because of the Government's commitment to information technology, the clear vision for health from the Government and the Health Commission and an integrated system of information technology. This export orientated project has already generated 30 new jobs in the health and software development fields. It is expected that a further 10 to 20 jobs will be created in South Australia in the near future as the project progresses. Indeed, this morning I visited the sixth floor of the Westfield Marion building, where I saw the newly renovated offices and met the 30 staff members who are enthusiastic and keen about their new job. The project links in with other Government initiatives to attract information technology research into the State and will

further promote South Australia as the Australian centre for computer software research and development.

MDIS is the largest supplier of integrated hospital information systems in Australia. It is part of the UK based MacDonnell Douglas Information Systems which worldwide has more than 400 hospital customers. The South Australian Health Commission will jointly cooperate with MDIS to develop the software project known as Health Care 2000. There will be not only the short-term benefit of $13 million being spent by MDIS and the creation of 30 to 40 new jobs but, importantly, international recognition and opportunities will flow from that with the capacity to attract similar investments. One of the people I met this morning came from the MacDonnell Douglas parent company in England, and there are a number of other people who have come to South Australia for the first time as part of this project.

It is a coup for South Australia and a real feather in the cap for the Government and the commission which won the contract. For patients, it will mean a much better system which will enable better resource management, easier access to test results, more streamlined ordering of tests and so on. It will also provide clinical care support for GPs, specialists, clinicians and nurses, and it is really a very positive project for South Australia.

Mr ROSSI: At page 263 of the Program Estimates and Information, under the heading 'Community based services', reference is made to the amalgamation of community health services with women's health services. How will this amalgamation of health services benefit people living in the northern region?

The Hon. M.H. Armitage: In the past, health services at Salisbury, Tea Tree Gully and Elizabeth have operated independently. Each previously had its own administrative infrastructure to support budgets ranging from $400 000 to $1.3 million, and the ratio of administrative staff to total staff at each service ranged from 31 per cent at Lyell McEwin to 38 per cent at Salisbury. The total ratio of administrative staff across the four services was 36 per cent (28.9 FTEs). The amalgamation of these various services will result in a decrease in the ratio of administrative staff to 28 per cent (23 FTEs).

A significant benefit of the administrative rationalisation for people living in the northern region is the movement of funds from the provision of administrative support to the funding of additional service professionals. The equivalent of 11.8 additional service professionals will be employed as a direct consequence of the amalgamation within the existing level of resources. Hence, the level of services available to people living in the northern region will be increased, particularly in the areas of speech pathology, podiatry and counselling, with special focus programs for youth, women and men. The regional approach to service planning and delivery will enable specialist professionals to be accessed by members of the community at a range of local service sites.

In the past, some community members have not had local access to specialist professionals such as podiatry or speech pathology because their particular service had one on staff, whereas people in other districts could not access such a service as it was not available at their local service centre. The amalgamation has resulted in a more equitable distribution of services across and between the sub-regional service sites. The overall coordination and planning of services will enable targeted programs to be developed in response to special needs groups such as youth, women, people of non-English speaking background and Aboriginal community members.

Such programs will be offered across the region and to particular district communities in response to the needs of the community. This is a very exciting project which has the full support of the administrative staff of the four centres. It has the full support of the people in the community and is a classic example of providing more services with the same amount of money by focusing on administrative efficiencies. It is a shining example of what can be done under restrained budgetary circumstances.

[Sitting suspended from 1.2 to 2 p.m.]

Membership:

The Hon. Frank Blevins substituted for Mr De Laine.

The Hon. M.H. Armitage: I refer to the up-front costing, for which the member for Elizabeth asked. During the lunch break, I was informed that there is roughly a $17 million up-front cost, of which the Health Commission has paid approximately $2.5 million—I can get exact figures later—and the Treasury has paid $15 million. Of the Treasury's contribution, some has gone to TSPs, which is not reflected in the Modbury Hospital budget, and some has gone to incentive payments to people who have moved to the private sector employer. That, together with the $2.5 million, is reflected in the Modbury Hospital budget.

Mr BRINDAL: My question refers to page 260 of the Program Estimates and it relates to country health services. The question is relevant, because the matter is currently being canvassed strongly in the media. In particular, the broad objective of country health services is to ensure the provision of integrated, high quality hospital, community, primary and domiciliary care services to rural South Australia.

In that context, the Minister will be aware of the recent debate regarding the position and the maintenance of country obstetric services. What can be done about that? I am sure that all my colleagues, including the member for Giles, are concerned to ensure that country women continue to have access to the highest standards of obstetric care.

The Hon. Frank Blevins interjecting:

The CHAIRMAN: The Chair finds asides totally inaudible and out of order.

The Hon. M.H. Armitage: The member for Unley has asked about an important matter which, as he correctly observes, has been of great interest in the media recently. I preface my response by indicating that the Government certainly realises the importance of the provision of appropriate services in rural areas. In many instances, the provision or otherwise of health care is one of the most important factors to a town. I am informed that, if appropriate health services are not available, it is more difficult to encourage teachers, police officers and so on with young families to move to rural areas. That was reflected in our pre-election commitment, which has been well emphasised in the budgetary process since the election, to maintain country public hospitals unless local constituents desire a change of function.

Over the past week, the Health Commission has been involved in negotiations to conclude a new fee-for-service agreement for 1995-96 with doctors in rural areas. Into that was mixed a dispute not with the Health Commission but between the Medical Defence Association of South Australia and rural obstetric practising doctors. Because of a variety of

risk factors which primarily relate to large claim settlements and an increase in the number of those claims, I am told that, consequent upon various legal practitioners advertising their services in the country, there was a need, the MDA thought, to satisfy its reinsurers, that it would need to increase premiums. Premiums for a rural doctor practising obstetrics went up by $4 500.

As part of our general fee-for-service agreement negotiations, we have now placed before the AMA and the Rural Doctors Association a new fee-for-service agreement which includes for their consideration an amount of $4 500 for private general practitioners and obstetric specialists who can provide evidence of appropriate admitting and clinical privileges in a recognised hospital and who are doing at least 20 deliveries per year, or who can demonstrate that they have recently updated their skills by recognised in-service training at a teaching hospital. That offer is also available to medical practitioners who do obstetric refresher courses during 1995-96. In other words, that payment will remove the financial penalty of GPs who wish to practise obstetrics in the country. Perhaps some change in service provision pattern will occur, but it will no longer be because of the financial extra commitment of indemnity insurance.

To make sure that the process is available as readily as can be, the rural registrar scheme is operating, and funding has been increased as part of the joint Health Commission-rural divisions of general practice integrated rural locum service to expand opportunities for rural doctors to attend continuing medical education and training. The opportunity will be there if doctors wish to update in the ensuing financial year. We are suggesting that it is a matter of standards. We are never happy to part with taxpayers' money but, recognising the imperatives of rural obstetrics, we are happy to pay if the appropriate standards are being upheld.

The President of the AMA and the President of the Rural Doctors Association have been involved in all those negotiations and, I am informed, will offer their support for that process and the offer from the Health Commission to a meeting of the AMA and the Rural Doctors Association of South Australia tonight. We hope to hear a positive outcome, with the acceptance of that offer, after the meeting.

Mr BRINDAL: The Minister is to be congratulated. I am sure that the Opposition will join me in applauding his initiative in such a serious matter. The Minister might not be able to answer directly, but my question arises from the increasingly litigious nature of our society. The Minister has said that Health Commission dollars or public dollars have to be used to protect genuine medicos from some elements of rapaciousness within the community or the need to blame somebody when something goes wrong.

Is not that part of a wider problem? Should not Parliament and the Executive Government look at the nature of claims that seem increasingly to be made against professionals who are trying their best, sometimes in difficult circumstances, and who are increasingly under threat because of it? It is all right for the Minister to give $4 500 this year, but it might go up to $8 000 next year. How long can the community afford to bear the desire of some people to cash in whenever there is misfortune?

The Hon. M.H. Armitage: As I indicated in my original response, I am informed that the number of potential claims increased as a result of an advertisement placed in several rural newspapers. I wrote to the Law Society about the matter at the time. It is a matter for the Law Society, with its ethics and control over its members, rather than for the Minister for Health.

There is no doubt that, for people who have had a genuine problem or something go awry, particularly with a birth, because they seem to be the areas of greatest problem, if there is a genuine problem which is genuinely sheeted home to blame, I believe it is appropriate for recompense to be given—there is no recompense really, but financial recompense to help with costs and those sorts of things.

The Medical Defence Association of South Australia rigorously studies every claim and clearly believes there will be a number in the offing which either will be settled for much smaller amounts than some of the well publicised ones recently or will not progress to any claim at all. Obviously, their reinsurers cannot afford to be so generous or so optimistic and have to insure for the worst case scenario.

Mr BRINDAL: I think the legal profession seems to be more happy suing than it is in being sued.

The Hon. FRANK BLEVINS: Following on from a point raised by the member for Unley, as to the question of payments to rural GPs involved in obstetrics, a significant precedent has been established. I wonder what will happen when the inevitable claims come from the specialists who are working in these areas outside the metropolitan area where they are funded by the hospitals. When these claims appear from specialists for supplementation, is the Minister inclined to follow the precedent he has set and reimburse or supplement the payment to the specialists? If the answer to that is 'Yes', and I suspect it will be now that the precedent has been set, will there be any supplementation to hospital budgets to fund that? If there is not, it will be funds transferred from patient care to the specialists. I am not arguing the merits of the specialists case; they are quite capable of doing that themselves. What does concern me is the possibility of hospital budgets in effect being cut to pay the inevitable supplementation.

The Hon. M.H. Armitage: I make two points in relation to that. First, hospitals do not pay medical defence for their staff. We are self-insurers for hospital doctors, so no increase in commitment would be expected from that angle. Secondly, I am glad the honourable member has given me another opportunity to refer to this matter: I meant to mention previously that this is, as part of our agreement with the doctors, specifically a 12 month agreement on the basis that we were faced with a situation which the Medical Defence Association, if you like, foisted upon the doctors within the space of the past two weeks. Doctors quite legitimately felt they would not subject themselves to a $5 million or $6 million claim, so we were faced with the Government's having to, if you like, be a white knight in the short term. In that 12 months, we will look at a number of other strategies to see that the best result ensues from all those negotiations. I do not regard this as precedent setting at all. This was nothing more or less than a short-term solution to a problem whilst a more considered response is worked out.

The Hon. FRANK BLEVINS: Regarding these 12 month interim payments, to the best of my knowledge they are still going and have been built on. Everything that is not a precedent is the first thing you use when you go back again. However, that is a headache for the Minister to suffer.

With respect to casualty and outpatient services, particularly in the Upper Spencer Gulf region, my understanding is that the Medicare agreement with the Federal Government insists that the casualty services provided at these major regional hospitals, and at outpatients, are at no cost to the

patient at the point of delivery of the service. In the mid 1980s, maybe 1987 or 1988, there was an agreement with the doctors in these regions that they would, on a roster basis, supply the service, given that the major provincial hospitals do not have resident medical officers. I am not suggesting that they should.

As I understand the state of negotiations, the Minister has said that there will be no more agreement with them or no further contract signed after 30 June, which we all know is Friday, unless the doctors go back onto inferior conditions that they 'enjoyed' in 1987. The doctors, quite properly in my view, say this is unacceptable in 1995, and they are certainly not going backwards. Given there will be no contracts after midnight Friday, my constituents and those of the members for Eyre and Frome, and others, would like to know what provision the Health Commission is making for Saturday morning when there are no medical officers in the hospital to staff the casualty or outpatient service?

The Hon. M.H. Armitage: This is a matter of considerable import to me and obviously to constituents in the triangle. This agreement was first struck in the mid 1980s, and I am not quite sure who was the Minister at that time—there is a Cheshire cat grin on my right—but I will look it up. The concept of ministerial responsibility, as the Opposition has been at pains to draw out—a bit like drawing teeth regarding a number of matters that have arisen publicly over the past 12 months—means that everything is sheeted home to the Minister. The Minister takes all the responsibility. It does not matter what the advice is, this is the Westminster system of Government, and it is the Minister who takes responsibility.

In the mid 1980s, there was an agreement for after hours services in Port Augusta, Port Pirie and Whyalla, at a cost of $200 000. It was a shared agreement between the Commonwealth and the State, 50:50, with the Commonwealth contribution phasing out. The contribution from the State to that agreement in the past year was $1.2 million. Quite clearly, if you look at a CPI inflated figure or whatever, you see that that is a gross abuse of the system. Interestingly, the conditions in those three areas were discussed and exposed to me at a meeting I had a week or so ago with a variety of the doctors. At present, if a GP in the casualty section of a hospital in those towns as part of this agreement sees a patient with, say, a cold at, for instance, 9.30 p.m., they get about $60 for that service.

If they were to see that patient in their surgery, which I assure members from my personal experience Adelaide doctors do every night of the week, they would be paid $35. So, there is an immediate incentive for those people to be seen in casualty. Another concern for the South Australian taxpayer in regard to our budget is that the $60 in the hospital is paid by the State and the $35 (approximately) that would be paid in the surgery is paid for by the Commonwealth. I repeat: that is for something that doctors all around the metropolitan area do every single night of the week. When I was in Whyalla one of the doctors said he had been in practice for seven years and had never seen anyone in his surgery after hours. He never opened his surgery after hours.

Mr Brindal interjecting:

The Hon. M.H. Armitage: As the member for Unley says, all the patients are seen at the hospital. It may be convenient because there are nursing staff and others there, but there is also that financial difference between the two services. All we are trying to do is establish the fact that a normal general practice event ought to be seen as such, and we believe that that is not unreasonable. We certainly believe that taxpayers would ask that that might occur. To that end we have written to the three chairpersons of the boards of the various hospitals indicating that there will need to be some new arrangements to cover the casualty services and we are asking the boards—as we are attempting to devolve responsibility—to negotiate some new arrangements and have suggested a number of options in that regard.

In particular, for the next month we have offered to the hospital, as a block, a quantum of money which was required for the running of that after hours casualty service—in other words, saying to the hospital, 'You can either continue to pay it as you were or you can start negotiations with the doctors.' We will certainly be there helping with those negotiations and expecting to be part of them. Indeed, the President of the AMA has indicated his willingness to be part of the negotiating process as well, recognising the imperatives to which I have referred. At that time the remuneration will decrease but we would hope that some of the other options we have presented to the boards which would see a continuation of services provision in a more cost effective manner will be operational.

The Hon. FRANK BLEVINS: That was all very interesting. The Minister referred to gross abuse and I think he means gross abuse by the doctors. It is unfortunate that the Minister indulges in doctor bashing in this way. If the Minister has any examples of gross abuse or anything else that he thinks is untoward, there is machinery to take care of it. That patients may go to the hospital if they have a cold is something the Minister knows they are entitled to do. They can go to the Royal Adelaide Hospital or any other metropolitan hospital after hours if they have a cold. Do not let us assume that country patients want anything different from what metropolitan patients have, which is what the Medicare Agreement is all about.

While the Minister's response was interesting, it did not actually answer the question. At midnight on Friday there are no contracts with the doctors in the Iron Triangle area. The doctors tell me—and they have told the Minister—that they will not supply a casualty service without a contract. On behalf of patients, constituents and potential patients requiring casualty in the Upper Spencer Gulf, I am asking what arrangements the Minister has made to ensure a casualty service at those hospitals. That was the original question.

The Hon. M.H. Armitage: As I indicated before, the Government is providing for the next month exactly the same amount of money that was provided for an average month of running that service. In other words, the doctors for the next month with their hospital boards can work out an arrangement for providing those services. We believe that is appropriate. We would expect that there would be negotiations to come up with a workable arrangement at the end of that ensuing month.

The Hon. FRANK BLEVINS: Will you sign contracts with them for a month? They have no contract or basis to work there. Will you give them a 30-day contract?

The Hon. M.H. Armitage: I am informed that they do not have contracts at the moment; the actual agreement expired some time ago and it has been extended on a routine basis to this time. We are more than happy to look creatively at whatever arrangements the board wishes to make with doctors, but I emphasise they are being given the amount of money that will enable them to continue the services if doctors chose to do it. If doctors chose not to do it, it will not be because of a lack of money. There is an expectation that

in the next month negotiations will ensue. I have no dilemma with that and I do not believe the doctors will have. At the meeting I had with them a week ago, on numerous occasions they said, 'We are only too happy to negotiate.' The simple fact is that unless we provide the money they will withdraw their services, as you have indicated. We are saying that there is a short-term component to allow that to be provided and we will expect the negotiations to continue.

The Hon. FRANK BLEVINS: In essence there is a one-month extension of the present arrangements?

The Hon. M.H. Armitage: We are giving the hospital boards a quantum of money equivalent to one month. If they chose to make exactly the same arrangement, that is their decision. However, we would believe that the creative people who are on hospital boards around South Australia would recognise the imperatives of the financial situation that I indicated to the Committee earlier and that they may well start other manoeuvres immediately. We have suggested other options, but we have provided the money and, if the hospitals choose to do nothing more than recompense the doctors at the present rate while negotiations continue, that is their decision.

The Hon. FRANK BLEVINS: It is the Minister's responsibility: at the end of the day, with all your devolution, etc., it will be right back on your desk.

The Hon. M.H. Armitage: I accept that.

The Hon. FRANK BLEVINS: As to nurse education in Whyalla and the North West Health Education Unit, I do not know whether the Minister has had time to read the report prepared by the Health Commission, but I am sure he has had a chance to read the executive summary at least. I will read the relevant part that gives me concern. On page 16, point 1.8.5 'Nursing education within CHSD', it states:

> The present situation in regard to nursing education within CHSD is that statewide responsibility for nursing education is divided between Northcote Centre and Whyalla Hospital (North West Health Education Centre). The fact that CHSD has accepted model 2 as the model for the RHTU—

they have not improved with all their initials—

> effectively means that statewide coordination of nursing education will become the role of the RHTU. The transfer of the nursing focus to the RHTU and the creation of regional health boards will change the role of Whyalla Hospital with regard to education and training in other regions. The implications of these changes on the staffing and funding to Whyalla Hospital will need to be addressed during the 1995-96 budgetary process.

They have about two days left. I wonder what the Minister has decided and what the fate will be of the North West Health Education Unit. On reading that, it looked to me as though the country was to be hit again. We all know that people outside the metropolitan area have a perception that the Health Commission has nothing but contempt for them, sees them as—

Mr Brindal interjecting:

The Hon. FRANK BLEVINS: The member for Unley does not have to tell me what the perception is; he should stick two kilometres away from here. I am talking about the perception of people who live outside the metropolitan area, about which he would know nothing. I can tell the member for Unley that these people believe that the Health Commission treats them with contempt. That is what they believe—and it is true. Here will be another test whether or not their beliefs are justified—to see whether the North West Health Education Unit is about to disappear; another service gone from the country areas. I hope their fears on this occasion are unfounded. I look forward to the Minister's reassuring me.

The Hon. M.H. Armitage: As part of an attempt to integrate rural health training the Rural Health Training Unit is being formed. This will have responsibility for medical nursing and allied health training for rural areas. The Northcote Centre will be having responsibility for statewide training of nurses. I am informed that the decisions are not yet fully clarified. There may well be some outposting of people to Whyalla but these are matters that were discussed with me when I was in Whyalla recently, and I have undertaken to get back to the Whyalla Hospital about them when the matters are determined.

The Hon. FRANK BLEVINS: So, in other words, you are closing it down.

The Hon. M.H. Armitage: Definitely not. You did not hear what I said.

The Hon. FRANK BLEVINS: I wish to ask a supplementary question, Mr Chairman. What will happen to the 70 or so students currently studying there under the existing education facilities if their study centre no longer exists; and what happens to current further education activities, for example, graduate and advanced clinical nurse programs, midwifery students, etc., if their institution is no longer staffed with educators? If you shift all the educators out you cannot, in all honesty, say that the facility still exists because, to all intents and purposes, you have killed it. This has been a long-term aim, I may say, of the South Australian Health Commission. In all fairness to it, it has never made any secret of the fact that it has always wanted to close it down, and it looks like it is about to succeed.

The Hon. M.H. Armitage: I am informed that the students currently there are, if you like, the tail end of an enrolled nursing course which has been transferred to Whyalla University. So, the training will not cease at all: the course is being transferred to a different institution. In relation to training, we are looking for a statewide responsibility and an integration across all the areas for provision of those services—as I mentioned before, the rural medical, rural nursing and rural allied health training.

The Hon. Frank Blevins interjecting:

The Hon. M.H. Armitage: With respect, Mr Chairman, I indicated before that there may well be outpostings around the State, but the statewide responsibility will be at Northcote.

The Hon. Frank Blevins interjecting:

The Hon. M.H. Armitage: Those are the decisions that we are taking at the moment.

The Hon. Frank Blevins interjecting:

The CHAIRMAN: The member for Giles is really showing a gross abuse of the supplementary question and the interjection. The Minister is responding. *Hansard* must be having one hell of a time deciding who said what to whom and when. I ask the honourable member to abide by the Standing Orders.

Ms GREIG: The performance indicators in the public and environmental health services program on page 265 of the Program Estimates show a steady increase in the number of breast X-ray screens. Will the Minister tell the Committee about this important program?

The Hon. M.H. Armitage: I will ask Dr Kerry Kirke, Executive Director of Public and Environmental Health, to provide the answer to that question.

Dr Kirke: The South Australian breast cancer screening program continues to expand, as the honourable member said. Nearly 47 000 women have been screened during the 1994-95 year, compared with 40 000 the previous year. We anticipate

this number will increase further with a new full-time screening clinic to be located at Salisbury, which we hope will come on stream in September of this year. Equity of access is a major objective of the screening program, and a number of initiatives to this end are being pursued. For example, a second mobile screening unit to provide a service to country women was recently established, enabling all rural women now to have access to screening every two years, which is the recommended interval between screening mammograms. As another example, the Breast X-ray Service, in conjunction with the Anti Cancer Foundation and the Migrant Health Service, is developing a joint strategy to increase the participation of women of non-English speaking background in screening.

The breast screening program is directed primarily towards women aged 50 to 69 years, although clearly it does not exclude women in other age groups. Just over 50 per cent of all South Australian women in this target age group (50 to 69 years) are now clients of the Breast X-ray Service. This is the highest participation rate of any screening program anywhere in the country. The aim of the national program is that, ultimately, 70 per cent of women in this age group will participate. Only a few weeks ago the national program provided its one millionth mammogram. At the same time in South Australia, the South Australian Breast X-ray Service acquired its one hundred thousandth client and, to date, has provided over 160 000 screening mammograms, with many women having attended for their second or subsequent screen.

In excess of 800 breast cancers have now been detected by the Breast X-ray Service, and the majority of these cancers have been very small and without any sign of spread to other parts of the body. This service confidently expects that this encouraging preliminary indicator of success will begin to translate in the next couple of years into a very welcome reduction in the number of South Australian women dying from breast cancer.

Mr ROSSI: My wife has worked at the IMVS and been involved with organ donations and bone transplants and, of course, the Queen Elizabeth Hospital is located in the area which I represent. The metropolitan hospital program on page 259 of the Program Estimates refers to effective and efficient high quality services. One such service is kidney transplantation, for which the Queen Elizabeth Hospital has an international reputation. Will the Minister advise the Committee on initiatives to improve the availability of organs for transplantation in South Australia?

The Hon. M.H. Armitage: I am delighted to talk briefly about this matter, and in doing so I acknowledge the input of the members for Reynell and Unley in relation to a select committee into this matter. Large numbers of people are waiting for organ donations in South Australia and Australia: about 1 300 people are waiting for kidney transplantation, and a little over 3 000 people are waiting for an organ donation in general. Of those people it is believed that about 20 per cent will die while waiting for an organ transplant. The rate of organ donation in South Australia is 15.7 people per million.

In a number of other States it is worse, and the Australian average is 10.6 per million people. A number of very exciting avenues are to be explored and, indeed, the select committee indicated that it wished to progress the Spanish experience whereby, over the past five years, its rate has increased from 14 per million to 25 per million people.

Mr Brindal interjecting:

The Hon. M.H. Armitage: As the member for Unley says, I was lucky enough to spend a day in the Spanish national transplantation organisation, which is the brainchild of Dr Rafael Matesanz, who is quite inspirational. The key factor in the Spanish experience is the identification of a donor as soon as possible. In one of the various contacts I have had since the select committee was set up by Parliament, a few weeks ago a mother said to me, 'It is my son's twenty-second birthday today.' I thought the tense she used was particularly relevant because, in fact, her son had been an organ donor shortly after his sixteenth birthday.

According to this woman the donation of her son's organs meant three more people surviving when previously that would not have been the case. The story in relation to this young man was that his parents had discussed the matter of organ donation completely serendipitously a few weeks before he had an accident. According to the woman, he was in intensive care for 18 hours. The interesting thing is that she and her husband identified to the hospital that their son's wish was to be an organ donor. That clearly was very nearly a case that was missed. As I say, it is important because it emphasises the absolute vital role of donor identification.

The Spanish system is particularly good at that. It has transplant coordinators who are usually intensive care specialists, and it is their role to be intimately involved in every phase of the system. They provide results regularly. The minute there is a fall-off in any levels of the system they take action immediately. It is my view that we can increase our rate to 25 or more per million in the next few years as well. I am delighted to inform the Committee that I took this matter to the meeting of Health Ministers in Alice Springs. It was perceived as a very worthwhile initiative, and one which will be trialled in South Australia as a pilot, hopefully for adoption around Australia, because in Australia and New Zealand there is quite a lot of organ sharing.

The New Zealand Minister will certainly be involved, and we hope to have a meeting of the transplant community in the next few months. I have invited Dr Rafael Matesanz to address that issue. Every contact I have had from the transplant community, particularly some of the renal physicians who were participants in the select committee process and who have contacted me since then, has been enthusiastic and excited, and it is yet another example of South Australia being at the leading edge.

Membership:

Mr De Laine substituted for the Hon. Frank Blevins.

Mr BRINDAL: I refer to page 259 of the Program Estimates. I am most disappointed that the member for Giles has been discharged because I wanted to follow up his line of questioning.

Mr De Laine interjecting:

Mr BRINDAL: I will. I can inform the Committee that I have visited parts of the electorate of the member for Giles that he is still yet to visit. I returned from Yorke Peninsula yesterday, and I want to share that with the Minister later. I want to follow up the dissertation on outpatient services by the member for Giles because I am aware that I can go to the outpatients section of the Royal Adelaide Hospital with any sort of ailment. I am also aware that triage will assess me. I put it to the Minister that, if I dared to go to the Royal Adelaide Hospital with something comparatively minor, I would probably die of old age before I was attended.

The Hon. M.H. Armitage: That used to be the case; it is no longer the case.

Mr BRINDAL: But seriously, I am talking about something minor because the outpatients area deals with the important cases first, and quite rightly. The outpatients area is an important function of metropolitan hospitals, as the Minister would know. I ask the Minister to explain—not just for Whyalla but in the total context of the hospital system—what is being done with respect to outpatient services to complement the changes occurring with the provision of in-patient services at hospitals?

The Hon. M.H. Armitage: It is a very important question and, first, I refute the claim of the member for Unley that he would die of old age if he attended at the outpatient section of an Adelaide health service now. I was pleased to hear the honourable member preface his question by saying 'but seriously' because—

Mr Brindal interjecting:

The Hon. M.H. Armitage: I am quite happy if you do. In fact, let me know when you are going down there after that sort of question. Ambulatory care accounts for about 25 per cent of public hospital expenditure, and that proportion is likely to increase as a result of output-based funding. That has certainly been the experience in the United States, and we have recognised the need to be on top of this by establishing in the commission a short-term ambulatory care reform unit. We have been particularly successful in attracting approximately $3.5 million in funding from the Commonwealth ambulatory care reform program to pursue the activity.

That will enable us to provide a strategic focus for the study of ambulatory care. The overall objective is to better describe, classify and cost ambulatory care services and pilot alternative models of care. Fully-funded research projects and pilot projects are now being undertaken both by the Health Commission and by a range of health units with the following focus: to systematically describe, classify and cost encounters in outpatient clinics and accident and emergency departments. These projects will engage units throughout the State with specific projects targeting country services, allied health services and emergency departments.

Another focus will be to explore the possibilities for substitution of more cost effective and patient outcome orientated strategies for the provision of ambulatory care. Research and pilot projects focusing on post-acute care, pharmacy services, shared care with GPs for maternal and infant care, and community-based management programs have been approved. Another focus will be to develop a benchmark of patient health outcomes against which the impact on people of changes to outpatient service provisions can be measured over time. We believe that the outcomes from these projects will provide a lot of information and strategies to reform the outpatient services so that they will be a shining example of health care in South Australia.

Mr BRINDAL: As a supplementary question, I do not want the Minister's department to spend lots of money on this, but would it be possible to make a comparison of waiting times? Essentially, I was being a little flippant about outpatients. The point is that in a big city, where there are continual emergency procedures which always take precedence, if one attends at a large hospital, such as the Royal Adelaide, one is likely to wait longer because in the order of things it may be a less important procedure to get to immediately. Is there any way of getting a comparison between a regional and a city hospital with regard to the pressures put on outpatients and the sorts of things that they have to deal with in order? If that is not possible, I will understand, but it would be of interest.

The Hon. M.H. Armitage: I understand the relevance of the member for Unley's interest in the concept. We will take it on notice and see whether anything can be done. However, I am loath to expend enormous amounts of energy and funding on something which may end up without a specific response.

Ms STEVENS: My question relates to the Program Estimates, page 254, with respect to Healthscope. A report in last week's *Advertiser* suggested that the share price of Healthscope (the manager of Modbury Hospital) had fallen to a new low because of a worse than predicted profit performance. The Managing Director of Healthscope said, 'Unbudgeted expenses associated with the Modbury Hospital contract had contributed to Healthscope's poor performance.' The taxpayers of South Australia, through SGIC, are the largest shareholders in Healthscope. As a result of the fall in Healthscope's share price, the State's $15 million investment in Healthscope is now worth more than $7 million less than when the shares were purchased in April 1994. Was the decision by SGIC to sell its private hospitals to Healthscope and to purchase $8.85 million worth of shares in Healthscope in April 1994 endorsed by Cabinet?

The CHAIRMAN: I point out that this is a question on a statutory authority which acts in its own right, but if the Minister knows otherwise he is at liberty to respond.

The Hon. M.H. Armitage: I wish to make two points. First, whilst the member for Elizabeth has quoted the headline and a number of facts reported in the article, I do not believe she quoted the fact that the company still paid a dividend to its shareholders. That is an important factor in the way that any company performs. It was still making money and was prepared to share that money with its shareholders. Secondly, it would appear that the honourable member is asking for results of a Cabinet decision. As she knows, that is confidential, but I will look into it and if I can provide an answer I will.

Ms STEVENS: As a supplementary question, did you take part in any such decision by Cabinet; and, as a further supplementary question, does the Minister believe he has an obligation to protect the State's $15 million investment in Healthscope?

The Hon. M.H. Armitage: As a Cabinet Minister I have a responsibility to ensure that every dollar of the State is used as effectively as possible. However, I do not have responsibility within the health portfolio to maximise the profits of a statutory corporation.

The CHAIRMAN: The Minister has no responsibility for SGIC, and the question is really on the SGIC line. It is outside the ambit of the Minister and of the Committee, but the member for Elizabeth linked it by asking whether there was any decision making by Cabinet. It is fairly tenuous, but I did allow it to be pursued.

Ms STEVENS: My third supplementary—

The CHAIRMAN: On the matter of supplementary questions, Standing Orders provide that questions are allowed on the line and that a supplementary is allowed to conclude a line of questioning. The honourable member broaches a subject and then proceeds to finish the line of questioning with three or four supplementary questions. As I said the other day, members are making an art form of supplementary questioning. The end result is that the Opposition benches have 12 and the Government benches have six. Supplemen-

tary questioning is establishing quite an imbalance. The Chair will determine the nature of a supplementary question.

Ms STEVENS: Is the Minister aware of the unbudgeted expenses for staff and legal costs at Modbury Hospital which have caused Healthscope's problems?

The Hon. M.H. Armitage: Healthscope's costs are a matter for Healthscope. The health sector has a performance contract with Healthscope which can be determined in two ways: it is either fulfilled or it is not. How Healthscope fulfils it within that ambit and its costs and so on is a matter that the member for Elizabeth should address to Healthscope if she wishes that information.

Ms STEVENS: Has Healthscope sought the payment of any of its uncontracted expenses by the Health Commission?

The Hon. M.H. Armitage: There are some discussions about the siting of the State Bank office in relation to the building and its position where Healthscope wishes to put up the new private hospital. There have been discussions and commercial negotiations as to payment regarding loss of trade during that move and so on. To the limit of our knowledge at this stage, they are the only discussions that have occurred along those lines. We will check it and provide further information later.

Ms GREIG: Why is CAFHS taking on the responsibility for management of immunisation services, as described on page 263 of the Program Estimates, and what difference will it make to the services provided?

The Hon. M.H. Armitage: I will ask Ms Gaston to provide an answer in relation to those matters.

Ms Gaston: The question relating to immunisation services in South Australia is quite an important one, because it is in line with the national direction at the moment to give emphasis to immunisation, particularly to the children of Australia. In the past, immunisation services were randomly provided by local government and local general practitioners, and where it could be identified CAFHS would fill in the gaps. The coordination of immunisation programs has therefore been absent, although Child and Adolescent Family Health Services has for a few years been able to coordinate the distribution of vaccines statewide, which has certainly made a difference.

In December 1993, the Chair of the South Australian immunisation forum, Professor Kevin Forsyth, who is head of paediatrics at Flinders Medical Centre, indicated that there should be some organisation identified to manage immunisation services and that the agency best suited for that would be Child and Adolescent Family Health Services. The executive of the commission endorsed that recommendation. The important thing about CAFHS taking on this coordination and management is that we now have the ability to negotiate with local councils and private practitioners to ensure that the distribution of immunisation services covers the entire population of South Australia. It can ensure that the service is provided in areas by CAFHS where it cannot be provided by local government and general practitioners. It can monitor the standards for services provided by the multiple providers.

This is an important addition to immunisation services in that it is introducing a method of accreditation which has not been in existence before. CAFHS can also, through taking on this management role, facilitate training and education for providers, which has also been absent until now. It will continue to distribute statewide the vaccine and can put in place quality assurance processes. This, of course, will ensure that the immunisation services in South Australia are far more accessible to the general community and that the quality of the service is enhanced.

Mr ROSSI: Page 259 of the Program Estimates refers to the accreditation of hospitals and the metropolitan hospitals program in relation to the provision of effective and efficient high quality services. Will the Minister indicate any external measures of quality services?

The Hon. M.H. Armitage: I thank the member for Lee for his question, which is very important and timely. Possibly the best known and most established external mechanism of looking at hospitals, services and standards within is accreditation by the Australian Council on Health Care Standards. The national program was established in 1974 by the Australian Medical Association and the Australian Hospital Association. Initially, the council's primary goal was to improve patient care in Australian hospitals but, because of the success of the program and the credibility which it has taken to itself, it has been expanded to include other facilities such as nursing homes, community health services and day procedure facilities.

The council, which is completely independent, has developed standards and survey processes which look at the best care possible. The processes are based on the principles of quality care within a quality environment while maintaining patient dignity and self esteem and, very importantly, the effective and efficient use of resources. The standards have been formulated in cooperation with representatives from a wide variety of organisations including professional health associations, various royal colleges, health facilities, departments of health and so on. It represents a consensus opinion on the best possible level of care and services.

The accreditation process occurs with a visiting survey team of experts who critically review from go to woe within the organisation being reviewed such matters as documentation, every process that occurs and all the quality expectations of those processes. It is a particularly rigorous process, and it takes a lot of effort and cooperation over a considerable time from the staff. Well over 1 000 hospitals across Australia have now been accredited and more than 90 per cent of all the beds in South Australian hospitals are accredited. That includes Government, community, private and psychiatric hospitals, and nursing homes. It means that we have a great choice and great quality of health services.

As I indicated to the member for Lee, it is a timely question, because as it happens I am presenting the Queen Elizabeth Hospital with its accreditation certificate tomorrow morning. It is the fifth three year certificate of accreditation from the Australian Council on Health Care Standards. It is a very special occasion for the hospital as a quality health care provider, and it means that it has achieved 15 years of continuous accreditation. It grants the QEH the unique status of being one of the longest continually accredited teaching hospitals in Australia, which I am sure is a very proud moment for all the people who have worked there in the 15 years and who are working there at the moment. I know that the member for Lee has a great deal of affection for the QEH: he is a strong advocate for the QEH. Clearly, this accreditation process indicates that the services being provided there are of the best standard and quality in Australia, because they have passed the accreditation process. I am delighted to indicate that it has done that, despite the stories of doom and gloom which were predicted. The fact that it has been able to do that, as I have said before, is a credit to the staff.

Mr BRINDAL: I refer to STDs, and in so doing I compliment the Minister—and I hope all members would join

in this—and his predecessors together with the Health Commission, the AIDS Council and the STD clinic on the very valuable work done in South Australia over a number of years in relation to the educative work and the containment of high risk infections within the high risk groups and the general community. Is that work on track and on target, and do you envisage increased or at least continued success in terms of this budget and in the future?

A very disturbing piece of information was circulated recently by the Festival of Light, claiming that at least one sex worker in this State is HIV positive. Can you confirm or deny that? Is the Festival of Light privy to private and confidential medical information? If its assertions are true, will you investigate whether there has been a breach of clients' confidentiality in any aspect of your responsibility?

The Hon. M.H. Armitage: I recognise the value of the work that has been done in a very difficult area in the past and certainly since the election. The member for Unley would wish to acknowledge all the work that has been done to be acknowledged, as do I. There is no suggestion that the Government has been anything other than supportive of that work. A number of the programs and initiatives that have been taken in relation to HIV and various other diseases have been quite world shattering and leading. In particular, I refer to needle exchange programs and so on. In answer to the specific questions, I ask Dr Kerry Kirke to provide further information.

Dr Kirke: I am not aware of a sex worker with HIV infection in this State at the moment, although in the past we have had such, and we have a legislative way of dealing with such people. I could give a little detail about the HIV-AIDS epidemic as it stands at the moment.

In 1994, there were 36 HIV infections notified, compared with 56 for the previous year. That represented a return to the rate of notifications in 1992 and 1991 respectively. Of the 36 individuals notified in 1994, 32 were male, and 26 reported male-to-male sex as their risk factor. Six of the 26 reporting male-to-male sex had a negative HIV test in the 12 months prior to diagnosis, meaning that they were incident or recent infections. Contact tracing was carried out in relation to 28 of the individuals notified, resulting in 32 partners being identified and tested. Those procedures detected four of the cases that were notified in 1994.

In recent years, the proportion of individuals probably acquiring HIV infection in South Australia has been higher than reported previously. We believe that, in 1994, 58 per cent of the infections notified were acquired in this State. The number reporting that the infection was likely to have been acquired interstate was the lowest recorded. Reported acquisition while overseas represented 28 per cent of the infections, so that remains a big problem for us.

On confidentiality, I would be astonished if the Festival of Light was able to access records within the Health Commission. One individual has that information, and she will not part with it for anybody.

Mr BRINDAL: I thank the Minister and his adviser for that answer. I reiterate my congratulations on their work.

Ms STEVENS: My question relates to page 225 of the Estimates of Receipts and Payments and the 1995 budget in total. In 1995-96, Commonwealth grants to South Australia for health will total $638.8 million, which is $76.8 million more than for 1994-95. Commonwealth health grants to South Australia this year are, in turn, $48.704 million more than for 1993-94. In contrast with that $125.5 million increase in Commonwealth funding for health over two years, the South Australian Government's contribution is a cut in the appropriation from the Consolidated Account of $54.4 million over the past two years. Even if the funding for the Repatriation General Hospital at Daw Park, which is now under State control, is ignored, Commonwealth health grants to South Australia are still up by $45.2 million. The Commonwealth now provides 41.9 per cent of total health expenditure in South Australia, compared with 35.8 per cent in 1993-94.

Given the huge increase in Commonwealth funds for health in South Australia and the large cut in the Brown Government's contribution to health in its first two budgets, does the Minister accept full responsibility for the impact of budgetary decisions upon hospitals and health units?

The Hon. M.H. Armitage: In relation to the actual Commonwealth money, I am informed that there are large amounts of tied growth funds in the Medicare agreement, and that would obviously affect all States in a similar manner. It is not as though the Commonwealth has suddenly, out of its beneficence, decided to reward South Australia. Commonwealth and State Ministers have addressed such matters at some length in a couple of recent conferences and considered whether the Commonwealth should continue to provide further funding, given that the States are making efficiencies.

I have been definitive in saying to the Federal Minister that, if we are able to do more with less, which we clearly are, because we have increased throughput by 4 per cent despite the budgetary reductions, and if the Commonwealth is willing to put in more money, it is getting better value for the dollar than it was before.

With the Commonwealth Government's failure to address the private health insurance fall-off which, following the Ministers' conference a week or so ago, is an agreed position (that there is a financial effect on the States of that fall-off)—whilst that is an advance, it still does nothing to actually cover the shortfall. There is a varied estimate of that shortfall, one estimate being $27 million. The answer to the question whether I take responsibility for that is 'No'.

Ms STEVENS: The Commonwealth increase exceeds that estimate of $27 million. We note also that receipts from hospital patient fees is actually $6 million above the 1994-95 budget, and the Minister would have to admit that we did very well out of the Daw Park deal in respect of Commonwealth funding. In view of the rapidly increasing proportion of health funds in South Australia now provided by the Commonwealth, is the Minister concerned that the price for this growing Commonwealth share will be greater Commonwealth control over how health funds are spent?

The Hon. M.H. Armitage: I most definitely am, because I can assure the member for Elizabeth that, with the changes being brought about in the South Australian health sector of which, I may add, the Commonwealth is generally supportive—

Ms Stevens: That's a long bow.

The Hon. M.H. Armitage: It is not a long bow at all. However, the changes are seeing more efficient use of taxpayers' dollars to the benefit of the taxpayer and particularly the health sector. I would be very concerned if the Commonwealth felt that, in its usual bully boy fashion, it could come and take over and do things better.

It is interesting to see that people such as the new Minister in New South Wales, Dr Refschauge, from the Labor Party, having spoken loud and long against a number of the types of manoeuvres we have introduced in South Australia, on all the latest reports is the latest convert to casemix funding.

Slowly but surely people are realising that what is going on in South Australia is the way to go. I would be particularly perturbed if the Commonwealth was going to tell us how we would spend the money.

I should indicate that the $27 million of extra funding required, because of the private health insurance drop-off, is a direct cost to the health system. There is the lost revenue of those previously privately insured patients in the hospitals not being a revenue generator, if you like, for the system. There is an additional cost to the $27 million. Many of the Commonwealth grants, as I think the member for Elizabeth identified, actually come in a tied fashion, and they are not applicable specifically to hospitals.

Ms STEVENS: I refer to the Program Estimates at pages 259 and 260. The most recent gold book that we have seen, relating to events up to 31 March 1995, indicated on page 3 that many major hospitals were facing large budget deficits for 1994-95: for example, Flinders Medical Centre, a $5 million deficit; Queen Elizabeth Hospital, a $2.3 million deficit; and the Women's and Children's Hospital, a $1.5 million deficit. The gold book also indicated on page 18 that the Health Commission was holding $8.2 million in provisions to meet health unit deficits. Will the Minister provide details of the end of year budget deficit or surplus for each metropolitan and country hospital, and will he say how much of the budget deficit of each hospital will be bailed out by the Health Commission, and how much of the deficit will be carried over to 1995-96?

The Hon. M.H. Armitage: I am very pleased to provide projected end of year figures in relation to metropolitan hospitals, taking into account the latest budget variations provided by the Health Commission. These tell a very positive story. I emphasise in relation to my opening statement earlier this morning that we are not yet at the end of the financial year, so we are unable to give exact figures, and they will not be available for some time, but the latest projected figures are as follows: Flinders Medical Centre, $2.6 million deficit; Gawler Hospital, $112 000 deficit; Lyell McEwin Health Service, balanced; Noarlunga Hospital, $440 000 deficit, which includes a deficit for the private hospital of $250 000; Royal Adelaide Hospital, up to $800 000 surplus; Queen Elizabeth Hospital (which the member for Elizabeth quoted, according to the figures from several months ago, was $2.3 million), between $330 000 and $570 000 deficit; and for the Women's and Children's Hospital (which the member for Elizabeth quoted as having a potential deficit of $1.5 million) the deficit as projected most recently will be $400 000.

Ms STEVENS: Where the Health Commission bails out the deficit of individual hospitals from its provision funds—for example, the decrease in the Flinders Medical Centre deficit which the Minister has just explained—do the health units receiving the funds suffer any financial penalty, and are they expected to repay the sum received from the Health Commission?

The Hon. M.H. Armitage: All the units will be expected to carry over those amounts, but there will be no penalty exacted on that. I do not think that any taxpayer in South Australia would expect us to do any differently. With all the arrangements in relation to a wide variety of budget variations within hospitals according to individual circumstances, individual arrangements are made depending upon those circumstances. The strict answer to the question is, 'Yes, they will be carried over; no, there will be no penalty.'

Ms STEVENS: How are the deficits carried over by the health units to the next financial year treated in terms of future Health Commission allocations to the units?

The Hon. M.H. Armitage: Now that we have moved to a casemix system of funding, the total budget for the unit is determined according to its activity, which gives a total figure, if you like, and these various equilibrations will occur from that total figure.

Ms STEVENS: The deficit is taken off?

The Hon. M.H. Armitage: Exactly. It is carried over.

Membership:

Mr Wade substituted for Mr Scalzi.

Ms STEVENS: I refer to page 254 of the Program Estimates. How much has been paid to Gribbles for pathology services at Modbury Hospital for the first six months of its contract?

The Hon. M.H. Armitage: The matter of pathology services and the cost thereof is a matter between Gribbles and Healthscope. We have a service contract with Healthscope to provide all the services. The contract with Gribbles has been novated to Healthscope and it is a matter for the private sector company.

Ms STEVENS: That has escaped me, because I thought the Gribbles contract had been undertaken between the Health Commission and Gribbles and I did not realise it had gone Gribbles/Healthscope. Can the Minister give details of when that occurred?

The Hon. M.H. Armitage: The member for Elizabeth is correct: the original contract was effected; that was a timing matter. It was novated to Healthscope in mid-February. I reiterate: in relation to the pathology contract—this is a matter that the member for Elizabeth and I have discussed in Parliament on a number of occasions—the fact is that the contract when it was drawn up is clear in stating that the services which were provided will be provided at the same level or even increased to be of better quality. There was no expectation other than that, and penalties apply if there is a decrease in service. Some services are not being provided on site. About a third of the pathology tests being performed under the previous arrangement were being performed off site as well, and in this competitive process the taxpayer is the beneficiary by a considerable percentage which equates to several hundreds of thousands of dollars.

I wish to revisit the member for Elizabeth's question about Gribbles. I am informed and pleased to be able to alter what I indicated. The contract has not yet been novated and it is intended to be novated in the near future. The reason is that it is a legal technicality concerning the building plans where the provision of pathology is to occur: they have to be attached to the contract. That has not been able to be done and it is now being done and it will be novated in the near future. As to payment for the services, as I said before, it is a contract matter. Whoever holds the contract, be it at the moment the commission or Modbury Hospital Board or in the future Healthscope Hospital, what matters is the service level and, as I said before, that is quantified at the same level as previously with a reduction in funding. I have now received advice that Healthscope has expected no payments outside the contract. That relates to a question asked about an hour ago.

Ms GREIG: I am following the line of the member for Elizabeth about hospital deficits, and I refer to page 259 of the Program Estimates. What allowances have been made for Flinders Medical Centre to meet its budget projections for

1995-96, knowing that it is starting the new financial year with a considerable deficit?

The Hon. M.H. Armitage: The Flinders Medical Centre is projecting a budget deficit, as I previously indicated, of approximately $2.6 million, which is considerably less than anyone would have predicted in January this year when the projected overrun was in the vicinity of $6 million. The commitment of management and staff at Flinders Medical Centre to address a number of those difficult issues, in concert with the refinement to the casemix funding formula, further use of competitive tendering and private sector involvement, will provide further efficiency opportunities at Flinders to enable it to cope with budget pressures this year and in the future.

In the very recent past I have spoken in my office with the Chairman of the board and the Acting Chief Executive Officer who indicated that, whilst there are clearly considerable pressures, they are confident they will manage the situation appropriately. Flinders will benefit this year from the full year effect of savings from TSPs, which are expected to be approximately $5.5 million, and it will be given support by the commission to proceed to tender its non-core services, which Flinders Medical Centre estimates will provide it with considerable savings. Also, negotiations are in progress to transfer some services from Flinders Medical Centre to the Repatriation General Hospital, which will clearly relieve some of the pressure which Flinders Medical Centre has been experiencing from the increase in demand on its services.

I would suggest that, in the long term—if one includes Noarlunga Hospital in the southern area—we will see many efficiencies in the grand plan of a sort of sub-regional organisation. A number of initiatives will be taken which will help Flinders, but I should say that it is not being given any allowances. However, it is being given all the support it might need in order to continue along the path of reducing costs and managing the demands placed upon it.

Ms GREIG: Supplementary to that, can the Minister assure the Committee that a quality service will be maintained at the Flinders Medical Centre despite this year's budget cuts?

The Hon. M.H. Armitage: Yes, I can. Earlier today I told the member for Lee that tomorrow I will present the Queen Elizabeth Hospital with its accreditation, and recently I was contacted by Flinders to see whether, in the very near future, I could present its accreditation certificate as well. I have clearly indicated a desire to do that, because that is an acknowledgment by a totally independent body that the services being provided are absolutely A1. The health system, like other Government departments, has had to operate under the requirement that it contribute to the reduction of debt. It has had to deal with a number of pressures, such as increased demand on services and a fall in private health insurance, which we have already addressed.

I believe the system is coping very well, and at every possible opportunity I give credit to the people involved. It will not be easy for Flinders Medical Centre, or any other Government or hospital department, but I am sure with the commitment of the workers in the system and with the glimmer of light at the end of the long and dark debt tunnel—as was said when the Treasurer introduced the budget four weeks ago—we will have the system humming and we will be at the forefront of the provision of services in Australia.

Mr WADE: Page 267 of the Program Estimates refers to health services for homeless young people. Youth suicide is a significant health issue. What is the current trend in South Australia in respect of youth suicide?

The Hon. M.H. Armitage: For the age group 15 to 24 the incidence of suicide in South Australia has been reported as follows: 1991, 48; 1992, 37; 1993, 21; and, 1994, 24. That estimate is subject to retrospective adjustment by the Coroner. The national statistics indicate that South Australia can expect around 33 incidents per annum, but the data over the past two years indicates a very significant reduction. South Australia is the only State reporting a decrease in the incidence of youth suicide. Keen professionals working at a variety of adolescent health services are unable accurately to account for the reduction but it does seem to be sustained, which is very pleasing.

Certainly, a number of hypotheses have been suggested as impacting on the rate of youth suicide, including the in-patient units established at the Women's and Children's Hospital in 1992 with six dedicated beds, and in 1993 the number of beds increased to 20; a community awareness program; a media education process; and new initiatives to educate general practitioners. Earlier this year I was pleased to take part in the release of a video and kit for general practitioners, which was produced under the aegis of Dr Graham Martin, a recognised expert in this field.

The kit and the video were of extremely high quality. However, despite the fact that we have a good trend and are well below what might be expected, the real benefits of the education processes and initiatives to help GPs and so on will probably not be realised until next year or the year after. Let us hope we can continue with that downward trend. It is a very significant problem with many more girls attempting suicide than boys, but far fewer girls succeed in their attempts.

On 5 June this year the Health Promotion Unit from the Public and Environmental Health Service held a forum on youth suicide prevention. I am advised that 150 people, including a wide range of workers from health, welfare, youth work, correctional services, education sectors, non-Government organisations and other interested individuals, attended the forum. As I have mentioned, Dr Graham Martin (from Southern CAMHS), a recognised expert, and Barry Tucker from the Centre for Social Health in Melbourne gave different perspectives on suicide prevention.

The Health Promotion Unit is currently developing a directory of mental health promotion programs for adolescents in South Australia. To date, 80 programs have been identified as explicitly stating that they run mental health promotion programs or activities for adolescents. A lot of the work being done with adolescents deals with risk factors that are considered important in preventing suicide as a result of depression, family discord, substance abuse, and the experience of loss. A significant issue of concern for the professionals and the consumers is the perhaps less than satisfactory uncoordinated attitudes and treatment to which people who attempt suicide are sometimes exposed.

A project being conducted in Western Australia is addressing this at the moment, and it has reported early findings that show an encouraging reduction in the number of repeated attempts. It has been suggested that this could act as an additional model for work throughout Australia. It is pleasing to see that the figures are trending in the right direction in South Australia. We are below what we might expect on a national average, but one is too many; we have a long way to go in that area.

Mr WADE: I refer the Minister to page 266 of the Program Estimates where it lists as a specific target for 1995-96 the development of mechanisms to increase access to mainstream services by people with disabilities. Will the Minister elaborate how this will be achieved?

The Hon. M.H. Armitage: The provision of services and opportunities to increase access to mainstream services for people with disabilities is of great concern to the Government and to me as Minister. I will ask Colleen Johnson, Head of the Disability Services Office, to address those issues.

Ms Johnson: The honourable member may be aware that we are reorganising the disability system, and options coordination will have a key role in the future. One of the roles of people as options coordinators is to assist people with disability to access mainstream Government services. This will occur by assisting individual clients on a one to one basis and through the representation of the interests of respective client groups to the mainstream agencies as a whole. Options coordination agencies have already participated in the development of coordination mechanisms in respect of access and the coordination of services between the Disability Services Office and some mainstream service providers. In particular, work has occurred with the education sector. Over the past few years we have enjoyed the collaborative action plan, which is a plan for the coordination of the disability sector and the education sector in providing support for people with disabilities.

There are particular problems with children with disabilities as they approach the time to leave school. The Government offices sub-committee of the Disability Advisory Council has agreed to establish a working party to look at ways of ensuring coordination between the schools sector and those agencies providing a range of vocational, post-secondary education and disability support services for young people with disabilities. Core representation on that working party will be provided by the Disability Services Office, the Options Coordination Task Force, the Department for Education and Children's Services, the Department of TAFE and the Commonwealth Department for Human Services and Health, because it funds support services for employment.

We are hoping that out of that work we will have some agreed protocols for referral between agencies. That will include arrangements to ensure that school leavers are assessed and linked into the disability service system and that there is individualised transition planning well before children and young adolescents look to leave school. That will include a clear description and agreement as to the respective roles of the various agencies in the disability, education and employment sectors.

Considerable work has also been done with the Housing Trust. A document has almost been finalised agreeing protocols for referrals between the housing sector and the disability sector with clear descriptions and agreement as to the respective roles of both sectors in the provision of housing or support services. That includes a draft funding and service agreement for community housing associations which provide housing and tenancy support for people with a disability. In the development of these protocols and draft service agreements and role descriptions there has been extensive consultation with consumer and advocacy groups and with service providers from the housing and disability sectors.

Ms STEVENS: The Financial Statement indicates that metropolitan and country hospitals will be required to achieve further efficiencies to meet budget targets. It then pronounces:

> A number of measures will be introduced, including review of elective services currently offered and the targeting of a number of clinical services with significantly elevated hospital activity rates aimed at reducing them to comparable national averages.
>
> The increased efficiencies implied by these budget initiatives and the consequential restraints on additional admissions to hospitals will see spending on and utilisation of health services in South Australia fall closer to the per capita national averages by the end of 1995-96.

What specific clinical services will be targeted for reduced admissions?

The Hon. M.H. Armitage: First, I will address the matter of discretionary surgery, which we have decided to eliminate from the public sector. That includes a number of cases of discretionary plastic surgery: for instance, tattoo removal. There are not many of those cases in South Australia any longer. Nevertheless, the public system will no longer pay for that. We have also elected not to pay for vasectomy reversals. Given our straitened circumstances, I believe that, when someone decides to have a vasectomy, it is too much to expect the public purse to pay for a reversal. We have also elected not to pay for social circumcision on the public health purse.

Members interjecting:

The Hon. M.H. Armitage: I assure the Committee, without going into the gory details, that sometimes there are medical reasons for carrying out circumcision. I could go into the gory details, but I will not. Sometimes people elect to have circumcision. However, we believe that in the present circumstances that is inappropriate. Having talked about vasectomy reversals and social circumcision, this is almost a matter for the Equal Opportunity Commission because the other one that we are cutting out is the insertion of penile implants. There are some cases which, from the discretionary surgical angle, we have decided will not be paid for. There are also cases where South Australia is above the national average. We have decided to remove 5 000 weighted separations in those targeted areas from 300 000 across the system.

Ms STEVENS: I did not understand the 5 000.

The Hon. M.H. Armitage: The system does approximately 300 000 weighted separations. In other words, if I go into hospital and have a heart-lung transplant and someone else goes in and has an appendix operation, they use vastly different amounts of resources. It is an averaging out, if you like.

Ms STEVENS: It is not 300 000 penile implants?

The Hon. M.H. Armitage: Not in these straitened circumstances. That is a small number of discretionary cases which we have made a decision we will not pay for; however, the system as a whole does approximately 300 000 weighted separations. We have made a decision that we will cap 5 000 in specific areas where we are well above the national average. I will ask Carol Gaston to explain those categories further.

Ms Gaston: We have looked at the top 20 activities within the metropolitan health services and compared the rates per thousand with the equivalent rates per thousand for Australia as a whole. Having done that, we noted those activities or procedures where the South Australian national rate is considerably higher than the national rate. We have decided to reduce the hospitals' separations by an agreed percentage, which is yet to be determined because we have not finalised the health service agreement negotiations with the hospitals,

and to give the hospitals a list of those activities or procedures that are above the national average and enable them to manage within that. We are not specifying volumes by procedure that should be reduced: we are giving them the profile so that they can manage it within their own staff.

The areas we are looking at where South Australia is considerably higher in rates than the whole of Australia are a number of procedures relating to ear, nose and throat, tonsillectomies and grommets or tubes in the ears. Other things such as tooth extractions are done in hospitals under anaesthetic or just in hospital as hospital procedures. There are a number of other procedures of a vascular nature (for example, varicose veins) some of which we suspect are more for cosmetic rather than symptomatic reasons. There are a number of procedures in that same vein. The important thing is that we have determined that it would be too difficult for the hospitals to try to limit their staff to specific reductions. The hospital management in conjunction with the clinician should be able to make that adjustment internally.

Ms STEVENS: Ms Gaston said that working out the top 20 was done by looking simply at greater than average. Was any consideration given to why it might be greater than average in South Australia, or was it simply done on numbers and we just we sliced them off?

Ms Gaston: We have considered changes in clinical practice and also variations in distribution of procedures. We have taken those into account when assessing the percentage reduction that we wish to achieve. For example, there are some procedures where the percentage above the national rate is in the vicinity of 80 to 100 per cent but we are not reducing them by 80 to 100 per cent: we are moving towards the national average rather than bringing it down to the national average. With regard to understanding better why some of our rates might be higher than the national average, some work is being done in the commission—I think within public and environmental health—in regard to referral patterns. It is a very difficult thing to understand, because it is very much doctor decision driven.

Ms STEVENS: Which 20 procedures are above the national average? Will the Minister confirm whether the IVF program was considered in that group of procedures?

The Hon. M.H. Armitage: It is fair to say that I can confirm it is being discussed: no decision has been made at this stage. It would be fair to say that, almost every time there is some development in the health sector which gets negative publicity, I get reaction—as I am sure the honourable member's former colleagues would have—about the very high cost and potentially long-term cost of interventions in the whole of medicine. That is one of those areas being addressed for inclusion at the moment. No decision has been made, because there are a number of other effects which follow from legislation in relation to the provision of services in other areas and so on; but it is being considered.

Ms STEVENS: I return to something that the Minister said previously about Modbury Hospital, where another 1 500 weighted separations will be done at Modbury because they were funded at their 1992-93 level. Presumably they have not reached that and the Minister is signalling that Modbury Hospital will do more operations to reach the required target. Will Modbury Hospital also be cutting back on these operations? Will the Minister explain that in relation to the increasing activity levels he is forecasting for Modbury Hospital?

The Hon. M.H. Armitage: In 1992-93, for reasons that no-one is particularly clear about, there was a peak in activity in the north-eastern areas. Modbury Hospital did more procedures than it had done before. Following that, again for reasons which are a little indeterminate, there was a fall-off. It so happened that the contract negotiations needed a starting point upon which those negotiations could be built. At the time of the negotiations it was agreed that the 1992-93 level of procedures would be the level.

The fact that we suggest that there will be another 1 500 weighted separations at Modbury does not mean that Healthscope has not been fulfilling its part of the bargain. It has always been part of the planned dealing, and it is another example of what a good deal it is for South Australia. Not only are we reaping financial benefits but also we are able to drive up the number of cases that are being done in Modbury back to the 1992-93 level, because that was part of the contract. That is nothing new. Everybody—Healthscope and the commission—knew that that would happen.

Ms GREIG: My question is about the northern suburbs home visiting program. The development of a home visitation program in Elizabeth is included in the community-based services program, page 263 of the Program Estimates. How will the home visiting program differ from the range of services that are already available to parents with new babies?

The Hon. M.H. Armitage: It is an exciting program. Again, I ask Carol Gaston to provide details.

Ms Gaston: Currently, in the northern region a range of services is offered to expectant parents. It includes antenatal classes, CAFHS, women's health services, community health services, and hospital services. Also, for mothers requiring intensive services, there are services available from hospitals. Also, there are mental health services and disability services.

As you can imagine, the complexity of that web of services can often be very confusing for the new mother and family. Also, there are often situations in which the family members are unclear about the specific service that they need at a certain time. Many people who require those services do not access them at the right time or at all.

We have been looking at a program called family home support, which was piloted in Hawaii. It was an extraordinarily successful program, and to such an extent that it is a permanent program in Hawaii. It has now been introduced in nearly 30 states in the United States. It entails the assignment of a home visitor to a family when they are aware that they are having a new child. There is, therefore, contact with the family prior to birth and during the occasion of delivery, and then follow-up in the home. That home visiting can occur for up to 12 months. The home visitor provides the necessary minimal counselling and support services but is able to help families to diagnose their own needs and access the appropriate services when they need them.

Many of the outcomes of that program have been quite startling. They relate not just to the baby, the mother or the family but, in many cases, to the siblings. We have seen an extraordinary increase in immunisation rates, longer periods of breastfeeding and, therefore, improved nutrition of the baby, and improved nutrition of other children in the family. There has been increased attendance at school—that is, decreased non-attendance at school. The list could go on.

We have chosen to pilot that program in the northern suburbs because of the particular needs of families there and also because of the existing network of services. The northern suburbs are well endowed with excellent maternity and family child support services. It will be a two-year pilot, with extensive evaluation. Because the program is not cheap—it

is intensive—we need to be convinced that the cost and the care outcomes support the need for the program's existence.

We have no reason to believe that the pilot will not be successful. However, by evaluating it, we will ensure that, if or when the program is extended across South Australia, it actually meets the needs of families in South Australia. Given that the basic concept of the program was taken from Hawaii, we want to be assured that it meets the needs of families in South Australia. We all, including the Minister, are looking with interest at the project. We firmly believe that it has the potential to change the face of family health in South Australia.

Mr WADE: My question relates to page 266 of the Program Estimates. The objectives for disability services refer to assisting people with disabilities to achieve their maximum potential. Will the Minister advise how that applies or will apply to people of non-English speaking backgrounds and to Aboriginal and Torres Strait Islanders?

The Hon. M.H. Armitage: As Minister for Health, I and the Health Commission are firmly committed to the provision of accessible and relevant health services to non-English speaking background South Australians, especially those who speak little or no English. I have had a commitment to that since I visited Sturt Street Primary School, which is one of the schools in which young migrants who come here with no English language at all are first taught. I acknowledge the fantastic work that goes on there under Tony Colebatch.

Before the previous election, the Liberal Party's ethnic health policy promised an increase in interpreting for patients in the public health system. I am sure that members of the Committee will be delighted to note that we have introduced competition into the supply of interpreters to public patients and that that has resulted in halving the minimum interpreter charges. It is amazing what competition can do.

Obviously, the lowering of those charges means that many more patients than ever before are able to receive interpreting assistance. The number of hospitals and other health agencies to which interpreting funds have been made available has risen from two about three years ago to 48 at present, including 13 country health services. All that has been achieved without any additional cost to the taxpayer. Also, the clinic of the Migrant Health Service is fully operational, providing a wide range of assessment, treatment and counselling, as well as health promotion and illness prevention services.

Because of the ageing ethnic population of South Australia, health promotion endeavours of the Migrant Health Service will not only produce better health outcomes for older South Australians but a decrease in the public cost of treatment associated with that ageing population. Of course, it is a particularly important area. I well recall from my own experience one particular episode when I was at the Children's Hospital. It involved an Italian-speaking person with no family members whatsoever, and an interpreter was provided (presumably in those days, because it is a long time ago, at great cost). Just to indicate the difficulty involved, although both these people spoke Italian, they spoke completely different dialects and it was absolutely no use whatsoever in the process. It is a very complex area but, pleasingly, the competition has seen the price decrease dramatically, and hence we are able to provide many more of those very important services.

Mr BRINDAL: I refer the Minister to page 266 of the Program Estimates with respect to disability services. The Minister will be aware that the previous Government introduced a system of mainstreaming, or putting people out of institutions and wherever possible placing them in the community. I know that this Government supports that program. However, the Minister will be aware of my opinion at least in the past that some of this had been done far too quickly and without providing the necessary support services. I can quote the Minister many instances where people were put out in the community and provided with less than adequate service, so that arguably they were better off when they were institutionalised than when they were mainstreamed. Will the Minister indicate any initiatives taken since he became Minister to improve the quality and efficiency of these disability services?

The Hon. M.H. Armitage: This is a particularly important question. I am very pleased to indicate to the Committee that South Australia is about to undertake the most intensive modernising of the disability services sector that has ever actually been undertaken by a State Government. It is a very difficult sector to administer, with only limited tools by which to judge the efficiency and quality of the services in an objective fashion, services for which the Government pays a variety of different private providers. Certainly at the moment also clients find it difficult to access the system and to get the kind and quality of services they want. The process of finding a way to evaluate the range of services provided in the past has been regarded perhaps as a suitable candidate for the too hard basket, but that has perhaps perpetuated a complex, maybe more expensive, difficult, sometimes threatening service. Clearly that has affected clients and their families.

The disability services in South Australia and throughout Australia developed from a wide and diverse range of individuals, institutions, charities and so on, all of which had many differences in philosophy, management style, service delivery patterns, and so on. Today in South Australia, we have 90 different organisations supplying not infrequently overlapping services of varying quality to people with disabilities. These people receive different qualities of services depending upon where they access the service and what sort of disability they have, and so on. We as a Government have few objective measures by which we can judge efficient providers—those providing quality services—and, importantly, whether over-servicing or under-servicing of a client's particular needs occurs.

As part of this very wide-ranging shake-up of the sector, we will focus on three main areas to set up the necessary protocols and procedures. Those areas include criteria for eligibility, assessment standards and procedures and, if you like, a benchmarking or matching personal support needs to a defined standard—to a defined intensity of care and a defined cost: in other words, seeking information about types of services, whether people are eligible and where they ought to be provided.

The development of those tools, once developed—and that is quite ground-breaking work—can then be applied objectively to every person in the system and to every provider (I mentioned previously that we have 90 different organisations). That will allow all of those appropriate things to be addressed within the providers and with the people with the disability. However, that will take some time. You can draw a parallel to the hospitals system with its protocols, standards and procedures. It gives a broad guide to the sorts of objective tools we are looking for in the disability sector.

Most importantly, the focal point of all this action is the support needs of individual people. The development of

personalised support plans, once we know all that information, will then be the foundation for ensuring really high quality and efficient services. As I mentioned previously, these tools have not been available before in South Australia, nor in Australia, and it is a very exciting opportunity we are embarking upon. Once again, it will put South Australia at the leading edge of innovation in what is a very important area, that of disability services.

Ms STEVENS: I refer to pages 259 to 267 of the Program Estimates. During last year's estimates, the Minister defended the Brown Government's position at the time of a two-year wage freeze for all public servants. He warned of the dire consequences that any wage increases would have on the health budget. The March gold book indicates that, rather than a wages blow-out in 1994-95, we will have a wages implosion, thanks to the slashing of hospital staff. The revised wages and salaries budget for health in 1994-95 will be $21.3 million less than estimated, while the goods and services budget will blow out by $34.4 million. What concerns, if any, does the Minister have about wage increases in the public health sector in 1995-96?

The Hon. M.H. Armitage: I am sure that every Minister and every employer is always concerned about a major wage increase, particularly in an exercise such as providing health care, where clearly hospitals are given a budget and the board and the executive plan services that they can provide within that budget. If there is a huge wage blow-out, obviously in having to absorb those costs from the hospital's point of view there would need to be considerable productivity improvements to make those equations work out.

Failing that, obviously one has to look at things like staff reductions. The reason it is particularly important in the health sector (it is important everywhere) is that it is a people-heavy organisation and about 75 per cent of costs are wages. So, if there is a wages blow-out it obviously has a major effect. We have some figures in relation to the various previous national wage case decisions. The total cost of $8 a week adjustment for all employees in the public health system has been estimated as a $10 million cost in a full year. As the member for Elizabeth can see, it has potentially huge effects.

Ms STEVENS: The three-year agreement covering visiting medical officers expires on 30 June, which is tomorrow. Has the agreement been renewed?

The Hon. M.H. Armitage: Following a number of productive decisions and meetings which have occurred in the past 24 hours with a number of people in relation to that, I will ask Mr Blight to provide information to the Committee.

Mr Blight: A meeting was held earlier today with the President of SASMOA and Dr Davey, who is head of the SASMOA negotiating committee, to explore options to progress or continue the provision of medical services as from 1 July in the present circumstances where SASMOA and the Health Commission have not been able to reach agreement for a new set of terms and conditions as from 1 July. As a result of that meeting the President and the head of the negotiating committee agreed to take a proposal to a meeting of visiting medical officers this evening. That proposal is for an extension of the present agreement until 31 July, with a commitment from both parties to resolve the outstanding points of dispute. In preparing for 1 July, I understand that all hospitals employing visiting medical officers have issued offers to those medical staff.

The offer is for a period of one year and provides a vehicle for their continuing appointment and employment past 1 July and, therefore, it is an obvious vehicle to use for continuity of services as from 1 July. The President and head of the negotiating team agreed to support the proposal to the meeting of VMOs this evening and we will await the outcome of that meeting.

The Hon. M.H. Armitage: In addition, in several discussions I have had about this matter with leading visiting medical specialists at a variety of hospitals in Adelaide in the last 48 to 72 hours, they have been quite definitive in saying that they as clinicians providing services are looking for an early resolution to this problem. Indeed, one person to whom I spoke late last night indicated that he is seeking nothing more or nothing less than the opportunity to continue to service his patients continually on Monday. I think we will find, from the discussions that Mr Blight and I have had, that that is a reasonably common feeling among clinicians—certainly, not all of them, and I do not back away from that. Overall, however, the visiting medical specialists who for many years have been dedicated to service of patients and hospitals, because they feel fiercely loyal to their own hospitals, want nothing more than to continue that service provision.

Ms STEVENS: I understand that many visiting medical officers threatened to withdraw their services from 1 July, which is on Saturday, if a new agreement is not struck. My understanding of the previous answer is that a proposal, which outlines an interim arrangement to enable further negotiations to occur, will be put to a meeting tonight and then we will know late tonight or tomorrow morning whether visiting medical officers will withdraw services from our hospitals as from Saturday. Is that the correct situation?

The Hon. M.H. Armitage: That is correct, as far as it goes. Already there are a number of important things that one needs to stir into that pot. First, as Mr Blight indicated, a negotiating team from SASMOA is taking an agreed position to the meeting. It is not as if the negotiating team and the Health Commission have daggers drawn. We want to move forward, as does the negotiating team. That in itself is an indication of a degree of optimism about the outcome of the meeting. By way of the aside to my last answer, I feel that the majority of clinicians want to continue their services—

Ms Stevens interjecting:

The Hon. M.H. Armitage: Certainly, some of them do, but others have been absolutely specific and said, 'I don't care if I get any increase at all.' It is not necessarily a group of rapacious doctors holding the system to ransom. Some want nothing more than to continue. It will sort itself out at the meeting tonight. There is every reason for optimism and we will never know until the meeting is finished, but as far as it goes that is correct. There are a number of other important points to note. First, a number of doctors have thus far formally rejected but, we believe, will now reverse that decision, given SASMOA's decision, and indicated that they will be happy to provide the services continuing on a fee for service basis at AMA rates.

That means that if there was a particularly sensitive area we could go down that avenue. A number of other areas are staffed by full timers who could continue to provide the services, and so on. There are many other opportunities, and it is not as if we are facing a crisis of a withdrawal of services across the whole sector or anything like that. As I say, the bottom line is that there is every reason for optimism that the meeting tonight will see a positive decision.

Ms STEVENS: In terms of the total costs and the potential costs of wages across the system in the coming year,

an increase in superannuation costs will occur after 1 July, on Monday. There is a fairly strong possibility of two safety net wage increases of $8 each across the system during the year; there is this issue relating to the visiting medical officers; and there is the potential in the issues raised earlier by the member for Giles. What is the Minister's estimate of the total cost, and have funds been allocated to hospitals to cover this or will hospitals be expected to absorb the costs from within their budgets?

The Hon. M.H. Armitage: I will ask Rod Bishop to provide the information.

Mr Bishop: If they were granted in full, the all-up cost of claims currently made against the Government and the commission—and I am referring to the 20 per cent claim by medical officers, the $65 a week claim by the Miscellaneous Workers Union, and the 8 per cent claim by the ANF for nurses—is approximately $78 million in a full year. Against that we have the undertaking from the Government to supplement a $15 wage increase, which one organisation representing employees in the Health Commission has indicated it would accept, whereas others have not yet done so. If the $15 were accepted, that would be supplemented, so the difference between the cost of the $15 wage increase and the $78 million, if those claims were granted in full, would have to be found within the system.

Ms STEVENS: Within budgets?

Mr Bishop: Yes.

Ms GREIG: Page 261 of the Program Estimates refers to Factor VIII. Could the Minister advise the situation to date on the availability of Factor VIII and the supply and use of recombinant Factor VIII, and what decisions regarding the supply and use of these blood products have been taken at national level?

The Hon. M.H. Armitage: Dr Michael Jelly, Chief Medical Officer of the Health Commission, will give the Committee an update on those matters.

Dr Jelly: Last year a national working party recommended an action plan to deal with issues relating to Factor VIII. As a result it was the unanimous recommendation that States purchase recombinant Factor VIII, that is, Factor VIII that is generated by DNA technology rather than from blood or blood products. Early in 1995 there was a shortage of Factor VIII in South Australia arising out of a failure to return some of the Factor VIII produced by CSL from blood and blood products in South Australia, and that caused some consternation.

We managed to purchase, by April, 100 000 international units of Factor VIII from the DNA technology Factor VIII and, along with an availability of more blood and blood products, that alleviated the concerns about Factor VIII. It is our intention in 1995-96 to buy additional recombinant Factor VIII, although at this stage I am not sure of the quantity we will buy. That will be subject to advice from my expert committee on the requirements of South Australians. There is a belief that recombinant Factor VIII should be purchased because it is pure, although that is not entirely true: human albumen is used in the production of recombinant Factor VIII, which creates a slight risk.

The blood and blood products Factor VIII at present can be said to be very safe indeed, and there is no evidence that, since testing for hepatitis C and HIV became available, any transmission has occurred or that those diseases were transmitted in the past. It is our intention to try to meet the standards set by the action plan, which was to exceed 2.0 international units per head of population from blood and blood products, a level which South Australia has been able to achieve and maintain in the past, and to supplement that with recombinant Factor VIII.

The international movement suggests that in the long term we ought to aim for the availability of three international units for South Australians, and that is something we will have to look at. The recombinant Factor VIII will be funded 50/50 by the Commonwealth and the State, and the Commonwealth has already made provision for some funds for that purpose.

The Hon. M.H. Armitage: I indicate that, as Minister for Health, I would assume every person in the Chamber is a blood donor.

Mr WADE: What action has been taken to improve access to mental health services, particularly for rural communities?

The Hon. M.H. Armitage: This is a particularly important area in which South Australia is doing very well. I ask Mr Jon Blackwell, Executive Director of Country Health Services, to provide the detail.

Mr Blackwell: For a number of years country mental health services in South Australia have been in need of some supplementation, and I believe we are currently addressing that situation. In September 1993 a report entitled A Framework for Country Mental Health Services was published by the South Australian Mental Health Services. That report identified that to provide a proper coverage, in terms of mental health in country South Australia, we would need approximately 120 community mental health workers comprising nurses, social workers, psychologists, and so on.

At that time only 25 mental health positions existed in the country, leaving a requirement of approximately 95 positions. Twenty of those positions were identified as high priority positions. Funding for those additional positions was to be provided through the devolution of Hillcrest Hospital and the SAMHS area project. The project did not move as quickly as had been hoped, and therefore funding for additional positions was identified from within Country Health Services, which is my division of the Health Commission. Funding of $1 million was made available as a measure to at least kick-start the process of providing better mental health services to country people.

We were told that it would be impossible for us to recruit mental health professionals to country areas, but we decided to make a big effort and give it a big push. In December last year we started advertising on a national basis to seek appropriately qualified personnel in psychiatric nursing, social work and psychology.

We were reasonably flexible, and fortunately we have been extremely successful in recruiting to those first 20 priority positions. As a result, 16 of those 20 positions have been filled and workers have commenced. I think we have proved that people will go to work in the country if proper facilities and support are provided. We do not have any further doubts about our ability to recruit people to go to the country. Two positions were identified as Aboriginal mental health positions. We are having discussions with the Aboriginal Health Council as to how those positions will be utilised and where they will be located. We need to consult Aboriginal communities about doing that. In future we expect that the further devolution of the SAMHS areas project will free more resources to provide the balance of positions within country South Australia.

Mr BRINDAL: My question relates to booking lists and the metropolitan hospitals program on page 259. Under the

1994-95 targets, there is mention of reduced booking lists. Can the Minister advise the Committee about the movement in booking list numbers this year? Will he also expand on his answer to the member for Elizabeth, if it is relevant to booking lists? I understand what he was saying about consideration of the IVF program. If the movement is to be made in that area, will the Minister first look at categories by which people come into the program? For instance, people who have had tubal ligations are currently accepted into the program. I see that as being a different order of need to a couple who, for medical reasons beyond their control, are not able to have children of their own. Will the Minister, before deciding that a program is to come off, look at reasons why some people might be on the program and reduce it in that way?

The Hon. M.H. Armitage: The introduction of casemix funding has allowed additional activity aimed at substantially reducing the booking list. For the purposes of the model, the base line for the booking list was the level in March 1994. By April 1995 the number of people on the list had declined by 801, those on the list for over 12 months had declined by 43 per cent and the overall turnover time had dropped from 2.3 months to 2.9 months. Overall, 41 696 people had been removed from the list whilst 40 898 had been added. This achievement has to be seen in the context of a continuing decline in private health insurance participation rates.

A joint study between Commonwealth and State officers has shown that 58 100 people in South Australia, who dropped health insurance coverage in 1992-93, gave rise to 7 685 public hospital episodes. Given the unfortunate trend for private health insurance coverage continuing to decline, there is no reason to suggest that the impact in 1994-95 will be any less. Therefore, our reduction in the booking list has occurred despite an additional 7 500 admissions due to declining private health insurance coverage. Not only have we removed people but it must be seen in the context of there being another 7 500 admissions. The booking list is clearly a focus, and the figures indicate that the system is coping well.

In relation to the tubal ligation about which the member for Unley talked, the categories that we looked at involved matters over which people had much greater discretion; for example, reversal of sterilisation or vasectomy. I think that other matters, such as the one that he addressed, will have to be considered; but, as an overall strategy of reducing the booking list, casemix allows hospitals to make the clinical decision, and we are encouraging them to do that efficiently.

Ms STEVENS: My question relates to the Program Estimates, page 259, regarding casemix. In its first year of operation there have been a number of problems with casemix. The throughput pool operated on a first in, first served basis, and it was exhausted in the first three months, leaving some hospitals out of pocket. Patients admitted to hospital before 1 July 1994, but separated after that date, were not funded under casemix. This cost some hospitals dearly. Wrong casemix financial information was forwarded to hospitals twice in December, and the data had to be reissued in February. This threw out the planning of many hospitals. Finally, hospitals have complained of many anomalies in the diagnostic related groups. Despite the promises made when casemix was introduced, most hospitals have been forced to close wards and cancel or restrict surgery for much of this year. Does the Minister still believe that the casemix funding system is a success?

The Hon. M.H. Armitage: Some time ago in England there was concern about machines that allowed advancing technology to increase production in the textile industry. There was a very famous person—perhaps a figure of imagination, but nevertheless very famous—Ned Ludd or Captain Ludd, who headed up the Luddites.

Ms Stevens: Is this a parable for the evening?

The Hon. M.H. Armitage: A parable, whatever. The principle is of a person who refuses to admit that modern technology is advancing the cause and, rather than grasp the benefits of that technology, adopts the Luddite philosophy, which would see all new technology destroyed.

Mr Brindal interjecting:

The Hon. M.H. Armitage: Smash the machines, as the member for Unley says. So, to be in the unfortunately outdated paradigm of talking about whether wards are closed or not is Luddite thinking.

Ms Stevens: Tell the people.

The Hon. M.H. Armitage: I will tell the people. I will tell every person who has been taken off the waiting list of the 4 per cent increase in services and exactly what has happened. They know what has happened. There is a revolution in health care.

Ms Stevens interjecting:

The Hon. M.H. Armitage: That's for sure. The member for Elizabeth acknowledges that the revolution is technological. I have personal experience of someone on my staff who had a gall bladder operation nine months ago. In the good old days gall bladder operations, without fail, entailed 10 days in hospital and four to six weeks off work. This member of my staff was in hospital for two days—it may have been two and a half or one and a half, but certainly it was no longer than two or three—and within three or four days he was back at work. That is what people want. People do not want to spend 10 days in hospital and four or five weeks off work; they want to get out of hospital.

That is what is happening. That is why there is efficient use of technology which allows much quicker throughput and much better management of resources. It does not matter whether there are 24 or 28 beds: what matters is the number of times procedures are done. As I have indicated almost *ad nauseam*, but I will continue to do so because the member for Elizabeth continues to ask these questions, we have decreased the booking lists by 10 per cent, we have decreased the number of people waiting for more than 12 months by 50 per cent and we have increased—

Ms Stevens interjecting:

The Hon. M.H. Armitage: We have closed down operations. That is Luddite thinking.

Ms Stevens: Tell the people who have been waiting all that time.

The Hon. M.H. Armitage: The simple fact is that, if we are doing 4 per cent more work, clearly the system is being more productive: it is doing better. It does not matter whether the bed numbers are the same, because a lot of people get the same or better treatment without ever getting into the beds. As part of an ongoing planning exercise, a number of clinicians were asked to give their opinion as to what might happen over the next 10 years so we might plan better. The advances that they are predicting in clinical areas are enormous, and that will allow further opportunities for bed closures. I am delighted about that: I do not back away from that at all. I am not a Luddite. I want to progress so that modern technology can be used appropriately and we can continue to take more people off the booking lists. Rather

than moving categories, as happened in July 1993, effective numbers can decrease and we can do more work. The system is being more productive: it is doing more work and deserves to be commended rather than criticised.

Ms STEVENS: The budget papers indicate that the private Southern Districts War Memorial Hospital was paid $497 000 more in 1994-95 than originally estimated for its contracted 15 public hospital beds. This represents a staggering 31 per cent overrun in this hospital's budget, yet the Minister stated the following in Parliament on 21 March:

> . . . we are providing financial assistance to assess the financial status of the hospital *in toto*, because we will not be wasting taxpayers' money if those services cannot be provided by the hospital.

Does the Minister still claim that the assistance provided to the hospital was only to assess the financial status of the hospital? If so, how does the Minister justify such an expensive assessment?

The Hon. M.H. Armitage: As I believe I have mentioned in Parliament before but nevertheless I will repeat, the simple facts are that the throughput at Southern Districts War Memorial Hospital was simply not controlled: it was appallingly managed. The exact figures I forget, but in February 1995 it became evident that the hospital was not managing its budget. It had drawn down $1.492 million of the total allocated funding of $1.649 million. It clearly indicated that it was simply making the wrong management decisions. That was a matter for the board, and we were keen to work out a solution. Southern Districts War Memorial Hospital agreed to the appointment of a manager selected by the Government, costs of the manager being covered by the Government, to manage the affairs of the hospital within resources available for the period up to 30 June.

The then CEO was offered and accepted a redundancy package from Southern Districts War Memorial Hospital, which is a private hospital. A consultant was appointed and an additional expenditure supplement of $309 000 was provided to Southern Districts War Memorial Hospital for the period to 30 June 1995 simply to prevent the hospital from becoming insolvent whilst services were still provided. The purpose of that consultancy was to determine whether the hospital was a viable concern, because it was that private hospital from which we were purchasing public hospital services. We were keen to ascertain the viability or otherwise of the private hospital. The final contract for the purchase of services and as to what services will be provided and so on is still being negotiated.

Ms STEVENS: Essentially, this was a bail-out of a private hospital. Does it actually have to repay this money and, if so, under what conditions? Did the Health Commission advise against the decision to make this payment to the hospital?

The Hon. M.H. Armitage: This is not a bail-out of a private hospital: we were seeing the continuation of public services which had been provided in the private hospital until the end of the financial year. Our commitment is to provide the public services. They could not be provided because the hospital was becoming insolvent at its present rate and, accordingly, we paid for a continuation of the public services to ensure that the public services were provided. In relation to whether the money will be repaid, the money will be recouped from next year's budget. In relation to whether the commission advised against the bail-out, the answer is 'No.' As Mr Blight has just reminded me, as CEO he specifically did not recommend the bail-out. We discussed the various options and there was no recommendation that this commitment to continued public services ought not be made.

Ms GREIG: What is the future of biomedical engineering within our hospitals.

The Hon. M.H. Armitage: I will ask Carol Gaston to reply.

Ms Gaston: I can assume only that the honourable member's question relates to a current review of our biomedical engineering services in metropolitan hospitals. The review was commissioned by the Metropolitan Health Services Division and employed the services of two members of the biomedical engineering advisory group. These two persons currently head two of our major hospital biomedical engineering services. We asked them to develop a model that would meet certain criteria. We wanted to ensure that the biomedical engineering services were cost-effective and that they were delivered to their customers in a timely manner. You might realise that we are dealing with the maintenance of quite sophisticated technology in our hospitals. It is incredibly important that the response rate be attended to. We also wanted them to meet certain best practice standards, which is certainly not unreasonable of us. We certainly did not say that they were below standard, but we wanted to ensure that they maintained or increased their standards.

We also looked at the possibility of the service extending its work outside the public sector. The review was undertaken—it has now been completed—and various options were recommended. We have employed an accountancy firm of consultants to do a cost-benefit analysis of the options. Recommended options included the standardisation of selected technology across the metropolitan area; a statewide approach to supporting equipment currently on service contracts; standardised policies, procedures, practices and documentation of services; and the development of a common management system, which is particularly important if we want to ensure that we provide a cost-effective service, by keeping a management record of the activities and the cost of each activity across services.

Also, it was recommended that there be some sharing of specialist services and of parts, resources and support services. That led the reviewers to recommend a form of centralisation of the management of biomedical engineering. That can take various forms. That is what we are doing a cost-benefit analysis on at the moment. We expect to have the results of that analysis within about four to six weeks.

The primary principle underpinning the recommendation for centralising management is to bring about the administrative and management efficiencies that have been highlighted as needed but, probably more important, also to achieve some economies of scale within the system.

Mr WADE: I refer the Minister to page 267: in the section dealing with the support services program there is a reference to a workers' compensation fraud strategy. Will the Minister provide details of what the South Australian Health Commission has done to prevent workers' compensation fraud?

Mr Bishop: In September 1993, the Health Services Risk Management Unit began the development of a strategy to minimise losses due to fraud against the workers' compensation scheme. The resulting fraud prevention strategy for workers' compensation was presented and endorsed by the Health Commission executive in March 1994 and was implemented over the ensuing 12 months.

The significant achievements of the strategy included the development of potential fraud indicators and training to

assist in the identification of possible fraud in new or existing claims. They also involved the creation of data bases for scrutiny by a sophisticated criminal intelligence analysis software package to identify links, trends and characteristics; the provision of policies, procedures, advice and assistance to health units for all stages of the fraud management process; the delivery of general fraud awareness ethics and specific fraud training packages to the health system; systems for assessment and follow-up on allegations; monitoring external investigations service providers; prosecutions; and reporting mechanisms in liaison with other agencies.

At the end of May this year, a total of 58 matters resulted in investigations being undertaken. Of those, four have led to the dismissal of the worker concerned. Four workers have resigned, and a further three claims have been rejected. Three successful prosecutions have been conducted. Two matters are presently before the court, and a further six workers are expected to be charged with dishonesty offences between now and the end of July this year. The 16 matters resulting in dismissal, resignation, claim rejection and prosecution had estimated liabilities of approximately $829 000. In each successful case, no more payments will be made. The potential real savings of those identified claims is approximately $262 000, plus any recoveries through court orders upon conviction. To date, defendants have been ordered to pay back approximately $56 000.

In one matter currently before the court, involving 11 counts of alleged dishonesty, the worker had received approximately $200 000 in medical costs and income maintenance. Although an order for repayment can be sought, it is unlikely that the court would award the full reimbursement.

Specific assessment of the overall cost benefits is not easy because of the great number of intangibles. For example, there is the difficulty of attributing a monetary value to the significant reduction in claims at a health unit in the month following delivery of a fraud awareness session to staff where notification was given of the introduction of sophisticated analysis and detection measures; and determining how many fraudulent claims have not been submitted following publication of successful prosecutions—we have publicised across the health system the successful prosecutions so that all staff are aware of what we are doing—or because of information received by workers over the so-called grapevine of those who have been caught out by surveillance resulting in resignations or, sometimes, dismissal. Although the exact savings cannot be easily identified, it is clear that apparent savings far outweigh the operational costs of the strategy.

Mr WADE: I do not need to know now, but is the data base or computer software at the Health Commission compatible with that of WorkCover?

Mr Bishop: I understand that the software we are using is also being used by WorkCover Corporation.

Mr BRINDAL: My question refers to page 259 of the Program Estimates. I refer to my abiding interest in country people and the provision of health services for them. Page 259 of the Program Estimates refers to the commissioning of the new Gawler health service. Can the Minister outline the special features of that important country service?

The Hon. M.H. Armitage: The new Gawler hospital and health service complex was commissioned on 30 October 1994 and I had the pleasure of opening it officially last Sunday. The member for Elizabeth was there. The new hospital is run by Gawler Health Services Incorporated, the previous body—Hutchinson Hospital Incorporated—having been dissolved. The new hospital was a long time coming and there were a number of changes before the present magnificent complex was commissioned. The project resulted in the transfer of hospital services from the old Hutchinson Hospital to the new hospital to become part of Gawler Health Services Incorporated.

The project included the provision of facilities for community health services, the South Australian Dental Service and the IMVS, together with facilities for consulting rooms which will be leased to private providers on a commercial basis. A private hospital ward was built as part of the project with funding provided by the private organisation—Gawler Private Hospital Incorporated. The private hospital is also contributing to a component of the obstetric facility. The total project cost was $21.8 million, of which $2.5 million will be paid by the private hospital. The old Hutchinson Hospital property will be sold and the funds used to partially offset the cost of the new hospital.

The facility has increased the number of hospital beds available in Gawler to 56 public beds and 30 private beds. It is an excellent example of the provisions that can be made for health care when the public and private sectors combine. A number of the allied health services that are provided in the private hospital are subcontracted back to the public sector. That allows things like radiology services with absolutely state-of-the-art equipment to be provided in the public hospital.

Another particularly creative use of the public and the private sectors relates to the catering department or division of the public hospital. A wonderful new kitchen has been commissioned which, I am told, is to be a model for several other areas. That kitchen is in the public hospital complex, but it provides meals for both the public and the private hospitals. Particularly creatively, it also provides food services for a number of external organisations.

One of those external organisations of which I took particular note is the Gawler and Barossa Valley Jockey Club. I used to be the medical officer for the Gawler and Barossa Valley Jockey Club many moons ago. In those days, the food was pretty second rate so I am glad that it has moved onwards. I could never quite understand why it was so second rate because every time I went up there, I came back with a lot less money than I took up with me. However, that is another story. The catering division also provides for external functions and it allows the lease of some halls and facilities within the public hospital for external organisations and the division also provides the catering.

That very creative solution is maximising the best of the public and private sectors. Everyone in Gawler was particularly happy that, eventually, after nearly 20 years from go to whoa, the magnificent complex was commissioned and then officially opened. At some stage this week, the results of an architectural competition will be announced. Having walked around the complex on Sunday and having seen how well it is designed and all the facilities, I can say that whatever beats it—if anything does—will have to be pretty flash. It is a terrific example of what can be done with public and private collaboration.

Ms STEVENS: My question relates to page 254 of the Program Estimates. The Opposition has been informed that renovations are currently being carried out on the ground floor of Modbury Hospital, but comprehensive asbestos removal from the area is not taking place. It was standard procedure under the previous Government that, when renovations were required, asbestos removal occurred and

that was funded by the Government. Are renovations taking place in Modbury Hospital in areas where asbestos is present? If so, is the full removal of asbestos from the area taking place?

Additional Departmental Adviser:

Mr Trevor Tomlinson, Manager, Health Facilities Branch.

The Hon. M.H. Armitage: I will ask Mr Tomlinson to provide the information.

Mr Tomlinson: Some work being carried out in Modbury Hospital on the ground floor was brought to my attention yesterday by the UTLC. Work has been carried out in accordance with the law in that the workers are working under accepted asbestos management conditions. The Department of Building Management has been engaged by Modbury Hospital to prepare an asbestos removal plan. That preparation is currently under way.

Ms STEVENS: Will the Minister direct the Modbury Hospital board to make available to the public the minutes of its meetings, in accordance with the advice provided to Parliament earlier this year?

The Hon. M.H. Armitage: I find this an interesting question, given that not long ago we were debating in this Chamber the Health Services Bill. The whole thrust of every objection from the Opposition to that Bill was that the Minister was being given too much power. The Opposition—

Ms Stevens interjecting:

The Hon. M.H. Armitage: I am answering the question. The Opposition, clause after clause, said that the Minister was being given far too much power under that Bill—why should the Minister be able to direct hospital boards? With the winds of change and the great mandala having turned, circumstances indicate that it is now politically propitious to accept totally the opposite view. So, at this stage, I indicate that I will discuss with the board the provision of the board minutes.

Ms STEVENS: I need to pad out my question a little with some details to refresh the Minister's memory, because he has obviously forgotten the circumstances concerning this matter. He is quite correct in saying that, in the debate on the Health Services Bill, he stated that the minutes of the hospital board were a public document. A week or so later in Parliament, I raised this issue with him because some members of the public fronted up to Modbury Hospital and asked to see the board minutes. They were refused. I understand that Modbury Hospital checked with the Health Commission and that refusal was verified.

As the Minister probably remembers, I followed up with a question in Parliament asking him about this confusion and he said that he would get back to me, but he has not done so. What I am saying is that, given that he made that statement in relation to the public nature of the minutes, the fact that they were refused means that something is wrong in relation to the hospital's understanding of the requirements as outlined by the Minister in the House. I ask whether he will direct the hospital to do what he said it would do. That is the explanation to my question, just to refresh the Minister's memory.

The Hon. M.H. Armitage: My memory needs no refreshing. I remember quite well that what we debated that night in Parliament was the matter of board constitutions and the availability of board minutes. What I have found is that the Modbury Hospital constitution is silent on the matter of the provision of board minutes. In other words, it makes no—

Ms Stevens interjecting:

The Hon. M.H. Armitage: No, the honourable member should look at what I said. That is irrelevant. The board minutes are silent on this matter, in which case there is no guidance for the board in this matter. As I have indicated, because of the deeply felt concerns of the member for Elizabeth that I ought not have the power to direct boards, as demonstrated in the previous debate, I will discuss with the board the provision of the minutes.

Ms STEVENS: My next question relates to the Program Estimates (page 257). Before the election, the Minister promised to 'dismantle the Health Commission and devolve significant administration responsibility to regional and local levels'. However, the budget supplementary papers (page 7) indicate that the central office budget blew out from an estimated $16.8 million in 1994-95 to $21.4 million, a 27.4 per cent increase. Expenditure for central office in 1995-96 will still be 14.1 per cent above last year's estimate. What were the reasons for this huge blow-out?

The Hon. M.H. Armitage: I ask Mr Peter Davidge to provide that information to the Committee.

Mr Davidge: The central office budget has had some rather unusual variations in it over the past couple of years, and the explanation sought by the Opposition spokesperson on health is largely attributable to the 1993-94 year when there was a significant carryover of funding from that year. In 1993-94, there was a lower than expected figure and, consequently, a higher than expected figure the following year when the impact of that carryover from the previous year is added. The extent of carryover was about $1.9 million from the previous year and that was associated with quite a wide range of variations in the central office budget.

If we add back that $2 million carry over to the previous 1993-94 year, you come up with a figure of about $20 million. Similarly, you can subtract from the 1994-95 outcome and even out at about a $20 million or a $21 million budget as a normal budget scenario. To give an example of some of the items in the $1.9 million carry over, there were security initiatives of about $300 000 where funding is included in the central office budget for security initiatives in the rest of the health system. That money was not spent in 1993-94 but was subsequently spent in 1994-95. Another example was a carry over of moneys from the South Australian Spectacles Scheme, which is administered centrally from the central office and $240 000 was carried over from 1993-94 and spent in 1994-95. They are two examples of the nature of carry overs taken into the 1994-95 year and spent. It indicates that we had a higher than normal spending in that year but a return to a normal level of spending in 1995-96.

Ms STEVENS: It seems that central office had the biggest expenditure increase across the whole health system.

The Hon. M.H. Armitage: I will not wear that observation lightly. The simple fact is that Mr Davidge has explained that it was a carry over from 1993-94. Any reasonable person can see the equilibration between the two years if the carry over of expenditure is put back into what had originally been budgeted for 1993-94 and was spent in 1994-95. They equilibrate. It is not a matter of excess spending or anything: it is simply carry over committed from the previous financial year.

Ms STEVENS: Can the Minister provide details of those increased costs, perhaps on notice?

The Hon. M.H. Armitage: Yes.

[Sitting suspended from 5.58 to 7.30 p.m.]

Ms GREIG: On page 265 of the Program Estimates in the public and environmental health services program there is reference in the 1995-96 targets to a 'Folate before Pregnancy' health promotion campaign. Will the Minister advise the Committee regarding this program?

The Hon. M.H. Armitage: This is a delightful set of circumstances, and I would like Dr Kerry Kirke to expand on that information and inform the Committee in relation to folate consumption.

Dr Kirke: In relate to folate consumption before and during early pregnancy, some recent international studies in which the South Australian Women's and Children's Hospital participated demonstrated that supplementing the diet of women with folic acid (one of the B group vitamins) before pregnancy and during the first three months can reduce the prevalence of neural tube defects in babies by about 70 per cent. Neural tube defects, which include spina bifida, are often severe birth defects that occur as a result of incomplete closure of the neural cord around the brain and the spinal cord at about the sixth week after conception, which is often before a woman knows that she is pregnant.

In South Australia, over the past three decades about 40 babies have been so affected per year. In June 1993, the National Health and Medical Research Council made recommendations that all women planning a pregnancy or likely to become pregnant should be offered advice about folate (the naturally occurring form of folic acid) in the diet and encouraged to increase their intake of folate rich foods, particularly in the month before and in the first three months of pregnancy. That is where the word 'periconceptionally' comes in. Those without a close family history of neural tube defects should be offered periconceptional folic acid supplementation of ½ a milligram a day, while those with a close family history of neural tube defects, who are at a much greater risk, should be offered 5 milligrams a day and also given genetic counselling. There was also a recommendation for fortification of some staple foods with folic acid as well as education programs for health professionals and the public on how to achieve adequate folic acid or folate intake to prevent these neural tube defects.

Folate-rich foods include green, leafy vegetables, some fruits, whole grain breads and cereals, and so on. Only South Australia and Western Australia have undertaken statewide health promotion programs as recommended by the National Health and Medical Research Council. The South Australian program has been funded by Foundation South Australia and the Health Commission and is coordinated by the Women's and Children's Hospital. A project officer was appointed 12 months ago, and educational materials consisting of posters, pamphlets, information sheets, and so on for health professionals have been widely distributed to doctors, pharmacists, dietitians, and CAFHS staff, and participation in numerous education sessions with professional and community groups has taken place.

Pre-campaign surveys of women of reproductive age and health professionals have been undertaken, and post-campaign surveys will be made in the next two months to evaluate the success of the program. The prevalence of neural tube defects in South Australia will be monitored by the South Australian Birth Defects Register.

Mr WADE: I refer the Minister to page 259 of the Program Estimates, which relates to the metropolitan hospitals program and, in particular, having spent my formative years at Elizabeth, to the amalgamation of the Queen Elizabeth Hospital and the Lyell McEwin Health Service. I am aware that one of the priorities of the Health Commission and the two hospitals is ENT services. Would the Minister please advise the Committee of any new developments in this area?

The Hon. M.H. Armitage: I thank the member for Elder for his question about a very important area, particularly given the information with which we were provided earlier about the areas in which South Australia has had, for a long time, a greatly increased percentage of operations compared with the national trend in other States. Bearing that in mind, it is very pleasing to say that the position of a professorial Chair in ear nose and throat, or otolaryngology, has been established in South Australia and will be advertised in the very near future.

The establishment of the Chair was a joint initiative of the two universities together with the Ear, Nose and Throat Society and the Health Commission. The commission approached the two universities and the ENT Society with a view to establishing a Chair in ENT to address several issues. The majority of the funding required has been made available by the Health Commission to the tune of $300 000 per annum. The Chair initially will be located at the Queen Elizabeth Hospital, moving to the Lyell McEwin Health Service as the ENT service develops at that site as part of the amalgamation process. The centre for ENT will cover the Royal Adelaide Hospital, the Queen Elizabeth Hospital, the Lyell McEwin Health Service, the Women's and Children's Hospital and Flinders Medical Centre.

The two years taken to establish the Chair is not a reflection of disinterest but a consequence of lengthy and successful consultation. The option which is now in the offing involves all metropolitan hospitals. The Centre for Otolaryngology (head and neck surgery) will be managed by a management board comprising two representatives of the University of Adelaide, two representatives of Flinders University and one representative of the Health Commission. In particular, the provision of a Chair in ENT being located eventually at the Lyell McEwin Hospital is tangible evidence of the upgrading of clinical services in the north. The Chair in ENT will provide very strong leadership within the speciality for service provision, teaching and research. There is no doubt that having an academic focus for a variety of these sorts of areas lifts the game markedly.

Another objective is to establish the reasons for varying surgical rates within South Australia, and in comparison with other States. We believe that, if there is academic status behind the person conducting the investigations and establishing the reasons, it will be possible to make some changes to the way those services are provided; to influence the provision of those services in the public sector; to be involved in direct service provision; and, particularly as a clinical academic, to encourage innovation in clinical practice and cost-effective service delivery. Obviously, if those benefits are to be long lasting, we would expect the medical students to glean information from this person.

Certainly, the professor of ENT will be expected to provide leadership in undergraduate and postgraduate training and in postgraduate continuing education. There are a number of other tasks, such as the development of protocols in ear, nose and throat surgery, which, we believe, will be an integral part of the strategy for ENT in those areas, which at the moment are above the Australian averages. It is a very exciting announcement. Not only does it address an area of great need, for example, ENT, but it is a very tangible indication of the long-term plans for the Lyell McEwin.

Mr WADE: I refer the Minister to some comments made this morning by the member for Giles, and in particular I refer the Committee to page 260 of the Program Estimates on the country health services. Earlier today the member for Giles said that country services are being forgotten by this Government. I would appreciate the Minister's comments on this statement.

The Hon. M.H. Armitage: Earlier today the member for Giles grumbled about the way the country is yet again being neglected by the Government. Clearly, he has neglected to look at the record. Certainly, we are committed to providing quality health services in the country, and this is certainly reflected in our capital works program. Major capital works projects include the Port Lincoln Hospital (stage two), Kangaroo Island (new kitchen and community health centre), the Mount Gambier Hospital, the Mount Barker Community Health and Day Care and the Murat Bay Aged Care Centre. Divisional capital works will see a number of communities benefiting, including Cooper Pedy, Roxby Downs, Angaston, Clare, Laura, Millicent, Murray Bridge and Port Pirie.

The electorate of Giles has not been forgotten—who could forget the electorate of Giles? I recently visited Whyalla for a number of reasons. I acknowledged the enormous effort that the staff and management of the Whyalla Hospital have put in in difficult times. They had a very large task because the local geography within the hospital makes it an inefficient hospital to run. As well as paying tribute to the staff and management for the work that they have done, I was able to open $1.2 million worth of new facilities and to foreshadow a further $700 000 in extra services and equipment. Part of the facilities which were opened were upgraded medical surgical and paediatric wards; a new 20-bed day surgery unit, which will lead to further efficiencies; new reception areas; new medical records areas; and an upgrade of fire standards. Together this package cost $1.2 million.

A number of other things have happened at Whyalla with the newly installed cardiac monitoring system in ICU. Again, there has been involvement of the private sector. The private radiology company, Perrett, Harrison and Partners, is moving the whole of its Whyalla operations into the hospital. The hospital will provide $230 000 to upgrade the building, and the private sector company will provide $250 000 in new screening equipment and it will also move its CT scanner into the hospital, together with other existing equipment. That is another example of excellent collaboration between the public and private sectors.

I saw a newly developed laboratory at Whyalla for the IMVS at a cost of $90 000, and a new telepsychiatry system has been installed in the hospital, allowing direct contact from Adelaide. Children with mental illness will have more local staff to help them. A number of local funding sources in Whyalla have provided funds for the purchase of a new bronchoscope, upgrading of the surgical theatre to provide laparoscopic surgery, a new slit lamp for the eye clinic, a new caprograph module for ICU, and donations worth $50 000 for equipment in the obstetrics and gynaecology area.

Therefore, many positive things are happening in capital works in the country. Certainly the allegation by the member for Giles that the country has been neglected is rejected. I am pleased to indicate that the commitment made in our policies and in all our initiatives in casemix funding with rural access grants, and so on, are further practical examples of the Government's commitment to rural health care.

Ms STEVENS: My question relates to the Program Estimates, page 259. The Minister's budget day media release contained the comment, 'The involvement of the private sector within our hospitals will accelerate this financial year,' and, further, 'Now that the Modbury Public Hospital benchmark is in place a strategic plan will be announced shortly which will detail the Government's overall strategy for private sector management within the State's public hospitals.' We know that the Queen Elizabeth Hospital will be the next major public hospital to have its management let for tender in September. Will the Government's policy on contestability be followed in the QEH outsourcing process and in all other outsourcing?

The Hon. M.H. Armitage: The policy of contestability, as I believe has been made quite public, had a number of steps in it. According to all the advice we received, there were some potential barriers to the most efficacious results coming from that policy. Given the success of the Modbury Hospital exercise, we believed it was important for the taxpayers of South Australia that we were able to generate savings as quickly as we could and still provide world quality services. So, that policy of contestability has been altered and is in the process of final negotiations within the Government to a policy of competitive tendering and contracting out. Certainly at the micro level those policy initiatives will continue to be followed and, at the macro level, there will be a process of calling for expressions of interest in which all players in the area—both public and private providers—will be afforded an opportunity to put forward a bid within that process.

I emphasise, as I have done on many occasions, that we as a Government have absolutely no predilection for supporting any particular sector to win the contracts: our only criteria are, first, world-class service and secondly, that service be provided cost effectively. To that end, I have had a number of discussions with public sector providers, both on the macro and micro level, and those discussions have centred around a number of potential avenues to encourage and to help them partake of any of these bidding processes. However, there is absolutely no doubt in the mind of these people to whom I have spoken and certainly a number of public sector providers who have been underbidders in some of these processes that the Government has no bias towards any sector. However, it does have a bias for ensuring that taxpayers' money is used as effectively as possible.

Ms STEVENS: In very brief and simple terms, I recall that the original policy on contestability essentially meant that, first, benchmarks were established; secondly, the public sector was given the opportunity to reach those benchmark standards of service; and thirdly, if they were unable to reach them, there would be a competitive tendering process. How does your new policy of competitive tendering differ from that?

The Hon. M.H. Armitage: It is fair to say that in some areas it is very difficult to establish benchmarks, and certainly it is difficult to establish particularly reliable benchmarks. So, by leapfrogging that process but at the same time putting out a tight tender, the market place—be it made up of public or private sector providers—indicates what its benchmarks might be for the provision of the services which are specified. So, it is the same process; one ends up with the same end result.

It is important to acknowledge that the health sector over the past 18 months—and particularly over the past 12 months—was under no illusions about the Government's desire to ensure that those services are provided as cost-effectively as possible. I know that the member for Elizabeth

visits various establishments and I am sure she is told that they are around South Australia preparing the way for these processes. I know that there are a number of potential opportunities at both the micro and the macro level where units have been frantically beavering away to ensure that they are efficient as possible. That does a number of things: first, and perhaps most importantly, it means that they provide the same service more cost-effectively or at the same price for more services where obviously the patients of South Australia benefit; and, secondly, it means that they are preparing their way to be potentially successful in any tendering process. As I indicated before, if they are able to convince the people assessing the tender that they are the best person for that tender, they will win the job.

Ms STEVENS: Essentially, the Minister said that you leapfrog the stage where a consistent set of benchmarks is set. The Minister said that everyone who tendered sort of put up their own benchmarks as they put the tender in. Essentially, the important thing I ascertained from what the Minister said was that they actually skipped the stage when a consistent set of benchmarks were set to start with. My concern is that in the Minister's previous answer he said how he had been about the system and how he had spoken to the public sector to help them partake in this process. How are they helped to partake in the process if there are no benchmarks for them to measure themselves against?

The Hon. M.H. Armitage: The simple fact is that one of the great difficulties or major barriers for the managers of public sector institutions being as efficient as they would like to be (make no bones about it) is often industrial practices. I am very impressed, because across all levels people want to be as efficient as they can. The South Australian taxpayer has the message that the State is financially under pressure and they want to help: that is the message I get. There are bits of advice which can be given in relation to those strategies—perhaps offering a private company or whatever within the public sector provisos. That is where the major benefits flow from exercises like Modbury Hospital.

Ms STEVENS: The Minister is saying then that the outsourcing process is not about establishing benchmarks of quality and service provision to start with: it is about bypassing industrial issues that the Minister sees as hard to deal with in the public sector?

The Hon. M.H. Armitage: The difficulty in coming up with reliable benchmarks, to which I referred before, is not in the area of quality: in many instances they are self-evident benchmarks. The difficulty is devising reliable benchmarks in the area of price. In a previous answer I indicated that, if one draws the tender document tightly enough, one is able very clearly to define the range of services required, the level of services required, the quality of services required, the amount of teaching and research required and so on. Those issues are easily benchmarkable. It is difficult in many areas to benchmark the price at which that quality ought to be provided. With the new policy now we are carefully identifying the range, level, quality of services, teaching and so on and going to the marketplace and saying, 'Tell us your financial benchmark for that quality.' That is the difference.

Ms STEVENS: The Minister stated in his press release:

> Now that the Modbury public hospital benchmark is in place then we can get on with the strategic plan.

That being the case, will the Modbury benchmark be published so that other units will have the option to measure themselves against that before going out to tender?

The Hon. M.H. Armitage: As I have indicated in all these responses, the financial benchmarks are found when one is looking at a particular range of services. The Modbury Hospital exercise has allowed us to establish a benchmark for that range of services. However, each hospital is unique around Australia. As everyone here realises, the Modbury Hospital is vastly different from the Queen Elizabeth Hospital, the Royal Adelaide Hospital and so on. Within that, there will be elements which would be approximately the same as the range of services in a particular area within the Modbury Hospital total exercise. However, the Modbury Hospital benchmark is quite specific for the Modbury Hospital range of services. So, we cannot draw any particular analogy between the price at Modbury and the price elsewhere. As I indicated previously, the price becomes available only when one has gone to the tender process. From the Modbury Hospital exercise, we have learnt that, if you go to tender, you get the best value for money.

Ms GREIG: My question relates to page 259 of the Program Estimates, which refers to metropolitan hospitals and to best practice guidelines being developed in several sectors. Will the Minister elaborate on those initiatives?

Ms Gaston: The Metropolitan Health Services Division of the commission is currently negotiating health service agreements with its health units. To provide some quality assurance and quality indicators for those health service agreements, it has pursued a process of developing best practice guidelines for a number of aspects of service delivery. Some examples of the work that has been done to date include best practice guidelines for the acute care of people with a disability—that is, when people with a disability are admitted to an acute care institution, they can be assured of being provided with services that best meet their needs. Of course, we all know that people with a disability have their own individual and particular requirements.

In order to establish those best practice guidelines, a working party and an expert reference group were established. They consulted widely with providers, carers and current consumers of acute care services. As a result of that extensive consultation, a report was developed outlining the best practice guidelines for acute care of that population. The report has just been tabled at executive level of the commission and endorsed, and it will shortly be distributed to all our health units. In support of that, it is proposed that the recommendations in that report be developed further into a series of implementation strategies. That is one example.

Another example is day surgery. We all know that there is a tendency towards, and a deliberate promotion of, day surgery. The Minister has said that there have been extraordinary advances in the use of technology, particularly in surgical procedures, which have ensured that we now have less invasive procedures. Among our hospitals, we have been promoting an increase in those activities. Statewide, just over 40 per cent of surgical procedures are now day surgery, and we expect to increase that over the next few years to as much as 70 per cent. It has been very important for us again to develop best practice guidelines for the initiative that we are promoting and accelerating.

Again, there was an extensive consultation process, not only with providers—that is, hospital management, surgeons and theatre nurses—but also consumers. A consumer survey was conducted, and as a consequence we now have guidelines for the conduct of day surgery, which certainly have a consumer focus.

The other area is obstetric care. Again, this process was extensive and it involved quite lengthy and detailed consultation with consumers in the antenatal and postnatal periods. There was also consultation with clinicians, administrators and, of course, midwives. As a consequence of that lengthy exercise, alternative models of care were developed for obstetrics. We are trying to encourage our health services to become involved in providing options for women during their pregnancy and delivery periods. This particular work has highlighted the various options available.

The report has again been endorsed by the commission and it has been distributed to our health units. We are using the various models described in that review in our health service agreements with health units. We are encouraging them to take up the alternative models to the traditional obstetric care so that the women of South Australia have a choice and can be provided with a number of alternatives to the traditional.

Those are just three examples. Others are in the process of commencement, but the three that I have described give an indication of the commission's intent when purchasing services to ensure that those services comply with quality guidelines and, as a consequence, meet the needs of the community of South Australia.

Mr WADE: I refer the Committee and the Minister to page 266 of the Program Estimates. I am aware that there is a high demand for services for people with intellectual disabilities and their carers. Can the Minister advise the Committee what has been done by the Government, and in particular by the Health Commission, to meet those needs?

The Hon. M.H. Armitage: As I understand it, the question was particularly broad. I will ask Ms Colleen Johnson to address the matter of the demand for services for people with intellectual disabilities and their carers, particularly in the northern suburbs.

Ms Johnson: In the past year, there have been quite a few developments in services for people with an intellectual disability. In 1994-95, the State received $1 million through the Commonwealth-State Disability Agreement and $545 000 recurrent dollars were allocated to intellectual disability throughout the State. Fifty-five per cent of that has been allocated for support services, particularly in the area of supported accommodation. There is $75 000 for Leveda Incorporated in the northern suburbs and that provided two additional people with high support needs through the redesign of the existing service.

Also, there has been quite an increase in community support and day activities, available through increased brokerage funding for day options. People who are to be accommodated and require day option for accommodation service in the northern suburbs also were provided with funds. Three people living in the north-eastern suburbs were allocated $16 000 for those activities. Seven people with very urgent and high support needs were also allocated a total of $48 000, involving two people living in the Barossa, three people living in the north-eastern suburbs and two people living in the northern suburbs.

Effort has also been put into making services more efficient and providing more services. In the northern suburbs, quite a bit or work has been done with an agency called Elizabeth Bowey Lodge to restructure its services to ensure that centre-based respite services have been increased. Throughout 1994 the Intellectual Disabilities Council reviewed the services provided by Elizabeth Bowey Lodge in close consultation with the management committee and the parents of the young people who use the services of that agency. They successfully reviewed that organisation and made quite a few recommendations, and the implementation of those recommendations is nearly complete.

As a result, the agency has been able to establish separate units for adults and children, and has increased its capacity from 1 370 overnight stays for adults to 2 272, and from 531 overnight stays for children to 984, and this has been a welcome additional service for the people living in those areas. A crisis response service has been established, and that also has been very well used. All of those changes have occurred from within the existing budget base of that agency, and feedback from families has been extremely positive.

During the coming financial year, the State Government is committed to providing additional services to people with disabilities through achieving efficiencies that will continue, and this process will continue to transfer funds from administration and inefficient practices into direct service delivery. That will result in the development of new services to meet the needs of people and their families.

Mr BRINDAL: We know that our friend and colleague the Hon. Caroline Schaefer is interested in country health and Aboriginal health in particular. She has referred to a document entitled 'Aboriginal health—Dreaming beyond 2000: Our future is in our history'. On page 264 of the Program Estimates there is a reference to Aboriginal health policy and strategic framework. Will the Minister provide more details about that document, particularly about any consultation that may have occurred in respect of it?

The Hon. M.H. Armitage: The 'Dreaming beyond 2000' document is really one of the most extraordinary pieces of work that I have seen in the area of Aboriginal health, and I was pleased to be able to tell the other Ministers at a recent conference in Alice Springs about it. We should have charged for it. It was a very hot item after we had expounded on its virtues. I will ask Mr Brian Dixon, Acting Executive Director of the Aboriginal Health Division, to tell us about 'Dreaming Beyond 2000'.

Mr Dixon: We have all known for quite some time now that the health status of Aboriginal people has been quite poor and certainly far worse than that of the general non-Aboriginal population of Australia. A lot of hard work still needs to be done to address the situation and to ensure that Aboriginal people are involved in these processes. To achieve success, special strategies and commitment are needed, and the commission is actively working towards this. As the Minister mentioned a little while ago, 'Dreaming beyond 2000: Our future is in our history'—a copy of which I have here, and it is easily accessible from areas in the department—will form the basis for an effective and appropriate Aboriginal health policy for the South Australian Health Commission. The development of this document was a joint Aboriginal Health Council and South Australian Health Commission supported exercise. I point out that the Aboriginal Health Council membership comprises members from the various Aboriginal-controlled health services in South Australia, ATSIC, the Department of State Aboriginal Affairs, the Department of Human Services and Health and the South Australian Health Commission.

This exercise, which commenced three years ago, was conducted under the auspices of the Aboriginal Health Council. The council employed a consultant who undertook an extensive consultation program with Aboriginal communities and organisations and Government and non-Government bodies throughout the State. A draft document was completed

after a period of 18 months and was dispatched for further comment and consultation. The important aspect of this consultation process was the fact that it operated from the ground up and involved people at grass roots level. This additional consultation phase took approximately 12 months, with the final product being launched by the Minister on 12 April 1995.

At the same launch, the Minister announced plans to establish an Aboriginal health division within the South Australian Health Commission. This is an extremely innovative development, as a structure of this nature does not exist in any other State health authority. It is proposed that, when the new division is fully functional, it will coordinate and support the implementation of strategies that will address the goals and targets contained in the 'Dreaming beyond 2000' document. This will be done in conjunction with the Aboriginal Health Council and other Aboriginal health bodies in South Australia. The combination of these two new initiatives will see many positive developments which will assist in addressing the poor health status of Aboriginal people and, just as importantly, it will give the opportunity to Aboriginal people to become more effectively involved in developing, operating and owning appropriate health programs in South Australia.

Mr BRINDAL: The Minister and his officers are to be highly commended for this initiative. I note that the Commonwealth Government considers itself overwhelmingly responsible for every aspect of the Aboriginal people and claims its constitutional rights to be so. In the context of this really good initiative, I ask whether the Commonwealth Government is adequately meeting its obligations in respect of this matter, especially in terms of the funding provided to the commission for the betterment of Aboriginal people in this State.

The Hon. M.H. Armitage: Through the Department of Health, Housing and Community Services, if that is what it is still called, the Commonwealth has made a decision to resume the funding that had previously been the responsibility of ATSIC. At a recent Health Ministers' conference, I was very keen to assess exactly what the outcome of that would be, and a number of plans were put forward for bilateral agreements between the Commonwealth and the State as to how that money might be spent with the object of getting specific outcomes for Aboriginal people.

The officers sitting at this table and I were quite distressed when we saw a time frame that included consultation between the State and the Commonwealth, and it looked like there was potentially another 12 months of argy-bargy before anything happened. However, as I indicated earlier, this was a very hot item at the conference, and when I, with Brian's help, expounded on the values of the document and what was in it, the Commonwealth acknowledged that we already had the project to put in place and that we were about to enter discussions in relation to getting some of the extra funding, which the Department of Health now has, to put this in place.

Mr BRINDAL: Can the Minister let us have a copy? It will be interesting to read.

The Hon. M.H. Armitage: Yes.

Ms STEVENS: I refer to page 259 of the Program Estimates. Does the Minister believe that private operators have an unfair advantage in the Queen Elizabeth Hospital tender bid because they can use the attractive private hospital development to subsidise their public hospital bid?

The Hon. M.H. Armitage: As to the private operators having advantages, it has been pointed out to me that if one was a private sector operator one might well feel that the public sector had an advantage because there is the opportunity for free capital. Public sector operators pay no taxes and have no dividends to pay to shareholders and so on. A number of advantages exist on both sides of the equation and it would be fair to say on both sides that there are roundabouts and swings involved in the exercise. In the tender process that we have adopted in latter times, the actual tender has been quite broad and the expressions of interest could be segmented into a variety of different exercises; for instance, that of a private development, of a private hospital on the campus.

Another option, which I know the member for Gordon would be interested in, involves the opportunity for private sector financing of a public hospital infrastructure development. Again, that is different from the first example and a third and completely different type of process would be private sector management of a public hospital. So, within broad expressions of interest we can segment out all of those and accordingly we do not believe there is any advantage for any sector in those processes, given the roundabouts and swings that I mentioned before.

Ms STEVENS: I refer to page 262 of the Program Estimates, the mental health programs, because I want to talk about the Willows program. The Minister will remember questions asked of him about that program, the closure of the program last year and questions as late as 11 April this year. I want to quote a couple of lines of the Minister's answer to me about the closing of that program (*Hansard*, 11 April 1995):

> . . . this is a clinical decision whereupon the SAMHS people have decided that it is better to provide the same amount of care to people in the community.

Later in the same answer the Minister said:

> We are moving these people into the community with all the staff who were providing services to the maximum of 20 people in the hospital. They will all be in the community. I am informed by SAMHS management that this will allow three times as many people with personality disorders to receive the same program.

The Minister may be aware that clients of the Willows program have formed themselves into an action group. They have done a lot of research and information gathering in relation to the program. They contacted SAMHS and requested a list of all the support groups in the community to which the Minister may have been referring in relation to where they would be able to go to receive the services that they would have previously received through the Willows program. They were provided with a list (of which I have a copy) of 122 available support groups in the community. Of that number, 99 were metropolitan groups.

The group surveyed 78 of the agencies nominated by the South Australian Mental Health Service. In that survey, they asked what sort of services were provided for people with a personality disorder and what was the waiting time, and they gathered the results. The 78 agencies that they surveyed were taken at random because they had to do it themselves and it was a matter of doing it within the time frame during May and June this year. Of those agencies, 20 said that they had limited services. Their average non-urgent waiting list was from three to four months, or a bit shorter if the client was able to pay. Of the 78 agencies, 42 said that they had no services at all for people with a personality disorder, and six were not sure whether they had any services for such people. A number of those services referred these people on to agencies such as Crisis Care, Life Line, SAMHS, shelters, the

Central Mission, general practitioners and, would you believe, the Willows program.

Of the 122 agencies on this long list, 27 were either an answering machine, a disconnected number, an incorrect number, closing within a month, no answer, a fax number or closed agency. One of these was a dog's boarding kennel and the other was a barrister's chambers. I was horrified to hear of the dog's boarding kennel, so yesterday I tried the number and found that it was true. The interesting thing is that no community based agency out of the whole 78 provided genuine services for clients with a personality disorder. In the light of that information, I ask the Minister whether he will reverse his decision to close the Willows program.

The Hon. M.H. Armitage: The answer to the question is 'No'; however, I will not be as dogmatic as that.

Ms Stevens interjecting:

The Hon. M.H. Armitage: No, I believe that you didn't make a mistake. However, the simple facts for those who do not remember the Willows episode and the answer that I gave in the House are that we are not talking about people who need 24 hours a day, seven days a week care. We are talking about people who have care during the week—

Ms Stevens interjecting:

The Hon. M.H. Armitage: It is not about a suicide prevention program, with respect.

Ms Stevens interjecting:

The Hon. M.H. Armitage: With respect, on my advice it is not. We are talking about people who have a five day a week care program, and for the other two days of the week they are in the community. They are in the community every week. We are not talking about people who need 24 hour a day care, and that is the first and most important issue. The second issue is that the program is particularly expensive and treats six people on an in-patient basis.

Ms STEVENS: It's $200 000 a year.

The Hon. M.H. Armitage: The whole point is that it would be clearly more effective to put that money into the community and to allow people in the community to provide services to more than just six people. That is the advice that we were given by SAMHS. That is what SAMHS suggested. It is not a direction from us; it is what SAMHS suggested. The doctors and the professionals looking after these people said, 'We can do a much better job if we distribute this money more widely rather than concentrating on six people who do not need our care seven days a week anyway.'

With respect to the variety of agencies which provide the care, the whole exercise of the SAMHS devolution is not to put people into the community and leave them to the whim of the groups already there; the whole exercise is premised on putting the services which were provided in large mental institutions into the community. That is what devolution is all about.

Mr Brindal interjecting:

The Hon. M.H. Armitage: They may have started in here, but certainly it has been a policy worldwide. The principle is to put the services from the cloistered environment of the mental institution into the communities. Four regional teams will be looking after the people in the community, and those are the sorts of people we would expect to be looking after these people and not self-help groups. That is not the purpose for which they were designed. The fact is that 230 people are now in the community: social workers, nurses, psychiatric nurses, and so, and 70 of that number are additional within the past six months.

There has been a major move from the provision of care in the major mental institutions into the community. They are the people who will look after the six people who were formerly in the Willows Program, who, I repeat, were not in hospital seven days a week. They are quite capable of living in the community because they did it every week. We are distributing the services in the community and helping more people. I would be interested to receive a copy of the survey, and I intend to refer it to SAMHS which will look at the actual instances and, more importantly, subject it to intellectual rigour.

Ms STEVENS: Minister, what are your plans for SAMHS?

The Hon. M.H. Armitage: The realignment report that I released last year contains specific milestones to indicate progress in mental health reform. From a customer's perspective, the most important is the growth of local services, particularly those that are community based, as I have just instanced. I am pleased to say that the targeted growth in services has been achieved ahead of the timetable. More than $2 million has been spent in community services without a reduction to needed in-patient care. A ward has been opened at Noarlunga Health Services, and plans are well advanced for amalgamation of SAMHS in-patient care with the existing ward of the Queen Elizabeth campus of the North-Western Adelaide Health Service. The realignment report also identified quick strike projects which would hasten reforms. Under these projects the SAMHS information systems plan is being funded via Info 2000. This will mean a greater ability to monitor, and it will ensure appropriate services and their efficient provision.

In consultation with nursing staff and their industrial bodies, SAMHS is developing a plan for the harmonisation of general hospital nurses' terms and conditions of employment, which will be implemented in early 1995-96. A high dependency unit, loosely termed psychiatric intensive care, has been built at Glenside campus for the short-term management of people who are extremely disturbed. This service, together with close observation beds in local units, not only provides savings to further develop community oriented care but also consolidates high level care, thus allowing best practice. Another means of reducing the transition time for redeveloping mental health services is the bringing forward of available Commonwealth funds. The early use of the funds means that the transition time frame for reform can be reduced. A total of $8 million is available in 1995-96 for sustainable developments.

The transition phase, as I am sure everyone recognises, is difficult. Client expectations are high and, although relatively short, the necessary delays in building community services concerns clients. Another realignment milestone for 1995-96 is the devolution of the corporate office of SAMHS. Given that this is to happen, and the potential for disruption of reform which might occur as the close of SAMHS as an entity draws near (which was always part of the plan), it has been decided to further shorten the period of transition. This also will bring forward reforms which will improve mental health services to and in the community.

To assist with this the board of SAMHS at its meeting on 22 June 1995 agreed to dissolve. That decision will take effect in six to eight weeks. Broadly, the proposals provide for the dissolution of the SAMHS board and the assigning of responsibility for completion of the devolution process to the South Australian Health Commission. They provide plans to

more closely integrate mental health with other area health programs.

The proposals further provide processes to reform mental health care programs which have not been addressed in the strategy to date. These programs include aged and extended care. Further provisions are a replacement of the SAMHS corporate office with local and some central commission arrangements for policy, planning and purchasing of mental health care; the creation of a mental health institute to take up the research, education and training roles currently performed within SAMHS; and the setting up of an advisory panel with strong community representation to assist the Health Commission in the planning decisions to be made. Each of these proposals will produce efficiencies that will be directed to improve services. For SAMHS to be devolved, as has always been the plan, it is necessary to institute new administrative arrangements. The key change will be the temporary direct linking of SAMHS with the commission.

The common links created in the direct reporting will be necessary to achieve the next phase of the reform agenda. Under this arrangement the position of Director, Mental Health Realignment, will be created, and that person will be Mr George Belchev. He will report to Carol Gaston, the Executive Director of Metropolitan Health Services, and he will provide a single point of contact for the SAMHS Chief Executive Officer and management team with the Health Commission during that transition process. SAMHS management staff will become employees of the Health Commission, reporting directly to the Health Commission. SAMHS area services staff will also become employees of the Health Commission, but only until an auspicing agency is arranged. Staff will be consulted about their options in the transition to this arrangement.

Statewide services remaining at Glenside and Hillcrest campuses will be incorporated with a new board. Importantly, as mainstream benefits are felt by mentally ill clients through a continuation of national and State reforms, consumers and carers will have more choice and say. Services will reflect community perception and need and they will be increasingly responsive and measured against benchmarks of service level, quality and competitive price. Together, these plans and initiatives mean that a record level of resources will be applied to mental health in 1995-96 and that the level of reform will also be historic. I particularly thank the outgoing board of SAMHS for overseeing the essential first steps in the reform of mental health, and also SAMHS staff for their efforts and endurance. In particular, I commend staff and clients for their tolerance throughout the difficult period of change.

Finally, I expect to be here in 12 months to report great success in implementing the new paradigm—a system of care which gives reality to the notion of a normal life for people suffering from mental illness, their contribution to society and least restrictive care.

Ms STEVENS: As a supplementary question, can the Minister confirm whether the Royal Adelaide Hospital is being negotiated or chatted with about taking over the management of the intensive care unit at Glenside Hospital?

The Hon. M.H. Armitage: No-one here is aware of any of those discussions, but the intensive care to which I referred is a different type of intensive care. We will clarify it, because we are all interested in it.

Ms GREIG: I too want to address the area of mental health services. The Minister has highlighted many initiatives of the 1995-96 budget, but I would like to go on with that because there is increasing concern in the local community regarding the care of mental health patients and the integration of patients into the wider community. Can the Minister assure me that adequate funding has been provided to assist mental health patients assimilate into the community, that crisis care is available for mental health patients and/or their carers if needed, and finally that regional mental health centres are adequately staffed to meet the increasing demand for services in local areas?

The Hon. M.H. Armitage: I thank the member for Reynell for her very important question. I certainly understand the concern of people with a mental health illness and of the wider community regarding the impacts of the current reforms or, indeed, the reforms that have happened to date. There is no doubt that the reforms do move towards a better and more acceptable system. In regard to the honourable member's specific questions, suitable community care has been put in place as in-patient care has been established locally. In particular, 20 beds have been put into the Noarlunga Hospital, which of course is a great advantage to the people in the electorate of Reynell because they no longer have to travel to Glenside Hospital for their acute care. So that is a plus.

Whilst the increase in appropriate community care flowing from the devolution was to take place incrementally over a three or four year period, as I have indicated on other occasions and in particular tonight when, with the establishment of the Director of Mental Health's realignment in the Health Commission, we are focusing absolutely on achieving that devolution more quickly, the time frame for putting even more services and money into the community can be quite drastically reduced.

Crisis care is available via the emergency services at Glenside. Also, there are plans to provide local crisis teams and, in fact, at the moment crisis teams are operating throughout the metropolitan area during the day, and there are evening crisis services in the northern and eastern regions, but not 24-hour local cover. I believe that local crisis care arrangements are required to complete the area services, and they are being planned. Obviously, as the devolution process is quickened, there is more opportunity for that to occur.

The increase in community resources is significant, rising by about 500 per cent on the levels from when we took over on 11 December 1993. It is a very genuine attempt to provide those services locally, and it is not simply deinstitutionalisation without providing those community services.

I recognise that there are many horror stories. However, I do not believe that there is a basis for that huge number of horror stories; it seems that one horror story is often blown out of proportion because of fear and stigmatisation of persons with mental health problems in the community. Nevertheless, I recognise that it is extremely important to provide care in the community when one deinstitutionalises.

The level and adequacy of those services will be monitored and, if any shortfalls are identified as the devolution process is increased, there will be an opportunity to take action to fix that. The evidence regarding integration into mainstream society and the adaption of mental health patients is quite specific in that local, less restrictive and more responsive services improve outcomes for mental health patients. That means that they adapt and, hopefully, thrive under the new approach to care. That is not a budgetary guesstimate: that is the experience in all the international psychiatric journals and is well recognised as the most appropriate form of care.

I understand the local community being concerned about people with a mental illness. As I said before, I am not sure that that is not embellished because of the unfortunate stigma which those with a psychiatric illness suffer. Nevertheless, with improved education programs, which are beginning to help to reduce the stigma, and, more importantly, the actual provision of the services in the community—and I made an announcement tonight in relation to the quickened devolution of SAMHS—I am sure we will see those concerns addressed.

Mr WADE: I refer the Minister to page 265 of the Program Estimates where reference is made to the South Australian Centre for Public Health. Will the Minister advise the Committee on this initiative?

The Hon. M.H. Armitage: I will ask Dr Kerry Kirke to provide the information.

Dr Kirke: The South Australian Centre for Public Health was created in 1994 and made a successful bid under the Commonwealth Department of Human Services and Health as a public health, education and research program. This resulted in funding of $550 000 a year for five years from 1995. The Centre for Public Health has as its mission to foster excellence in public health, teaching practice and research in South Australia and is, in fact, a consortium of the University of Adelaide, Flinders University and the Health Commission. The centre offers awards at the two universities—the Master of Public Health at Adelaide University and the Master of Primary Health Care at Flinders. In addition, the Centre for Public Health has successfully bid for funding from the Commonwealth in two special program areas, namely, environmental health and mental health.

The environmental health program involves the highly successful annual national environmental health short course, which is attended by postgraduate students from all over Australia and increasingly from South-East Asia. The mental health program is still being developed but will build on existing resources and will address three main areas: adolescent, community and Aboriginal mental health. The environmental and mental health programs have each been funded to the tune of $100 000 a year for three years. The Health Commission contributes quite considerably to the Centre for Public Health in that it provides the funding support for the Chair of Public and Environmental Health at Adelaide University, and a number of the Health Commission staff are involved in lectures, student work placements and student supervision.

Ms GREIG: I refer to page 259 of the Program Estimates which, under the heading 'Broad objectives', refers to trends to foster research and innovation. It goes on to highlight the many initiatives and achievements of the Health Commission. I believe some of these innovative ideas are being promoted internationally, particularly in South-East Asia. Will the Minister advise of the achievements in the areas of health exporting and promotion?

The Hon. M.H. Armitage: I will ask the Chief Executive to provide that information.

Mr Blight: It is very much part of Government policy for all areas of the Public Service to make an appropriate contribution to the economic development of the State, and regrettably the South Australian health system has been a little slow in recognising that. However, that has changed dramatically over the past 12 months or so and there is now wide recognition that the very sizeable medical, scientific and professional resources we have in the health sector should be making an appropriate contribution to the economic development objective.

Over the past 12 months or so there have been a significant number of achievements in the health exporting area and they cover a wide range of activities. For example, we have seen the establishment of a health industry export-oriented network in South Australia that brings together the private sector including health consultants, architectural firms, equipment manufacturers and health industry suppliers, together with the Health Commission and the EDA. That is essentially a local intelligence gathering network, which captures ideas or opportunities as they arise around the world. It is fed into the network to be worked up.

South Australian health has also established a presence at the national level through its participation in the national health industry development forum. That initiative is funded jointly by the Commonwealth Departments of Human Services and Health, and Industry, Science and Technology. That is another intelligence forum that gives early warning opportunities that may be coming along and they can be fed into the South Australian health arena. The Health Commission has developed a number of strategic alliances with South Australian firms, primarily for the purpose of adding value to their activities in the export area but, when opportunities come along, to also provide a commercial vehicle outside the true Public Service.

Two examples would be the relationship we have with the South Australian firm Woodhead, Firth, Lee. As a result of that partnership, Woodhead, Firth, Lee has won a contract to design a provincial hospital in China. Another example of such a relationship would be the arrangement we have with another Adelaide company, Asia Australia, which specialises in the development of stand-alone day surgery centres.

In terms of actual contracts in which we have participated, at the hospital level there are many examples of contracts for actual products and the medical-veterinary subsidiary of the Institute of Medical and Veterinary Science would be a good example with the substantial sale of diagnostic kits overseas.

Back at the health system level, in the past 12 months we have been engaged to carry out short consultancies in Malaysia in a range of technical support areas. We have worked with the Flinders University School of Nursing and the Women's and Children's Hospital nursing department in the successful gaining of a contract to provide continuing education for Thai nurses in Adelaide.

We have worked with SAGRIC International on a number of aid-funded projects. Successful projects include the iodine deficiency project in Vietnam and the hospital improvement program in Papua New Guinea. They have been carried out with a very modest investment of resources. One full-time equivalent officer is providing the focus on that effort. I expect that, as time goes by and as some opportunities crystallise, the effort will be appropriately expanded.

Ms STEVENS: I refer to page 266 of the Program Estimates relating to disability services. On 30 April, hundreds of angry parents of intellectually disabled children launched the Project 141 campaign to highlight the shocking state of disability services in South Australia. I should like to record the facts that were presented to that meeting in relation to accommodation services and post-school options in South Australia.

In terms of accommodation, 6 069 people with intellectual disability are registered with the Intellectual Disability Services Council. More than 4 000 live at home with their families. More than 250 of them are over 50, which means that the parents who care for them are elderly. Also, 1 090 people require accommodation, 331 would take accommoda-

tion placements today if they were available, and 141 are in urgent need of accommodation. When those people talk about urgent, they talk about horrific situations with which they are coping in family circumstances.

In terms of post-school options, there are 2 500 people with intellectual disability who have no known daytime activity. There are 400 people with intellectual disability over the compulsory school age of 15, and they are still in school. Approximately 70 students over the age of 20 are still in school, and 1 300 students with a varying degree of a variety of disabilities will leave school over the next two years with few options.

I listened to previous answers in relation to changes in the disabilities sector. We have heard about administrative restructuring, working parties and protocols for referrals, new assessment procedures, individual planning and role clarification. Although I do not disagree that those matters are important, when I discuss them with people in the community, they ask, 'When are we going to see help for us in terms of our accommodation needs and post-school options? All that we see is continual reorganisation and restructuring, and lots of procedures, but, when it comes to the crunch, there is no money for services.'

There being a disturbance in the gallery:

The CHAIRMAN: Order! I ask members of the gallery to refrain from any gesture or comment.

Ms STEVENS: Project 141 estimates that it requires $12 million to start to make a dent in this situation. I would like to point out to the Minister that if $12 million were taken out of the efficiencies gained in the health sector (and he initially promised that they would be returned to the health sector) and put into those programs, we would see a significant change. Does the Minister accept that the figures for the unmet accommodation needs and post-school options for people with disabilities are correct? If he does, when are they going to see a change in the situation?

The Hon. M.H. Armitage: I am not going to accept the numbers as I do not know the exact position. However, I do not walk away from the scope of the problem, but it is a problem that we inherited. I forget the exact figure that the member for Elizabeth quoted, but she said that a number of the people involved were over 50 years old. That is not a problem that has arisen suddenly in the past 12 months. It is a problem which has been around for a long time. I do not walk away from it: I think that it is appalling. That is why we are trying to overcome it. However, it is not a problem of our making.

The problem has not been addressed by previous Governments and that is why we are now excited about the restructuring because it will put us at the forefront. It will allow us to make some sense of what has basically been a mess. I do not deny that for a moment. However, I deny responsibility for the problem. I do not for a moment walk away from the challenge involved in fixing it up.

With regard to disability, we have quarantined the budget from many of the savings expectations or returns to Treasury. Accordingly, that has been in some way an acknowledgment of the problem. We have also expected that the disability sector will make a 3.8 per cent efficiency dividend return, not to the Treasury, but to the system. I am informed that a 3.8 per cent dividend on $152 million is in the vicinity of $5 million. That is a large sum of money when we are considering the problems that the member for Elizabeth has identified. When the efficiency dividend is generated, that sum of money will be directly available for increased services because the budget is quarantined again this year so the money will be available for service provision.

The kind of changes to which I referred before, involving eligibility criteria, assessment protocols, benchmarking and so on, will allow all the savings, and all the money that is already being spent, to be targeted most appropriately. At the moment, because of the mess that we inherited in this area, it is simply impossible to determine with absolute certainty whether the most appropriate use of the funds is occurring.

We recognise that there are services which everyone believes are most appropriate, but we are not entirely sure about that. That is why we are considering the changes. As I have said, the changes are completely necessary because of the mess that we inherited. I stress that the 3.8 per cent efficiency dividend by the end of this financial year 1995-96 is not a budget cut. It will be reinvested in disability services to increase service provision levels.

There are many ways to achieve that dividend, one of which could be market-driven choices by clients. That would not necessarily be a matter for Government dictating where efficiencies will be made. But, through options coordinators, which instils competition, if you like, into the system, clients may well force market-driven reform among service providers. That is one of the prime reasons for going down the options coordination line—to set up, if you like, this sort of funder-purchaser-provider model, where the providers are competing. We may well glean a dividend from reducing duplication of effort.

As I go around and speak with parents of disabled children in particular, one of the most important things they get very cross with is the multiple assessments they have to undergo to access services. If we minimise the duplication of those administrative overheads by encouraging the sharing of resources and amalgamation of service provisions and, with the protocols and so on that we are developing, allow a ready reckoner of where clients ought to go, hopefully we will perhaps eliminate a large number of those multiple assessments. Therefore, we will eliminate duplication of effort, excess administration costs and, very importantly, a lot of anxiety for carers and people with disability.

The better information and case management through the options coordination system will ensure the most appropriate match of clients with the services. This also will lead to less duplication. As I have indicated before, the benchmarking of service types will allow for the first time reasonable costs to be established for specific service types. I do not acknowledge the actual numbers, because I do not know them. I certainly do not walk away from the scope of the problem, but that is exactly why we are going down this line. I emphasise that this is not a problem that this Government has made. It is a problem that the Government has inherited and with which it is dealing.

Ms STEVENS: I absolutely agree that it is not a problem of your making. However, before the election, you made a promise that the efficiencies gained within the health sector would be ploughed back into it. You have now, in your power, the ability to put $12 million into the health sector, because you have touted the efficiencies you have made, none of which you have returned to the sector. I believe that you stand condemned because you made that promise. You now have the opportunity to honour it in a very significant way in a sector which—in your own words—has huge needs. They are not of your making, but you have the responsibility and the means to deliver that, and you also made that promise. I do not believe that your answer is satisfactory. I believe that

you have a responsibility to honour that promise, particularly in this area of all areas.

The Hon. M.H. Armitage: If I was not a member of a Cabinet which is addressing the State Bank disaster and the financial problems that that has caused with the South Australian community, I would be able to do many things I would like to do. However, as I have indicated in a majority of answers today, the health sector is playing its part in redressing the economic situation in South Australia. It is also playing its part in being more efficient within those parameters with the strategy of quarantining the disability budget from any budgetary return to the Treasury in the first instance, and by insisting upon the same scope of dividend which the other sectors of the health portfolio are returning to Treasury being made within the disability sector; in other words, focusing on the types of administrative change that I have quoted in all sorts of answers already today, and by ensuring that that money is available for the increase in services. I believe that I am acting responsibly and appropriately, given the State's financial plight.

Ms STEVENS: My question relates to general hospitals (page 254). How much money was paid to the Women's and Children's Hospital and the IMVS for the costs associated with the HUS epidemic?

The Hon. M.H. Armitage: The sum of $450 000 was paid to the Women's and Children's Hospital and nothing has been paid to the IMVS.

Ms STEVENS: I understand that the full cost to the Women's and Children's Hospital of that epidemic was $620 000 and that the cost to the IMVS was between $25 000 and $50 000. Why has not the full amount been paid? Has the Minister's department received full payment from Treasury for the costs of the epidemic?

The Hon. M.H. Armitage: I am informed that those two answers collaborate. Full contribution has not been made from Treasury. Accordingly, that money and a supplementation from the Health Commission has been passed on to the Women's and Children's Hospital. In relation to the IMVS cost, the Public and Environmental Health Branch made a contribution of $25 000 to upgrade the PCR testing process, which was used during the epidemic.

Ms STEVENS: Is there still a shortfall?

The Hon. M.H. Armitage: Yes.

Ms STEVENS: What will happen about that?

The Hon. M.H. Armitage: I am prepared to discuss that with the Women's and Children's Hospital.

Ms STEVENS: What about the IMVS?

The Hon. M.H. Armitage: The honourable member's figures are roughly in the ball park and, as I indicated, we have already given $25 000 from the Public and Environmental Health Branch to help upgrade the PCR testing, which means polymerase chain reaction. As to the funding that has been provided to the Women's and Children's Hospital, there is an argument that that is the variable cost of its expenses in this epidemic and the shortfall is the fixed cost of the equipment and so on which they had, anyway. As I say, I am happy to discuss that further.

Ms GREIG: In regard to asthma, page 265 of the Program Estimates makes reference to asthma continuing to have a significant impact on younger people. Can the Minister advise the Committee of any initiatives being taken in an effort to redress that situation.

The Hon. M.H. Armitage: I will ask Carol Gaston to give the detail but, as background, asthma is a major public health problem with 8 per cent of males and 10.5 per cent of females in South Australia currently having asthma and each year there are around 50 to 60 deaths. Research over the last decade has led to great advances in the understanding and management of the treatment of asthma but, unfortunately, the prevalence of asthma and, amongst those who have it, the severity of it continue to increase. One in 12 asthma sufferers is admitted to hospital each year and only one-third of suffers have an actual management plan. That is a bit of backgrounding and I would like Carol Gaston to talk about the initiatives that the commission is adopting.

Ms Gaston: The commission has commenced a number of initiatives in recent years but I will refer specifically to just three. The first is the Asthma Control Education project, known locally as ACE. The ACE project is based in the northern suburbs—we seem to be looking after the northern suburbs! The project conducted an analysis of children and families asthma management, information and resource needs and the project developed a resource pack as well as worker training and development programs. It implemented and evaluated these family resource packs.

The project also produced resource manuals for various professional groups involved in the management of children's asthma, including early childhood workers, school staff and primary health care workers. Workshop formats were developed for a wide range of community and professional groups. Links were created between various sectors—this is one of the important aspects about these initiatives—and the cross-sectoral involvement included health, education and welfare through a regional steering committee. This intersectoral approach to children's health/education can be used as a basis of addressing other children's health issues, which we are in the process of doing in a number of other areas.

Another is the Asthma Plus SA report. This report was commissioned by Foundation SA and the South Australian Health Commission. It identifies major opportunities for improved health service coordination to facilitate better asthma management. It recommends three priorities for service reform: clinical protocols for each component of service, which were endorsed by all participants (families, perhaps teachers and health service providers); standardised patient information formats and communication systems, which can be supported and transferred across all relevant components of the care system; and an asthma health promotion and illness prevention approach, which addresses the skills and information needs of patients and carers and relevant physical, social and environmental issues. A number of these reforms have been picked up by the Metropolitan Health Services Division and are requirements in health service agreements with some of the appropriate health services, whether they be hospitals, women's health services or community health services.

The other initiative of significance is the best practice guidelines study. Adelaide Hospital clinicians, together with general practitioners, are working to: develop best practice guidelines for asthma management (as a direct result of the Asthma Plus SA report); develop comprehensive education programs for general practitioners—this may sound strange, but general practitioners often need assistance in some of the practical aspects of educating families and individuals regarding asthma management; assist general practitioners in teaching others, whether it be family members or even teachers; and examine current methods of assessing morbidity of asthma in South Australia for both adults and children.

This so-called counting of asthma morbidity is needed in order to provide a baseline so that we can examine the

effectiveness of the initiatives as we implement them. This project is continuing and has moved into a second stage which focuses on the ways in which general practitioners can be educated about the minimum standards of care for asthmatics. The final phase will look at community measures and morbidity to evaluate the effectiveness of general practitioner education programs on clinical practice.

Mr WADE: I refer to page 259 of the Program Estimates and the Health Commission's objective 'to provide effective and efficient high quality services'. I am mindful, as are all members of the Committee, that our hospitals are large, 24-hour institutions which use significant amounts of energy. Does the Health Commission have any initiatives to conserve energy and reduce costs in our hospitals, preferably in other areas as well as those in the northern suburbs?

The Hon. M.H. Armitage: I am delighted to inform the member for Elder that there is a particularly good system for doing this, and it is at the Gawler Hospital, which I visited the other day. I will ask Peter Davidge to talk about the matter in general.

Mr Davidge: The commission has been looking at the installation of cogeneration facilities in its public hospitals to bring about a net reduction in operating expenses as a result of the efficiencies associated with this type of plant. The efficiencies come about as a result of a gas-fired turbine generating electricity and at the same time utilising the heat produced in that process to meet the thermal needs of the hospital.

As part of this process we have been assisted by the Office of Energy Planning in analysing the benefits from introducing these types of facilities into our hospitals. Installation of cogeneration systems in the four major hospitals (the Royal Adelaide Hospital, Flinders Medical Centre, the Queen Elizabeth Hospital and the Women's and Children's Hospital) has been assessed, and the potential aggregate generating capacity is about 8.7 megawatts. The estimated capital cost of these facilities is about $14.1 million, and we would expect that, if all plants were installed and operating efficiently, they would generate energy savings amounting to, in aggregate, about $2.2 million per annum on a recurring basis.

A cogeneration system has been installed at the Women's and Children's Hospital and also at the Gawler Hospital, as mentioned by the Minister. Both are in operation and their performance is currently being evaluated. These projects have been financed through the commission's capital works program, but we are looking at alternative options for financing any future ventures, such as build, own, operate, etc. We have reached the stage at Flinders Medical Centre where tenders could be called shortly, and design work for the Royal Adelaide Hospital and the Queen Elizabeth Hospital will not commence until the metropolitan health service's strategic facilities review is completed.

Ms STEVENS: I refer to page 266 in the disabilities section. No-one in the Health Commission, the Disabilities Service Office or the Disability Advisory Committee has a role to overview community services for people in the community with a psychiatric disability. Will a unit be funded to do this? How can efficiencies be gained with no overview? How can the Disability Advisory Committee operate as an independent body advising the Minister when its secretariat is comprised of staff from the Disabilities Service Office? If the Disability Advisory Committee is to be seriously treated as an independent body, surely it must have an independent secretariat?

What action plans have been developed within each Ministry and individual departments to comply with the Federal Disability Discrimination Act? What proportion of funds have been set aside for consumer consultations to develop the action plans? What consultative process will be used to develop the action plans? What is the budget allocation for the above?

I turn now to mental health services on page 262. What will be the average of the optimum staffing levels if there is an acceleration of the community areas strategy? Will infrastructure be in place, particularly as a result of acceleration of the devolution process?

What will happen to the provision of services in community based teams, particularly as services in the field have received numerous reports of patients attempting suicide and being denied access to services by community based teams because they are not classed as being ill enough to receive treatment? Can the Minister indicate whether there will be functional levels of staffing for the community teams across the State this financial year, and are they meeting the demand of active clients in community care? Can the Minister confirm that they will be able to meet the increased demand for services? Can the Minister detail the efficiency gains for SAMHS over the past 12 months, and what cost savings does this involve? Will the debt repayment figure of $750 000 still apply? What will now happen to this following the disintegration of SAMHS?

What will happen to the Community Grants Advisory Committee under the new structure? What is the current figure for the capital expenditure plan, and what are the projected revenue projections for the sale of land held by SAMHS? How many crisis care teams are in Adelaide, and how are those in the country who require acute care receiving treatment? Is their new information system obtaining this sort of data? Does the Minister have any information on how many psychiatric patients were transported to treatment services by ambulance, and what did this cost SAMHS?

The Hon. M.H. Armitage: Mr Chairman, I have a point of order. I believe that this type of questioning has never happened before, and a similar opportunity was not given to me when I was the shadow Minister. It may be something that has grown up in other Estimates Committees. I point out that this is the last Estimates Committee, which means that, compared with the first Estimates Committee 10 days ago, we have 10 days fewer to provide answers. The questions will require an endless amount of work. Given that this is the final Estimates Committee, I believe it is only fair that we are afforded some accommodation in the rules. This is not something about which I was consulted.

The CHAIRMAN: The Minister's complaint is not really in order. The Estimates Committees are essentially for the Opposition to question Ministers. The Minister is a witness, and therefore his complaints may not be entirely relevant. I would ask the member to cease questioning now and to place the rest of her questions on notice, as I asked the Leader of the Opposition to do in respect of the Premier's lines. I invite the Minister to do what he said he would like to do, that is, express thanks to his Committee.

The Hon. M.H. Armitage: I do wish to thank everyone involved in the Committee on both sides of the Chamber and you, Mr Chairman, for your usual pleasant, inimitable style. I would also like to thank everyone from the commission who has been involved in the preparation of the information briefings. It is an enormous task to prepare this amount of work and, given that it has been done in an unusual time

frame and there have been a number of other events which have required a lot of extra work, the work that has been done is extremely valuable and well done. I congratulate the members of the commission, particularly the upper management levels, not only for the production of these sort of reports and briefings but for all the work they do in difficult times and in producing a health service which is leading Australia.

The CHAIRMAN: I wish to thank you, Minister, and the members of all the Committees for their generally good-humoured and friendly cooperation. I thank the advisers for their clear, concise and informative responses: they have been exemplary. It has been a pleasure to work with all of you. I also thank the hard working staff who are constantly by my side, the table clerks, and, above all of us, *Hansard,* who do such a wonderful job in the transcriptions. Thanks to everyone, it has been a very good Estimates Committee session. There being no further questions, I declare the examination completed. I lay before the Committee a draft copy of the report from Estimates Committees A.

Ms GREIG: I move:

That the draft report be the report of the Committee.

Motion carried.

At 10 p.m. the Committee concluded.