HOUSE OF ASSEMBLY

Thursday 27 June 1996

ESTIMATES COMMITTEE A

Chairman:
The Hon. H. Allison

Members:
Mr M.R. Buckby
Mr R.D. Clarke
Ms J. Greig
Ms A.K. Hurley
Mr J.K.G. Oswald
Ms L. Stevens

The Committee met at 11 a.m.

South Australian Health Commission, $734 634 000

Witness:

The Hon. M.H. Armitage, Minister for Health and Minister for Aboriginal Affairs.

Departmental Advisers:

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

Mr M. Forwood, General Manager.

Dr D. Filby, Executive Director, Policy and Planning.

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

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

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

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

Mr B. Dixon, Executive Director, Aboriginal Health.

Ms C. Johnson, Executive Director, Disability Services.

Mr I. Dunn, Regional Director, Southern Country Health Services.

Mr G. Beltchev, Director, Mental Health Realignment.

Mr J. Dadds, Director, Public and Environmental Health Services.

Mr S. Conboy, Acting Manager Finance, Corporate Finance.

Dr M. Jelly, Chief Medical Officer.

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

Mr L. Payne, Regional Director, Northern Country Health Services.

Miss J. Murray, Senior Project Officer, Policy and Planning Division.

The CHAIRMAN: Does the Minister have an opening statement?

The Hon. M.H. Armitage: Yes, Mr Chairman. First, I would thank my staff for all the work they have done in the past 12 months and, in particular, in the past couple of weeks, in preparation for Estimates. I particularly thank Miss Jean Murray for her work over the past couple of weeks.

In making my opening statement, I indicate that I wish to table the statement and read from it the highlights. I am pleased once again to present the budget estimates of the South Australian Health Commission for the forthcoming year. This year's health budget reflects a far more optimistic view of the future than the two previous budgets I have presented.

The health system will have achieved total savings of $61 million *per annum* by the end of this financial year. A further saving of $10 million *per annum* is required in 1996-97 to meet the Government's saving target for health as part of the overall three year debt reduction strategy. The Premier and Treasurer have already indicated substantial success in achieving the Government's debt reduction strategy. As a result, health and other human service agencies will be able to give increased priority to infrastructure and service development issues rather than the achievement of significant savings.

The hospital system in this State is recognised as one of the most efficient public health systems throughout the country. Grants Commission data confirms that substantial progress has been made in reducing average *per capita* spending on health in South Australia from 7.4 per cent above the national average in 1992-93 to at or below the national average in 1995-96, which is an excellent achievement. The budget for 1996-97 provides for:

- an increase of $58.9 million (8.7 per cent) to $734.6 million as the State's contribution from the Consolidated Account;
- a $52.4 million increase (3.7 per cent) in recurrent payments to $1.482 billion; and
- a capital works program of $105 million, which is $39.1 million higher than last year.

The 1996-97 program includes major expenditure on buildings and equipment of $124.1 million. The centrally funded capital works program of $105 million provides a $39.1 million increase over program levels last year. In addition, $19.1 million will be spent on minor capital works and equipment which is not centrally funded. The increase will provide impetus to the Metropolitan Adelaide Strategic Services Plan, in relation to which developments at Lyell McEwin Health Service and Repatriation General Hospital can commence, together with high priority interim upgrades at the Queen Elizabeth and Royal Adelaide Hospitals. Additionally, a number of privately provided facilities for public use are under way at Flinders Medical Centre, Day Surgery and Eye Clinic; Mount Gambier, a new acute hospital and community health centre; and Port Augusta, a new acute hospital.

In August 1994 Cabinet endorsed the Info 2000 strategy for the South Australian Health Commission. This project involved the replacement of the majority of existing health unit systems with new common systems over a five year period. An allocation of $16 million, in line with that recommended by the strategy, was made within the 1995-96 capital budget which, together with carry over from the previous year, provided $21.5 million. The current estimate of expenditure for 1995-96 is $7.7 million. In accordance with the plan, a further $16.5 million has been budgeted for 1996-97 which, with the $13.8 million carry over, will make available funds of $30.3 million this year.

As the momentum has built up on Info 2000 projects, in particular, Homer 2.7, OACIS and pathology, it is anticipated

that available funds will be fully expended this year. This represents a significant increase to this area of expenditure and provides the potential for the realisation of significant benefits and improved health care for the community. Current activity covers a broad range of systems within the public health sector. Implementation ranges from whole of Government desktop (Microsoft Office) to the leading edge clinical information system and repository (OACIS), which will result in the development of an electronic medical record. Priority has been given to the implementation of clinical systems.

The current realignment process in mental health is the culmination of four years of reorganisation begun under the previous Government and in line with the national mental health strategy to make mental health services more accessible and responsive by bringing them into the mainstream of general health services. Health service agreements are currently being signed to establish regional community-based mental health services under the auspices of general hospitals. The reorganisation has resulted in:

· a greater voice for consumers in influencing the development of mental health services;

· a substantial increase in community treatment and support, with 307 staff now located in 17 metropolitan centres, more metropolitan health staff in country centres and the development of a country in-patient unit at Glenside campus;

· resources to establish assessment and crisis intervention services, which will be available over 24 hours seven days a week;

· mobile assertive care services targeted at those who most need support;

· increased access to acute in-patient care in local general hospitals;

· increased availability of a wider range of accommodation and support options; and

· allocation of resources to encourage the involvement of non-government organisations in supporting consumers in their day-to-day activities.

This State now has one of the highest *per capita* allocations for mental health (approximately $64 *per capita*), and ratios of community staffing per population (28 per 100 000 in 1994-95). Community services continue to expand whilst maintaining high levels of acute and extended care in-patient services: 70 per cent of the budget is expended on hospital-based care and 30 per cent on community care. Achieving such massive change has been difficult for consumers, carers and staff. For those with mental illness and their carers there is always more that can be done. However, there is no doubt that for most people with a mental illness there are now more services available closer to where they live. This next year will see a consolidation of regional services and access to 24 hour emergency care. These are significant achievements in mental health services.

Shortly after gaining office in December 1993 the Government announced its intention to introduce a casemix payment system as part of an initiative to reduce the size of public hospital waiting lists. When casemix was introduced on 1 July 1994, March 1994 was chosen as the base line month for measuring the success of the system. During the period March 1994 to March 1996 the number of people on public waiting lists fell by 15.4 per cent. During the same period, the number of those waiting more than 12 months declined by one-third.

A reduction in the size of waiting lists was achieved in an environment where admissions from waiting lists increased by 5.1 per cent in the first year of casemix whilst demand for elective surgery grew by 3.1 per cent. Had demand for elective surgery remained constant at levels prior to the introduction of casemix, it is estimated that waiting list numbers as at the end of March this year would have declined by 30 per cent. Admissions from waiting lists consist of 15 per cent of total admissions. It is recognised that initiatives aimed at reducing waiting lists by funding increases in hospital activity are unlikely to achieve long-term positive results.

In 1995 the South Australian Health Commission Management of Metropolitan Elective Surgery Steering Committee was established. The committee comprises the professor or head of surgery from three major teaching hospitals (Professor Villas Marshall, Professor Guy Maddern and Mr Tony Williams) and Mr Jim Birch, Chief Executive Officer of the Women's and Children's Hospital. The committee advised that the focus should be moved from numbers on the waiting list as the measure of surgical performance to a system based on waiting times, throughput capacity and the process of prioritisation for surgical procedures.

This reporting system, incorporating incentives for hospitals to reduce waiting times for elective surgery, is a key objective of the committee in the development of the 1996-97 elective surgery strategy. The strategy will be similar to the 1995-96 strategy, which aimed to reduce waiting times, improve coordination of surgical services and promote sustainable changes in elective surgery.

During the 1995-96 financial year the South Australian Health Commission continued its implementation of initiatives which provide opportunities for private sector participation in the funding and delivery of facilities and services for public patients. Particular attention has been given to competitive tendering of hotel and other support services in the major metropolitan hospitals under arrangements that allow for both in-house and private sector bids on the basis of extremely detailed and comprehensive specifications of requirements from tendering parties. The commission has been impressed with the high quality of tenders from the private sector and in-house bidding teams. Extreme care has been taken to ensure that all bidding parties are treated fairly and with probity during the tender process and evaluation. The planning, design and management of request for tender processes and evaluation has been a credit to the administration and staff of participating hospitals and to the staff themselves, and the Government is extremely satisfied with the significant benefits achieved to date from these processes.

The second major area of private sector participation in the public hospital sector has been in the provision of private sector capital funding for the development of new and replacement facilities for public patient services. Two major developments in 1995-96 have been private sector funding for the replacement hospitals at Mount Gambier and Port Augusta. In both cases the private sector will finance, build and own new hospitals for public patients, with the public sector continuing to be responsible for the management and delivery of services through the new facilities. In the case of Port Augusta Hospital, it is fair to say that the new hospital facilities might never have been provided if the private sector funding option had not been available. The new facilities will be far more efficient than the current facilities, and the standard of patient amenity will be significantly enhanced.

Significantly, at Port Augusta the tender process invited proposals from the private sector for the management and

delivery of public patient services. However, it was clear from the comprehensive evaluation of proposals that the better option for Government was continued management and provision by the private sector. This point is worth noting, because it demonstrates clearly the balanced and responsible approach being taken by the Government to outsourcing and confirms the public commitment of the Government to support the best arrangement for the taxpayer, whether it be acceptance of the private sector offer or retention of responsibility within the public sector.

At Mount Gambier the provision of private sector funding for the new hospital will free up public sector capital funding which is required for other major developments for South Australian public hospitals. As such, it offers a valuable augmentation of our ability to finance current and future requirements for new and replacement facilities for public patient services.

Ms STEVENS: On a point of order, Mr Chairman: I thought the time allocated for opening addresses was 10 minutes each.

The CHAIRMAN: We suggested 10 minutes, but there has never been any hard and fast ruling in Committees. It is at the discretion of the Minister.

The Hon. M.H. Armitage: In addition, there is a significant capital benefit in the arrangements at Flinders Medical Centre, in which the successful private sector consortium, led by Ramsay Health Care, will be conducting new private facilities on the Flinders Medical Centre campus. These will incorporate urgently required facilities for public patients in the areas of day surgery, patient hotel accommodation and cardiac catheterisation, at an estimated capital saving to the public sector of approximately $12.5 million. These three projects establish emphatically the benefit to the South Australian public hospital system of cooperative arrangements between the public and private sectors in the provision of facilities for public patients.

The third area of significance with regard to joint public-private sector cooperation is the continuing program of collocation of private hospitals on public hospital campuses. At Flinders Medical Centre, after lengthy and detailed negotiation, the Flinders Medical Centre board and Ramsay Health Care have concluded negotiations for a 100 bed collocated private hospital facility, which will be physically linked with the Flinders Medical Centre public hospital. As part of the new development, Ramsay will build and equip a day surgery complex capable of between 8 000 and 10 000 day cases per annum; and Flinders Medical Centre will contract the delivery of public day procedures from this facility. Ramsay Health Care will provide the physical and support infrastructure, and Flinders Medical Centre doctors will carry out the procedures on public patients. A new facility will also provide a cardiac catheterisation laboratory, with public patient services being purchased from Ramsay. Ramsay Health Care will also lease currently under-utilised space within Flinders Medical Centre and redevelop and manage this as a 30 bed step down nursing unit for public patients.

As everyone is aware, the Health Commission has commenced the Queen Elizabeth Hospital development project, which has the major objectives of the provision of a 60 bed private hospital, private sector financing for new infrastructure for public patients, and the development of mutually beneficial cross-service contracts between the public and private sectors on the QEH campus. As part of the QEH development project process, bidding parties will be able to submit proposals for the management and provision of public patient services. The Government will determine which proposals, if any, meet its requirements with regard to quality, teaching, research and financial benefit.

The Government has agreed to a public sector bid being mounted by an in-house team as well as inviting private sector proposals. This project is currently at the stage of evaluating the expressions of interest. The Government is expected to receive advice from the North Western Adelaide Health Service Board regarding continuation of the project and the short list of preferred tenderers, should the Government decide to proceed to the request for proposals.

Accepting the implied criticism, shall we say, of the Opposition, the important matters in relation to casemix funding, regionalisation, disability services, and public and environmental health services, I will leave in the statement as I have tabled. I want to thank all staff in the health sector, whether clinically or non-clinically based, for their dedicated work and efforts on behalf of the consumers of public health care.

Restoring the ravages of the last decade of the Labor Government has meant that some difficult decisions have been forced upon South Australia. Without the efforts of those staff, the health sector would not be recognised as the most efficient in Australia, nor would what is being done be of international interest to health care administrators and providers and, above all, South Australians would not be able to be secure in the knowledge that their health system is world class. I commend the budget to the Committee and look forward to responding to questions.

The CHAIRMAN: The Minister did ask if he could table his opening statement. There is no provision for tabling but the Chamber messenger will circulate the statement to members of the Committee. I invite the lead speaker for the Opposition, the member for Elizabeth, to make a statement or, alternatively, open the questioning.

Ms STEVENS: Thank you, Mr Chairman; I will be considerably shorter in my remarks. I must say it feels a little like David and Goliath here, with the 20 bureaucrats and members of the Government present. However, we all know the outcome of that particular contest. On 13 February the Minister told Parliament:

> One can draw one simple conclusion. Our public hospitals will benefit enormously and we simply cannot afford the Federal Labor Party's health policy.

The question now is whether we can afford the Liberal Government's health policy. The deal brokered by the Premier for Commonwealth funding for South Australia has been described as the worst in living memory, and it has the potential to be felt in health more than in any other area of Government activity.

Over the last two budgets the Brown Government dramatically cut spending on health in cash terms and in real terms, while at the same time accepting increased funding from the Commonwealth. In 1993-94, the appropriation from the consolidated account was $676 million. In 1994-95 it was cut to $643 million, and in 1995-96 it was cut again to $630 million—a decrease in cash terms of $46 million, and a decrease in real terms, after a conservative estimate of inflation, of $79 million. Nurses were cut, wards were closed, and Queen Elizabeth Hospital said that it would have to reduce patient admissions by 5 000. At the same time Commonwealth funding increased by $62 million, from $511 million to $573 million, excluding funding for the transfer of the Repatriation General Hospital to the State

Government. The Commonwealth put its money in: the Brown Government pulled its money out.

Following the Premier's Conference, the Commonwealth will now cut $1.519 billion from general purpose grants to the States over three years. On top of this will be cuts of up to 3 per cent for special purpose grants, including health but not education. The States will pay about an extra $100 million a year in sales tax on motor vehicles. The Premier says that these decisions will cost South Australia $83 million this year. In a deal to save the general purpose grants, the Premier explained to the Parliament how he brokered a deal that all the $83 million could be cut from special purpose payments—all the $83 million—that is an option.

South Australia must be told how these cuts to special purpose payments will affect our health services. Last year South Australia received $633 million from the Commonwealth in special purpose payments for health; a cut of 3 per cent would knock a massive $19 million hole in the budget. On top of that, the Minister actually budgeted this year for an increase of $15 million in Commonwealth specific purpose payments, from $633 million to $648 million. At the very least, this could mean a reduction to the State budget of $15 million if the Commonwealth contribution remains static. I believe that, at best, this would be wishful thinking.

If a Commonwealth cut is made, depending on the extent of that cut and whether the Commonwealth makes its calculations based on last year's actuals or the inflated figure in this year's State budget, the reduction to the State budget will be much more. When this budget was framed, did the Minister really believe that a Federal Liberal Government would hand out more money?

Then there is South Australia's share of the $619 million cut this year to general purpose grants, estimated to be $50 million. On the basis that health expenditure from the consolidated account represents about 10 per cent of total outlays, this would be an additional cut of $5 million. So, we are looking at another round of multimillion dollar cuts to our already savaged health system. That is the true situation that we face. Cuts of this magnitude must mean more privatisation, more bed closures, fewer nurses, longer waiting times and abandoned capital works projects unless the Brown Government is prepared to reinstate funding it has cut from health services over the past two years. The Premier has said that the State will not fund programs cut by the Commonwealth. I challenge the Minister for Health to say whether he accepts that decision.

The task of analysing this budget has been made more difficult again this year because of the paucity of information available to the Opposition and to Health Commission units yet to be advised of their funding. Information requested on 14 June on community-based services and the breakdown of country services arrived on Tuesday evening; and the disability services information arrived yesterday afternoon while I was involved with the Estimates for Family and Community Services. This has made the task of effective scrutiny very difficult, but I must say that it has also helped us empathise with those health units which tell us time and again that they are never sure of what their budgets are and they never really expect to hear until three or four months into the financial year. So, I guess it is good for us to be able to also experience the frustration of that.

The Opposition has a full range of questions to put to the Minister, which we will do. The key question to be answered today is this: how will services that have already been cut by State reductions over the past two years be maintained in the face of Commonwealth reductions?

The Hon. M.H. Armitage: There are a number of issues in that opening address that I am clearly obliged to correct. The first is that the previous Commonwealth Government had a 2 per cent Medicare review—a review carried out by State and Commonwealth officials—and the accumulated cost to South Australia of the consequent transfer of demand from the private sector to public hospitals since 1989 was estimated to be $128.7 million; and in the same period the accumulated increase in Commonwealth funding to South Australian public hospitals was $43 million, which leaves a shortfall of $85.6 million. So, the member for Elizabeth is crying poor and is on the wrong track when she talks about what a wonderful boon the previous Commonwealth Government was to this State. In particular, I emphasise that the previous Commonwealth Government blustered about microeconomic reform but left it up to the States to do it, and I think the States are proud that they have done that.

The member for Elizabeth also brought up the now hoary old chestnut of the paucity of information. The same comment was made last year, and it is no more than I would have expected if the boot were on the other foot, because the information is simply not available. As the honourable member would realise, the information with which she has been provided is a draft on the basis that we cannot set any budgets until we know the results for the 1995-96 financial year. So, we have provided the information that we can: the implication that we held it up is simply untrue. Indeed, if the member for Elizabeth was reasonable she would accept that we went to great lengths to deliver the information personally to her home as soon as we were able to do so, which was about half an hour after I received it.

The allegation that units in the system do not receive their budget for three or four months, and what an unbelievably terrible situation this is and what a lousy Minister I am, again flies in the face of the simple fact that the budgets are released to units in exactly the same time frame as they were released under the Labor Government, because the information is not available until the end of the financial year. So, there has been no change there whatsoever. Again, that is just bluster.

Ms Stevens interjecting:

The Hon. M.H. Armitage: Once again, the member for Elizabeth does not want to listen to the facts. The fact is that they are released in the same time frame as they were released under the previous Government. I refer to the allegation that, if there were to be any Commonwealth cuts, that would mean that there would have to be more privatisation and so on—as if this is a dastardly thing, as I think we may hear later. In fact, I think the people of South Australia would be pleased if that were to occur. The key point is that, in her opening statement, the member for Elizabeth asked what areas will be cut and what will be done if a cut is made. The simple fact is that I am unable to answer the question, as she knows, because it is hypothetical. I simply do not know how much is to be cut or in what areas. Just as we have dealt with the ravages of 13 years of a State Labor Government, when the budget figures are available we will deal with whatever we are forced to.

Ms STEVENS: My question relates to Program Estimates, pages 249 and 253. In the first two Brown budgets, recurrent allocation from the Consolidated Account fell by $46 million from $676 million to $630 million, and fell by $79.7 million in real terms adjusted for inflation.

Commonwealth grants increased from $511 million to $573 million over the same two years. This year, recurrent expenditure from the Consolidated Account has increased by $17.7 million including $7.5 million from the pokies. After inflation, this is an increase of just $1.3 million in real terms, before any cuts by the Commonwealth. What is the Minister's estimate of the total effect of Commonwealth funding cuts to health? We calculate the hole in the State budget to be at least $39 million. What is the Minister's best figure?

The Hon. M.H. Armitage: It is a totally hypothetical question. I am unable to give an answer and I will not bother to speculate because it would be used as an opportunity to scaremonger in the community. The information is unavailable.

Members interjecting:

The CHAIRMAN: As it was hypothetical, I will not count the question.

Ms STEVENS: The Premier announced that the budget would provide for 3 000 more admissions. I refer to page 255 of the Estimates, which show that admissions will increase by only 265. By 'admissions', did the Premier mean to refer to day-only patients, which were estimated to increase by 2 801?

The Hon. M.H. Armitage: The Opposition has not taken account of the fact that the system has created enormous efficiencies and increases in productivity creatively within the parameters that the Government gave it. I remind the member for Elizabeth that there has been a documented 4 per cent increase in activity in the system. We are budgeting for an increase in productivity, and it is across all types of admissions.

Ms STEVENS: Given that in 1995 the head of the Premier's Department coordinated meetings to introduce new policies to ration health service, did the Premier decide to reverse this policy in favour of more admissions because of the Government's poor showing in public opinion polls on health services?

The Hon. M.H. Armitage: No.

Mr BUCKBY: My question relates to waiting times. On page 255 of the Program Estimates, one of the goals is to provide effective and efficient high quality services. Can the Minister explain how it is proposed to pursue that goal with particular reference to surgery waiting times?

The Hon. M.H. Armitage: I acknowledge the work that the honourable member has done as my parliamentary secretary and thank him for that. He has asked a particularly important question about a most exciting initiative that the Government launched this morning with the chief surgeons at our major hospitals. It is a $6 million plan that will see waiting times for people facing surgery slashed further. The $6 million will be provided to the Royal Adelaide Hospital, the Queen Elizabeth Hospital, the Women's and Children's Hospital and the Flinders Medical Centre to provide a boost for a new strategy that has been endorsed and developed by surgeons.

The strategy includes the purchase of new equipment and new ways of looking at surgical services from the moment a patient requires an operation until they are fully recuperated. It will lead to patients spending less time waiting for surgery and in hospital, which is a true measure of a highly efficient surgical system. It is the goal of the Government and of surgical departments to ensure that patients requiring elective surgery are operated on as quickly as possible, and the additional $6 million announced today will be spent on equipment to improve productivity, the installation of computer technology for theatre management systems to improve scheduling, and a number of other proposals to be developed by the heads of surgery at the hospitals that I mentioned.

At the announcement of this new strategy and funding, it is fair to say that the surgeons and the staff were very excited by the fact that the shackles will be released. They believe that that is what has allowed them to be so much more productive in the past couple of years. Since the Government came to office, there has been a drop of almost 35 per cent in patients waiting for more than 12 months and, until March this year from the index month, the number of people on public hospital waiting lists fell by 15 per cent.

A variety of strategies has brought down those waiting times, including an expansion in the range of procedures that can be offered, which is an important capturing of modern technology, and the introduction of hospital-in-the-home services, where a nurse is provided to go to a person's home after their operation. When we announced the strategy today, one of the surgeons identified that it is good for the budget, that it is good for opening up the roadblock, so to speak, and that it is also good for the patient because they are clinically proven to recuperate better, they rehabilitate better into their previous lifestyle and, very importantly, they are not exposed to infections which, in hospital, tend to be of the more severe type.

Other mechanisms for bringing down waiting times are better education for patients, introduction of clinical pathways for surgery and new techniques such as laparoscopic surgery which require minimal invasion. The expert committee that we put together indicated that it was frustrated that efficiency is measured by the numbers on waiting lists. The committee's point is that, if someone is on a waiting list, what is important to that person is how quickly they get the operation, not whether there are another 5 000 people or 6 000 people or, as when we came to office, 9 500 people on the list. What is important is the individual patient, and their measure of the efficiency of the surgery service is how quickly they get the operation. We have been particularly adroit in bringing those waiting times down, and it is the view of all the surgeons that the new approach—which continues the Government's focus on the most efficient use of taxpayers' money—will continue that decrease in waiting times and hence be a real boon for South Australian people requiring surgery in public hospitals.

Mr BUCKBY: Regarding public hospital patient satisfaction survey results, the Program Estimates refers to maintaining quality of care while achieving efficient provision of service. Has any work been done to gauge the quality of care at Modbury Public Hospital?

The Hon. M.H. Armitage: Again I thank the member for Light for his important question and I draw the attention of the member for Elizabeth to a patient satisfaction survey which was conducted in September-October 1995 and which was coordinated by the Association for Quality in Health Care in which some public and private hospitals in South Australia participated. Modbury Public Hospital was one of the five metropolitan hospitals involved in the study which gave it the opportunity to benchmark patient satisfaction. In the survey 21 questions were asked, covering topics such as cancellation of surgery, the amount of time in hospital, staffing standards, hospital quality and outcomes of hospital care.

Regarding the 21 questions asked of those people attending the hospitals, Modbury Public Hospital rated above

average on two-thirds of the questions and at least 5 per cent above average on one-third of the questions. In particular, Modbury Public Hospital rated highly on the willingness of staff to meet needs, the team work of the hospital staff and the ability of the staff to make a person comfortable. The most crucial of all the statistics, particularly given the claim of the member for Elizabeth in her opening statement that hypothetically, if there were to be cuts by the Federal Government, this would mean more privatisation, is that 97.9 per cent of people indicated that they would recommend Modbury Public Hospital to family and friends if they needed hospital care. This is an ideal opportunity to indicate that the satisfaction levels at Modbury Public Hospital are an absolute credit to everyone involved in the project.

Mr BUCKBY: Does the Government plan to withdraw teaching hospital status from the Queen Elizabeth Hospital?

The Hon. M.H. Armitage: It is an important question because of the rumours that are being fuelled for all the wrong reasons at the Queen Elizabeth Hospital. Although the report of the South Australian Commission of Audit of April 1994 recommended that the Government consider whether it was necessary to retain and redevelop the Queen Elizabeth Hospital as a major teaching hospital, all the Government's actions over the past two years have been designed to assure that the Queen Elizabeth Hospital would retain that status. After the Audit Commission Report, significant discussion was held with the then board of the QEH and two decisions were taken. First, a North Western Adelaide Health Service would be created with a single management and board structure encompassing the management of both the QEH and Lyell McEwin Hospitals. The grouping of the two hospitals was aimed to underpin the status of the QEH as a teaching referral hospital; to transfer clinical services and expertise from the QEH to the Lyell McEwin campus; and to gain efficiencies in management and administrative services. That amalgamation took place in 1995. Secondly, it was agreed that the proposed redevelopment of the QEH campus should proceed and that private sector involvement in this comprehensive redevelopment would be sought.

I am sure every member present would be aware that the expression of interest stage seeking private and public sector proposals for the redevelopment and future management of the QEH is, at present, in train. The Government will analyse options for driving the process further when it receives recommendations from the EOI stage.

I ask everyone to note that the project documentation for the expression of interest process clearly states that the Queen Elizabeth Hospital will retain its status as a teaching referral hospital and be redeveloped in a manner befitting that status. The Government recognises that such a redevelopment must occur in the medium term and that the QEH campus cannot be allowed to become dysfunctional as a teaching referral hospital in the interim.

To that end, significant capital investment is occurring on the site for facilities that will not form part of the overall redevelopment and for interim upgrades of facilities that simply could not be allowed to remain in their current condition over the next three to five years. Examples include, the $5.57 million new psychiatric facility on campus, a new cardiac catheter laboratory to be constructed this year with a project budget of approximately $1.55 million, interim upgrades of critical care and allied health areas so that accreditation standards can be maintained, and efficiencies in management have been achieved. There will also be approximately $1.5 million spent in the 1996-97 financial year on interim upgrade of some clinical wards. These Health Commission funded capital works are in addition to upgrade work to be carried out by the North Western Adelaide Health Service from its own internal budget resources. I am informed that work funded from this source will include parts of the radiology department, an interim upgrade of the ophthalmology clinic and ENT administration area, and accommodation for the proposed Chair of Nursing.

The QEH has also been given additional funding above its baseline work load to meet growing community need. In 1995-96 this has included additional elective surgery funding of $1.265 million of which $450 000 was spent on specialist equipment. This funding also enabled another 830 surgical cases to be performed. The hospital received a target efficiency grant in 1995-96 of $1.475 million for a range of efficiency measures, including 579 additional cases. In addition to the above, over $550 000 was provided for medical equipment upgrade or replacement in 1995-96.

As I am sure the member for Light and other members of the Committee will acknowledge, the facts I have cited clearly demonstrate our very strong commitment to the future of the Queen Elizabeth Hospital and reinforce its role as a teaching referral hospital closely linked with the University of Adelaide and the University of South Australia.

Ms STEVENS: The documents show a blow-out in the central office budget of $6.688 million over last year's estimate and an increase this year of over $2 million on last year's estimate. Can the Minister provide an explanation for the blow-out and give details of the expenditure?

Mr Davidge: The Program Estimates indicate that the recurrent budget for the central office of the Health Commission in 1996-97 is $26.2 million. That compares with our estimated outcome for 1995-96 of $29.8 million which, in fact, is a decrease of $3.7 million on what is expected in this current year. The majority of that decrease is associated with a factor in the current financial year 1995-96. There was a carry forward amount of $3.1 million from 1994-95, and we expect that money to be spent in this current financial year and not to recur in 1996-97. That is the first component of the explanation.

The initial budget set for Central Office, as shown in the financial papers, was just over $20 million: there is a difference between that figure and the 1996-97 estimate of $5.2 million. That difference is explained by the fact that, as a result of some internal changes in the Department of Treasury, which has made different arrangements associated with the recording of its borrowings and interest payments on those borrowings through the budget (it has brought them on line), there is a component now in the Central Office budget that amounts to $2.8 million associated with interest on borrowings that the Central Office manages on behalf of health units in the system. They are borrowings with the State Finance Authority. So, that is $2.8 million of the $5.2 million.

There is also additional ambulatory care funding of just under $2 million that was received from the Commonwealth, and at the time the initial budget was struck that component of funding had not been incorporated into the budget. In fact, that money is normally allocated to health units during the year. Other minor amounts are new initiatives that have been implemented during the year. There is an additional $250 000 for the Health Industry and Export Development Unit; the Health Plus Unit has another $250 000; and the final item was some extraordinary costs that the Health Commission incurred in relation to the Garibaldi claim.

Ms STEVENS: I want to raise with you the amounts that I have in front of me on the documents that you had delivered to me yesterday afternoon. This is where I got the figures from, so I will interested in your explanation. It is under the heading 'Part 9, Support services', and 'Executive professional support and administrative, Central Office'. That shows the 1995-96 estimate of $19.223 million, the actual payment of $25.911 million, and then the estimate for 1996-97 of $21.51 million. That is what I was referring to. Will you clarify that? It is under Central Office on page 8 of your letter.

Mr Davidge: The figures that I was explaining were the bottom line figures of $20.9 million, $29.8 million and $26.2 million.

Ms STEVENS: Will you explain the figures that I used, as that is what I asked in my original question?

Mr Davidge: The carry-over amount that I mentioned of $3.1 million still largely applies to the difference between the $25.9 million and the $21.5 million. A large component of the difference between the $19.2 million and the $25.9 million is the ambulatory care funding money that I mentioned of just under $2 million. Then I mentioned a number of other items with regard to the Health Industry and Export Development Unit, the Health Plus Unit and legal costs. Also, the figure for the outcome in 1995-96, the $25.9 million, also includes the carry-over, which was not expected at the time the 1995-96 initial budget was calculated. So, the two main components of that difference—the $19.2 million and the $25.9 million—are the carry-over item, which I mentioned is a one-off item expected to be spent in total in 1995-96; and the ambulatory care funding of just under $2 million, as well as those other minor amounts.

Ms STEVENS: The Minister will recall an incident at the Lyell McEwin Hospital in April when a baby was abducted from a ward and a frantic search lasting some hours ensued before the child was located. According to reports in the *Advertiser* of 9 April, the Minister called for a review into security in all public hospitals as a result of the abduction. What were the results and the resource implications of this review?

The Hon. M.H. Armitage: I am unclear of the exact resource implications; we will take that on notice and send it to the honourable member. I received the outcome of the review a month or so ago and, frankly, I did not believe that it was substantial enough to give the degree of confidence that I felt people required, and I actually have some more work being done on it. As was quite evident not only from my comment but from public comment at the time, the difficulty is moving in a late twentieth century society and the impositions that some things that would imply 100 per cent security on the other end might impose on society. So, I am having more work done on the report itself. We will obtain the financial details for the honourable member later.

The review has been done and our security is more than comparable with that of other States, so I am relaxed about that. But in view of the incident, I believed that there were more things we could work out. That is what I have asked for and that is being done at the moment.

Ms STEVENS: When you said that the degree of confidence was not there, was that in relation to the results?

The Hon. M.H. Armitage: No. Following the publicity about the incident, I believed that it was appropriate—and that is why we had the review—in some way to extend security measures that are comparable with those in the rest of Australia. That is what I am looking at, to ensure that the public is reassured that those measures are the appropriate balance between a twentieth century society and something that is quite dramatically draconian. I should state clearly that a number of people indicated to me that, if as a result of any review of security we intended to go back to a system whereby there was a single visiting hour between 7 and 8 p.m. (as I recall it was a number of years ago), that would be unacceptable. So, a balance is being sought.

Ms STEVENS: I refer to the same page (253). Will the Minister confirm that the Star Force was recently called to the Women's and Children's Hospital to deal with a security scare at the hospital involving a distraught father, and will the Minister also confirm that since the Lyell McEwin incident a new security system has been installed at the Health Commission head office?

The Hon. M.H. Armitage: In relation to the Star Force incident, I have no idea; it has not been brought to the attention of anyone here. I will get the details. I know from my personal experience at the Women's and Children's Hospital, where I spent four years, that there are some very emotional cases at that hospital. I do not recall the Star Force ever being called out, but I do recall the police being called to a number of incidents. It may be nothing more dramatic than that, but I will get some detail. It has not been brought to our attention as a matter for concern. In relation to the security system in the commission, within the past week I have been issued with a different tag with the same access and so on as before, and that is basically the same system as we have had.

Ms STEVENS: What was the cost of that?

The Hon. M.H. Armitage: It was about $100 000. I should emphasise that there were a number of occupational health and safety reasons for doing that.

Mr OSWALD: I would like to pursue the issue of Health Plus. According to page 263 of the Program Estimates, the Health Commission has completed consultation on statewide goals and targets for the health of all South Australians. I also note that the commission intends to establish the infrastructure to manage the Health Plus coordinated care program. Given those developments, how will the delivery of health services to chronically ill patients be addressed to improve these outcomes?

The Hon. M.H. Armitage: I thank the member for Morphett particularly for his question, because I believe this goes to the nub of health care for the next couple of decades not only in South Australia but also around the world. Initiatives such as Health Plus are creative ways of dealing with issues about which people have normally just thrown their hands up in the air, said it is an insatiable demand and asked how we will deal with it in a creative way. It is this program and others—but this one in particular—to which I referred in my opening statement as being measures which we are adopting here and which are of interest to people elsewhere in the world. I will ask Mr Ray Blight to provide further information.

Mr Blight: The South Australian Health Plus initiative is an extremely important project, as the Minister has just said. It is an idea that we have been working on within the health system for approximately four years. I pay very high tribute to Professor Peter McDonald, who was one of the first to recognise the importance of this approach. In the next few weeks we expect to receive approximately $3 million in development funding from the Commonwealth Government under the COAG (Council of Australian Governments) trials in coordinated care for that project. That is further evidence

of the significance of this work. Health Plus aims to trial integrated care systems for people with severe expressions or crisis complications of complex or chronic long-term illnesses. It is a new management support system targeted at the sickest people in our community.

The system will incorporate individual consumer care planning and scheduling. The essence of Health Plus is that each of these chronic condition sufferers will have a personalised care plan which is tailored to their particular condition or conditions and which will help them understand their disease and perceive very fully what role they can play in managing the condition and improving their health. It will also provide them with information on who is the best provider to take care of their needs at any time.

There are some other very important aspects of this trial. For example, it is based on the pooling of both Commonwealth and State funds to deliver the system of care. One of the major deficiencies that we have in the Australian health care system is the separation of the funding and management of general practitioner (that is, Medicare) services from the funding and management of the hospital services. So, we have a major fragmentation in the Australian health care system which mitigates against effective integrated and coordinated care. Under this project, we have a commitment from the Commonwealth that it will pool or 'cash out' the Medicare pharmaceutical benefits scheme and perhaps other program funds for these people. Those funds will be combined with the State resources so that we can have single and integrated purchasing of holistic care for those consumers.

Another important aspect of Health Plus is that it assumes a network of service providers. There is no assumption that just one provider is the best at all times to meet the changing needs of the consumer. So, with this network of providers we could imagine that, for a diabetic sufferer for example, the network of providers would include a general practitioner but also a local pharmacy or hospital pharmacy for advice on drug therapies, perhaps a diabetic educator from a local community health service and perhaps some home nursing.

What we expect to get out of the Health Plus program is first and foremost to improve the health and well-being of our consumers—and I stress again that we are targeting those most in need, that is, those with chronic and/or long-term illnesses. The Health Plus system is about providing more responsive services. One of the principles of Health Plus is that, by being supported in monitoring their own condition, the consumers will be able to spot sooner a complication arising or escalating. Then, through the network of service providers, they will be in touch with the most appropriate care provider in the shortest possible time, so we expect that under this system we will get better clinical decisions in shorter time frames.

We have approximately a further 12 months of development work to do on this project. Then we would expect, in approximately 12 months, to commence the enrolment of between 3 000 and 5 000 participants into this system of care for the purpose of approving the concept and demonstrating that we are getting better health at the individual level at a reduced cost. A key element of that enrolment is that it will be completely voluntary. It will be up to the project to convince consumers that this system of care does offer a better outcome for them, and they will come in of their own free choice. Consumers who do not want to do that can, of course, stay in the existing Medicare system.

In developing the proposals for trialling in approximately 12 months, the Health Plus unit of the commission has worked in very close consultation with the divisions of general practice, not only in the metropolitan area but also in one of our country regions, the Lower Eyre Peninsula. It is proposed that we will have four demonstration projects, three in the metropolitan area—the north-east, west and south—and the country project on Eyre Peninsula. Across those four projects we will be testing the response of consumers who are suffering from conditions such as asthma, diabetes and one category of mental illness—most probably anxiety conditions.

We are still somewhat subject to Commonwealth decision making processes and we are awaiting their approval for the $3 million worth of funding, but we would expect within the next 12 months to begin enrolling clients into this system of care and to have proof of concept demonstrated approximately 18 months after that time. This is very much a world class project. The interest, both nationally and internationally, has been intense, but we view this as a community-based effective response to the most needy in our community, and it is therefore considered to be a very important strategic project.

Mr OSWALD: There is growing interest in telemedicine, both in Australia and around the world. On page 263 of the Program Estimates, there is mention of further development of telemedicine in pursuing opportunities to provide health services and information on a commercial basis to remote locations via a telelink. Does South Australia have significant skills, expertise or experience in this area, and does the South Australian Health Commission plan to promote its use; if so, what steps will it take?

I am mindful of a recent trip I made with the Minister to the West Coast, where we visited hospitals from Port Lincoln going up through the interior. What stuck in my mind was the interest in telemedicine by the one and two person practices. It appealed to me at the time: there is a huge field in South Australia for telemedicine and one in which local medical practitioners in rural practices seem to want to embrace as soon as they can.

The Hon. M.H. Armitage: It is a most exciting area for the provision of health care where we are in a city-state with large distances between small towns outside a major city. The interest has certainly increased due to the rapid technological advances in computing and telecommunications and so on which are, if you like, opening up the areas that were previously regarded as isolated by their distance to a number of spheres that were previously not in contention.

The South Australian Health Commission has pioneered telemedicine applications in a number of areas. It has been successfully used in the medical supervision of renal dialysis patients in satellite dialysis centres both in the city, where it is a number of thousands of dollars cheaper than providing them in major hospitals, and also at Port Augusta. Glenside Hospital is using telemedicine to provide specialist psychiatric services to rural communities. That includes Mount Gambier, Whyalla and Berri, and extensions are planned.

Just as an example of how creative people can be once telecommunications networks are put in place, I visited the Riverland shortly after telepsychiatry had been put in and asked how it was going. I was told it was being used an awful lot and had been used particularly in the past month for interpreting services for an itinerant grape picker who had an unusual language and no-one up there in the health system

spoke it. It has been used in many other situations as well. That is an example of how these things can be used.

A number of other things we are looking at in the telemedicine field include a combined proposal being developed between South Australia, Western Australia and the Northern Territory with support from other groups, such as the Australian Defence Forces, to establish a comprehensive emergency network over the western two-thirds of Australia, covering Aboriginal communities, mining sites, defence facilities, aircraft, ships at sea, oil rigs and all those isolated things out there. Queen Elizabeth Hospital is developing a relationship with the Northern Territory southern region in what is known as the Tanami network, providing services and support especially for renal illness, diabetes and mental health.

The Women's and Children's Hospital is holding discussions for child and adolescent mental health support in the Northern Territory. The Royal Adelaide Hospital is installing equipment for its link with the Royal Darwin Hospital, and cancer services are involved in the telelink. The health services and hospitals of southern Adelaide are developing a network as well to assist medical education and their training project with Darwin Hospital and Darwin University. They are just some of the footprints we have out there.

There was a telemedicine research conference in South Australia in about December last year to explore some of these opportunities. Some of these have actually come from that conference. I think it is acknowledged that South Australia has stolen a march in this area on some other States, perhaps all other States, and our use of telemedicine was recognised in, of all places, the United States Senate (either the Senate or the Lower House). We are recognised as the third best users of telemedicine in the world. Some of our equipment is not as sophisticated as in other areas but it is utilised appropriately, whereas other people have put in incredibly sophisticated materials but it is not utilised. It is a brave new world which is being utilised to provide better services to more isolated people with enormous export potential.

Mr OSWALD: Page 263 of the Program Estimates refers to the prospect of establishing a health on-line unit to develop multimedia health education programs. Can the Minister say whether the Health Commission has been active in finding ways to use South Australia's strong multimedia capacity to assist doctors in rural areas, as well as medical students, in gaining information which will assist them with their practice?

The Hon. M.H. Armitage: That is a particularly important question again in relation to export initiatives. Perhaps before answering that question, I have been given some information about a question raised by the member for Elizabeth earlier. As a result of an action by a child protection unit at the Women's and Children's Hospital, a man was heard to issue a verbal threat indicating he was going to get a gun and shoot someone. Star Force was called and the man was confronted at the nearby Cathedral Hotel, and without resistance was taken in charge by the police. This incident occurred about two weeks ago. As I indicated, it seems that it was a disturbing incident at the time but of no enormous consequence, and thank goodness it was so easily solved.

In relation to the honourable member's question, the Health Commission has established a Health On-line Unit, under the directorship of Flinders Medical Centre's Professor Malcolm McKinnon, to develop a range of tele-education applications to support the education of medical students and the continuing education of rural doctors. Information packages aimed at consumers will also be developed. This will allow people to better understand their own illness and to play an effective role in their own care.

It is quite clear to me that, with the explosion of the Internet, many people are now connected to information of dubious quality, in particular through the bulletin boards, and I believe that there is a real danger of people getting the wrong idea about what is appropriate for their health care. As part of our thrust into tele-education, some units will be directed at consumers to provide them with correct medical education rather than what someone in Sweden thought about their condition three weeks ago.

Nevertheless, medical knowledge will be presented through these packages as integrated concepts with animated graphics, audio and downplay textual presentation on screen. Each module will be presented at defined levels of learning so that the medical student, or whoever, can progress at a pace at which they are comfortable. Every aspect of the program will provide facilitated learning and interactive material so that there is no static, unsupported picture or diagram. I assure those who do not know that the old style of medical education was incredibly static.

The interactivity is designed to facilitate the learning process. It is not just a matter of clicking a mouse to move to the next module: you have to answer questions. I have seen one module in relation to bile-salt metabolism where one needs to do a number of things in order to move on. It is an excellent mechanism. It is an interesting development not only for medical students and consumers but also as an export initiative because some of these things around the world are done in a lousy way and we think we can do better.

Ms STEVENS: The Minister's media sheet boasts that the capital works program of $105 million is $39 million more than last year. While that is true at face value, it does not tell the whole story. First, the 199-96 capital budget for health was actually $8 million less than the previous Government's 1993-94 budget, which was $78 million. Secondly, this year's budget includes projects with expenditure worth $11.6 million being slipped from last year and announced as new works for the second time. Even the gold book for March acknowledges the slippages that the Minister has announced as new money. At page 2 of the March edition it states:

> Capital program: $13.4 million favourable. . . the capital works program is favourable mainly from the slippage within the Metro Facilities Program $6.3 million, information technology $4.6 million and medical equipment $2.4 million.

Does the Minister consider a slippage in the capital program of $13.4 million to be a favourable outcome; does he agree that this represents under performance by the South Australian Health Commission; what steps is he taking to ensure the proper programming of capital works and that Government funds are not locked up in projects that are not being delivered?

Additional Departmental Adviser:

Mr T. Tomlinson, Manager, Health Facilities, South Australian Health Commission.

The Hon. M.H. Armitage: In relation to the figures which the member for Elizabeth quoted, the simple fact is that we intend to spend $39 million more on capital works this year than last year. Another simple fact is that slippage occurs; it always has; and it certainly occurred when the

previous Government was in office. To imply that this is something terrible is incorrect.

Ms Stevens interjecting:

The Hon. M.H. Armitage: It is factual; it is what happens in capital works projects. Many of the slippage factors are completely external from anything over which the Health Commission has immediate control. I ask Mr Trevor Tomlinson to detail some of the reasons for slippage.

Mr Tomlinson: In developing the capital program and planning of forward works, we must balance two components of the budget in the capital area—capital receipts with capital payments—to ensure that the Health Commission and the Government are not embarrassed by over-expenditure of funds that have not been achieved. Last year's proposed capital program had a significant amount of money for receipts from the disposal of properties as part of the areas project of the Mental Health Program (Hillcrest) and the Queen Victoria Hospital. We received receipts from the Queen Victoria Hospital this financial year and that was settled.

Our total receipts from property disposal at Glenside, Hampstead Centre and Hillcrest formed the major part of our budget last year. We were $13.6 million behind in our capital receipts. There was a compensating slow-down in the capital program to ensure that our expenditure did not increase beyond the funds available to the commission in 1996-97; we expect to receive those receipts from Hillcrest and Glenside in 1996-97.

On the payments side, new projects are always difficult to get started, particularly in the changing environment of the need to undertake an extensive master plan, planning and capital and asset sustainment plans. The days of putting a new wing on the QEH (which happened in the 1980s) and leaving the rest of the hospital in decay cannot be sustained if we intend to provide competent health services. A considerable amount of time is put into the establishment of projects and putting to the parliamentary Public Works Committee—and other committees—firm positive proposals based on master planning that encompasses the immediate five year and 20 year needs of a health unit to sustain the services and for changing the method of delivery of those services.

The Hon. M.H. Armitage: I refer to the honourable member's use of the word 'favourable' and point out that that is an accounting term which means that there is money which has not been spent, as opposed to 'unfavourable', which means that you are over budget. It is not a value judgment; it is a term to indicate that there is money to spend.

Ms STEVENS: I heard the information that was provided by the Minister's officer, but I do not think I received an answer as to whether this was a favourable outcome in terms of the health system. Also, the Minister did not respond to my other questions: does the Minister agree that this represents under performance by the Health Commission; and, what steps are being taken to ensure that there is proper programming? I would like an answer to those questions.

The Hon. M.H. Armitage: With respect, I would ask the honourable member to look at the information provided by Mr Tomlinson and review it, because that is in fact proper programming. As Mr Tomlinson was at pains to say, it is prudent management not to spend the money before you have it. If the member for Elizabeth likes, I am happy to refer back to when I was the shadow Minister and detail the number of times that there was slippage in other budgets. It is what happens.

Ms STEVENS: Is it right?

The Hon. M.H. Armitage: It is as right as when the honourable member's Government did it.

Ms STEVENS: We are the benchmark, I see.

The Hon. M.H. Armitage: You are a benchmark but not the benchmark. It has just been brought to my attention that, whilst there is the acknowledged under expenditure on the metropolitan facilities project, there has been, negotiated and agreed, over $60 million of private capital for public infrastructure at the Flinders Medical Centre, Port Augusta and Mount Gambier. There is a progressive move towards managing the capital works as a pool with flexible management in the light of complementary private sector funding for public infrastructure, and I think that that is again a prudent way of managing the capital works budget.

Ms STEVENS: I should like to continue in relation to slippage. Why have the following works been announced as new works for the second year in succession, and will the Minister make a further announcement explaining the delays: Daw Park, an amount in the 1996-97 budget of $6 million, original start date February 1996, new start date November 1996; the Marion Community Health Centre, $880 000 in the budget, original start date January 1996, new start date July 1996; the Modbury upgrade, $1.4 million in the budget, original date September 1995, new date August 1996; the Northern Community Health Centre, $2.968 million in the budget, original start date February 1996, new start date August 1996; and the psychiatric ward at the Queen Elizabeth Hospital, $3.174 million, original start date February 1996, new start date August 1996?

The Hon. M.H. Armitage: We have had discussions with the individual officers involved with the specific projects. Mr Tomlinson will talk about Daw Park and the Marion Community Health Centre.

Mr Tomlinson: With respect to the Daw Park hospital, the Commonwealth has provided $13 million and we have just received the second instalment, but the needs of the Daw Park hospital are far greater than that. In fact, we have completed a master plan which has identified capital expenditure in excess of $20 million. The board has now accepted the master plan and we are currently appointing consultants to accelerate the delivery of this project, which will cost more than the Commonwealth funding initially provided.

The Marion project has been part of the program for 10 years. The commission and community health agencies in the south seek consolidated accommodation in the developing precinct of the Marion triangle—an area that is constrained by development capital and recurrent costs for leasing. We will continue to seek an outcome for the Marion project to enable us to provide all community health services at the one location.

The Hon. M.H. Armitage: Michael Forwood, the General Manager of the South Australian Health Commission, will respond in respect of the Modbury upgrade.

Mr Forwood: In relation to the funds allocated for upgrading parts of the Modbury public hospital under Healthscope management, there have been discussions between the Health Commission and Healthscope, and Healthscope has asked that the proposed works be deferred until it is ready to proceed with the Torrens Valley Private Hospital development, because it makes best sense to do them together.

The Hon. M.H. Armitage: Carol Gaston, the Executive Director of Metropolitan Health Services, will deal with the other two questions.

Ms Gaston: With respect to the proposed new psychiatric facility at the Queen Elizabeth Hospital site of the North Western Adelaide Health Service, it is recognised by all that this is part of the mental health realignment program, which is one of the most significant reforms in our health system in recent years. As a consequence, it is very important that we get an agreement between all parties, that is, the North Western Adelaide Health Service, the Health Commission and mental health services, on aspects of the service that ensure that it fits with the realignment plan.

This is not just about beds but about service models, staffing levels, association with universities, teaching facilities, and so on. It is quite a complex process. However, that is now complete and approval has been received to proceed with that development. We hope that it will not be long before we see that unit functioning in the western suburbs. With respect to the northern suburbs, we probably need some more detail on that because there is a very large package of small capital works programs that are going on in the north to support the changes to community health services. I would need some particular details.

Ms STEVENS: I will provide that information.

Ms Gaston: Thank you.

Ms STEVENS: I thank the Minister's officers for their information. I refer to the Capital Works Program, page 255. The issue is certainly about the individual delays but it is also about the dishonesty in announcing projects one year and then re-announcing them the next year as new works. Will the Minister guarantee the quarantining of capital works funding in the face of cuts to Commonwealth specific purpose payments imposed by the Federal Liberal Government and agreed to by the Premier so that these capital works programs will not slip again?

The Hon. M.H. Armitage: In answering the question, I reiterate that we have no idea what challenge we might be faced with. As the challenges have been faced in the past 2½ years, so will any challenge that might arise be faced. It is a hypothetical challenge. I ask the member for Elizabeth to recognise that, in a previous answer, I indicated that we are being very creative in the use of private sector capital and that we are looking at a flexible use of public and private sector pools so any decision that we might have to take in relation to any supposed outcome after the Federal budget would obviously be taken in that context.

Ms GREIG: My question relates to the mental health issue, in which I have a particular interest, and the changes that have already taken place and those that are proposed, as referred to on page 258 of the Program Estimates. What has been the impact on people needing mental health services?

The Hon. M.H. Armitage: As the member for Reynell acknowledges, there have been a number of changes in the mental health system, and what is important is how those changes impact on consumers. Given the work of the national mental health strategy, and so on, it is important that we look particularly at what is occurring in the community. Just 2½ years ago in metropolitan Adelaide, there were two community teams, an accommodation service and a limited outreach service from Glenside and Hillcrest Hospitals. There are now 16 community-based teams and soon there will be 21 teams.

Our two large psychiatric hospitals have been reduced to one, with inpatient services transferred to local general hospitals, and I emphasise that they are local general hospitals, because one of the major complaints about the system a number of years ago was that acute psychiatric admissions were often a long way from people's homes. Inpatient services to create those transfers to local general hospitals have been established at the Lyell McEwin Hospital with 20 beds, there is an additional 20-bed unit at Noarlunga Hospital, and a new 40-bed unit will be established at the Queen Elizabeth Hospital.

Ms STEVENS: When it is built.

The Hon. M.H. Armitage: Exactly, that is what I have said. In 1992, there were 139 staff in the community and there are now 307 staff. In 1991-92 approximately $11.5 million was spent on community services, whereas the total is now $24.2 million. I remind the Committee of the Estimates Committee in 1994 when we acknowledged through the KPMG study that there was an $11 million hole, if you like, in the community psychiatric budget which we had been expected to take over. All the above changes, which have been positive for consumers, mean there has been a large increase in the number of both community and hospital services provided locally, hence they are much more accessible to consumers.

In the very near future there will be 24 hour a day emergency services available in the east, south and north-west metropolitan regions. In addition, each region will have a mobile assertive care service which will focus on the consumers who are most vulnerable and most at risk. It is the view that this will assist those consumers to avoid hospitalisation. It will also assist them to integrate into the community and to be maintained successfully in the community. The short compact answer to the question asked by the member for Reynell is that today SAMHS provides more services to clients than ever before.

Ms GREIG: Will the Minister explain the way in which the planned emergency service will operate in regions? I note that some overlap in funding has occurred to maintain emergency services during the transition period.

Mr Beltchev: In the process of the reform of mental health, which began in detail and earnest approximately five years ago, in all consultations with consumers and staff the high priority issue—which has always been presented to the mental health professionals—has been the need for an emergency service which was able to provide a 24 hour a day service and to provide the service where the particular crisis was in evidence. The emergency service which has been provided by the South Australian Mental Health Service has operated almost exclusively from a base at the Glenside Hospital. This is known as the casualty department to which people who are experiencing a critical episode are taken either by ambulance, the police, friends or the family.

Discussions and consultations with all the stakeholders about the establishment of an alternative way to provide this service, which have been going on in some detail for three years, have now been completed. A very detailed set of procedures and structures have been defined and are about to be implemented to establish within the three metropolitan regions a 24 hour mobile emergency service and a 24 hour emergency triage service, which will be based in conjunction with the telepsychiatry unit, to service country areas and support local mental health teams. The emergency service, when operational, will be unique within Australia in that there will be one telephone number to be used by all needing the service. Through that one number the system will be able to recognise from where the call is made and automatically divert a call to the triage within each region. That triage will then be able to make an assessment and activate whatever is required for the appropriate intervention.

The emergency services will operate over a 24 hour period seven days a week. In line with the extensive analysis of the usage of emergency and casualty services to date, it has been determined that the emergency service will operate on an active basis with a fully staffed team from 8.30 in the morning to 11.30 in the evening and, after that time, an active triage system, which will be supported by professional staff on call, will be in operation.

The links between the emergency service—particularly after hours—and emergency and casualty departments in general hospitals will be very close, so that people who need to present will be able to go to their local hospital and receive the immediate triage, and the specialist mental health emergency service will attend when required. In cases of very clear and immediate danger to self, or others, people requiring an emergency intervention in that situation will go directly to the closed emergency acute unit which will continue to operate at the Glenside campus. The role of the emergency service is to provide a highly accessible public acute psychiatric assessment and treatment service in the most appropriate and least restrictive environment.

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

Mr Beltchev: Before the adjournment I began to explain what the role of the emergency service would be in a realigned mental health system. Its primary role is to provide a highly accessible public acute psychiatric assessment and treatment service in the most appropriate and least restrictive environment. It will refer clients to the most appropriate available mental health program within the relevant region and in statewide services. It will provide a comprehensive acute psychiatric service in a setting which is familiar to the client and which maximises the use of the supports that are available in that client's usual environment in the community. It will work collaboratively with clients and their families or carers in the assessment and treatment of the psychiatric crisis. It will liaise with mental health workers and other service agencies, in particular, with police.

These services will enable people with a mental illness to remain in the community during times of psychiatric crisis in a supported and controlled way. It will ensure that public adult acute psychiatric in-patient services are targeted at those people whose needs require placement in an in-patient unit and, finally, it will be responsible for the good management of clients in their own geographic region.

Ms GREIG: Considerable attention has been given to mental health services, but this has focused on adult services. I note from page 258 of the Program Estimates that significant achievements for the South Australian Health Commission include the reorganisation of child and adolescent interagency responses and the recruitment of staff to country child and adolescent services. Are there developments in services for children and young people?

The Hon. M.H. Armitage: In South Australia we have mental health services to children and young people, with innovations that are recognised at both the national and the international level. Significant changes are in train, and over the next two years we will consolidate that reputation. The OECD (Mental Health Programs in Schools, World Health Organisation, Division of Mental Health, Geneva 1994) has recognised that South Australia's work in the area of interagency responses to school children with social and behavioural problems is equalled by only Sweden and some Canadian Provinces. Other States have modelled their child and adolescent mental health services on our model. Northern CAMHS received the Hospitals and Health Services Community Outreach Award for country services, and both CAMHS, southern and northern, were accredited by CHASP (Community Health Accreditation Standards Program), which was a national first for CAMHS.

The first national child and adolescent mental health conference was held in Adelaide, initiated by CAMHS, in late 1994. That created a lot of goodwill and some momentum, which led to the Commonwealth Department of Health and Community Services funding a $1 million national policy development process for goals and targets in the area of child and adolescent mental health. The second of those national conferences is to be held in Melbourne in November this year. There were a number of new funding initiatives for 1995-96 under schedule F of Medicare, which included: Country Child Mental Health Services (Northern), $308 000; Country Child Mental Health Services (Southern), $332 000; and early detection and intervention, southern area, $58 500.

New funding initiatives provided by the commission for 1995-96 included:

- Evaluation of mental health outcomes, $105 000;
- Murraylands youth and mental health, $43 000;
- Murraylands parents phone network, $14 000;
- suicide prevention (mid-north), $6 000;
- independent schools early detection, southern area, $6 000; and
- anxiety disorders, $3 750.

A number of country services, early detection and other developments are to be funded through schedule F funds. New developments specifically include: the establishment of a behavioural intervention service, which is a major commitment in collaboration with FACS and DECS, $365 000; $600 000 is being put into developing and redeveloping facilities and services for secure care and first psychosis and related services; and $400 000 for startup funds associated with the strategic purchasing of mental health services for young people.

Following the realignment of adult mental health services, Helen Mayo House has transferred to the auspices of the Women's and Children's Hospital. That deals with postpartum psychosis and will be a statewide nucleus for improving infant and maternal health care. Southern CAMHS has a Commonwealth grant under the 'Here for life' program of $650 000 over the next two years to conduct a national education project for GPs in youth suicide prevention, a particularly important subject and one in which we in South Australia do considerably better than in other States, although any figures, of course, are a tragedy. Northern CAMHS has led a successful consortium securing $600 000 from Foundation SA. Southern CAMHS, in association with Suicide Prevention Australia, secured a one year grant of $80 000 from the Apex Music Muster at Gympie to conduct a fully evaluated three State education program, again on youth suicide prevention.

There are a number of other such initiatives, so it is fair to say that there are many developments in services for children and young people, and they are world recognised.

Ms STEVENS: I would like to preface my question by reading the editorial from the *Border Watch* of Tuesday 25 June 1996. Headed 'It's about time, Dr Armitage', it states:

Health Minister Dr Michael Armitage's agreement to come to Mount Gambier to discuss regional health issues is long overdue. Dr Armitage has indicated his willingness to attend a public meeting at the invitation of Mount Gambier City Council. Council has been

pressing the Minister for weeks to come to publicly discuss the drawn out obstetrics dispute which clouds the future of expectant mothers giving birth in the South-East. In fact, Dr Armitage says he won't discuss that matter but will address other regional health matters. Well, any public meeting should be able to produce some tough times for the Minister, given the number of health related crises which have confronted Mount Gambier in the recent past.

In fact, we can go back eight years—naturally to the days of the previous Government—when all hell broke loose at the hospital over nurses' resignations and the first evidence of low morale emerged. Today the story is no different, except that nurses are being pushed by a cutthroat Government mentality designed to give Mount Gambier a new hospital of no more than 80 beds, with decreased staffing to match. Nurses' morale has not improved, yet the Minister, the Health Commission and hospital senior management have shown little public remorse about an unfair and unreasonable situation.

Maybe the Minister will have some answers to the questions he will no doubt face from the nursing quarters. Other issues he will also confront should include:

· Budget cuts and ward closures at the existing Mount Gambier Hospital—causing major morale problems for staff—have not been addressed by the Minister in anything other than under money saving budgetary conditions. But the compression of the hospital from 140 beds to 80, while expecting it to provide a regional service, is unbelievably narrow-minded thinking in the context of the South-East as a projected future growth region. People's health needs have come second in every instance in the putting together of a 'doll's house size model' instead of a hospital with the capacity to serve massive regional requirements. Perhaps the Minister will have some answers to the questions he will no doubt face from a general community concerned about the destruction of an important health facility, linked to an almost carefree attitude towards their health needs, both now and in the future.

· The inability to attract specialist doctors to country areas, quite apart from the level of general practitioners, which often has people waiting up to three weeks for a doctor's appointment. Perhaps the answer to the specialist doctors would have been to ensure the new hospital was a big, bustling regional centre demanding the attendance of such medical experts because of the work level offered. Perhaps the Minister will answer questions about why specialists should work in a 'doll's house' and bother to set up practice in an area which this State Government has clearly earmarked as 'going nowhere'.

· Privatisation and regionalisation of the new Mount Gambier Hospital. The State Government keeps baulking at suggestions it has plans to privatise the entire State hospital health system—and as soon as possible, given the problems emanating at Modbury. Considering there will be no aged care beds in the new hospital and talk grows of 'some area set aside for private beds', perhaps the Minister will directly answer queries about whether total privatisation is the path being followed. Denying plans for privatisation now and then allowing it to proceed later will not be acceptable.

· Aged care accommodation—the crisis within the overall Mount Gambier Hospital and general health care crises. Frail aged people are being shunted all over the South-East and Victoria's western district as facilities in this city dwindle to nothing—and waiting lists grow for the accommodation necessary to enable these people to enjoy their twilight years in comfort and with dignity. Admittedly, the problem is largely in the Federal arena, especially with money—but the State Government has a role to play also. It doesn't have to slash the aged care beds of new hospitals to meet its own pathetic budgetary restrictions—why shouldn't the Mount Gambier Hospital be allowed just as many aged care beds as it has been providing for many years now? Because a Government wanted to cut the cost and presumably wash its hands of the problem, able then to direct its scorn at the Federal Government as the one abdicating responsibility. Perhaps the Minister will answer some general public questions on this matter and bring some joy to our elderly, many of whom are looking to the future with a great deal of despair and must wonder what they have done to cause Governments to ignore their plight. Yes, Mr Minister, your visit is welcome—because you have plenty of questions to answer to a community angry about the way it is being treated and fearing, in many instances, what the future holds in the most vital of personal concerns—health and health care.

Have the South-East doctors accepted the Government's plan to resolve the obstetrics issue by increased obstetrics fees and more resources at the Mount Gambier Hospital? What are the details of the offer, and did the Minister consult the member for Gordon before he informed the community that he would not answer any questions on the obstetrics issue when he attended the public meeting?

The Hon. M.H. Armitage: That was four questions. I must clarify one thing: I want to be absolutely clear about these figures. I have to say that this is the dilemma of being a Minister in any portfolio, where one is subject to the vagaries of the media. The editorial states that 'nurses have been pushed by a cutthroat Government mentality designed to give Mount Gambier a new hospital of no more than 80 beds, with decreased staffing to match'. The simple fact is that the facility is designed as a new 100 bed facility—not 80—commenced, as you would realise only too well, Mr Chairman, in January 1996 and expected to be completed in May 1997. It will provide 100 public beds, three operating theatres (including day surgery) and community health facilities, together with facilities for pathology, radiology, dental surgery and a day care centre.

If we turn to budget matters, and that may be potentially where the editorial is going awry, we believe that the present budgetary allocation, at its present level of activity, is about 80 beds. As you would know only too well, Mr Chairman, we have given a guarantee for next year that the hospital will be funded at its activity level for this year. If the activity level is about 80 beds—and I am not sure about that; that may be the case—the simple fact is that, if the beds are not being utilised—and that is the case in today's technology, as I indicated in my very first answer with the use of technology in day surgery cases and so on—there is absolutely no reason for staffing them. The simple fact is that it is a 100 bed facility plus day surgery.

If we look at the actual budget for Mount Gambier, we see that it is framed using exactly the same criteria as every other hospital in the rural areas, and that is one of the benefits of casemix funding. Like is compared with like, as opposed to historical funding which may have had some vagaries. It is therefore reasonable that any Government expending taxpayers' money can expect that all hospitals that are equally funded will produce the same outcomes. To that end I am surprised—and I was surprised a number of months ago when it indicated as much—that the Mount Gambier Hospital is in specific difficulties. I believe that a number of people in other hospitals faced with the same funding rationale would have been surprised as well, because it was not as if we made any specific cuts or whatever to Mount Gambier that were not being coped with elsewhere around the State.

It is also factual to say that we committed extra funding to the Mount Gambier Hospital, recognising its particular short-term difficulties. Mr Chairman, you would know only too well the promises made to this hospital at every election during the reign of the most recent Labor Government—promises that never came to fruition, even though the hospital was in grave need of being fixed, redesigned and rebuilt because, with its present structure, it is an inefficient hospital. That is being done, and we believe the modern building design will result in greater productivity increases.

In relation to aged care, it is perhaps reasonable that the Editor of the *Borderwatch* does not know—but I am surprised that the member for Elizabeth does not know—that aged care is the responsibility of the Federal Government, not the State Government. However, despite that, one of my first approvals as Minister was $300 000 from the South Australian Health Commission's 1994-95 capital works program to construct

18 additional nursing home beds at Boandik Lodge in Mount Gambier. We recognised that there was a need, even though it was the Federal Government's responsibility and not ours. So, as I say, that is a nuance which I would not expect the Editor of the *Borderwatch* necessarily to know, but not so the members of this Committee.

In relation to the obstetrics matter, doctors in 90 per cent of South Australia have agreed that our obstetrics indemnity offer is fair, reasonable and appropriate. According to the representations we have received from the delegates of the AMA and the Rural Doctors Association after a conference, they are accepting that offer. That leaves the South-East, which has resisted this offer which their colleagues have accepted and which has been acknowledged by the AMA and the Rural Doctors Association as being appropriate.

The Government and the commission are using this as a potential opportunity to redraw the rural health care map, if you like, by offering to provide the hospital with a senior obstetrics registrar. This would be the first footstep in terms of post graduate training moving from the metropolitan area into the country, which has been a policy commitment of the Government since before the election, and of a number of the royal colleges. The reason for this is that it has been clearly identified that, if you can get doctors into the country in the first place, they will often decide it is a nice place to practise and will return their.

We believe that this is a real opportunity to kill two birds with one stone—to have our first foray into increasing the number of rural specialists and, at the same time, increasing the profile for continuing medical education, obstetrics standards and so on in the South-East. We believe that that is a particularly positive outcome. At this stage, as I have said on many occasions, obstetrics services in the South-East are guaranteed. I do not wish to prejudice discussions, but at this stage I am prepared to acknowledge that a number of towns have identified that they will continue to provide obstetrics services through their local GP obstetricians; and discussions are continuing with the other towns.

Ms STEVENS: In relation to page 250 of the Program Estimates, will the 1995-96 debt incurred by the Mount Gambier Hospital be carried over to the new hospital, and does the Minister still believe that the hospital board should accept responsibility for this blow-out?

The Hon. M.H. Armitage: It is no different to the budgetary policy embraced by Governments around Australia. I assure the honourable member that it is certainly no different to the approach of the former State Labor Government, so I would have expected the member for Elizabeth to acknowledge that this is prudent management of the State's finances, as it is State taxpayers' money. There is an expectation that the board will carry over funds which it has over-expended. It knows that, and I acknowledge it.

However, we have looked at recognising the fact that a new hospital is in train at the moment, shortly to be fully completed in May next year. So, we believe that there is an opportunity to bring forward some of the works required to ensure a smooth transition to the new hospital. At the moment we are having discussions with people in the South-East to determine whether that is an appropriate mechanism to assist them with the transition to the new hospital. The simple fact is that the Mount Gambier Hospital board's budget has exactly the same parameters as the budgets of all other hospital boards, and those budgets were set according to casemix.

I refer to the question of professional indemnity, which was the subject of a motion in another place. Certainly members of the other political spectrum believe, as we do, that these expenses are business expenses.

Ms STEVENS: I have received two letters, one from the Millicent and District Action Group for Health Services and one from the Chairperson of the Millicent and District Hospital and Health Services Incorporated. The letter from the Chairperson of the Millicent and District Action Group (Fiona Telfer), which is dated 24 June 1996, states:

> Dear Ms Stevens, We need your help! We are a group of concerned mothers and will be mothers. We have already read that you believe that the South-East is in trouble in regard to losing their obstetrics services and the problem needs to be fixed urgently.
>
> Dr Armitage has promised South-East women will not need to leave the South-East to have their babies. His latest offer is to set up registrars in Mount Gambier. Where does this leave other South-East towns? The downline effect is that jobs, businesses and services will be affected. The dollars and cents are apparently not the issue. Dr Armitage could have resolved the crises by paying a lot less, than paying hundreds of thousands of dollars and disrupting the lives of women embarking on one of the most stressful, emotional and important times in their lives. We need answers and we needed them yesterday.

The second letter is from the Chairperson of the Millicent and District Hospital and Health Services Incorporated, Mrs N. Sapiatzer. This letter is similar to the previous letter, so I will quote only a paragraph, as follows:

> While the board is pleased to see the Minister attempt to provide services in Mount Gambier, it is concerned that this arrangement will become permanent, thus denying Millicent women the opportunity to have their babies in their own community and their own hospital. Millicent Hospital currently delivers about 140 babies per year, which is a significant portion of its activity. If Millicent Hospital was to lose the activity it would be detrimental to its viability and impact on the economy in the Millicent community through loss of income and positions.

I should like the Minister to respond to the issues raised in those letters.

The Hon. M.H. Armitage: Whether or not the Millicent doctors provide services in their area is a matter for them. I have been absolutely specific throughout this exercise in saying that the goal of the Government is to have local doctors deliver their patients in local hospitals; that is why we have been able to offer a deal in respect of professional indemnity which has covered the needs of 95 per cent of doctors in South Australia. That is why we did it. If we had not wanted local doctors to deliver local babies, there were other solutions. However, that is not what we want: we want the Millicent doctors to deliver the Millicent women in Millicent—that is our goal.

In relation to the payment of 'hundreds of thousands dollars', I have no idea what that refers to. However, I assure all members of the Committee that to do as the doctors appear to want us to do—that is, to fund the vast majority of their obstetrics indemnity premiums, instead of locking in their contributions for the next three years at what they paid last year—will cost a vast sum of money across the State. Everybody—including, I believe, the consumers of health services—would prefer that, rather than taxpayers' money being used to pay a business expense, money be put into services. I believe that approximately 95 per cent of doctors around South Australia acknowledge that as well.

Mr BUCKBY: One of the objectives of the South Australian Health Commission in 1996-97 is to complete implementation of the Mental Health Realignment Report, with particular focus on establishing integrated regional community mental health services, specialised State mental

health programs and a country mental health service. What plans does the commission have for the development of an adequate mental health system in country South Australia?

The Hon. M.H. Armitage: In September 1993 a report entitled 'A Framework for Country Mental Health Services' was published by the South Australian Mental Health Service (SAMHS). The report identified that 120 community mental health workers are needed to provide a service to residents of country South Australia. At that time there were approximately 25 existing mental health workers in country health services, leaving a requirement for 95 positions; 20 positions were identified as high priority, and all of those have been filled, including two Aboriginal mental health workers.

A comprehensive model has been developed for country mental health services as part of the realignment project. From 1 July 1996, the country health services division of the commission will assume responsibility to implement and develop the model, which has five major components including:

· a 20 bed country acute in-patient unit to be located in Adelaide where the telepsychiatry unit will be located; that will provide both a 24 hour emergency service for country GPs and local hospital staff, and facilities for general psychiatric consultation;

· community mental health services based on an expansion in the number of community mental health workers to be employed in each region;

· community and mental health support services, which is a range of services provided by Government, non-Government community groups, agencies and individuals to support consumers and carers;

· mental health education and promotion services provided by the rural health training unit; and

· improved coordination with and access to statewide mental health services.

A program identifying increased funding for country mental health services to facilitate the phased implementation of the model, which is estimated to cost $17 million, has been developed. The executive has approved an additional $1.8 million for 1996-97. The capital funding will facilitate the purchase of equipment to extend the telepsychiatry system to regional and sub-regional hospitals—that is, an additional 10 sites—and to the rural health training unit for distance education programs.

The recurrent funding will be used to employ additional country mental health workers to augment the existing 15 teams; to provide additional staff for the telemedicine unit; to establish community support services such as consumer and carer self-help groups; to support respite accommodation and provide travel assistance; and to pay for visiting psychiatrists and for GP time.

Mr BUCKBY: Training opportunities are an important operation that goes along with the supply of facilities. In relation to the many major changes in the way mental health services are to be managed in South Australia, will the Minister tell the Committee whether there are any plans to provide training opportunities for community based mental health workers? On page 258 of the Program Estimates, one of the specific objectives for the 1996-97 financial year is a specific focus on establishing integrated community mental health services.

The Hon. M.H. Armitage: This is an opportunity to inform the Committee about a great deal of activity directed specifically at increasing health workers' ability to recognise early signs of mental illness and to make appropriate management decisions when that has been recognised. Under the realignment of mental health services, multidisciplinary training is given a high priority. A central staff training service will provide training to all community teams. Under SAMHS two staff were providing staff development; this will increase to four in the near future—obviously a 100 per cent increase. Those positions will include a coordinator, a staff development and training position and three staff development positions.

All the emergency teams and mobile air service teams, which will be coming on stream shortly, will receive an intensive period of training before taking up their positions: indeed, they are undergoing that training at the moment. Each region will have a clinical director to facilitate research and training. An Associate Professor of Mental Health Nursing has been appointed at the University of South Australia to provide research and training in relation to nursing practices.

In addition, SAMHS has funded a Chair in Rehabilitation and Community Psychiatry, which is filled by Professor Sandy McFarlane. There is a full-time lecturer in youth mental health appointed at the Flinders University, and we are expecting that to progress well. The Western Division of General Practice has funded a project to deal with milder forms of anxiety disorders; and a western area staff member has been paid to write self-help manuals for patients of GPs which will be implemented under the guidance of the GPs. The mental health staff members will train the GPs in the use of these manuals and act as a consultant in the more difficult cases.

Southern CAMHS, under the leadership of Graham Martin and with support from the South Australian Centre for Public Health, is looking at strategies to improve outcomes in many different community settings to reduce youth health problems including suicide—and Southern CAMHS is very influential in this area—and to elucidate and find ways of dealing more effectively with the social health issues in the Aboriginal community.

SAMHS has also funded SACOSS to provide training to consumers to support its involvement around consultations in mental health. A number of workshops in suicide prevention have also been sponsored by the commission, and they were so popular that they may have to be repeated. It is proposed to use a recently developed computer assisted telephone interviewing system to gather information from the community later in 1996 to enable the production of a chart book on mental health to establish a database against which the effectiveness of the programs can be assessed.

Mr BUCKBY: I now turn to regionalisation and the budget for same. According to page 259 of the Program Estimates, seven regional health boards have been established and will allocate the 1996-97 budget to health units in each of those regions. How this will assist in making the most of the health dollar?

The Hon. M.H. Armitage: One of the highest priority projects being undertaken by each of the seven new regional health boards is the development of a regional strategic plan. These projects have been provided with funding through the Medicare incentive program. The plans will include a health needs assessment and a capital resource evaluation. As a result of the development of the plans and also as a corollary of regionalisation, the regions will be able to eliminate unnecessary duplications and will be able to concentrate on the services that are most needed in their area. I think it is very clear to the regional boards that that is their prime focus

and is one of the greatest advantages that they can expect from regionalisation.

Obviously, the Health Commission, Country Health Services Division, has endeavoured to work towards all the objectives in the past, but the need to negotiate with each health unit as a separate entity has made progress somewhat more difficult than we might have hoped and perhaps a bit slower than might have been desired. Now that each regional board has the ability to develop a regional plan and involve each of the health units in progressing that plan, we believe that that should enable a more rapid rate of change and a more efficient outcome genesis.

In essence, it really is the regionalisation process which is the stimulus for that, because it allows decisions concerning the delivery of services to be made very closely with the community which will be receiving those services and which has such an intense interest in what services are provided.

Ms STEVENS: My question relates to community health centres. The Opposition has received many letters over the past few weeks deploring the Brown Government's decision to close three of the six community health centres in the fast growing southern suburbs. These centres are located at Hallett Cove, Aberfoyle Park and McLaren Vale. I will read part of one of these letters, which is from the Coordinator of the Happy Valley Youth Network and which states:

> Organisations such as ours have contributed many hours of staff time and funding to support various projects in partnership with a health centre. The manner in which the closure has occurred without apparent consultation will cause unnecessary hardship and reflects poorly upon the administration of the health services. . . The membership agencies of this network, including the City of Happy Valley, Aberfoyle Park High School, Family and Community Services, Aberfoyle Park Community Health Service and the Place Youth Centre express serious concerns about how the health service sees the role of families in the lives of young people.

The letter also points out:

> Current services located at Woodcroft, Noarlunga, Marion or Morphett Vale require a four bus journey to get there and back.

Why has the Minister sanctioned the closure of these centres?

The Hon. M.H. Armitage: I remember asking a question along these lines of your former colleague, Don Hopgood, when he was the Minister for Health, in relation to a letter that had gone out about some budget imperatives that were being looked at, and the response I got was that people were looking at some indicative figures. As I indicated in relation to one of your earlier questions, the simple facts of the matter are that the budgets are not yet known. The board of Noarlunga Health Services has asked the contributory components to look at figures which would give them some guidance in their budgetary decision making process. The simple facts of the matter are that those budgets are not yet 100 per cent clear, so the discussions are premature.

Ms STEVENS: Will the Minister confirm the information provided to these doomed centres (or possibly doomed centres) that the reason for their closure is based on reductions to the community health service budget and on the health status of the area as defined in the social health atlas?

The Hon. M.H. Armitage: As I understand the process, the board has looked at the social health atlas to determine the areas of greatest need. There are a number of accusations in relation to the figures that are used, which are incorrect. The answer to your question is 'Yes', and that is exactly the use of a social health atlas—to allow appropriate resource allocation and decision making.

Ms STEVENS: Will the Minister confirm that the statistics used regarding the closure of these centres were based on ABS data which is now 10 years old? Is that the reason why he is now reconsidering the decision to close these vital public facilities?

The Hon. M.H. Armitage: I reiterate, to try to make it clear to the member for Elizabeth, that I have not made a decision to close it: I have not been involved in any decisions along those lines. They are preliminary discussions by the board of the Noarlunga Health Services. If you are going to try to link me into this decision making as a scaremongering tactic, it will not work. It is simply not true. Secondly, we have heard the accusations—and that is exactly what I was referring to in my previous answer—and I am told that the figures that have been used may, in some instances, have been based on those as source data, but the majority of them came from—and I have seen it—years such as 1992, 1993 and 1994.

Ms STEVENS: The majority of the statistics were recent but some of them were 10 years old?

The Hon. M.H. Armitage: If you do not have more recent statistics you can take only what is available. There was no suggestion, as perhaps the member for Elizabeth is making, that we had statistics for 1986 and 1996 and that the board ignored the 1996 figures to make this decision. That is simply untrue. As I understand it, the minute that went out was based on what figures were available at the time, and that is all anyone can be asked.

Ms GREIG: I should like to ask a question about the Noarlunga Health Services, and I relate it to page 4.9 of the Financial Statement where mention is made of extended links between hospitals and community based services. There is lack of clarity as to the budget task being set for the Noarlunga Health Services, with figures ranging from $170 000 to $550 000 being offered. Can the Minister clarify what is being asked of Noarlunga in the 1996-97 financial year?

The Hon. M.H. Armitage: The only uncertainty is to the eventual outcome. As I have indicated, those budgets are not known at this stage. The uncertainty is that figures have been bandied around, none of which are yet clear because of the uncertainty about the end of year financial position.

Ms GREIG: I refer to my discussions with the Minister on the proposed restructuring of community health services in the southern suburbs. Does the Government consider that the net level of services in the southern area will decline as a result of this decision? I highlight concerns with respect to the changes to the Aberfoyle Park Community Health Centre and the Southern Women's Community Health Service.

The Hon. M.H. Armitage: As I understand it, the board's proposal is that this putative exercise is based on overheads and duplications—not services—being eliminated. If one looks at the data that are available, one sees that there are areas where need may be deemed to be greater, and that is what the board believes. That is a reasonable assessment of its situation. I believe that is what the board's decision making is based on—that, if it is able to cut out administration and focus on services, that will be to the benefit of the constituents.

Ms GREIG: I have spoken to the Minister about the allegations that are circulating in the community about the Noarlunga Health Services. He has addressed some of those issues but I ask him to clarify the situation with respect to the alleged misappropriation of funding, that the Southern Women's Community Health Service budget was to remain a discrete budget line, and that the decision to restructure was

based on 1986 data. I know that the Minister has already addressed that point but I ask him to reiterate.

Ms Gaston: In respect of the first part of the question, which concerns allegations of misappropriation, I understand that there is some confusion in the south about an amount of money which is available to Noarlunga Health Services this financial year which will not be available to it next year. It is an amount of about $150 000 and it is in part as a result of an efficiency gain that the community health service made in 1994-95, so it was able to carry over a surplus. It does not look as though it will be in surplus: it will come in on-line this year, so that will not be available next year.

The other component is to do with an amount of money that was given to the service when the Woodcroft site was constructed. It was given that amount to amortise its furniture over five years. It managed, within its budget, to do it in three years, which gave it moneys that it has since used on services in the last two years. That money will not be available in 1996-97. From my assessment, there is certainly no justification to believe that there has been misappropriation of funds at Noarlunga Health Services. In fact, it looks as though it is being penalised for efficient and effective allocation of funds in the past.

The second part of the question related to the women's health service and a promise, I believe, that the budget would remain a discrete budget line. Yes, that promise was made; yes, it is a discrete budget line; and, yes, it will remain a discrete budget line. Women's health is a discrete program, not just in the southern area but in other metropolitan areas, and as such it has a discrete budget line and that will remain. The third matter was a repeat of a question that was asked about the 1986 ABS data. I understand that the Minister has already replied to that question.

Ms STEVENS: My question relates to the Noarlunga Hospital, and I want to follow up on something that the Minister said in answer to the member for Reynell's question in relation to the funding of Noarlunga Hospital. From memory, the Minister intimated that he could not comment because the budget was not quite firmed because of the uncertainty of the end of year financial position. To what did the Minister refer when he said 'the uncertainty of the end of year financial position'?

The Hon. M.H. Armitage: I am referring to just that. We do not know what the figures are for the past several weeks. The answer to the uncertainty is that, under the casemix model, before we can run next year's model, we have to know what the base workload was for this year. Those figures are always being collected but, until we have collected for the full financial year, we cannot make a legitimate comment about the following year. That is the problem that we have elaborated on several times today. Having said that, I point out that the difficulties and dilemmas to which the member for Elizabeth referred earlier ought not be over stated. This is no different from any other budgetary situation which these agencies and units have gone through every year.

Ms STEVENS: My next question relates to community health in the northern suburbs, page 259 of the budget papers. The Opposition has received a copy of a memorandum issued to staff of the Northern Metropolitan Community Health Service earlier this month. The memo states:

> The executive and management team are extremely disappointed and concerned about the proposed budget cuts and we are doing all we can to prevent them being implemented. However, we are told that a 5 per cent cut is almost certain.

The budget papers issued by the Minister two days ago confirm that its budget has been cut by almost 6 per cent. The memo then announces that the management of the health service has recommended that the required savings be made by not appointing 1.9 speech pathologist positions, 1.8 clinical psychologist positions, 0.6 podiatrist position and 1.0 nutritionist position. The memo concludes:

> We realise that there will be community and service repercussions and difficulties which will arise from this decision. . .

Why does the Brown Government give such a low priority to preventative health programs, such as those which now must be cut from the Northern Community Health Service, when the Minister's new Federal colleague, Dr Wooldridge, has stressed the importance of such services? Will the Minister reconsider those cuts, given the impact they will have on vital community health services?

The Hon. M.H. Armitage: First, the budget quantum relates back to the previous question and all the other questions, so I will not take up the time of the Committee by repeating the answer. I cannot give any more detail than that so, if there are series of other questions along those lines, the answer will be the same. Prevention has been a focus of the Government. We are looking at a number of initiatives in the goals and targets area.

Certainly, our primary health care initiatives program is focused on primary and preventative care; it takes money from the acute sector of the hospitals and puts it into primary care. Prevention has been the talking point at a number of ministerial conferences which I have attended and people who think it is an incredibly innovative and excellent program have asked how we have done it. With the change in Ministers in some jurisdictions because of elections, and for other reasons, they have come to me saying, 'We have heard all about your preventative health program.' Whilst the member for Elizabeth does not acknowledge it, that is an acknowledged commitment Australia-wide.

Ms STEVENS: You are cutting them; that's what I'm talking about.

The Hon. M.H. Armitage: No.

Ms STEVENS: That's what the memo is about.

The Hon. M.H. Armitage: No, the memo is about the same budget matters which we have discussed on three occasions before and on which I cannot give you any more information. Many of the questions asked by the honourable member relate back to the philosophy of how the Labor Party believes the health system ought to be run. During the health services Bill debate six or eight months ago in this Chamber, the Opposition waxed lyrical about how important it was for boards to have local responsibility and the thought of any potential increased centralisation was akin to Armageddon being released. The antithesis is that all the decisions are made centrally. The member for Elizabeth cannot have it both ways: she cannot say that she wants the decisions to be taken in the periphery and then, when they are taken, blame the centre.

Ms Stevens interjecting:

The Hon. M.H. Armitage: Mr Chairman, I do not interrupt; I expect the same courtesies. The simple facts are that we are allowing responsibility to go into regions. It has never been done before. The ALP tried it—green paper, light green paper—and failed, but in less than two years in Government we have done it. The people are making their own choices about these matters. This is unrelated to the matter about which we are talking now, but it is the philoso-

phy behind the implied criticism. Either give the centre the power, which the Opposition refused to do, and then we will be blamed for them, or leave the power in the periphery and expect that the periphery will make its own decisions according to its own priorities. As I say, it is a philosophical argument. We believe that the regions have the credibility, if you like, to make their own decisions.

Ms STEVENS: The memo from the Northern Metropolitan Community Health Service continues:

> Carol Gaston advised us recently that the stated priorities indicated by the health advisory panels should direct us in what services not to cut.

However, the *Guardian Messenger* on 19 June reported that the Minister:

> . . . has hit out at the findings of metropolitan health advisory panels saying that they are 'statistically invalid'. Dr Armitage last week said the methods used by the panels to come up with a list of health priorities had swayed the results, and that not enough people had responded. The simple fact of the matter is those panels were statistically invalid, he said.

Has the Minister informed the Health Commission of his changed views on the value of health advisory panels, which he set up last year? Does the Minister intend to scrap these panels now that clearly he has lost faith in their performance?

The Hon. M.H. Armitage: I will address the matter via looking at what we can take on the input of the panels. The input upon which the decision-making has thus been made is statistically invalid. I am not a statistician, but I know these reports are invalid: not enough people have been asked. Therefore, to make decisions and to expect that we would make decisions on them is, I believe, an abrogation of the role of community input in whatever form it may be. We believe that community input is important, but I will insist that it be statistically valid because, if it is not statistically valid, it is a total waste of money: it is as simple as that. There are methods of community consultation which are statistically valid, and I will insist that they form part of this process so that the input from the community that goes into the decision-making process is valuable.

I also add, in relation to a previous question, that the rationalisation of Northern Community Health Services which occurred last year has led to a 28 per cent decrease in overheads and an increase in services in that area and, according to the Grants Commission figures, South Australia spends more on community health services than any other State.

Ms STEVENS: Where does it leave them in terms of the decisions they have made based on the recommendations of the Northern Health Advisory Panel on what not to cut?

The Hon. M.H. Armitage: I am not sure the question asked by the honourable member is different from the previous question which I have already answered, but I will repeat the answer. On the information I have been provided, there is no valid conclusion statistically that can be drawn. That is not just my view: it is also the view of one of the Chairs of those panels, who acknowledged that that is factual. Therefore, my goal in attempting to get valid, reasonable community input from which we can draw appropriate conclusions is to discuss with the commission how we can make sure that the input is statistically valuable. It is pointless to get information that is biased.

Ms STEVENS: Will the Minister ensure that all his officers in the Health Commission do not give advice to any of the units to use this statistically invalid material when they make decisions, and where does it leave the health service in the northern area, which has done what it was instructed to do and now, it seems, this is the wrong thing?

The Hon. M.H. Armitage: I fail to see what a budget Estimates Committee has to do with that, but we will answer the questions. The question was, will I ensure that information that is statistically invalid is not provided. That is exactly what I am saying. The simple facts are that, if these community panels choose methods that do not give information upon which one can base a legitimate conclusion to spend taxpayers' money, something else has to be done—and that will be done.

Ms STEVENS: Perhaps I am not being clear in what I am asking: let me say it again. I asked whether the Minister would ensure that his officers no longer indicated to health units that they should use findings of health advisory panels in relation to what services they should cut or not cut.

The Hon. M.H. Armitage: First, the findings that were allegedly in these reports are preliminary and, accordingly, the allegation that they are reports I find disturbing, but I will give a guarantee that we will work with whoever is necessary to ensure that there is an effective, statistically valid method of getting information from the community about important matters to do with decision making in health care.

Ms STEVENS: My concerns are that this health service in my electorate and the electorate of my colleague the member for Napier made decisions to cut services such as speech pathology, podiatry and nutritionists, and we know that out in the north people are crying out for those services. That group made those decisions because it was advised that it had to follow the stated priorities indicated by the health advisory panels, and they were told that by Carol Gaston. The Minister just said that they are invalid: will he make sure that his officers do not say that again, because my community is missing out now as a result of that particular instruction?

The Hon. M.H. Armitage: I will repeat what I have said—and I am really not trying to be perverse. The simple facts are these. The honourable member is saying that decisions have been made. I am saying to her that, if that has occurred, that is inappropriate, because the final budget outcome is not known. We do not know what level of cut, if any, will be necessary. That goes right back to about question 1 or 2 that the honourable member asked.

Ms STEVENS: About Commonwealth funds?

The Hon. M.H. Armitage: No, it has nothing to do with that. It has to do with the fact that this is 27 June and we do not know what the final budget position is until a number of weeks from now. What has happened, as I said two or three answers ago, is that these people have done what Don Hopgood did: they looked at a best case and a worst case scenario. If they have made those decisions, that is inappropriate, because their budgetary allocation is not yet final, and the decision is made by the Health Commission with advice from a variety of different sources, including those health services.

I repeat: if the decisions have been made, that is inappropriate. There may have been discussions about what would happen if various levels of funding were given to them, and that is appropriate, but we have not yet identified the level of funding.

Mr OSWALD: I note from page 258 of the Program Estimates that one of the 1995-96 achievements was the implementation of services for people with behavioural disorders. What is this service and what is its significance and cost?

The Hon. M.H. Armitage: The honourable member has identified a particularly important area of the budget papers, because it goes to the nub of the fact that in South Australia we have been a world leader in interagency cooperation for children and young people—and that is a judgment of the World Health Organisation. The Behavioural Intervention Service builds on this good work that has gone on in the past and is a cooperative venture between Health, Education and Family and Community Services to target young people whose problems and behaviours most challenge our existing programs.

The Behavioural Intervention Service creates a special team within CAMHS that will receive referrals of young people with these persistent or extreme behavioural problems. In doing so, it recognises that they may have needs across a number of services and service sectors and may have a number of different problems such as abuse, drug use or drug abuse, borderline disability, etc. The core business of the Behavioural Intervention Service is to apply expert knowledge and develop programs that will allow clients for whom a single core program may not have been successful to escape from their multiple problems with all the difficulties that they cause. Education and Family and Community Services are willing participants in the service: Family and Community Services is providing residential support staff, a facility and offices; and Education will ensure that learning opportunities are available for particularly challenging young people. That is a big task.

The obvious significance of this service is the cross-portfolio cooperation, which has been both enthusiastic and generously offered. It removes boundaries that are sometimes seen as being very negative. It is also a very significant boon to the carers of these young people, and in time I believe that the option of the Behavioural Intervention Service will save a number of families which to date have not really had the cross-sectoral support that this will offer. There is also a much wider community significance in that these young people are often pictured as perpetrators of offending behaviour and sometimes may be considered dangerous but, by tackling the behavioural problems from a multisectoral approach, the community at large will benefit immediately and, hopefully, with the success of the program, through enduring improvement in the public eye.

Particularly important is that the problems are being addressed when the actual users of the service are young, and hopefully that in itself will be an educative process. The treatment team will be part of Child and Adolescent Mental Health Services. The service is therefore significant, because it also illustrates the Government's commitment to child and youth services as well as adult mental health. It is also part of a wider package of initiatives to emphasise the importance of early intervention, and hopefully much better outcomes will be achieved as a result. The cost of the service is very modest compared with the benefits that we hope will come from it, as the Estimates information indicates. The component from health is $365 000, which is being met from Medicare funds, to employ a multi-skilled treatment team. For the benefit that the individual clients, their carers and society will reap from this program, that is a very small investment.

Mr OSWALD: I refer to options coordination. There has been a major change in the provision of services to South Australians who have a disability, particularly with the development of options coordination, which is highlighted as a significant initiative of the Health Commission on page 262 of the program papers. What are these changes, and how have they impacted upon consumers?

The Hon. M.H. Armitage: I will ask Colleen Johnson, Executive Director of Disability Services, to answer that question.

Ms Johnson: The disability sector is in the process of major structural reform, which will see the development of three areas of focus. One is the Disability Services Office, which will provide central planning, policy direction and broad sector coordination; the second is options coordination agencies, which will coordinate local client services; and the third is the service delivery sector, which will comprise a range of specialists, generalists and mainstream agencies. This structure will increase access, equity, efficiency and effectiveness across the field and will impact positively upon consumers in the following ways. Options coordination provides a single entry point to the service system for people with disabilities and will ensure the consistent determination of eligibility, assessment of need and the allocation of resources for the purchase of disability services across all disability areas. Options coordination also ensures the consistent collection of data to establish a statewide picture of needs across the sector, and this will ensure that planning for future services reflects this identified need.

The efficiency of services will be increased by developing and implementing a consistent funding methodology across services and by increasing the funding directed to service delivery both by reducing the funding of infrastructure and by tendering services. The effectiveness of services will further improve with the development of uniform standards monitoring for all funded or purchased services and by options coordinators ensuring that services that are purchased for consumers are tailored to meet their individual needs.

Since the establishment of options coordination in February 1995, many new clients have received substantial support. Many of these clients have also received some support services with no additional allocation of resources to the options agencies. In addition, a number of people who have been referred to options require not funded services but a higher level of detailed case management. This case management was missing in their lives before options coordination was established, and many clients and families have expressed positive views about the new system.

The Disability Services Office and the options coordination agencies have been working together to introduce a coordinated and equitable funding system that will provide funding to services on the basis of individual consumer need, service type and identified outcomes. It is important to note that, within the disability field in Australia, South Australia is at the forefront of these developments.

Mr OSWALD: I refer to efficiency dividends on page 262 of the Program Estimates and the objective of assisting people with disabilities to achieve their maximum potential as members of society. I understand that the State Government has asked the disability sector to achieve a 3.8 per cent efficiency dividend by June 1996. Has this been achieved; if so, how has it been achieved; and how will it assist in achieving the goal to which we have referred?

The Hon. M.H. Armitage: Whilst the disability sector has been quarantined from budget cuts because of the importance of the area, the Government believes that efficiencies can be produced to meet the growing demand for support services. Accordingly, we asked the disability sector to achieve a 3.8 per cent efficiency dividend by June 1996. The total efficiency saving identified across the disability

sector to date is $6.4 million—a huge sum of money. It is not a budget cut, however, as it is being reinvested in disability services, and its specific purpose is to increase service provision in the sector. So, $6.4 million of efficiency dividend has been reinvested in services, totally quarantined from any budget cut. It is anticipated that the costs will be lower and that more services will be provided for the same budget allocation to the system, because we have expected an efficiency dividend to be forthcoming. So, not only do we have the increased money but we have also forced the services to be provided more efficiently.

The ways in which the efficiency dividend was achieved and will continue to be achieved include the fact that clients have made some market driven choices. The implementation of the efficiency dividend does not mean that the Government is dictating where the efficiencies will be made. Through the options coordinators, clients may well continue to force market driven change merely as a result of their service requirement patterns. Another method is by reducing duplication of effort. One of the major concerns expressed to me in the disability area is the multiple assessments, which are required for all sorts of different matters.

Part of that efficiency dividend has been generated by eliminating multiple assessments and diminishing duplication of administrative overheads by encouraging the sharing of resources or the amalgamation of services. Another way of generating it is with better information and case management through options coordination to ensure the most appropriate match of clients to services. It will also result in less duplication of service provision to clients who in many instances have multiple service providers, and again that is fairly inefficient.

The efficiency dividend has been derived through determining funding levels for specific service types. A new way of funding based on client support needs that is being developed by the Disability Services Office is the establishment of reasonable costs for service types. In other words, because of the work that is going on, we will have an idea of what is a reasonably efficient way to provide two people with the same service from two different providers, and hence it will generate more efficiencies. Obviously, that includes encouraging improved coordination of effort amongst service providers. A wonderful example of that involves SCOSA and the Crippled Children's Association. They have arranged their services so that SCOSA provides accommodation, respite and day activity, and the CCA provides therapy and equipment.

The IDSC is implementing the efficiency dividend in two stages. Agencies are required to achieve a 1 per cent reduction in administrative costs in the first instance. The IDSC has established an inter-agency committee which includes representations from ACROD, ANGOSA and the non-government sector to make recommendations on how the dividend would be achieved. Further savings by the corporate office of IDSC have been achieved through administrative efficiencies. The most important thing is to re-emphasise that all the savings from that efficiency dividend, $6.4 million to June 1996, have been reinvested in client services. It is a credit to the disabilities sector as a whole that it has met the challenge by increasing services to its primary constituents.

Ms STEVENS: I refer to page 252 of the Program Estimates and the coroner's report into the Garibaldi incident. On 28 September 1995 the coroner, inquiring into the death of Niki Robinson, handed down his report, including 12 recommendations. The Minister made a statement on the same day outlining the Government's response to those recommendations and indicated that some of them had already been implemented. What has happened in relation to recommendation No. 12 that the Minister, in consultation with the Minister for Primary Industries and the Minister for Housing, Urban Development and Local Government Relations, conduct a review of resources available to enforce the food legislation? Has there been any increase in resources for this area in the budget?

The Hon. M.H. Armitage: I will ask Dr Kerry Kirke to comment.

Dr Kirke: There have been very significant increases in resources in those areas of the Health Commission's public and environmental health service which are responsible for surveillance and control of food-borne communicable disease. Two additional part-time medical specialists, a senior epidemiologist, a data manager, a nurse epidemiologist and an administrative officer have been appointed to the Communicable Diseases Control Branch, which itself has been upgraded from unit status to branch status. Also, a position of senior manager to coordinate the activities of the food unit within the Environmental Health Branch has been created, and a person with many years relevant experience has been appointed. One of his major tasks is to oversee a total review of food safety legislation in consultation with industry, local government and other relevant departments.

The South Australian Food Act has not been reviewed since it was introduced in 1985. Many changes have occurred in the food industry and in the regulatory environment since that time, not the least of which is the creation of the National Food Authority. A complete review of the provisions of the Act has been undertaken with the aims of addressing the impact of changes to the national food regulatory system, variations from the model food code, and to ensure that adequate powers and offences are provided for.

The review of the Food Act has been expanded into a comprehensive review of the system of administration and enforcement of food legislation throughout the State to ensure that efficient and effective mechanisms are in place in respect of food safety and that changes occurring at the national level can be adopted. The main aims of this review, the roles and responsibilities of State and local governments and industry, are being examined.

Proposed changes to the current system include establishing local government controlling authorities to administer all food legislation. Industry-based quality assurance is also proposed through the introduction of food safety programs in line with the national food hygiene regulations currently being developed by the National Food Authority. A discussion paper outlining the proposed changes to food legislation and the mechanisms of administration is currently in the final stage of preparation. This document is intended to form the basis of public consultation and will be released for public comment within a very short time.

In respect of the Garibaldi issue, notification has been received that amendments to standard C1 of the national standards for uncooked, fermented, comminuted meat products was gazetted nationally today and comes into effect from today. A notice informing manufacturers of their responsibilities under these new provisions has been prepared and will be distributed today and tomorrow.

Ms STEVENS: I am interested in the status of the three page discussion paper dated 2 April 1996. Will the Minister clarify whether that is also part of the discussion paper just referred to as nearly being finished? The first three page

discussion paper—and it may have been a draft paper—prepared by the South Australian Health Commission was entitled 'Options for the Future Administration of Health Legislation in South Australia.' It is now 27 June 1996; the coroner reported on 28 September 1995. Why is it taking so long?

The Hon. M.H. Armitage: I will address the last matter and ask Dr Kirke to address the first one. The simple fact is that there have been a number of discussions behind the scenes in relation to all of the matters in relation to national standards. If the member for Elizabeth consults with her colleague who was previously the member for Elizabeth, I am sure he will acknowledge that some of these national exercises take some time to come up with specific recommendations and approvals. Recognising the importance of national standards, laws and so on in this area, we wanted to make sure that that was part and parcel of any legislative package we might put out in the discussion paper.

The NFA and Health Ministers will be meeting next week in Hobart. It was my intention to then clarify, if you like, or finesse any final touches to the paper and release it a week or so after the changes had been made: it will be released in the near future.

Dr Kirke: The three page discussion paper was drawn up preparatory to discussions with local government and I initially took that paper to local government at the end of January this year. As a result of discussions, we have created the bigger discussion paper to which I referred.

Ms STEVENS: It was a discussion paper for the discussion paper.

The Hon. M.H. Armitage: It is part of the bigger one.

Ms STEVENS: What changes have occurred to recall procedures as a result of the Coroner's recommendation 10 and the statement by the Minister that this was being dealt with by a national review and that South Australia was playing an active role in that review?

Dr Kirke: There have not been formal changes in the legislation in relation to the food recall system as yet although they being discussed. The current episode in relation to peanut butter is an example of how the system works. The National Food Authority is responsible for organising national recalls in association with the manufacturer or food processor concerned. States then have the responsibility of implementing and overseeing the recall in their States. Following the Garibaldi affair last year, those involved in recall processes are much more acutely aware of their responsibilities. Within the Health Commission two facsimile machines are arranged to enable urgent facsimiles to be broadcast to each of the 118 local government councils in this State and to a number of retail outlets in those parts of the State not covered by local government to inform them of the products that we are interested in. This week three faxes were sent to all those people following the incremental recall in relation to peanut paste, of which I am sure everybody is aware.

Mr BUCKBY: I refer to page 255 of the Program Estimates, which states that issues for the South Australian Health Commission include:

> Maintain quality of care whilst achieving efficient provision of service. Coordination of clinical services across all teaching hospitals. Appropriate distribution of hospital services . . .

Will the Minister explain what steps have been taken to improve the equity of funding across hospitals since the introduction of casemix?

The Hon. M.H. Armitage: As everyone involved in this committee would be aware, the introduction of casemix funding has clearly generated a number of significant improvements in the efficiency of hospitals. Considering the challenges which were set to the health sector, casemix funding thus far has been a great success and I am sure that we are at the forefront of this microeconomic reform process—if not the leader. Indeed, a number of people would lead me to believe that we are regarded around Australia as the leaders in this area.

The funding mechanism was introduced on 1 July 1994. Metropolitan hospitals were aware of casemix issues at that time as they had been involved in casemix modelling exercises for some time prior to that, but for the majority of country hospitals it was a new experience. As I have said *ad infinitum*, the type of casemix funding we would introduce on 1 July 1994 would differ from that of July 1995 and that of July 1996. In other words, we were bringing into play a flexible instrument to fund hospitals most appropriately.

To address some of the issues raised in 1994-95, some of the changes that were made in 1995-96 were as follows. In the National Diagnosis Related Groups Costing Study commissioned by the Commonwealth Government, costs for intensive care were attributed to all patients in all hospitals. That is clearly not the case, because the major proportion of the cost of intensive care is incurred at the teaching hospitals, not elsewhere. The inherent cost component of intensive care was extracted from the casemix budget of all hospitals and allocated to the teaching hospitals and a restricted number of major metropolitan and country regional hospitals. That actually meant a reallocation of some $21 million but clearly it was putting the funding where the services were being provided.

Another example of a change in 1995-96 from the previous year is that the Institute of Medical and Veterinary Science provides pathology to a number of public acute hospitals at no cost and the remainder of those hospitals have in-house laboratories for which recurrent costs must be met. In 1994-95 a price differential was imposed to deal with that issue, but in 1995-96 the budget for the IMVS relating to public hospital pathology tests was allocated to the relevant hospitals, which are now responsible for the volume and the price of tests ordered, and that reallocation was some $17 million.

The third example is that rehabilitation is provided in a number of designated rehabilitation units and hospitals. In 1994-95 it was specifically funded only at the Hampstead Centre. That clearly ignored rehabilitation in hospitals, specifically in country hospitals where country patients had the acute component of their care provided in a teaching hospital and were then down-transferred to the local country hospital. So rehabilitation funding, in recognition of this, was increased to $18 million in 1994-95—again a very significant change to improve the equity of funding across the hospitals.

The impact of the funding changes was to halve the price differential between teaching in sub-regional hospitals, and that has significantly increased the equity of funding in the system. In addition, as the funding system is now based on outputs—in other words, what casemix is based on—there can be some surety that the funding can be moved equitably to reflect service needs in the local communities. So there have been a number of significant changes to improve equity of funding.

Mr BUCKBY: I turn to the purchase of capital equipment by hospitals. From pages 32 and 33 of the Capital Works

Program, I note that there is to be increased capital funding to major hospitals. How does the Minister intend to support the public hospitals in the south in purchasing items of capital medical equipment which cost large sums of money and which impact substantially on hospital budgets?

The Hon. M.H. Armitage: This is a particularly important question, as many of the efficiencies which hospital teams wish to be party to generating are in fact led by the purchase of appropriate capital equipment. For many years the commission has assisted hospitals in purchasing items of capital medical equipment, especially those costing more than $100 000, and the very expensive items such as those costing more than $1 million, which are clearly beyond the normal recurrent expenditure capacity of the hospital.

What happens is that the commission seeks from hospitals an appraisal of the items requiring urgent replacement and an evaluation then occurs to ensure that the most urgent items in need of replacement are dealt with in priority, and it helps the commission to ensure that the roles and functions of the hospitals are met across the board.

In 1995-96 the dollars expended on medical equipment increased from $3 million to $6.7 million—a very significant increase; and in 1996-97 an additional $6.2 million will be made available. As an example, the sort of purchase that this enables is evident in the North Western Adelaide Health Service, where a new cardiac catheter laboratory is to be established. People from Adelaide's north-western suburbs requiring particularly important heart treatment will benefit from a $1.55 million upgrade of cardiac services at the Queen Elizabeth Hospital so that diagnosis, angioplasty, pacemaker insertions and so on can be enhanced in this new cardiac catheterisation laboratory, which is run so well by Professor John Horowitz. Work will start in July on the new laboratory, which will deal with a full range of cardiac services. This is in recognition of a need to update the cardiac laboratory within the QEH to take, I suppose, a greater role in cardiac disease identified in the social health atlas in that area.

The sorts of services that will be provided will be diagnostic cardiac catheterisation; coronary angiography (about 1 500 cases a year); coronary angioplasty (about 120 cases a year); permanent pacemaker insertions (about 80 cases a year); temporary pacemaker insertions (43 cases a year); intra-aortic balloon insertions, an absolutely life saving emergency procedure (11 cases a year); and electro-physiological studies and radio frequency ablations (about 80 cases a year); and a whole lot of other research programs, myocardial and metabolic investigations and so on will be enabled by the new laboratory.

So, it is a great advance. Indeed, it is not a moment before time because, since the Queen Elizabeth and Lyell McEwin Health Service amalgamation, the cardiac laboratory has taken on the highest concentration in Adelaide of people requiring diagnostic or therapeutic heart procedures. The existing laboratory has equipment which is between five and 15 years old. It has been let go to such a state over the previous Government's time in office that replacement parts are now difficult to obtain for the equipment which is presently there.

The plan would be for this $1.55 million new laboratory to take the lion's share of the diagnostic and therapeutic cardiac work, and the old laboratory would still be available to serve as a backup. It is believed that 1 820 procedures *in toto* are performed and, during each of the past seven years, that number has gone up by about 10 per cent. It is a need that has been there for a long time, and I know that Professor John Horowitz and his excellent staff at the QE campus of the North Western Adelaide Health Service will be delighted that again the Government has put in place what has been long overdue.

Mr BUCKBY: I note that Info 2000 will receive a large allocation, as detailed on page 32 of the Capital Works Program. What are the benefits from this level of spending and what is the overall strategy?

The Hon. M.H. Armitage: In asking this question, the member for Light is asking one of the crucial questions in relation to how the health sector will cope with many of the challenges over the next decade or so. It is clearly an amalgamation leading towards best practice for the patients and the Government's overall information technology strategy. Prior to the development of the Info 2000 strategy, the health system was spending only about .75 per cent of its budget on IT. This has now increased to 1.5 per cent and, while still short of the ultimate goal of somewhere between 2½ per cent and 3 per cent, it really will allow significant development to take place over the next three or four years. The dovetailing with the Government's IT strategy is particularly important.

The Info 2000 strategy will help a number of areas. It will attract leading-edge health care technology as it is seen to be such an important instrument for us; it will help with the development of clinical best practice; it will promote South Australia again as a leader in health care practice not only in Australia but in the world; importantly, it will reduce the costs; it will transfer skills to South Australia—as we become pre-eminent in this area people will move to South Australia to be a part of it; and it will certainly help in the export of health management services. As I have said, from the consumer's perspective the most important of those elements is the development of clinical best practice.

In particular, the strategy focuses on the implementation of clinical information systems. Quite a bit of clinical staff time is now spent doing clerical tasks—transcribing information from a monitoring device to a form, or from one form to another, or transcribing results from a laboratory into the notes or whatever. It is factual that data may be illegible or inaccessible, and clearly that mitigates against best practice.

The use of clinical information systems is expected to improve patient care as there will be better access to patient information at the point of care with easy access through desktop machines and so on. The quality of care and the impact on the outcome can be captured to allow the tracking and auditing of many relevant care processes with simple databases and so on. It is a research facility, if you like. There is great productivity through automation. Productivity and cost benefits will accrue from the simple things such as fewer paper records, elimination of manual transcription and electronic filing of results. It will also give a much greater standard of care because the clinicians will be spending more time with their patients rather than filing through notes that might be two or three inches thick looking for one result that might be in there somewhere—and I can assure members that that is extremely frustrating.

In April 1996, Cabinet approved the initial implementation of a common clinical information system and data repository system across the health area. It is very much a leading edge project which I believe will be a catalyst for major change in clinical processes and it will certainly enable the sharing of health care information across public and private providers. Considerable interest has been generated in this initiative, and

it is certainly anticipated that it would complement the Health Plus exercise, about which I spoke in response to a question from the member for Morphett. It will be a major component of this improved service delivery under Health Plus.

The commission has also recognised that business partnerships can provide capital, skills and opportunities otherwise unavailable in the public sector, and a good example of that is the McDonnell Information Systems (MDIS) Health Care 2000 project. In July 1995, Cabinet approved the commission's entering into a joint enterprise agreement with McDonnell Information Systems for the production in Adelaide of health industry software for the commission and the international and national marketplace. It is expected to cost $20 million and is already employing in excess of 30 staff locally who are developing a new generation of patient administration system. It is exactly the sort of usage of the leverage of the good work that goes on in health care in South Australia which can appropriately be leapfrogged into Asia and other areas through these sorts of IT exercises.

Ms STEVENS: My question relates to the Program Estimates, page 250, and casemix funding. On 6 May 1995, in a joint media release, the Minister for Health and the Minister for the Ageing announced a strategy to implement the recommendations of a consultancy entitled 'Responding to the needs of older patients following the introduction of casemix funding in public hospitals', which included the formation of a new advisory committee. I will quote from that joint press release, as follows:

> The Ministers said the new advisory committee would be chaired by Dr Elizabeth Hobbin, who is Director of Clinical Services at the Southern Domiciliary Care and Rehabilitation Service and consultant geriatrician at Flinders Medical Centre. The committee will comprise nominees from Domiciliary Care and Royal District Nursing Society, [the] Aged Care Organisations' Association, Nursing Homes Association, AMA Aged Care Committee, a consumer representative, Council on the Ageing, Health Commission, FACS and the Commissioner for the Ageing.
>
> Mr Wotton said he was keen for the advisory committee to meet as soon as possible. The committee's terms of reference include:
>
> · advising on emerging trends and issues relating to older persons arising from the introduction of casemix funding arrangements;
> · advising on the development of non-acute services for older patients in response to needs emerging or increasing as a result of casemix funding;
> · providing a forum for the coordination of effort by Government and non-government agencies in developing non-acute services; and
> · looking at future developments in the health and community care systems that may impact on the availability and delivery of post-acute care of older patients.

It was necessary to read that all out because it is very important in relation to the issue that I am raising. In addition, last year in July 1995 both the Minister for Health and his colleague the Minister for the Ageing launched the Health of Older Persons policy, and that also involved the setting up of an Older Persons Health Council. The role of that council was to provide advice on the health status and needs of older people and, as part of its role, to advise on the effect of changes in the health system on older people.

I asked the Minister for Family and Community Services about both these committees last night in his Estimates Committee. The Minister replied that the Older Persons Health Council had not yet been established—one year after the announcement of the policy. Obviously, nothing has been done about their providing advice to both Ministers on this issue. Can the Minister comment on the other advisory committee in relation to the first report that I mentioned? Can the Minister detail the number of times that that committee has met and the outcomes in relation to those terms of reference?

The Hon. M.H. Armitage: I have discussed these matters on a number of occasions, in particular with representatives of COTA, and the most relevant matter which I can raise and which COTA understands is that, in an ageing population, the majority of people who utilise public health services are the aged and that proportion is increasing. Hence, in a 2½ year period, increasing the activity of the hospitals and the efficiency of the hospitals, such that there is a 4 per cent increase in activity, benefits the people who utilise the hospitals most frequently and, as I indicated, that is the aged. That is a matter that COTA recognises and understands. In relation to the committees, I ask Dr David Filby to provide the facts.

Dr Filby: The advisory committee chaired by Elizabeth Hobbin has met on a number of occasions, but I am not sure how many. It has seen its primary responsibilities in its early life as coming to understand what the impact of casemix funding on health services for older people might be and trying to make some assessment of possible impacts, as well as providing advice to the commission through a number of its members in relation to the allocation of resources under the primary health care advancement program, which was initially set up in order to deal with a number of issues that were of interest to this committee.

In particular, that program was allocated $2 million in 1995-96 for a variety of projects. Of that sum, $1.4 million went to projects relating to the continuity of care, and significant numbers of those projects have been related to the priority area of the health of older persons. In addition, $150 000 has been put aside for targeted projects such as the cost benefit analysis of different discharge management models and some funding for the extension of projects which were funded in the previous year and which the evaluation had shown were particularly successful proposals.

I am aware that the committee has spent a significant part of its time in consultation with officers of the casemix unit collecting data and trying to understand exactly what happens. It is unfortunate that Dr Hobbin has indicated to the commission that she wishes to stand down as the Chair of this advisory committee, and her advice to me was that, as the Minister indicated, it would be sensible to put to the Older Persons Health Council the need to bring together the work of these two bodies.

Ms STEVENS: I seek further clarification on that matter. Can the Minister refer to each term of reference of the committee that I have outlined and tell me which ones have been addressed?

The Hon. M.H. Armitage: I cannot do that because none of us is a member of the committee, so we are not sure what work it has done.

Ms Stevens interjecting:

The Hon. M.H. Armitage: Not anything formal that I can go on.

Ms STEVENS: They were established on 6 May 1995.

The Hon. M.H. Armitage: I do not dispute that but the facts are as I have said.

Ms STEVENS: I note that the advisory committee on casemix has spent most of its time talking with the casemix unit, but there has been considerable concern in the community about early discharge from hospitals and the lack of services in the community. I highlight a couple of examples. An article in the Messenger Press in the western suburbs stated:

A man who last year underwent brain surgery at the Queen Elizabeth Hospital says he went home without staff referring him to any support or rehabilitation networks.

Another article appeared in the *Weekly Times* on Wednesday 19 June 1996 following a public meeting at Port Adelaide in relation to early discharge at the Queen Elizabeth Hospital. The article stated:

Queen Elizabeth Hospital patients say they are being sent home too soon after surgery to rely on family or neighbours for help during their recoveries. . . The meeting, at Port Adelaide Community Health Service, was told that patients often felt abandoned because hospital staff did not check up on them.

Patients said staff also did not find out what support they would receive at home or link them to agencies such as the Royal District Nursing Service and Western Domiciliary Care. The complaints occurred despite a pre-admission clinic survey which aimed to link elective surgery patients with support services.

Those examples are only two of a number of problems about which I have heard. Given the problems of early discharge from hospitals without adequate care and support, why did the Minister's department spend only $318 000 of the $4.72 million available for further allocation under the category of home based care services when there has been so much need for these services?

The Hon. M.H. Armitage: Where did those figures come from?

Ms STEVENS: They were included in the information delivered to me yesterday evening from Mr Davidge (page 5).

The Hon. M.H. Armitage: I am pleased to have been asked the question today of all days, having launched the new surgical strategy this morning, which was put together with the help of the surgeons. One of the standard questions put to me by the media relates to early discharge from hospitals. I have identified, as I have before—but the member for Elizabeth and others who look at these things politically rather than factually refuse to acknowledge, despite the fact that they have been told before—that the readmission rates since casemix funding was introduced have gone down. In other words, people are not being discharged—to use the phrase which the member for Elizabeth delights in using—'quicker and sicker'. They are not in that category, because the percentage of patients readmitted to hospital because something has gone wrong after they have been admitted has gone down under casemix. Now, that is a measure of quality of service.

Ms Stevens interjecting:

The Hon. M.H. Armitage: With respect, Mr Chairman, I would ask that the member for Elizabeth keep her chirpings until she has the floor and allow me to give the facts.

The CHAIRMAN: If the Minister does not respond, the comments are not noted in *Hansard*: they are ignored both by the Minister and by *Hansard*.

The Hon. M.H. Armitage: They deserve to be ignored but it is jolly hard to get the point across to you, Mr Chairman, and to the people who want to listen when that is going on. Anyway, the facts are that readmission rates are a measure of quality of service—they always have been. They have gone down under casemix funding. That is a fact and it is a point I have made before. The reason I referred to this morning's launch of our new strategy is that one of the leading professors of surgery in South Australia chose to take this matter up with the journalist who asked the question, and he was insistent about a number of issues. The most insistent he was about anything related to the fact that people who are discharged earlier do better clinically. There are clinical indicators for people to be discharged early. He said that they recuperate and rehabilitate better and, if they are at home, they are not vulnerable to a number of major infections which, distressingly so but nevertheless, are factually present in hospitals.

So, not the Minister for Health in a Liberal Government but a professor of surgery said that this is a clinically good thing to do. He went on to say that he was involved in day surgery when it was first introduced into the Royal Adelaide Hospital, and they were very concerned about how people might react, because there was some resistance. It was, in fact, a brave new world of medicine. So, they did a survey afterwards, with their hearts in their mouths, to determine how people felt about it. He informed me and the media this morning that 95 per cent of the people who had undergone the first day surgery in the Royal Adelaide Hospital said that they were absolutely delighted and hoped that any further episodes of surgery might be performed in a similar fashion. So, the professionals in the field are saying that it is a good idea to discharge people early, and the people who have had day surgery and are discharged say that it is the best thing since sliced bread. To provide the financial answers, I will ask Peter Davidge to address the Committee.

Mr Davidge: In relation to domiciliary care services, the information showed, on a subtotal basis, the 1995-96 initial budget for home based care services at $44.8 million, our latest expected outcome for 1995-96 at $41.6 million, and the estimated budget for 1996-97 at $41.8 million. I believe that the question revolves around the reduction from $44.8 million to $41.6 million. In respect of the $44.8 million, that information was provided to the Estimates Committee 12 months ago and was our best estimate of what funding might be allocated to the home based care program for 1995-96. That information is based on the best information we have at the time. A large component of the home and community care program funding is allocated to home based care services—I think in excess of 50 per cent of the money that the Health Commission receives under that program.

I understand that at the time the initial budget was struck there was an expectation of full indexation of around 4 per cent on funding, and that indexation, as it turned out, was significantly lower than that, resulting in a large reduction in what we expected to receive in 1995-96. There is also another component in respect of award funding that was expected to be allocated under that program. That did not eventuate either, because we have not been able to allocate the enterprise bargaining funding, as enterprise bargaining agreements have not been struck in the PSA and ancillary workers area. That would also have an impact on a reduced budget in that area.

Ms STEVENS: Will the Minister confirm that what he is saying is that there is not a problem with early discharge in our health system at the moment?

The Hon. M.H. Armitage: What I have said is that the professionals indicate that there is a clinical argument for discharging people from hospital as soon as possible. I have also indicated that the professionals say that they are the ones who ought to make the decision. As everyone on this Committee knows, it is the professionals who make the decision, not Government. For instance, the professor of surgery that I mentioned has actually taken some money from his surgical budget and put it into a salary for a nurse to visit people in their homes. The feedback they are getting from that program, which is allowing him to break down the roadblock of having people lying in hospital subject to

nosocomial infections, and having them out in their homes instead, is that people are saying that, provided there is a facility for identifying when something goes wrong—in other words, a wound infection or whatever—and there is ready access to a return admission to hospital, such as I identified before now occurs on fewer occasions than it did before, the patients love it.

Ms STEVENS: I asked for the Minister's view on whether there was a problem with early discharge in our health system—the Minister's view.

The Hon. M.H. Armitage: My view is that I will always take the professionals' advice.

Mr OSWALD: The Program Estimates at page 260 states that in 1995-96 the commission:

· commenced discussions with the Aboriginal Health council and TAFE concerning training and employment of Aboriginal health care workers;

And that 'increasing the employment of Aboriginal people in mainstream health services' was one of the 1996-97 objectives. What has the health system done towards increasing Aboriginal participation in its work force?

The Hon. M.H. Armitage: Before asking Brian Dixon to provide the answer, I should like to indicate that Mr Dixon's position as Executive Director of Aboriginal health within the commission was the first executive appointment in the Aboriginal health area in Australia. It was the first Aboriginal health division anywhere, so we have been particularly keen to focus on Aboriginal health as an issue. Obviously, Aboriginal employment is a major factor in general Aboriginal health. To provide the specific answer to the question, I hand over to Brian Dixon.

Mr Dixon: As the main focus on employment within the health system this financial year has been on increased participation of youth in the work force, the Aboriginal health division has been actively promoting the training and employment programs available through the South Australian Government's youth training and employment schemes for young Aboriginal persons. A total of 25 Aboriginal youth this financial year have participated in or are currently participating in these programs in the health system. To assist with the promotion, the Aboriginal health division has published and distributed a booklet entitled *A Career in Health*, which provides detailed information on occupations available within health, the qualifications required, if any, and details of relevant courses of study.

The booklet aims to encourage Aboriginal people to consider a career in health and/or study toward a health related qualification. This booklet was the main marketing tool used to promote the health system as a potential employer of the Aboriginal community at this year's work skills expo held at the Wayville Showgrounds in May.

There are also some important initiatives in relation to Aboriginal medical students. Currently there are three Aboriginal students studying medicine at Adelaide University—one third year and two second year students. The Aboriginal Health Division has successfully negotiated with the Aboriginal Employment, Education and Development Branch to provide financial support to these students in addition to their Abstudy allowance for equipment, textbooks and stationery. Further to this, the division has assisted with support for these students by providing work experience placements across the health system in both remote and urban settings, unlimited access to resource materials within the commission and provision of support personnel in a mentoring capacity.

The Hon. M.H. Armitage: Information that I have just received provides the Aboriginal employment statistics for the past four financial years. In 1991-92 there were 117 full-time equivalents; in 1992-93 there were 144, which is a 23 per cent increase; in 1993-94 there were 157, which is a 9 per cent increase; in 1994-95 there were 195 FTEs, which is a 24 per cent increase; and the projected figure for 1995-96 is 224 FTEs, which is an increase of 15 per cent. Importantly, we believe that the end of the financial year in a couple of days will see the health sector meeting the Government's target of 1 per cent Aboriginal employment for the first time. So, our movement upwards has been constant and pleasing.

Mr OSWALD: Before I ask this question, on behalf of the Committee I congratulate Brian Dixon on his recent appointment. How will the new Commonwealth-State framework agreement referred to on page 260 of the Program Estimates contribute to a better intersectoral approach to improving the health of Aboriginal people in South Australia?

The Hon. M.H. Armitage: It is very important to note that the signatories to this Commonwealth-State framework agreement will be the Federal Minister for Health, whom coincidentally I first met when he was the Federal shadow Minister for Aboriginal Affairs a number of years ago, so he has a longstanding commitment in this area, me as State Minister for Health and Minister for Aboriginal Affairs, Lois O'Donoghue from ATSIC, and I believe the Chair of the Aboriginal Health Council from South Australia. The goal of the agreement is for Aboriginal people to achieve equitable health outcomes with the broader community. All members of the Committee would recognise that, on the vast majority of indicators, Aboriginal communities certainly do not have equitable health outcomes. All the signatories to the agreement recognise that to ensure equitable health outcomes there will need to be a sustained, prolonged and cooperative effort from everyone, not only over the agreement but also beyond. Certainly, I know that the Federal Minister for Health and I are looking upon this as a very long-term agreement.

The emphasis on joint planning with a focus on the development of regional and community plans, which are so important to the Aboriginal community—they simply will not back anything which does not have community input—offers each party to the agreement an opportunity to form policies and make decisions with respect to existing and new mainstream and Aboriginal specific primary health care services. The principles in the agreement offer an opportunity for a coordinated and collaborative approach to the identification of health issues, including environmental health issues in Aboriginal communities which are so important, such as sewerage, water, electricity, housing and so on. In fact, environmental and primary health care policies and program arrangements will be addressed simultaneously as the regional plans are developed. The key is that the agreement contains a specific commitment to exploring innovative options for better intersectoral collaboration, and accordingly we should see a much more coordinated approach.

Mr OSWALD: Over the years, successive governments have attempted to address the issue of Aboriginal health, yet very little progress has been made in this area. On page 260 of the Program Estimates I notice that the Health Commission intends to 'improve access to mainstream health services for Aboriginal people' and 'initiate forums which encourage Aboriginal people to participate in decision-making processes regarding health issues that directly affect them'. Given that Aboriginal health still remains worse than for any other group of people living in Australia, how does the Health

Commission plan to address Aboriginal health issues that arise in the future?

The Hon. M.H. Armitage: We believe that, through the Aboriginal Health Division and the Aboriginal Health Council, the commission will have much better knowledge of current health issues and how best to address them in a culturally appropriate and sensitive manner which respects Aboriginal culture and the diversity that exists within Aboriginal communities. The beginning of the strategy is to ensure that appropriate consultation occurs with Aboriginal communities and health service providers. To that end I have ensured that there will be Aboriginal representation on each of the newly established country regional health services boards.

The Aboriginal Health Division is in the process of establishing Aboriginal health advisory forums in country and metropolitan regions to assist and support those regional health services and the regional advisory panels in their deliberations around Aboriginal health issues. The Hills, Mallee and Riverland Aboriginal forums are already established through initiatives taken by the Aboriginal communities in the area. Through preliminary discussions with other Aboriginal communities throughout the State, the Aboriginal Health Division found that Aboriginal people really like this option, saying that it allowed for active participation in decision making processes, which the Aboriginal communities like, in health issues that directly affect them. In collaboration with regional health services, the Aboriginal Health Division intends to develop training and support mechanisms for those Aboriginal members.

The forums will have an important role in assisting the commission to develop culturally appropriate strategies to address the imbalance existing in Aboriginal health at the local level and to give appropriate policy advice via the Aboriginal Health Council. The members of the Hills, Mallee and Southern Regional Board were recently involved in the development of initiatives to support the Aboriginal representative on the board, Shirley Gollan. The Aboriginal health worker and the regional CEO (respectively Barbara Wingard and Kevin Eglington) organised a cultural awareness day for board members. They involved local Aboriginal people from Camp Koorong, Point McLeay, Tailem Bend, Murray Bridge and Kalparren. The local board members were taught about the history of Aboriginal health in the area, the health services that Aboriginal people need, how they could be provided, how to ensure that they were accessible for Aboriginal people and so on. They discussed how future consultation should occur with the Aboriginal people in the area and how to support the single Aboriginal representative on the board.

It was there that the decision was made that a regional Aboriginal advisory group should be formed which would have two nominated representatives from each of the areas that I mentioned. The role of that advisory group will be to provide relevant information, support, advice and so on to the Aboriginal representative on the regional health board. I understand that similar advisory boards in other regions will be discussed in the very near future. I have to say that that is a fantastic initiative from the Aboriginal community, because sometimes the machinations of the board decisions might well seem irrelevant to some members of the Aboriginal community, and it is very important that the Aboriginal representative on the board is supported. I am very pleased with that outcome.

Ms STEVENS: I refer to page 258 of the Program Estimates concerning mental health. Will the Minister confirm that a serious incident recently occurred at a hospital in the country? The Opposition understands that, in this incident, a man suffering paranoid schizophrenia was released from Glenside Hospital, even though his medication had just been changed and his condition had not been stabilised. Following a relapse, we understand he was persuaded to attend the country hospital where apparently he assaulted the only GP in the town and held patients at bay for sometime.

The Opposition understands that the local police officer had a rostered day off and that police had to be called from 70 kilometres away to deal with the situation. We further understand that, because of their haste, the engine of the police vehicle blew up. Fortunately, this incident ended without disaster, but it highlights both the inadequacy of mental health facilities in country areas and the vulnerability of many small country hospitals.

Will the Minister urgently address the lack of adequate security at vulnerable country hospitals, and will he also ensure that, if this incident has been correctly reported to us, the protocols for the release of patients from Glenside and other psychiatric units are reviewed, particularly when patients are to be sent to isolated country areas that have no mental health facilities?

The Hon. M.H. Armitage: We are not aware of the incident to which the member for Elizabeth refers. If she chooses to give us some detail, we can obviously chase it up. I would remind members of the Committee that the last incident regarding which the member for Elizabeth raised a matter in relation to mental health was in Question Time when she indicated that someone had slashed their wrists and throat, and clearly the allegation was that we were providing inadequate services. You will probably remember, Mr Chairman, that the report was there was no wound at all on the throat, and the slashed wrist was fixed with a bandaid. I would like to know the actual details so that we can determine whether or not the facts are correct.

Six to eight weeks ago, the chairs of the regional boards raised with me the issue of training for staff and I discussed the implementation of in-service training for people to better understand the demands of those with a mental illness. The regional board chairs thought that would be an excellent outcome from the meeting that we had, and that will be applied.

In relation to security, obviously anyone dealing with hospitals, for all sorts of reasons, have security problems. We will address that matter. Some of these questions in mental health go back to the general philosophy of how one treats someone with a mental illness in twentieth century liberal democracies. I am almost tired of saying to the House that the Government does not believe that it is appropriate to lock people up.

The Opposition has delighted in identifying alleged problems—and I emphasise alleged problems—in the system, and criticising what we are doing, despite the fact that it is in line with national mental health policy, without at any stage identifying what it believes is appropriate. If having people in the community is inappropriate, as the Opposition is telling us, the only conclusion that I can draw is that the Opposition wishes to lock up people with a mental illness. I have to say that I thought those views went out with buttoned-up boots. It is disappointing, but evidently they have not. However, in relation to the specific protocols about which the member for

Elizabeth asked, I would like Mr Beltchev to provide some information.

Mr Beltchev: The specific protocols for discharge of clients who come from country areas are about to undergo major change as new services are developed centrally. Essentially, the current situation is the discharge decision is a clinical decision and, where it is at all possible, a discharge plan is developed at the point of admission of a client. When the point of discharge has been reached, depending on the legal status of the client concerned, a support program is developed and responsibility for that is transferred to the community-based team.

In relation to protocols for discharges in the future, there will be the opportunity for a far more focused approach. The planned development of an acute inpatient unit dedicated to servicing the country population, its link with a telepsychiatry unit—which will also provide a direct service, a clinical service and a support service to country mental health professionals—and the strengthening of the community teams in the country will enable discharge protocols to be developed in a very detailed way so that not only is the plan for the individual done in more depth and detail but also there will be the opportunity for follow-up by community teams, and the telepsychiatry and emergency and triage service will be able to monitor the discharge once it has occurred.

Ms STEVENS: I understand that this incident occurred at Karoonda hospital. I would appreciate the Minister's looking into it. The Minister referred to an issue that I raised previously in the Parliament, that is, a letter from an acquaintance of that person. In the letter, that person was talked about being overlooked and uncared for in the casualty section of one of our major teaching hospitals. In the Minister's attempt to be defensive, he seeks to diminish the real issue in that letter by focusing on the detail he mentioned.

The Opposition does not delight in raising mental health problems, but I must say that, every time we do raise them, we get hundreds of calls and contacts from people who say that the services are presently inadequate. Our position is not a return to institutionalisation but the setting up of a comprehensive range of services from acute hospitals through to community care, which is not provided at the moment.

The Hon. M.H. Armitage: A couple of days ago the Leader of the Opposition was quoted as saying—and we all know it was for the political headline—'We got it wrong. Deinstitutionalisation is not the right policy.' Therefore, the obvious conclusion is that institutionalisation is correct.

Ms Hurley interjecting:

The Hon. M.H. Armitage: As I said, it is back to the nineteenth century.

Ms STEVENS: The Minister and the Premier have continually reassured us that all problems in the mental health system will be overcome when the new arrangements for the mental health realignment commence on 1 July. I listened with interest to the description of the community staffing arrangements for the crisis intervention teams, the mobile assertive care teams and the case managers, but I understand that not all the positions will be filled by 1 July. Will the Minister guarantee that those positions will be filled by 1 July; if not, when? Will he say whether he is satisfied that the level of staffing will be satisfactory; if not, are there any contingency plans to increase the number of staff to the required level?

The Hon. M.H. Armitage: I am satisfied that the level of staffing will be appropriate and adequately trained, but in relation to the overlap of the new service with the present one, I ask Mr Beltchev to explain the details.

Mr Beltchev: The structure of services for the realigned mental health system provides for the establishment of two new services, therefore two new teams, in each of the three metropolitan regions, with similar arrangements in the country areas.

The two new teams and services are the ACIS teams (the Assessment and Crisis Intervention Service) and the MAC teams (the Mobile Assertive Care Services). In addition, there will be a continuation of case management teams and rehabilitation services. The two new teams have been defined in terms of numbers and, based on interstate experience, on a per capita basis; teams will vary from region to region, but approximately 10½ positions will operate the emergency services and seven positions will operate the mobile assertive care services. The new services will be phased in, the original plan being that they would begin on 1 July. Because of continuing detailed and thorough consultations with staff and unions to ensure that every aspect is covered, these services will commence later in July rather than on 1 July. They will be systematically phased in so that current services remain operational until the new services can take over.

Ms GREIG: I am keen to explore initiatives undertaken in the export health area. Will the Minister outline where we are on the global market. I note from page 263 of the Program Estimates that the South Australian Health Commission intends to 'assist new opportunities within health which may attract and generate economic activity including opportunities to sell skills, intellectual property and services'. Have we won any major overseas projects and what work are we doing internationally with health education?

Mr Blight: In October the Health Commission formally established a health industry and export development unit within its central office. This is a modest commitment of resources—a little over two full-time equivalent staff—but in these times it is a significant commitment to an important area of our responsibilities. This unit is tasked to identify commercial opportunities and to sell South Australian skills, intellectual property, systems and services on international markets. The unit is headed by Mr Andrew Davis, who has completed for executive consideration an export strategy for the South Australian health system.

In February this year, the Premier launched a contacts directory which listed over 100 South Australia businesses that export overseas, products ranging from sutures through to services such as medical education. The Premier also launched a video and brochure promoting South Australia's health industry's skills, services and products; copies of that video have been sent to our agents and representatives all over the world; and the initial feedback has been very encouraging. We are working with the industry in South Australia to develop its own health industry association so that members can cooperate in supporting each other to maximise their trading potential. The response from the private health and health related industries in South Australia has been strong and that is welcomed. There is certainly a growing enthusiasm and interest on the part of the private sector in working with the public sector in this State.

Within South Australia a number of health export projects have been proposed, investigated or launched by public and private hospitals and health services. One project has been a patient transfer scheme to Adelaide and the Aushealth group, a unit under the control of the IMVS Council, is bringing patients into Australia, mainly from Indonesia. Recently, they

were awarded approval to operate a clinic in Jakarta, which is a major plus: until now the placement of expatriate service staff in Indonesia has been prohibited. That reflects the long commitment and relationship that Aushealth has had with its Jakarta counterparts. The Ashford Hospital is also operating a patient transfer scheme to Adelaide for cranio-facial, renal and cardiology patients.

Another important area is education and training for medical, nursing, allied health and administrative staff. This is now reasonably common in each of our tertiary institutions throughout South Australia and is often the result of the initiative of individual practitioners or managers from our service and educational units. This year projects have proceeded in Thailand, Indonesia and PNG. Importantly, we believe that there are about 40 Asian medical students who are passing each year through our medical schools, largely as a result of initiatives of the University of Adelaide, and we believe that augurs well for our future prospects in Malaysia.

Education is recognised overseas as a strength of the SA health system. Not only do we have full fee paying medical students in Adelaide but there is a growing off-shore commercial market for nursing education. An example would be the Flinders Medical Centre and the Flinders University School of Nursing initiative, where they completed a contract to train a group of nurses from the Ramathebodi Hospital in Thailand.

We believe that there are major opportunities in the area of applying advanced telecommunications and IT to health service provision and health education. We talked earlier about our efforts in the telemedicine health-on-line and Health Plus arenas. On a recent visit to Malaysia we were pleased to hear from the developers of a technology park in Malacca that South Australia was considered to be a world leader in telemedicine, and we intend to build on that reputation. We expect that in future these sorts of applications will form a basis for substantial export opportunities as Asian countries continue to develop and modernise their health systems.

The third category of opportunity relates to the sale of intellectual property and licensed products. This group of opportunities includes support for overseas ventures by providing consultative advice and the sale of products and services exported by Medvet Sciences, under the IMVS Council, which is earning real cash for South Australia.

Other types of opportunity are those in which overseas investors are showing an interest in South Australian-based health businesses. For example, during the year Berjaya, a Malaysian company, purchased a 50 per cent interest in Gribbles. The Health Commission played a significant role in bringing those two companies together, and we are now engaged in discussions with Berjaya and Gribbles to provide off-shore training in laboratory technology.

We believe that there are considerable opportunities for South Australian health products and services overseas, particularly in the Asia Pacific region. Success does depend very substantially on the development of relationships. These relationships require a significant investment of time, and we have to be committed to being in the market in the long term in order to capitalise on the very significant wealth that can flow from contracts. The Health Commission is committed to identifying and pursuing opportunities to make South Australian health-related products available overseas.

Ms GREIG: On page 34 of the Capital Works Program, Financial Information Paper No. 2, details are given of three private sector projects which will proceed at public hospitals during the 1996-97 financial year. Can the Minister elaborate on the work being done by the Health Commission in encouraging private sector involvement in collocation on all metropolitan hospital campuses?

The Hon. M.H. Armitage: In answering this particularly important question, I would like Mr Michael Forwood to address the Committee.

Mr Forwood: The Government's program in providing opportunities for the collocation of private hospitals on metropolitan public hospital campuses derives from the Metropolitan Adelaide Strategic Health Facilities Plan, which provides a strategic framework for the reconfiguration and development of facilities for public patients at our major metropolitan hospitals. The program has been designed to attract private sector investment in the provision of new and replacement facilities for public patients and to optimise mutually beneficial arrangements between collocated private and public hospitals.

Every effort has been made to resolve the issues which have delayed the commencement of construction of the Torrens Valley private hospital on the Modbury public hospital campus, and it is expected that a definitive solution will be determined in about two months time. Contracts have been signed with Ramsay Health Care for the construction and commissioning of a 100-bed private hospital on the Flinders Medical Centre campus which will include cardiac catheterisation and day surgery facilities for public patients. In addition, Ramsay will lease and refurbish an area in the FMC public hospital for step-down nursing and public patient hotel accommodation.

The Queen Elizabeth Hospital development project aims to secure a 60-bed private hospital as part of a comprehensive redevelopment of that campus, including the provision of substantial new facilities for public patients. The master planning study under the Metropolitan Adelaide Strategic Health Facilities Project at the Repatriation General Hospital, Daw Park, was recently completed, and the Repatriation General Hospital board and the Health Commission have formally endorsed a planning option which will provide a significant area with Daws Road frontage for a potential collocated private hospital.

Planning is proceeding towards obtaining formal Government approval for a public call for proposals for a collocated private hospital to provide private patient services and programs which are complementary to the medical rehabilitation, geriatric and mental health services located at RGH and which are, in every respect, consistent with the agreed future role and function of the Repatriation General Hospital.

Master planning studies are also proceeding and nearing conclusion at the Noarlunga Health Services and the Royal Adelaide Hospital. These are well advanced, and the master planning options will include options which are amenable to private sector participation in the financing, construction and provision of public and private hospital facilities and services. It is expected that master planning at these two hospitals will be concluded early in the 1996-97 financial year.

On the basis of the excellent outcomes for Government at the Flinders Medical Centre, the Health Commission is optimistic that the planning and tendering processes at the Queen Elizabeth Hospital, the Repatriation General Hospital, the Noarlunga Health Services and the Royal Adelaide Hospital will provide significant benefits for those participating in public hospitals and for any successful private sector bidders.

Ms GREIG: I refer to page 34 of the Capital Works Program. I note that a contract was signed between FMC and Ramsay Health Care for the building of a private hospital at the Flinders Medical Centre. Will the Minister provide details of the contract and explain how this will be beneficial to the Flinders Medical Centre and people living in the southern suburbs?

The Hon. M.H. Armitage: This is a particularly important question for people in the south, and I am delighted that the member for Reynell has asked it. It is a great example of what cooperation between public and private sectors can do for the public sector patient. The recently signed contract between the Flinders Medical Centre and Ramsay Health Care will provide a wide range of benefits to residents in the southern suburbs, and not only in the health area. The construction to be undertaken at the Flinders Medical Centre will be the largest construction project that has occurred in the southern region for a number of years, with a total project cost of approximately $60 million, including a construction and equipment cost of almost $50 million. That is a very large expenditure and clearly it will have significant multiplier effects within the South Australian community in general and within the southern suburbs in particular.

The investment by Ramsays will see the construction of a 100-bed private hospital linked physically on three or four levels with the northern end of the Flinders Medical Centre. Very importantly, as part of the building project, Ramsays will build and equip a day surgery complex which has the capacity to take between 8 000 and 10 000 day cases per year. The Flinders Medical Centre has contracted the delivery of a substantial number of public day procedures from this facility with Ramsay Health Care providing the physical and support infrastructure and Flinders Medical Centre doctors carrying out procedures on public patients.

Ramsays will provide this service at a cost well below Health Commission benchmark prices. Not only do the patients benefit from the new day surgery unit and the advantages of that but the budget line is also served particularly well because it is carried out at less than benchmark prices. Ramsays will lease space within the public hospital at commercial rates and refurbish this space to provide a 35-bed step-down nursing unit for public patients which will relieve a lot of pressure on the Flinders Medical Centre acute beds. Again, this service will be provided by Ramsay Health Care at a significant saving to the Flinders Medical Centre budget.

Ramsays are also providing a cardiac catheterisation laboratory to carry out all such procedures for public patients at a price that is extremely attractive to Flinders and the Health Commission. Savings from these contracts for public patient services and the voluntary move of privately insured patients from Flinders to Ramsay's facility will enable Flinders Medical Centre to provide an additional 2 100 surgical inpatient weighted separations at no additional cost to Flinders or to the Health Commission. These additional separations will be critical in helping Flinders meet the increasing demand on its surgical services caused by the southern suburbs population growth, about which the member for Reynell reminds us so often.

Flinders is also providing a number of services to the Ramsay's facility on a commercial basis, including pathology and radiology, and profits from those commercial arrangements are part of the reinvestment to enable the increased service load that I have just mentioned. The Government is providing no financial guarantees to Ramsays and the public patient contracts are provided on a purely commercial basis. In obtaining access to day surgery, cardiac catheterisation and step-down nursing care facilities through this arrangement, the Health Commission and Flinders have saved approximately $12.5 million in future capital investment, which would have been required in the medium term at Flinders to provide that sort of infrastructure.

In addition, for the risk of procuring and maintaining these facilities at the higher standards reached with Ramsays, Flinders pays only a service charge for public patient services and no availability charge is required for access to those vitally needed facilities. As I am sure the member for Reynell acknowledges, the board of Flinders Medical Centre, Ramsay Health Care and the commission have done a fantastic job in putting together this innovative and very mutually beneficial arrangement. I am confident that the residents of the southern suburbs will benefit and will be delighted with all the pluses that will flow from the project.

Ms Greig interjecting:

The Hon. M.H. Armitage: As the member for Reynell says, it is a real win for the southern suburbs. It is great.

Ms STEVENS: My question relates to the Program Estimates, page 250, and Modbury Hospital. In a recent letter to shareholders, Healthscope Chairman (Mr Kevin McCann) announced the appointment of a new Managing Director (Mr Bill Kricker) at an extraordinary general meeting of shareholders on 30 April. Mr McCann's letter stated:

> I also informed the meeting of our experience to date with the management of the Modbury Public Hospital, outlined the difficulties we have had in managing this contract and stated our intention to resolve these issues with the South Australian Government in a constructive manner as soon as possible. . . Governments have experience in contracting for building and equipment but little experience in contracting for services. . . It should be clearly stated that our problems are concerned with the management of the contract and not the management of the hospital which continues to provide excellent public health services to the people of Adelaide. We now intend to clarify Healthscope's contractual obligations with the South Australian Government. We have confidence that Mr Kricker and his executive management will achieve this.

This letter to shareholders comes after comments in the press on 15 March by acting Healthscope Chief Executive Mr Geoff Leonard indicating that returns from the hospital were 'unsatisfactory' but Healthscope was 'working with the South Australian Government to secure long-term financial returns from the Modbury Hospital contract that were originally contemplated by both parties'. What is the nature of the difficulties that Healthscope has experienced with managing the Modbury Hospital contract, and what clarification of Healthscope's obligations has the Government provided?

The Hon. M.H. Armitage: It is important to spell out that we have a contract with a private provider of services to provide public hospital services. If the private provider's return from the contract is unsatisfactory, that means that the contract that the Government wrote is a very tight one for the private sector. In other words, we have out-negotiated the private sector—clearly that is the implication. It is not a matter of its being an unsatisfactory contract. The bottom line is that Healthscope does not want to concede that there is a possibility that its return may be not what it expected.

The fact is that the contract went through all the due diligence processes of Government, with vetting by endless numbers of central agencies, and that was the genesis of a five or six week delay in the final signing of the contract, to ensure that all those agencies would sign it off, and it was

signed off as a wonderful contract for the Government. I do not want the member for Elizabeth to have forgotten the Modbury Hospital patients' satisfaction survey, which I detailed earlier today. If Healthscope is finding contractual difficulties, that is a matter between the contractors, but it is having no effect whatsoever on the services being provided.

Let me remind the member for Elizabeth that 97.9 per cent of patients who had been in Modbury Hospital identified that they would recommend the public hospital to their friends and relatives, and that it was above average on two-thirds of the questions and 5 per cent above average on one-third of them compared with hospitals around South Australia. If Healthscope has some contractual concerns, it is not affecting the patients' service delivery one iota. I invite Ms Gaston to talk generally about the issues that were raised at the liaison meetings, which was part of the substance of the question.

Ms Gaston: A liaison meeting is held on a regular basis—it is now fortnightly but generally monthly—between representatives of Healthscope, the Modbury Public Hospital board and the Health Commission. Recently, we formalised an agenda consisting of a list of the expectations outlined in the management agreement of each of the parties to the agreement. Specifying the expectations from each party has proved to be a very workable way of managing the contract. The other elements dealt with by the liaison committee tend to focus on issues around the contract as opposed to the management of the service. As far as service management is concerned, meetings are held between a representative of the Modbury Public Hospital board and Healthscope on a weekly basis to deal with the general day-to-day running of the organisation of the hospital.

Another matter in respect of the contract is the proposed post-implementation review of the Modbury Public Hospital management agreement. We are currently in the process of drawing up the terms of reference for that review, which was promised following the first 12 months of the Modbury Public Hospital management outsourcing. We expect the review to commence next month, in line with the terms of reference that will be agreed by each of the parties—again Healthscope and the Modbury Public Hospital board. However, it will be the responsibility of the commission to manage the review. Other management activities include a requirement on the part of Healthscope to provide monthly management statistics along the lines of those required of other hospitals. As indicated previously, the hospital is also required to have a quality control committee, and we have already heard the results of the patient satisfaction survey.

Ms STEVENS: Does this clarification process involve any reinterpretation of how the commission will enforce the contract?

Ms Gaston: Certainly not to my knowledge. There are no discussions about aspects of enforcement, but rather aspects of expectation and responsibility within the management agreement.

Ms STEVENS: The summary of the Modbury Hospital contract issued by the Minister in early 1995 indicates that provision is made for a dispute resolution committee involving members of Healthscope, the Modbury Hospital board and the Health Commission. Given the comments of the Chairman of Healthscope concerning the contract, has this committee been activated to deal with the concerns of Healthscope? Can the Minister outline its membership and the number of times it has met?

Ms Gaston: As I have indicated, the liaison committee has established an agenda for determining not only the expectations of each of the parties outlined in the management agreement but also some of the functions. One of them, as the member has indicated, is the dispute resolution committee. That committee has not been established yet. In fact, discussions are occurring at the moment in respect of the establishment of that dispute resolution committee. The fact that it has not been established indicates that, to date, there have been no disputes.

Ms STEVENS: In view of the Minister's answer to the questions in relation to the metropolitan health planning committee and his insistence that the committee's findings were not statistically valid, and therefore were not worthy of real consideration in terms of decision-making, can the Minister provide the Committee with all that information and the evidence of its statistical validity?

The Hon. M.H. Armitage: I indicated earlier today that the survey was coordinated by the Association for Quality and Health Care. I have asked that question—is it statistically valid—and I have been told that it is. I am informed that we can provide the honourable member with the information, and I undertake to send it to the honourable member.

Ms STEVENS: The Minister has been informed that it is valid. Has the Minister seen any evidence to indicate that it is valid?

The Hon. M.H. Armitage: I have not, but Ms Gaston informs me that she has. I will provide the honourable member with the information.

Mr BUCKBY: Page 257 of the Program Estimates mentions including ISDN lines to country hospitals as a strategy to increase communication, including the use of electronic mail. Can the Minister explain what this is expected to achieve?

The Hon. M.H. Armitage: As I have indicated in previous answers—and I believe even to the member for Light, but certainly in the Committee today—we are putting great store on information technology to help us generate efficiencies and improvements in patient care over the next decade. The corporate objectives of Info 2000 are dependent upon a stable area network. Without the implementation of that network, many of the Info 2000 objectives would be undermined. The corporate objectives include common systems across the whole of South Australian Health and the introduction of a clinical information system to support the continuity of care. Indeed, earlier today we identified the benefits of some of those clinical information systems.

A wide area network is available for the use of a number of Government agencies, including Health. We do not own the network—we lease it from EDS. The larger country hospital sites need access to Statenet for electronic mail (e-mail), Microsoft exchange and MMSS reporting to which spreadsheets can be attached as mail documents. WISE connectivity is in place with three of the four large health facilities; and ISCOS connectivity (which I am told is a New South Wales morbidity and patient information data collection function), which deals with on-line queries from the facilities on the performance of the facilities in each of the regions, is also available. It is also important to be on Statenet for the integration of voice and data over the same services. An improvement in the application of pathology services will also be possible with a move to 'ultra' Internet connectivity via the existing Statenet service. So, there are a number of opportunities for better coordinated, more efficient and more effective care through the use of modern technology underlying all the corporate objectives of Info 2000.

Mr BUCKBY: How will the commission regulate its business with each of the seven new regional health boards, as described on page 259 of the Program Estimates?

The Hon. M.H. Armitage: The principal regulation of business between the commission and the regional boards will consist of an extension of the health service agreement system that has been implemented over the past few years between the commission and the health units. The health service agreements with the regional boards will spell out in quite broad terms the areas of health service delivery that each region will be expected to provide and the level of activity that the region will be expected to achieve. A working group of regional Chairs, regional General Managers and commission staff has examined the existing service agreements. A process of modification has occurred, so that the altered reporting and management relationships that now exist under a regionalised system (as opposed to the previous system) suit those changed circumstances.

Once there is a service agreement between the Health Commission and each regional board, the regional boards will in turn arrange health service agreements with the boards of each local health unit, with the same types of expectations and so on to come out of them. Basically, the business will be regulated via the health service agreements that have been extended for the circumstances of regionalisation.

Mr BUCKBY: What are the advantages of the new country regional health board system, and will these boards be able to make any improvements in the services delivered to the communities within each region?

The Hon. M.H. Armitage: The member for Light has really addressed the reason for regionalisation, in asking whether the boards will be able to make any improvements in the services delivered to the communities. That is the underlying reason for regionalisation. I thought it might be good backgrounding to detail some of the figures in relation to the regions, so that everyone has a concept of what the regions are dealing with.

The seven regions are: the Hills, Mallee and Southern, which in 1994 had a population of 99 673 people and a budget in 1994-95 of $31.6 million, which is a significant amount of money; the Wakefield region, with a population of 78 578 and a budget of $26.2 million; the Mid-north, with 32 000 people and a budget of $22.4 million; the Riverland, with a population of 34 213 and a budget of $16.7 million; the South-East, with 62 044 people and a budget of $31.1 million; Eyre Peninsula, with 32 724 people and a budget of $19.5 million; and the Northern and Far Western, with 54 093 people and a budget of $41 million. So, we are dealing with quite large groups of people and quite sizeable budgets.

The boards themselves comprise as membership nominees from the health service units or clusters (as one of the arrangements was) legal, financial and management expertise, Aboriginal representation, as I have detailed, the regional medical practitioners and consumers. In fact, the main advantage of a regional health board system is the ability of the boards to involve the individual communities in the regions in dialogue and planning concerning the delivery of relevant and reasonable services in those areas. The process ensures that the decisions about the health services provided in regions are made at regional level rather than by the central bureaucracy. It is certainly one of the things that people in rural areas have complained about for the longest time. This overcomes that problem.

Very importantly, the boards are made up of people who work and reside in the region. In the regionalisation process, certainly in some other States, there was some concern, particularly with the more easily accessible rural boards, that people swanned in from the large towns and in fact had no idea of regional dynamics. The people on the boards will work and reside in the regions and, importantly, they have accepted quite a deal of responsibility for ensuring that the health services available to the people of the region are relevant and appropriate within the finance available. They know that they have a number of constraints, but it is really delightful to see the enthusiasm with which those boards are approaching the task of being a really representative board for their communities and their regions in the provision of health care.

What all that leads to, of course, is that now there will be an improved ability to coordinate and integrate the provision of services to the communities of a region rather than with any parochial focus, and as a direct consequence of that it will be possible to provide better service because of decreased administration, duplication and so on, which may well lead to savings, which can be reapplied into service provision etc. The question really allows the reasons for regionalisation to be fleshed out.

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

Ms STEVENS: My next question refers to page 262 of the Program Estimates and the Julia Farr Centre. Recently I had a meeting with a number of parents of patients at the Julia Farr Centre. A meeting was organised for me by the Brain Injury Network. I quote from a letter which was written to the Minister on 23 January 1996 by Ms Dawn Brooks, the Executive Officer of that group, and to which she has not yet had a reply. Some of issues raised were covered in her letter to the Minister back in January. In part, the letter states:

> The Brain Injury Network has had a number of phone calls and office contacts with family members concerned about their relatives in Julia Farr Centre. Some relate to the recent announcements that the number of nursing staff will be reduced as a result of a Health Commission review. Those who have contacted BINSA are concerned mainly because nursing staff have given them alarming forecasts about the future well-being of their relatives. There do not seem to be plans to ensure that adequate staffing levels of appropriately trained staff to assist in rehabilitation and daily living, training or personal care are going to be available.

The letter goes on, and the Minister may recall receiving it back in January. How many nursing staff were reduced at the Julia Farr Centre as a result of the Health Commission review, and what action did the Minister take to address concerns raised by parents and family about alarming forecasts for the well-being and future care of clients at the centre?

Membership:

Mr Rossi substituted for Ms Greig.

The Hon. M.H. Armitage: Before asking Colleen Johnson to address the substance of the question in relation to nursing numbers, I would like to clear up a couple of things which I think have been alluded to in the question and which clearly need explanation. The first was an allegation that I had not responded to a letter from Dawn Brooks of BINSA who is the Chair of the Disability Advisory Council on my recommendation and who I believe has an excellent knowledge of matters in the disability area. I guess if you are

asking whether I have put pen to paper, the answer is 'No,' but if you are asking whether Dawn has had numerous contacts with my office and a number of specific phone appointments with me in relation to matters dealt with in the letter, the answer is 'Yes.' So, whilst I might not have written to her, it is simply incorrect for an allegation or an assumption to be made that I have either ignored or not taken account of her input or concerns. As I indicated before, Dawn is an extraordinarily adroit advocate and a very skilled person with lots of knowledge about the system.

With respect to the general matter of Julia Farr and an allegation, I guess, of savage cuts in nursing numbers and so on, I need to revert slightly to history. When I was made the Minister in December 1993, one of the very first issues with which I was confronted, which caused me considerable angst as to how it might best be handled, was the release of the Ernst and Young report, a consultancy called for not by this Government but by the previous Government. The previous Government, one can only imagine, would have called a consultancy in good faith, recognising that there were some matters that needed to be looked at.

It is fair to say that that consultancy has been accepted by the Government on the basis that the directions it was heralding for Julia Farr were in line with, I believe, best practice for people who are at present in Julia Farr Services. So, it was a matter of a consultancy that has been actioned, but the consultancy's terms of reference were called by the previous Government. So, there is nothing sinister about this at all.

Ms Stevens interjecting:

The Hon. M.H. Armitage: Well, one usually takes the advice of consultants. One appoints them because one believes they have some expertise or skill in an area, and accordingly it is wise to accept their advice, unless it is clearly unsatisfactory for a specific reason. In this case, it was not.

We will deal with nurse numbers in a minute, but it is fair to say that one of the prime focuses for change in relation to the way in which services will be provided through JFS in the future in fact did revolve around nurse rostering, nurse numbers and so on. It does not surprise me that there are some people who potentially misunderstand—I am not in any way suggesting that Dawn does, but I know that a number of residents and carers perhaps do—the intent of the Ernst and Young consultancy report and hence are, I believe, unnecessarily fearful for the outcome once those recommendations are actioned. I would ask Colleen Johnson to address the Committee with respect to the specifics.

Ms Johnson: I believe there are several issues raised in that question: one is the matter of nursing numbers; the second is the concern about the future service delivery within Julia Farr; and the third is the quality and direction of rehabilitation services. It is true, as the Minister said, that a review of Julia Farr commenced some years ago, and that was a review undertaken by Ernst and Young to give advice on future direction for Julia Farr Services. There were 47 recommendations in that review, the report being released in May 1994. Some of those recommendations were directed at nursing practices, rostering arrangements and shift patterns, staffing numbers, skill mix and so on. There has been some implementation of those recommendations since then.

However, subsequently, about 12 months ago, Julia Farr, in cooperation with the Disability Services Office, had a review of its nursing services undertaken by Ms Kay Martin from the Country Health Services Division, using models and methodology well utilised in country hospitals and so on within this State. The outcome of that review identified 181 FTE excess positions. The nursing report was tabled at the meeting of the board of directors of Julia Farr on 24 November 1995, and at the December meeting the board decided to accept in principle the recommendations of the review, and asked the Chief Executive Officer of Julia Farr to develop an implementation strategy. This included consultation with unions with a view to implementation occurring during 1996.

I understand that several meetings have taken place between the management of Julia Farr, representatives of the Health Commission Human Resources Division, the Disability Services Office and the Australian Nurses Federation to discuss the implementation of that report. Management at Julia Farr has conducted information sessions with nursing staff to ensure that they are aware of the implementation and, as I understand it, any implementation is in the very early days.

The larger issue is the concern and confusion that arises within an organisation when it is facing significant change. The original consultancy conducted by Ernst and Young and the subsequent consultancy examining the nursing services were undertaken for a couple of reasons. First, as the Minister has said, the style and model of operation of an institution such as Julia Farr Services is far out of date. It is a style of service that others within this country and elsewhere in the world have deemed to be inappropriate in this decade. Secondly, activity and client numbers within that organisation have been falling dramatically over the last decade. In fact, I understand that at present they have 250 residents: a decade ago the figure would have been 600. They have nursing and other staffing numbers which are not in accord with their activities. In effect, the cost of services at Julia Farr is far in excess of the cost of similar organisations and institutions both within this State and interstate. It was for that reason that the Ernst and Young review was followed up with the nursing review.

I understand that some people are concerned about the future. Every effort is being made to ensure that service delivery is not being compromised or threatened and, in looking at the current cost of care within Julia Farr and the current staffing complements, there is no reason why services and quality of care should be compromised. There ought to be considerable leeway for further adjustments before there is any threat at all to the quality of care. However, in line with our philosophy and direction in the disability sector as a whole, we are being pro-active and asking all residents to indicate what sort of lifestyle they would prefer. Many people do not want to live in an institution of that type and are keen to see other arrangements in place. Options coordinators are now working at Julia Farr—an options coordinator is assigned to every resident—and they are discussing with residents what sort of service they might like and where they might want to live. We are hoping that we can individually design services for all residents.

I have been involved in discussions with parents associated with BINSA. Those discussions have indicated a slightly different concern in that they are unhappy with aspects of the community rehabilitation services operated by Julia Farr. I had an extensive meeting with them at which they voiced some concerns, and Julia Farr management recorded those concerns to facilitate a process of addressing those concerns. The Manager of Brain Injury Options Coordination, Geraldine Jones, agreed to convene further meetings of

parents to give them an opportunity to voice their concerns and then for options coordination to participate in helping Julia Farr address those concerns and put other arrangements in place.

I think that covers the nursing question; hopefully, it covers the concerns about rehabilitation services and also the concerns arising where we have activity falling, excessive staffing numbers in some areas and the necessary concern that that can cause the staff involved. I can assure all members that there are many discussions and negotiations taking place, and options coordination has a key role in identifying more appropriate alternatives for residents. Many residents are keen to get on with those altered arrangements and create a different lifestyle from the one they have had over the last decade or so.

The Hon. M.H. Armitage: This is one of the best examples of the options coordination role. There may be quite significant change for someone with a disability, and the options coordinator's specific role is to ensure that that person's needs are met through the services provided rather than because they are in an institution. Whilst we are addressing these matters, I think it is important to comment on the post-acute beds at the Julia Farr Centre, so I will ask Mr Blight to address that matter.

Mr Blight: In 1987, following the closure of the Kalyra Hospital (a 46-bed post-acute facility for rehabilitation which was used predominantly by the Flinders Medical Centre) those beds were transferred to the Julia Farr Centre. Following the Ernst and Young April 1984 review, there was a recommendation that those beds be transferred to the acute sector. The Health Commission arranged for consultants to analyse the options to do that and determine the most appropriate assignment of those beds back into the acute sector. Following that announcement, the Health Commission approved the transfer of those beds partly to the Royal Adelaide Hospital and partly to the Repatriation General Hospital, which occurred from 31 January. That is further evidence of action taken on that report.

Ms STEVENS: As I mentioned three weeks ago, I had a meeting with parents, arranged by the Brain Injury Network of South Australia, and I received a letter summarising what we had talked about. I want to detail this for the Committee because I think it is very important. I will summarise it as best I can. In part, it reads:

> The specific concerns at the service delivery level raised by our members are:
>
> 1. Poor management of change. . . .
>
> 2. Poor care practices; for example, wrong medication doses, splints not put on, or put on incorrectly (that is, the wrong way around, wrong limb, etc.); clients being left without panties on, not toileted when requested or required; not fed because it takes too long so the person said to be 'not hungry'; constipation not treated; fluid intake not monitored and drinks not given, resulting in the resident becoming quite ill; physiotherapy to reduce spasticity not provided; menstruation not monitored, resulting in parents finding their daughter saturated and having to throw her clothes away because they were so badly stained (panties and track suit); a person who is ambulant and able to speak and communicate and needing the stimulation of conversation with others placed in an area with other clients who are severely physically disabled and unable to communicate; placed in a share room with a client who is incontinent and having that person being changed in her presence constantly with no consideration for her embarrassment and dignity; and staff reprimanding clients as though they were naughty children.
>
> 3. Staff not focusing on the rehabilitation needs of clients. . .
>
> 4.' Holding on' to clients longer than necessary on one hand whilst at the same time having others waiting six to eight weeks for assessment and not able to get any formal rehabilitation. . .
>
> 5. Consumers feel there is no consistency in decisions about who gets what and that they are ill informed about the processes, eligibility and/or other criteria on which decisions are based. Decisions often seem to be made behind closed doors and then they are called in to be told what those decisions were rather than be included in the whole process.
>
> 6. Where plans agreed between staff and families were in place they are frequently ignored by the staff. . .
>
> 7. Poor discharge planning i.e. lack of referral to Options Coordination and/or involvement of Options Coordinators in the discharge planning process.
>
> 8. Families having to buy in additional services or provide therapy themselves daily because the level of services provided is inadequate.

There are a few more points. Dawn Brooks wrote again to the Minister on 21 May and I believe that she has not received a reply in writing to the second letter. In that second letter she states, 'Some recent decisions seem to reinforce and entrench the traditional model rather than reflect the recommendations of the Ernst & Young report.' In regard to what we have just heard, your officer said that she saw no reason why services or the quality of care cannot be improved and that a great number of discussions and negotiations are occurring, but when is this going to change?

The Hon. M.H. Armitage: The answer to that question is that it will change when the recommendations of the Ernst & Young report are completely actioned.

Ms STEVENS: When will that be?

The Hon. M.H. Armitage: A dichotomy of messages is coming from the member for Elizabeth, because what a number of the people have protested to her about is a fear of what will happen from the changes. On the one hand, the member for Elizabeth is saying that it is terrible that these changes are to be implemented but, on the other hand, she is asking when they are to be done—get on with it, what is taking so long? There is a dichotomy of messages.

The Government made a commitment in May 1994 that the Ernst & Young report would be actioned. Some of those changes will affect the residents and, importantly, industrial matters and budget savings, which are clearly a feature of the report, which states that there are 181 full-time equivalent nurses over the number. Some of those changes would be difficult for any organisation to engineer. While the Government recognises that, for the good of the people in Julia Farr, the changes need to be made, it equally realises that it does not want a revolution or great problems because of the speed of change.

The Government called in the then Chairman and the Chief Executive Officer, and we worked over a month or so to come up with a staged plan of action for the recommendations. The board, which does not now comprise all the same members, has backed those recommendations firmly. The board has agreed to that plan, and I have quarterly meetings with the Chief Executive Officer and the Chair of the board about the progress of these recommendations.

The answer to the honourable member's question is that there is a staged process over the next couple of years, given that it has been ongoing for a couple of years. When significant changes are made, most organisations can cope if they are allowed time to work through the issues, particularly the staffing issues. It was most noticeable to me that, when the report was brought down, a number of very senior people elected to take a TVSP. That can be worked through over the course of a number of years, but if you expect everything to happen immediately it is sometimes not easy. The recommendations are in train. As I said, we get a regular update on those matters. It is important to examine the sorts of accusa-

tions made by the member for Elizabeth in reading out the letter.

It seems to me that a number of those matters are eminently well addressed by considering the type of life-style that the clients, patients, or whatever one chooses to call them, may have. Matters such as poor care and poor management of medication are matters of standards which I will refer to the board, because they are important matters for the board. But a number of other issues concern the type of life-style that the person may want to live. Do they actually want to spend their lives in Julia Farr, or do they want the option of being in the community and living a different life-style? We are no longer in the paradigms of 20 or 30 years ago. In fact, many people with severe disabilities live perfectly well in the community. If anyone on the Committee wishes to visit some community homes I would be delighted to organise it, because it is a revelation. The changes will focus on those sorts of things which will allow a lot of those matters to be addressed.

In case anyone thinks that we are being overly harsh on Julia Farr, I should point out that the cost of care at Julia Farr on an annual basis is about double the cost of similar types of care at Strathmont and is nearly three times that at Minda. At Julia Farr the cost per person annually is about $100 000; at Strathmont it is about $45 000; and at Minda it is about $35 000 to $40 000. Where there are unmet needs in the disability area—and I make no secrets about that—it is imperative for the Government to move forward on a recommendation from a consultancy that provides carefully planned steps which allows choice for the people who are presently resident and which enables considerable savings to be made. Frequently, carers and parents are justifiably concerned about their relatives who are in places such as Julia Farr. Clearly, some of the matters are addressable by the board, and I shall do that. The bigger picture is what sort of treatment and life-style is best for those people. That is what these recommendations will do. I am absolutely confident that that is the way forward for the residents in Julia Farr.

Ms STEVENS: I found the 'poor practices' section which I read out extremely concerning. I would like to be able to assure parents that it will be less than two years before they can expect those things to change. I would like some assurance about what is happening in relation to addressing the matters I outlined because, quite frankly, two more years of that is completely unacceptable.

The Hon. M.H. Armitage: I agree. There is a misunderstanding which I definitely want to clear up. What I was talking about in a couple of years is the full implementation, denouement, if you like, of the report to see the recommendations in place and to see, potentially, very significant change at Julia Farr in the way services are provided for the present residents.

I agree that, if matters go to the nub of the standard of care, they can be addressed immediately. They are not difficult matters. They are not matters of budgets or politics, or anything like that: they are matters of standards of care. I am surprised that these matters are raised in this forum—that is what boards are for—but I will be delighted to refer them on to the board.

In relation to the general rate of progress on the recommendations, it is a fact that the board largely determines the rate of progress. We have an agreed position with the board that the progress will be according to a timetable. We can attempt to drive the process, but the board members make the final decisions. I make no bones about it: we would like the progress towards final implementation of the report to be quicker. One of the reasons is that money will be freed up from a number of these industrial changes which will provide opportunities for other service provision. I may be simplistic, but I would much rather have the salaries for 181 superfluous people identified independently from my going to provide services.

The board is the instrument making the pace of the change. As I have mentioned previously, we tried to change the Act, which would have given us more central power to make the changes; according to Opposition, we would have stomped on these sorts of boards. That Act was thrown out. By legislation, we have to agree with the individual fiefdoms that they are able to do what they want—and I am quoting the member for Elizabeth in using those phraseologies, as she would know. We are largely in their hands.

I am informed—and this is something the member for Elizabeth may wish to take up with some of her colleagues outside Parliament—that at this stage negotiations with the ANF in particular is one of the stumbling blocks. If the member for Elizabeth can do anything to advance those negotiations, clearly that would benefit the patients. We would be more than happy to partake in it because our goal since May 1994 has been to implement the recommendations as quickly as possible to allow the people presently in Julia Farr the choice to live where they may choose and to maximise the savings so that more services can be provided.

Mr OSWALD: Much discussion has occurred concerning insufficient medical staff in the mental health services. Can the Minister advise the Committee what steps are being taken to remedy this problem, if it exists?

The Hon. M.H. Armitage: I am delighted that the member for Morphett has asked this question because an impression has been created in the community, either malevolently or through lack of knowledge—but for whatever reason—that there are insufficient medical staff in the mental health service. The overall number of medical staff in the South Australian Mental Health Services at June 1996 is the highest that it has been in any year for the past five years. In June 1991 there were 85.5 full-time equivalent staff: in June 1996 there are 101. That is an increase of 18, 19 or 20 per cent in medical staff full-time equivalents from June 1991 to June 1996.

It important that we also look at the mix of medical staff. The number of consultants has decreased from 30 to 26, not the huge exodus that has been alleged. The number of registrars and trainees has decreased from 37.6 to 31.5. The number of medical officers has increased from nine to 20.6. The number of visiting specialists has increased from 6.3 to eight, which almost makes up for the decrease in the number of consultants, and the number of non-salaried medical staff has increased from two to 15.

An extensive recruitment process has been undertaken in an attempt to increase the number of consultants—there is no doubt about that—and overseas recruitment has resulted in the employment of several senior consultant psychiatrists with the added benefit of blending in their experience in psychiatric practice in different countries and cultures with our present medical services. Of course, this is of particular concern as Australia becomes much more multicultural. It is important that people with a psychiatric illness be given the greatest opportunity to communicate with their medical practitioner in the best way possible. Clearly, if the doctor speaks the same first language as the patient, that is of great benefit. So, the fact that we have been able to bring here several senior consultant psychiatrists who are obviously of

the highest quality in their medical work and are also fluent in another language is very positive.

As I said, the number of consultants has decreased, but interestingly it is not a precipitate fall-off. In June 1991, it was 30.39; in June 1992, it went up a little to 30.61; in June 1993, it was 29.87; in January 1994, which is basically when my Government took over, there were 23.48; and in June 1995, the number was 28. So, although the number went down by six from June 1993 to January 1994, it went up by four or five again in June, and it is now 26. Registrars and trainees have also oscillated, with numbers varying over that period from between 30.66 and 44.55, and it is now 31.5. That may be consequent on a number of things such as examination timetables. As I indicated, the number of medical officers has also oscillated, although not quite so much; indeed, it is now at its highest level.

The total of salaried staff has moved from 76.99 in June 1991 to 78.1 in June 1996—almost the same. It is in visiting specialists and non-salaried staff that there has been a great increase. Since June 1991 that has increased from 85.52 to 101.025 in June 1996. I think the answer to the question is that it is a furphy to say that medical officers have deserted public psychiatry in droves. We make no bones about the fact that we would like to have more, particularly senior, staff, but the figures prove incontrovertibly that the number now is the highest that it has been for the past five years. I seek leave to insert in *Hansard* some purely statistical figures which I think are appropriate.

Leave granted.

South Australian Mental Health Service
Analysis of Medical Staffing (in full-time equivalents)
1991-96

Category	Jun '91	Jun '92	Jun '93	Jan '94	Jun '95	Jun '96
Consultants	30.39	30.61	29.87	23.48	28.9	26.0
Registrars/Trainees	37.63	43.68	44.55	30.66	36.2	31.5
Medical Officers	8.97	6.83	6.96	13.68	20.2	20.6
Total Salaried Staff	76.99	81.12	81.38	67.82	85.3	78.1
Visiting Specialists	6.33	6.66	6.96	8.0	7.7	8.025
Non-salaried Staff	2.02	7.39	11.75	10.0	*7.0	*15.4
TOTAL	85.52	95.17	100.09	93.68	100.0	101.025

* This number is made up of other hospital staff working within SAMHS and also includes locum doctors

Mr OSWALD: Will the Minister provide details of the Health Commission's enterprise bargaining agreement with nurses?

Additional Departmental Adviser:

Mr R. Bishop, Executive Director, Human Resources.

Mr Bishop: From late 1994 to early 1996 the Australian Nursing Federation pursued a national salary increase for general nurses and mental health nurses through the Australian Industrial Relations Commission. The 8 per cent quantum originally sought was increased to 10 per cent in 1995. The increase that the Australian Nursing Federation sought was claimed for past productivity only. In December 1995 the Government agreed to secure a wages settlement that recognised the contribution of nurses for past efficiencies in the health system as well as gaining a commitment to future productivity improvements. In order to facilitate this strategy, the Government approved a departure from the whole-of-agency approach that was contained in the enterprise bargaining framework agreement, so that negotiations for an enterprise agreement with nurses could take place.

The negotiations resulted in an enterprise agreement with a life of two years being certified in the Australian Industrial Relations Commission on 28 February 1996. The 10 per cent outcome is consistent with increases gained by nurses in other States. The increase is to be paid in three phases: the first component of 6 per cent was paid from 28 February 1996; another instalment of 2 per cent will be paid from September 1996; and a final 2 per cent is to be paid from July 1997. The increase is in addition to the first $8 safety net increase and absorbs the second and third $8 safety net increases. The purpose of the agreement is to increase productivity and efficiency in the public health sector and to improve the quality of services provided.

The agreement contains a clause entitled 'Agreed agenda items', which are designed to achieve these efficiencies. Included within that list are the following items:

· Nurse classifications: definitions. The definition of 'registered nurse' and 'mental health nurse' as prescribed in the current respective awards is to be varied to reflect more accurately the needs of health units in relation to patient care and service delivery. The new nursing definitions to be inserted will be jointly developed between the Australian Nursing Federation and the Health Commission.

· Uniforms. The parties have agreed to examine the issue of uniforms in the context of organisational requirements. It is recognised by the parties that some individual health units may not require nursing staff to wear uniforms on duty and, where uniforms are required, the parties have agreed to investigate alternatives to the provision of uniforms by the employer.

· Board and lodging. The parties have agreed to review the existing board and lodging provisions with a view to developing a mechanism by which board and lodging charges are set and varied. It is recognised by the parties that the standard and type of accommodation varies between health units and that charges should be determined accordingly.

· Application of a 38 hour week. The method of working an average of 38 hours per week by nursing staff may be by rostering employees for one programmed day off per work cycle, which is defined within the award or, where appropriate, other than rostering for a programmed day off and having regard to service delivery requirements, with the agreement of the majority of affected employees.

· Respective hours of work. The parties acknowledge that the current award provision already provides some flexibility in the rostering of staff, and the parties recognise that, due to the varying operational needs, there is no single arrangement that is appropriate for all health units. Therefore, it is agreed that a more flexible approach will be adopted to hours of duty

with a view to developing effective and efficient options for health units. In doing that, matters to be considered would be things such as flexible start and finish times; variation in shift lengths; rostering arrangements; other methods which could provide flexibility in hours of work as agreed by the parties; and the use of part-time and casual staff.

· Clinical pathways and managed care. The parties acknowledge that traditional working arrangements concerning service provision such as admissions, discharges, ward rounds and clinic times need review for the purpose of focusing on customer needs and efficient service delivery. It has been agreed to further develop clinical pathways and managed care initiatives in consultation with other clinical professionals in order to maximise benefits to patients.

· Continuum of care. The parties agree that the changing trends in health care delivery and, in particular, the growing desire and need to provide health services to patients in a community setting dictates that consideration be given to the development of seamless services. These services are fully integrated to ensure that all patient care needs are met throughout the episode of care and following discharge. The parties have further agreed that, in the interests of the continuum of care, policies and strategies will need to be developed to facilitate more flexible and appropriate deployment and utilisation of nursing staff.

· Establishment of key performance indicators. Here the parties acknowledge and agree that appropriate performance indicators should be established to measure the productivity of nurses covered by the agreement we have reached. The parties have recognised that the criteria on which the performance indicators are based should be focused not only on the issue of quantity (and cost per unit output) but also on the quality and effectiveness of the health services provided. The parties intend that a broad view be taken in assessing quality. The parties have also agreed to develop meaningful performance indicators as part of the agreement and to work cooperatively to establish appropriate performance objectives with respect to each of the indicators. As a minimum, the indicators will cover factors affecting cost effectiveness, throughput and resource management.

Evaluation criteria have been listed and will be used to assess each of the relevant components of the agreement, including success in meeting agreed objectives, effectiveness in implementation, the impact and effect of the implementation, problems and unintended consequences of implementation, the role and impact upon different occupational groups within the nursing award and a longer term assessment looking towards future needs. The performance management of employees is also an important aspect. The parties have agreed to negotiate and implement a performance management process to identify and enhance employees' skills and contribute to workplace productivity improvements.

Work absences is another area where the parties have agreed to examine the level of unplanned absences from work in accordance with relevant interstate and national benchmarks and to work cooperatively to develop programs to identify and minimise unplanned work absences. This program will include investigation of issues surrounding those unplanned absences. It has been agreed that targets will be set for reductions in those absences, with the overall aim again of reducing the level of absence to an agreed minimum level in accordance with the principles of continuous improvement.

Occupational health and safety is another area where the parties have agreed to focus their attention to improve the occupational health and safety performance in the nursing profession. Finally, the parties have agreed to examine the grading system and salary and related conditions associated with the employment of directors of nursing.

It is intended that many of the agenda items will be discussed and implemented at workplace or health unit level to maximise the potential for savings. Workplace consultative committees, comprising management and Australian Nursing Federation nominees, have already been established at each workplace for this purpose. The overall implementation is being monitored by a central monitoring committee which includes representatives from the Health Commission, health unit management at director of nursing level and the Australian Nursing Federation. This committee will have responsibility for monitoring the agreement and will require health units to provide quarterly reports on the progress they are making towards the agreement's objectives.

The committee will also assume primary responsibility for the discussion of matters which have service wide implications. The parties to date have approached their obligations to the agreement in a positive and constructive manner, and it is hoped that this spirit of cooperation will continue and result in a more efficient and productive South Australian public health system which provides quality patient care through our committed and highly respected nursing work force.

Mr OSWALD: At page 263 of the Program Estimates, reference is made to provision for the Government wage offer under enterprise bargaining. Will the Minister provide details of the Health Commission enterprise bargaining agreements with the medical officers?

The Hon. M.H. Armitage: Clearly, there are a number of important matters in relation to medical officers, so we will incorporate the agreement in *Hansard*.

The CHAIRMAN: Is the information to be provided at a later date, Minister?

The Hon. M.H. Armitage: We will provide the information in relation to the actual agreement, but there are a number of other matters. This was an incredibly important enterprise agreement with the medical officers. It is important that we detail it but without mentioning the parameters.

Mr Bishop: The agreements run to many pages. On 17 May 1996 the Industrial Relations Commission of South Australia approved the medical officers' enterprise agreement which was negotiated with the Salaried Medical Officers Association and which covers salaried medical officers employed under the Medical Officers Award. Briefly, the key features of this agreement are that it has a life of two years, and it has a phased in 10 per cent wage increase for all classifications, payable again in three instalments: 6 per cent in May, 2 per cent in September this year and 2 per cent in September next year.

In addition, a maximum 25 per cent salary sacrifice arrangement has been made available to all classifications of medical officers employed in health units recognised by the Australian Taxation Office as public benevolent institutions, and this option becomes available from 1 July 1996. We have been running information sessions for medical officers in relation to this matter. The agreement again contains a number of agreed agenda items, which I will not list; they will be on the record. A term of the agreement was that SASMOA and its Federal body, the Australian Salaried Medical Officers Federation, discontinued its application for Federal award coverage for medical staff. A central committee has been established to monitor the agreement.

Ms STEVENS: I refer to page 250 of the Program Estimates. In mid 1994 a series of announcements were made about the sale of the Queen Victoria Hospital to Healthscope. The Queen Victoria Hospital was to be demolished and a new hospital built by 1996 as part of a major shake up of private hospitals. The option to buy the Queen Victoria Hospital for $3.5 million was included in Healthscope's deal to buy seven private hospitals owned by SGIC. What payment arrangements were entered into between the Government and Healthscope, when was the first payment due, have all amounts owing under the contract been received, did the contract with Healthscope include any conditions concerning the future use of the site, and was there any covenant requiring Healthscope to build a new private hospital?

The Hon. M.H. Armitage: In relation to the sale of the former Queen Victoria hospital, I think the member for Elizabeth misunderstood: from the health perspective it was just a sale of property. We were a vendor, and what the purchaser decided to do with that property in that instance was irrelevant. We were keen to maximise our asset, and whether any purchaser, in this instance Healthscope, decided to put up a private hospital, that was a matter for them, once they had purchased the actual property. To that end, I am informed that there were certainly no covenants about building a private hospital. I am told there were a couple along the lines such that, if a private hospital were built, it could not be called the Queen Victoria Hospital, and a couple of basic things such that. There was certainly no expectation in relation to the use of the land itself.

I am also informed that the final payment for the Queen Victoria Hospital has been received, and that was in 1995-96. Obviously, it is not sold through the Health Commission as such but through the Minister for the Environment and Natural Resources, and the payment is then passed on to the commission. In our dealing in this, it was a matter of merely identifying—as we do for all the property we wish to sell—that the sale is on our agenda and, once the sale has gone through all the due processes in Government through other portfolio areas, it is sold. However, there is really no covenant on any land, because we are merely selling a property to another purchaser. In these matters, the Health Commission is interested literally only in the amount of funding that comes to us at the end of the day. We are not aware of any specific covenant.

Ms STEVENS: Have all the amounts owing under the contract been received?

The Hon. M.H. Armitage: Yes; I indicated that the payment that was received during 1995-96, which was $6 000 over what was expected—and I do not quite know why that was, but that was to the benefit of the public sector, so it is great—was the final expected payment of that exercise.

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

The Hon. M.H. Armitage: I acknowledge the incredible amount of work that goes into the preparation for these Estimates Committees. I do not know that anyone other than Ministers would realise that this exercise takes a number of months in total of Public Service time. I am very grateful to all the Health Commission staff for doing it so efficiently.

State Aboriginal Affairs, $7 994 000.

Membership:

Mr Clarke substituted for Ms Stevens.

Departmental Advisers:

Mr D. Rathman, Chief Executive.
Ms J. Cirson, Financial Accountant.
Ms V. Pepper, Project Officer.
Ms C. Divakaran-Brown, Facilitator.
Mr P. Campaign, Senior Project Officer.

The CHAIRMAN: I declare the proposed payments open for examination and refer members to page 63 in the Estimates of Receipts and Payments and pages 265 to 272 in the Program Estimates and Information. Does the Minister wish to make an opening statement?

The Hon. M.H. Armitage: Yes, Mr Chairman. It is my privilege to appear before the Estimates Committee tonight to present the 1996-97 appropriation for the Department of State Aboriginal Affairs. The department is a key agency in the delivery, coordination and monitoring of services to Aboriginal South Australians by the State Government. It is important, however, for the Committee to appreciate that the Department of State Aboriginal Affairs' activities reflect one—vital, but only one—part of the Government's activities to deliver quality, culturally appropriate services to the Aboriginal community members living in South Australia. Whilst it is clearly out of order for the Committee to look at the appropriations for other departments and agencies, I want to highlight briefly some key developments which indicate the Government's determination to work to address the social and economic needs of the Aboriginal community across the whole policy spectrum.

On 1 July the Aboriginal Health Division will assume program and operational responsibility for a range of Aboriginal health services. The division, the first Aboriginal Health Division in Australia, is being established with full executive status so that Aboriginal health perspectives will impact on all decisions of the Health Commission at the highest level. The Minister for Housing, Urban Development and Local Government Relations has announced a $3 million program to add to the Aboriginal housing stock on the Anangu Pitjantjatjara lands. During the past year the Government has introduced the nation's first State-based native title regime. Aboriginal cultural tourism is being recognised as a major element in the heritage of the State with the launch of the Aboriginal cultural tourism strategy and associated promotional material.

Lastly, the Government is committed to State Government employees being aware of cultural issues in delivering quality services. To this end, cultural awareness training is a special emphasis of Government. The South Australia Police, the Department for Correctional Services and the Health Commission are all undertaking or planning extensive cultural awareness programs. As a Government we are committed to delivering quality, cost efficient services to South Australians and especially to our most economically and socially disadvantaged community, that is, Aboriginal South Australians.

Mr CLARKE: In the interests of time, particularly as this will be our last Estimates Committee, I will not make a formal opening statement except by way of a preamble to my first question to the Minister. The Minister would no doubt be aware from media reports that the Australian Institute of Criminology issued a report today broadcast under the heading, 'Deaths in Custody. Australian deaths in custody

and custody-related police operations 1995', which on the first page reported on Australia-wide figures showing that the number of deaths in custody during the year at 86 is higher than that reported for the previous year (80), and in fact was exceeded in only one of the 16 years for which data was available, namely, 1987.

Of some significance is the fact that while the total number of deaths in all forms of police custody has remained at the same level, 26 Australia-wide, as instanced in the previous calendar year, the incidence of 58 deaths in prison custody during the year represents the highest number recorded. Regrettably, in South Australia, among the prison population, of the 11 deaths in total whilst prisoners held in custody, we see that six deaths were people of Aboriginal descent, and that was the highest of any State in Australia.

I am not going over ground that is inappropriate. This matter was raised by me in another Estimates Committee involving the Correctional Services Minister, but the Department of Aboriginal Affairs has a very important role across agencies, as we know, and in particular has a duty under its own charter with respect to these Program Estimates to monitor the implementation of the Royal Commission into Aboriginal Deaths in Custody.

It is my information that, since 1989, the incarceration of Aboriginal people in South Australia has doubled and, during the course of this evening, I would like to know from the Government its belief as to the reasons for that and what at a governmental level is being done about it. It was a recommendation of the royal commission that there be presented an annual report by State Governments setting out the steps they have taken to implement the recommendations of the royal commission. The last one I can find was issued by the Department of State Aboriginal Affairs in April 1994, and no such report has been issued since that date. I am aware that the Minister has made some ministerial statements, but in terms of the comprehensiveness of the report issued in April 1994 nothing similar has occurred since this Minister has been in office. When will such a report be presented, belatedly, and released for public dissemination?

The Hon. M.H. Armitage: That is certainly a wide-ranging question about matters that are of enormous import. If I can answer the substance of the immediate question first and then perhaps range a little more widely. A compiled draft has been at my office for some time. I have made some alterations to that, and it is now back in DOSAA's hands of very recent date for some final editing. I would anticipate that it would be released within a month. I was hoping it would have been done by now. It is almost in that printable form, so that will be very soon. There has been no attempt not to provide that. I guess one of the things involved here is that the reporting period is altering from calendar year to financial year, so that has meant looking at figures and so on. The answer to your question is that it is almost ready for printing and we have no desire to do anything other than release it. Although that does not give you a date, I guess I would say it would be released by the end of July.

In relation to the other matters of deaths in custody, it is a matter which the Aboriginal Affairs Ministers from around Australia have addressed. Dr Adam Graycar from the Institute of Criminology spoke to our last meeting held in October or November last year in Melbourne. Interestingly, this year the Ministers' meeting will be held in Adelaide, so I am the chair for this calendar year of the Ministerial Council. As chair of the council I have written, on behalf of the council, to the new Federal Minister suggesting that calls for a summit on this problem ought to be taken up: I will certainly be a willing participant in that.

However, I am a little concerned that it might degenerate into a talkfest. What is needed is action rather than talk. To that end I have taken an interest in the workings of the Aboriginal Justice Interdepartmental Committee since the last of those deaths to which the honourable member referred, and it is pleasing to say that we have had a long period free of Aboriginal deaths in custody—and long may that last.

I have been asking the AJAIDC to focus on some of the more simple remedies. For instance, it is difficult when the statistics indicate that Aboriginal people often receive less original custodial sentences than non-Aboriginal people: they may be fined, but then they are unable to pay the fine and so go into prison for fine defaulting. It tends to be a catch 22 situation. Through the AJAIDC we are looking at increasing the number of non-custodial sentences and we are making commitments through the MAP program which is a diversionary program.

The work of the AJAIDC, which includes representatives from the police, Correctional Services, Family and Community Services, Health Commission, DOSAA, Courts Administration, DETAFE, Attorney-General's and AJAC (Aboriginal Justice Advocacy Committee), is wide-ranging and has now formed itself into task oriented groups. The feeling is that a number of those matters will be addressed in the near future and all I can say—not having had the portfolio for long—is that it is a pity that some of those things were not done before, but the Government is committed to moving on those sorts of issues.

Mr CLARKE: You referred to the report that you hope to hand down in July. It is now 1996: the last report was tabled in 1994. I would hope that future reports will be tabled annually (and not biannually) to explain the Government's intention in this area so that the implementation of those recommendations can be properly monitored. It seems to me that so much relies upon the resources allocated and the priority that the Government gives to the prevention of deaths in custody.

Earlier this year I was at Port Augusta prison—and I raised this matter earlier today with the Correctional Services Minister—and the only person at that time with any medical training to, if you like, screen Aboriginal prisoners, to try to ascertain whether or not they may have had suicidal tendencies, was a registered nurse about whom I make no complaint. She did her best to assess Aboriginal prisoners by gut feeling as to whether they may have suicidal tendencies. The prison manager advised me that they had a payroll vacancy for a psychologist but that the salary level of $40 000 plus was not sufficient to attract a trained psychologist to go to Port Augusta. I understand that will be rectified in August when a trained psychologist from New Delhi goes to Port Augusta. That was the only applicant for the position. Some interesting cultural problems may or may not emerge. Nonetheless, there are some real problems.

When I asked the registered nurse whether she was able to look at the medical records of Aboriginal prisoners or, for that matter, any prisoner at Port Augusta gaol to determine whether they may have suicidal tendencies—this related to an actual suicide—I was given to understand there were no facilities to enable her to inspect the medical records of a prisoner who may have been transferred from one prison to another or from the prisoner's medical practitioner. There was an absence of medical records. That may be because of confidentiality between doctor and patient or it may be a

legislative problem. In any event, the nurse—and I am not blaming her—did not ask the permission of the prisoner to access those medical records. If they could not get a trained psychologist for $40 000 plus, a trained psychiatric nurse might have been a useful stopgap in that area. I understand the financial constraints on Governments, but a number of things can be done if there is some lateral thinking. In addition, there has to be a will and a commitment by the Government that deaths in custody will be addressed and that the necessary resources are made available and employed to do so.

The Hon. M.H. Armitage: I do not dispute that for a moment, and there is that commitment. I guess that the staffing matter has now been addressed. The member talks about lateral thinking. I think this is a good example of something which is occurring in my other portfolio. It may be that the dilemma in getting an appropriately qualified professional is the same difficulty as we have—the tyranny of distance. It is difficult to get professional people to go into the country, so that may be part of it.

The Health Commission is looking at telemedicine as a way of doing many innovative things. South Australia was the focus State for a telemedicine conference in November last year. We believe that there are great opportunities to provide prison medical services via telemedicine. The opportunities for that in remote areas of South Australia, enabling better assessments, and so on, to be done by appropriately trained psychiatrists, are enormous. We shall certainly be looking at that.

The whole exercise of prison medical services is in the throes of being offered for tender, and the Health Commission will be an enthusiastic tenderer in that respect. They are the sorts of issues that ought to be addressed. How can we provide those services in the more remote communities? It is a perfectly valid objection and it is one about which we are thinking creatively.

Mr CLARKE: I appreciate that the department is not a mainstream department in terms of the delivery of all these services and that it acts more in an advisory capacity. In so far as the recommendations of the royal commission are concerned, what is the department doing in pressing those recommendations onto the mainstream departments? It seems to have worked, whether it be through this department or for other reasons, with respect to the Police Department with the number of black deaths in police custody, but to date it seems to be an abject failure in the prison system.

The Hon. M.H. Armitage: I am not sure what the honourable member is suggesting.

Mr CLARKE: What is the Department of State Aboriginal Affairs doing in pressing mainstream departments to come to grips with the recommendations of the royal commission?

The Hon. M.H. Armitage: The most important thing is the Aboriginal Justice Interdepartmental Committee (AJIDC), which is chaired and held at DOSAA. That is where the system-wide justice overview is taken, and that is exactly where we are trying to advance a number of the systemic problems leading to an increased number of Aboriginal people being incarcerated. In attending the AJIDC, it has been my intent to up the ante from the department's perspective. There are some other issues as well, and I should like the Chief Executive Officer (David Rathman) to address the Committee.

Mr Rathman: As the Minister said, the interdepartmental committee has changed its focus to try to address the key issues and to try to get some ownership in respect of these matters. The honourable member is correct in saying that the police are taking a very proactive view of their responsibilities, and the working groups that we have established are looking at policing issues. Non-custodial sentence options are being looked at with the Courts Administration Authority, and the Department of State Aboriginal Affairs is looking at the whole question of remand rates.

We are also looking at custodial health services with the Aboriginal Health Division of the South Australian Health Commission; we are looking at juvenile welfare issues in respect of Family and Community Services; and we are looking at the Anangu Pitjantjatjara lands in respect of justice issues in that area, and that has been taken up by the South Australian Police as the lead agency.

Some of the other initiatives that have come from these groups include recommendations about the criminal law sentencing legislation with regard to community service orders. These proposals have the support of the Attorney-General in principle, and DOSAA has also looked at culturally appropriate community service orders, and a community-based CSO manual is being looked at as well. Importantly, we have been very successful in securing a national drug crime prevention resource to study the impact of the application of section 132 of the Liquor Licensing Act and the impact that has on imprisonment and recidivism rates.

We are also participating with the Department for Correctional Services in a task force with respect to the outsourcing of prison transport. For the first time our involvement has been invited in inquiries into deaths in custody within the prison system, and that is a major breakthrough for our participation. Our department and also the Aboriginal Justice Advocacy Committee and other representatives of the Aboriginal community have been invited to become involved in an endeavour to overcome some of those problems.

I recently attended a conference of Aboriginal liaison officers and other liaison staff within the Department of Correctional Services who are endeavouring to introduce systems which will solve some of the problems. Our reporting to Government has been designed to deal with systemic issues as opposed to just reporting on recommendations being implemented. We are trying to address key issues, alleviate some of the problems that have occurred in the past and see whether we cannot model the same system that we had with the Police Department in overcoming some of the unfortunate deaths in custody that occurred.

Mr BUCKBY: I refer to the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families. It is noted in the program description at page 271 that the Department of State Aboriginal Affairs has a role in implementing initiatives that specifically address Aboriginal family issues. One of the main issues currently facing the Aboriginal community is the ongoing impact of the separation of Aboriginal and Torres Strait Islander children from their families. What role has the Department of State Aboriginal Affairs had in the State response to the national inquiry on this issue?

Mr Rathman: The question of the separation of Aboriginal children is fairly close to the heart of most Aboriginal people. It is a very passionate issue to me, because my mother was subject to the same treatment. So, I am very interested in this topic, as are many other Aboriginal people. The department was assigned the role by the Government to coordinate the State response to the national inquiry into the

separation of Aboriginal and Torres Strait Islander children from their families. With assistance from other State agencies in South Australia, the Government was able to prepare an interim submission to the national inquiry which was tabled before the inquiry on its visit to Adelaide on Monday 4 March. Upon presentation of the report, I provided the inquiry members with a verbal summary of the contents and issues contained in the submission, which included a history of the treatment of Aboriginal children and their families in South Australia from the time of settlement.

On Friday 8 March the inquiry allocated two sessions to the questioning of State officials on the State submission. That took quite a considerable amount of time and, in fact, resulted in more discussions and more questions and queries being directed to us. I was supported in these question sessions by senior officers from the Department of Premier and Cabinet, FACS, the Department for Education and Children's Services, police, the Department of Correctional Services and the Courts Administration Authority.

During the week in Adelaide the inquiry took the opportunity, in consultation with the Premier and Cabinet, to visit and speak with Aboriginal people in Yatala Labour prison, the Northfield prison complex and the Magill and Cavan training centres. To assist in ensuring that appropriate and effective Aboriginal community awareness was provided within the community of South Australia, the Minister approved the Department of State Aboriginal Affairs to fund the South Australian Aboriginal child-care agency to implement a community awareness program in support of the national inquiry.

The program conducted workshops across South Australia to advise Aboriginal people on matters such as terms of reference, retrieval of personal records held in relation to family separation, preparation of submissions to the hearing by those persons, legal proceedings of hearings, social issues directly relating to the removal, for instance, native title and treatment of Aboriginality, and the possible emotional upheaval of detailing past events and experiences.

In view of the wide implication of the inquiry and the depth of research that is required to give full and frank consideration to the terms of reference, we will provide a final submission to the inquiry. Submissions will incorporate from other relevant agencies matters that relate to police relations, the Department for Correctional Services' impact, the South Australian Health Commission's views, as well as those of the Department for Education and Children's Services.

The first submission to the inquiry was based on facts relating to Family and Community Services or the old child welfare system. The Department of State Aboriginal Affairs, in coordinating the role of the submission to the national inquiry, focused on an extremely important issue—the need to deal appropriately with the process of reconciliation between Aborigines and other Australians, and in particular between Aboriginal people and the Government. The general feeling from the inquiry is that South Australia has cooperated in the process. The inquiry was pleased with our frank submissions and that we did not attempt to hide any of the facts—and we were supported by the Minister and Cabinet in that endeavour. Our effort to date has resulted in putting forward some very vital information which is of use not only to the inquiry but to Aboriginal people who are also making submissions to the inquiry.

Mr BUCKBY: I refer the Minister to the program description for the Department of State Aboriginal Affairs and the goal to support the Aboriginal land-holding authorities. I presume that this refers to the three statutory authorities—the Aboriginal Lands Trust, the Maralinga Tjarutja and Anangu Pitjantjatjara lands. Can the Minister explain the nature of the support being provided in 1996-97?

Ms Cirson: The Department of State Aboriginal Affairs contributes annual budgets towards the recurrent operating costs of the three land-holding authorities. In 1993-94 the land-holding authorities all received significant budget increases. The Aboriginal Lands Trust had an increase of 78 per cent, which was primarily for improved landcare management and to establish and operate a business advisory panel; Maralinga Tjarutja had an increase of 76 per cent; and Anangu Pitjantjatjara had an increase of 33 per cent. These increases were for the provision of financial assistance to improve liaison between the authorities, the community and Government service providers for administration and the management of the land.

Recent requests have been made to the State from the three land-holding authorities for further increases in their administrative budgets due to the extreme pressures placed upon them to deal with sensitive and complex issues. The authorities have been asked to operate on a greater commercial platform with the increasing necessity to engage experts to provide legal, business and technical assistance as required. As a result of the increased demands placed upon land-holding authorities to operate effectively, the Department of State Aboriginal Affairs is assessing the possibility of identifying savings within its budget that may be redirected to increase funding levels for the land-holding authorities. Indeed, in 1995-96 the department allocated an additional budget of $100 000 to enable much needed upgrading work to be carried out on land trusts.

Mr BUCKBY: The program description for the Department of State Aboriginal Affairs at page 271 refers to the promotion of a healthy living environment in Aboriginal communities through the provision of maintenance services for water, power and common effluent. Can the Minister provide information on how successful the Department of State Aboriginal Affairs has been in ensuring that essential services are maintained effectively and efficiently in Aboriginal communities and, in particular, in its reaction to emergency situations which impact on the provision of a safe and healthy living environment?

The Hon. M.H. Armitage: This is a particularly important question, and it is something which DOSAA does extraordinarily well. It is a commitment of the Government that those services will be provided. I believe it is appropriate that the Chief Executive, Mr David Rathman, provide the specifics of the answer.

Mr Rathman: The department has struggled with the question of essential services maintenance for some time, and particularly the question of reactive maintenance. As a department, we have introduced what we call a period contract system to ensure that our commitment to a 24 hour service for Aboriginal communities in remote areas is maintained, particularly where we are responsible for the maintenance of electrical and water systems. It is DOSAA's intention to extend period contracts to include sewerage systems. At present, period contracts are limited to electrical and water systems.

Period contracts for routine maintenance, repairs, replacements and emergency breakdown services for bore pumping and also power generation are for one year. The period contract requires the contractor to conduct quarterly mainte-

nance trips and provide advance itineraries before visits. After the trip, we are to be allowed to look at a detailed technical report so that our officers can examine it. That often includes photographic or video evidence of any areas that need attention. The quarterly report contains a very comprehensive summary of the maintenance carried out in the communities on each installation.

At the end of the 12 month period, the contractor is required to submit a detailed annual report, which allows us to have a very good record of all the maintenance that goes on in Aboriginal communities. The contract provides for an emergency breakdown service. In this sense, before we let the contract, we vet the contractor to ensure that they are adequately resourced to take up emergencies quickly. Maintenance work must be carried out by qualified staff. This ensures the integrity of the systems which are installed. The introduction of period contracts has resulted in there being no major emergency situations this financial year. In fact, it has allowed us to provide a very proactive preventative model to replace the traditional emergency breakdown schemes which have operated in the past.

DOSAA is satisfied that the period contract will ensure early detection of problems before they become major and ensure ongoing maintenance by contractors who are familiar with the equipment and the regions in which those installations operate. In addition to period contracts, DOSAA has adopted a strategy to target communities so that we can detail an operation, go in and look at all the infrastructure and do some whole-of-community maintenance. The strategy was recently successfully applied to Yalata on the West Coast, and a number of community groups have been involved in the contracts in gaining employment and skills for their communities. We personally believe that the model that we have adopted can be efficient and will result in savings to the program that can be directed towards badly needed activities in other areas of Aboriginal affairs in South Australia.

Mr CLARKE: My question relates to the promotion of employment opportunities for Aboriginal persons in both the State public sector and the private sector. As I recall the figures when the previous Government was in office, about 1.5 per cent of the State public sector work force were Aboriginal or of Aboriginal descent. It is my understanding that that has slipped since that time. What activities has the Minister's department adopted specifically with his other mainstream departments at least to maintain 1 per cent of the State public sector work force consisting of Aborigines, and what work is being done by his department to promote employment for Aboriginal persons in the private sector?

The Hon. M.H. Armitage: The figures I have been given for June 1992 to June 1995 show that the number of Aboriginal GME Act employees has decreased by 12.9 per cent—from 248 down to 216—but that the total has decreased by 12.1 per cent. So, there is a marginally smaller fallout of Aboriginal people than in general. In other words, the number of FTEs is down, but the percentage is about the same, being 1.58 per cent in June 1992 and 1.56 per cent in June 1995. Regarding administration unit employees—and I will give just the percentages—the figure for Aboriginal employees at June 1992 was 1.13 per cent and in June 1995 it was 1.28 per cent. So, in percentage terms it is about line ball, in essence.

Certainly, there are a number of very positive matters, and I reported in relation to my other portfolio today that it is pleasing that, for the first time, we believe that at the end of June the number of Aboriginal employees in the health area will be greater than 1 per cent. That has been creeping up quite dramatically, with increases of 15 per cent and 20 per cent over the past several years; but we are going to be at 1 per cent at the end of June. So, that is pleasing. This is absolutely serendipitous: a brochure was left on the table from earlier today. The Aboriginal health division of the commission, for instance, put together a document entitled *A Career in Health*. So, there are a number of initiatives in the health area. In relation to an economic forum concept that we hope will stimulate more Aboriginal employment, I would be grateful if Mr Rathman could address the Committee.

Mr Rathman: The issue of Aboriginal employment within the private sector has become a major concern, and we are endeavouring through the economic forum to try to promote enterprise in Aboriginal communities. We in South Australia have developed and supported the funding of the community development employment programs to hold a statewide conference, which they did last year, to try to encourage greater effort in terms of promoting employment through economic development. In fact, the committee is now involved in holding a forum workshop within the next month or so to try to promote a dialogue between Aboriginal people and Government agencies to see whether we cannot break into the private sector in greater numbers than in the past.

There is an effort to look at models whereby we could train Aboriginal people within the public sector with a view to having some cross over into private employment. We have put forward a number of papers to this end, to target Aboriginal young people whom we could bring into the service and try to train in the service with a view to their going on to having earned a place in the private sector. That will all take time. We have to get over some of the barriers in the private sector, but some of the private firms have now started to look at employing Aboriginal people, particularly where there can be an economic advantage to them.

A number of private consultancy agencies are now taking on Aboriginal people, although certainly not in the numbers we would like. We are hopeful that the economic forum can be a vehicle by which, through the economic agencies in the South Australian Government, we can promote greater employment amongst Aboriginal people.

The Hon. M.H. Armitage: Briefly, I would add a number of other agencies to those to which Mr Rathman referred. SAPOL has committed to a 2 per cent participation of Aboriginal and Torres Strait Islanders and the development of an Aboriginal support unit. Importantly, cross-cultural training has been conducted for 700 officers. The Office of the Commissioner of Public Employment is working toward achieving a commitment of placing 100 Aboriginal and Torres Strait Islander young people through the traineeship scheme across Government. That is a cooperative venture between the OCP and the Commonwealth Department of Employment, Education and Training and the budget is $750 000, estimated for this financial year. There is a permanent position for an Aboriginal and Torres Strait Islander consultant within the Work Force Management Services team of the Office of the Commissioner of Public Employment involving a commitment of $50 000.

The Department for Correctional Services has a $62 000 budget this year to provide specialist training for Aboriginal persons showing potential within that area, to utilise outside agencies. The Department for Education and Children's Services has a recurrent budget of $134 800 for the Aboriginal and Islander Career Aspirations Program, where secondary Aboriginal students are supported through career

workshops, study counselling and so on. They are just a few: I will not take up the Committee's time, but there are a number of projects that are being specifically generated towards increasing Aboriginal employment.

Mr CLARKE: As a supplementary question, what areas in the private sector have been identified by the department as being susceptible to employing more Aboriginal people?

The Hon. M.H. Armitage: It would be fair to say that every sector is appropriate for employing Aboriginal people. I have been struck by the willingness of a large number of people in different sectors to at least contribute to discussions on how they might as a sector stimulate more Aboriginal employment. As Minister, I have had a number of discussions with senior executives from various chambers and so on in an attempt to increase employment.

As to the specific question, the most appropriate area would be tourism. I have been in major international hotels in Australia and talking with people who have pleaded with me, when they found that I was the Minister for Aboriginal Affairs, to get Aboriginal people in tourism in major hotels in the city and not only in the tourism ventures that people might imagine. Many international tourists come to Australia for Aboriginal cultural values and the hotels think it would be wonderful to have young Aboriginal staff members. I have mentioned that to a couple of hospitality industry people in Adelaide who are looking to see whether they can do something. The sorts of things I mentioned in my opening statement, where the Government has stimulated some Aboriginal tourism brochures and so on through tourism, are the types of elements most likely to lead to an immediate jump in the private sector.

Mr CLARKE: My question follows on fairly well from the Minister's last answer as it deals with tourism. I am probably stating what the Minister already knows, but the Tourism Commission in a South Australian Aboriginal tourism study in August 1995 (page 18) reported that more than 100 000 North American and Europeans visit South Australia annually and nearly half those visitors surveyed wanted an Aboriginal tourism experience. The figures from 1992 showed that about $40 million of Aboriginal art, craft and the like were bought by international visitors. That was in 1992.

I raised this question with the Minister for Tourism yesterday, and it would be fair to say that he was certainly supportive of the idea. When I visited Granite Island earlier this year with some overseas visitors, we went into the tourist shop which had for sale porpoises made of cheap porcelain, or whatever, made in Taiwan, and stuffed penguins made in China. I believe those overseas visitors would have been very keen to purchase Aboriginal art. I understand that those types of tourist centres need to be able to cater to visitors who are on tight budgets, hence the stuffed penguins made in Taiwan or China, but we need some quality Aboriginal art.

Whilst there is the magnificent Tandanya centre, it seems to me that we could—because of our recent visit, Minister, to the north-west communities—with the assistance of Tourism SA, find good retail outlets throughout the State to which local communities, such as those people in the north-west, could supply quality art works, artefacts, and the like, on a regular basis, which would improve immeasurably the economic standards of those north-west communities, as well as satisfying a natural demand. Will the Minister say what work, if any, his department is doing in trying to link in with Tourism SA, or any other Government agency, whether it be the EDA or whatever, in promoting Aboriginal art through various retail outlets, which I am sure would be an outstanding success?

The Hon. M.H. Armitage: Both Tourism SA and EDA are on the Economic Development Forum, which the Chief Executive mentioned earlier. The honourable member brushed over a couple of very important points, for no reason other than that he mentioned them. Granite Island was one place he mentioned. The Granite Island redevelopment was the first Aboriginal heritage agreement signed under the Aboriginal Heritage Act. That was one of the most delightful things I have done as Minister for Aboriginal Affairs.

Mr Clarke interjecting:

The Hon. M.H. Armitage: We are moving on.

Mr Clarke interjecting:

The Hon. M.H. Armitage: I do not know when the honourable member was there, but Stage 2 of the Aboriginal component is due for completion by 1997, and 18 Aboriginal youths have been employed on the island to work on vegetation, the boardwalks, and so on. Other opportunities are available, such as the Wirrina development with MBfI. A number of discussions have taken place between MBfI and the Kaurna community about the ways in which they might acknowledge Kaurna interests along that general coastline.

I am not sure whether we must identify a site where these things might be available, because I am informed that one of the most frequently accessed Internet sites in Australia from the world is Tandanya. That means that we must work out ways—and it is a worldwide problem—of having appropriate electronic business, because if a third, a quarter or a tenth of those people who accessed the Tandanya Internet site bought a painting, a boomerang or a didgeridoo, think of the money that would flow to the Aboriginal community members who had produced that art work. The honourable member is quite right: it is a market waiting to be picked, and that is exactly the sort of thing the economic forum will be looking at.

As I say, we need to be a little more creative. Whilst we recognise that many tourists come to Australia—and let us see whether we can snaffle them—things such as the development of the Aboriginal Cultural Gallery, for which we hope to get some Federal funds and about which we spoke to the previous Government, would be good for Adelaide, given our museum, artefacts, and so on, because that would draw more people to this State. Hopefully, we can also access the people who do not even come to Australia. DOSAA is actually funding an officer in the Tourism Department.

Mr CLARKE: My colleague the member for Taylor has raised with me an issue concerning her shadow portfolio involving youth: what funds will be made available for young Aboriginal people in Ceduna? The member for Taylor has been approached by the West Coast Youth Services with a plea for funding to secure a drop-in service for Aboriginal youths in Ceduna. These young people have seen the Government commit to a facility in Port Augusta. Apparently, there was some strife in Port Augusta which resulted in a drop-in centre being established. Those young people basically raise the question, 'Do we have to create strife to warrant funds being put into a drop-in service in Ceduna?' Apparently they have the free use of a building but need money to fit it out with kitchen facilities and the like to make it fully operational.

The Hon. M.H. Armitage: We do not believe we have had any request or input whatsoever from anyone in relation to that. Now that the honourable member has raised the issue with us, if he would like to provide me, through the member for Taylor, with some further information, I would be very

happy to speak with the appropriate Minister, Bob Such. Obviously, the case the honourable member mentions is a valid, reasonable one and we will see whether we can lend support to it. As the honourable member would realise, we are not a funding agency but we are happy to advocate.

Mr ROSSI: I refer to the Program Estimates (page 271), which identifies one of the broad objectives of the Aboriginal Cultural Awareness Program as being to promote equality of opportunity by working to eliminate barriers such as discrimination and prejudice. Have any initiatives been taken which address this objective?

Ms Divakaran-Brown: The Aboriginal Justice Interdepartmental Committee, convened by the Department of State Aboriginal Affairs, has been promoting the importance of mainstream agencies in Government, providing Aboriginal cultural awareness training course officers. To date, the Department of Correctional Services, South Australian Police Department and Courts Administration Authority have responded to this important initiative consistent with recommendation 96 of the Royal Commission into Aboriginal Deaths in Custody. After several months of discussion and articulation of needs, the first Aboriginal cultural awareness seminar for the judiciary was held on 31 May 1996. Twenty-seven judges and magistrates from the Supreme Court, District Court, Family Court, Federal Court, Children's Court, Magistrates Court and the State Coroner participated in this program. This was an historic event, opened by the Chief Justice and ATSIC's own commissioner, both acknowledging the significance of judicial officers enhancing their understanding of Aboriginal issues.

The Department of State Aboriginal Affairs has been working closely with the judiciary and Aboriginal Legal Rights Movement in presenting this initiative. Information on Aboriginal history and perceptions of the criminal justice system were delivered by a panel of Aboriginal speakers and a non-Aboriginal legal historian shared the podium. The Chief Executive of the Department of State Aboriginal Affairs was a keynote speaker. Evaluation responses from both participants and Aboriginal people involved at the seminar were extremely encouraging. The presence of the Chief Justice during the entire duration of the seminar offered significant promise to Aboriginal people of the commitment the judiciary shares in this important recommendation of the royal commission.

The longer term impact of this cultural awareness program is to increase judicial officers' sensitivity to Aboriginal issues in the way they receive evidence from Aboriginal defendants and consider non-custodial options in the sentencing process. The Australian Institute of Criminology report released yesterday noted the importance of minimising the number of Aboriginal people being sentenced to prison, and we believe that this cultural awareness will encourage the judiciary to use non-custodial sentencing processes.

The Hon. M.H. Armitage: I really think that that is an incredibly important series of programs Ms Divakaran-Brown has just outlined. It is certainly a major commitment of the Government to improve matters.

Mr ROSSI: I refer to page 271 of the Program Estimates, describing appropriate alternative technology for the Department of State Aboriginal Affairs. This indicates that the goal of the department is to provide maintenance of water, power and common effluent systems in Aboriginal communities. What steps are being taken to ensure that the services can operate effectively in the harsh conditions of the Australian outback?

The Hon. M.H. Armitage: I will ask the Chief Executive Officer to provide an answer.

Mr Rathman: The department is committed to alternative technologies, but we are very conscious of the fact that we need to provide reliable technologies in Aboriginal communities. Very often the alternative technologies are untried, but as a department we are committed to looking at other options, particularly in the area of energy provision, because of the use of diesel fuel for power generation. We have engaged a consultant to carry out a feasibility study and to look at the assimilation of the use of a green grid and using inverters with the augmentation of alternative energy power generation into a mini reticulation grid.

The research and development project has been funded by the Commonwealth using our officers and also the expertise of a private company. We have the potential to reduce both recurrent and capital funding requirements for power generation in particular, where we have large costs for fuel. The feasibility study will be using Ernabella as the focal point of the project and will examine mini reticulation grids in those areas. It will then extend to Umawa and also Kenwell Park. In doing this we will reduce the number of generators that are required, and we are in the process of considering a power line that will operate in those communities so that we have only one source of power. We also have a loss of power, so we are looking at the system in areas where people have homelands from which, through solar technologies, they might provide energy back to the system.

We are looking at the feasibility of these technologies but, again, it is important to recognise that we are not necessarily committed to taking on alternative technologies as a toy, because we see the importance of making sure that what is placed in those communities is reliable, based on the fact that often it requires a trip from Adelaide or other places to get to these areas, and that can take up to 24 hours. So, we need alternatives but we also need reliable services for those remote areas. In stage 1 we are hoping to investigate options with this grid in particular to connect a photovoltaic system so that we can go into the north and look at the system that is being used in Western Australia, to determine whether that has an application in this area. So, we will be investigating this technology and are keen to look at alternative technologies where they reduce the cost of diesel fuel in power generation. That will be the focus the use of alternative technologies.

Mr CLARKE: On 26 March 1996 there was a report in the local Messenger Press down south with respect to the southern expressway. It referred to an announcement by the State Minister for Transport that a compensation package to the Kaurna heritage committee was almost finalised for disturbing Aboriginal sites and Laffler's Triangle. I note that a press release issued by the Minister on 15 May 1996 referred to formal consultation with the Aboriginal community in relation to Aboriginal heritage and the southern expressway. How can you have a package put together before you have announced a formal consultation?

The Hon. M.H. Armitage: As everybody who has been at my consultation—and it has been wide, broad and public—would acknowledge, almost *ad nauseam* I have said that any discussion about a compensation package is totally irrelevant to my statutory responsibilities. If there have been some other discussions with other departments, that is a matter for the other departments and the committee. It is simply not a matter of my consideration.

Mr CLARKE: In other words, whatever the Ministry of Transport has done with respect to a compensation package, that was done prior to the Minister's involvement as Minister for Aboriginal Affairs and basically you start from day 1 on 15 May?

The Hon. M.H. Armitage: I have certain statutory responsibilities under the Act. None of those include any compensation package. My responsibilities are in the area of Aboriginal heritage. It is as simple as that. That is what my consultation has been focused on and what my decision will be based on.

Mr CLARKE: I will be happy for the Minister to take on notice this next question which deals with the Konanda organisation, which is within my electorate. It is complicated because they are funded through ATSIC, but they are in legal dispute with ATSIC. They perform a valuable service in the local Aboriginal community. I understand that the State Department of Aboriginal Affairs does have a handle on it, but I would appreciate a briefing and report with respect to what is going on with respect to that organisation and the future of those employees who have still not been paid, as I understand it.

The Hon. M.H. Armitage: I will take it on notice to give the honourable member a full response in writing. The bottom line is the ATSIC contribution is in doubt. I will provide the honourable member with further details.

The CHAIRMAN: There being no time for further questions, I declare the examination of the vote completed. I also bring up a draft report of Estimates Committee A.

Mr BUCKBY: I move:

That the draft report be the report of the Committee.

Motion carried.

The CHAIRMAN: I would like to thank not only the Minister and his staff but all members of the Committee, members of *Hansard* and my table staff who have been indispensable over the past seven days of the Estimates Committees.

The Hon. M.H. Armitage: I want to acknowledge the work of the staff of DOSAA in relation to the detailed briefings for these budget matters. Unless one has been involved as a Minister and seen the work that goes on over many weeks in the preparation of all of these briefings and facts and figures and so on, one never understands, so I am very grateful to all the staff at DOSAA.

At 10 p.m. the Committee concluded.