HOUSE OF ASSEMBLY

Thursday 26 June 1997

ESTIMATES COMMITTEE A

Chairman:
Mr I.H. Venning

Members:
Mr M.J. Atkinson
Mr M.K. Brindal
Mr R.L. Brokenshire
Mrs R.K. Geraghty
Mr J.P. Rossi
Ms L. Stevens

The Committee met at 11 a.m.

South Australian Health Commission, $671 818 000

Witness:

The Hon. M.H. Armitage, Minister for Health and Minister for Disability Services.

Departmental Advisers:

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

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

Mr M. Forwood, General Manager.

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

Mr A. Greyling, Executive Director, Information Management.

Mr B. Dixon, Executive Director, Aboriginal Health Services.

Mr P. Davidge, Executive Director, Business Advisory Services.

Mr K. Mortimer, Acting Executive Director, Disability Services.

Mr R. Bishop, Executive Director, Human Resources Strategy and Advice.

Mr G. Beltchev, Executive Director, Health Unit Management Support.

Ms J. O'Callaghan, Executive Director, Purchasing.

Dr M. Jelly, Chief Medical Officer.

Mr D. White, Chief Nursing Officer.

Ms V. Deegan, Director, Financial Risk Management.

Ms K. Martin, Director, Operational Support and Development.

Mr M. Zissler, Director, Capital and Asset Management.

Mr E. Davis, Acting Director, Private Development Unit.

Mr A. Davis, Director, Health Industry and Export Development Unit.

The CHAIRMAN: As all members would be aware, the Committee hearings are relatively informal and there is no need for members to rise when they ask or answer questions. The Committee will determine the approximate time for consideration of proposed payments, to facilitate the changeover of departmental advisers. In this instance there will be no changeover because there is only the one line. Changes to the composition of the Committee will be notified as they occur. Members should ensure that they have provided the Chair with a completed request to be discharged form. If the Minister undertakes to supply information at a later date, it must be in a form suitable for insertion in *Hansard* and two copies submitted no later than Friday 11 July to the Clerk of the House of Assembly.

I propose to allow the Minister and the lead speaker for the Opposition time to make opening statements, if desired, of about 10 minutes but no longer than 15 minutes. There will be a flexible approach in relation to giving the call for the asking of questions, based on three questions per member, alternating sides. Members will also be allowed to a ask a brief supplementary question to conclude a line of questioning, but I stress that supplementary questions will be the exception rather than the rule.

Subject to the convenience of the Committee, members outside the Committee who desire to ask questions on a line of questioning currently being undertaken by the Committee will be permitted to do so once the line of questioning on an item has been exhausted by other members of the Committee. An indication to the Chair in advance from the member outside the Committee wishing to ask a question is necessary.

Questions must be based on lines of expenditure as revealed in the Estimates of Receipts and Payments, Printed Paper No. 2. Reference may also be made to other budget documentation, including Program Estimates and Information. Members must identify the page number or program of the financial paper to which their question relates. Questions not asked at the end of the day can be placed on the next sitting day's House of Assembly Notice Paper.

I remind the Minister that there is no formal facility for the tabling of documents before the Committee. However, documents can be supplied to the Chair for distribution to the Committee. The incorporation of material in *Hansard* is permitted on the same basis as that which applies in the House on a normal sitting day, that is, it must be purely statistical and limited to one page in length. All questions are to be directed to the Minister and not the Minister's advisers, and the Minister may then refer questions to his advisers as he wishes. I also advise that some freedom will be allowed for television coverage by permitting a short period of filming from the northern gallery, which is not normally the case. Does the Minister wish to make a brief opening statement?

The Hon. M.H. Armitage: Yes, Mr Chairman. There are many people here for two reasons: first, health spends 25 per cent of the State's budget, and it is an indication of how diverse the health portfolio is and the responsibilities involved; and, secondly, it has always been my view that the Estimates Committees are here to provide answers. Instead of having a series of questions for which we have to provide answers later, I would rather provide the information upfront. Once again, I am pleased to present the Budget Estimates for the South Australian Health Commission for 1997-98. First, I thank my staff for all the work they have undertaken in the past 12 months, and in particular in the past couple of weeks, in preparation for the Estimates.

As members would know, the 1997-98 budget has been framed against a background of a continuing push by the Government to bring the State's fiscal position into balance. This requires the sustainment of efficiencies achieved over the past three years and further ongoing efficiencies within public finances during 1997-98. I am delighted to report to

the Committee that the health system has responded magnificently.

The Industry Commission report on Government Service Provision highlights the following criteria against which the South Australian hospitals can be judged as the most efficient in Australia: 3.4 public hospital beds per 1 000 population, which is 13.3 per cent higher than the national average and ranked No. 1; 215 public hospital separations per 1 000 population, unadjusted for casemix, which is 10.3 per cent higher than the national average, ranked No. 2; and 172 public patient separations per 1 000 population, unadjusted for casemix, which is 9.3 per cent higher than the national average and ranked No. 2.

The costs per casemix adjusted separation, including medical labour costs, is the lowest of any State at $2 113 per episode, or 88.2 per cent of the national average. The latest Commonwealth Grants Commission relativities also complement the efficiency measures in the Industry Commission data. In other words, the high level of services provided to South Australians at the lowest cost means that South Australian taxpayers are getting the best value for their investment in health services in this State. The budget context for 1997-98 therefore recognises the tremendous efforts made by all employees of the South Australian public health system during the past three years and in particular the hospital sector in meeting the Government's debt reduction targets. The budget also provides a more optimistic view of the future than the previous budgets that have been presented.

I will detail some highlights of the appropriations. The appropriation of $671.8 million is an excellent result for the health of South Australians and the South Australian health system. Together with State sourced revenues financed from petroleum products licensing levies of $131.1 million, the total State funding provided is $802.9 million. That is an increase of $53.9 million, or 7.2 per cent or, in real terms, 4.8 per cent—a great result. Unquestionably, this real increase in resources presents a far more optimistic view of the physical effort being made by the Government to secure the health of South Australians.

Key appropriation increases over the additional support provided during 1996-97 include the following: a bonus $25 million that will be provided to hospitals which, in all, will get an extra $40 million during 1997-98 (this increase is in addition to those funds provided to meet wage increases and funding to acknowledge falling private patient revenues); $26.8 million for enterprise bargaining agreements which have been struck with the support of all employees; a $10 million priority funding package, of which $7.5 million will target booking lists, $1 million for drug psychosis units at Glenside and Flinders Medical Centre, $1 million for equipment for older persons and those with a disability, and $500 000 million for hospital capital purposes; and $2.5 million raised through increasing the tobacco licence fee according to tar content, which funding has been allocated to anti-smoking education and promotion, particularly aimed at young smokers.

I turn to disability services. I am often reminded of my responsibility to those with a disability and their families, and as Minister I am delighted to say that the Government has not forgotten these people. This budget provides an additional $5 million of new recurrent funding for disability services. This funding is in addition to the $3 million provided last year, part of which was HACC matched, to provide total new allocations of $5.4 million. In addition, a further $6.4 million in efficiencies has been ploughed back into services. Following years of real term cuts under the previous Labor Government, the area of disability services was quarantined from the effects of the debt reduction strategy, and the reinvestment of efficiencies and new funding provided over my term as Minister has resulted in $16.8 million being pumped into disability services.

I now turn to the impact of the Commonwealth budget on Health Commission funding. Apart from the carry-over effect of the cut to the Commonwealth dental program and cessation of defined project allocations, the Health Commission has fared reasonably well in the recent Commonwealth budget. At this stage, the final details of the 1997-98 Commonwealth budget impact on the operations of the Health Commission are still being discussed and sought, but I can advise the Committee that the estimated revenue streams can be considered to be solid.

The centrally funded capital works program of $102.4 million represents a very healthy program, which will enable the first two stages of the Royal Adelaide Hospital redevelopment to proceed. In addition, $19.1 million will be allocated for minor works and equipment provisions made by health units themselves, resulting in a total capital program of $121.5 million. Other new works this year include $5.7 million on strategic works at country facilities; $1.6 million for day surgery at the Daw Park Repatriation Hospital; $3.6 million for a new laboratory complex at the IMVS; $2.8 million for the first stage of a major development at the Lyell McEwin Health Service; $2 million for an upgrade of the intensive care and high dependency units at the Queen Elizabeth Hospital; and $1.2 million for upgrading the dental hospital.

In addition, $10.6 million has been allocated for medical equipment, an increase of $3.7 million; and a provision of $23.9 million for information technology, an increase of $1.9 million. The budget also provides a significant boost to secure the health care of rural South Australians by attracting and retaining more doctors to rural areas through a $6.1 million rural enhancement package. The package will increase remuneration for doctors for a range of services, such as obstetrics, and provide extra training and support for doctors. The budget also sows the seeds of the future of health care in South Australia.

Today I want to outline very briefly to the Committee the strategic directions for the health sector, which will lead to an improvement in the health of all South Australians. We are committed to exploring improved health outcomes through the integration and coordination of care for those most in need. With respect to medical services, the division of responsibilities between the Commonwealth Government, Medicare, PBS (Pharmaceutical Benefits Scheme) and the State Government (with responsibility for hospitals) causes significant fragmentation in service delivery and reduced health outcomes for patients.

Coordination of services will therefore lead to significant improvements, particularly for chronic illness sufferers who are heavy users of our services. The SA Healthplus initiative, which the Commonwealth and State Governments have agreed to fund, will allow South Australia to pilot effective ways of improving coordination of services. This approach has equal applicability in other service areas—for example, in disability services, where the commission is already implementing an options coordinations system. Over the past three years, the Health Commission has taken a leadership role in formulating a wide-ranging program of structural and management reform to ensure that the public health system

is well equipped to meet the challenges of population ageing, the emergence of new epidemics and the demands of rapid development of new clinical and information technologies.

The essence of these reforms is a population focus in the planning, funding, purchase and evaluation of public health services and programs. In conclusion, I wish to thank all staff in the health sector, whether they are clinically or non-clinically based, for their dedicated work and efforts on behalf of the total community of South Australia. Without the efforts of those staff, the health sector would not be recognised as the most efficient in Australia, and what is being done would not be of international interest to health care providers and administrators and, above all, South Australians would not be secure in the knowledge that their health care is world class. I commend the Health Commission budget to the Committee and look forward to responding to members' questions.

The CHAIRMAN: I declare the proposed expenditures open for examination. Does the lead speaker for the Opposition wish to make an opening statement?

Ms STEVENS: Yes. We are nearly at the end of a four-year term presided over by the present Liberal State Government. We have seen unprecedented cuts in funding administered by this Government which, prior to the last State election with the full knowledge of the State's financial situation, promised extra funding for public hospitals, better care, more nurses and a hospital bed when you needed one. It promised to halve the wasting lists in its first term of Government and to encourage management efficiencies within the public hospital system which would create savings of between $40 million and $50 million a year that would then be returned to the health system to improve patient services. It has broken these promises, and the facts speak for themselves. Allowing for inflation, the cumulative cut in real terms over four years has been $206 million. The staff losses in the health system over this time amount to 2 250 full-time equivalents (FTEs), a significant number of these being nurses. In fact, I understand that there has been an 11 per cent reduction in nursing FTEs over the last three years.

These funding cuts have occurred over four years in spite of the fact that in three of these years the Federal Labor Government increased funding for health by $83 million in real terms. The cuts occurred without any articulated vision for the future in either health services or health outcomes for South Australia. Instead, the Government embraced strategies such as privatisation and casemix funding, with the prime purpose of using them to deliver spending cuts rather than provide an efficiently run, high quality health service. The feedback that we and others have received says that people are concerned about being discharged from hospitals quicker and sicker, that our hospitals are dirty and that the nurses are so run off their feet that they cannot attend to the basic needs of sick people—even to the extent of offering them help in feeding.

People still wait on trolleys in A and E departments; they leave hospitals needing rehabilitation, and there is not any; they are told that if they want their hip replacement done within a reasonable time to get private health insurance; and if they have a mental illness the service they can expect is hit and miss and still nowhere near good enough in terms of community support. If they are pensioners needing routine dental treatment, they can expect to wait several years to be seen by a dentist. If they live in the country, all of this is worse.

After all this, when they speak out the Minister refuses to acknowledge their complaint. When it differs from his view of the world he negates advice given by his consumer planning bodies as not statistically valid and winds back his commitment to consumer input on a whole range of bodies. We believe that South Australians have lost confidence in the public health system and that they have done so with justification. After three years of cutting the health budget and three years of confusion about privatisation, the Government has predictably promised a bagful of election goodies designed to lift its image in health. As this will be the last Estimates Committee before the election, I highlight how the health budget compares with the Government's rhetoric. In 1994 the Premier's budget pamphlet told South Australians:

> Even after adjustments to the health budget this year of $35 million, spending on health care in South Australia is expected to remain above the standardised national average.

This was a significant announcement because, as I mentioned, the Government admitted that it was cutting the health budget, and in doing so it broke a whole raft of election promises.

An honourable member interjecting:

THE CHAIRMAN: Order! I ask that members of the Committee refrain from interjecting. The Minister was heard in silence and I ask that the same courtesy be extended to the Opposition lead speaker.

Ms STEVENS: The announcement was also significant because it was the only time that the Government publicly admitted the truth about cuts being made in real terms to State funding for health. By 1995 the honeymoon was over and the line changed. Members will recall that the Premier's pamphlet announced, 'We're coming into the home straight', and claimed, 'This year we will spend $70 million building better hospitals and providing better equipment.' However, four weeks later the Minister admitted to this Committee that the Government had decided to increase the cut to State expenditure on the health sector over three years from $63.5 million to $70 million.

In 1996 the Premier's pamphlet was even more misleading with the announcement, '$90 million more for a healthier South Australia'. Four weeks later, however, the Minister again admitted to the size of the cuts when he told this Committee that the health system would have achieved total savings of $61 million per annum by the end of that financial year and that a further saving of $10 million per annum was required by the end of 1996-97. I invite the Committee to compare the Minister's confirmation of a cut of $71 million to the health budget and the Premier's claim that there was $90 million more for health. After two years of being 'in the home straight', the Premier's pamphlet this year was 'looking forward to the future'. The Opposition certainly looks forward to asking the Minister today to justify new claims of more hospital services, including the $60 million upgrade to the Royal Adelaide Hospital.

We know that these new claims by the Premier will be sorely tested by a budget that cuts another 250 full-time positions from health care; a budget that brings the number of health jobs axed by the Minister to 2 250, a cut from 23 600 jobs in 1993-94 to 21 350 jobs in the coming year. Members will recall that last year the Minister's opening statement included argument that the decision to keep the management of the new privately funded hospital at Port Augusta in the public arena demonstrated the Government's 'balanced and responsible approach to outsourcing'. Another view is that the failure to attract an acceptable proposal to

manage the new hospital was symptomatic of the Minister's lack of direction.

The Minister now has a panoply of outsourcing deals that include private funding for publicly managed facilities at Port Augusta and Mount Gambier; the private management of publicly owned facilities at Modbury; the location of a temporary private hospital in the public hospital at Modbury; the collocation of private and public facilities at Flinders; plans to outsource specific medical functions (surgery at the Queen Elizabeth Hospital); and both in-house and private catering and other support services. While the Opposition agrees that there must be strong links between the public and private sectors in the delivery of public health services, there is now no clarity in terms of defining the scope of the public and private sectors in the delivery of health services.

I believe that there is more confusion to come as the Minister grapples with resolving the failed and secret contract to manage the Modbury Hospital, the continuing uncertainty of privatisation at the Queen Elizabeth Hospital, and the Minister's recently announced plans to introduce private facilities at the Royal Adelaide Hospital. In conclusion, I would like to make one further observation. I note that again this year we received final figures for these Estimates Committees on which to base our questioning only two or three days ago. We received this year's figures with a covering letter, from which I will quote a portion as follows:

> The figures presented also show the estimated allocations based upon resource variations known at the time of framing them, that is, early April 1997. Anticipated policy changes associated with the casemix funding model and other subsequent resource variations will mean that the final budgets to be provided to health units at the end of July with their health service agreements will be different from those provided in the attached 1997-98 budget supplementary information.

I wonder about the point of a full Estimates Committee hearing when the figures with which we are presented are not accurate. I also sympathise with the managers of all those health units who do not know their budgets and who probably will not know their budgets for another two or three months. Is this any way to run a system the size of this one?

Members interjecting:

The CHAIRMAN: Order! We will try not to be too provocative at this early stage. I will be pretty strict in relation to supplementary questions and will at all times maintain the decorum of this Committee. With members' support, we will have a successful day.

Mr Brindal interjecting:

The CHAIRMAN: Order! The member for Unley is out of order.

Ms STEVENS: My first question relates to page 314 of the Program Estimates and Information. I preface my question by referring briefly to a media release put out by the Minister for Health on 30 November 1994 entitled 'Modbury Hospital—The facts versus the fiction'. It states:

> The Minister for Health, Dr Michael Armitage, today said Modbury Hospital will be a millstone around the neck of Labor at the next election.

Further on it states:

> By the next election the Modbury Public Hospital will have had nearly three years of private management, the Modbury Private Hospital will be up and running and the new public hospital facilities such as the 26-bed obstetric ward, the extra intensive care and coronary care beds, the step down beds and the like will be in operation.

Mr ROSSI: What is the question?

The CHAIRMAN: The member for Lee is out of order.

Ms STEVENS: The flagship of the Minister's deals to privatise the management of our public hospitals was the secret contract to manage the Modbury Hospital. We now know from evidence of the Chief Executive of the South Australian Health Commission to the select committee inquiring into this contract and from public statements made by Healthscope that the contract entered into the by the Minister has clearly failed. It has failed in that Healthscope has made unsustainable losses and has sought renegotiation of the way in which the company is paid, and it has failed because Healthscope has failed to deliver the Minister's promise of a new stand-alone, collocated 65-bed private hospital completed by the beginning of this year.

Following Healthscope's public statements that it was seeking a renegotiation of the Modbury contract to remedy unsustainable losses, has the Government agreed to any changes to the method of paying Healthscope; if so, what variations have been agreed; and, if not, what proposals are being considered?

The Hon. M.H. Armitage: The short answer is, 'No', we have not agreed to any changed way of payment. The question allows me to pose some hypothetical questions to the member for Elizabeth. The first of those hypothetical questions relates to the fact that the contract for the private management of Healthscope has delivered to the South Australian taxpayer benefits of $16 million. If anyone in the Labor Party believes that that is a failed contract, I would be very surprised. The short answer is: there has been no agreement as to any altered contract. There is a total benefit of $16 million thus far estimated in the contract—that is the benefit to the South Australian taxpayer—and, further, as the Government has proven time and again, it will continually press the boundaries of the provision of the most up-to-date and modern health care so that all South Australians can benefit.

If, in doing that, we are able to capture some of those benefits so that more operations may be delivered via day surgery, for instance, which is what patients want and it has a benefit to the system, to the patient, to the patient's family and to the patient's employer and so on, and, if to provide that benefit we need to redraw a contract that may be set in stone, we will certainly investigate all those ways.

Ms STEVENS: I have a supplementary question.

The CHAIRMAN: As long as it is directly on the same line.

Ms STEVENS: Yes, Sir. The Minister has just said that there has been no agreement to any changes to the method of paying Healthscope or to the pricing arrangements of the contract. Have any discussions been held in relation to changes to the method of paying Healthscope and the pricing agreements?

The Hon. M.H. Armitage: As I have indicated before, we are always looking at improving the way in which services can be provided in any contract, be it a public or a private sector contract, and by that I mean a contract with the consumers of health care. The fact that there have been discussions as to how we might do that is hardly a secret. I have admitted that in this Chamber following questions from the member for Elizabeth on at least two occasions, and I will certainly admit it again. We are always looking to redefine the way in which health care is provided in South Australia. The question I was asked was had the Government agreed, to which I said 'No.'

Ms STEVENS: How has the Government dealt with Healthscope's claim that during the six months to

December 1996 when the company lost $1 million Healthscope was owed more than that amount for extra work done in the same period?

The Hon. M.H. Armitage: Very easily. Healthscope got it wrong and it has now admitted it. Any money which Healthscope did not get was a benefit to the South Australian taxpayer. I would again ask a hypothetical question. Does the member for Elizabeth want me as Minister for Health in South Australia to look after the health care of South Australians or the income float of a private company?

The CHAIRMAN: Standing Orders do not allow Ministers to ask the Committee questions.

The Hon. M.H. Armitage: I can ask hypothetical ones.

Ms STEVENS: I ask the Minister to confirm whether he intends to hold Healthscope to its initial contract agreement, which was signed in February 1995, in relation to the way in which Healthscope is reimbursed for the services it provides?

The Hon. M.H. Armitage: The answer to the question is 'Categorically not'. If we can get better benefits for the taxpayer of South Australia, I would not be so silly as to say that I am going to ensure that a contract is written in stone. I forget the exact date the contract was written, but the member for Elizabeth quoted 1995. Does the honourable member seriously expect that, with the pace of change in technology and in health care today, the Minister for Health in the year 2015 will still—

Ms STEVENS: You signed the contract.

The Hon. M.H. Armitage: Exactly. Of course I signed the contract.

Ms STEVENS: It broke down after two.

Mr BRINDAL: Two what?

Ms STEVENS: Two years.

Mr Brindal interjecting:

The CHAIRMAN: Order! Interjections are out of order.

The Hon. M.H. Armitage: The simple fact is that in the year 2015 the member for Elizabeth would have us providing health care to the people of South Australia according to a contract that was written 20 years ago. I know that some of the principles of the Labor Party are rooted in the past, but that is ridiculous. No Minister for Health—even, dare I say it, a Labor Minister—in the future would suggest that something should be done as it was 20 years ago. I correct the member for Elizabeth because the board signed the contract, not I.

Mr BRINDAL: I do not know whether the Minister will admit that he listened in silence or shock to the opening statement of the Opposition. I wonder which world it has been living in.

The CHAIRMAN: Order! Will the honourable member ask a question, please?

Mr BRINDAL: No, an honourable member does not have to ask a question; a member is allowed to make statements. The honourable member should read the Standing Orders.

The CHAIRMAN: There is some latitude, but please proceed.

Mr BRINDAL: The Opposition has used the formula of Shakespeare: upon the Minister let us lay our souls, our wives, our debts, our careful lives, our children and our conscience. According to the Opposition, he is responsible for everything, and I want to put my first question into context. I remember very well when the Minister was shadow Minister asking questions about maggots at the Queen Elizabeth Hospital. I am sure that maggots no longer fall through the roof at the Queen Elizabeth Hospital.

Ms STEVENS: Is the question coming?

Mr BRINDAL: Yes, the question is coming. I am equally sure that there are problems and shortages in our health system. I would like to know who created the problems and shortages. I would like to know where the shadow Minister was when she was listening to the Minister's opening statement about $26 million for enterprise bargaining, $10 million for priority funding, and $2.5 million for tobacco tax. Where was the shadow Minister—

The CHAIRMAN: Will the honourable member direct his question to the Minister, please.

Mr BRINDAL: I will, Sir. Where was the shadow Minister when the then Government was losing all this money? It is the Minister who is trying to clean up the mess. It is the Minister who is taking responsibility but it was not he who created the mess, and in that context I will ask my question. It refers to page 327 of the Program Estimates and SA Healthplus. Will the Minister inform the Committee what contribution SA Healthplus will make to the State of South Australia in the future?

The Hon. M.H. Armitage: I thank the member for Unley for his question, which gets to the nub of the way in which health care will be provided in the twenty-first century. The Government is not prepared just to sit on its hands and, as the honourable member's question implied, allow the system to decay around it.

SA Healthplus was officially launched this morning in the presence of the Federal Minister for Health (Dr Michael Wooldridge). He and I signed an agreement between the Commonwealth and the State which will see the building blocks of SA Healthplus in place as it becomes one of the most exciting and innovative projects in health care internationally. It will play a key role in the development of health services as a model of health reform in the country. Health systems throughout Australia and internationally are faced with a number of challenges: escalating costs, new technologies, ageing populations, and better health outcomes being expected quite legitimately by providers and consumers. Combined with all these is a need to ensure that health policy is congruent with the values of society.

Today we face significant health challenges in Australia. Current financial systems which relate to casemix funding, the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) are all geared towards meeting the needs of the health system from a financial management perspective. While funding outputs may provide an improved financial framework for the management of the health system, they are not directly related to health outcomes of the population.

The very fact that two levels of Government deal with those things I have mentioned provides the basis for a fractured range of health services, which makes it very difficult for patients to navigate their way through the complex system of services that are available. The current systems mean that the focus is on the supply of health services as a goal, rather than on meeting the needs of individual patients. With SA Healthplus, the commission has developed a framework for coordinating care across the whole spectrum of services that I am absolutely certain provides a starting point for a new way of delivering health services in South Australia, Australia and the world.

It is much more than just economic reform. It is a realisation that the Government is more than prepared to make a courageous, outside-the-square type decision. This decision puts individual clients in the driver's seat. We are able to progress this system with the full support of the

Commonwealth Government, which today signed the agreement which enables the funding to be cashed out for 8 000 volunteer individual clients. The Government recognises that we cannot just keep going down the same well-worn path. It is no longer acceptable to be a follower in an area as important as health care. There are other trials throughout Australia, but we are embarking on our trials as part of a systemic reform process, and Dr Wooldridge certainly acknowledged that today.

Accordingly, the Healthplus initiative should be regarded as an indication that the Government is prepared to move towards the millennium, to look at the major challenges and to have a better health outcome as the focus. It is a very exciting initiative; it a starting point for a new way of doing business; and I am absolutely certain we will create international interest when it works. I repeat: it is outcome focused. For instance, a patient at the launch today suffered from asthma. His general practitioner has been putting into train some of the individual tenets of Healthplus. Prior to that coordination of care with the patient and the GP having a pact on how the care will be managed, this patient would be admitted to hospital on two to three occasions every year. He told me on Sunday that, on two of those occasions, it was touch and go as to whether he would survive. Under the new way of looking after his care, he has not been admitted to hospital in the past 12 months. So it has huge potential both for the patient and for the health care system.

Mr BRINDAL: I refer to page 325, with regard to the stated broad objective to provide proper standards of public and environmental health in the State generally through the prevention of disease, illness and injury, and the promotion of health. I wish to congratulate the Minister, his predecessors and, indeed, the Federal Ministers for the constructive approach taken on the matter of HIV/AIDS and its threat in Australia. The Minister would be aware that we have much less of a problem than many other countries, because in many countries in Africa and Asia whole populations are threatened. However, in Australia, because of responsible attitudes by high risk groups and public health authorities, that threat is much more confined. The issue of HIV/AIDS remains a public health issue of global significance. Will the Minister provide details of a framework within which it is proposed to approach the issue from the turn of the century?

The Hon. M.H. Armitage: I am delighted to answer a question about such an important matter. In doing so, I am pleased to advise that the State Cabinet has endorsed the release of the South Australian HIV/AIDS strategy for 1997-98, a green paper for public consultation. This strategy paper follows on from two prior strategies—the first produced in 1987—and takes into account the current national HIV/AIDS strategy. As the member for Unley intimated, South Australia has been extremely successful in reducing the numbers and the rates of people infected by diseases such as HIV/AIDS and hepatitis. It has also developed a good support network for HIV positive people and for their carers. However, we acknowledge that more work has to be done to reduce further the transmission of such diseases within the South Australian context, and we are focussing on six priority groups. Highest priority will be given to people living with HIV/AIDS and their carers; to gay and homosexually active men; and to Aboriginal and Torres Strait Islander communities. The other three priority groups are: injecting drug users, sex workers and prisoners.

The goals of the strategy are to eliminate HIV transmission in South Australia; to minimise the personal and social impact of HIV infection; and to improve the quality of life and life expectancy for people with HIV infection. Other measures include: improved and targeted HIV primary health care; pre-HIV and post-HIV test counselling and advice; health worker training and support; and ensuring mainstream community health agencies integrate the HIV priority population groups into their target groups where appropriate. There is a very important difference, though, between this strategy and the previous two. The latest strategy has been framed in the broader context of sexual health and related communicable diseases. It looks at integrating programs dealing with all infections with similar means of transmission, whilst maintaining the focus on HIV. Key programs will be designed to provide people at potential risk with information not only about HIV but also about other diseases of concern.

This holistic approach is a significant step in the State's progressive attitude towards such issues and, as I said before, is consistent with the national HIV/AIDS strategy. It will be very important in relation to Aboriginal populations, where evidence indicates treatment of sexually transmitted diseases is a major factor in reducing the spread of HIV. In the past, the approach has been focused on HIV on its own, rather than looking at the population group and its broader health needs. The latest strategy builds on previous strengths such as continued partnerships involving community groups and reinforcing harm minimisation principles. It is those strengths that have set Australia's and South Australia's HIV strategies apart from those of the rest of the world, as the member for Unley recognised.

The key points within the 1997-98 strategy green paper are: a need to maximise the effectiveness of resources, structures and programs for populations considered a priority; the framing of the strategy in a broader sexual blood borne disease context (the new strategy acknowledges the importance of hepatitis C for some populations which have been considered a priority); an urgent need to strengthen sexual health services for indigenous people, given the relatively high rates of transmission of sexually transmitted diseases in Aboriginal communities; increased attention to decrease further new infections among homosexual men and men who have sex with men—lead agencies identified the six priority groups to take on the role of planning and coordinating HIV related programs and services; a treatment and care action plan for people living with HIV/AIDS in South Australia; and, lastly—and very importantly—the establishment of a Prisons and Health Committee to develop policy, procedures and standards for communicable diseases in prisons similar to the one in New South Wales.

The Prisons and Health Committee, with high level membership, will develop and oversee communicable disease programs and will implement best practice strategies aimed at reducing the spread of diseases such as HIV/AIDS and hepatitis C. Such strategies include cost effective testing and surveillance of blood borne diseases within prisons; reducing the risk of infection of blood borne diseases to Correctional Services staff and to prisoners; introducing other harm minimisation approaches for drug use, including the methadone program; and appropriate treatment and care of prisoners with a blood borne virus.

In general, AIDS has been a controlled notifiable disease in South Australia since 1985, and HIV since September 1991. There have been 647 people diagnosed with HIV infection—600 males and 47 females. Seventy-six per cent of males reported male to male sexual contact; 9 per cent

reported injecting drug use; and 5 per cent reported both risk factors. Forty-seven per cent of females reported injecting drug use, and 41 per cent reported heterosexual transmission. The strategy green paper advocates increased research and targeting educational prevention programs within the six priority groups. It also focuses on providing culturally appropriate information for people from non-English cultural backgrounds. The green paper will be distributed widely to key players within the HIV/AIDS community for comment. It will be available to individuals through the Health Commission's HIV/AIDS Programs Unit of the Public and Environmental Health Service (the phone number for that is (08) 8226 6604). The consultation period for the green paper will last until late August. I am confident that the final document will make a very real contribution in maintaining the low levels of transmission of HIV virus amongst South Australians.

Mr Atkinson interjecting:

The CHAIRMAN: Order! The member for Spence is out of order.

Mr BRINDAL: The member for Spence gads in and out of this place like butterfly. He constantly questions the Minister in relation to the Queen Elizabeth Hospital, but he does not appear to be interested in paying enough attention. I suggest he has BFW syndrome.

The CHAIRMAN: Order! The honourable member will ask his question.

Mr BRINDAL: That is Bob Francis withdrawal syndrome, for the benefit of the Minister. My supplementary question relates specifically to what the Minister just said about the green paper. I note with much interest that prisons has been added as the new target population, and that is a radical step forward that was never achieved under the previous Government, so the Minister is to be congratulated. Does that mean that the prisons and health committees will definitely come into being, or is that just a concept in the green paper?

The Hon. M.H. Armitage: The green paper is obviously out for a period of consultation, but it is certainly my view that a prisons and health committee with high level membership will be formed to investigate the sorts of issues that have been identified around the world as problems for both the prisons community and the prison officers. I in no way underestimate the importance of correctional services officers having every right to feel safe in their environment, to be non-threatened and to be able to administer the penalty which the justice system has meted out, in the most ideal circumstances. Equally, there is always a balance between those ideals and the simple fact that, if someone goes into a prison either HIV/AIDS or hepatitis C free and comes out infected with those diseases, that is a penalty above that which the justice system had expected.

Mr BRINDAL: I refer to page 320 of the program descriptions, because this matter was alluded to by the member for Elizabeth in her opening statement when she tried to belittle the Minister's contribution to regional health and country health generally. I will be interested to hear her; when she does start on that she will probably get it as wrong as she has got everything else wrong this morning. Will the Minister outline the benefits and costs of regionalisation as a result of the creation of regional boards under his ministry?

The Hon. M.H. Armitage: This is an important question. Indeed, as you would know from your own local electorate, Sir, regionalisation is an issue of great importance. It is an issue with which the population of rural South Australia has expected that Governments would grapple and deal over many years. Indeed, the previous Administration made several attempts to achieve regionalisation, without success, so I believe that our presenting the opportunity to country people of being more in control of their health care is very important. It is a key component of our health policy, it was identified in the 1993 policy and it is already delivering more and effective services in rural areas of this State. It has provided an opportunity to streamline the provision of all health services within each of the seven country regions now established and to improve the range of services as well as access to them locally.

It provides the potential for much better planning by each local regional health service board for its regional population and for the more efficient and effective delivery of services through economies of scale and better integration at the local level. A regional general manager has been appointed to each of the regional health services, and regional boards and positions have been established from within the health budget for each region. The boards and managers have already assumed important roles and functions, previously the responsibility of the Country Health Services Division of the commission, and will continue to consolidate the administrative aspects of service delivery within the region.

In this financial year, an extra $14 million has gone to regional health services. In all, $198.2 million has been spent on country health services, compared with $184 million in the previous year. Funds are now allocated by the Health Commission directly to regional boards, which distribute an operational budget to each health unit in their region. In the first year of operation, regional boards have either applied a small levy of the funds allocated to each health unit in the region or have negotiated the allocation of funds with health unit CEOs to do two things: to fund the administration of the extra moneys they have been provided with; and, importantly, to create a pool of funds for local initiatives in the provision of health services.

One-off funding was provided to regions in recognition of cost savings to be achieved through the replacement of unit CEO positions and other rationalisations. It was recommended that these funds, if not fully absorbed, be set aside as a reserve. I believe that has been done. In relation to the financial benefit to the regions, I will ask Mr George Beltchev to demonstrate the finances of regionalisation and indicate the several million dollars available through the way we have set this up in financial terms. I will then continue by giving some examples of current initiatives within each region.

Mr Beltchev: The total funding which was available for the establishment and development of regional offices for 1996-97 was $4.6 million. That total fund was comprised of levies which were made by regional boards on their respective health units; a once-off fund provided by the Health Commission for the establishment of the regions; an additional fund to cover additional insurance costs; and a specific fund for the development of strategic plans. That total of $4.6 million was disbursed in the following ways. First, there was a total cost of running all regional offices of approximately $1.7 million, and a further amount was spent on the development of regional strategic plans. An amount of $2.2 million was returned directly to health units for health unit and regional initiatives in each of the regions and as at 30 June an estimated $880 000 remains in reserve, which will be carried over to the next financial year for further regional initiatives.

The Hon. M.H. Armitage: So, in essence, as can be seen, $4.7 million was available and $2.5 million was spent, leaving $2.2 still available for regional initiatives. I will detail some current initiatives in place. The Hills, Mallee and Southern Regional Health Service has instigated regional, strategic and business planning to determine priorities for service development and allocation of resources—exactly what rural consumers have wanted for years; it has established new, Commonwealth funded nursing home beds in the region—exactly what rural people have been requesting for years; it has amalgamated the chief executive and DOM positions, releasing resources; it has explored options for coordinated care within the region; and there has been collaboration on options for local mental health services.

The Wakefield region has instituted regional strategic and business planning to determine service development and resource allocations. There have been regional contracts for a number of services about to be confirmed, all of which achieve savings on previous arrangements. Restructured administration of the Chief Executive Officer and Director of Nursing and other senior nursing positions has occurred following board amalgamations. Further efficiencies have occurred in administration and hotel and maintenance services allowing other foci. The Mid North, the Riverland, the South-East, Eyre Peninsula and the northern and far western regional health services have exactly the same sorts of stories to tell.

This is a major success story for the Government in that it provides local money to be administered locally which is exactly what rural consumers have been seeking for years and which we have achieved.

The CHAIRMAN: I understand that the members for Torrens and Spence defer to the member for Elizabeth.

Ms STEVENS: I refer to page 314 and the privatisation of the Modbury Hospital. The Minister has boasted on many occasions, but particularly on 27 June 1996, that he had out-negotiated the private sector in the contract with Healthscope to manage the Modbury Hospital: why is he now saying that he will categorically not hold Healthscope to the contracted agreement—an advantageous position for South Australian taxpayers about which he has also boasted on many occasions? Why does he not apply the penalties and re-tender or, better still, return the Modbury Hospital to the public health system, which he has stated earlier today is the most efficient in Australia?

The Hon. M.H. Armitage: If that was in the best interests of the community, that is what we would do. The simple fact is that, in indicating that categorically I would not rule out anything which provided better health care for South Australians, which is exactly what I did, I hold to that. The whole concept of health care is changing. At the risk of repeating myself I shall reiterate what I have said on a number of occasions in this Chamber. When I was in Medical School, and that is not so long ago—

Mr Brindal interjecting:

The Hon. M.H. Armitage: I will respond to that interjection from the member for Unley later. When I was in Medical School, which is not so long ago, people who needed a cataract operation would lie in hospital for two to three weeks with a sandbag on either side of their head so that their head did not roll around which would result in making the lens unstable in their recently operated-on eye: three weeks in hospital. Nowadays, a person enters hospital for a cataract operation at 7.30 in the morning, and at 3.30 in the afternoon that person has returned home. Health care is advancing in leaps and bounds, thank goodness, because—

Mr Brokenshire interjecting:

The Hon. M.H. Armitage: As the member for Mawson says, these days people are able to play football several weeks after cartilage operations. I can remember 25 years ago when some of the great Norwood superstars had a cartilage operation that it was the end of their career. Medicine and health care are advancing dramatically. It is factual that, in the past two to three years, change is asymptotic. Obviously, if we are able to make gains for South Australians by capturing the advances of that technology, which are prevented in contracts that are written in stone, we will obviously contemplate varying those contracts. We will not contemplate it, might I add, if there are not benefits to the South Australian public, and that is what I have said all along.

Ms STEVENS: I thank the Minister for the lecture on modern health care. When the board of Modbury Hospital signed up with Healthscope in February 1995 it presumably signed up for a certain level of high quality services for a certain price. There is a balance between services and the efficient delivery of those services. The Minister now says that he will renegotiate the pricing of those services. Surely the whole contract should go to re-tender. How will the Minister know whether he has an efficient and high quality service provision, because he will have no way of testing it? Why does he not re-tender or, better still, return it to the public health service; or is he too afraid to admit that what he signed up has been a dismal failure?

The Hon. M.H. Armitage: In answer to that last emotive little gibe, I point out that the taxpayers of South Australia have benefited by $16 million. I know to a Labor Party politician that is not much, but I think it is terrific. Most taxpayers of South Australia, I am sure, would agree with me: they are very pleased they have not had to pay $16 million extra for those services. I accept the emotional gibe but, nevertheless, those are the facts. I repeat what I said before in answer to the previous question: if that is in the best interests of South Australia we will do it.

Ms STEVENS: Will the Minister provide a full breakdown of the $16 million advantage to the South Australian taxpayer? I note that when the Minister originally talked about this contract he said there was to be a $6 million saving per year. I would like a full breakdown of that $16 million as soon as possible.

The Hon. M.H. Armitage: I will be thrilled and absolutely delighted to provide it because then, finally, the member for Elizabeth will have to keep quiet about how this contract has been a failure. Once she has the facts and figures in front of her she will have to stop this continual carping, because the simple fact is that the South Australian taxpayer has a $16 million benefit, and I will be only too happy to provide the breakdown.

Ms STEVENS: I again refer to page 314 and the privatisation of the Modbury Hospital.

Mr ROSSI: You have a one-track mind.

The CHAIRMAN: Order!

Mr Rossi interjecting:

Ms STEVENS: In the public interest. On 30 November 1994 the Minister announced, 'By the next election the Modbury Private Hospital will be up and running.' The cost benefit analysis for the Modbury contract released by the Minister in October 1996 revealed that, although there was contractual commitment by Healthscope to construct this hospital, the Government was considering proposals to

establish the 65-bed hospital within the existing structure. Given the advice to the select committee by the Chief Executive of the South Australian Health Commission that the construction would have to commence by August 1997 and be completed by August 1998, and that this year's capital program at page 47 states that $5 million will be spent on the new private hospital by Healthscope in 1997-98, where will this new facility be built, what is the total cost of this project and when will the facility be completed?

The Hon. M.H. Armitage: As I previously indicated, we are most keen as a Government to ensure that the taxpayer of South Australia receives the greatest possible benefit and equally, as I have previously indicated in this House and so it is no surprise, planning a facility that may be inside the present Modbury Public Hospital indicates that, for argument's sake, if a Torrens Valley Private Hospital were to expand on the hospital already operating (I should indicate that a private hospital is already operating there)—

Ms Stevens interjecting:

The Hon. M.H. Armitage: —yes, but it is operating there—it could provide 65 private beds within the existing public hospital without impacting upon the current or future demands of bed availability for public patients. If that were the case such an arrangement would optimise the use of public hospital space, and it would provide a substantial financial benefit to the Government through Healthscope lease payments to the Modbury Public Hospital board. If the private hospital were to be built in unused public hospital space, there would be a revenue flow. As I have indicated, a temporary Torrens Valley private hospital was commissioned on 18 January 1996, and it will continue to operate as it is doing. There is no secrecy about those facts. We are very keen to see the new hospital built.

Mr ROSSI: I bring to the Committee's attention the fact that I have lived in a fine area of Adelaide two bus stops away from the Queen Elizabeth Hospital since I was 12 years old. I have a strong interest in the hospital of the north-west. I object to some of the member for Elizabeth's statements in her opening remarks, because when she accuses the Liberal Government of breaking promises she fails to point out that the State Labor Government broke the State and that the Federal Labor Government broke Australia. Various committees were formed; members of the committees were paid a performance commission; they did not produce or implement any new ideas; they did not reassess those things that had been implemented; and they did not produce to this Parliament any accurate balance sheets from 1982 to 1993.

Page 319 of the Program Estimates refers to interpreting services. My mother, being Italian born, did not know of any interpreting services while the Labor Government held power between 1982 and 1993.

An honourable member interjecting:

Mr ROSSI: She goes there quite regularly, and there are no interpreters. With regard to interpreting services, will the Minister outline what improvements have been made since the Liberal Government gained power in this State?

Mr ATKINSON: I rise on a point of order, Mr Chairman. Surely that question should relate only to this year's budget line and not to the three previous financial years of the Government.

The CHAIRMAN: The question concerns payment and receipts; it is allowable.

Mr BRINDAL: I rise on a point of order, Mr Chairman. The member for Spence is neither in the seat that he is assigned in this Parliament nor the seat that he is assigned by virtue of being on the Committee. I challenge his right to take points of order when he is sitting at the rear of the Chamber doing something else.

The CHAIRMAN: I did seek advice on that matter earlier. The member for Spence is in the Chamber and can sit where he likes.

The Hon. M.H. Armitage: I thank the member for Lee for his very important question, because the provision of care in a language which is culturally appropriate is a prerequisite to the best health care. The Continuity of Care Review, a review for elderly non-English background patients at the Queen Elizabeth Hospital, was published last year, making a number of recommendations about improving interpreter services. The review investigated the problems of those elderly patients who speak little or no English, and it made the following recommendations: that the hospital work closely with the Migrant Health Service to improve access to interpreter services; that interpreters and bilingual staff be used at all times when indicated; that the number of bilingual signs be increased; that training in cross-cultural communication be made available to all staff; that elderly migrant and non-English speaking patients be more involved in decision making about their own care; and that discharge planning and especially continuity of care (something upon which this Government is focusing) be improved for migrant and other non-English speaking patients.

It is with great pleasure that I advise the Committee that $350 000 was allocated to provide the State's first multicultural coordinator at the QEH campus of the North-Western Adelaide Health Service to ensure that the best possible interpreter services are available to older patients who use that service. The coordinator will be appointed for a three-year period, and he or she will implement the recommendations of the Continuity of Care report. They will establish liaison with the Migrant Health Service to ensure that health care delivery is culturally attuned and appropriate. I am sure that the implementation of those recommendations will improve access to services for people of non-English speaking background in the north-western suburbs of Adelaide, a subject that was attested to by large numbers of leaders of the ethnic community who like the member for Lee were with me when this service was launched a couple of weeks ago.

Mr ROSSI: What other interpreter services have been implemented by the Minister and the Liberal Government in regard to helping people of an ethnic background with drug and alcohol problems?

The Hon. M.H. Armitage: In the Drug and Alcohol Services Council, South Australia is lucky enough to have a body which leads Australia and which has an international reputation in providing drug and alcohol service, advice, treatment, counselling, and so on. That organisation was aware of the difficulty which a number of people have in seeking help in relation to drug and alcohol issues, as they are sensitive emotional issues even if there is no language or cultural barrier. Accordingly, if one adds on the dilemma and the difficulty of a cultural or language barrier to the already difficult emotional circumstance, it is particularly difficult. A service has been provided at the Drug and Alcohol Services Council, linked with an interpreting service, whereby through a single number people are able to access appropriate advice in a cultural language and background which suits them. A number of posters have been developed in a series of different languages which will advertise that service in a number of culturally appropriate venues and circumstances so that,

hopefully, people will not have that added barrier to accessing the excellent services that are available.

Mr ROSSI: With respect to page 322 of the Program Estimates, referring to mental health, will the Minister advise of any specific projects for children and young people?

The Hon. M.H. Armitage: It is with pleasure that I am able to inform the Committee that the Government has secured $645 000 for child and youth mental health initiatives to be run in metropolitan and rural areas. They are part of national mental health funds to be applied to once-off projects, and expressions of interest will be called for organisations to conduct the projects anticipated to take place this financial year.

The projects have been identified in a study by the commission called 'Strategic purchasing of mental health services for children and young people'. The main projects that will receive funding are: care linkages for children of psychiatric patients, which will benefit by $115 000; detailing a comprehensive and coordinated crisis service, benefiting by $70 000; local crisis protocols and linkages for rural areas, $200 000; developing school programs for early intervention and prevention of mental illnesses, $160 000; and training and promotion programs in Aboriginal mental health, $100 000. Each of the projects has been crafted to deliver services to specific areas of need for South Australian children and young people. Each of those areas obviously deals with areas of particular concern. For instance, children of psychiatric patients often encounter a range of risks and trauma and, given that, they may well experience extreme helplessness in difficult family situations. By dealing with the issues confronting the children or young adults, trauma to them can be minimised, and early intervention at the point of crisis may well reduce the need for greater levels of intervention later.

Indeed, the trauma of the parents, the people with the psychiatric illness, is also likely to be reduced if they know that their children are being appropriately looked after. Another project will look at extending the successful mobile acute mental health services to assist children in the home. A scheme looks at the provision of crisis services for young people in South Australia's rural and remote communities, where it is felt that improvements to the care and suffering of young people and their families can be made if local communities have a formalised set of protocols to deal with mental health crises if and when they develop.

A school based scheme is an ideal way of nipping in the bud potential mental health problems in children. A project officer for each of the Child and Adolescent Mental Health Service teams will work on training programs to help teachers identify mental health issues and to intervene where appropriate to develop mental health programs for use within the schools, to foster mental health promotion initiatives, and to discuss interagency collaboration to address issues for school aged children.

Aboriginal mental health is also a key issue to which a substantial amount of funding will be directed, and issues there include the need for culturally appropriate services, the training needs of Aboriginal health workers (specifically in the area of mental health), and some understanding of the mental health needs of Aboriginal children and young people in metropolitan and rural and remote South Australia. I am sure that this project will be of great benefit to the mental health of young South Australians.

Mr ROSSI: Page 323 of the Program Estimates refers to the 'ongoing expansion of home delivered and community based services'. Will the Minister advise the Committee of the benefits of Hospital at Home programs based on the new technology in medicine whereby, as the Minister mentioned earlier, knee operations take under 10 hours and eye cataract operations need only one to two days' recovery. How is that new technology used in conjunction with Hospital at Home programs?

The Hon. M.H. Armitage: The member for Lee asks a particularly pertinent question as we re-engineer health care into the twenty-first century, because Hospital at Home programs have been demonstrated to be a very cost effective method of care that is beneficial to patient recovery. The programs enable patients who require short-term nursing care after they have had their major episode of hospitalisation to be cared for by specialist nursing staff (under the direction of a consultant or the general practitioner who is looking after them) in the patients' own home. At Flinders Medical Centre the Hospital at Home programs commenced in May 1994, and at the QEH in August 1995. About 2 000 patients have benefited from the programs at each site. Many people who have been directly involved with the programs are confident that the Hospital at Home service accelerates the patient's recovery. If it did not do that, we would not be going down this path.

Patients and their carers have reported benefits such as a quieter, more restful environment at home; the ability to get a good sleep; returning to their normal lifestyle; food that is to their liking; and the feeling that they are in control of what is happening to them. The commission has introduced changes to casemix funding that ensures that the Hospital at Home service is funded where appropriate, and the result should be that Hospital at Home may well be a partial or even full substitution for inpatient care. Specific areas where care can be conducted under this sort of program might include wound care; medication; stoma care; patient education; IV antibiotic therapy; anticoagulation therapy; and transitional support. Also, some oncology services are provided in this way.

Recently I spoke with the Chief of Surgery at the Queen Elizabeth Hospital campus, who indicated to me that this project was so successful that they had been able to almost reallocate the nursing load. They had expected that there would be quite a large call on the nurses from the patients who, once they have been discharged from hospital, have the option of calling the nurses whenever they wish. The facts completely belie that, because the Chief of Surgery told me that rarely do patients call the nurse more than once. In fact, once people are comfortable in their own surroundings they almost wish to sever the ties with the acute hospital system.

Mr ROSSI: I have a supplementary question relating to the people in the north-western suburbs. Will the Minister explain how the interpreter services in the north-western suburbs of Adelaide and the Hospital at Home program affect older non-English speaking people?

The Hon. M.H. Armitage: Just as I indicated in relation to the other questions about interpreting services, it is clearly not in anyone's interests to provide a service that is not well understood by the person receiving that service. I am well aware of the fact that large numbers of people who have English as a first language, let alone as a second language, have difficulty understanding what is being done to them in an acute hospital setting. Many of them do not understand why procedures are done, what results are being given to them, and so on. If you add a cultural or language barrier to that, it is even worse. Clearly, it is exactly the same for care

being provided via Hospital at Home. For instance, if someone is having medication or intravenous antibiotic therapy or anticoagulant therapy, all those require an element of patient understanding and must be provided with culturally appropriate messages.

Ms STEVENS: My question relates to page 314, 'metropolitan hospitals', and Modbury Hospital in particular. I would like the Minister to provide the full breakdown of the $16 million savings. He has 23 advisers: I am sure that they can provide that information. I would like it in detail, and I would like it relating to the last cost benefit analysis of service that the Minister provided in October 1996.

The Hon. M.H. Armitage: We do not have the immediate detail here but, as I said before, I will be delighted to provide the information. I will put the officers onto it and we will get it as soon as possible. I know the member for Elizabeth very well, so I will not nominate a time by which the breakdown will be provided, because, if it is one minute later than that, that will then be the issue. We will provide the information as soon as possible after lunch.

The CHAIRMAN: I note that the Minister put that on notice earlier in the day.

Ms STEVENS: I have a supplementary question. The Minister is accompanied by 23 advisers from the Health Commission. I have sat and listened to long-winded filibustering while the Minister avoids proper examination by the Opposition. The Minister made a statement to the Committee and pulled a figure out of the air in relation to savings for Modbury Hospital and then, even though he has 23 advisers present, he was not able to give me the answer to the question I put to him. That is completely unacceptable.

Mr BRINDAL: Mr Chairman, I have a point of order. The proper function of the Estimates Committee is to question the Minister. The number of advisers that the Minister may or may not choose to have is totally irrelevant, and the member for Elizabeth is out of order in referring to the advisers. The Minister may refer to his advisers, but to mention the number of advisers he has with him is totally out of order and it is rude.

The CHAIRMAN: Order! It is not a point of order. The Minister is endeavouring to answer the question.

The Hon. M.H. Armitage: I am delighted to provide a first cut now, but I know the member for Elizabeth backwards and I know that, if the figure is altered later by as little as 50¢, the member for Elizabeth will indicate—

Ms Stevens interjecting:

The Hon. M.H. Armitage: It will be correct when we get the figure for you. The savings come from a discount on services, from elimination of expenditure overruns and the benefits from payroll tax. In 1994-95 that is thought to be somewhere between $3 million and $3.5 million; in 1995-96, it is greater than $7 million; and, in 1996-97, it is greater than $6.5 million. That adds up to greater than $16 million. We will provide a line by line outcome.

Ms STEVENS: That is a joke.

The CHAIRMAN: Order!

The Hon. M.H. Armitage: The member for Elizabeth says, 'It is a joke.' What is a joke is the fact that the member for Elizabeth would complain about this Government saving the taxpayer $16 million when her Party blew $8 billion of hard earned taxpayers' money: that is the joke.

The CHAIRMAN: Order! The Committee will come to order. We will just cool down a little.

Ms STEVENS: My next question relates to Program Estimates and Information, page 313, capital works funding. This year's capital budget is said to be $103.4 million. The question concerns the value of the old money component of the current capital works program for works already in progress and the value of new works scheduled to incur costs for the first time this year and their combined forward expenditure commitments. Of the total value of this year's capital expenditure of $103.4 million, what is the value of the estimated expenditure this year relating to works already committed either because work has commenced or because contracts have been signed, and what is the value of new works planned to incur expenditure for the first time this year?

The Hon. M.H. Armitage: I am informed that we can provide that detail. It will take some time, but we will get back to the honourable member today.

Ms STEVENS: Will the Minister provide a list of all capital projects already committed and a list of new works planned to commence and incur expenditure for the first time this financial year?

The Hon. M.H. Armitage: Yes.

Ms STEVENS: As a supplementary, what is the total estimated expenditure on works already committed and works to be committed this year for 1997-98, 1998-99, 1999-2000 and 2000-1? I am happy to take that on notice.

Mr Rossi interjecting:

The CHAIRMAN: Order!

The Hon. M.H. Armitage: I am very happy to provide that information, but I find it interesting that earlier the member for Elizabeth became hot under the collar when I suggested that I would provide her with a paper on notice, yet she now says that she is quite happy to take this question, which also requires detail, on notice. However, I am certainly very happy to do it.

Mr BRINDAL: My question refers to Program Estimates and Information Financial Paper No. 1, page 327, where various health technology initiatives are mentioned. For South Australians to have access to the latest developments in medical research it is important that the health sector is at the cutting edge of technology. What role does the Internet play in the health sector in South Australia?

The Hon. M.H. Armitage: The South Australian Health Commission certainly recognises the importance of establishing an Internet presence as an alternative means of making information available to clinicians and to the public. The technology, though, is relatively new and the degree of access to and acceptance by the various categories of health clients is not known, and therefore the commission is adopting a relatively low cost and progressive approach with an emphasis on coordination of the activities of the various health units, ensuring that services are not being duplicated but they are of an adequate standard and available as they are through other health sites. In March 1996 the commission endorsed an Internet policy and the establishment of a World Wide Web steering committee to facilitate the use of the Internet for the improvement of health services.

As I said, the steering committee was endorsed in March 1996. It was established in May 1996 and includes representatives from the broader health community. A number of workshops have been conducted to enable health units to share information on issues and requirements relating to establishing an Internet presence. An experimental web server was also established with links to health units and other relevant home pagers. Following further development in November 1996 a business case was endorsed and initial funding was approved for the Internet presence. The steering

committee endorsed the view that web site services infrastructure and maintenance should be outsourced to an Internet service provider and, following a tender process, Webb Media has been awarded an initial six month contract to design and maintain that web site. This company will establish and manage the equipment and design and create the relevant infrastructure, publish information on the SA Health web site in accordance with agreed standards and practices and policies, and provide consultancy services where appropriate.

Health units will have the option of creating or amending their web pages either in-house or through the services of an independent company of their choice. As part of the agreement, the current SA Health web site will be redeveloped and will involve establishing a health brand on the Internet to promote the improvement of health care across the community. The firm is undertaking a scoping exercise, which involves consultation with health units, to discuss marketing and communication objectives, strategies and solutions appropriate for the on-line achievement of the strategies. This will be completed in mid 1997.

Mr BROKENSHIRE: I refer to Program Estimates and Information Financial Paper No. 1, page 325. Mention is made in that line of increased community concern over the safety of food. In this context, what action has the Government taken following the coroner's inquiry into the death of Nikki Robinson related to the consumption of Garibaldi mettwurst to reduce the risk of such food poisoning incidents occurring in the future?

The Hon. M.H. Armitage: This is a very important question because on occasions there have been accusations that the Government has not responded to the Coroner's inquiry, and I wish to lay that bogey to rest. The Government has made a number of changes to address each of the Coroner's recommendations. These include amending the disease notification requirements of the Public and Environmental Health Act, improving communicating arrangements with general practitioners about public health alerts, increasing staffing to deal with outbreak investigations, and commencing a complete review of the State's food legislation. Some of these changes are linked with national developments. I wish to deal with each of the recommendations in turn and the Government's response.

Recommendation 1 indicated that the Minister and the commission should review the system of disseminating information to doctors about disease outbreaks and whether it should be linked to medical registration. More rapid electronic communication systems for informing general practitioners of public health alerts so that they can look out for persons presenting with particular symptoms and advise the Public and Environmental Health Service immediately of such cases have been developed. This has involved using facsimile machines and pathology laboratory couriers and, more recently, an Intranet project, which will become increasingly effective as more doctors embrace IT.

The possibility of making subscription to such a system a prerequisite for medical registration was discussed with the Medical Board, which did not consider such a proposal within its powers. Also, the Public and Environmental Health Service has retained a part-time communications adviser-cum-journalist to assist in providing timely information to the community about public health issues, particularly those relating to communicable diseases.

Recommendation 2 was that the commission review its practices in relation to follow-up breaches of the Food Standards Code. Local government officers have the legal responsibility to ensure the observation of proper standards of hygiene in relation to the sale of food and the manufacture, transportation, storage and handling of food that is intended for sale under section 28(1)(a) of the Food Act. Follow-up inspections by the Health Commission Food Unit in conjunction with local council staff are now routine in such cases. Links with local councils which are involved in the investigation of outbreaks and the inspection of food premises have been improved, using facsimile transmission, and further improvements using electronic mail are being investigated.

Recommendation 3 was that the National Food Authority establish a standard relating to E.coli in uncooked fermented smallgoods. The National Food Standards Code now includes a requirement that uncooked fermented smallgoods be free of E.coli. The laws relating to food safety are under review. A discussion paper entitled 'Protecting the safety of food supply in South Australia' was circulated last August. Comments on the discussion paper have been collated and an implementation committee, including representation from local government and industry, has been established.

However, a complete review of food law for the whole of Australia has been given top priority at the national level through the Council of Australian Governments. This will cover the development of uniform Food Acts, national food hygiene standards and a review of the Food Standards Code. It will also include New Zealand food law in its consideration. It is working to a tight time frame and it is intended to produce draft legislation by the end of 1997. These events will to a large extent set the agenda for the South Australian review, which will take any national development into account.

Recommendation 4 suggested that the South Australian Health Commission should ascertain whether there is a faster system for national reporting of communicable disease outbreaks and the Morbidity and Mortality Weekly Report (MMWR). The MMWR is now on-line. In addition, the Communicable Diseases Network of Australia and New Zealand holds teleconferences on a regular weekly basis and more frequently whenever there is a particular outbreak or issue of concern. Information about perceived or potential outbreaks is sought and given instantaneously.

Recommendation 5 was that the South Australian Health Commission should review its internal procedures concerning the flow of information between the Food Section and the epidemiologists. Increased staffing has been provided in the Communicable Disease Control Branch at a cost of $250 000 annually. These staff comprise skilled public health doctors and nurses, epidemiologists and data managers who are able to analyse the data and look for the early signs of an outbreak associated with a common source. They have established protocols to mobilise to investigate such outbreaks quickly and effectively.

Additional staff have also been provided in the Food Section of the Environmental Health Branch at a cost of $100 000 per annum. With their knowledge of food processing, these staff are able to support the CDCB in outbreak investigations. The Communicable Disease and Environmental Health Branches have been collocated to improve communication and interaction not only during such outbreak investigations but on an ongoing basis. They share a conference room and meet daily to discuss and resolve issues of mutual concern.

Recommendation 6 indicated that the Health Commission should review its procedures in relation to outbreak question-

naires. Basic standard questionnaires are prepared and available which are modified to meet the requirements of each particular outbreak investigation. They are reviewed by qualified staff for their appropriateness to the particular case.

Recommendation 7 was that the Health Commission should review its procedures concerning interviewing persons during an outbreak investigation to devise ways in which they may be arranged more urgently. In response to that recommendation, the nurse-epidemiologists whose role is to interview cases and contacts searching for information that may lead to the source of an outbreak are highly trained and expert. They know when the situation requires urgent handling and I assure everyone that they conduct interviews as soon as possible.

Recommendation 8 indicated that the Health Commission should review its procedures in relation to data analysis. As mentioned previously, additional staff have been recruited to the Communicable Disease Control Branch. They are expert in epidemiology, data analysis and management, and analysis techniques are being continually improved.

Recommendation 9 was that the Minister consider amendments to the notification requirements of the Public and Environmental Health Act. As members would be aware, amendments were made to the disease notification requirements of the Public and Environmental Health Act to ensure both treating doctors and laboratories provide earlier notification of diseases of public health concern. This is now on the basis of suspicion rather than confirmed diagnosis and must occur within three days. Haemolytic uraemic syndrome, thrombotic thrombocytopoenic purpura and shiga-like toxin E.coli are now routinely being reported by laboratories.

Recommendation 10 was that the Health Commission review its policies and procedures in relation to voluntary recalls. The Australian and New Zealand Food Authority is reviewing the national recall guidelines. However, the Health Commission may, where it is of the opinion that food is not fit for human consumption, *inter alia* prohibit its sale or movement or even order its destruction. In the case where food has already been sold, the Health Commission may publicise warning notices. However, in such circumstances, manufacturers invariably conduct their own recall, which is likely to be much more effective than a recall conducted without their cooperation.

Recommendation 11 was that the Health Commission review its policies and procedures in relation to authorised officers' powers. This recommendation is particularly relevant to local government staff. It is an issue which is being taken up as part of the review of food legislation. As mentioned previously, the State has commenced a complete review of the Food Act, but national developments will, to a large extent, set the agenda. These national developments are proceeding as a matter of high priority. They link to national proposals about food premise registration or accreditation and mandatory training of food handlers. As mentioned previously, additional staff have been appointed to the commission's food unit, and better methods of communicating with local government staff have been and are continuing to be developed.

The final recommendation, recommendation 12, was that the Minister, with the Minister for Primary Industries and local government, review resources for enforcement of food legislation. As I have already outlined, staffing within the commission has been increased. More effective arrangements in relation to local council administration of the Food Act were canvassed in the green paper on the legislation. Again, progress towards national standard legislation is being made, and the relative roles of primary industries and health departments in relation to food safety are being addressed to ensure the consistency which is obviously necessary across State boundaries. Some of these developments, in particular those relating to outbreak investigation and restructuring of the CDCB, have been informed by the recommendations of professor Mike Lane. Professor Lane, an American expert, reviewed the haemolytic uraemic syndrome outbreak in South Australia and made recommendations for improvements.

It is important to acknowledge that the Health Commission's handling of the HUS academic equated to world's best practice. This is supported by Professor Lane's review, which compared and contrasted the management of 37 E.coli HUS outbreaks reported in the scientific literature, including the 1995 Adelaide episode. The developments outlined indicate the Government's commitment to ensuring that what was already a good system is even better and further reduces the risk of food poisoning outbreaks in South Australia.

Mr BROKENSHIRE: I refer to the Program Estimates (page 314) regarding casemix funding for 1997-98. I note with interest that the shadow spokesperson tried to convey many unfortunate messages regarding the Garibaldi incident. However, as soon as a positive question was asked, she left the Chamber. Also, once the television cameras left, the shadow spokesperson left, and that is similar to what the Leader of the Opposition does. I also note that she tends to be as negative and carping about South Australia as is the Leader of the Opposition. They are following a very similar pattern. I am sure that the shadow spokesperson did not get a 10 second grab on the television this morning, and that may be why she left.

My constituents appreciate the efforts that Health Commission staff and you, as Minister, are putting into improving health services. I was pleased to see an increase in the budget line for the Noarlunga Hospital. It indicates that most hospitals will see a funding increase. I understand that this has really occurred since the introduction of casemix. Will the Minister provide a brief overview for the reasons for introducing casemix funding to South Australians hospitals initially, and describe how the funding changes will occur in 1997-98?

The Hon. M.H. Armitage: The casemix funding model has been designed to produce an incentive for hospitals to be creative and innovative; to provide the best quality services cost effectively; to reduce significantly the waiting list for elective surgery at public hospitals; to expand primary health care services, particularly domiciliary care, home nursing and health promotion; and to place the public hospitals on a cost effective footing to better enable them to meet the growing demands for additional quality hospital care. By its nature, it has allowed the purchase of outputs rather than funding based only on historical budgets which has no efficiency benefit whatsoever. As a longer term strategy, the commission will move to purchase for health gain or improved health outcomes via the health service agreements. The cost effectiveness of our hospitals cannot be questioned. Our casemix price is 12 per cent below the national average for the treatment of inpatients. The funding model is structured to provide two methods of funding: variable funding, based directly on patient activity, and fixed funding, related to other necessary activities that cannot easily be tied directly back to patient activity. Fixed bunding is provided for such items as teaching, research, clinical development, infrastructure and so on. In addition, special funding arrangements apply where

necessary to recognise the differences between country and metropolitan hospitals.

Very small hospitals, also known as minimum volume hospitals, are protected under casemix funding to ensure their operations are funded adequately. Medical services in country South Australia are delivered under different arrangements from those in the metropolitan area, and casemix funding accounts for those differences. It is becoming less appropriate to refer to casemix funding of just South Australian hospitals. Over recent years, the scope has been broadened to include specialist psychiatric hospitals and the Institute of Medical and Veterinary Science. During 1996-97, innovative work has been undertaken to cost and classify domiciliary care and the RDNS clients, as well as child and adolescent mental health and community mental health clients and services which will considerably increase the understanding of health care services provided to South Australians across the whole sector.

Innovative funding arrangements are in place to allow for treating in their home patients who would traditionally have received treatment as inpatients. The service is cost effective and provides greater patient satisfaction. A major project is in train to cost and classify ambulatory patients, to allow greater understanding of this important component of health care, and to ensure equity of funding for the services across the State. That work is expected to be completed this year. As a result of work undertaken previously, we have incorporated additional funding for Aboriginal and Torres Strait Islander patients. As we more thoroughly understand the issues involved in treating children, we have amended the model to incorporate specific funding for areas where children require additional resources, when you compare them with equivalent adult patients. Improved clinical practice has been recognised by the provision of additional specific funding for areas such as cardiac stents, hip revisions, complex pelvic fractures and pain clinics. The cost pressures of providing unusually expensive treatments to some patients have also been recognised by increasing the pool of funds available for the treatment of such patients. More work will be continuing during 1997-98 to further refine and improve the casemix funding model for hospitals and other health care services.

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

Ms STEVENS: My next question relates to page 314 of the Program Estimates and concerns hospital budget outcomes. The yellow book for March predicted cost overruns that included the following: North-West Adelaide Health Service, $4.3 million; Flinders Medical Centre, $.6 million; Royal Adelaide Hospital, $.8 million, Women's and Children's Hospital, $.7 million; Port Augusta, $.5 million; Whyalla, $1.6 million; Millicent, $.3 million; and Port Pirie, $.3 million. Will the Minister provide the end of year figures for overruns? Will hospitals be reimbursed from reserves or from other programs underspent, or are the hospitals carrying the overruns into the next year as debt?

The Hon. M.H. Armitage: I am absolutely confident that my answer to this will be unsatisfactory. However, the answer is that I am unable to provide the end of year figures, because the year has not yet ended. It is 26 June; the financial year ends on 30 June. That is exactly why the member for Elizabeth's letter which was sent to her recently and which she made such a point of reading into *Hansard* stated that the figures were an estimate. The financial year has not yet ended. We are unable to provide those figures. However, as always, I am happy to supply them when they become available.

Ms STEVENS: Surely the Minister must have a more recent projection of these figures? I quoted the March figures from the yellow book. It is now June; surely the Minister is able to provide the Committee with a more recent set of figures. The Minister might have checked with his hospital CEOs to determine what they were projecting their debts to be.

An honourable member interjecting:

The CHAIRMAN: The member for Lee is out of order.

Mr Brokenshire interjecting:

The CHAIRMAN: Order! The member for Mawson is out of order.

Members interjecting:

The CHAIRMAN: Order! The Committee will come to order.

The Hon. M.H. Armitage: The figures the member for Elizabeth quoted were to the end of March. I am informed that we have April's figures which were sent to the printer about a month ago and which I am very happy to provide, but I do not have the end of year figures, because it is not the end of the financial year. Of course, that is one of the dilemmas in holding Estimates Committees at this time. This is absolutely no different from my receiving blue books, and so on, when I was on the other side of the Chamber. So, for the member for Elizabeth to raise this issue again, as she did last year, indicates a misunderstanding of the way it all runs. I did not get any figures other than those provided to me now, and also to the member for Elizabeth, when I was in Opposition.

Mr Brindal interjecting:

The CHAIRMAN: The member for Unley is out of order. He is misleading the Committee.

Mrs GERAGHTY: Perhaps the member for Unley can accept that ruling and behave.

The CHAIRMAN: The member for Torrens will ask her question without being provoked.

Mrs GERAGHTY: To preface my question, I will read part of a letter which I have received and of which I think the Minister is aware. A woman wrote to me, as follows:

> My mother. . . is 88 years old and used the Hampstead Centre from 6 to 20 January. . . for a period of respite. Having used this facility for respite for some years in ward 1A, the dementia unit, and being satisfied with the care my mother received, I was dismayed and concerned at the apparent decline in expert care during this last respite stay. It was during this period that budget cuts at the Hampstead Centre led to 12 beds in ward 1A being allocated to stroke patients. The consequences have directly affected my mother.

My constituent's mother was not supervised properly and fell on several occasions. On the last occasion she required an X-ray because of a suspected fractured collarbone. The letter goes on to state:

> In the past the regular experienced staff in ward 1A have protected my mother from hurting herself, which has given me confidence to leave her there. On this occasion, the traumatic events haven't helped my mother or given me my most needed respite.

She further states:

> . . . I understand that there were no crisis beds during this period of January. . .

The Minister wrote back to my constituent and advised her that the decision to close the beds and restrict some inpatient services at the Hampstead Centre during the Christmas and new year period was based on the anticipated occupancy of the holiday season, and that the object of these measures was to redirect available resources to another period when patient

activity at the centre was high. He said that there had been consultation with the staff and that, once this decision was confirmed, the management of the centre invested a significant amount of time in planning the closures in ward 1C. He went on to state that the hospital had acknowledged that a number of ward 1A staff were not present during my constituent's mother's stay, that the ward was amalgamated in the last week of December and that some nursing staff from both wards 1A and 1C had commenced annual leave.

The Minister goes on to state that he was given the impression that no crisis respite beds were available in January. He comments that he had been advised that three beds were made available in ward 2B for crisis respite care patients who did not require a secure environment. Given the problem in the mix of stroke and respite or dementia patients in that ward, why does the Minister think that putting in ward 2B dementia patients who do not require a secure environment (and I will address the issue of that ward later) would be any different from dementia patients being placed with stroke patients in ward 1A? Why does he think it would be any different putting them in ward 2B?

The Hon. M.H. Armitage: It seems to me that this is not an issue of budget appropriation but, in case there is any suggestion that it is a budget related issue, I am informed that the budget for the Hampstead Centre has been at standstill plus enterprise bargaining. Therefore, I believe it would not be a budget issue. I believe that the member for Torrens read out that the allocation of beds was discussed with the staff but, given that detailed questions are now being asked about mixes of patients within wards (which are quite appropriately matters for administration of the area concerned rather than for Ministers for Health), I will be very happy to take the question on notice and get an opinion on it.

Mrs GERAGHTY: Even though the Minister said that no staff cuts or budgetary measures had been implemented, we believe that that is not the case; that is why I raised that point.

The Hon. M.H. Armitage: I can only provide the information about which I am informed, and my information is that the budget was at standstill, plus enterprise bargaining.

Mrs GERAGHTY: What is the bed occupancy rate at the Modbury Hospital? I specifically ask that question because a constituent of mine, who was taken by ambulance to the Modbury Hospital, was unable to walk and in acute pain. Hospital staff provided some treatment for pain and my constituent was returned by ambulance to a home-alone situation. I rang the Modbury Hospital and, later that evening, the patient was readmitted and remained for the weekend. In a similar case a constituent was sent home because she was advised that no beds were available. When I rang the hospital I was told that that was not the case: beds were available. However, my constituent was specifically told that she could not stay as no bed was available—

Mr Brindal interjecting:

Mrs GERAGHTY: The staff told her—

The CHAIRMAN: Order!

Mr Brindal interjecting:

Mrs GERAGHTY: Exactly, but why was she returned to a home-alone situation having been told that no public beds were available? She was also told that, had she been a private patient, she could have been admitted.

The Hon. M.H. Armitage: I would like to expand a little on what appears to be the thesis of some of the question, that is, that the Labor Party continually focuses on bed numbers. That is fair enough; it has been doing it for years.

Mrs Geraghty interjecting:

The Hon. M.H. Armitage: Yes, the member for Torrens says that that is where sick people go, and I emphasise that a bed was available.

Mrs Geraghty interjecting:

The Hon. M.H. Armitage: I will come to that in a minute, but the point that I make is the point that I do not really have to make because the member for Torrens lined up her right foot and pulled both barrels. A bed was available.

An honourable member interjecting:

The Hon. M.H. Armitage: Beds were available. However, the simple fact is that, as we move towards the twenty-first century, we no longer look at bed numbers as a way of measuring how effectively a service provides health care to constituents. It is much more related to the number of services that are provided and whether those services are provided in a way that is appropriate at a time when we are nearing the twenty-first century. Bed numbers are not important. What is important is the number of times each bed is utilised and how many procedures are being done.

Secondly, the member for Torrens seems to be making a big issue of the fact that a bed was not available. A bed was available, which the member for Torrens has admitted by her own question. What the honourable member identifies is that a patient was told that no bed was available, and that appears to be incorrect on the member for Torrens's own admission. I am unclear as to why that advice might have been given, but I would be interested in approaching the Manager of Modbury Hospital, who I believe has thoroughly investigated this matter and who provided the member for Torrens with a complete result of the investigation.

The CHAIRMAN: Does the member for Torrens wish to ask a supplementary question?

Mrs GERAGHTY: Yes, please. Why was the person told that had she been a private patient a bed was available but that as a public patient no bed was available and she was sent home by ambulance?

Members interjecting:

The CHAIRMAN: Order!

Mrs GERAGHTY: What is the bed occupancy rate?

An honourable member interjecting:

The CHAIRMAN: The Committee will come to order.

Mr Brindal interjecting:

The CHAIRMAN: The member for Unley is out of order.

Mr Brindal interjecting:

The CHAIRMAN: I suggest the member for Unley have a cup of coffee.

The Hon. M.H. Armitage: If we are talking about the same patient, and if it is the patient about whom the member for Torrens received a complete report from the Chief Executive of Modbury, then all I can say is that public beds were available, so that the information was incorrect and did not reflect the situation. What is important is whether the bed was available. It was available. If the member for Torrens wishes later to provide me with all the information, I am happy to check with the Chief Executive of Healthscope and see whether the facts as related to me are the same.

Mr BROKENSHIRE: This is a relevant question to me. I wonder whether my wife wrote this question as a result of what happened to me on Sunday, although she did say that she thought of telephoning Blackwells Funeral Directors and not the public health system. My question relates to farm safety and page 325 of the Program Estimates and Information, Financial Paper No.1. One target of the Health Commission is to monitor causes of accidental injury to assist design

and implementation of preventive systems. The social and economic costs of farm injury have been widely recognised—and I know the Chairman would be interested in this—as detrimental to the health and wellbeing of the farming sector.

The agricultural industry has more injuries and deaths resulting from occupational work than many other industries. That is probably because most of us have been doing it for a long time and we are a little complacent. Given that this is an issue of concern to many Government portfolios, for example, Health, FACS, Primary Industries and Industrial Affairs, how does the Minister plan to address the issue of farm injury?

The Hon. M.H. Armitage: The whole issue of primary health care and farm safety is one of great interest to the Government. In the past there has been an *ad hoc* or uncoordinated approach from a number of organisations, all of which have been operating with the best of intent but the activity has been uncoordinated and much of it has therefore been reactive rather than active. It is part of our primary health care initiatives program and I will ask Dr David Filby to provide the complete answer.

Dr Filby: As the Minister said, there has been an *ad hoc* approach within a number of organisations dealing with issues surrounding injury prevention on farms. The commission, having recognised the need for some coordination, dealt with a farm injury prevention coordinating group which has been established and for which the commission has provided some funding. The organisations associated with this group include the Agricultural and Horticultural Training Council, the Country Women's Association, the South Australian Farmers Federation, the rural divisions of general practice and their coordinating unit, the Women's Agricultural Bureau, WorkCover, the Insurance Council, a range of State Government organisations, and Farmsafe Australia.

Following the establishment of that group, the Minister recently approved some funding under our primary health care initiatives program to develop a coordinated farm injury prevention strategy. The funding provided will support not only the development of the strategy but also some demonstration projects which we believe would have the potential for strategic change. The goal of this coordinated project is to reduce farm injuries by coordinating current programs and organisations associated with farm injury prevention, and to implement a series of short and long-term strategies which we anticipate would result in fewer contacts with South Australian hospitals.

The project has provided us with an opportunity within South Australia to help achieve a series of nationally agreed targets for farm injury which have been developed by the Australian Agricultural Health Unit. Those targets include a 30 per cent reduction in the number of injury related deaths on farms, a 30 per cent reduction in compensable and time-lost injuries, a 30 per cent reduction in hospital admissions as a result of injury on farms and a 15 per cent reduction in the number of young people on farms suffering from noise-induced hearing loss. We hope to achieve all those targets by the year 2001.

The key strategies which the project will cover include: liaison with the key organisations to look at what is going on in the area; establishment of baseline data on farm injuries; identification of key areas of need and prevention; and the establishment of links with the divisions of general practice to raise awareness of safety through farm safe committees and community groups as well as looking for additional sources of funding.

Mr BROKENSHIRE: I sincerely appreciate your efforts in this respect, because it is a serious matter. I can tell you that the pain in my left leg is confirming that right now. The Noarlunga Health Services, through the Southern Vales Community Health Services, has already conducted a lot of programs in terms of farm injury prevention work, chemical safety and so on. Do you believe that that is a positive program that the commission should continue to support where possible as an adjunct to making sure that we do whatever we can to eliminate farm injury?

Dr Filby: The short answer is 'Yes.'

The Hon. M.H. Armitage: Can I ask the member for Mawson whether or not he went to hospital with his injury?

Mr BROKENSHIRE: In the interests of the Minister's budget, I decided to put up with the agony.

Mr BRINDAL: It is interesting that the member for Mawson should mention his wife, because my stepdaughter asked me to ask this question because of a problem we had with my grandson. In this respect I refer to page 327 of the Program Estimates and the various health technology initiatives. Given the Internet awareness of young people today, does the Government have any plans aimed at greater availability of health services using that type of technology to reach young people in our community?

The Hon. M.H. Armitage: There are four innovative Internet projects in which the commission has participated via the Government Internet Venue Project with DITS. They are particularly innovative and creative. I will ask Andre Greyling to provide some detail on those four projects.

Mr Greyling: I am pleased to advise that the Health Commission has participated in the 'Government Internet Venue' project with the Department of Information Technology Services, which has provided funding to support the development of four Internet projects. An on-line story book web site teaching children about hospitals is just one unique measure aimed at de-mystifying health care for young South Australians. This project is one of four health care programs to receive $50 000 in State Government funding. The four health programs will be found on an exciting and interactive CD-ROM web site, INsites, which will teach people of all ages how to surf the Internet. INsites is a joint venture between the Department for Information Technology Services and the South-East Institute of TAFE. INsites has seen four SA Health Commission services funded to assist the development of the interactive *SA Social Health Atlas*, the cancer support site, education about sexually transmitted diseases and hospital familiarisation for children and parents.

The SAHC has been one of the Government's key agencies in developing and implementing the latest information technology. Now we have four cutting edge projects to be incorporated onto INsites to provide the latest health information in a range of areas. The Women's and Children's Hospital 'Check it Out' web site aims to de-mystify hospitals for young people aged three to nine and their parents. It will be available from Friday 11 July. The web site will help children become familiar with hospital experiences via an on-line story book of 20 pages with audio, animated files and object selection. It is an extension of an existing print and video service and will widen options for children and their parents in seeking more information. The proposed CANCARE SA web site project will highlight SA expertise in the treatment of cancer and haematological disorders and

provide information on the cancer centre, counselling services, support groups and the Anti Cancer foundation.

The Clinic 275/STD Control Branch will update its current site to add and build on its content about sexually transmitted diseases. Education about STDs, safer sex and other issues related to sexual health will be found on this web site. This important service is aimed at a young Internet-aware audience with a preference for using this type of technology to obtain information. An interactive web site will be created for the *SA Social Health Atlas* to give clients the ability to select maps from the atlas and navigate around them. These maps provide an overview of the health status and patterns of health and welfare services for different parts of South Australia's population. INsite can be accessed on:

www.sacentral.sa.gov.au

under the Education and Technology category.

Mr BRINDAL: I refer to page 320 of the Program Estimates where reference is made to the provision of ISDN lines to regional countries areas. Will the Minister elaborate on the benefits of this initiative?

The Hon. M.H. Armitage: Several years ago a health data network was established with ISDN lines and routers being installed in a number of country centres. The major driver behind that decision was the need to have in place communication facilities for the WISE system which dealt with the processing of WorkCover claims for health units. At that time, only the major country centres of Port Pirie, Port Augusta and Mount Gambier were connected to the network. The emerging need for electronic mail and other electronic services has generated a requirement for a more widespread data network in country areas.

During 1996-97 the network has been expanded to include regional centres in each of the country regions. In addition, IMVS country laboratories are also sharing in the network, reducing the potential costs of the separate networks. In addition to Port Pirie, Port Augusta and Mount Gambier, which were previously connected to the network, connections have now been made to Berri, Whyalla, Port Lincoln, Murray Bridge, Victor Harbor and Wallaroo. So, it is an expanding network. Again, this Government has realised that if we wish to provide the most appropriate and cost-effective services we must have an opportunity to capture the advantages from information technology, and things such as this will allow us to do it in a very widespread manner.

Ms STEVENS: I refer to page 314 of the Program Estimates and to regional health services. Will the Minister provide details of the operating costs, including overheads, salaries and other expenses such as travel, for each of the seven regional health administrations?

The Hon. M.H. Armitage: We can do that, but whether we can do it immediately is another question. I do draw the Committee's attention to the fact that I have answered a previous question in relation to this which did identify in the broad the administrative costs of the seven regions. I am happy to obtain further detail on that and provide the answer later.

Ms STEVENS: Under the same line on page 314, what level of costs is charged against the budgets of the health services in each region as levies or direct charges for services, and how much is contributed from the South Australian Health Commission's central funding for the cost of running the regional structures?

The Hon. M.H. Armitage: In answer to a previous question I identified to the Committee that there is a sum of $14 million extra in the regional budgets this present financial year, so obviously all the figures must take into account that large injection into the regional budgets. In the member for Elizabeth's question there seemed to be an inference, I believe, that the commission centrally was levying the regions. That is not correct. In fact, centrally the Health Commission provided this year (1996-97) about $750 000 as an extra resource for planning, through funds that were added from the Commonwealth, and so on. So, extra money was put in from that perspective.

Recognising that there is a huge benefit in providing health care in a regionalised, coordinated fashion (hence their desire to have this form of administration for almost a decade now), the regions themselves in most instances (although not all) decided to apply a levy across the board. One particular region negotiated the funds separately with each health unit CEO, but that levy went primarily towards providing extra services. If extra money and services are to be provided, they need to be administered—and that is part of the deal; one must have probity in these issues—and there is some administration cost in that, but the bulk of the levy provides extra services on a regional basis. I believe that the regional reserve that has been carried forward to extra services that will be provided from that levy for 1997-98 is $880 000.

The value of that is that, because it is regionalised, the regions are able to get more grunt for the dollar. They may well be able to employ, for argument's sake, a physiotherapist or social worker, wherever there is an area of need, and spread it throughout the region, rather than one of the smaller individualised hospitals doing that because they do not have the flexibility of having a person across the whole region. So, there is no central levy. In some instances there was a levy in the regions; in others there was not and they got funds separately, but the majority of those funds have gone to provide extra services in the region, and I identified a number of those sorts of services in response to a previous question.

Ms STEVENS: In relation to the same line, is the Minister satisfied that the working relationship between regional boards and their health service units is functioning well? I would like to read from a letter from a woman in Gilbert Valley, as follows:

> As a resident of the Gilbert Valley, a taxpayer and health consumer, I am writing to voice my disappointment with what is happening to health in the area. We in the Gilbert Valley are being stripped of all that we have and the community is suffering to save money so that more can be spent in the cities and bigger regional centres. Ms Horsnell (Regional General Manager of the Wakefield Health Region) has recommended that our hospital board cease advertising for a doctor for this community. This community is in need of three or four doctors. How can she dictate to this community which doctors will serve it? I will not be told where I will go to see a doctor. If Ms Horsnell gets her way, all residents of Saddleworth and Riverton will go to Clare for their medical needs. The residents are not going to be dictated to.

She continues with other comments but, obviously, as the Minister can hear from the tone of the letter—and I am sure that he has had letters sent to him from residents of this community—people are not happy with the way things seem to be working between regional health services and health units. I know that this is not the only region in South Australia where there are concerns between regional boards and health units, but is the Minister satisfied that things are working well within this regional structure?

The Hon. M.H. Armitage: I am extremely satisfied. I have endless examples of people who have written to me and identified that, through the regionalisation process, they are

now able to have local control over the services provided, they have a much greater say in how those services will be provided, and they believe that the cooperation within the regions and between the regions is extraordinary. The member for Elizabeth may well have that letter, and I would not dispute it for one moment. I can only say that, if I had known that that question was coming up, I could have had a stack of letters that are very supportive of regionalisation. In relation to the issue raised by the honourable member, doctors are free agents. They can leave town when they wish. I believe that always ought to be the case, because, if doctors are conscripted to work in a particular area, they are dissatisfied with that conscription and the community suffers.

It is Government policy—unlike the policy of the previous Government—that health units will not be closed, which the previous Government did; so, I am pleased to see the member for Elizabeth being so supportive of these country units. At the moment the particular instance has cover provided by the doctors in Clare, and we understand that the local hospital will advertise for a general practitioner. I am more than happy, as I have stated to the Chairman and a number of other people in other fora, that the Government will be very supportive of any plans that would see doctors provided in those towns where there are none at the moment.

Mr ROSSI: My question relates to page 319 of the Program Estimates, and it refers to a completed helipad at the Royal Adelaide Hospital. The rapid and effective retrieval of critically ill patients from various parts of the State has always represented a major challenge to our trauma services. Will the Minister explain how this will help in that important task and outline the costs of this venture?

The Hon. M.H. Armitage: The member for Lee will know that the Royal Adelaide Hospital has been a primary force in pioneering the effective retrieval of critically ill people for emergency medical treatment. In the early 1970s, the hospital led the way in airborne transport for the critically ill as the first such service in Australia, and indeed it was a former Liberal Premier, David Tonkin, who let the first contract. I spoke with him about that on the day of the opening of the helipad. The approach soon expanded to involve the other major teaching hospitals in South Australia and now is a model for similar services. The original aircraft used—which was a Bell 206 jet ranger, I am informed—was shared by medical and ambulance services, the police, the Country Fire Service and the Surf Lifesaving organisations.

Lloyd Helicopters, a then rising local South Australian firm, was awarded the first contract to provide both aircraft and pilots for an airborne transport for critically ill patients and has since evolved to become pre-eminent among the providers of helicopter services in this country and throughout the world. I know that the principals of Lloyd Helicopters are very grateful for the opportunities that were provided to them in the late 1970s and early 1980s in South Australia. The increasing role of emergency helicopters required an upgrading to a Bell 412 twin engine aircraft in 1990 for medical retrieval work and police search and rescue. This aircraft incorporated a number of features such as instrument flight rules capability and global positioning systems using satellite navigation, and it enabled retrieval services to be undertaken reliably 24 hours a day.

The aircraft was complemented by a smaller Bell jet ranger for less demanding missions, and the use of the two aircraft in different situations proved to be very cost-effective. The increasing requirement for helicopter transport prompted the hospital to investigate a more efficient means of facilitating area medical services. In 1987, a helipad project definition report—I re-emphasise in 1987—was prepared that outlined the basic project. This has now provided the basis for the construction of the new helipad. It was interesting to note that the report was prepared with much input from Dr Fred Gilligan who led the medical team which escorted Mika Hakkinen back to London after his crash at the 1995 Adelaide Formula 1 Grand Prix. Dr Gilligan used the occasion to revisit the London Hospital's helipad and that provided many of the concepts involved in the design of the new helipad at the Royal Adelaide.

Rooftop helipads 42 metres above the ground are still rare in Australia. This was the only practical solution and it has meant that there is no longer a need to use the parklands for landings and to have ambulances waiting to ferry the patient to the hospital. Retrievals have been reduced in many instances by up to 30 minutes and this is of critical importance in many, if not all, cases. The helipad has cost $2.05 million and already I can report that the facility has proved to be of great benefit. For example, on average each year in the past about two or three critically ill patient lives have been saved as a direct result of airborne retrieval by helicopter. Since the helipad was brought into use about two months ago, there have been 36 retrievals to the Royal Adelaide Hospital, and I am advised that at least three and possibly four of these were critically ill and would have died if the helipad had not been available to facilitate rapid retrieval.

It is clear that the helipad is already bringing great benefits to the people of South Australia and is helping to minimise the effects of serious injury in the many cases of retrieval. It will save lives and assist in preventing or reducing the residual handicaps that can result from major trauma. One of my friends lives in the apartments in the Botanic Hotel and he informs me that he has been woken up on a number of occasions by the helicopter coming in on some of its 36 retrievals thus far. He has said that his immediate reaction the first time he heard it was that it was noisy and a bit of a nuisance, but immediately he felt that that was a life that was potentially being saved—it may have been someone he knew or a relative. He said that the local community is incredibly supportive of the initiative.

Mr ROSSI: Page 319 refers to projects to assist better management of the emergency health care needs of the elderly. Will the Minister elaborate on those projects?

The Hon. M.H. Armitage: Mr White will answer that question.

Mr White: The purchasing office of the Health Commission has pooled $825 000 from ambulatory care, primary health care and central funds to run four projects which explore alternatives to the acute hospital care for elderly patients. The Emergency to Hospital Outreach Service (ETHOS) has been funded at a level of $260 000. It is run from Flinders Medical Centre in partnership with Domiciliary Care and the Royal District Nursing Society. It evaluates all admissions to the emergency department of people over 65 years of age and it assesses those people who would be suitable for a program that enables them to receive care at home.

The General Practitioner Home Link project in the north has been funded at $179 300. This is a project run by Helping Hand Aged Care Incorporated, which, together with the General Practitioner Home Link program in the eastern area—also funded at $179 300—is managed by Aged Care and Housing. Both these projects accept referrals from GPs

of all clients over 60 years of age, and 45 years of age for Aboriginal people, who could remain at home with support, instead of presenting to the emergency department of an acute care teaching hospital. The Nursing Education and Training project (NEAT) has been funded at $28 000. This is a competency based training program which is managed by the Flinders Medical Centre and which is training nurses in aged care facilities in the management and insertion of in-dwelling urinary catheters. The aim is to enhance the ability of nursing staff within nursing homes to manage elderly residents of aged care facilities rather than transporting them to a public hospital emergency department for a minor acute condition.

Each project is directed by a steering committee which includes community representation. The results to date show that the ETHOS project has 94 clients a month who receive information and referral, coordinated home care, early discharge planning and respite care in the community. The GP Link project has a steady number of referrals of highly complex cases which formerly would have been referred to emergency departments of public metropolitan hospitals. The pilot phase of each project is to be completed by February 1998.

Mr ROSSI: My third question is very close to my heart and concerns the organ donation agency. Until 1992 my wife worked at the IMVS. The previous Labor Government undertook various actions to try to encourage more donations to the organisation but, as was typical of Labor-run departments, bickering occurred regarding who was senior and who should take responsibility for the job. Page 319 of the Program Estimates and Information refers to innovations in the hospital sector, organ transplantations and donations, an area that has grown dramatically in recent years. The South Australian Organ Donations Agency was established in 1996. Will the Minister confirm whether this agency has had an impact on the rate of organ donations in the State, as I believe that significant increases have occurred in the past two years.

The Hon. M.H. Armitage: I am very pleased to report to the Committee on one of the great success stories in health care around Australia. In looking at organ donation, we sought to be innovative and creative and we looked at adopting a unique strategy in what I acknowledge is a very sensitive area.

The South Australian Organ Donation Agency commenced operation in July 1996, approximately 12 months ago, with the appointment of Professor Geoffrey Dahlenburg as its Director. It has a shopfront office at 10 Pulteney Street and provides information to the community on organ donation. The agency is also responsible for organ donation in the Northern Territory.

I am very pleased to confirm that, since the establishment of the South Australian Organ Donation Agency, there has been an increase in the number of organ donors from 23 donors in the previous year to 36 donors in the first 11 months of the operation of the agency. This has resulted in the rate of organ donation rising to 22 donors per million, which is a rate double the Australian average of 11 donors per million and it is a rate second only to that in Spain in the western world. As a result of this increase and as a result of the generosity of large numbers of family members and individuals, 65 people are now free of the huge burden of kidney dialysis, 19 have new hearts, 21 can breathe more easily with new lungs, 24 have new livers and 16 can see. The impact clearly is noticeable across Australia.

The South Australian Organ Donation Agency also provides information and support to the Health Departments of Victoria and Western Australia on establishing independent organ donation facilities. Professor Dahlenburg was an invited speaker in Melbourne promoting the agency and how it is being done in South Australia. Victoria is contemplating installing a similar program. In August, Australian Health Ministers will consider a proposal to establish a national organ donation and transplantation agency, which will be located in Adelaide initially.

Organ donation is being actively promoted through service and community groups. Letters have been written to all leaders and articles have been prepared for publication in newsletters providing information and offering guest speakers on organ donation. In addition, many Government and private organisations have been approached about placing a message on pay slips. Those sorts of initiatives are very important, as it is clearly an issue that we will have more success with if people have addressed a difficult and emotive issue in a quiet, relaxed circumstance rather than with the huge trauma of having a relative in intensive care.

A database has been developed to cover transplant recipients who are prepared to help in the promotion of organ donation. This information includes ethnic groups and any special skills that can be used for promotional purposes. A contract has been let for the longer term counselling and support of donor families. It is very pleasing to report on such a successful first 11 months of the South Australian Organ Donation Agency.

Ms STEVENS: My question relates to waiting times for elective surgery, and I refer to page 314 of the Program Estimates. Since the decision to change the performance indicators from numbers on waiting lists to waiting times, the South Australian Health Commission has issued three sets of statistics: in October 1996, February 1997 and April 1997. This issue shows a steady trend in the numbers and percentages of people waiting longer than the recommended times for both urgent and semi-urgent surgery across the system. It highlights that the greatest percentage increase in the clearance time for surgery has occurred under the Modbury Hospital contract.

The clearance time in months and percentage change at Modbury was 4.4 months since September 1996, an increase of 22.2 per cent from 1995. The latest statistics show that the clearance time in December 1996 was 4.39 months, an increase of 17.1 per cent on 1995. Why?

The Hon. M.H. Armitage: For many years, large numbers of people in the north-eastern suburbs would drive past Modbury Hospital. For a variety of reasons, it was not necessarily the hospital to which people would rush. That is not the case now. As the member for Elizabeth knows, patient satisfaction surveys are running at 98.4 per cent and that means that people who have gone to the Modbury Public Hospital were satisfied and they have reported that satisfaction to relatives, friends, neighbours and so on.

If you add to that groundswell of support within the community the extra services being provided, including outpatients, you find an increase in the number of people wishing to use that or any other hospital. It is no different from what we have noted at the Women's and Children's Hospital since its lovely new facilities have opened. It is being inundated with births. When a hospital becomes popular, the number of people wanting to use it increases.

Ms STEVENS: I have a supplementary question. I am pleased that the Minister mentioned the Women's and Children's Hospital in that light. As I said in my question, the clearance time for Modbury in December 1996 showed an

increase of 17.1 per cent on 1995; yet the Women's and Children's Hospital, over the same period, had a figure of minus 24.7 per cent. They are both popular hospitals, so why is it that the Women's and Children's is doing so much better?

The Hon. M.H. Armitage: The answer may well be that one of the areas that has traditionally been a problem in South Australia has been the availability of ear, nose and throat operations—the otorhinolaryngological area. Under the public management of Modbury Hospital there were no ENT services at Modbury, but now there are. The private management of the public hospital decided that this was an area of need, and ear, nose and throat services are now provided at Modbury Hospital.

I have no evidence to support this, but it may well be that some of the decrease at the Women's and Children's Hospital is because patients who live in the north-eastern suburbs and who previously drove past Modbury Hospital to go to the Women's and Children's Hospital are now on the waiting list or have had their operations done at Modbury. That is exactly the sort of thing that we expected to see from improving hospital services.

Ms STEVENS: It is a lot more complicated than that, and it might have a little more to do with the efficiency of the hospitals concerned and their ability to manage. I again refer to page 314. The statistics show that the number of urgent patients experiencing a long wait across the major hospitals increased from 26.7 per cent at June 1996 to 27.4 per cent at September 1996, and a big increase to 37.4 per cent at December 1996. Included in these statistics were increases of 64 per cent at the Flinders Medical Centre, 28 per cent at the Royal Adelaide Hospital, and 26 per cent at the Queen Elizabeth Hospital. Why?

The Hon. M.H. Armitage: From which document are you quoting?

Ms STEVENS: *Waiting for Elective Surgery*, issue No. 3, April 1997, produced by the Health Information Centre of the South Australian Health Commission, endorsed by the management of the Metropolitan Elective Surgery Steering Committee.

The Hon. M.H. Armitage: I do not have the exact figures in front of me. The specific question asked was why it went up in that month, and we will look at that. However, the simple facts are that we are doing 11 per cent more work than was the case; waiting lists are down by nearly 20 per cent; and, with the $7.5 million priority funding package, the surgeons have indicated to us that they believe the waiting lists may well go down by another 10 per cent. Also the number of patients waiting for longer than 12 months for their surgery has decreased by nearly 50 per cent. The classifications utilised in these descriptions are those of clinicians, which is very appropriate. However, I indicate that the urgent classification does not apply to—

An honourable member interjecting:

The Hon. M.H. Armitage: No, it is urgent—anything life threatening, which is obviously done immediately. I will look at the details for that month and get some information.

Ms STEVENS: I am surprised that we are unable to have these answers. Statistics from the same publication show that the number of semi-urgent patients experiencing a long wait across the major hospitals increased from 17.0 per cent in June 1996 to 17.6 per cent in September 1996, and 20.6 per cent in December 1996. Why?

The Hon. M.H. Armitage: Similarly, I will get the information for the honourable member.

Ms STEVENS: Another significant statistic relates to the number of procedures that are cancelled. The April bulletin indicates that 50.2 per cent of all cancelled procedures between October and December 1996 were initiated by the hospital. How many cancellations were initiated by each metropolitan hospital for each month since July 1996?

The Hon. M.H. Armitage: Of course, I cannot answer that question now, but I am more than happy to provide the information. That question illustrates beautifully the fact that the Labor Party in South Australia is rooted in the past. Today, we have announced frankly the most visionary program for health care in Australia and potentially the world in SA Healthplus. That will make sure that the people with chronic conditions do not utilise hospital beds as often as they do now for complications of chronic complex conditions: for instance, people with asthma, which can be much better controlled by having their care coordinated. That will mean that the beds in the hospitals will be available for acute and elective patients, which is exactly what they should be available for now but they are not. They are often available not for acute and elective admissions but are being utilised by people who have complications of long-term chronic conditions which can be much better managed elsewhere.

Another initiative that the Government has taken is that we are creatively looking at the provision of aged care beds within hospitals in the country regions, because a regular complaint is that the acute hospitals have a backlog of people who would be better treated in an aged care facility or an appropriate bed, but none are available. We have looked creatively at doing that. All those initiatives are designed to move the non-acute patient out into the community where they can be better looked after. It is a simple fact—not just under this Government but all Governments—that unless that sort of strategy is adopted there will be these sorts of cases to which the member for Elizabeth referred, whereby someone is on a waiting list but the beds in the hospitals are being utilised by people who are there inappropriately.

There is absolutely no point in calling someone in for a condition which requires operation but which is minor, if it is felt that a bed may not be available because of the large numbers of chronic patients who are utilising those beds. Hospitals cancel operations for reasons of that sort. They do not do it malevolently; clearly, it is in their interests not to do so. It is by looking creatively at the way we will provide health care in the future that these problems will be overcome. I stress that they are not related to the budget or this Government: they are a feature of the way health care is provided around the world.

Mr BROKENSHIRE: I draw the Minister's attention to page 322 of Program Estimates and Information, Financial Paper No.1, referring to more flexible, community-based support options in mental health. Many of our colleagues have talked to the Minister about mental health over a period now. It is fair to say that when we came into office we were at a real crossroads with mental health services and needed a clear plan for the future. To that end, will the Minister explain the benefits of moving hospital based mental health services to community based services?

The Hon. M.H. Armitage: I will ask Mr George Beltchev to provide the answer to this very important question. He was involved with the realignment of mental health services from their previous institutional base into the community, where they are much more appropriately provided, in line with national mental health strategies and so on.

Mr Beltchev: In the year 1996-97 further important initiatives have been planned and implemented by the Health Commission and this Government in response to the national mental health strategy. South Australia has now moved from being at the tail end of reform in mental health to being at the forefront in Australia. In 1991-92, when the national mental health strategy was implemented, approximately $11.5 million was spent on community mental health services in South Australia. Today that figure is about $24 million and growing. Adult mental health services are now regionally based. This was fully implemented at the beginning of this financial year, continues to grow and develop, and will assist the development of the future provision of better services and local support for people with serious mental illness. There is now a greater range of local services working in a collaborative manner providing coordinated care to people with serious mental illness. These services include not only the services provided by the health units but also local community health bodies, local government and voluntary groups and other community bodies such as local churches and service clubs.

Mental health community support and accommodation services are now widely dispersed in the metropolitan regions. Plans for the further transfer of inpatient services to local general hospitals are progressing. The first of these will occur when the 40-bed unit at the Queen Elizabeth Hospital is completed, and that is anticipated to be in 1997-98. Mental health services to people in rural and remote areas of the State are also increasing, with the establishment in particular of the Rural and Remote Mental Health Service and the provision in the 1996-97 budget of an additional $1.5 million specifically aimed at expanding country mental health services.

Community mental health teams are now in place in each country region, and a dedicated country inpatient unit is operating from the Glenside campus. The number of staff now placed in the community to provide support for people with mental illness in the metropolitan area has increased by 68 full-time equivalents in the metropolitan area and 23 in country areas. There are now 375 full-time equivalent staff in community based mental health teams in the metropolitan area, and 42 in rural and remote areas. Provision is being made for the recruitment of staff with specialist language and cultural skills, particularly in those parts of the metropolitan area with a high density of people from non-English speaking backgrounds.

In November last year the Minister announced the establishment of assessment and crisis intervention services to provide 24 hour a day, 365 day a year service to respond to people in crisis due to a mental illness and in so doing also provide support for their carers. These teams have been established, are all operating and are all accessible from anywhere in the State through a single 1300 telephone number, which is 131465. A review of the assessment and crisis intervention services (ACIS) showed that after one month 3 689 calls were received by those services and, of these, it is difficult to estimate precisely but an extremely conservative figure is that 696 calls were from consumers not previously known to the Mental Health Service. Approximately 10 per cent involved callers from rural and remote areas of the State.

Recently, the Minister has also announced the establishment of neighbourhood network services. These services are aimed to assist people with a serious and persistent mental illness to live comfortably and effectively in their local communities by the provision of a whole range of supports to enable them to get access to and use the services that other members of the community can use. The combination of this range of new services has dramatically increased the support that is available for people with a serious mental illness now living in the community.

Mr BROKENSHIRE: At this point I thank the Minister, Mr Beltchev and his staff for the way in which they have gone about advising and working with the community in this area. I certainly was on a long learning curve when it came to changes in the health services, as was the community. I have seen a lot of positive improvements in both health services and the understanding of the broader community in a difficult area, and I sincerely thank you for that. Did Mr Beltchev say that in 1992 about $11 million was spent and in 1997 about $24 million is being spent on community based services?

Mr Beltchev: That is correct: $11.5 million in 1992 and approximately $24 million this year.

Mr BROKENSHIRE: I refer to page 322 of the Program Estimates and community-based mental health services. In the answers to questions on community-based support options, the Minister referred to a number of community-based initiatives in the mental health field. Will the Minister outline some of the initiatives and the costs associated with these initiatives?

The Hon. M.H. Armitage: I thank the member for Mawson for allowing me to elucidate on these very important initiatives. One of the most important initiatives is the neighbourhood network service, which assists people with serious and persistent mental problems and ill-health to build relationships in their local community and to be guided as they access a range of nearby mainstream services. The services are being trialled over one year in two metropolitan regions and one country region. They will be provided by non-government organisations, with the budget for the trial of each service being $100 000, making a total therefore of $300 000.

The services, which are quite unique, will provide social support, advocacy, befriending, involvement of volunteers and the development of a range of social opportunities for people with long-term disabilities. One of those metropolitan trials is very close to the member for Mawson's electorate. Mental health services for Aboriginal people have also been expanded. An Aboriginal health division has been set up within the commission, which includes mental health in its portfolio. At Nunkuwarrin Yunti in Wakefield Street the number of workers in the emotional and social well-being mental health team has been increased.

Two Aboriginal workers are employed also in rural and remote mental health services at Port Lincoln and Port Augusta. In response to people from ethnic communities who have mental health problems, the multicultural mental health access project helps people from non-English speaking backgrounds to use appropriate mental health services, and it has obtained ongoing support from regional mental health services. Recently, the detail of the project's work and achievements was documented in a two-year evaluation report entitled 'Mental Health For All'. Also, initiatives have been put in place to increase the types of supported housing available to people with chronic mental ill-health who require continuing support, supervision, surveillance, etc., to live appropriately in the community.

The approach that has been taken will enable consumers to live in regular housing of their choice for as long as they choose and to provide support services to assist them to lead

a satisfying life in their community. The supported housing options program provided by the Port Adelaide Central Mission, I think, is a shining example of this approach, where the mission was awarded a $1.8 million contract over three years to provide supported housing options for people with serious mental health care needs. For the month of January 1997, 46 people received a total of 629 hours of direct support, which covered the range of activities one would expect if one is supporting people in a community housing option.

Those supports covered meal planning, cooking, shopping, cleaning, social and personal care and recreation. All those programs identify the Government's commitment to the progressive development of community-based support services. Excellence in mental health treatment and care as we move to the next century is not only a question of devolving services from the large mental hospitals, which the last Government was keen to do without the necessary planning to provide community supports. One of the earliest reports I received as Minister for Health related to a mythical $11 million which supposedly had been saved and with which we would provide community services from the closure of the major institutions, but not $1 was left. It is—

Mr Brokenshire interjecting:

The Hon. M.H. Armitage: It was appalling. However, we have moved on and we are now concerned to provide a range of community supports and, very importantly, to engage the local community through the informal and non-government sectors in helping to provide that support. The benefits, I should add, are not only financial, although they are quite significant, but they occur through the proper integration and inclusion of seriously and chronically mentally ill people in the community. They are among some of the most disadvantaged people and are certainly discriminated against in society. It is my view and that of the Government that society benefits as well as the people by providing these appropriate options.

Mr BROKENSHIRE: With further reference to page 322 of the Program Estimates and health resources and health services, mention is made of the development of services by the non-government sector, which is of particular interest to me. The Minister recently visited my electorate, and I am sure he would have noted some of the self-help groups, associations and church groups that are doing some very good work parallel to the commission with respect to mental health services and resources. Will the Minister indicate what progress has been made to involve further the non-government sector in the provision of support services for people with mental health disabilities?

The Hon. M.H. Armitage: One major thrust of the mental health service realignment process has been to involve the non-government sector in the provision of support services for people with mental health problems. The goal has been to broaden the range of opportunities for people with mental health problems so that they can receive the lifestyle support they need to maintain a satisfying, productive and socially valuable life in their local community. In 1992-93, the base allocation to the non-government sector to assist people with mental health problems was $729 000, and for 1997-98 an amount of $1.523 million has been allocated.

In other words, more than double has been committed to the non-government mental health sector, which increases the number of additional health services provided. The funds allocated already represent, as I said, more than a 100 per cent increase on the amount provided originally through the Mental Health Community Grants Program funded by the former SAMHS. In past years, funds did not allow new services to be established. However, new non-government service initiatives have been funded from a variety of sources which include the Commonwealth National Mental Health Project, the Commonwealth Reform and Incentive Funding, other Commonwealth programs, Health Commission specific purpose grants and, importantly, Living Health.

In addition, savings from the realignment and restructuring of State adult mental health services have been released to the Community Grants Program. Some of the additional projects funded this year include $300 000 for one rural and two metropolitan pilot schemes under the Neighbourhood Network Service I previously mentioned; $250 000 as a capital grant for the establishment of the first clubhouse in South Australia, known as Diamond House, with an operating budget of $40 000; $60 000 for the Multicultural Mental Access Project, formerly funded as a project of national significance through the national mental health strategy; $45 000 to integrate the Port Accommodation Access Service with the Supported Housing Options Program to assist consumers in metropolitan regions who wish to make the transition to independent community settings; $35 000 to the State Consumer Advisory Group, the Recreation Link-up Project and Mental Health Week; $20 000 to assist country consumers in particular to participate in the first consumer-led mental health conference entitled 'Our Lives Our Choices'; $15 000 for consumer training and externally facilitated meetings of the regional and State consumer advisory groups, and I was delighted to meet one of the those groups recently; the transfer of resources from existing mental health housing and support services to the Supported Housing Options Program run by the Port Adelaide Central Mission; and the funding of some individual projects such as $5 000 for both the community radio program called *Psycho Waves* and to heads of churches for consultancies to determine a future structure for chaplaincy services. Many additional projects are being funded this year as we increase and continue to increase mental health resources in the non-government sector.

Membership:

Mr De Laine substituted for Mr Atkinson.

The Hon. M.H. Armitage: Mr Chairman, I wish to provide an answer to a question asked earlier today in relation to capital works. It is a difficult question to answer in that some of the new work may be in the budget but has not yet been through the Cabinet process; however, the answer is as follows. The value of works committed in 1996-97 or before by financial year in terms of works in progress are: 1997-98, $46.69 million; 1998-99, $20.371 million; 1999-2000, $16.117 million; and 2000-2001, $16.617 million. The value of new work to be committed in 1997-98 is $56.772 million. The total list of projects already committed and those to commence in 1997-98 in terms of committed works are: the SAMHS areas project, the RAH cancer services, Modbury Hospital, the private hospital proposal at Flinders Medical Centre, Port Augusta Hospital development, Mount Gambier, Northern Community Health at Elizabeth, Marion Community Health, Flinders Medical Centre Lions Eye Centre, Women's and Children's Hospital, SADS Clinic Five, Hills and Mallee aged care, Millicent Hospital, Port Lincoln redevelopment stage 3, Roxby Downs and Info 2000.

Under the same category of new works are the following: Daw Park, the RAH car park, major medical equipment, IMVS laboratories, other metro strategic projects, IDSC Strathmont, Lyell McEwin strategic plan, RAH strategic plan and the QEH strategic plan. Finally, the proposed expenditure of new works carried forward from 1996-97 to 1997-98 is $18.65 million.

Mrs GERAGHTY: I ask the Minister not to interpret the questions I am about to ask as criticism of this project. I refer to page 314 of the Program Estimates. If the Healthplus project is to commence on 1 July 1997, what costs have been incurred in its development to date, what costs are anticipated and where are they described in the current budget Estimates document?

The Hon. M.H. Armitage: It is identified in the support services line, because that is where it came from. I do not believe it is identified specifically. We can get those figures for the honourable member if she wants them in any greater detail. It is important to acknowledge that during 1996-97 there was a large Commonwealth contribution, because this is a Commonwealth-State Government proposal under the coordinated care trial. Obviously the Commonwealth was keen to see someone grasp the nettle as we have done, and so the Commonwealth made a major contribution.

Mrs GERAGHTY: If the project is to commence on 1 July 1997, what processes and systems are in place for this to occur? Is the information technology system set up and running?

The Hon. M.H. Armitage: It is commencing on 1 July. Indeed, the first patients will be voluntarily enrolling in relation to that time frame. The whole project has been in the design for nearly two years, with endless consultation between the Commonwealth and the States and with a number of consumer groups, including consumers themselves and providers, for example, hospitals, divisions of general practice, individual practitioners who are already providing the strategies, the Royal District Nursing Service, domiciliary care and rehab services, and so on. So, everyone has been brought along with this process over the past couple of years.

The most important element of it is the individualised care plan written by the consumer and health care mentor, or GP. That has actually been designed and has been tested to see how long it takes for someone to go through and fill out the plan, because clearly people doing that need to be remunerated for that effort. Care manuals have been developed, and so on. The information technology for tracking payments and so on is almost complete at the moment, and we understand that that will be ready by August. It is fair to say that the full blown exercise will commence thereafter.

Mrs GERAGHTY: Clearly, for the project to work I agree that the commitment and input of a large number of stakeholders is required. Is it true that a former senior Commonwealth health policy analyst now working as a private consultant has undertaken an external evaluation of the Healthplus project and has come to the view that, whilst the concept is sound, its implementation in South Australia is significantly flawed and unlikely to succeed?

The Hon. M.H. Armitage: I am informed that that is not the conclusion that has been reached. Indeed, if someone had reached that conclusion, I believe that it is 100 per cent unlikely that the Federal Minister would have signed the agreement with me this morning. I do not believe that the honourable member was here earlier this morning, but the Federal Minister for Health, Michael Wooldridge, flew to Adelaide specifically because he has great faith in this project, and together we signed an agreement that allows the cashing out of the money for the 8 000 volunteers into the Healthplus entity so that the people can be appropriately remunerated from that pool on a fee for service basis if they are a GP, or whatever. So, there is absolutely no question that everyone is confident that it will work. The money has been committed.

Mr BRINDAL: My question relates to page 319 of the Program Estimates, which refers to the introduction of competitive tendering and the contracting of services. Will the Minister explain what benefits have accrued from the implementation of the competitive tendering and contracting policy within the South Australian health sector?

The Hon. M.H. Armitage: The commission adopted the competitive tendering and contracting policy in July 1995. It was developed as one response to the Government's challenge to the commission to increase the value for money in the public health sector for the taxpayer. The policy acknowledges that the application of market testing principles to the delivery of services is an important contributor in identifying whether services are being delivered in the most efficient and effective manner possible. The Government's policy allows this to be done in a manner that is open and fair to those of its employees who are currently providing those services.

This process is not just a matter of saving money but focuses on increasing the quality of services. This is attained both through the ability to specify expected minimum quality standards in any of the documentation and through the incentive created to a successful tenderer to ensure continued improvement in the approach to the delivery of the contracted services. There are also other potential benefits in that often tendering processes can allow additional services over and above those currently available to be provided without increasing budgetary allocations, and the private sector tenderers often provide those as sweeteners. The Government can access the services available in the private sector through this mechanism, which may not be available in the public sector.

Given the commitment to ensuring that funds are concentrated on the delivery of direct public services, the policy initially focused on ancillary and hotel-type services. Although all major metropolitan health units have now commenced competitive tendering processes, care was taken to stage the implementation so that existing employees and private sector companies were able in each case to address the issues involved properly without being overwhelmed by too many simultaneous activities. To date, six competitive tendering processes have been successfully completed across the major metropolitan teaching hospitals. These are: at the Royal Adelaide Hospital, cleaning and grounds maintenance, security and orderly services; at Flinders Medical Centre, non-ward cleaning, catering, grounds maintenance, security, warehousing and distribution; and at the Queen Elizabeth Hospital, security, engineering and building services, in which the in-house bid was successful.

This has resulted so far in total estimated recurrent savings of $3.7 million per annum in addition to numerous quality improvements and quality outcomes. Several other projects are currently under way that will ensure that this will significantly increase over the ensuing 12 months. Importantly, feedback from management teams very strongly indicates that competitive tendering processes to date have not only reduced costs but improved the quality of services. This has occurred both as a result of the exhaustive specification processes and the move of service delivery responsibility to

private sector companies with vast experience in these areas, and management teams dedicated to achieving the contract objectives.

The other side of the arrangement means that the management teams of public hospitals are freed up to focus on their core business, which is to ensure the delivery of high quality clinical services to the people of South Australia. That is not to say that good contract management is not essential, but this now occurs within a well defined commercial contractual relationship with clear separation of roles and responsibilities. All contracts contain penalty clauses that provide a powerful incentive for private providers to deliver.

Other real benefits to the South Australian Government include the shift of risk to the private sector on matters such as recruitment, training, superannuation and workers' compensation; and, again, risk transfer will help to ensure that the maximum dollars go to public services and that public sector managers focus on the main game, which is quality service delivery to public patients.

Mr BRINDAL: This budget seems to have more good news than a David Jones sale. I noted during the Minister's answer that the member for Elizabeth was poised and will probably go on with this line of questioning, so I would like to do it for her and refer back to page 319 of the Program Estimates and the continued response to competitive tendering and outsourcing in the hospital system specifically. I note in the Minister's answer that he mentioned the Royal Adelaide. Therefore, will he provide a summary of the competitive tendering initiatives—and he listed some undertaken by the Royal Adelaide Hospital—and the associated flow on benefits which he believes those outsourcing initiatives have achieved?

The Hon. M.H. Armitage: Again the member for Unley's question is very important, because it allows me to flesh out some of the on-the-ground benefits of the competitive tendering and contracting process, which sometimes becomes a little too focused on the dollar values, extraordinarily good though they are for the taxpayer. The Royal Adelaide Hospital has shown a very clear commitment to the market testing of its hotel services and has been very pleased both with the savings generated and, more importantly, the enhancement of all services.

In relation to the results of the competitive tendering initiatives undertaken at the Royal Adelaide Hospital, I give the following three examples. First, a contract for the provision of cleaning and grounds maintenance services was signed with Tempo Health Support Services on 18 June 1996 following a very thorough competitive tendering process. Tempo assumed responsibility for these services from 22 July 1996. In the ensuing 11 months Tempo has successfully met the hospital service requirements for cleaning and grounds maintenance. The Royal Adelaide has utilised an independent cleaning auditor to monitor performance and, very pleasingly, the Royal Adelaide Hospital has twice in the past four months been ranked as the leading hospital nationally from a group of 12 similarly assessed institutions. Hospital staff have responded positively to Tempo's performance, with nursing staff noting a very quick response to the clean up of spills—a service now provided on a 24 hour basis. Both those factors were relayed to me when I visited the Royal Adelaide Hospital a mere 10 days ago. Not only are those benefits on the ground but financially the contract will realise recurrent savings of approximately $850 000 per annum.

Secondly, the Royal Adelaide security service was the second service to be outsourced with a contract signed on 15 August 1996 and the new service implemented four days later. The successful tenderer on this occasion was MSS Security, although the service provider is now Chubb Security following a corporate takeover. The impact of the change to an external security service has been dramatic. Since the implementation of the contract, not a single bike theft has occurred from the hospital grounds, surveillance of the north car park has resulted in the apprehension of car thieves, and purse thieves have been successfully pursued and captured because of the quick response of properly qualified guards. Importantly, staff and patient safety has also been improved because of the rapid actions of security staff in the provision of patient restraints, and the presence over night of a uniformed guard in the emergency department has moderated unruly patient behaviour and defused many potentially troublesome situations. While savings have been generated by the outsourcing of security services, they are secondary to the dramatically improved service and, to a larger degree, have been applied in providing an enhanced restraint team—something that was needed.

Thirdly, the outsourcing of orderly services has been the most recent competitive tendering exercise conducted at the Royal Adelaide with the contract being signed on 27 February this year and subsequently implemented on 14 April. Tempo Health Support Services was again the successful tenderer. Of the three services that have been outsourced, the orderly service undoubtedly has provided the greatest degree of business re-engineering with the result that a service previously provided by approximately 100 staff is now provided by approximately 40 contracted staff and 14 hospital nursing staff. Through the use of communication technology, which negates the need for orderly staff to be constantly returning to a central area for allocation of work, a much enhanced service is being provided by a smaller work force.

Nursing staff, patients and the South Australian Ambulance Service have all commented favourably on the new orderlies who have proven to be well presented, well mannered and punctual. The issue of punctuality is perhaps best illustrated in the physio department, where inpatients were being consistently delivered up to half an hour early for appointments by the new physio contractor because physiotherapy staff were allowing for accustomed delays when booking patient transport. As is the case with cleaning and grounds maintenance, expected savings from this outsourcing will be significant, in the order of $1.5 million per annum, when compared with the previous cost of providing the services. We are getting a much better service at a greatly reduced cost.

Mr BRINDAL: My final question refers to incident monitoring. The Program Estimates, page 327, refers to the completion of the South Australian incident reporting monitoring system. Will the Minister explain to the Committee what action has been taken in the incident monitoring area?

The Hon. M.H. Armitage: I invite Mr Peter Davidge to address the Committee.

Mr Davidge: The impetus for the incident monitoring system arose primarily from South Australian involvement in the Quality in Australian Health Care study. This study, which was funded by the Commonwealth, commenced in 1994 and concluded in 1995 and involved a retrospective analysis of over 14 000 admissions to 28 public and private hospitals in New South Wales and South Australia during 1992. The findings of that study revealed that a higher than

expected level of admissions was associated with an adverse event; that each of those adverse events accounted for an average of 7.1 additional days in the hospital; and that 51 per cent of the adverse events were judged to have high preventability. The study therefore highlighted that significant opportunities existed to improve the quality of patient care and, at the same time, substantially reduce costs in hospital systems across Australia.

At a Commonwealth level, the concern about these findings was so great that the Australian Health Ministers agreed in June 1995 to establish a task force on quality in health care to identify a range of strategies, priorities for action, quality indicators and changes in professional education and training likely to have a positive impact on the high level of preventable adverse events. The final report of the task force was completed in June 1996 and among its 56 recommendations were two key ones: that Governments should increase resources to develop databases which routinely gather information on the outcomes of care provided; and that further development of a generic occurrence classification of adverse patient events should take place.

I add that the Australian Patient Safety Foundation was very much involved in this initial study and had obtained Commonwealth funding for the development of the generic occurrence classification. The Australian Patient Safety Foundation is a South Australian based organisation having its headquarters at the Royal Adelaide Hospital. The Chair of that organisation is the Head of the Department of Anaesthesia at the Royal Adelaide Hospital.

During this period, the Tito review on compensation and professional indemnity in health care further reinforced the importance of this work, devoting 38 of its 169 recommendations to the promotion of prevention strategies, including improved education and training, incident monitoring and quality assurance processes. Also coincident with this was the development of some new insurance arrangements for medical malpractice in this State. As part of that development, our lead insurers were strongly promoting the need for incident reporting mechanisms to provide them with a comfort that appropriate risk management existed across our health units and hospitals.

Some significant events happened at that time. During this period, the Health Commission has been particularly active in continuing initiatives to improve the quality of health care outcomes in South Australia. The following initiatives have been implemented over the last two to three years as part of a concerted effort to improve an already excellent system. There has been the appointment of four risk managers in the major metropolitan public hospitals to focus on issues and policy improvement associated with adverse events. Through an organisation called LADD Australia, which provides claims management services to the Health Commission, we have strengthened our capacity to service country regions on these matters, as well.

I have already mentioned the signing of a contract with the Australian Patient Safety Foundation for the implementation of a common incident reporting and monitoring system across all major health units in South Australia. The agreement was signed in November 1996 for a two-year term with an option to renew on mutual agreement by both parties for a further two years. Implementation of that system in the major metropolitan health units commenced in the first quarter of this calendar year. The system has been promoted widely throughout our metropolitan and country hospitals, and significant commitment has been gained for its introduction through the efforts of a project officer assigned to the project and the quality work undertaken by the Australian Patient Safety Foundation.

South Australia is well in advance of all other States in this area, and the information gathered on adverse events will be used to assist in developing quality improvements nationally, as well as strengthening quality assurance processes on a more localised level within individual health units in this State.

I will now outline the current status of the project. The system provides for both anonymous and identified reporting on a common set of forms across all health units. Prior to the commencement of the system, a range of different forms operated, sometimes within the same health unit, but certainly differently across all health units. There are significant benefits to be gained in terms of common processes of reporting. The data from these forms can be fed into local health unit and national databases for reporting, analysing or benchmarking. We will be able to benchmark practice in this State against best practice or practice in other States and overseas. All major metropolitan hospitals, three community based organisations and one country health region are using the system to date.

The Australian Patient Safety Foundation has just released the software to participating health units and this will allow health units to self-manage their data collections. Development has also occurred by the APSF of generic occurrence classification, and this will enable health units to consistently and readily code the data. This has applicability not just in South Australia but across Australia and it has potential for use internationally.

As part of the implementation process, quality assurance processes at each hospital site have been rationalised and strengthened, and, having visited a number of hospitals which have implemented the system, I have been extremely encouraged by the enthusiastic way in which they have embraced its implementation. Implementation across all health units is expected in the next 12 months.

Implementation of the incident reporting and monitoring system is being funded centrally by the Health Commission. It is being actively supported at a local level by the health units participating in the program and, in the longer term, it is expected to provide significant benefits to patients and hospital administrators through the development of improved clinical processes and the acquisition of more cost effective professional indemnity insurance.

Mr De LAINE: My three questions refer to community health services (page 315, Program Estimates). I note with concern that there has been a reduction in funding in this budget line of $9.25 million. I refer in particular to the Port Adelaide Community Health Service. Staffing levels in 1992-93 were 18.2 full-time equivalents. There was a 7 per cent cut in 1994-95 and a further 3 per cent cut in 1996-97. Now the staffing levels at this excellent health centre are 14.67 full-time equivalents. The new funding cut will force the Adelaide Central Community Health Service, of which the Port Adelaide Community Health Service is a part, to further reduce the staff at the Port Adelaide service to 10 full-time equivalents.

The Minister would be well aware of the South Australian Health Atlas and the enormous health problems experienced by people in the catchment area of the Port Adelaide centre. Apart from the environmental and demographic problems there are two main reasons: one is an ageing population, and

the other is that it is an area of rejuvenation, which means that a lot of younger people with children are moving into the area. That means that more resources and staff, not fewer, are needed.

A large focus of the Port Adelaide Community Health Service is on preventative health initiatives, so funding cuts are false economy. Because of the range of necessary services available at this excellent health centre, the further reduction in staff will have enormous adverse implications in terms of service delivery and preventative health programs. Does the Minister fully understand the concept of community health? How does he think that these further cuts will be accommodated without a further substantial loss in service delivery?

The Hon. M.H. Armitage: The short answer is 'Yes, I do understand the delivery of community health.' I could ask a hypothetical question of the member for Price as to whether he understands, because the simple fact is that one does not necessarily provide more services by piling in more dollars. If one can be more effective in administration, and so on, one is able to provide altered and improved—

Mr De Laine interjecting:

The Hon. M.H. Armitage: No, but if the staff are administrative and the administration is done elsewhere, the services are still provided. That is why I ask whether the member for Price understands what it means. However, in order to give a complete answer to the question, I ask Mr Beltchev to respond.

Mr Beltchev: There are some proposed changes for the construction of the services at the Port Adelaide Community Health Service. The proposed changes mean that there will be a dedicated service delivery team of the equivalent of 10 full-time equivalent service delivery staff based there. The substantial administrative functions will be performed at the central administration centre for the region. Most of the administrative tasks currently performed locally will be transferred and operated centrally. In addition to that, the regional Aboriginal health team will be based at Port Adelaide and will provide a service not only to the Port Adelaide area but to other parts of the region. In addition, there will be other critical service delivery staff in other locations within the region who will provide a service to the Port Adelaide catchment area.

In summary, although fewer people will be based at the Port Adelaide Community Health Centre, the net effect will be that, as a result of service restructuring which has been planned by the board of that service, and that is based on their interpretation of the social health atlas in responding to needs in the whole of the region, there will be a total staff of 15 full-time equivalent people within the Adelaide Central Community Health Service who will be providing services in the catchment area of Port Adelaide, 10 of whom will be dedicated to that area, and five will provide services to that area and other parts of the region.

Mr De LAINE: Does that mean that the central administration will be based not at Port Adelaide but at some other location? I understand that the Aboriginal component would be located at the Parks Community Centre and not at Port Adelaide?

Mr Beltchev: The proposals are that the central administrative function will be performed centrally. I am not 100 per cent certain but I understand that it will be at the regional office, which is not at Port Adelaide. Secondly, the plan of the board is that the regional Aboriginal health team will be based in Port Adelaide.

Mr De LAINE: Will any staff be taken from the Port Adelaide Community Health Centre, as it is now, to staff the administrative centre?

The Hon. M.H. Armitage: I am happy to determine that later; I do not know the answer to that.

Mr De LAINE: Will the Minister come to Port Adelaide to see what is being done at the Port Adelaide Community Health Centre and to see how it works?

The Hon. M.H. Armitage: I have been to Port Adelaide recently, within the past year or so, and discussed matters with people from that area. I was at the Parks Community Centre perhaps three or four months ago. I was recently at Mareeba and discussed a number of these matters with the people from that area, and I am regularly briefed about it. If there is new information, I am sure that the member for Price can provide it for me. Previously, I was asked a question about the present state of budgets of a number of selected health units.

The most recent estimates that we can determine—and these are estimates only—of the end of year outcome are as follows: the Royal Adelaide Hospital will be $1.2 million favourable; Flinders Medical Centre, $0.5 million unfavourable; North Western Adelaide Health Service, $1.2 million unfavourable; Women's and Children's Hospital, $0.6 million unfavourable; Port Pirie, balanced; Port Augusta, balanced; Whyalla, $430 000 unfavourable; and Millicent, balanced. Once the actual end of year outcomes are finally known, the commission will then consult with the individual hospitals and regions as appropriate and make assessment of the reasons behind the end of year position, taking into account a number of factors, as is always the case, such as activity levels and other cost pressures. Having done that, decisions will be made regarding any potential financial adjustment for 1997-98 or otherwise once the final position is known.

Mr ROSSI: I refer to page 320. With regard to the recruitment and retention of country medical practitioners, much concern has been expressed recently about the progressive loss of rural medical practitioners. With regard to Financial Paper No. 1, what steps are being taken to replace rural medical practitioners when they retire or move on?

The Hon. M.H. Armitage: Mr Chairman, I understand that this is a matter dear to your heart, as it is to my heart and to the Government.

Ms Martin: The recruitment and retention of medical practitioners has been an issue for a number of years throughout rural Australia. A number of packages are funded by both the Commonwealth and the State to encourage medical practitioners to move and to remain in the country. These include: a project funded by the Health Commission to assist medical students to gain valuable experience through placements with experienced country doctors; a continuing medical education scheme for rural GPs funded by the Health Commission to the value of $250 000 *per annum*; and the rural incentive programs sponsored by the Commonwealth Government which include generous relocation and family support grants, training grants and assistance with continuing education and locum relief. In addition, the rural health training unit, which was established in March 1996, has a major role in the recruitment and retention of all rural health practitioners. The unit has funded and supports several initiatives, as follows: an emergency medicine update course for rural GPs and locums held at the Flinders Medical Centre; the formation of rural clubs at the universities to provide a focus for medical students who wish to practise in the country

once qualified; and specific programs to assist country high school students who plan to take up medicine as a career.

The unit administers the rural health scholarships and provides a library and information service to rural and remote health workers. This unit has 18.7 FTEs, four of whom are funded by the Commonwealth. A further important initiative of the Health Commission is the establishment of the rural health enhancement package which provides significant financial rewards to country practitioners at a total annual cost of $6.06 million. The package offers country directors enhanced hospital fee for service payments in return for their commitment to a series of best practice initiatives. These initiatives aim to improve health services to rural and remote populations, through the involvement of medical practitioners in quality assurance and hospital accreditation initiatives and their input to hospital boards via medical advisory committees.

Initiatives also require commitment to continuing medical education, primary care and preventative medicine schemes. In particular, medical practitioners with multiple skills in anaesthetic surgery and obstetrics will benefit from these arrangements. Discussions have been held also with the Commonwealth with a view to allowing country hospitals to cash out Commonwealth medical benefits and Health Commission fee for service payments to enable hospitals to establish medical practices and employ doctors on a salaried basis. A proposal along these lines has been developed by the Hills Mallee southern region to provide a medical service for the towns and hospitals of Karoonda, Lameroo and Pinnaroo. In addition, key stakeholders have been involved in the development of a model for the integration of training and support services for rural practitioners, which will bring these services together to be coordinated by an umbrella organisation.

At present, undergraduate and postgraduate training, locum and continuing medical education support services are fragmented and lack coordination and consistency. In response to these discussions recently, the Commonwealth Government has provided funding of $1.5 million over five years to establish a university Department of Rural Health. This will be a joint project at the University of Adelaide and the University of South Australia. It will assist in the postgraduate training of rural health practitioners and contribute to their retention in rural health positions. Finally, it must be understood that the difficulty in attracting appropriate medical practitioners to work in the country is compounded by the many factors which influence practitioners to work or not to work, which involve matters related to the kind of lifestyle they wish to live. Nevertheless, this matter has been taken seriously by the Minister and within the Health Commission, in working with both the regional boards and the wider rural health system.

Mr ROSSI: I congratulate the Minister and his staff on coming up with new ideas to improve the health system in this State. I think we have progressed quite a long way in the short time that the Liberal Party has been in power, compared to what the previous Labor Government achieved. My second question is on rural health scholarships. Following the question about the loss of rural medical practitioners and again referring to page 320 of the Program Estimates and Information, will the Minister describe what is being done to encourage young people from rural areas to return to the country to practise in their chosen health profession once they have qualified?

The Hon. M.H. Armitage: I am grateful to the honourable member for this important question. As members would be aware, the considerable changes that have occurred in recent times have placed a large burden on the lifestyles, career prospects and economy of many Australians and, as you would be aware, Mr Chairman, none more so than those living in rural and even remoter areas than Crystal Brook. We are often reminded of the very stark and harsh conditions that cause property damage, stock loss and so on. Those country hardships are further compounded by limited access to schooling, family support and opportunities for young people to live at home and achieve appropriate career options within a reasonable travelling distance—things which we in the city tend to take for granted. Over many years, sometimes not for particularly well understood reasons but also for some of the reasons I have identified, there has been a steady decline in the number of health professionals who want to return to and practise in the country following qualification in the city. This has resulted in a general shortage of medical, nursing and allied health staff in most country regions.

The idea of awarding rural health scholarships, which is an undergraduate support program designed to provide monetary assistance to rural students to enable them to complete their undergraduate studies, is one of a number of strategies aimed at recruiting and retaining health professionals in rural and remote South Australia. Through the Rural Health Training Unit, the commission provides funding to support selected undergraduate students from rural areas in their last three years of undergraduate study. The scheme commenced in 1994 and since then 34 students have been granted scholarships of up to $5 000 a year, and this year 18 students have been awarded scholarships. I will check that number: I thought it was 13, but it is still a large number of students. The scholarships are available for rural students in the disciplines of medicine, nursing and the allied health professions, including dentistry, radiography and pharmacy. The recipients of the scholarships are required to work for one year in a rural area for each year they receive the scholarship.

So far, five medical practitioners, four nurses, three occupational therapists and a social worker have graduated through the scheme. Increasing interest in the scheme has encouraged the rural health training unit to look for additional external source funding to determine whether the number of scholarships can be expanded and to examine a similar scheme to attract students from a metropolitan background to consider rural placement on graduation. I have approved sponsorship by the private sector to supplement the existing State funding for the scholarships scheme, and I have invited private organisations to consider sponsoring at least one student for three years, at a cost of $5 000 each year. Naming rights would be available to sponsors, who will be able to establish a personal link with the sponsored student, but they will not be able to determine where the student will be allocated following the successful completion of their degree. I am pleased to confirm that the Rotary Club of Modbury has agreed to become the first sponsor, and it will provide $5 000 for a student. The club raised the money through a lottery held last year, and I presented that and the other scholarships about a month ago to a series of very grateful undergraduate students.

Mr ROSSI: Acknowledging the very good job the Minister has done looking after the aged in the metropolitan area, my next question relates to aged care accommodation in rural areas. On page 320, the Program Estimates and

Information, Financial Paper No.1 refers to the upgrading of these facilities in a number of country hospitals. Although I am aware that this matter is primarily the responsibility of the Commonwealth Government, will the Minister outline what this Government is doing to improve access to nursing home accommodation in rural areas of the State?

The Hon. M.H. Armitage: This is a particularly important question, which I am sure has been raised with you, Sir, and all other members of Parliament with rural constituencies. Innovative programs are being developed, and to provide details I ask Ms Kay Martin to address the Committee.

Ms Martin: This is one of the regional initiatives that have been established through regionalisation. It is necessary to minimise the need for older people in rural areas to access accommodation outside their communities. Due to the reduction in acute services within these hospitals, a project was funded jointly with the Commonwealth and the State to review models of aged care in rural South Australia. The new developments are of course to be welcomed, as they have improved the overall efficiency and effectiveness of rural health services. However, some such developments have also threatened the viability of smaller and remote country hospitals. In response, the Health Commission will ensure that a basic range of general practitioner, aged care, rehabilitation and acute services is available in all country regions. In this context the provision of long stay and aged care facilities will become more critical to the viability of smaller hospitals.

With the support and encouragement of the Commonwealth Government, a project was funded to develop models for aged care in rural and remote areas of the State. This work has resulted in the identification of a range of cost effective models and concept designs for the redevelopment of surplus accommodation with acute hospitals in the country. Existing hospital facilities will be redeveloped to meet the Commonwealth standards for aged care accommodation, and existing staff will be provided with additional training and education to take on their enhanced roles. This initiative will contribute greatly to the stock of suitable nursing home accommodation available to older country residents and will in time provide an additional 127 Commonwealth funded nursing home beds within existing country hospital buildings.

Following extensive consultation with regional health service boards and the Commonwealth Department of Health and Family Services, it was agreed that the project should be implemented in three phases. These phases are commensurate with the Commonwealth priorities for the allocation of aged care services in the country. In the first phase the Hills Mallee Southern region will be provided with 39 additional Commonwealth funded nursing home places in this financial year. These will be incorporated within six health units in the region that already have a total of 40 placements at present. The total cost of this first phase of the project is $3.8 million and will come from the Health Commission's capital works program as well as a significant contribution from the regional and individual health units.

The region has commenced capital infrastructure upgrades and training and development programs for staff, executives and board members. It is anticipated that the additional beds will be occupied in September 1997. During the second phase the Wakefield region will receive an additional 25 places in the 1997-98 financial year, and program planning has now commenced for the identification of places within that region. During the third phase the South-East will receive an additional 35 places in the 1998-99 financial year, and further discussion with the Commonwealth at a later date will confirm the remaining places in the remaining regions.

Ms STEVENS: I refer to page 313 of the Program Estimates. During today's hearing we have all noticed the number of advisers sitting around this Chamber assisting the Minister with answers to questions. I counted at least 23 people, but I would like to know precisely how many advisers attended today and, in dollar terms, what is the total cost of the hours spent in this place by these bureaucrats most of whom, as yet, have contributed nothing.

The Hon. M.H. Armitage: I will certainly prepare that, but I assure the honourable member that the first paragraph will identify the numbers of people who attended the Estimates Committee when I was the shadow Minister when Labor was in government. I will equally provide an indexed amount of costing for that because, despite the not very well hidden attempt of the member for Elizabeth to pour scorn on the officials and their being here, it is no different from the situation when a different Party was in Government. As I have already indicated, there is another solution: we could have no-one here other than me and I could take most of the detailed questions on notice. However, we saw a particularly petulant display from the member for Elizabeth when I indicated that I would do that and, accordingly, I believe it is inappropriate. We will provide the information, but a little sting will be in the tail because I will provide a listing of the people who attended under the previous Administration.

Ms STEVENS: I refer to page 314 of the Program Estimates and the Noarlunga Health Service. Will the Minister confirm recommendations to the Government that the Noarlunga Hospital be expanded by an additional 100 beds, has this project been approved by Cabinet and will it be announced by the election?

The Hon. M.H. Armitage: I know that there is a Metropolitan Adelaide Strategic Health Facilities Plan and, as part of that, a variety of facilities assess how they might best provide health care into the future, recognising always that there are now different ways of providing health care from the time when people first started talking about some of these measures many years ago. To provide detail on the status to date, I will ask Mr Michael Forwood to address the Committee.

Mr Forwood: Following the completion of the Metropolitan Adelaide Strategic Health Facilities Plan the Health Commission, in conjunction with the major metropolitan hospitals, has proceeded with detailed master planning to determine precisely what facilities are required in order to provide appropriate and accessible services. Over the past two years, a tremendous amount of planning activity has occurred in the southern region involving the three hospitals, the Flinders Medical Centre, the Repatriation Hospital and the Noarlunga Hospital, to determine the appropriate clinical linkages. That study, which is known as the Southern Metropolitan Clinical Services Plan, was completed in late 1995.

Master planning has proceeded at Noarlunga. I have been a member of the project steering committee which reported to the board; and the board is making arrangements to meet with the Minister to discuss the recommendations of that report. The proposals include an expansion of bed capacity but, once again, I think the exact number of required beds requires careful thinking in the light of developments towards ambulatory care services, coordinated care trials, and the like. It follows on from what I was saying about the Government

not yet making a decision. A proposal has not been submitted by the Minister to Cabinet, but I would expect that to occur in the next few months.

The planning exercises also looked at the demand for private hospital services. It looked at the arrangements at the Noarlunga Hospital and its private hospital which is privately administered. The jury is out on what will occur following the commission of the Ramsey private health facility at the FMC campus, so again it would be premature to make a final decision with regard to any expansion or change to private hospital services. However, it has been established through an independent review that that arrangement has been beneficial to the Noarlunga Public Hospital's administration and that that arrangement actually supports the provision of public patient services at the Noarlunga Health Service. That covers the main points, but I am always happy to answer supplementary questions on behalf of the Minister.

Membership:

Mr Atkinson substituted for Mr De Laine.

The Hon. M.H. Armitage: I want to add that, in emphasising what Mr Forwood has just said, nothing has come to me. There was a clear inference in the question that we, as a Government, were utilising these sorts of decisions for reasons other than good health care for South Australians, and I emphasise that nothing has come across my desk.

Ms STEVENS: Will additional facilities at Noarlunga be funded by the Government through the central capital works program, or will the Minister seek private sector involvement or other arrangements in the provision of finance?

The Hon. M.H. Armitage: No decision has been made.

Ms STEVENS: I refer to page 314 of the Program Estimates. This question relates to the redevelopment of the Lyell McEwin Hospital. On 3 June 1996 the Minister made an announcement about a five year, $28 million redevelopment of the Lyell McEwin Hospital at Elizabeth. The Minister talked about expressions of interest being called on the following Monday and then the process proceeding. The Minister also said that $4.2 million had been provided in the 1996-97 capital works budget for work to begin on facilities for ambulatory care, teaching and research. I do not believe that that money has been spent. I note that on page 44 of the 1997-98 Capital Works Program the Lyell McEwin Health Service redevelopment is listed again but that no total commitment of funds is listed. It is stated that the figure is not available. A proposed expenditure of $2.8 million is referred to.

Precisely what will happen in relation to the development of the Lyell McEwin Hospital? Obviously, the northern suburbs has heavy population growth and needs an updated facility to take its place in partnership with the Queen Elizabeth Hospital as part of the North Western Adelaide Health Service. What is happening? Will it be $28.5 million as the Minister said last year? Will the Minister acknowledge that, in order to provide a facility of the extent required, a lot more money needs to be spent? What is the status of discussions in relation to determining how much and when money will be spent?

The Hon. M.H. Armitage: With the amalgamation of the QEH and the Lyell McEwin Health Service in July 1995, the boards of those former hospitals and health services resolved to dissolve the independent incorporation of their respective bodies to form the North Western Adelaide Health Service Incorporated under the South Australian Health Commission Act, which was approved by the Governor and Executive Council. That amalgamation initiated a process of providing a very strong focus on planning and resourcing new and expanded clinical services at the Lyell McEwin Health Service, drawing upon the expertise of senior clinicians and clinical academics of the Queen Elizabeth Hospital. It may well be a matter for the Committee's perusal later to have expounded the additional services now provided at the Lyell McEwin Health Service.

A master plan for the Lyell McEwin Health Service, prepared by Hassell Health Planning and Architects, was completed in November 1995. The master plan formed the basis for detailed planning and documentation for the proposed Lyell McEwin stage 3 redevelopment. Indeed, the Lyell McEwin Health Service has proceeded to conceptualise some plans, which we will discuss with it. The current budget included in the capital works allocation and forward estimates is $48 million over five years, with $2.8 million allocated for 1997-98. In accord with best practices, Services SA organised a value management study to review the revised plan for the hospital, and that value management study raised a number of issues: construction programming, recurrent costs, demographic projections, the recapture of leakage (which is the issue I referred to earlier in relation to building better hospitals) and so on. I have occasionally read the Messenger newspaper distributed in the northern suburbs, and I know that this has been an issue in that area.

It is important to note that the Government is committed to this process and that as a first stage for the redevelopment it is necessary to relocate the Northern Metropolitan Community Health Service to a purpose-built facility at Elizabeth and to relocate the Northern Domiciliary Care Service off the site of the Lyell McEwin Health Service, because those are rate limiting factors. At this stage, proposals have been developed for both the community health and domiciliary care service relocations and for the works to occur. I know that we have had a number of long-term and protracted discussions, in particular with the council there, in relation to some of those sites, but the simple fact is that one has to do things in stages when one redevelops or redesigns something as large as a hospital, otherwise the service provision stops. We are not keen for that to happen. The very fact that we are undertaking these first phases of the redevelopment indicates the sincerity with which we are approaching the project.

Ms STEVENS: Did the Minister say $48.5 million?

The Hon. M.H. Armitage: I am informed that the forward estimates involve a $48 million commitment over five years.

Ms STEVENS: I refer to page 313 of the Program Estimates in relation to the anti-smoking initiatives announced by the Minister as part of this budget. I preface my remarks by saying that I was very pleased to see the $2.5 million additional allocation set aside from the increased funds received by this Government following the introduction of the tar tax. I was very pleased to see that, because that involved an agreement between all Parties at the time to put at least some health measures into the tax Bill.

I note that in the Minister's statement he said that anti-smoking initiatives will be funded by an additional $2.5 million allocation, with the aim of reducing the prevalence of smoking by 20 per cent over five years. I understand that would involve young people, as that was the agreement reached in the House. Precisely what structures has the Minister established to administer that fund? What will be the

criteria for people to be selected for grants? Who will be on any committee or group that will determine recommendations to the Minister? When will the first allocation of funds from that $2.5 million be made?

The Hon. M.H. Armitage: I am absolutely fascinated, as I often am in Parliament, to hear the member for Elizabeth indicate that the $2.5 million was to put some health measures into the tax Bill, because now I understand why the shadow Minister for Health spent such a long time talking against the proposal to have restaurants smoke free. It is clear that the member for Elizabeth did not realise that that was a health measure.

Ms Stevens interjecting:

The Hon. M.H. Armitage: No, the member for Elizabeth said that the $2.5 million was put into this—

Members interjecting:

The Hon. M.H. Armitage: I merely quote what the member for Elizabeth said when she said that she was delighted to see this money because she wanted 'to put some health measures into the tax Bill'. Now I understand why the member for Elizabeth, the member for Ross Smith and the member for Giles (a former Health Minister) spoke against the health measure of having non-smoking in restaurants. They did not understand that not having smoking in restaurants was a health measure. So, it is all clear to me. I am delighted.

Members interjecting:

The CHAIRMAN: Order! The member for Unley is totally out of order.

Mr Brindal: The member for Unley spoke intelligently.

The CHAIRMAN: Order! The Committee will come to order. Will the Minister continue with his answer, please?

The Hon. M.H. Armitage: I am thrilled to do so. The target of $2.5 million will be to reduce the level of smoking by 20 per cent over five years, with a particular emphasis on young people. The new Act came into operation on 5 June 1997, and the funding will be additional to that provided by Living Health for anti-smoking programs. Funding by Living Health supports the SA Smoking and Health Project, a joint initiative of the Anti-Cancer Foundation and the National Heart Foundation, and its activities include the annual Quit campaign. Living Health is looking to support additional anti-smoking initiatives in 1997-98. These include a smoke free venues campaign to promote smoke free areas in public places, building on its sponsorship policy that requires recipients to have smoke free public areas. It will also be developing a smoke free generation project, which I identified in the House previously, aimed specifically at young people.

Other initiatives will include increased education and publicity about the rights and responsibilities of retailers and the public in relation to the sale of tobacco products to minors under 18 years. This will draw attention to the new provisions, which will enable retailers to request proof of age. Increased priority of enforcement of the provisions relating to sales to minors is also proposed. Education and publicity material about the provision relating to smoke free enclosed dining areas and cafes to apply from January 1999 will be developed. This will cover the rights and responsibilities of the hospitality industry and diners, and will deal with exemptions relating to bar and lounge areas set aside primarily for drinking.

Proposals are being developed to address the structures needed to ensure that the initiatives are implemented in a consistent and coordinated way, which will also address the resources needed to ensure their effective implementation.

Ms STEVENS: In prefacing my supplementary question, I need to clarify some of the issues that the Minister raised before he answered the question. As usual, the Minister tends to give a rather jaundiced view of events, and I want to put this on the record, because I will not let him get away with what he has just said. In fact, the reason why the Opposition in the Lower House voted against his smoking in enclosed spaces amendments was that we got them five minutes before the debate, because the Minister had had such a debacle in his own process with the stakeholders and his own Party that he was not able to get them into the House. We had five minutes to look at them, therefore we voted against the Bill on the process issue. As the Minister knows, that Bill was finally supported in the Upper House. Even then, we did not have a lot of time to discuss it—one week against three months or so of procrastination and mess-ups by the Minister.

However, because the Minister got so carried away in trying to score a point on that issue, I want to bring him back to what I actually asked. I asked the Minister what structures had been put in place; what criteria applied; what committee or body would make decisions; and what was the time line? All I got from his answer, I think, was that proposals are being developed. What does that mean? Does that mean that the Minister does not know all these things, that there is no answer yet because he is still working on it? If that is the case, when will the Minister have the answers and, if he does get them, will he let me have the answers? If he has some of that information that I asked for, will the Minister answer my question?

The Hon. M.H. Armitage: One of the things which I indicated in the House and which I reiterate is that I have no intention of authorising funding on historical bases. I know that there are a number of people who have interests in the $2.5 million and, accordingly, I am seeking advice as to how it might best be applied. We are looking at some options—and I stress that at the moment they are only options—for perhaps a discrete tobacco control unit within the commission to manage the new funds, to develop strategic directions and to collaborate with all the other agencies that I mentioned before—Living Health, the Drug and Alcohol Services Council, the Australian Cancer Foundation and so on—but they are not firm proposals. Obviously, there will be further collaborative planning between the commission and a range of organisations that either are presently skilled or would be interested in developing skills to provide education and prevention programs for young children.

Mr BROKENSHIRE: I refer to page 319 of the Program Estimates with respect to health services for veterans. I would like to preface this question with a few points, because the Minister knows that I have a particular interest in repatriation and would like for the first time to be able to put on public record that, had it not been for repatriation, I would not have seen my father for too long after the Second World War. Thirteen major operations later and many years spent in that hospital at least allowed us to have him here for some considerable time.

That is just one example of the great work that the Repatriation Hospital has done over more than 50 years. Recently, a constituent, a returned service person, raised a concern with me about repatriation. Interestingly enough, my own mother has, through repatriation, just been involved in an operation and, by paying a small gap, through Veterans

she was able to go to St Andrews to have that operation performed by the very best ear specialist around.

Another person in my region, whom I visited the other day, had a tragic car accident and spent 14 weeks in Flinders Medical Centre, where he received fantastic attention. He will now spend at least a month at the Repatriation Hospital. The other night I said to him, 'Have you any complaints or concerns whatsoever about health services at either Flinders Medical Centre or the Repat?', to which he replied that he did not have one complaint. He could not believe how well he was being looked after. For example, every time any issue arose concerning some potential ramification from his injuries there was no hesitation in X-raying him, having the best surgeons and specialists examine him, and so on.

I feel comfortable knowing that things have improved. I know of other constituents who have said how they appreciate the opportunity to come back to the McLaren Vale Southern Districts War Memorial Hospital which they and their parents helped to build rather than having to stay at the Repatriation Hospital all the time. We are seeing much more flexibility in this respect. However, this constituent is still concerned that repatriation war veterans and war widows have lost some priority when it comes to patient care with repat—and that would worry me, too, although I have not seen any evidence of it. Will the Minister enlighten the Committee on what changes are taking place to ensure that there will be an ongoing and continuing high level of service to all war veterans in South Australia?

The Hon. M.H. Armitage: In providing the answer to this question, I indicate that I have a personal interest in repatriation services because my father (now deceased) was in the 2/7th Field Regiment and a very keen member of the RSL. Therefore, I was quite surprised to find that indeed the father of the Chief Executive Officer of the SA Health Commission was also in that regiment and, I have just heard, was one of the first hip replacement patients at the Repatriation Hospital. However, I ask Mr David White to address the Committee in response to this very important question.

Mr White: The responsibility for the Repatriation General Hospital transferred to the State in March 1995. The terms of that transfer included reference to the continued eligibility of veterans to access the health care services at the hospital. The continued access is outlined in a document which provides guidance for the hospital. The document is titled, 'Arrangement between the Commonwealth of Australia and the Repatriation Commission and the State of South Australia concerning the provision of treatment, care and welfare of persons eligible for treatment under part 5 of the Veterans Entitlements Act 1986 at the Repatriation General Hospital Daw Park and other public hospitals in South Australia'.

The document states *inter alia* that the State will, to the extent possible and practicable, ensure the provision of quality health care for eligible persons at appropriate public hospitals in this State, including the use of a sufficient number of beds at the RGH Daw Park to meet demand from eligible persons within the full casemix range within a reasonable time. Eligible persons will continue to have rights for treatment as inpatients and outpatients of the RGH Daw Park regardless of the areas in which they reside, where beds are available and the type of treatment they require is available at that hospital. Access to RGH Daw Park will be timely and in accordance with medical need recognising, where appropriate, established doctor-patient relationships, the provision of special services for veterans, war widows and dependants at Daw Park and the Commonwealth capital funding of the rehabilitation facility which is to be constructed.

RGH Daw Park has provided assurance that its own expectations coincide with those of the arrangement document and those of the community, in that the priority for the provision of clinical services must be determined in accordance with medical need. In this crucial area whether or not the patient is a veteran does not determine the priority for access to clinical services, and it should be noted that this standard would apply even if RGH Daw Park treated only veterans.

Mr BROKENSHIRE: I understand from what Mr White is saying that from the way in which the agreement is written, given the particular illness that the war veteran may have, if there is a better place at which to treat that illness there is a better option. In other words, if there was a better chance of treating such patients by sending them to Flinders or another hospital, that would now be quite allowable.

Mr White: That is correct. The reference is 'is available at RGH Daw Park'. Clearly, services may be available more appropriately at Flinders Medical Centre or elsewhere.

Mr BROKENSHIRE: I know that the Minister was very keen to ensure that everything was correct before agreeing as Minister to sign the agreement. I understand that the then President of the RSL, Mr John Bailey, was satisfied with the way in which things were worked through and the consultation that occurred on behalf of the veterans through the RSL.

The Hon. M.H. Armitage: That is correct. Even in Opposition we indicated that we would not be prepared to go down the line of accepting responsibility for the Repatriation Hospital to become part of this State's health services unless the veteran community was in favour. In fact, they had some oscillations over perhaps the two years that that was being discussed, but there was full agreement at the end.

I provide clarification to a question asked earlier by the member for Price. I now have some further information. In relation to the Port Adelaide Community Health Service, I am informed that the current plan is that the regional administration staff will be based at Port Adelaide, and I am further informed that the Aboriginal team, which was mentioned in the answer by Mr Beltchev, at the request of the Aboriginal health workers is planned now to operate regionally from The Parks. Mr Chairman, given that you did ask me to expand previously about the Repatriation Hospital, I found another member of the people sitting behind me whose father was in the 2/7th Field Regiment and who went to the Repatriation Hospital. It is almost becoming a promotion prerequisite.

The CHAIRMAN: Thank you, Minister, for the answer to the question. I hope that the member for Elizabeth will inform the member for Price of the answer to the question. I am sure the honourable member will be very pleased with that answer.

Mr BROKENSHIRE: I refer the Minister to the ambulatory care program. The Program Estimates and Information, at page 319, refer to pilot projects in ambulatory care having been reviewed. Will the Minister elaborate on the program?

The Hon. M.H. Armitage: In the context of the Medicare agreements, the Commonwealth began a program of reform to clarify the functional responsibility for aspects of outpatient services, and the need for more sophisticated information about such services was quickly apparent. The Health Commission accepted $4.39 million from the Commonwealth Ambulatory Care Reform Program to look at 19 specific research and demonstration projects in ambulatory care. They have been undertaken by health units and the commission, with the overall objective of better describing, classifying and

costing ambulatory care services, piloting and evaluating alternative models of care, and providing a strategic focus for the reform of ambulatory care.

Many of the projects are demonstration projects associated with the substitution of acute inpatient care, or they are descriptive studies associated with the development of information systems and classification and costing systems for non-admitted patients. The role of the Ambulatory Care Unit has been to undertake overall management of the projects, to support development of the funding policy and the requisite systems by undertaking further research and analysis, including the establishment of additional demonstration projects for key target groups, and to review options for sustainable services on the basis of project outcomes which have identified best practice in ambulatory care.

Some of the projects are relevant to the Healthplus initiative in that they provide alternative service delivery models for individuals with chronic conditions. They are currently being evaluated in the context of developing sustainable mainstream services. In particular, Noarlunga Health Service will continue to provide an alternative antenatal and postnatal care service for women at low risk in the southern metropolitan region, something about which the member for Mawson will be pleased; checks of home-based stroke rehabilitation for patients with mild to moderate stroke will continue at the Repatriation General Hospital, where early results have been positive, to assess more fully the long-term patient outcomes; at Flinders Medical Centre, dermatology day care will substitute for inpatient ultraviolet therapy treatments; home-based enterol feeding treatment for children receiving long-term nutritional supplementation will substitute for inpatient care; and early intervention and assessment services for elderly patients in the emergency department will prevent, hopefully, inappropriate admission to hospital and provide alternative services.

Another major interest is in the development of relevant reporting and monitoring systems so that the performance can be assessed and the Commonwealth targets can be met. All projects were funded to 30 June and some have been completed with the remainder due for completion in late 1997. I should like to read out some of them very quickly. They include a statewide project of costing ambulatory services ($525 000); a statewide project for non-admitted patient costing for country hospitals in South Australia ($145 000); the Lyell McEwin Health Service has trialled the Excelcare emergency department module ($40 000); the Royal Adelaide Hospital has looked at the allied health hospital outpatient service ($163 000); a statewide project evaluating health status outcomes ($182 100); Flinders Medical Centre post-acute ambulatory nursing study ($45 000); a statewide project comparison costing study ($296 000); Repatriation General Hospital pilot community based multidisciplinary treatment service ($71 660); Royal Adelaide Hospital study of pharmaceutical care ($194 325); Queen Elizabeth Hospital network pharmacy project ($251 000); Noarlunga Health Service and Flinders Medical Centre enhanced continuity of maternal and infant care ($602 000); Flinders Medical Centre emergency department ($521 000); and the Repatriation Hospital home-based stroke rehabilitation project ($96 000).

Having initiated those projects, we are now looking to evaluate them to see whether they have met the goals that were set for them. If that is the case, the next aim is to assess their sustainability within the system on a cost benefit analysis. It is a reasonably major reform.

Mr BROKENSHIRE: On page 319, the program description refers to the development of business plans for sustainability of selected ambulatory care projects. Can the Minister give indicate the likelihood of some of these projects continuing?

The Hon. M.H. Armitage: As I indicated, it is most important that the projects which work are funded. It is a fact that there is a tendency for a number of Commonwealth projects to be funded on a time-limited basis. People have their expectations built up and then the funding ceases. As the member for Mawson has said, it is very frustrating. The projects are now being evaluated and a number are likely to be sustainable in the longer term, and these particularly include the home-based stroke rehabilitation at the Repatriation Hospital.

This project trials a program of rehabilitation at home for patients who have suffered a mild stroke, and it involves a multidisciplinary team involving medical, nursing and allied health staff. Another project that looks like being sustainable is the hospital-at-home project at Flinders Medical Centre. This is a viable service model that we believe can be funded through the casemix model in 1997-98. As I indicated, other projects operating under this innovative care program will be evaluated during the year. Business plans have been developed as a process of this evaluation, looking at the sustainability of each completed project, and they will obviously form part of the evaluation of the future of the projects.

Ms STEVENS: I refer to page 313 and health programs for older persons. The Minister would be aware that last year the Council on the Ageing and the South Australian Council of Social Services conducted fairly extensive consultation throughout the community and presented their results in a document called 'A Vision for Health'. I have spoken about this in the House before, and the Minister would be aware that quite a range of concerns were raised by older people in South Australia about the health system. They ranged from accident and emergency to a lack of community-based care, hygiene and pharmaceutical matters. They raised a whole range of different issues. The Minister also would have received a budget submission from the Council on the Ageing in relation to health services. One section of that document states:

> COTA reiterates its previously expressed concern that there is no focus within the Health Commission for aged services. The commission needs to create such a focus linked to the Older Persons Health Council and to adopt clear targets to improve the health and wellbeing of older people and adequately fund these.

Finally, I would like to refer to a letter that was written to Mr Ian Yates, the Executive Director of the Council on the Ageing, by the Premier (John Olsen) dated 27 April 1997. Although I do not want to take it out of context, in the body of the letter the Premier refers to COTA's concerns about the 10-year plan for ageing and HACC funding. I quote the following two sentences:

> Your comments on issues relating to health services for the aged are noted. These issues point to the considerable amount of work which needs to be done to improve the planning, coordination and delivery of health services to the aged.

That was written by the Premier two months ago. Has the Premier had discussions with the Minister about comments he made in his letter to the Council on the Ageing? If so, what does the Minister intend to do about improving the situation, that is, the planning, coordination and delivery of health services to the aged? I ask that the Minister refer to the Health of Older Persons Council as part of his answer.

The Hon. M.H. Armitage: Can the honourable member tell me how many respondents there were?

Ms STEVENS: No, I cannot.

The Hon. M.H. Armitage: My recollection is that it was a reasonably small number of respondents; it does not mean that they were not all genuine. I emphasise that there are over 306 000 inpatient admissions each year, and 1.6 million or more outpatient services every year. As the greatest users of our hospital services are aged people, they are beneficiaries of all the projects we put in place to provide an increased throughput in our hospitals. The fact service provision is up by 11 per cent is of direct benefit to the aged community of South Australia. As I identified in my opening statement, we have provided $40 million extra to hospitals, and obviously the aged will be the beneficiaries, as they are the major users of hospitals.

The innovative project I have talked about on a number of occasions already today, Healthplus, which I have discussed with COTA on a number of occasions, the last time of which was a month or so ago and which I understand COTA supports completely, will provide a lot of the care and coordination in the community, which is exactly what the aged community has been seeking, not for the term of this Government but for decades. Our Healthplus initiatives will answer a number of those issues.

As well, I am informed that Mr Ray Blight and Mr George Beltchev did address Dame Roma Mitchell's Advisory Committee on the Aged—I forget the exact name, but it is something like that—about a number of issues that were raised in that survey. However, perhaps most importantly of all, through the realignment of the Health Commission, where we now have a specific purchasing function, that will obviously focus on purchasing on a needs-based planning exercise. Clearly, that will take into account a number of the initiatives that COTA has been raising with Governments over the years.

Also, the Health of Older Persons Council, which was formed in December 1996, has initiated a process to develop a framework to address key priorities and principles which include: inequalities and equity; health promotion; maintenance and function; support for carers; and education and training. I expect that the Health of Older Persons Council will provide me with very interesting input in relation to those matters. However, I stress that—and this was agreed with COTA in our last discussion—as the ageing community is the major user of health services, the initiatives we have put in train to increase funding and make hospitals more efficient are of direct benefit to that constituency.

Ms STEVENS: I am interested in the Health of Older Persons Council. In fact, the Minister may remember that last year I asked questions about this in Estimates. The council was announced the year before, but nothing happened for a year—which showed a commitment to older people's health! However, I know that it has now been formed. How many times has the Health of Older Persons Council met during the year? Has the Minister attended any of those meetings or received any direct representations from the council? I understand, from what the Minister said the council achieved, that it has worked towards developing a framework to discuss a whole lot of issues. Has there been any discussion of the issues or only the development of a framework? Will the Minister clarify that? Were there any other outcomes as a result of its work during the past year?

The Hon. M.H. Armitage: I happy to report to the Committee that the Health of Older Persons Council has met on three occasions. I reject the suggestion that I should attend every one of those meetings and take a greater role in it. The whole purpose of having a Health of Older Persons Council is so that it can provide independent advice. I am further informed that, only at the last meeting, it was decided to invite Minister Wotton and I to attend a meeting of the council. To date, I do not recall receiving that invitation but, when it comes in, I will look at it favourably.

Ms STEVENS: I refer to page 316, with regard to public and environmental health. How often during 1996-97 did the Environmental Health Unit inspect South Australian sewage treatment plants to ensure that processes were being properly managed and that there were no implications for public health from discharges from those works?

Dr Kirke: We do not believe that we have direct responsibility to inspect sewage treatment or waste water works. However, we have a Health Aspects of Water Quality Committee, which comprises SA Water, local government, the EPA and the Health Commission. We debate these issues at great length, and we provide the health advice that the SA Water people seek. We are in constant touch with them. We have microbiologists on our staff who are experts in water quality. So, rather than physically inspecting waste water treatment plants, we provide expert advice.

Ms STEVENS: I refer again to Page 316, concerning environmental health. Has the South Australian Health Commission inspected the Bolivar plant since it became public knowledge that the process had broken down; and is there any public risk from infections—airborne or otherwise—as a result of the biological process breaking down?

The Hon. M.H. Armitage: Again, I will ask Dr Kirke to provide an answer to the Committee.

Dr Kirke: We have not been asked to inspect any of these facilities directly, but we talk about the issues a great deal. It is fair to say that an odour which pervades does not necessarily represent—in fact, almost never represents—a health hazard of itself. There is no evidence in this recent case to suggest that there has been a direct health hazard. E.Coli do not fly around like that, although it is true that some odours can be sufficiently offensive to cause people to complain of ill health. In this case we have been unable to identify any specific health hazard.

Ms STEVENS: Is the South Australian Health Commission monitoring the incidence of conditions such as meningitis?

The Hon. M.H. Armitage: Yes, that occurs regularly. I am informed there has been no evidence of any increase.

Mr BRINDAL: Is the Minister aware if or how many times officers of his department under previous governments may have been called out when partly treated effluent was released into the gulf and other parts of the environment? Was anyone in the Health Commission ever contacted or were any measures taken to ensure that the public health was not endangered, when there has not been a pong because the stuff has simply been released into the environment?

The CHAIRMAN: The Minister can choose whether to answer the question or not.

The Hon. M.H. Armitage: I am informed that on occasions officers were asked to check those things, as we would expect. If there were instances where the public health may have been at risk, we would expect to be asked to be involved.

Mr BRINDAL: I refer to disability services and the increased funding, which was most pleasing. It is a pity the

Opposition keeps concentrating on the negatives of the budget rather than the good, positive news it embodies.

Mr Atkinson interjecting:

Mr BRINDAL: On page—

The CHAIRMAN: The member for Unley will proceed and not react to interjections.

Mr BRINDAL: I will not react to interjections, Sir, because like the Opposition I have tried taking the road to Damascus of late, but I cannot get on it because of all the Labor cars blocking it.

The CHAIRMAN: The honourable member will ask his question without being too philosophical.

Mr BRINDAL: Page 326 of the Program Estimates and Information and Financial Information Paper No.1 remind us of the increasing number of people with disabilities reaching old age and the consequent increased demands on services. I am aware (because the Minister mentioned them this morning) of significant additional funds being provided for disability services last year, and I believe there is an increase this year. Will the Minister explain the process of identifying priorities that were used in allocating this increase in funding and outline the ensuing benefits? Will the Minister also clarify in the context of this and previous questions the age at which you are considered to be one of the ageing? Is it after age 50, 55, 60 or 65?

The Hon. M.H. Armitage: In May 1996 the Government made available $3 million to the disability budget. Of this, $1.5 million was matched through the home and community care program to create total new funding of $5.4 million. The Disability Advisory Council had a key role in giving advice on the broad priorities of need as to how that money may be expended. The council was supported by its various subcommittees, made up of people with disabilities, carers, advocates and Government officers. In addition, consumer groups were invited by the Disability Services Office to identify broad priorities and specific areas of need. Disability services agencies were also asked to identify new or additional services that would meet identified areas of need, and options coordination agencies were asked to advise on priorities within their own areas of responsibility. The DSO collated the advice from the Disability Advisory Council, Options Coordination Agencies, consumer groups and so on and provided recommendations to me.

As a first instalment, the $1.3 million from the unmatched portion of recurrent funding was distributed in December 1996 to meet the following areas of need within the intellectual disability sector: $160 000 was provided for intensive home support or supported accommodation; $50 000 ongoing for day options, including post-school options; and $250 000 for ongoing behaviour intervention services and skills training. For adults with a physical and neurological disability, $50 000 was provided for ongoing therapy services. For people with a brain injury, $150 000 was provided for therapy services and $50 000 for behaviour intervention services and skills training. For children with a physical or neurological disability, $190 000 was provided for therapy services and, for people with a sensory disability, $50 000 was provided for skills training. The one-off $150 000 funding was allocated to adults with a physical or neurological disability.

Final approval from the Federal Minister for Health and Family Services for allocations within the total HACC-matched funding was announced on 12 June. Further funding has been allocated to the Intellectual Disability Services Council for home support, including day activities for adults, respite for carers and home support, including home help and personal care for those living in their own accommodation.

Further, $90 000 was specifically targeted to people with autism to provide personal care, career counselling and support, and respite care; $950 000 was allocated to APN options coordination for provision to maintain clients in their own home and teenagers who have become primary carers of parents with a disability, and $50 000 was provided for rehabilitation. Brain injury options coordination received funding of $225 000 to support individuals with children to carry out parenting roles, respite for carers, home help and personal care, and $80 000 was provided for skills training, therapy and rehabilitation. Sensory options coordination received $180 000 for the provision of respite for carers and adults living in their own accommodation and $30 000 was provided for communications equipment.

In addition, $130 000 was made available through the Sports, Arts and Recreation Council for the Disabled and Riding For The Disabled for recreation programs and programs to enhance client participation in sport and the arts; $30 000 was provided for therapy and daily living skills therapy for people with autism not associated with an intellectual disability; and $10 000 was provided for rehabilitation and therapy for children with physical and neurological disabilities or with brain injuries. In addition, the equivalent of a full year's effect of $6.4 million of new services was achieved in 1996-97 through efficiency measures in the disability sector. These efficiencies have been largely achieved by restructuring of staff and services.

Those efficiency dividends have been channelled into increased direct service provision, for example, increased accommodation services, increased respite care, additional day options and additional support packages to clients who previously had little or, indeed, no support. I know that the efficiency measures caused some difficulty and dilemma within the provider organisations. I accept those criticisms but, in doing so, I note that a number of agencies that came to see me complained about the fact that we were asking for a 3.8 per cent efficiency dividend—which would be turned back into services—but had administration costs in the vicinity of 35 per cent and 40 per cent. In an area that has unmet needs, such as the disability sector, I felt it was absolutely inappropriate that those sorts of organisations would not be asked to make a contribution to an increased service provision which provided, at the end of the year, $6.4 million worth of new services.

Mr BRINDAL: As a supplementary question, that is good. That is all money in the bank and they are all achievements, but you are too modest.

An honourable member interjecting:

Mr BRINDAL: He is. The Minister is modest and self-effacing, because his answer outlined what we have done, but I also asked what were the initiatives under this current budget. What is it you plan to do? Those achievements are terrific, but what else do you have on the books?

The Hon. M.H. Armitage: In 1997-98 the State Government will commit $5 million of new recurrent funding for disability services, that is, in addition to the $3 million provided in last year's budget, part of which, as I indicated, was HACC-matched to provide a total new allocation of $5.4 million. Frankly, there have been years of real-term cuts, but disability services was quarantined from the effect of the debt reduction strategy, and that meant we have had $6.4 million of efficiency. The cumulative effect of these

totals means that the Government has injected or committed $16.8 million into the disability sector.

We are also providing an additional $1 million, a one-off payment, to the independent living equipment program. This will provide equipment for people with disabilities and older persons, and the recurrent funding will be applied to a number of initiatives to address priority areas such as urgent cases where accommodation, personal care services, respite or day support arrangements are needed. It will also address priority areas such as the development of alternative community services for people currently living in sub-optimal arrangements as well as increased and innovative therapy services, including behaviour services and skills training.

The new funding that has been provided in this budget is an additional bonus to the disability sector. As the Minister for Disability Services, and as I have stated to a number of organisations that have come to see me, I acknowledge that there is still unmet need in the disability sector. However, I have asked the organisations who have come to see me to acknowledge that we are chipping away at that unmet need, and they have done that. They are delighted that, finally, a Government is listening to their needs and providing some comfort and solace, as we have done.

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

The Hon. M.H. Armitage: Earlier, I was asked a question in relation to the number of procedures that are cancelled. While I do not have the number of cancellations by month by metropolitan hospital, I would like to share with the Committee some numbers on an annual basis. For the Women's and Children's Hospital, patients cancelled in 1994-95, 27; 1995-96, 80; and to April this year, 76. Flinders Medical Centre cancellations for the same years are 1201, 761 and 578; the North Western Adelaide Health Service (QEH), 1732, 1622 and 1367; the North Western Adelaide Health Service (Lyell McEwin Health Services), 374, 318 and 150; the Royal Adelaide Hospital, 1667, 1574 and 1288; and Modbury, 296, 278 and 203. By total, in 1994 the number of cancellations was 5297; in 1995-96 it was 4633; and to April this year, it is 3662.

The number of cancellations per 100 admissions has decreased by 14 per cent from 1994-95 to the year to date. The reasons given by health unit management for cancellations by hospitals are all understandable. I touched upon some of them before, including bed shortage, doctor unavailability, surgical implant not available and so on.

Mr BRINDAL: I refer to page 326 of the Program Estimates where reference is made to the devolution of residential services at the Julia Farr centre which, as the Minister would know, is in my electorate. I understand that trials are currently being conducted to implement a different nursing staff configuration. I also believe that the member for Mawson has some interest in staffing at Julia Farr as well, because he has contacted me in this respect on a number of occasions. What is the implication of the new configuration for nursing staff, and have trials thus far conducted been successful?

The Hon. M.H. Armitage: Recognising the great importance of Julia Farr everywhere but particularly to the members for Unley and Mawson, I will ask Mr Karl Mortimer to address the Committee.

Mr Mortimer: In October 1995 a nursing services review of Julia Farr Services was completed, and that review was initiated jointly by the Disability Services Office of the Health Commission and the executive staff of Julia Farr Services following the operational review which most people would know about and which was conducted by Ernst & Young in 1994. The nursing review was initiated to analyse and report on the level of nursing resources required to provide the current level of client and resident services. The review analysed nursing staff requirements to determine the base requirements. These were calculated for the nine client or resident care areas, and allocations were provided for the education unit, administration and specialist nursing positions. The outcome of the analysis provided for a two-staged implementation process to provide opportunity for the Disability Services Office, Julia Farr Services, the Australian Nursing Federation (SA Branch), the Liquor and Hospitality Miscellaneous Workers Union, staff, residents and clients—in the broader sense—to be involved in the change process.

The review indicated the potential to achieve a significant reduction in full-time equivalent nursing positions. The preliminary meetings took place between Julia Farr Services management, representatives of the Health Commission, Human Resources Division, the Disability Services Office and the Australian Nurses Federation to identify a process to implement the recommendations of that review. The management of Julia Farr has conducted information sessions with nursing staff to ensure that all staff are fully aware of the implications of the review, to maintain constant lines of communication and to avoid any negative impact upon the provision of services.

On 13 December 1996 a stop-work meeting was held to discuss the staffing allocations in accordance with the nursing review. As a result of this stop-work meeting, the Australian Nurses Federation lodged a dispute concerning the implementation of the nursing review, and this was to be heard before the Industrial Relations Commission on 18 December. However, the matter has since been adjourned indefinitely, following agreement by all parties to enter into a program of discussions. As a result of this, the Industrial Relations Commission recommended that the Australian Nursing Federation, Julia Farr Services, the Disability Services Office and the Health Commission undergo a number of meetings to resolve the staffing issues.

The relevant parties have met on a number of occasions to discuss and negotiate how to progress the situation. As a result of these meetings, it was agreed by all parties to undergo a trial—which was referred to in the question—in relation to the number of hours per resident per day necessary to perform the required nursing duties safely. Julia Farr Services met with the Australian Nurses Federation to discuss the proposed trial and the evaluation tools that were to be used and to identify an independent evaluator of the trial. The evaluator, Mr Rawinski, who is the labour force planning consultant from the Nursing Advice Unit, has since been agreed by the parties involved and has been assisting the Nurses Federation and Julia Farr in the development of the evaluation tools.

The trials commenced on Sunday 11 May 1997 and involved an evaluation of the existing nursing supports to provide a baseline for the trials. Information sessions were held with the residents who were to be involved, their families and staff during the week commencing 12 May. The first four week trial of four hours per resident per day has been completed. We are now into the second week of trialing three hours per resident per day. Trials will be completed soon. An evaluation of the results will be undertaken, and we hope to have that information by the end of July.

Mr BRINDAL: I take it from that very complete and encouraging answer given by one of the Minister's advisers that, if, as this progresses, I am approached either by clients of Julia Farr, who are often electors of mine, or by families associated with clients of Julia Farr, I can assure them that this is a process undertaken by all parties in consultation at a professional level and that therefore the playing of trite politics and the pointing of fingers at the Minister or at the Government is not relevant in this case, because it is a professional body working with Government to get good results for patients and clients. Is that correct?

The Hon. M.H. Armitage: Yes, it is very much a collaborative exercise. Any politicking in relation to it on these facts would simply be unsustainable.

Mr BRINDAL: My electors know that, Minister.

The CHAIRMAN: I call the member for Elizabeth.

Ms STEVENS: I refer to page 322 of the Program Estimates and to mental health services. I have looked carefully at what Mr Beltchev said earlier today and I have some questions of clarification about the matters he raised in his contribution. The first one relates to his statement that 'plans for the further transfer of inpatient services to local general hospitals are progressing'. Further, he said that 'the first of these will occur when the 40-bed unit at the Queen Elizabeth Hospital is completed, and that is anticipated to be in 1997-98'. What are the other plans? The Minister said that they are progressing: what is the rest of the plan for the transfer of inpatient services to local general hospitals? What are the time lines, and what are the resource implications of putting these other plans into practice?

Mr Beltchev: The further plan for the relocation of inpatient units from the Glenside campus in adult services is the relocation of Paterson Ward, which is currently operated by the Southern Regional Mental Health Service. That is an acute unit planned to be relocated at the Flinders Medical Centre. At the moment a facilities plan is being developed for the Flinders Medical Centre, which includes an investigation of whether that unit can be incorporated within the existing facility or whether additional facilities would need to be built. In addition to that, the rural and remote acute unit, which is also based at the Glenside campus, is also being considered for relocation at Flinders. That is part of that same investigation occurring at the moment in terms of the overall facility at the Flinders Medical Centre.

Ms STEVENS: So, it is just those two. What will that then leave behind at Glenside, and how do the finances work out in terms of what you have lost from Glenside and what you have put into place at Flinders with those two units?

Mr Beltchev: Once those units have been relocated, what will remain on the Glenside campus for adult services is Cleland House, the acute unit servicing the eastern region. At this stage there are no plans for its relocation. The two Brentwood wards, which provide the intensive acute service, will remain. They are closed wards, and there is no plan at present to relocate those. There are also the extended care services, and there are no immediate plans for their relocation. Mason Ward (which will relocate to the Queen Elizabeth Hospital), Paterson Ward (which will relocate to Flinders) and the Rural and Remote Ward are each currently operating as recurrent budget items as part of their regions, so there would be no change at all to recurrent funding.

The funding for the new facility at QEH is already funded and committed. There is preliminary funding for planning purposes already committed for Flinders and, once its planning is completed, that would become part of the normal process of seeking commitment from the capital fund, and the same would apply to the rural and remote unit. The Minister has already announced that some capital money has been set aside to enable a facility to be established at Flinders Medical Centre for adolescents with the dual drug dependence/drug abuse and serious mental illness problems. Those funds have already been allocated for the development of five beds at Flinders Medical Centre.

Ms STEVENS: In the earlier information it was stated that there are now 375 full-time equivalent staff in community based mental health teams in the metropolitan area and 42 in rural and remote areas. I understand that those community based teams are made up of three different components: the assessment and crisis intervention teams; the mobile assertive care teams; and, I assume, ordinary case managers. Will the Minister tell me the deployment in the east, south, north and west metropolitan areas of each of those teams in terms of those categories, and will he also tell me how the 42 in the rural and remote areas break down in terms of those categories and their geographical location?

The Hon. M.H. Armitage: We have a listing here of the services that are provided in the north, west, south and east, services to the elderly and rural and remote, which I will ask Mr Beltchev to provide. We do not have the numbers, particularly, of staff that attach to each of those services, but in relation to those areas it is important that we identify to the Committee what services are provided.

Mr Beltchev: I will just go through these on a regional basis. In the north-west region there are continuing care teams, which are the base case management teams. There are teams based at Salisbury, Modbury, West Torrens, West Adelaide and Port Adelaide. The Assessment Crisis and Intervention Service operates for the northern area out of Salisbury, and the western area service operates out of the West Adelaide office, formerly the Beaufort Clinic.

Mobile assertive care services in the northern area operate out of Salisbury, and in the western area out of the Port Adelaide office. Day vocational recreation and lifestyle services, which were formerly called rehabilitation services, operate in the northern area out of Elizabeth Park and Modbury and in the western area at Woodville, West Adelaide—which again was formerly the Beaufort Clinic—and Port Adelaide. In the southern region the continuing care teams operate out of Unley, Marion and Noarlunga. The ACIS team operates out of the Marion office. The mobile assertive care team operates out of the Marion office, and the rehabilitation services operate out of Unley, Marion and Noarlunga.

In the eastern region there are continuing care teams based in East Adelaide, at Felixstow, and in the city. The crisis and intervention service operates out of Glenside campus, and the mobile assertive care service has its base at Cleland House on the Glenside campus. They operate the rehabilitation services out of facilities at Payneham, Stepney and Enfield. The rural and remote service does not operate an assessment and crisis intervention service, but it does provide a 24-hour triage service and that operates out of the Glenside campus in conjunction with the acute unit. The continuing care teams are dispersed through all of the regions. Again, I can provide the details of precise location and numbers later.

Ms STEVENS: Will the Minister still provide the numbers for which I asked?

The Hon. M.H. Armitage: Yes.

Ms STEVENS: Again, in relation to mental health services, what was the dollar value of establishing 375 full-

time equivalent staff in the metropolitan area and 42 in rural and remote areas; and what is the Minister's estimate of the level of unmet need in terms of all those services in the metropolitan and country areas and the dollar value of that unmet need?

The Hon. M.H. Armitage: Earlier today we identified that, in 1991-92, $11.5 million was spent on community mental health services and in 1996-97, this present financial year, $24 million was spent.

Ms STEVENS: That was not my question.

The Hon. M.H. ARMITAGE: The question you asked was: what was the dollar value? The dollar value is $24 million. That was exactly the question and that is exactly the answer. If the honourable member wants to ask another question, I will answer it.

Ms STEVENS: I would love to follow that up and clarify that. What I asked was: what was the cost of establishing 375 full-time equivalent staff in the community based mental health teams in the metropolitan area and 42 of those people in rural and remote areas? The Minister is telling me it cost $24 million for 415 staff.

The Hon. M.H. Armitage: Those are the staff that are in the community mental health teams in those areas that have been identified—the 375 and the 42—and the cost is $24 million.

Mr ROSSI: The Labor members opposite do not know how to add up and the figures always seem the same to them. I like to be more positive about what this Government is doing. I refer the Minister to waste management, a matter in which I am very interested, because they were going to put a waste transfer station at the corner of Old Port Road and Tapleys Hill Road in my electorate.

Mr Brokenshire: You stopped it.

Mr ROSSI: Yes, I stopped it. I always do what I say I will do and represent the electors. I refer to the Program Estimates and Information—

Mrs Geraghty: Tell us about the high school?

The CHAIRMAN: Order!

Mr ROSSI: Your Government closed it, not ours. No schools in my electorate have been closed. Financial Information Paper No. 1, at page 318, refers to environmental management in hospitals. I understand that metropolitan public hospitals have been focusing on improving their waste management programs. Can the Minister outline whether there has been any progress in reducing waste volumes and costs in recent years?

The Hon. M.H. Armitage: This is a very important question, obviously, as we are more and more a disposable society and people are more and more concerned about the management of our general waste, and when it comes to hospital and medical waste it is even more of interest. It is pleasing to advise the Committee that the majority of metropolitan public hospitals in the past three years have made very significant improvements in their waste management practices. These improvements have resulted in a very significant reduction in the level of waste requiring disposal and considerable cost savings in addition. The success of the programs within the major metropolitan public hospitals is highlighted in an annual review of waste management practices which reveals that over the past three years there has been a 46 per cent reduction in medical waste requiring incineration, a 29 per cent reduction in general waste going to landfill and, on top of those extraordinarily good figures, a cost saving of 23 per cent.

The waste reductions have been made through a process of focusing on educational programs for the disposal of medical waste and through the establishment of successful recycling programs for cardboard, paper, plastics and glass. The improvements have realised cost savings in absolute terms of about $300 000 and have gone a long way to meeting both national and State Government waste disposal and waste reduction targets.

Mr ROSSI: I am very impressed with the Minister's answer, which reinforces my attitude regarding the difference between Liberal members and Labor members. I believe that the Liberal members are the cooks in the kitchen who produce and the Labor members are the topless waitresses who have nothing to manufacture except show their body.

I hope the Minister will be as positive with this topic as he has been with other topics today, namely, drug dependence in South Australia. I note on page 325 of the Program Estimates and Information the reference to additional funding for tobacco legislation initiatives (Financial Information Paper No. 1). Drugs of dependence are also an issue concerning our community. What steps are being taken by the Public and Environmental Health Service to ensure an adequate level of surveillance, monitoring and reporting of the use of drugs of dependence in South Australia?

The Hon. M.H. Armitage: A significant increase has occurred in the quite legitimate prescribing of drugs of dependence by medical practitioners over recent years, and this includes the prescribing of opiates associated with pain control and management of dependence, and particularly the prescription of amphetamines for children with attention deficit disorder. The drugs and poisons section of the Public and Environmental Health Service in the commission proposes to use information technology to reorganise a number of functions to deal with the subsequent increase in workloads from that increase I mentioned previously. The increases in the workload are principally associated with the authorisation and monitoring of the use of drugs of dependence and the maintenance of the databases relating to those activities.

A three-part project involving the electronic transmission and storage of data is being explored which has the potential to reduce direct and indirect cost through increased efficiencies, to eliminate paper-based correspondence and therefore reduce the need for filing space, to reduce data input within the section, and to allow more timely transmission of and access to data. The first part of the project will be a network linking pharmacies in South Australia with the Drugs and Poisons Section of the Public and Environmental Health Service using the structure created for the Virtual Health Network (Medical Virtual Private Network Project) by the Information Management Division of the Health Commission, Telstra, Matcom and Internode.

This network will link Warinilla Clinic and selected medical practitioners to the Drugs and Poisons Section for the purposes of monitoring and authorising the prescribing of drugs of dependence. The electronic transmission of prescriptions between Warinilla and nominated pharmacies will then be evaluated. It is anticipated that the resources no longer required for those activities will be used for more extensive analysis of the date and follow-up interventions and investigation of inappropriate prescribing of drugs of dependence.

Mr ROSSI: My question concerns the WorkCover audit against performance standards and a continued commitment to corporate governance and risk management in the health sector (page 327, Program Estimates). Will the Minister

indicate what progress has been made by health units to achieve top level performance against the exempt employer performance standards?

The Hon. M.H. Armitage: In response to this important question, I ask Mr Rod Bishop to address the Committee.

Mr Bishop: I am pleased to report that considerable progress has been made on this matter. Since 1992 the Health Commission has required all health units to conduct annual self-audits against the exempt employer performance standards and to submit their consequent assessments of compliance to the Health Service Injury Advisory Unit within the central office of the Health Commission in order for performance to be monitored and improved. The results of these audits show both an increasing commitment to and an understanding of compliance to these standards by health units which are making slow but steady improvement.

The Chief Executive Officer of the Health Commission has committed the health system to best practice in occupational health and safety and to achieve and maintain top level performance against the exempt employer performance standards set by WorkCover. This commitment is in response to a directive of the WorkCover board, which requires all self-insurers, including Government employers, to achieve level 3 of the standards by June 1998.

In order to assess the level of performance within the health system, WorkCover consultants have been conducting evaluations in the 26 largest health units, that is, those units employing approximately 90 per cent of the health sector's work force. The Lyell McEwin Health Service was the first Government body to achieve the highest level attainable in prevention, rehabilitation and claims management audits. As a result of the Lyell McEwin Health Service obtaining that last year, it was awarded the outstanding Government exempt employer award at the WorkCover safety awards dinner, as well as receiving a second prize for outstanding achievement by a Government exempt employer.

The Flinders Medical Centre, the Noarlunga Health Service, the Port Augusta Hospital and Health Service, the Queen Elizabeth Hospital and the Royal District Nursing Service have recently been advised by the auditors that they have achieved level 3 in each of these three areas. When evaluations are ratified by the WorkCover board, it is expected that at least eight more health units will achieve this level. That will mean that more than half the health units funded by the Health Commission will have achieved a top level of performance 12 months ahead of the required date. I am advised that no other Government body has achieved level 3 in all three areas audited by WorkCover.

All health units have been provided with specific assistance by staff of the Health Service Injury Advisory Unit in central office in line with their particular needs. Small country units have been provided with training and assistance in the self-audit process, occupational health and safety systems and the development of suitable action plans. The Health Service Injury Advisory Unit is also working closely with regional general managers to facilitate regional systems for the prevention and management of injuries, and this will assist all regional health services to achieve top level performance in these areas.

Ms STEVENS: My question relates to mental health services (page 322). I asked this question before but I did not get an answer, so I will ask it again. I presume that the department does forward projections as to the level of need. In relation to community based mental health services, what is the Minister's current assessment of the level of unmet need?

The Hon. M.H. Armitage: The easiest way of responding to this question would be a little glib but, as I am getting tired, I will give a glib answer: the level of unmet need is a whole lot less than when we came to Government, because no money was provided for community mental health services following the changes made by the previous Administration.

The ASIS team was formed to respond to a need which we knew was in the community. The response has been large, as Mr Beltchev indicated in a previous answer. Indeed, the level of response is about four times that which was being provided in the casualty or accident emergency section at Glenside. The previous response indicated that a large number of those are new clients. The activity of the community teams themselves has increased by about 15 per cent in the past 12 months. We estimate that that is the backlog. There is really no way that one can identify what is an unmet need in this area. However, we estimate that the backlog is about 15 per cent, and it has increased in 15 months. The important thing about that is that, whether or not that was the unmet need, it was an anticipated response to the community teams. We were able to respond to it, and we did.

We are also about to undertake a SERCIS mental health survey which will again give us some further identification as to the types of needs, and so on, that are in the community. The most relevant information that I can provide—because we do not have the figures, as there is no way it can be measured—in addition to all the other material, is that it would seem as though access to the ASIS teams is tapering off. We surmise that we are approaching the end of the unmet need in the community. If we are not, we will address it just as we have other issues.

Ms STEVENS: I refer to the anxiety disorders review. I know that the review has been completed and that there are 16 recommendations. Recommendation 2 states:

> It is recommended that each regional mental health service establish anxiety disorders diagnosis and treatment services for persons experiencing a serious level of disorder. The Director, Mental Health Realignment, should establish a benchmark figure based on the population requirements of each region and upgraded services be staffed by clinical staff with a sound record of expertise in treating anxiety disorders or resources be allocated to contract in an equivalent level of services.

What is the status of all the recommendations and, in particular, this recommendation? If the Government intends to implement this, what is the time line and the resource implications of such a decision?

The Hon. M.H. Armitage: I have not yet received the final report. It is in the process of wide consultation. I understand that a number of the recommendations have been warmly received. However, when I receive the final consulted report, a decision will be made. As far as time frames and resources go, I have absolutely no idea, because I have not received the report.

Ms STEVENS: I will read a portion of a letter that was sent to me recently, dated 7 June 1997, as follows:

> Dear Sir/Madam,
>
> I wish to make a complaint about the faceless bureaucrats who make stupid decisions concerning the health and well-being of patients at Glenside hospital. I am currently a detained patient at this hospital, due to a suicide attempt last week. Upon my admittance to Glenside, it was decided that I would be detained at North Glen annexe, a closed ward, for my own safety and that of my father, who I hate.
>
> On Friday 6 June 1997, all patients were advised that the ward was to be closed and all patients relocated to other wards. This placed considerable stress amongst patients. Later in the day, we

were told that the ward would remain open and we would remain there. An hour and a half later, we were again informed that the ward was again to close and we would be relocated to other wards, which eventually occurred. I would like to point out that, due to this gross incompetence on the part of the department, there were only two staff members present, who were kept busy answering phone calls all day and went without their designated lunch break.

How much of this happens in wards at Glenside? We have heard of many instances similar to this. We have heard all about the realignment and about many of the increased resources the Minister has talked about. Why does something like that happen to somebody who is distressed and in a closed ward at Glenside hospital?

The Hon. M.H. Armitage: I have not received that letter. I am not sure what it has to do with the budget Estimates.

Ms STEVENS: It is about management of the hospital.

The Hon. M.H. Armitage: That is exactly right; that is the answer. North Glen is an overflow ward, which is opened in response to a need for patients to be detained when Brentwood is full. As soon as beds are available in Brentwood, the patients who are in North Glen are transferred back to Brentwood, and North Glen is then closed. In essence, it is exactly as the member for Elizabeth said—good management of the resources. Further, it is responding to a need in the form of patients who need to be detained if there is not enough room in Brentwood.

Ms STEVENS: I did not actually say it was good management. I did not use the words 'good management': I said it was a management issue. I see what the Minister is doing in terms of managing the wards. I wonder about his comment regarding the stress and trauma caused by those people's being shifted around, because it is traumatic.

The Hon. M.H. Armitage: In all these cases, and under every Administration, clinical assessments play a large part in the movement of patients. I am absolutely confident that staff would not make a clinical decision unless they perceived it to be in the best interests of the patient. If the member for Elizabeth does not wish us to manage hospitals in this way, the only way around it is to have Brentwood and North Glen fully opened and fully staffed all the time, even if North Glen has no patients in it. That is the only corollary to the member for Elizabeth's question. I shall provide for the member for Elizabeth the cost of keeping North Glen open 24 hours a day, seven days a week with no patients in it.

Ms Stevens interjecting:

The Hon. M.H. Armitage: The member for Elizabeth says, 'How silly!' That is exactly the point that I am making. This is good management of available resources in response to a clinical need of a patient.

Mr BROKENSHIRE: The Program Estimates (page 324) refer to increasing the employment of Aboriginal people in mainstream health services, which I see as a positive move. What steps have been taken to achieve equity in employment for Aboriginal people?

The Hon. M.H. Armitage: I ask Mr Brian Dixon, the Executive Director of the Aboriginal Health Division, to respond to this particularly important question.

Mr Dixon: The South Australian Health Commission is committed to and actively promotes the increased employment, training and development of Aboriginal people throughout the health system. The commission recognises the value of Aboriginal employees in its work force and the vital role we play, particularly in achieving better health outcomes for Aboriginal people in South Australia. A booklet entitled *A Career in Health*, produced by the Aboriginal Health Division, was launched in May 1996. The booklet aims to promote the health system as a potential employer and to courage Aboriginal people to either consider a career in health or study towards a health related qualification. It provides detailed information on occupations available within the health arena, the qualifications required and details of relevant courses of study. This booklet was updated and reprinted this financial year and was used once again as our main marketing tool at the 1997 Youth Careers Expo held in May at the Wayville Showgrounds.

The Health Commission also strongly supports the State Government's youth training and employment strategy. Through its national training wage traineeship, the Health Commission has recruited 13 young Aboriginal persons into clerical traineeships and one laboratory technician. Of the 13 young people employed, three are in country areas and the remaining 10 are in the metropolitan area. One Aboriginal student graduated from nursing at the University of Adelaide Underdale campus this financial year and the Health Commission secured a position for her on the graduate nurse program at the Women's and Children's Hospital. The Aboriginal Employment Officer within the South Australian Health Commission continues to work closely with the Aboriginal Employment, Education and Development Branch of DETAFE, particularly for access to career development initiatives available for Aboriginal employees and for recruitment to base grade, day-to-day health system vacancies.

Health system Aboriginal employees are increasingly participating in career developing programs offered by DETAFE. An example of this is the family well-being counselling program, which approximately 30 Aboriginal employees have attended. In conjunction with the Aboriginal Employment, Education and Development Branch, the Health Commission continues to sponsor an Aboriginal student on the cadetship program. The student is currently in her third year of study towards a BA in dentistry. Upon successful completion of studies, she will be employed by the South Australian Dental Service. Three Aboriginal medical students currently study at the University of Adelaide: one fourth year student and two third year students. Support is provided in the way of financial assistance, work experience placements, unlimited access to resource materials within the commission and provision of support personnel in a mentoring capacity.

Although Aboriginal representation in the South Australian health work force has significantly increased, this is largely at the base grade level. The Health Commission recognises that increasing Aboriginal participation in management in health services creates opportunities for the development of culturally appropriate health care. It is essential that Aboriginal people have an increased input into the design, implementation and evaluation of health services. To achieve this, it is necessary to increase the numbers of Aboriginal people in senior or decision making positions. Cadetships provide the means to acquire professional staff, particularly in areas where it is not possible to directly recruit graduates into the health system. To address the above inequity, the Health Commission announced that it will allocate three cadetships per annum, at a cost up to $15 000 each, to Aboriginal people who are studying for or enrolled in an approved degree or postgraduate degree level course. The program will provide financial sponsorship to Aboriginal students, with the guarantee of permanent employment in the South Australian health system upon successful completion of their studies.

Mr BROKENSHIRE: The Program Estimates (page 324) refers to improvement of the health status of Aboriginal people, something we all want to see urgently. In this context, will the Minister explain how the special needs of Aboriginal and Torres Strait Islander patients are recognised under casemix funding?

The Hon. M.H. Armitage: In 1995 the Commonwealth Department of Health and Family Services commissioned an independent study that concluded that in fact there was a cost differential in the treatment of Aboriginal and Torres Strait Islander inpatients compared with non-Aboriginal and Torres Strait Islander inpatients. The report found that the treatment of Aboriginal and Torres Strait Islander patients is more expensive for almost every component of inpatient care. Based on that study and consultation with stakeholders, the commission has increased the casemix reimbursement for the treatment of Aboriginal and Torres Strait Islander inpatients by 30 per cent compared with equivalent non-Aboriginal and Torres Strait Islander inpatients.

Despite the report's including data only on rural and remote hospitals, the increase will apply to all publicly funded hospitals in South Australia, given that costing data from the metropolitan teaching hospitals has exhibited the same trend in increased costs. This does a number of things: it indicates the Government's determination to provide appropriate health care for Aboriginal and Torres Strait Islander people and it also displays the ability of casemix funding to target particular patient groups and provide appropriate resources for their specific treatments.

Mr BROKENSHIRE: I refer again to page 324, concerning sexual and reproductive health education programs for indigenous primary health care workers. Reference is made to cross-cultural awareness in relation to Aboriginal health issues. Given the sensitive nature of sexual health education, how is the Minister planning to deal with the issue of sex education for our indigenous people in a way that is culturally appropriate?

The Hon. M.H. Armitage: Again, this program comes under the primary health care initiatives and programs of the Government, and I ask Dr David Filby to provide an answer.

Dr Filby: The Minister has recently approved funding for a project that seeks to develop a core post certificate course in sexual and reproductive health for indigenous women primary health care workers. The objectives of this project are to develop and evaluate a curriculum on sexual and reproductive health and wellbeing for indigenous primary health care workers, to develop the competence and confidence of these workers in providing sexual and reproductive health services into their own communities, and to improve access to culturally appropriate services for indigenous South Australians.

This program is aimed at indigenous primary health care workers who have completed their primary health care certificate. In the pilot phase we propose to identify 20 workers from a variety of geographic locations across South Australia to participate in this course. That selection will involve community and primary health care worker consultations. The program will commence in July and come under the auspices of the Family Planning Association of South Australia and it is expected to run for about six months.

Ms STEVENS: I refer to page 313 of the Program Estimates and the Supported Residential Facilities Act. On 10 June a memo from Dr Kerry Kirke, Executive Director of the Public and Environmental Health Service, was sent to the chief executive officers and city managers of local councils in relation to exemptions of facilities under the Supported Residential Facilities Act. The memo included an attachment that listed a range of organisations funded by the Disability Services Office including Minda, Julia Farr Services and a range of country and city agencies which are exempted from the Act.

The Minister would be aware of the Supported Residential Facilities Advisory Committee whose job it is to work with and implement this Act. What was the view of that committee in relation to this matter, because I know from reading its annual report of the previous year that it had been working on protocols for exemptions? It had also been waiting on the Minister's acceptance of recommendations in relation to these protocols. What was the committee's view in relation to the exemption of these organisations, and does the Minister have any concerns about accountability and the ability to provide unbiased monitoring of these facilities, with particular reference to the residents? Do you have any concerns that this will now be any less as a result of this decision?

The Hon. M.H. Armitage: The Supported Residential Facilities Advisory Committee is, indeed, an advisory committee. It is not, however, the only body from which I seek advice. The committee, as the member for Elizabeth has identified, was preparing a process for exemptions, if you like. A large number of other bodies wished to be exempted more quickly than through that process. I took advice from the Disability Advisory Council in addition to the Supported Residential Facilities Advisory Committee and, in this instance, decided to exempt the bodies that were identified in the minute from Dr Kirke.

It is important to identify that the national disability standards will apply to all those exempted bodies through their service agreements and, basically, the thesis of giving these exemptions was that, without them, these bodies, whose primary goal is to provide appropriate supported residential facilities, would have spent a lot of their time preparing for standards, monitoring and visits from different bodies. That to me seemed double counting or duplication. So, in this instance a decision was made with the support of the Disability Advisory Council. The Supported Residential Facilities Advisory Committee was of a different view but was more than happy to work with that decision.

Ms STEVENS: As a supplementary question, I understand that the Supported Residential Facilities Advisory Committee has been operational for 2½ years. How many times has the Minister met with that committee over matters of concern in relation to this Act?

The Hon. M.H. Armitage: I would have to consult my diary, but two or three times. It is at least twice. I think it may be three—in that vicinity. Each time we have discussed a range of matters of mutual interest.

Ms STEVENS: I refer to page 326 and disability services. What is the total cost of the management structure of the options coordination program, including the managers, support staff, rent and utilities? What is the total cost of the options coordination infrastructure system.

The Hon. M.H. Armitage: It is a difficult answer to provide for a number of reasons, not the least of which is the difficulty in separating out the service provision from the management of IDSC and the Crippled Children's Association—and I have been asked to provide the management costs. In essence, the previous funding went into the case management exercise before options coordination was transferred over, and there was approximately $.5 million in addition to that provided from savings at Julia Farr. I am also

informed that the salaries of managers' of the new agencies, in other words, APN, brain injury and sensory options coordination, are in the vicinity of $50 000 and have been provided each year from one-off funding slippages, or whatever. IDSC has 102.5 FTEs, brain injury, 13.5; APN, 25; sensory, 5; CCA, 5; and country offices (all agencies combined), 26.5.

It is important to acknowledge that in many instances the options coordination process provides clients with a great bonus and a boost. Indeed, several days ago I received a letter—unfortunately I do not have it here, otherwise I would be most pleased to quote it—from the APN clients advisory group praising options coordination and making a specific point that it is now able to access services which it previously never had.

Ms STEVENS: Could the Minister provide the cost of the management coordination services at the Gilles Plains location for the options coordination project, including the managers, support staff, rent and utilities?

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

Ms STEVENS: I refer to page 316 of the Program Estimates with respect to noise in nightclubs. Is the Minister aware of research undertaken at the University of Adelaide showing that excessive noise in nightclubs can cause permanent hearing damage to patrons and staff? I understand that Scott Snyder of the Department of Mechanical Engineering at the University of Adelaide says that nightclub staff are particularly at risk because of their continued exposure. He says that tests conducted at two Adelaide nightclubs earlier this year found that the average sound levels near nightclub bars ranged from 105 to 110 decibels. He said that long-term exposure to that kind of noise means that a very high percentage of people, possibly up to 60 per cent, will have permanent hearing damage. What action has the Public and Environmental Health Division taken following these claims, and is there a case for promoting public awareness and for conducting some tests in this area?

The Hon. M.H. Armitage: I am informed that the Public and Environmental Health Division is aware of the report. It has not in any way been asked to do anything in particular about it as such, but it is looking at a number of features in relation to deafness in the community in general. If and when all those studies collaborate and provide some useful conclusion, that will be made public. However, it is fair to say that people enter nightclubs voluntarily and that they know there will be loud noise. Indeed, I suggest that from the time when I visited those establishments it has been—

An honourable member interjecting:

The Hon. M.H. Armitage: I went once; I was too busy going to the trots at Wayville. Over many years people have had a number of views about these matters, but at the end of the day adolescents who visit these establishments believe that they are indestructible and that no noise will affect them. Whether we can do more than just provide further education and information on top of that which is already there is a question that we will have to address, but short of locking the doors on the nightclubs I do not know what we can do.

Ms STEVENS: I am very surprised at that answer coming from the Minister, who was putting up the bans on smoking in enclosed places, because we could actually put the same argument that it is your own choice if you go into a bar or restaurant. The Minister has to take a little more responsible view, if I may suggest. I must say that the Minister's answer seemed to me to suggest that nothing much at all is planned. Is my conclusion correct? It seems to me that the Minister was saying that there would be some looking at research here and there but there was no time line, no specific commitment to do anything, and the Minister virtually said that it is up to them.

The Hon. M.H. Armitage: I had actually written something down and elected not to read it but, given what the member for Elizabeth said, I will. It is absolutely extraordinary that the member for Elizabeth would be crying crocodile tears in this matter when she voted against stopping passive smoking involving nightclub staff. The passive smoking by nightclub staff is appalling and is clearly a danger to them, yet the member for Elizabeth voted against measures that would protect nightclub staff from that passive smoking. Getting to the substance of the supplementary question, I suppose that there are a number of very easy ways of stopping this. One could ban nightclubs, or one could have noise police and ensure that there are no bands playing at over 50 or 70 decibels, or whatever the level might be. We could fine people if they did not wear ear plugs. It just goes on and becomes more and more ridiculous. The simple fact of the matter is that there will always be an element of youth who would challenge what other people may determine is in their best interests—

Ms Stevens interjecting:

The Hon. M.H. Armitage: It is actually different. The member for Elizabeth says it is like smoking. It is not like smoking because, if I do not want to go into the nightclub, I make that choice. If someone smokes next to me, I do not have a choice; it is exactly the opposite. However, at the end of the day, as I indicated before, the Public and Environmental Health Division is aware of the survey and, if and when it is appropriate that public statements can be made to protect young people's hearing in any way, we will certainly do that.

Mr BRINDAL: I am interested: it is quarter past nine. We have had a whole day of Estimates Committee hearings and there must be a good news story here, because the member for Elizabeth has failed to ask an important question. On her behalf and on behalf of her electors I ask the following question. Page 319 of the Program Estimates refers to the provision of effective and efficient high quality services. In this context will the Minister outline the benefits to patients of the amalgamation of the Queen Elizabeth Hospital and the Lyell McEwin Health Service to form the North Western Adelaide Health Service? I know that it is a positive story, because I am absolutely convinced that, if there was any negativity in it at all, the member for Elizabeth would have asked the question about five hours ago.

The Hon. M.H. Armitage: The amalgamation of the Queen Elizabeth Hospital and Lyell McEwin Health Service in July 1995 had two major goals: first, to enable the Lyell McEwin Health Service to attain teaching hospital status by the development of academic linkages with the QEH and the University of Adelaide; and, secondly, to increase the range of specialist services at Lyell McEwin Health Service through the direct recruitment of medical specialists and by capitalising on the links established with the QEH. These aims have required major changes in the organisation and culture of both hospitals and associated health services. Of course, such changes cannot be achieved overnight, but a number of initiatives involving both clinical and non-clinical services have taken place to improve services, and these have been the direct result of the amalgamation or are related to it in some way. I will elaborate on some of these achievements.

Prior to the amalgamation, the Lyell McEwin Health Service's medical staff relied on *ad hoc* specialist consultative services from cardiologists based predominantly at the Royal Adelaide Hospital with a very limited outpatient cardiology service. The general physicians were mostly responsible for cardiac services and oversaw the treatment of cardiac patients in both the special care unit and the general wards. One of the earliest amalgamation initiatives was the establishment of a daily ward round by the QEH cardiologist. There are plans to establish a full-time presence on campus of a specialist cardiologist and eventually a registrar. Some new equipment for the coronary care beds and the emergency department was purchased with Health Commission funds in support of the cardiology initiative.

The much needed day chemotherapy service, established in early 1996, has been successful in meeting the needs of patients who live in the northern metropolitan region so they no longer have to travel to the Royal Adelaide or to the QEH for day chemotherapy treatment. A full-time clinical oncologist was recruited to work half-time at both hospitals and to oversee the work at the Lyell McEwin Health Service. The well publicised medical staffing problem in the Department of Anaesthesia will be solved once the three overseas appointees take up their positions later this year. This result was due in large part to the collaborative effort within the critical care division and the leadership shown by key North Western Adelaide Health Service personnel in pursuing solutions to this crisis with the Health Commission and me. If it were not for the amalgamation, there was every chance that the staffing problem at the Lyell McEwin Health Service would have continued.

The appointment of Professor Bob Bauze to oversee the establishment of orthopaedic services at the Lyell McEwin would not have been possible without the amalgamated structure. It is arguable that the Lyell McEwin would not have been able to attract someone such as Bob Bauze to the Elizabeth campus alone. Professor Bauze has proposed a detailed stage plan to reintroduce orthopaedics with the assistance of specialist resources and registrars from the QEH, which will transcend the service previously provided by a sole surgeon at the Lyell McEwin.

The appointment of Dr Allan Hunt, formerly staff consultant in the QEH Emergency Department, enabled the establishment of dedicated medical management of the Lyell McEwin Emergency Department, which had been struggling with quality and staffing problems for some time. The implementation of a teaching program for registrars and other trainee medical staff has led to accreditation from the Australian College of Emergency Medicine for the training of emergency medicine registrars. In the long term, this will lead to the attraction of higher quality trainee medical staff for the Lyell McEwin, who, in turn, will provide better supervision and teaching to the other staff.

Higher quality trainee medical officers have been attracted to work in the Emergency Department due to the accreditation of registrar posts. In time, more positions will be created to ensure that a more experienced and better trained registrar is on duty during every shift around the clock providing enhanced supervision of more junior doctors in the department. Following the resignation in 1995 of an anaesthetist who had a half-time supervisory role in the special care unit, a dedicated full-time intensive care specialist was recruited to change the orientation and medical direction of the unit to that of a level 3 intensive care service. Dr Sandra Peake, formerly from the QEH, was appointed as director in late 1995. The link with the QEH intensive care unit will be critical in attracting further intensive care specialists to Lyell McEwin who wish to avoid professional isolation.

The Department of Vascular Surgery at the QEH has commenced a new fortnightly vascular surgery operating list and outpatient clinic at the Lyell McEwin, with the plan gradually to operate on more complex and higher risk vascular patients who otherwise would have had to have surgery elsewhere. This service will expand over the next couple of years to meet demand whilst support staff gain the necessary expertise. The operating list doubled in frequency to a weekly list earlier this year.

Following the resignation late last year of Mr Adrian Burke, senior visiting specialist in general surgery, the Division of Surgery organised a temporary replacement, Mr David Rodda, who works 80 per cent of the week at the Lyell McEwin and is responsible for clinical teaching as well as providing clinical services. Mr Rodda's time commitment is greater than the three sessions per week for which Mr Burke was contracted previously.

A number of new outpatient clinics have been established at the Lyell McEwin by the QEH specialist, predominantly in the division of medicine. These clinics are in specialties not adequately provided prior to the amalgamation and include thoracic medicine, renal medicine, rheumatology, endocrine and diabetes and the amputee rehabilitation clinic. Neurology EMG studies are run by the QEH scientist, testing telemedicine link to a medical consultant at the QEH, and there is an additional list by the QEH specialists in general surgery and gastroenterology.

In 1997, an extra three or four medical registrars from the QEH's physician training program will rotate to the Lyell McEwin each term, boosting the quality and reliability of medical registrar staffing. In addition, a 12 month advanced general medical training post has been accredited at the Lyell McEwin for the first time, which has been filled by a high quality registrar who was attracted to work at the Lyell McEwin by the accreditation of the post as well as the favourable teaching environment. Previously the Lyell McEwin relied heavily on casual medical officers to fill rosters seven days a week. Good quality medical registrars have a profound effect on the provision of quality patient care.

Additional surgical registrar support has also been made available by the head of surgery. I am informed that the state of information technology infrastructure at the Lyell McEwin was a long way behind that of other major hospitals. The amalgamated finance and information services directorate prepared a very sound business case for a major upgrading to the computing infrastructure. This work continues and probably would not have proceeded were it not for the amalgamation. Devolution of management had already taken place at Lyell McEwin prior to the amalgamation. However, due to the size of the organisation and cultural issues, I am advised that the model adopted did not involve many senior managers. The new divisional structure now being finalised will place both authority and responsibility in the hands of medical, nursing and allied health managers and obviously will benefit the organisation in the longer term.

As members of the Committee would be aware, the creation of the North Western Adelaide Health Service has allowed greater opportunity for cooperation between relevant services of two or more service locations in competitive tendering processes. In other areas, such as biomedical engineering, I am advised that an amalgamated structure has

been proposed by the staff which will provide a number of benefits. I am absolutely sure that this clearly indicates the benefits that have accrued so far following the creation of the North-Western Adelaide Health Service. Those benefits improve the efficiency, effectiveness and quality of health services to the north-western metropolitan population.

Membership:

Mr Clarke substituted for Mr Atkinson.

Mr BRINDAL: Before I ask my next question—

The CHAIRMAN: Is this a supplementary?

Mr BRINDAL: No. I just want to say something before I ask my next question.

The CHAIRMAN: It is either a supplementary or it is another question.

Mr BRINDAL: It is the introduction to another question then, if you want to be pedantic, Sir. I do not know whether the Minister is aware that that answer took nearly seven minutes and it probably encapsulates this whole budget. There is so much good news that the member for Elizabeth will not ask the questions, the ABC will not run the answers and certainly Leigh McClusky will not film the answers, but those who are listening know that this is a good budget. Because the member for Adelaide cannot ask any questions about his electorate—

Mr Clarke interjecting:

The CHAIRMAN: Order! The member for Ross Smith is out of order.

Mr BRINDAL: My question refers to page 319 of the Program Estimates and tendering for the Royal Adelaide Hospital car park. The Minister would be aware that I wrote to him on this issue. I am not sure why the hospital needs to tender for a car park when it already owns a car park and when, if we listen to the member for Elizabeth, the hospital has so few staff that they can probably all park outside. Can the Minister update the Committee on the situation regarding car parking at the Royal Adelaide Hospital?

The Hon. M.H. Armitage: The Government is very keen to see the development of the East End of Adelaide and, as part of that, following a meeting held in the Premier's office some time ago, it was felt that there was a need to free up public use of the 585 spaces at the Union Street car park currently used by the staff of the Royal Adelaide Hospital for the very vibrant rejuvenation of the East End of Adelaide. As a result, in cooperation with the Health Commission, the Royal Adelaide Hospital has sought to provide a comprehensive solution to car parking for staff, patients and the public associated with the hospital as we look towards the twenty-first century.

Currently we have put out to the marketplace a proposal to build a new car park on the hospital campus which will have in excess of 1 300 spaces to cater for the needs of staff, friends and relatives of patients and the public. In providing convenient parking on site, there will be a need to replace the existing IMVS facility located on the site where the car park is to be built. The Health Commission has made provision for the construction of a new IMVS facility in its capital works program. This new facility will be a state-of-the-art complex to cater for the continuing advances in medical science and technology expected into the next century.

A major feature of the project is the successful consultative process which has involved the University of Adelaide, the University of South Australia, the Adelaide City Council, the Botanic Gardens, the Adelaide Zoo and protagonists in the East End development. As a result of the negotiations, it is pleasing to inform the Committee that the project will ensure that land currently being used for car parking will be returned to its original use as parklands, and approximately 2.3 hectares of parklands will be given to the Botanic Gardens Board in the year 2000.

In recognising the complex nature of the project and its impact on the City of Adelaide, the Royal Adelaide Hospital has conducted an extensive study on the potential impact of the car park on traffic flow along Frome Road. As a result, a recommended solution is in the request for proposal given to bidders. Both the Union Street and the new RAH car park are expected to be operated by private companies. In particular, the new car park will be built, owned and operated by the successful bidding consortium.

At this stage the Government has retained options at the end of the contract period either to extend or re-tender the operation of the car park or to transfer ownership back to the Government. We expect bids to close in August this year, and construction is planned to commence in early 1998. This is a solution to a difficult problem and it shows that, with wide consultation and creative thinking, we have developed a solution that will benefit the public in a most positive way.

Mr BRINDAL: I refer to page 318 of the Program Estimates where reference is made to the trauma systems plan. Can the Minister bring us up to date with what is being done to improve trauma services in the health sector in this State generally?

The Hon. M.H. Armitage: In answering this very important question, which details an innovative program for people in South Australia who have been unfortunate enough to suffer trauma, I invite Dr Michael Jelly, the Chief Medical Officer of the commission, to address the Committee.

Dr Jelly: The Health Commission through the Trauma Systems Committee, chaired by Sir Dennis Paterson, has undertaken a major review of trauma services in this State. The recommendations of the important review are now being implemented and will have wide-ranging benefits not only to individuals who are the unfortunate victims of severe trauma but also for the State as a whole due to the economic effect of people who suffer morbidity following trauma. The essential component of that is to get appropriate treatment as early as possible to minimise the trauma effect. Flinders Medical Centre and the Royal Adelaide Hospital have been designated as the major trauma centres for adults, and the Women's and Children's Hospital was identified as the major trauma centre for children. Late in 1996 a pilot project was implemented and had part of its bypass plan implemented as a result of the training of paramedics within the South Australian Ambulance Service. Those paramedics were able to triage patients so those patients in need of major trauma services could bypass other hospitals and go directly to the major trauma centres.

That pilot project was evaluated and it was a success and will be implemented as a whole. That does not mean that patients who are deteriorating during the period of transport cannot be taken to another hospital if that sort of support is needed on the way. However, the intent is to get people to the definitive place of treatment as quickly as possible.

Significant changes have also been made in the rural and remote areas. Major trauma services can now be contacted through one telephone number at the South Australian Ambulance Service, which in turn can link them to the appropriate hospital and monitor the call so that the Ambu-

lance Service knows what it is needed for as well as hearing what the trauma service will do.

To simplify referrals, there is a line from Glen Osmond to the eastern border of South Australia, from Cross Road-Anzac Highway: those south of that line will go to Flinders Medical Centre, and those north of that line and the rest of the State will go to the Royal Adelaide Hospital. That aspect ensures that there is primary call of retrieval teams to the site of the trauma in many cases, and that gets a specialist team on site much more quickly than the old system, under which the patient was initially taken to a rural hospital and then a decision was made to call a trauma team. That all took time.

The emergency services at Flinders Medical Centre have been upgraded, and it is intended that the Royal Adelaide Hospital will be upgraded in the near future. The completion of the helipad at the Royal Adelaide Hospital, which the Committee heard about earlier, has contributed further to effective trauma service. Reorganisation of services within the hospitals has also occurred, and there is now a much more organised response with early consultant involvement, which is important in getting the appropriate treatment to people as early as possible.

In rural areas, many GPs are now undertaking emergency management surgical training and, whilst not enough has been done in that area, it is progressively being upgraded. Following an earlier review of GP trauma services in rural and remote areas, regional arrangements, including the provision of additional equipment at hospitals, has been occurring. A very large percentage of rural general practitioners are now being trained. The trauma systems committee for South Australia, which was established, has now ceased but there will be an ongoing clinical trauma service which encompasses both the metropolitan and rural and remote area trauma services so that they can more closely coordinate the responses. Recent initiatives in telemedicine at the Julia Farr Centre demonstrate the effort being made to improve the lot of those persons suffering from severe trauma. That is a new initiative which seems to have had a great effect also.

Mrs GERAGHTY: What specific funding, if any, is provided for the needs of deaf/blind people in our society? Where in the health budget is it identified, and what is the level of that funding? I refer to page 316.

The Hon. M.H. Armitage: I ask Mr Karl Mortimer to provide an answer.

Mr Mortimer: The range of services provided to people who are deaf/blind or have a vision and hearing impairment is broad and varied, and the services are provided not just within the health and disability system but also within the education system. In 1991, the previous Government established a vision and hearing impairment service. That was a case management service and, as such, when options coordination was implemented, that service transferred and became part of sensory options coordination. At the time of that transfer, funding to that service was about $105 00 to $110 000. About 40 per cent of that was for staffing costs, the case manager and the oncosts, and the rest was specifically for brokerage funds for purchasing services. When that service transferred, the brokerage funds and the service money were quarantined specifically for people who are deaf/blind or have a vision and hearing impairment. An options coordinator is specifically employed and focuses on people who are deaf/blind or have a vision and hearing impairment.

In the disability sector, we fund a number of sensory disability agencies, including the Royal Society for the Blind, the Royal SA Deaf Society, the Guide Dogs Association of South Australia and Northern Territory and, within the Guide Dogs Association, a new service for people with a hearing impairment, and there is some funding to Townsend House. All these services would provide support to people who are deaf/blind, but it would be difficult to estimate whether it was 5, 10, or 20 per cent of their budget. Most people with sensory disability do not have just one: if they have a severe hearing loss, they are often losing their sight as well, particularly if they are aged. Many clients for an agency such as the Royal Society for the Blind are ageing and therefore losing both senses. It would be difficult to put a specific dollar figure on it, apart from the fact that we provide specific brokerage funds of about $50 000 to $60 000 for people who are deaf/blind within the sensory options coordination budget.

Mrs GERAGHTY: Mr Mortimer, you said that approximately $50 000 to $60 000 would be specifically targeted to the deaf/blind, and I refer particularly to that group. How many people would that cover? It would be a small number?

Mr Mortimer: It is a very small number. It depends on what definition of 'deaf blind' is used. We actually think of the broader group of people with a vision and hearing impairment. The deaf blind group, who have no sight and no hearing at all, is very small—fewer than 20 people in South Australia. Most of those people also have an intellectual disability and are accommodated in places such as Minda and Strathmont, and so already receive services relevant to their accommodation and support needs and would not necessarily access the brokerage funds of sensory options coordination. From memory, I think that approximately 120 to 150 people would have been referred to the vision and hearing impaired service and would still be supported by sensory options coordination in some way.

The Hon. M.H. Armitage: Earlier in the Committee I indicated that I would provide some information on the Modbury Hospital outsourcing budget and a cost benefit estimate for February 1995 to June 1997 in relation to the savings compared to the average hospital. The South Australian Health Commission determines funding to public hospitals on the basis of its casemix funding model, which has been developed over several years to provide funding on the basis of services provided by each hospital. The casemix funding model, as everyone realises, is quite complex but is continually evolving.

In 1995-96 the South Australian Health Commission casemix funding model would have provided the Modbury Hospital board with $40.6 million based on the levels of activity generated. The full cost of the Modbury Hospital under the South Australian Health Commission public funding arrangements would have been $41.3 million after making adjustments for budget variations and accrual accounting. The $41.3 million would be equivalent to the gross level of funding provided to hospitals under the public hospital funding arrangement. The total value of the South Australian Health Commission funding arrangement would be $40 632 184.

The adjustments include budget variations for enterprise bargaining, $290 000; accrual for earned but unpaid leave (long service leave, annual based on the Lyell McEwin Health Service), $316 000; a supplement for minor works (estimate), $164 500; and an adjustment for patient revenue fall-off (negative) $65 000, leaving an adjusted value of the South Australian Health Commission funding arrangement of $41 337 184. The actual cost to Government of Modbury Hospital services during 1995-96 was $37.6 million, includ-

ing all outsourced services and the cost of the board itself, and recognising receipts of payroll tax and insurance premiums from Healthscope.

These costs included: a payment to Captive Insurance for catastrophe insurance of $1.5 million; the cost of Modbury board operation, $138 900; and a number of items which are commercial in confidence, including the Healthscope contract price in 1995-96, the Gribbles contract costs in 1995-96, Benson Radiology supplemental contract costs paid by Modbury board, payroll tax for Healthscope, payroll tax for pathology, radiology and engineering and the insurance contribution by Healthscope, leaving the total annual cost of Modbury board in 1995-96 of $37 605 531. The savings to Government in 1995-96 compared to the funding that would have been provided under the South Australian Health Commission public funding arrangement to a hospital of average performance was approximately $3.7 million. That is made up of the cost of the Modbury board using the South Australian Health Commission pricing model of $41 337 184, minus the net cost of the Modbury Hospital in 1995-96 of $37 605 531, leaving the savings compared with the average hospital of $3 731 653.

There were then the savings resulting from the elimination of cost overruns at Modbury Hospital. The casemix funding model is essentially a tool to apportion funds to each hospital, assuming that it operates at an average level. Each year some hospitals are able to achieve their targets with lower than average costs, whilst others either are unable to meet their activity targets and/or incur a deficit. Typically, additional funds may be loaned to the underperforming public hospitals to allow them to meet their financial obligations, with the expectation that these loans will be recovered in the future. Traditionally, Modbury Hospital's cost of treating inpatients had been above the average funding level and between 8 and 15 per cent more expensive than Lyell McEwin Health Service, the most similar hospital in terms of size.

The contract involves additional savings by offloading risk of cost overruns at Modbury. These consist of: the savings on inpatient inliers of $3 485 683; the savings on outpatients of $1 106 180, the savings on long-stay outliers, $129 740; and the savings on short-stay outliers of $202 980. Therefore, the total Modbury cost savings on overruns relative to the average funding level is $4 924 583. However, a more realistic estimate of achievable reduction in the cost overrun at Modbury Hospital as a public sector hospital in 1995-96 would be about $3.4 million. In the opinion of the Chief Executive Officer of the Health Commission, the best estimate of the benefit of the Modbury Hospital outsourcing during the 1995-96 financial year is $7 million.

Mr Clarke interjecting:

The Hon. M.H. Armitage: No, I am paid to give answers to the questions that I was asked before.

Members interjecting:

The CHAIRMAN: Order! The Committee will come to order.

Mr Clarke interjecting:

The CHAIRMAN: Order! The member for Ross Smith is out of order.

The Hon. M.H. Armitage: Over the full contract term to date, the estimate of the benefit of the Modbury Hospital outsourcing would be in excess of $16 million—the last five months of the 1994-95 financial year, $3.4 million; 1995-96, $7 million; and the balance in the not yet complete 1996-97 financial year. An estimate of the benefits derived from Modbury Hospital by the State Government is currently being prepared by external consultants.

Mr Clarke interjecting:

The CHAIRMAN: Order! The member for Ross Smith is out of order.

The Hon. M.H. Armitage: That assessment will be completed and released within a month and a copy of it provided to all members of the Committee.

Ms STEVENS: My question refers to page 314 of the Program Estimates, in relation to palliative care services. The Lyell McEwin Hospice has been in need of a Director of Medical Services for some time. I understand that there is a submission before the South Australian Health Commission for $100 000 for this position. Will the Minister provide any information about whether this money will be forthcoming so that the position can be filled as soon as possible?

The Hon. M.H. Armitage: I am informed that a submission may have come in in relation to that matter literally yesterday. I know that we are a Government that moves with the speed of light, but that is a bit much even for us. We will obviously assess it. I have not seen it: it arrived on our doorstep yesterday.

Mr CLARKE: Given that I am one of the Minister's poor constituents who happens to suffer his representation in State Parliament, I would like to raise a couple of points. First, I would like to thank the Minister for being able to have here tonight more advisers than George Bush had when he settled the Cold War in 1989 with Mikhail Gorbachev. And at least when he consulted with them, George Bush got an answer. I want to turn the Minister's attention to the issue of the Head Injury Society, the Club Friday organisation that runs from my electorate and the Hampstead Centre in Northfield. What Government funding is available to existing organisations, such as the Head Injury Society working voluntarily in the community, to enable those organisations to deliver therapy and social activity programs to head injury survivors in the community?

This organisation that operates out of the Hampstead Centre does so on a purely voluntary basis. Many of the clients of that centre are persons regarded as not being in the mainstream. They are adult persons who are so severely head injured that their chances of re-entering the mainstream of society are extremely limited. According to my advice from it, that organisation has been precluded from tendering for grants from the Government department with respect to providing services that the organisation has been providing on a voluntary basis for a number of years.

Mr Brindal interjecting:

The CHAIRMAN: Order! The member for Unley is out of order.

The Hon. M.H. Armitage: The Deputy Leader is indeed one of my constituents, and I am delighted that he is and I presume that he enjoys my—

Mr Clarke interjecting:

The Hon. M.H. Armitage: I would have thought that, on the results of the last election, it was better for the honourable member in his own seat, as it was very marginal. I am lucky enough to represent from the Labor Party the present Deputy Leader, the present Leader, one former Federal member, a former State member whom the Deputy Leader beat in the present selection, a present member of the Legislative Council and a former State Premier. I am obviously doing something right as the member for Adelaide.

Members interjecting:

The CHAIRMAN: Order! Does the Minister wish to answer the question, because I am about to close the Committee?

The Hon. M.H. Armitage: I thought we would have a good bit of argy-bargy to finish off.

Mr Brokenshire interjecting:

The Hon. M.H. Armitage: I could make a comment about that, but I shall not. To respond to the question, I would like Mr Karl Mortimer to address the Committee.

Mr Mortimer: Earlier today the Minister outlined additional funding that was made available in 1996-97. In relation to the proportion of funds that were matched through the home and community care program, $225 000 was made available for people with brain injury for a range of programs including respite and day activities. In answer to the question about what level of funding may be available to groups such as Club Friday, the answer for 1996-97 is $225 000. Of course, part of the process of giving out that money will be through Options Coordination. Some of it will be targeted around individuals and some of it will be tendered to service providers.

Club Friday is run and coordinated by volunteers. At this stage it does not have any ongoing Government funding but relies on support from concerned individuals, many of whom are parents of the people attending Club Friday. Club Friday is a meaningful activity provided to people with head injuries. It operates under the aegis of the Head Injury Society of South Australia. One of the things Club Friday has done is demonstrate that the traditional way of providing services to people with head injuries in terms of day activities, which has largely been centre based and operated by the Julia Farr service, is not meeting everyone's needs.

The Brain Injury Options Coordination Agency has put out expressions of interest for running community networks of meaningful day activities for people with head injuries. In February 1997, an expression of interest document was forwarded to 10 service providers for consideration for the provision of community networks. At that stage the Head Injury Society of South Australia was not included in the mailing list because it had indicated that it wished to be considered as an advocacy agency and not as a service provider. The closing date for registration of interest was on 14 March, and a total of five responses were received. In consultation with the Brain Injury Options Coordination Agency and the private development unit of the South Australian Health Commission, the Disability Services Office developed a tender document for the provision of community networks and the document was released to the five service providers that had registered their interest in providing a service. That process closed on 20 June.

Meetings have been held with the President of the Head Injury Society of South Australia and a representative of Club Friday in relation to the tendering of community networks. We have provided the Head Injury Society of South Australia with a copy of the document and we have indicated that, should it wish to tender for the service, we will give it consideration.

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

Mr BRINDAL: I move:

That the draft report be the report of the Committee.

Motion carried.

The Hon. M.H. Armitage: I would like to thank everyone, including the member for Ross Smith, for the good humour in which they have approached this Committee. I particularly thank my staff and the members of the Committee who have been present a little longer than the member for Ross Smith. Mr Chairman, I congratulate you on your handling of a difficult role.

The CHAIRMAN: I thank the Minister and his advisers for their efforts during the long day, and also the members who have worked diligently and cooperatively with each other and with the Chair. I also thank the table staff and *Hansard*.

At 10 p.m. the Committee concluded.